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**HEALING PLURALISM AND RESPONSIBILITY:
AN ANTHROPOLOGICAL STUDY OF
PATIENT AND PRACTITIONER BELIEFS**

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ABSTRACT

Combining the use of alternative and complementary therapies and orthodox medicine is an increasing phenomenon. This thesis examines the implications of mixing and matching plural healing modalities against a backdrop of patient and practitioner responsibilities.

From an anthropological perspective, the predominant use of qualitative methodology is an integral part of this research project. Central to this study is the views of a variety of participant categories – patients who use both alternative and orthodox healing methods; non-medical alternative and complementary practitioners; medical doctors who integrate orthodox and CAM therapies into their daily practise; and orthodox general practitioners. Interviews with these participants took place over an eighteen-month timeframe and involved face-to-face interviews, telephone interviews, and focus group research. Social constructionist theory, which forms part of the compendium of interpretive theoretical approaches adopted under the medical anthropology paradigm, has been used in order to expose the beliefs patients and practitioners hold about their own responsibilities, and those of the other participant categories.

This study reveals a palimpsest of complex, contradictory and competing discourses in relation to patient and practitioner expectations and responsibilities. One important finding relates to the significance of neo-liberal and individualistic ideologies. This thesis concludes that the rhetoric from complementary and alternative practitioners, and their integrative colleagues, is heavily imbued with ideas about self-responsibility, particularly in relation to patient lifestyle choices and therapeutic compliance. Patients and orthodox general practitioners share some of these views but in general adopt a more collective approach to health care responsibilities. While patients are prepared to accept some responsibility for their illnesses and health keeping practises, they express strong reliance towards the orthodox health model as well as those doctors who practise integrative medicine. However the same cannot be said of their attitudes towards CAM modalities where considerable ambivalence is evident towards both practitioners and the therapies themselves.

The role of the state, and its responsibilities for the structure of the health care system in New Zealand, is also clearly influential in the construction of belief systems. This is especially so because the rhetoric underlying neo-liberal and individualistic discourses now permeates the direction of health policies. Increasing levels of surveillance, both at bureaucratic and individual levels, also attests to the influence of neo-liberalism and individualism. This study exposes the tensions between the rhetoric of self-responsibility and the lived experiences of patients and health practitioners, which in many cases is more collective in its focus than is initially apparent.

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ABBREVIATIONS

ACC	Accident Compensation Corporation
A&E	Accident and Emergency
CAM	Complementary and alternative medicine
CMA	Critical Medical Anthropology
Dr-CAM	A medical practitioner who practises both orthodox and CAM
EBM	Evidence Based Medicine
GMC	General Medical Council
GMS	General Medical Services
GP	General practitioner
GPCME	General Practitioner Continuing Medical Education
HDC	Health and Disability Commissioner
HPCA	Health Practitioners Competence Assurance Act (2003)
HPDT	Health Practitioners Disciplinary Tribunal
HRRT	Human Rights Review Tribunal
HRT	Hormone Replacement Therapy
IHC	Integrative health care
IPA	Independent Practitioner Association
MACCAH	Ministerial Advisory Committee on Complementary and Alternative Health
MCNZ	Medical Council of New Zealand
MD	Medical Doctor
MPDT	Medical Practitioners Disciplinary Tribunal
NCCAM	National Centre for Complementary and Alternative Medicine
NZASMS	New Zealand Association of Salaried Medical Specialists
NZCH	New Zealand Council of Homeopaths
NZCHP	New Zealand Charter of Health Practitioners
NZAMH	New Zealand Association of Medical Herbalists
NZMA	New Zealand Medical Association
NZQA	New Zealand Qualifications Authority
NZSON	New Zealand Society of Naturopaths
RCT	Randomised Clinical Trials

CHAPTER ONE

INTRODUCTION

I: Beginnings

The ubiquitous phrase *I want to take responsibility for my health* provided the impetus for this research project and a chance discussion cemented the topic. I was listening to a group of general practitioners (GPs) talk about aspects of their work when one of them began to describe his frustrations with a patient who was using both orthodox and alternative medical treatments¹. This patient had developed a boil on the back of her neck and initially decided to consult an alternative practitioner about the problem. Despite various treatments meted out by the therapist the situation had worsened and by the time the patient made an appointment with her GP she had required hospital admission in order for the boil to be drained and treated. The doctor was perplexed by the patient's attitude because, apparently, she believed that the responsibility for resolving the situation lay with him. The patient showed no signs of accepting that either she, or the alternative practitioner, may be in some way culpable for the problems she was now facing. The doctor wanted to know if it was his sole responsibility to 'pick up the pieces' when a patient chose to mix and match therapeutic modalities.

Thinking about the question of how responsibility (within the context of medical pluralism and patient and practitioner viewpoints) could be examined from a medical anthropology perspective I began to do some reading. The first paper I looked at on the subject of patients and medical pluralism proved to be an excellent jumping off point. Philip White (2000) presented a thought-provoking account of why patients use complementary and alternative therapies and promoted a more holistic and patient-centered approach to general practice. His article alerted me to the work of Ursula Sharma (1992; 1994; 1996) and I have found her research and analysis particularly insightful with regard to why people use a variety of healing modalities as well as detailing alternative practitioners' views on their therapeutic responsibilities. In tandem with Sarah Cant (1999), Sharma has also compiled a comprehensive account of how medical pluralism has affected health practitioners and patients and the implications this has for the state. The role of the state should not be underestimated because in most western societies it is the state that both

¹ I discuss these terms in Section IV of this chapter.

regulates the health sector and funds the majority of public health services. June Lowenberg's (1992) ethnographic research of a holistic family practice and a holistic dental office in the United States, and her subsequent analysis of how blame and responsibility for illness and healing is attributed, has been integral to my own study. Anne Hunsaker Hawkins' (1999) account of pathographies inspired me to search out and read the experiences of health and illness from the perspective of patients and health practitioners².

I think it is pertinent to point out at this stage that prior to embarking on research for this thesis I had very limited experience of orthodox medicine, and almost no dealings with complementary and alternative therapies. My personal experiences of orthodox medicine related to consultations over the years for a variety of minor ailments, pregnancy and childbirth, and my two children's coughs and colds. Marriage to a medical practitioner and the subsequent raising of step-children did little to greatly increase my knowledge of orthodox or alternative medicines, apart from witnessing members of my now extended family coping with asthma and food allergies through the use of inhalers and conventional therapies, and menstrual discomfort treated with Evening Primrose Oil. However over the period of this research project I have become increasingly exposed to a variety of orthodox and complementary and alternative therapies because of family and friends' ill health. I have witnessed the successful outcome of two major plastic surgery operations; wept copious tears over a close family member's cancer diagnosis and looked on as chemotherapy and radiotherapy and a host of other interventions have been used; and off-spring have managed to break limbs and needed either surgery or weeks in plaster (or both) to mend bones and recover mobility. At the same time as all these orthodox methods have been used I have been aware of alternative remedies being added to my family's healing compendia: arnica, ginkgo and other herbal remedies, as well as osteopathy and colour therapy.

II: The Research Question

The research question appears deceptively uncomplicated – when plural healing methods are used where does the ultimate responsibility for health care lie? The complication arises with ascertaining a clear understanding of what is meant by responsibility and how this is translated into the daily existence, that is - the lived

² An example of this literature includes John Dimond (2001, 1998); Michael Foxton (2003); Arthur Frank (1991); Atul Gawande (2002); Anne Hellman (2005); Robin Kelly (2000); John Lantos (1997); Sherwin Nuland (1994).

experiences, of patients and practitioners. For example, one of my research participants, Faye, described the expectations she had of health practitioners, and in doing so she revealed a complex and contradictory rhetoric surrounding the concept of responsibility:

I want [practitioners] to give me informed options and then it's up to me what I do with that. But if I decide on something I have to put my faith in them because I don't know enough to know if it's right so I suppose I have to take responsibility for that. Whatever they suggest and whichever option you take, if it's the one they specialise in they have that responsibility to ensure that I'll be okay and to give the best possible care and advice.

From an anthropological point of view I was also interested in whether this rhetoric was symptomatic of a change in the way New Zealand society regarded the use of plural healing methods. This question had been previously raised by Rosalind Coward (1989) (and critiqued by Ursula Sharma 1992:87-88) when she queried whether the use of complementary and alternative therapies represented a cultural change in western belief systems³. I thought it timely to re-examine this issue to see if a change had occurred, and if so, how this has impacted upon or influenced patient and practitioner perceptions of responsibility.

The concept of what responsibility means and how it should be enacted is complicated by the competing discourses of neo-liberalism, individualism and collectivism that inform our social sphere. Most western governments, including those in New Zealand, have adopted policies that have increasingly reflected neo-liberal ideologies. The most strident rhetoric accompanying these ideologies is one promoting individual responsibility. This does not just pertain to health, but to other areas that had previously enjoyed considerable state support. As I show throughout this thesis, patients and practitioners have constructed a number of strategies enabling them to negotiate between these competing discourses. The state is also complicit in the construction of varying strategies in order that it too can infiltrate and influence discourses concerning its perceived responsibilities in providing a publicly funded health care system.

III: The Research Project

This thesis is divided, somewhat arbitrarily because much of the material overlaps, into two main sections. In the first section a review of literature, while by no

³ Melinda Goldner (2004) questions whether CAM is a social movement as opposed to a belief system. She concludes that CAM is consumer focused and there is little evidence to suggest a desire for formal organisation or national leadership. Despite the emphasis on consumerist activity Goldner suggests that the CAM movement is influential in changing health care systems (ibid:19).

means exhaustive, contextualises the research topic and provides an overview of the two central themes of this study: the attribution of responsibility in a plural healing environment, and how neo-liberal and individualistic discourses have impacted upon and influenced the way this is done. The second part of the thesis is where my research participants' voices predominate. Although I have incorporated some of their views into the initial chapters of this thesis, it is in Chapters Six to Eight that detailed excerpts from the transcripts are revealed together with a comprehensive analysis of participant views on responsibility.

Chapter Two sets out the research methodologies for this project. Because I wanted to discover what various individuals and sector groups thought about the concepts I have outlined in my research question, qualitative methodologies have been central to my data collection and analysis. It is here that I outline how a social constructionist perspective has been integral to this study and justify the use of the medical anthropology paradigm. I describe the research methods used together with the development of the central themes of this study.

The research question provoked me into trying to define how responsibility, within the terms of this thesis, is actually constructed and how meaning to the concept is ascribed, and I explore these issues in Chapter Three. Responsibility is a complex idea and within the social milieu of this study, the discrepancies and tensions between the individualistic and collective responsibilities that underlie our belief systems are exposed.

The impact of individualistic ideologies is central to this thesis and Chapter Four reviews the role of the individual within neo-liberal society. Neo-liberal and individualistic discourses have dominated western societies since the late-twentieth century and I believe that many of these ideas have permeated alternative and complementary medical discourses, as well as state ideologies. This has resulted in a rhetoric advocating self-responsibility for both illness and healing. This rhetoric has become increasingly prominent and has been influential in determining the direction of government policy in defining what sort of public health service the state has a responsibility to provide. This rhetoric has also encouraged private sector investment in the health industry, clearly evidenced by an increasing number and variety of alternative and complementary therapies and training courses now available to the public.

In Chapter Five I outline the framework constituting the New Zealand health sector, from its inception during early colonisation to the contemporary model we experience today. I trace the development of both orthodox and alternative and complementary modalities and describe the influence science and technology has had in establishing biomedicine as the predominant medical model in New Zealand, and western societies generally.

The regulation and training of all health practitioners, orthodox and alternative, and how this impacts on patient and practitioner responsibility, is pivotal to this study and is discussed in Chapter Six. For example, professional bodies, such as the Medical Council of New Zealand (MCNZ), have their responsibilities enshrined in legislation to ensure that all doctors practising in New Zealand are appropriately qualified and registered. Alternative and complementary therapists currently operate within a much less regulated environment than biomedical practitioners. This situation has recently been under review by the Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) and its findings are outlined throughout this study.

Chapter Seven sets out patients' opinions of responsibility while Chapter Eight outlines the views of health practitioners. The research participants canvassed a range of topics that related to responsibilities within a plural healing landscape and these included: the etiology of illness; why mixing-and-matching of therapeutic modalities occurs; the importance, or otherwise, of diagnosis, holism, lifestyle choices, and financial responsibilities.

In essence, I have sought to understand how particular (although not necessarily homogeneous) groups view their responsibilities when a variety of healing methods are used. Do patients believe they cause their own illnesses, and if so, how does this influence their health-keeping behaviour? What expectations do patients have of the practitioners they consult, and are these expectations the same for all practitioners – orthodox and alternative? And what about practitioners – are the beliefs and actions of alternative and complementary therapists patently different from orthodox medical practitioners? How do they perceive their responsibilities; and what about the responsibilities of other sector groups: other practitioners, the patients themselves, and the state? This study focuses on the situation within New Zealand (although comparisons with other western societies are noted). Within the

context of research based on medical pluralism within New Zealand, a limited number of studies are available (see Dew 2003; Dixon et al 1977; Hadley 1988; Leibrich et al 1987; MACCAH 2004; Marshall et al 1990; Taylor 2003). No studies have focused on how a plural healing environment might affect health practitioner *and* patient views about responsibility. This thesis therefore addresses this situation.

IV: Terminologies

A variety of terms have been used throughout the course of this thesis and for the purpose of clarity I now outline these.

As I illustrate below, a search through literature focusing on orthodox, alternative and complementary medicines reveals that defining what is meant by any of the aforementioned terms is a contentious matter. For example, the terms can be pejorative; 'alternative' and 'complementary' healing systems being construed as inferior or subordinate to the biomedical model. On the other hand 'orthodox' and 'biomedicine' are also terms that can be imbued with negative nuances. This not only involves the healing model itself but also the people who work within it, especially doctors, because their position is viewed in terms of dominance and power within the health sector. This in turn invokes criticism relating to the disempowerment of patients as well as other health workers and other healing modalities.

I found further problems with terminologies when attempting to understand why certain therapies or healing modalities are described as orthodox, complementary and alternative. For instance is there a difference between alternative and complementary therapies, and if so, what is it? And can a particular therapy be both orthodox and complementary or alternative? If a registered medical doctor practises an alternative therapy does it then become orthodox? Is it as straightforward as slotting 'scientifically' proven modalities under an orthodox umbrella and relegating all others to categories such as alternative or complementary? In trying to sort out this complexity I found it important to set out which types of health treatment were included under the various modalities because ideas about responsibility are intrinsic to many of the therapies. A review of some of the literature discussing the various terms and their meanings is now outlined.

i: What's orthodox and what's not?

Orthodox medicine in this thesis refers to healing modalities conducted under a western scientific paradigm, although it is important to recognise that this form of medicine, as well as being practised by non-western individuals, also occurs in many non-western societies. In New Zealand orthodox medicine is the dominant model of health treatment available and practitioners such as doctors, dentists, nurses and physiotherapists receive their training at state funded tertiary institutions. At the completion of their training practitioners are required to be statutorily registered under the Health Practitioners Competence Assurance Act 2003 before they can practise. Support of orthodox medicine as the predominant model in New Zealand society is reinforced through the funding it receives from the state (largely through taxation revenue). Central government provides funding for public hospitals and health administration, it subsidises general practice and midwifery, and supports health research (White 1991:4). Taxpayer funds are also used to pay for accident compensation (through the office of the Accident Compensation Corporation) which can include payment for some complementary and alternative therapy treatments.

Some of the words most commonly used to describe orthodox medicine are biomedicine, orthodox, allopathic, conventional, modern, and scientific medicine (for a further discussion on terms relating to orthodox medicine, see MACCAH 2002:5-6). White (1991:4) argues against the use of the term 'scientific' because this presupposes that some healing modalities, especially those incorporated under an alternative or complementary paradigm, are not scientific. Such a contention, she believes, has yet to be proven. The other terms mentioned appear in a variety of literature, however, all categories of participants I spoke to clearly understood what was meant by orthodox medicine and biomedicine, hence these two terms are used interchangeably throughout this thesis. However, I have also on occasions incorporated other terms or descriptions used by my research participants.

And so what healing modalities fit into the orthodox category? For the purposes of this thesis orthodox medicine includes therapies and practices provided by statutorily registered health professionals, such as medical practitioners, nurses, physiotherapists, dentists, psychologists and chiropractors (Leibrich et al 1987:1). Osteopaths became a statutorily registered profession while I was undertaking research towards this thesis, hence leaving me in a quandary as to whether to

include the modality as orthodox or not. Because I interviewed osteopaths prior to the passing of the legislation, for the purposes of this thesis, I decided to include osteopathy as an alternative or complementary therapy, at the same time recognising the contestability of this decision.

ii: **What's complementary and alternative medicine?**

A wide-ranging number of descriptive terms are used when discussing complementary and alternative medicine: holistic, traditional, unconventional, natural, fringe, alternative, complementary, complementary and alternative medicine (CAM), non-orthodox and heterodox, to name a few, and attempting to negotiate the nuances behind the terminologies can be confusing. As Kevin Dew (2003:18) eloquently points out:

A problem in defining what alternative medicine means is that what is perceived to be alternative at one time may not be perceived as alternative at another; indeed, even at the same time people differ in their views about what is alternative and what is orthodox.

This is especially pertinent in the case of therapies such as chiropractic and, as outlined above, osteopathy. As Dew (2003:42-57) notes, chiropractic in New Zealand used to be considered more an alternative than orthodox modality. However, the findings of the Commission of Inquiry into Chiropractic in the late 1970s recognised chiropractic as having some scientific foundation and viewed the treatment as a “speciality rather than an alternative healing system” (ibid:51). One outcome of this inquiry was the statutory registration of chiropractors in 1982 and their subsequent incorporation into an orthodox medical paradigm. As Leibrich et al (1987:1) demonstrate in their report for the New Zealand Department of Health on complementary and alternative medicine, chiropractic was listed as one of the modalities offered “within the western orthodox health care system”. In September 2004 osteopathy became a statutorily registered profession under the provisions of the HPCA Act (2003) and it is likely that, given time, osteopathy will also be viewed as more an orthodox, as opposed to an alternative modality. However, despite supposed acceptance by many sectors of society, opposition to chiropractic and osteopathy being labelled ‘orthodox’ is still prevalent (see for example, Crelin 1989) and they are still considered alternative or complementary therapies by some commentators.

Alternative and complementary medicine cannot be considered a homogeneous paradigm because of the diverse range of therapies on offer and their different ideologies. I outline below some of the literature surrounding three main categories: alternative medicine, complementary medicine and complementary and alternative medicine (CAM). It is acknowledged that there are many other descriptions available (for example, see Saunders 1996).

Alternative Medicine

What is meant by 'alternative' medicine? For some patients and practitioners alternative therapies are perceived to be neither aligned with nor complementary to orthodox medicine. For instance, alternative therapies may be construed as incorporating ideals that are absent from biomedicine, such as the importance of working in harmony with nature, individuality, patient as a partner in the healing process, and unconventional or alternative world views (Fulder 1996:4-7; Sharma 1992:5). These views can be problematic because there are orthodox practitioners (especially those involved in general practice) who argue that their model of medicine is holistic (Adams 2001; Cant and Sharma 1999:8) and that the relationship they have with patients is non-hierarchical. Several GPs I spoke with said they saw themselves as holistically orientated. They also supported patient autonomy as opposed to adopting a hierarchical relationship during consultations. However, it is recognised that some practitioners are adamant the therapies they offer are 'alternative' to orthodox medicine and they do not want to be seen providing a type of health care that is in any way aligned with orthodox medicine. Ursula Sharma illustrates this point when recalling an interview she held with a homeopath - who said "homoeopathy is not complementary to orthodox medicine. It is an alternative and the patient has to make the choice" (Sharma 1992:159). Another point of view was expressed by a herbalist I interviewed:

I think somehow along the line the whole health thing has got a bit twisted because herbal medicine was the original medicine and it's actually the drugs which is the alternative medicine, but drug medicine has stolen everything, they've even stolen the word 'drug'. The word drug meant dried herb and so they stole that word and if you look back through history there has been constant friction between the doctors and natural therapists and it's still happening today.

(Lorna, herbalist)

Alternative and complementary therapies can be perceived as marginal compared to orthodox medicine for a number of reasons (Dew 1998). First, many therapies do not attract government subsidies. Second, course fees for students wanting to study alternative and complementary modalities are often unable to attract government

subsidies. And third, many alternative practitioners are unable to gain access to hospital facilities and patients. Further marginalisation occurs because, currently, there is a little in the way of legislation or audit regulating the practice of alternative therapies.

Pietroni (cited in Fisher and Ward 1994:107) argues against the use of the terminology 'alternative therapy', believing it to be pejorative because it defines therapies by what they are *not* as opposed to what they *are* (see also Cant and Sharma 1999:8-9; White 1991:3-4). Fisher and Ward (1994:107) propose the term 'unconventional therapeutic methods', but Dew (2003:19) disagrees because he believes this ignores the philosophical underpinnings of many of the therapies and concentrates instead on their methods. Dew prefers the use of the word 'alternative' because it denotes that "there may be differences between therapeutic philosophies that cannot be reconciled and that are not complementary" (ibid:19). Cant and Sharma (1999:8-9) also support the use of the term 'alternative medicine' because it is, internationally, a widely used and recognised description. However they also acknowledge and use other terms as detailed below.

Complementary Medicine

In 1986 the Department of Health commissioned a report on complementary and alternative therapies in New Zealand. This report defined complementary medicine in the following way:

Complementary therapies are those diagnostic healing or health promoting techniques which are not usually offered within the western orthodox health care system (that is, care provided by statutorily registered 'health professionals' which include medical practitioners, nurses, physiotherapists, dentists, psychologists and chiropractors) (Leibrich et al 1987:1).

At the beginning of the 1990s Sharma advocated the term 'complementary' because it implied a co-operation with orthodox medicine and, she believed, reflected "patients' actual behaviour and practitioners' views" (1992:6). Fulder contended that the term 'complementary' depicted a partnership with scientific medicine, while still recognising the differences between the modalities (1996:3). Saunders (1996:103) believed that unorthodox therapies should be seen as "additional or complementary" to biomedicine as opposed to replacing it. Willis (1994:64-69) also supported the term 'complementary', stating that it did not imply ideas about healing modalities being inferior or superior to one another. However, there is an

argument that the term does in fact support existing hierarchical structures, which currently favour orthodox medicine (Dew 2003:19; White 1991:5).

Complementary and Alternative Medicine (CAM)

In more recent years the acronym CAM (complementary and alternative medicine) has become increasingly popular. For example, the White House Commission on Complementary and Alternative Medicine (2001) defined CAM as:

...a group of medical, health care, and healing systems other than those included in mainstream health care in the United States. CAM includes the worldviews, modalities, products, and practices associated with these systems and their use to treat illness and promote health and well-being.

Although heterogeneous, the major CAM systems have many common characteristics, including a focus on individualizing treatments, treating the whole person, promoting self-care and self-healing...Unlike mainstream medicine, CAM often lacks or has only limited experimental and clinical study; however, scientific investigation of CAM is beginning to address this knowledge gap. Thus, boundaries between CAM and mainstream medicine, as well as among different CAM systems, are often blurred and are constantly changing.

In Britain, the House of Lords Select Committee on Science and Technology (2000) described CAM as a “diverse group of health-related therapies and disciplines which are not considered to be part of mainstream medical care”.

In New Zealand, MACCAH (2004:1) recommended the following definition, derived from O’Connor et al (1997)

Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well being.

As can be seen from the discussion above, there is ongoing debate as to what terms and definitions should be used to describe the plethora of healing therapies and modalities on offer in western societies. For the purposes of continuity and clarity, I have adopted MACCAH’s recommendation and will use the acronym CAM to describe complementary and alternative therapies throughout this thesis as well as the terms complementary and alternative interchangeably. However other data utilised during the research process, such as interviews with patients and

practitioners, will incorporate the terms these people use, such as natural or holistic medicine.

iii: Integrative Health Care

Integrative health care⁴ (IHC) is a term that is creeping into the plural medical lexicon. However, David Hollenberg (2006) points out, there is debate over whether the terms integrated or integrative mean the same thing. In general, either term is considered to refer to the combining of both biomedicine and CAM models. However, some commentators argue that ‘integrated’ care is a model which maintains physician control in the consultation process, whereas ‘integrative’ care suggests the merging of the orthodox model into a “new health paradigm” (ibid:733). I have decided to adopt the term integrative medicine when referring to the type of healing utilised by medical doctors who combine the use of biomedicine with CAM therapies and I also describe patients and practitioners mixing and matching their therapeutic options.

iv: Healing Modality Categorisation

Because I interviewed patients and practitioners about the types of healing systems they used, it seemed appropriate to clarify which modalities were considered CAM. MACCAH’s research and recommendations are very recent and pertinent to New Zealand therefore I have used their categorisation model (Figure 1, p.13) to outline which modalities should be considered alternative or complementary to orthodox medicine. This categorisation was based on a model developed by the National Centre for Complementary and Alternative Medicine (NCCAM) (2001). However, it should be noted that chiropractic, although listed here as an alternative modality, is aligned in New Zealand with orthodox medicine as it is a statutorily registered therapy. Throughout this thesis I use the words therapy or treatment to describe specific and general healing interventions, together with phrases and descriptions provided by the research participants.

⁴ See also Caspi (2001); Maizes and Caspi (1999); Rees and Weil (2001) and Schroeder and Likkel (1999) for discussion regarding interpretations of this term.

Table 1: Model of Categorisation (MACCAH)

Sourced from MACCAH *Terminology in Complementary and Alternative Health* (2002:14)

Group 1: Alternative medical systems	Examples
Alternative medical systems involving complete systems of theory and practice that evolved independently of, and often prior to, the biomedical approach. Many are traditional systems of medicine that are practised by individual cultures throughout the world.	<ul style="list-style-type: none"> • Ayurveda • traditional Chinese medicine • Pacific traditional healing systems • homoeopathy • naturopathy
Group 2: Mind / body / spirit interventions	
Mind–body interventions employ a variety of techniques designed to facilitate healing. Only a subset of mind–body interventions are considered CAM. Many that have a well-documented theoretical basis (for example, patient education and cognitive-behavioural approaches) are now considered ‘mainstream’.	<ul style="list-style-type: none"> • hypnotherapy • rebirthing • spiritual healing
Group 3: Biological-based therapies	
This category includes natural and biologically based practices, interventions and products, many of which overlap with biomedicine’s use of dietary supplements.	<ul style="list-style-type: none"> • herbal medicine • homoeobotanical therapy • biological therapies
Group 4: Manipulative and body-based therapies	
This category includes methods based on manipulation and/or movement of the body.	<ul style="list-style-type: none"> • chiropractic • osteopathy • massage (therapeutic and remedial) • Alexander technique
Group 5: Energy therapies	
Energy therapies focus on either energy fields originating within the body (biofields) or those from other sources (electromagnetic fields).	<ul style="list-style-type: none"> • chi kung • reiki • touch for health • bioelectromagnetic-based therapies

v: Patients or Clients?

Again, deciding what to call the users of health services is open to debate. Within the CAM modalities many practitioners refer to the people who seek their services as ‘clients’ or ‘customers’. Some orthodox and Dr-CAM practitioners do this as well, although it is a less common practice. One reason for using the term ‘client’ or ‘customer’ is that it may denote a non-hierarchical relationship between client and practitioner. It also recognises that people pay for consultations themselves. However, during interviews I held with all healing practitioners the majority referred to the people who came to see them as ‘patients’. The users of the medical services I talked to all referred to themselves as patients, and therefore I decided to use this term throughout the thesis when describing people who seek health treatment, whether it be orthodox or CAM.

vi: Practitioners

The people involved in practising both CAM and orthodox medicine are described by a variety of terms. CAM practitioners are often referred to as therapists, health professionals/practitioners, healers or by their particular modality, such as homoeopath, herbalist, naturopath, osteopath and so on. Occasionally the title ‘Dr’ is used, and this practice will be further discussed in Chapter Six.

For those working within biomedicine, practitioners are often referred to as doctors, general practitioners or GPs, medical specialists (for example, orthopaedic surgeon, physician and cardiologist), nurses, midwives, dentists, physiotherapists and psychologists.

Throughout this thesis I will refer to CAM practitioners as therapists, health practitioners or their professional title (eg: naturopath) and medical personnel as doctors, orthodox or medical practitioners or their professional nomenclature (eg: dermatologist). Doctors who practise integrative medicine are referred to as Dr-CAMs

vii: Medical/Healing Pluralism

Medical pluralism is a term that is increasingly evident in the lexicon of mixing and matching therapeutic options (see Cant and Sharma 1999; Sharma 1992:28-30; Stevenson et al 2003). While I have used this term on occasions, I felt uncomfortable adopting it as a blanket description in this thesis because of the connotation ‘medical’ has with biomedicine. As such I have generally adopted the term ‘healing pluralism’ because I believe this best reflects the views of my research participants. Many of them talked in terms of looking for healing options as opposed to medical ones.

V: Conclusion

As this chapter shows, the complexity of the field of healing pluralism and responsibility is reflected through competing and conflicting discourses. The rhetoric from patients and health practitioners is often contradictory and the state’s role in shaping discourse about individual and collective responsibility adds to the complex nature of the research topic. Further evidence of this complexity is evident through the variety of terms used to describe healing pluralism: the modalities

themselves, the practitioners, the users of health services, and so on. Many of these terms remain contested.

CHAPTER TWO

METHODOLOGY: FRAMEWORK, THEMES AND METHODS

I: Introduction

The central theme of this study relates to discovering how patients and health practitioners attribute responsibility when plural healing methods are used. As I mentioned in the previous chapter, my interest in this topic was initially piqued by seemingly contradictory statements expressed by a woman about not only her own levels of responsibility in relation to her health care, but also those she attributed to CAM and orthodox practitioners. I decided that in order to explore the subject of responsibility and healing pluralism I would need to elicit the views of patients and health practitioners who either used or practised both orthodox and CAM modalities. From the outset of this project it was clear that beliefs relating to illness, healing and responsibility are part of a complex interweaving of personal and socio-cultural interactions and therefore the methodology I used would have to cope with this complexity. To this end a medical anthropology perspective has been adopted, and social constructionist theory has proved a useful, although not exclusive, tool. Sections II and III outline the reasons for these approaches.

Glaser and Strauss (1999), proponents of the grounded theory approach, advocate that researchers keep an open mind about the theoretical framework(s) they use. This is because analysis might reveal information or insights that are best suited to a different or new theoretical approach than what was originally anticipated by the researcher. This happened to me during the course of this research project. The methodological framework I use is interpretative in nature, drawing its conclusions from a literature review that encompassed not only anthropological, and in particular medical anthropology, viewpoints, but also fields as diverse as New Age religion, biomedical and CAM literature, and ethical and philosophical discussions on responsibility, individualism, and professional and personal autonomy. As such the medical anthropology and social constructionist frameworks proved both instructive and useful. However, it was the opinions of my research participants, especially the CAM and Dr-CAM practitioners, as well as some of the literature, that alerted me to the paradoxes and contradictions evident when ascribing responsibility. These paradoxes and contradictions were, I found, fuelled by a neo-

liberal rhetoric that has now infiltrated CAM and biomedical discourses as well as New Zealand's political, economic, social and cultural environment. Alongside these discourses are the rhetorical strategies adopted by a variety of groups and individuals as they attempt to negotiate these different spheres. For example, while neo-liberal discourse promotes freedom of choice and individual responsibility, there is a concomitant political and bureaucratic rhetoric advocating increased surveillance of individuals by the state. This can be seen through the implementation of nation-wide government-funded health screening and immunisation programmes. It would seem that these concepts - freedom of choice and surveillance - are ideologically incompatible, and yet rhetorical strategies blur and confuse the distinctions between these different discourses.

Throughout this thesis I discuss the impact of neo-liberalism and how its philosophies have influenced healing modalities and the health sector in general, as well as New Zealand's social landscape. Chapter Four, in particular, focuses on the increasing prominence of individualistic ideologies as opposed to those of a collectivist nature and signals the contribution of neo-liberal discourse to this change.

This research project has seen the development of two main themes: the attribution of responsibility, and the role of the individual in a neo-liberal society. Both these themes are discussed within the context of health and illness in New Zealand's increasingly plural healing environment. While these themes are threaded throughout this thesis, I introduce them in Section IV and present a detailed exposition of how each is pertinent to this project in Chapters Three and Four.

Intrinsic to this research project has been the use of qualitative research methods. Section V describes the reasons for this approach, while Sections VI-XI examine the methods used.

II: Medical Anthropology

Medical anthropology is a sub-discipline of anthropology and its origins can be traced back to the 1950s. However, as Foster (1975:427) points out, even before this era ethnographies had been written which contained observations about the healing practices of the exotic 'other' (see for example, Evans-Pritchard 1937). During the 1930s and 1940s the culture and personality movement saw anthropologists collaborating with psychiatrists and following World War II

anthropologists turned their attention to international health care projects (Foster 1975:427). This work was instrumental in establishing medical anthropology as a viable and dynamic discipline (Joralemon 1999:13), largely due to the ethnographic approach of focusing on extensive and intensive participant-observation fieldwork. Contemporary examples of ethnomedical research include Allen (1988), Brown (1991), McElroy and Townsend (1989), Nichter and Nichter (1996) and Singer and Garcia (1989). Over the past twenty years medical anthropologists have included in their investigations not only those with an ethnomedical stance focused on the 'other', but have also turned their gaze inward to study their own society's beliefs about health, healing and illness¹.

And so what is medical anthropology? One of the best descriptions of medical anthropology I have read comes from Peter Brown (1998:1). He says:

Medical anthropology provides a unique way of understanding the human experience. This is because all human beings – irrespective of culture, class, or historical epoch – experience sickness and death. Simultaneously, all cultures – irrespective of technological complexity – have medical systems that help people cope with the inevitability of sickness, just as all cultures have religious systems that deal with the inevitability of death. Medical anthropology tries to understand the causes of health and illness in societies. Our own health is influenced by the environment, our genetic inheritance, and, most importantly, our socioeconomic circumstances; all of these factors interact in complex ways.

It is this holistic approach to studying the human experience of health and illness that I believe makes medical anthropology so appealing because it reveals the "social and cultural variables affecting health, illness, behaviour, medicinal practices, and medical beliefs" (ibid:8). It is a discipline open to both social scientists and health professionals and is especially pertinent to researchers wanting to develop a thorough understanding of how lay and professional people view their experiences of health and illness (Macdonald 1999:116-117). As Arthur Kleinman, (a psychiatrist trained in anthropology) argues, a positivistic perspective on health and illness can produce a limited understanding and appreciation of the socio-cultural factors behind ill health:

¹ See for example Angrosino and Scoggin 1987; DiGiacomo 1987; Good and DelVecchio Good 1993; Jaye 1998; Lowenberg 1992; Martin 1994; McGuire 1988; Ohnuki-Tierney 1984; and Sharma 1992, 1994 and 1996). Some of these studies are sociological in origin as opposed to adopting a strictly anthropological focus. However as demonstrated in Lowenberg (1992) for example, the fieldwork in many of these studies is ethnographic in nature and I believe can be included within the anthropological paradigm. See Foster (1975) for a discussion about the similarities and differences between the medical anthropology and medical sociology disciplines.

...positivistic scientism and atheoretical pragmatism discourages attempts to understand illness and care as embedded in the social and cultural world. Their [doctors'] reliance on 'common sense' often masks ignorance of relevant behavioural and social science concepts that should be part of the foundation of clinical science and practice (Kleinman 1981:xii).

And it is the cultural and social setting that both health researchers and health practitioners need to pay particular attention to because an analysis of these areas helps reveal the human *experience* of health and illness. Kleinman points to cross-cultural studies as being fundamental to developing an understanding of lay perspectives because they embrace a holistic approach revealing medicine as a cultural system where both individuals and social institutions respond to the illness experience (ibid:24). This study however is not cross-cultural as participants are drawn mainly from a Pakeha, middle-class background. In saying this I do point out that New Zealand society cannot be viewed as a homogeneous unit because of differences relating to class, gender and ethnicity, and certainly a cross-section of views is revealed throughout the thesis. It is also important that the biological aspects of illness are not ignored at the expense of cultural viewpoints (Romanucci-Ross et al 1991:421) and I believe that in order to obtain as holistic an understanding of participants' belief systems as possible, it is incumbent upon a researcher to at least remain cognisant of biological and clinical factors, while retaining a focus on socio-cultural aspects.

Ideas about health, including those relating to orthodox and complementary and alternative medicine, are embedded within New Zealand society, and adopting a medical anthropology approach to this research project has revealed ideas to do with responsibility as well as beliefs and understandings about the health care system in this country. While health care systems may incorporate "patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; socially-legitimated statuses, roles, power relationships, interactions settings, and institutions" (Kleinman 1981:24), individuals and institutions respond to these factors in different ways. It has therefore been necessary to adopt a variety of methods during this research project to elicit information from the different participant groups. The research methods I have used are largely qualitative and include face-to-face interviews with patients and practitioners, telephone interviews

and focus groups with practitioners, correspondence, and attendance at seminars and conferences, and these methods are described in detail in this chapter.

While I have described the advantages of medical anthropology as a research tool, particularly its holistic approach, in providing an understanding of both biological and cultural beliefs to health and illness, not all researchers working within the discipline support this approach. In particular critical medical anthropologists argue that there are other components of health and illness that need to be closely examined and I outline some of these in the following section.

i: Critical Medical Anthropology

Singer and Baer, the original proponents of Critical Medical Anthropology (CMA), describe their perspective in the following way:

Critical medical anthropology understands biomedicine not solely as a socially constructed system embedded in a wider cultural pattern, nor only as a mechanistic and depersonalizing structure with important social control functions in contemporary society, but more broadly in terms of its relationship with the truly global capitalist world economic system (Singer and Baer 1995:33).

CMA offers a critique of biomedicine, often invoking a political economy focus (see Singer 1998). It questions the relationship biomedicine has with those who possess power and how this has helped the biomedical model achieve a privileged position in many societies. This situation, in tandem with capitalistic ideologies, has strongly influenced the way health care is now delivered². CMA also challenges the biomedical view of women and the resultant treatments meted out, especially in the fields of obstetrics and gynaecology (Singer and Baer 1995:35). It studies the effects of colonialism and neo-colonialism and the impact this has had on health services in Third World countries. CMA has also turned its attention, in more recent years, to the area of medical ecology.

² Hans Baer and Charles Hughes' (1987) study into the implementation of a state funded health care programme in the rural district of Utah (America) offers a CMA perspective. Their research revealed complex and competing interests between various sectors of these rural communities, which in the main negatively impacted on the success of the programme. Much of the negativity related to the conservative political philosophies held by many of the physicians and community bureaucrats who resented "unwarranted government intervention" in the delivery of health care (ibid:39). In essence, these individuals appeared more concerned to preserve their own financial and political autonomy as opposed to providing an adequate health service to the communities they worked in.

Supporters of CMA argue that medical anthropologists have tended to support or at least accept a subservient position in relation to biomedicine and have therefore come, perhaps unwittingly, to be viewed as ‘handmaidens’ to the medical profession and “capitalist hegemony” (ibid:5). In order to ameliorate these concerns CMA advocates that medical anthropologists need to take into account the micro and macro viewpoints that help formulate experiences of health and illness and be mindful of the political and economic forces that often underpin belief systems (Shorter 1986; Singer and Baer 1995; Tesh 1988). There is dismay in some quarters regarding the apparent “medicalisation of anthropological training” (Singer and Baer 1995:32) where social science subjects have been discarded in favour of those with a biomedical component³. CMA also critiques the way that social problems are becoming increasingly medicalised (ibid:31) giving medical practitioners increasing power over the general populace⁴.

Although CMA has focused its critique on the biomedical model of health care, it has also cast a critical gaze upon the way complementary and alternative therapies are practised in the West. CMA questions the way CAM provides a “rather limited holism, in that [its] focus is largely on the individual rather than on society and its institutions” (Baer 2003:245). In other words CAM remains supportive of the individualistic approach to health care and has not challenged the status quo in relation to health problems caused by “stress in the workplace, socioeconomic inequities, racism and environmental pollution” (ibid:240). Strong echoes of these concerns are also found in the writings of Coward (1989), Crawford (1978; 1980), Freund (1982:31-35) and Lopelman (1981). In this thesis I challenge the assumptions of CAM as a holistic and egalitarian form of medicine because of its strong individualistic focus.

As described above, the disciplines of medical anthropology and critical medical anthropology broadly consider the universality of illness and healing and the way lay, professional and research groups respond to these. A number of theoretical perspectives are used to underpin these disciplines, including those with an interpretative focus. Social constructionism is one of these and while I have not

³ While it is beyond the scope of this thesis to provide a definitive history of medical anthropology/critical medical anthropology, for a further discussion on the argument that anthropologists have been ‘over-medicalised’ see Singer, M. and Baer, H. (1995:29-33).

⁴ cf Seedhouse, D. (1990:xvii-xxx).

used it to the exclusion of other approaches, it does form the theoretical framework of my thesis and I outline its approach in the following section.

III: Social Constructionism

Although the following quotation is long I believe it is worth including here as it outlines the benefits of social constructionism:

...[social constructionist theory] is a useful one in the field of sickness and health because it leads to an investigation of the ways in which both professional and lay people construct explanatory cultural schema about the physical realities of the body in nature. Because health professionals must be licensed or registered by some controlling authority, their construction of ideas about health and sickness often reflects official ideology, as the critical theory approach notes. The history of their discipline (especially for doctors and nurses) also contributes to their present definitions of their roles, but might not be useful in confronting the panoply of lay constructions of sickness and health. By contrast with professional models of health (which are usually positivist), there is an almost infinite variety of ways in any society through which people come to understand their bodies, the ways to keep them healthy, and what to do when they break down...the complexity of responses required of health professionals is almost insurmountable (Macdonald 1999:116-117).

In other words social constructionism is a useful tool enabling researchers to unravel the complexities of human discourse and lived experiences, and for this reason it provides the theoretical framework of this thesis. As Gergen (2003), Lupton (1994) and Schwandt (2003) indicate, the construction of our belief systems should not be seen as ‘truth’ but as knowledge gained through social relationships pertinent to a particular socio-historical epoch. What humans do is

...invent concepts, models, and schemes to make sense of experience, and we continually test and modify these constructions in light of new experience...there is an inevitable historical and sociocultural dimension to this construction. We do not construct our interpretations in isolation but against a backdrop of shared understandings, practices, language, and so forth (Schwandt 2003:305).

All facets of human interaction concerning ideas about bodies and their relationships with different groups of people, such as what it means to be a patient or a health practitioner, are viewed as being socially constructed (Shilling 1993:70). For example, none of the participants I spoke with regard the body as solely a biological entity but viewed it in terms of being affected by its environment and psychosocial experiences. The ideas we have about our bodies are “shaped, constrained and even invented by society” (ibid:70).

Of particular interest to medical anthropologists are not only the socio-cultural aspects of the biomedical and CAM environments, but also the way “medico-scientific and lay medical knowledges and practices” have been constructed (Lupton 1994:11). For example, ideas about why we get ill are complex. A medical practitioner may understand that a patient diagnosed with Hodgkin’s Disease has a condition which can be defined in biomedical terms as a “disease of lymphatic tissue characterized by the presence of Reed-Sternberg cells and variable proliferation of lymphocytes and histiocytes” (Moore 1967:1087), whereas a lay person’s idea of why they are ill may relate to a more metaphysical etiology. As one of my patient participants said to me:

I do wonder if [ill health] is connected to our emotions and spirituality...and our physical health is a side effect of that. (Faye)

In other words the beliefs of patients and practitioners have been socially constructed – either through personal and social experiences and/or medical school or CAM training. By adopting a social constructionist approach a researcher is attempting to “uncover” or “deconstruct” “underlying meaning and values” and uses a variety of tools to do this focusing on qualitative and interpretive methodologies (Lupton 2000:52).

IV: Themes: Responsibility and Individualism

These themes are manifestly difficult to explain because they are subjective. To use a *palimpsest* metaphor, these themes are like layers of paint on a canvas and are overlaid and intertwined by other colours, other brush-strokes and other shades. To separate them out into discreet entities is problematic, but for the purposes of this thesis I have elaborated each theme in detail in the following two chapters. However a brief overview of these themes is warranted here.

Responsibility, of course, is at the core of this research project. Its concept is malleable depending upon ideologies and worldviews. It is one thing to suggest that individuals should be responsible for their own health when they are healthy, and quite another if they are faced with a serious illness. It may be easier to say that people should be responsible for meeting the cost of their own health care if they have a steady job and a good income, but a student or single parent or a family on a low income might believe the state should provide free or easily affordable access to health professionals. Health practitioners and health providers also have

differing views on responsibility: the role of the practitioner, ethical considerations, beliefs about the cause of sickness, their expectations of patients, and the degree of regulation and legislation the state imposes upon them. Similarly the state and health bureaucrats also perceive responsibility from different vantage points, such as the need for fiscal restraint, legislation to ensure health practitioners are adequately trained, and the provision and regulation of therapeutic drugs.

Along with responsibility, individualism is also a prominent theme. New Zealand has experienced a number of shifts in political ideology: from the individualism of early European settlement to a political climate favouring collectivist policies and then, from the late-1970s, a swing again towards individual responsibility. These ideological shifts have been evident throughout the West and New Zealand's socio-political and socio-economic environment has reflected these changes. As economies ebb and flow repercussions have become evident because social policies have been scrutinised and policy directions changed. Right-wing governments have tended to support individualistic policies, while left-wing politicians have favoured a more paternalistic attitude to social spending, especially within the health sector. However in New Zealand both political factions have become increasingly individualistic in persuasion and as a result, increasingly reliant on the private sector to provide additional health services.

Another manifestation of individualism has been a challenge to authority (Heelas 1996). Traditional hierarchies that formerly existed within orthodox religions and the conventional medical model have come under attack for being paternalistic, autocratic and patriarchal. A consequence of this for the biomedical model and its adherence to science and technology has been increasing pressure for those who work within this system to adopt a more patient-centered approach towards its mode of delivery. Another result of the challenge to medical authority has been the growth of alternative and complementary therapies. These modalities have gained an increasing share of the health sector market because they appear, amongst a raft of reasons, to offer a more holistic approach to health care based around a non-hierarchical relationship between patient and practitioner.

Ideas about autonomy mirror many of those contained within individualistic ideologies. There are some individuals who want to make health care decisions for

themselves and are seemingly prepared to accept the consequences of their actions. In short, these patients want to be treated as autonomous beings, to be considered as partners in the consultation process and be given access to information so they can make informed decisions about their health care. Many health practitioners now view contemporary bureaucratic society as impinging on their right to practice autonomously. The privileging of administrators over medical personnel in the health sector highlights changes and the possible deprofessionalisation and proletarianisation of the health workforce.

V: Qualitative Research

While all the above comments focus on the relevance of medical anthropology and CMA as paradigms to use with regard to health research in general, I believe their greatest advantage and most exciting aspects can be found in the discipline's predominant use of qualitative research methods. By utilising these types of methods the stories of research participants are often to the fore of analysis undertaken. It is this attribute that enables their *voices* to be heard. In my case it was the stories of patients and health practitioners that I was particularly interested in. I now discuss the variety of research methods used in this project.

First I asked myself - what is meant by qualitative research? There is a plethora of literature on this subject, with some particularly applicable to health sector research⁵. I believe that Denzin and Lincoln (2003) offer a very comprehensive commentary on qualitative methodology and their definition is well worth quoting here in full:

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of them, or to interpret, phenomena in terms of the meanings people bring to them (Denzin and Lincoln 2003:4-5).

Health researchers are often presented with an environment that involves interpretation of a diverse range of areas including emotional, political and technical arenas (Rice and Ezzy 1999:ix). In order to elicit as 'thick' a description

⁵ See for example Crombie and Davies 1996; Denzin and Lincoln 2003; Firestone 1987; Helman 1991; Maykut and Morehouse 1994, and Rice and Ezzy 1999.

(Geertz 1973) and interpretation as possible, qualitative methods are vital to this type of research project and hence have been the predominant paradigm used. As David Helman (1991:120) states "qualitative research is particularly useful in studying why people act in particular ways and in investigating the relationship of beliefs and behaviour to one another". Such an ethos is very relevant to this research project because by finding out *who* is perceived as having the ultimate responsibility for health care, the actions of those who use and practise orthodox and CAM medicine, as well as those who control access to health care, can be carefully scrutinised. Qualitative research methods have enabled beliefs and behaviour patterns to be revealed and, most importantly, uncovered some of the reasoning behind them.

Qualitative methodology is an intrinsic component of anthropological research because it provides a platform for a holistic understanding of a particular culture, society or group of people. It is a tool to help researchers gain insight into the action and words of individuals in order to develop insight into how participants construct and give meaning to events in their lives (Maykut and Morehouse 1994:18). It helps researchers reveal the minutiae of participants' daily lives, which in turn allows for a comprehensive analysis of a research topic and, most importantly as I outlined above, it enables participants' stories to be told. For example, Ann Hunsaker Hawkins' (1999) excellent research on pathographies, and the anthropologist Robert Murphy's (1998) poignant autobiography about being diagnosed with a slow-growing cancerous tumour affecting his spinal cord, provide interesting if not sobering insights into the lived experience of illness for both patients and their caregivers⁶.

The strengths of qualitative research are contained within the "concrete depiction of detail, portrayal of process in an active mode, and attention to the perspectives of those studied" (Patton 1980 cited in Firestone 1987:20). It is worth noting that

⁶ As well as the readings recommended on page 2, the following offer interesting insights. For example, Susan DiGiacomo's (1987) view of illness through her role as both patient and anthropologist when describing her experiences of being diagnosed with and then treated for Hodgkin's disease. For insight into the perceptions of doctors coping with their own ill health see the pathographies edited by Harvey Mandell and Howard Spiro (1987). Chrys Jaye and Hamish Wilson's (2003) study into the experiences of doctors as patients, and as practitioners to doctor patients, highlights the tension both roles bring to the healing encounter (see also Thompson et al (2001) for research on a similar topic). I also recommend Saunderson and Ridsdale (1999), and David Watts (2005) for insight into how medical practitioners view aspects of their chosen profession.

there is an increasing body of research literature relating to the role of CAM and Dr-CAM practitioners⁷. However, Simon Williams and Michael Calnan (1996) argue that very little detailed qualitative research has been done in relation to lay perspectives of medicine within western societies. What has occurred has been a plethora of consumer satisfaction surveys. This has meant that "lay experiences and evaluations of modern medicine" have been ignored (ibid:2). To some extent, this research redresses this situation.

Recognising that qualitative research methods contained the qualities I wanted for this project, I then asked myself - how do I as a researcher actually carry out the research? What methods do I employ? Again Denzin and Lincoln (2003:5) provide a useful guide: qualitative methodology involves the use of a variety of empirical material such as "case study; artifacts; cultural texts and productions; observational, historical, interactional, and visual texts – that describe routine and problematic moments and meanings in individual lives".

Once I had decided upon the methods I needed to employ, I needed to be clear about the type of information I was actually looking for. For example, I knew that I was not primarily interested in the efficacy of CAM or orthodox therapies per se, or data that could easily be quantified, such as how many practitioners' patients visit or the number and type of illnesses they experience. While some demographic information was collected (see Appendix I) my prime focus was to uncover ideas about responsibility; the thoughts people had on this subject and how these concepts impacted on their lives and behaviour patterns. I wanted to hear the views of the participants in their own words.

As well as the more formal research methods I describe I believe it is pertinent to mention here that while I was carrying out my research I had many informal conversations with a wide variety of people about my thesis topic. Some of these people were family and friends, some academic colleagues, others were people I met at social gatherings or had just struck up a casual conversation with while shopping, sitting in a waiting room or even talking to a teller at a bank. I became aware that nearly everyone I spoke with had a story to tell about their health or their experiences with a range of healing modalities and therefore I also gathered a

⁷ For example Adams 2000, 2001, 2003; Adams and Tovey 2000; Budd and Sharma 1994; Cant and Sharma 1996, 1999; Lowenberg 1992; Featherston and Forsyth 1997; and Sharma 1992, 1996.

significant amount of anecdotal evidence. To this end I found the description offered by Denzin and Lincoln (2003:5-9) of a qualitative researcher as a “*Bricoleur* and Quilt Maker” very evocative and meaningful. The *bricoleur* was an analogy originally used by Claude Levi-Strauss (1966) when discussing the concept of mythic thought. Levi-Strauss perceived a *bricoleur* as a ‘do-it-yourself’ person who carried out a wide and diverse range of tasks using “whatever is at hand” (ibid:17). Denzin and Lincoln have built on Levi-Strauss’ concept: like a ‘do-it-yourself’ handyman, or perhaps a painter, musician, film-maker, quilter or other type of artist, a researcher has at his or her disposal a wide range of implements and methods they can use to create their project⁸. They can employ “different voices, different perspectives, points of view, angles of vision...they move from the personal to the political, the local to the historical and the cultural...they create space for give-and-take between reader and writer” (ibid:7-8). It was within this context that I adopted a multi-method approach to my study. I used a variety of interview techniques: semi-structured face-to-face interviews, telephone interviews and focus groups. I also wrote letters and emails to key personnel at training and practitioner organisations. I reviewed relevant literature, attended CAM and orthodox medical seminars and conferences (I presented a paper at the inaugural 2004 MindBody Conference in Auckland) and visited CAM health festivals. In the following section I give a brief overview of these methods and then describe in detail how I used them for this research project.

VI: Semi-Structured, Face-to-Face, In-depth Interviews

I held a number of interviews that had the following components: they were semi-structured, face-to-face, and in-depth. For the purpose of clarity I am going to define these types of interviews as in-depth. However I acknowledge that deciding what label to give this type of interview is contentious. Rice and Ezzy (1999:52-53) prefer the terminology of in-depth interview because they believe describing qualitative interviews as semi-structured infers that they are a “watered-down version of structured interviews” (ibid:53) which are often prevalent in quantitative analysis. To add to this argument Minichiello et al (1990:93) believe that in-depth interviews should involve *repeated* face-to-face encounters. However Kelleher

⁸ I believe that Levi-Strauss views the *bricoleur’s* binary, the *engineer*, as being the more intellectually capable partner in this pairing. However I doubt this implication is what Denzin and Lincoln intended by using this example because social science researchers need both the practical and intellectual skills exhibited in Levi-Strauss’ analogy.

(1993) prefers the term semi-structured to describe interviews he held with people dying from cancer. Many of these interviews were 'one-offs', usually because of the precarious state of many of his respondents' health. The interviews he and Ezzy and Rice describe in their research occupied a variety of time schedules: half an hour, two hours, and sometimes multiple interview sessions. However usually interviews are one-off occasions lasting for around ninety minutes.

In-depth interviews involve a conversation between a researcher and a participant. It means the researcher asks the participant questions about a certain topic or topics and the participant talks about his or her views and experiences. By having these types of conversations, researchers "can gain access to, and subsequently understand, the private interpretations of social reality that individuals hold" (Minichiello et al 1990:87). Interviews are semi-structured when an interview guide is involved, in other words the interviewer has a list of questions which focus on the research topic, but these are not asked in any fixed order and the wording is not always kept the same (ibid:92). This allows the interviewer flexibility and allows for a greater in-depth examination of the participants' views.

In the following section I describe how I developed an interview guide for my research, located participants, and then carried out the interviews.

i: The Interview Guide

As I have mentioned above, the pivotal strategy used to examine participants' ideas about responsibility and other related issues was by way of in-depth interviews with two groupings pertinent to the research topic: patients and health practitioners. The interviews I carried out were face-to-face and semi-structured in as much as I had an interview guide with me as a prompt to ensure certain topics were discussed. However this method did not preclude the interviews being of a conversational nature with a wide variety of aspects covered and I anticipated the interviews would reveal information I had not previously considered. As new information or ideas came to light these were then incorporated into the interview schedule. An example of this occurred during interviews with patients when an initial analysis of data from the first few interviews revealed contradictory opinions regarding expert knowledge and expectations of health providers. More specific questions regarding these areas were then included in subsequent interviews. Although there

were a number of areas I wanted to discuss, the approach adopted meant that the interview schedule was not rigidly adhered to and interviews were conducted more as conversations as opposed to a question and answer format. Respondents were therefore encouraged to express ideas and opinions about a variety of topics, which was important in both building up a relationship between myself and the participants, and the eliciting of detail concerning the research questions.

Participants within the patient category were the first to be interviewed and a pre-test of the interview schedule was held with two individuals (the information from these two sessions was not included in the overall analysis of data) to ensure the questions were comprehensible and in an appropriate sequence. However, as described above, it was acknowledged that participants were likely to discuss information at random and I only used the interview schedule as a general guide and prompt.

ii: Coding

After an initial literature review a number of themes became apparent and a loosely structured list of open-ended questions was devised for all groups to be interviewed (see interview schedule for patients, Appendix II and CAM practitioners, Appendix III). As I was compiling the questions I also inserted a code name beside it (these are seen highlighted in bold in the interview guides). This was in part a measure put in place to justify the reasons for asking the question as well as preparation for the coding process that would follow transcription. Throughout the interview process data was systematically analysed and if new themes emerged, further codes were allocated⁹.

iii: Interviews with Patients

After deciding on the interview structure my next task was to find people to interview. I wanted to speak to patients who were using both orthodox and CAM therapies and this category of participants was located using snowball sampling methods. This involved asking a participant if they knew of other people who might be prepared to take part in an interview. Sometimes my participants were able to oblige (for instance one woman I interviewed gave me a list of four possible

⁹ For an example of similar approaches to coding see Daly, J., Kellehear A. and Gliksman, M. (1997).

interviewees) and at other times participants were unable to suggest any further contacts. For example, the first person I spoke with, Jack, was known to a faculty graduate student. She spoke with him and asked if he would be interested in taking part in my research project and when he agreed, I followed up that lead. Similarly for all the other interviews, I phoned the participants, introduced myself, reiterated how I had been given their name as a possible contact and explained the nature of my research. I then asked if they would agree to an interview and, if so, arranged an appointment time and location. I also asked the participants if they would be agreeable to my taping the interviews. The majority of the participants were interviewed in their own homes. I also held one interview at my office at the university and one in my home. In total seven people (1 male and 6 female) were interviewed¹⁰.

The response rate was very gratifying. I approached eight people and all agreed to be interviewed. However, one woman said because of her current commitments to work and family she would not be available for an interview for several months, and I therefore decided not to include her in my possible list of participants.

Upon my arrival at the interview participants were given an information sheet about the research project (see Appendix IV together with consent forms Appendices V and VI). All of the interviews were tape-recorded and lasted between one and two-and-a-half hours. In hindsight I believe it would have been better to send the participants the paperwork prior to the interview, as it would have given them an opportunity to read and digest the material at their leisure. I amended this procedure for my other groups of interviewees.

The Participants

Throughout this thesis direct quotes from my research participants are used and I have also included a 'word portrait' of each of them in this chapter. The detail is limited in order to protect their anonymity but my general impressions are recorded.

¹⁰ The gender distribution of my participants reflects overall patient use of health services. Results from the Ministry of Health's New Zealand Health Survey *Portrait of Health* (2004) indicates that 85.5% percent of females visited a GP in the previous 12 months compared to 75.7% of males. Similarly, 29.2% of females had consulted with a CAM practitioner in the previous 12 months compared to only 18.4% of males.

Jack was the first participant and only male patient interviewed. He was in his sixties and had worked as a builder for many years before deciding to make and market an office product that he had 'invented'. I think he was surprised at the success of what had started as a hobby had turned into a flourishing business. He showed me around his workshop, which was located in the basement of his house. We sat in an enclosed glass porch at Jack's home and his wife very kindly provided us with coffee and biscuits as we chatted. Jack had been diagnosed with osteosarcoma affecting a leg and had undergone various treatments, finally culminating in amputation of the limb from above the knee about three months previous to our interview. He said that he was monitored closely as this type of cancer was known for its malignancy and he said that the chest x-rays he underwent were checking for "spuds in my lungs". Despite a relatively conventional lifestyle he said that he had always used alternative therapies alongside orthodox ones.

Genevieve was in her late thirties and a post-graduate student working on a doctoral thesis (we had much in common!). She was strikingly attractive and I was surprised to hear that she had struggled with quite a number of health problems from a young age, including anorexia. She had approached me about being interviewed because she had heard about my research topic and was very keen to talk about her experiences, especially because she had found the use of CAM very helpful. She described ongoing health problems, some of which were psychological in nature.

Phyllis was the eldest participant I interviewed and was in her seventies. She was a small-boned ball of energy. Previously married to a farmer she had been widowed some time ago. As well as owning a few acres of land, she was a stalwart of her community's Senior Net group, and also carried out a considerable amount of voluntary work. Her childhood was spent in rural Northland and she said it was a healthy atmosphere to grow up in and her family 'lived off the land'. She appeared wary of orthodox medicine and I wondered whether this might be because of her experiences of a sister dying when she was aged only twenty-nine. Phyllis also mentioned that her own son had died some years ago, but gave no details. Phyllis was enthusiastic about the use of CAM and she described visiting a therapist who used an 'Iphis' machine. Amongst its repertoire was a facility to reveal a patient's past lives. In Phyllis' case she was told she that in "1504 I was a serf in Asia".

When I asked, with some skepticism, if she believed this information, she replied with an emphatic “yes”.

Faye was in her thirties and separated from her husband. She had two primary school-aged children and cared for them and also attended university part-time and worked as a gardener. She had previously worked in the mental health sector. She described a peripatetic lifestyle, which had at one point involved drug and alcohol abuse. She struck me as being a passionate person: passionate about her children, her studies and making a future for herself. The way she dressed and the décor in her home were suggestive of her leanings towards an ‘alternative’ lifestyle.

Elizabeth was in her thirties, married with no children, and worked full-time as a manager in the tertiary education sector. She detailed a long history of health problems, including migraines and joint and back pain; pain is a constant feature in her life. An immigrant to New Zealand she expressed unhappiness with the way the health sector here was managed, especially the waiting times at public hospitals and the way she was unable to access the results of x-rays or blood tests without having to go through her doctor.

Sarah was a petite woman in her forties and separated from her husband. She was attending university and had previously worked as a school teacher. She lived alone. Her childhood was spent in the Pacific Islands and she said that her use of herbal medicine had started then and continued throughout her life. Although rarely ill she did towards the end of our interview concede to a period of post-natal depression where she had been prescribed Aropax and said that coming off that drug had been a “very bad experience”. I noticed some paintings in her living room and when I commented on these she acknowledged herself as the artist. She said she used painting as a way to sort her life out, and had turned to it when her marriage had broken up. One of the recent paintings was her way of dealing with the death of her sister-in-law who had been killed in a car accident.

Stevie was a larger-than-life personality. In her fifties, married and working as a nurse in a rural hospital, she was passionate about the use of complementary and alternative therapies. Her grandmother and mother had both been nurses and had also used, what Stevie termed, “Maori medicine”. Stevie also expressed strong

religious beliefs. I found her a complex character: she enjoyed working in hospitals but was frustrated by what she saw as biomedicine's rejection of CAM. She had tried to persuade the hospital authorities to implement some aspects of CAM, but with little success.

iv: Interviews with Health Practitioners

When people are unwell they follow a hierarchy of resort as far as intervention is concerned. First is self-medication, second is talking to family or friends and third, people approach chemists or natural health shops for advice. If they do not feel any better the next rung of the hierarchy is a visit to an orthodox practitioner and if that type of treatment is deemed unsatisfactory then patients may try complementary or alternative medicines (Sharma 1996:235). I wanted to interview practitioners who used both orthodox and CAM modalities and I therefore considered general practitioners (GPs) would be the most appropriate category to speak to because there are an increasing number of doctors involved in this type of practice. However, I also wanted to speak to CAM practitioners, and GPs who did not practice CAM, to ascertain whether their ideas about responsibility differed from the doctors who incorporate CAM into their healing armamentarium. I chose to interview CAM practitioners who were of a more orthodox or conventional genre as opposed to those who practice 'fringe' modalities, such as spiritual surgeons or colour therapists. I did this because I believed that generally patients would consult the more 'orthodox' CAM practitioners more readily than those on the fringes and to a large extent this belief was borne out by the health seeking practices disclosed by the patients I interviewed.

Participants within the health practitioner category were located through a variety of means. CAM practitioners were selected from the Yellow Pages section of the Waikato/King-Country telephone directory. Letters (see Appendix VII) were sent to five practitioners requesting an interview and an information sheet and consent forms were also attached. A follow-up phone call was made several days after the letter had been posted and all agreed to be interviewed. After an initial analysis of three interviews I became concerned about some of the information revealed. This related to right-wing views expressed by the participants and I wondered whether these were representative of CAM practitioners generally. I decided to contact five more CAM practitioners to ascertain the validity of the data and all but two of these

practitioners agreed to be interviewed. One practitioner refused on the grounds that she was no longer practising because of family commitments, and another practitioner, although initially agreeing to be interviewed, postponed our meetings several times and so in the end I elected not to continue pursuing this potential participant. Interestingly, one participant contacted me prior to my making the follow-up phone call to say she was very interested in my research and would like to be interviewed. These further interviews confirmed the original analysis. Interviews were conducted with four male and four female participants. All participants gave permission for their interviews to be recorded.

I also interviewed one Dr-CAM practitioner in-depth. All other participants from this category were interviewed by telephone and the reasons for this are outlined in the following section. Again, I forwarded the information sheet and consent forms to the practitioner prior to the interview and was allowed to tape-record our conversation. This was one of the longest interviews I held, lasting well over two hours, though part of the reason for this was because of continual interruptions. Several phone calls were put through to the practitioner while the interview was in progress and he left the room to deal with these. Also, the receptionist repeatedly phoned through to the practitioner advising him that a patient was waiting to be seen. This person had apparently requested an urgent consultation and consequently had been given an appointment at the end of the working day. I suspect the doctor had not originally intended that he would have any more patients to see once our interview was under-way and had not anticipated that our discussion would have to be conducted within a specific time frame, although in my introductory letter I had suggested interviews would last about an hour. The repeated interruptions from the receptionist meant that the flow of the conversation became difficult to retain and at times both the participant and I lost the thread of what we had been talking about. It also put me on edge because I became concerned I was taking up valuable consulting time and I felt pressured to complete the interview as soon as possible. In the end the receptionist actually walked uninvited into the room interrupting our conversation to again remind the doctor that the patient was waiting, a fact he and I were both acutely aware of, and I offered to end the interview. The practitioner said he would be available for a follow-up interview if I needed one and was agreeable to my request for email contact if required.

This experience highlights two problems that can occur during interviews – those of time constraints and interruptions. Asking people to take part in interviews, especially during working hours, has its limitations. Of the seven CAM practitioners and one Dr-CAM practitioner I had in-depth interviews with, only two of these were held outside working hours. One practitioner requested that the interview be held at his home during the evening and another participant was interviewed in my home. Interviews with the other participants took place in their consulting rooms either during working hours or at the end of a working day. Unlike the interview I have described above, all the other in-depth interviews with practitioners flowed smoothly and without interruption. I was mindful of time constraints and limited the interviews to around about an hour in length. However, some of them did last up to ninety minutes.

Participants – CAM Practitioners

Lorna was in her fifties and had been a social worker before deciding to study herbalism. While she utilised a variety of modalities the mainstay of her practice was based around the medical herbalism paradigm. She was in her early fifties and displayed a very pragmatic and no-nonsense personality and was particularly focused on CAM as a business – as she said to me – all she saw was “opportunity”.

Margaret was also a herbalist. After obtaining a Masters degree in science she had worked for some years as a research scientist, but had found that unfulfilling. Her father was a GP and had been unimpressed by her career change. She said one of the reasons she was drawn towards working within a CAM environment was that now that she had young children she was keen that they be offered gentler medications than those utilised under the biomedical model. She worked in sole practice, although tutored part-time at a herbal college. Her consulting rooms were attached to her house and while comfortable, also maintained a clinical feel as many of the remedies were lined up along shelves behind Margaret’s desk. I was reminded of being in a chemist shop.

John was an osteopath in his early forties; his consulting room was austere and so was he. I found it hard to imagine that any patient would readily confide in him. John had left school and initially attended university but after staying just a year left and subsequently worked as a carpenter for many years. His interest in osteopathy

had come about after hearing how a young boy's leg was saved from amputation through the use of this therapy. While he was quite prepared to discuss the philosophies and mechanics of osteopathy, my questions in relation to responsibility were answered, on the whole, sparingly.

Hugh, another osteopath, was the complete opposite to John. Urbane and charming, he had been trained in Britain and was one of the more altruistic CAM practitioners I interviewed. Before training as an osteopath he had worked as a chef and had travelled extensively. Quite a few members of his family worked in the biomedical sphere and he had initially encountered resistance and skepticism from them when he chose to study osteopathy. However, Hugh said that his father had been involved in a car accident and sustained serious injuries and Hugh had been able to offer him considerable relief through his osteopathic skills, hence much of the skepticism had dissipated. While Hugh maintained that patients should accept a large degree of responsibility towards their health, he also believed that patients should never be blamed for their illness or failure to recover.

The third osteopath I interviewed, Steven, had worked for many years as a secondary school teacher before travelling to Britain, where he decided upon a career change and had become interested in osteopathy. He had also developed a strong interest in nutrition. He worked in private practice as well as at a medical centre in his local town. He was a fairly pragmatic individual and said that while some osteopaths also incorporated counselling into their practice, he was happier working on his patients' "musculo-skeletal system". A note in my research diary following the interview (1 October 2003) records my following impression:

Initially I thought his views were quite conservative – wasn't too harsh about orthodox medicine – but as he talked he moved into the realm of immunisation (against) and was quite enthusiastic of modalities such as colour therapy because it involves energies – and a more alternative point of view emerged.

April worked part-time as a Bowen and massage therapist and homeopath. A shy woman in her early fifties she was very hesitant about being interviewed because she believed she would have very little to offer me. She had trained as a nurse but had left to be married before completing her final exams and had subsequently lived on a farm and raised a family. After attending a massage course her interest in alternative medicine had grown and she had travelled long distances over four to

five years to obtain qualifications in the therapies she now practised. Although she spoke of patients being responsible for their health, she, like Hugh, showed an altruistic spirit and of all the CAM and Dr-CAM practitioners I interviewed, was concerned about the cost to patients and she charged very modest fees. I really enjoyed my interview with April and came away thinking that she possessed some 'gift' that could make a patient feel 'better'.

The mainstay of Joseph's practice was built around his qualifications in physiotherapy and homeopathy. He sat at a large old-fashioned desk during the interview (and I sat on a very uncomfortable chair!). The room was very much like a doctor's consulting room with an examination couch along one wall. He was vocal about the need for a more transparent regulatory system in relation to the training and qualifications of practitioners, but more reticent about the regulation of health supplements (the sale of which was an important component of his business).

Glenda came to my house to be interviewed and was a large-boned woman in her late fifties-early sixties. She had worked as a nurse both in New Zealand and overseas. Following the break-up of her marriage she completed a herbal medicine course and was now involved in Bioptron light therapy. She was passionately enthusiastic about this therapy and had brought a considerable amount of literature with her to show me. Much of what Glenda talked about related to her religious beliefs and how the treatment she offered was 'metaphysical'. Glenda talked incessantly, often not in relation to the questions I asked, and I experienced some difficulty in bringing our interview to a close.

VII: Telephone Interviews

I also held semi-structured telephone interviews. The advantages of using this method are various. First, it enables the researcher to collect information from geographically scattered participants in a much more cost-effective manner than face-to-face interviews (Thomas and Purdon 1994:1). Second, telephone interviews tender to be shorter than face-to-face interviews and this may appeal to participants who have busy timetables, thereby encouraging them to take part in research projects (ibid:5). Third, because the interviewer and participant are not visible to one another, in certain research situations where sensitive or contentious topics are discussed, participants may be more inclined to agree to an interview

situation where they remain physically anonymous (ibid:5). However critics of this approach point to the problems of obtaining a representative sample, non-response rates and information validity (ibid:2-5).

I sourced likely participants from anecdotal and personal knowledge, and newspaper and medical journal articles. Anecdotal evidence suggested that medical doctors are notoriously difficult to interview because they are usually busy and preoccupied during their working day, and many of them also have on-call commitments after-hours. I was also aware that cost factors would preclude me from travelling around New Zealand to conduct face-to-face interviews (this is the reality of undertaking research on the gratefully received but limited funds provided by a university doctoral scholarship). Because of these two factors - time constraints relating to doctor availability for interviews, and travel costs - I decided to carry out all but one of the interviews for the 'doctors-who-practise-CAM' category by phone. The interview schedule was pruned to last between 30-60 minutes, in an effort to encourage doctors to participate (Appendix VIII). Letters Appendix IX) outlining the research project were sent to seven practitioners located throughout New Zealand, attaching an information sheet and consent forms. Telephone calls were made a few days later and interview times arranged. Six of the practitioners contacted agreed to being interviewed, and five of these interviews were carried out over the phone. I made numerous phone calls to one practitioner and was always advised by the receptionist to phone at another "more suitable" time and despite doing so received the same message from her, and eventually I decided not to follow that lead any further. As described in the previous section, one participant, who lived within a reasonable driving distance from my home, agreed to a face-to-face interview. The phone interviews lasted between thirty minutes to an hour and a half. All but one of the participants agreed to have the interviews taped.

One of the advantages of being able to interview participants from a wide geographical area was that it was much easier to preserve the anonymity of the practitioners. Within the Waikato-King Country region only a small number of medical doctors publicly advertise that they practise CAM, and if interviews had been held with doctors from this area alone, there was a distinct possibility they could have been identified. Another advantage was that, as mentioned above, in light of the difficulties in getting medical doctors to agree to take part in research,

telephone interviews offered participants an opportunity to be interviewed when it best suited them (one phoned me early morning and said she had a half hour free “now” if I wanted to talk to her; another suggested lunch-time; and all the others preferred to be interviewed in the evening). By paring down the interview schedule and suggesting that the interview would only take approximately half an hour, but with the proviso that email follow-up could occur if necessary, the time taken to participate in the research was not too intrusive in what is usually a busy time-schedule for these health professionals.

Disadvantages of this method include the inability to develop much of a rapport with participants, especially because it is not possible to take into account body language and so on. Initially I lacked confidence in relation to interviewing such well-qualified ‘experts’ and when there were pauses in the conversation I had to be careful not to misconstrue these as either a participant not understanding a question or thinking that the line of questioning was not particularly worthwhile. However, in general it proved to be a worthwhile technique as it enabled me to talk with a broad range of participants and, most gratifyingly, all participants contacted were very interested in the research topic and appeared happy to be interviewed.

Nearly all participants from the practitioner groups expressed an interest in my research findings and to this end an executive summary will be sent to all participants at the conclusion of the research project.

Participants – Dr-CAMs

The vignettes I can offer about these practitioners are brief, as I only interviewed one of them face-to-face, and in half an hour to an hour over a telephone it was difficult to build up much of a mental picture about each of them. All of them were well-spoken and aged in the mid-forties to early sixty range. I did meet Julian at a conference some time after our interview (I went and introduced myself – he was wearing a brightly coloured Hawaiian shirt) and he was a gregarious and enthusiastic personality. I enjoyed talking to Peter who combined anthroposophical medicine with his general practice. He ran educational groups for his patients – both in the area of children’s health and adult biographies. Bob was quietly spoken and said that acupuncture was where his main interest lay. He had built up a good rapport with practitioners of other modalities near his practice and talked about the

need for co-operation between the different groups. Fran was the only female GP-CAM I spoke with and seemed a fairly pragmatic personality. She said she thought that some of the other GPs she dealt with thought she was a 'bit weird' because of her use of homeopathy. Brian was an enigma to me – he was outrageously outspoken about Maori, people receiving welfare benefits, and 'alternative' lifestylers. I wondered if he actually understood what the discipline of anthropology was based around when he commented that he did not want to treat Maori! And yet at the same time he appeared concerned that orthodox medicine was not meeting the needs of many of the population and said he was passionate about his use of alternative therapies and that he "loved" his work. The only GP-CAM practitioner I met for an interview was Ernest. His consulting room offered the most stunning view of any office I have ever been in and was beautifully appointed. He was a very lean and fit looking person and conservatively dressed. I interviewed Ernest at the start of my sessions with practitioners who had 'alternative' leanings, and it was here that I first encountered a discourse imbued with neo-liberal and individualistic ideals.

VIII: Focus Groups

I held two focus groups with general practitioners. This type of research usually involves a small group of participants. Ten to twelve participants used to be considered an optimum number (Krueger 1994:ix); however ideas have changed and smaller groups are now preferred as they are easier to set up and manage and it also gives participants a greater opportunity to take part in the discussion. The participants usually have similar backgrounds and are likely to have common experiences and ideas (Kitzinger and Barbour 1999:7, Rice and Ezzy 1999:72). The moderator or researcher puts a topic to the group and encourages in-depth discussion between participants (Rice and Ezzy 1999:72). It is the interaction between participants that often results in this method being a dynamic and cost-effective form of interviewing (Greenbaum 1988:18). Greenbaum (ibid:18-19) also notes two main advantages to using focus group methods:

1. People usually feel more comfortable offering their views as part of a group discussion as opposed to being interviewed on an individual basis.
2. Interaction by a group usually generates more information than individual interviews are able to do.

In other words, focus groups offer participants a permissive environment where different points of view are accepted (Krueger 1994:6). Another advantage of this type of research tool is that questions are open-ended, enabling

...individuals to respond without setting boundaries or providing clues for potential response categories. The open-ended approaches allow the subject ample opportunity to comment, to explain, and to share experiences and attitudes as opposed to the structured and directive interview that is led by the interviewer (ibid:7).

However as Lynn Mitchell (1999) points out, much depends on the research topic, and at times a combination of methods is appropriate, especially if the information sought is of a sensitive or intimate nature. She argues it is important that attention be paid to the “sensitive composition” of groups and although some participants may thrive in a situation where they can share experiences, other people may be both “silenced and marginalized” by the group experience (ibid:45).

Because anecdotal evidence indicated practitioners were unlikely to want take part in individual face-to-face in-depth interviews, I assumed that enticing such a group of participants to become involved in interviews for a post-graduate anthropological research project might prove both time consuming and difficult. An on-line review of articles found in the *British Medical Journal* and *NZ Medical Journal*, using keywords such as ‘interviewing doctors’, pointed to postal questionnaires and focus groups as the predominant methods used when wanting to involve medical doctors in research studies (see for example Thompson et al 2001).

As far as this research project was concerned I wanted to talk to doctors who did not practise CAM because I was interested to see if their beliefs about responsibility differed from their colleagues who integrated CAM into general practice, as well as non-medical CAM therapists. It seemed that the easiest way to obtain information from a group of busy professionals was to organise focus groups and I set up two of these. I approached two key individuals with regard to facilitating the composition of these focus groups: one from a group of rural general practitioners and the other who had contacts with city practices. I requested that between five and seven GPs take part in the focus groups.

Once I had received permission to hold the focus groups I forwarded the practice managers of both medical centres copies of the information sheet and consent forms

and asked that these be distributed to the practitioners prior to the interviews being held. Following discussion with one of the key individuals I reduced the interview guide to seven main points (see Appendix X). This was done because I knew I only had limited time available (sixty to ninety minutes at most) to obtain opinions from a number of participants.

The first focus group was held in the early evening and I provided a light supper for the participants. Five practitioners took part (three male and two female). When I arrived there was some confusion over consent forms as a couple of the practitioners had obviously mislaid the paperwork and it took a short while to ensure that all consent forms were signed (I had taken spare copies). All practitioners agreed to my taping the discussion.

I had been filled with some misgivings and trepidation about how well the focus groups would work. Part of this related to my lack of confidence when confronted with 'experts' in the health field, and I also was concerned about the audibility of the tape-recording when a number of participants were involved. I had wondered about asking participants to ensure that only one person spoke at a time, but ultimately opted not to give any instructions prior to the discussion commencing. My fears proved groundless. I opened the discussion with a general statement - "The first thing I wanted to ask your opinion about was what the concept of responsibility, with regard to the provision of health care, means to you as general practitioners?" - and was delighted with the way the conversation flowed from that point, the engagement with the topic, and the way the participants bounced ideas off one another. They also challenged one another about certain points as well as asking me questions about some of my research findings. No one particular participant dominated the group discussion, although some were certainly more eloquent than others at expressing their opinions. One female participant had a particularly soft voice and I had reservations that her voice would be audible on the tape so I made notes of what she said. Another participant, not a New Zealander, had a strong accent and at times I struggled to pick up all he was saying. Interestingly when I transcribed the discussion the following day his voice proved very distinct and I was able to understand his comments relatively easily. I was correct in my summation of the soft female voice being mostly absent on the tape, but the problem was assuaged because of the notes I had taken.

Heartened by my first focus group experience I looked forward to the second one. This had been arranged as a lunchtime meeting and the practice manager explained to me that I would have to complete the interview within sixty minutes because the doctors had appointments scheduled as soon as the hour was up. Being mindful of this I arrived at the medical centre with plenty of time to spare and, as previously arranged, I provided a lunch for the participants. Four doctors took part in this group, two men and two women. They had all completed their consent forms (I felt this was in part due to the efficiency of their practice manager). All practitioners were agreeable to my taping the interview. Again the discussion proved insightful with the practitioners engaging with the topic and each other. At the end of the interview this group of participants congratulated me on the way I had arranged the focus group, saying they felt it had been conducted in a very 'professional' manner.

Following the focus groups I forwarded thank-you letters to the participants and practice managers. Both groups of practitioners had expressed interest in my findings once the research was completed and, as I had signalled to the CAM therapists interviewed, I said I would provide them with an executive summary once the thesis was completed.

Participants – GPs

All the general practitioners interviewed were aged between the late thirties to early fifties. All but one of them was a partner in their practice, Ravi, worked as a full-time locum. Andrew and James spoke in the most sympathetic terms about the use of CAM. Andrew had studied anthropology papers at university prior to undertaking a medical degree and showed considerable understanding about alternative worldviews. None of the practitioners showed strong opposition to the use of CAM by their patients but they did express some skepticism towards practitioners in relation to their training, their clinical responsibilities and the fees they charged.

IX: Disadvantages of Interviewing Styles Undertaken

I have already described some of the disadvantages inherent in these interviewing techniques, such as being interrupted while conducting an interview and the lack of rapport available during telephone interviews. Time constraints are always

problematic, however by asking if a follow-up interview could be arranged or email or telephone contact made if further clarification was necessary, the door was always open to discuss things further with research participants. Some of the respondents, both patients and practitioners, had their own agendas and were keen to vocalise their support for various types of CAM treatments. One practitioner in particular appeared to be marketing her product to me and I found it challenging to bring our conversation back to the research topic as well as actually bringing the interview to a close.

X: Transcription and Analysis

Transcription is a time consuming business and can be seen as a disadvantage of taping interviews. The biggest problem, apart from the time it takes, relates to audibility. However I was lucky enough not to encounter too many problems apart from sometimes struggling to understand certain participants because their accent or inflection masked their comments. On one occasion during an interview I became aware that a chainsaw being used outside could jeopardise the quality of the tape-recording so I asked the participant if I could close the window and she was happy to oblige. Overall, however, I found that the interview methods undertaken worked well and provided a good repository of information for analysis.

I transcribed all the recorded interviews on a verbatim basis. As mentioned above one participant declined to allow his interview to be recorded and therefore I took notes during that telephone interview (which was not problematic because I used a speaker phone) and typed up the data afterwards. Once all transcriptions were completed Atlas-ti software¹¹ was used as a data management tool to assist with discourse analysis. Within the context of the research project, meaningful phrases and words were highlighted and codes were attached. In this way certain themes became apparent, such as those relating to autonomy, individualism, expert knowledge and, of course, ideas about responsibility.

I have used pseudonyms throughout this thesis in order to protect the identity of all my research participants and have incorporated a different font throughout this thesis to highlight their words.

¹¹ For a comparison between available qualitative data analysis software see Lewis, R.B., (2003).

XI: Correspondence

I sent letters to a variety of CAM organisations outlining my research and requesting information about a number of areas (see Appendix XI). The organisations contacted were: NZ Association of Medical Herbalists; NZ Society of Naturopaths; NZ Register of Osteopaths; NZ Council of Homeopaths; Naturopathic College of NZ Inc.; NZ Charter of Health Practitioners, and the New Zealand Natural Medicine Association. Initially I received responses from the NZ Council of Homeopaths and the NZ Association of Medical Herbalists. When I did not hear from the other organisations I sent follow-up letters via email and this method produced a reply from the Society of Naturopaths. I phoned the remaining correspondents and elicited brief information from people who answered the phone at the NZ Charter of Health Practitioners and the NZ Natural Medical Association. I sent further emails to some of these organisations but no further information was forthcoming.

It has to be said that this method of information gathering was not, on the whole, successful. There is of course no compulsion on the part of these groups to take part in my research project. I felt when I phoned these organisations that there was an air of apprehension or suspicion about what I was doing. This could be due to the fact that at the time the Ricky Gorringe case (briefly discussed in Chapter Four), and the debate about the aligning of New Zealand's regulation of therapeutic products with Australia were being highlighted in the media with some negativity conveyed about CAM therapies, therapists and products.

XII: Research Validity

Although the sample sizes used in this research project are small, as Daly et al point out "it is not the sample size *per se* but the convincing nature of the account of that data that determines the methodological rigour of the study" (1997:102 emphasis in original). My research aims to gain an understanding of people's experiences and beliefs. The methods adopted were not set in place to gain information which I was then going to attribute to a distribution across a population sample (ibid:99). Allan Kellehear (1993:136) makes a compelling argument for qualitative interviewing techniques and the validity of their findings:

Highly structured or highly unstructured interviews are not intrinsically ahistorical, less valid or theoretically impoverished. If the categories and questions used are not derived from the respondent this does not

necessarily mean that the instrument is less valid, or hopelessly lost and alienated from the world of the respondent. The researcher is not always...a bringer of etic meaning. Past literature can sensitize where personal biography limits. Empathy, understanding and identifications with others have many sources; and some of these may emerge in a narrative analysis and others may materialize through contact with a wide range of creative and scientific literature.

As a qualitative researcher I am not searching for an 'ultimate truth' (see Kelleher 1993; Lincoln and Guba 2003; Rice and Ezzy 1999), and my research findings are interpretative, based on interviews I have held with participants (and I have used direct quotations from these interviews to back up my analysis), and an extensive literature review. The transcripts of my interviews have been available to my supervisors for inspection and comment.

XIII: Ethics

Because my research deals with human participants, prior to any interviews being conducted an application for ethical approval was submitted to the University of Waikato Anthropology Human Research Ethics Committee (Appendix XII). Copies of an information sheet for participants and consent forms were provided and after some minor adjustments to the initial application, approval for the research project was received on 21 June 2002 (Appendix XIII).

This process worked well. One point of contention I had with a member of the Committee was that I wanted to have the participants sign their consent forms *after* the interviews because I believe they are then affirming their discussion and are doing so on an informed basis. However I was over-ruled on this point and requested to ensure that the participants signed their consent forms prior to the interview commencing. I still am of the opinion that my viewpoint has validity and merit.

Another dilemma I was faced with was that it became apparent in my discussions with some of the participants, especially patients and CAM practitioners, that they believed I was 'on their side' or championing the cause of CAM modalities. My research was not focused on the rights or wrongs of CAM or orthodox therapies, or the efficacy of treatments, and it clearly stated in the information sheet given to all participants that the research theme related to ideas about responsibility. I talked this point over with my supervisors and was told that I cannot be held responsible

for participants' interpretations of my research and I certainly believe that I did not deliberately mislead anyone into thinking I was undertaking the research for the purpose of advocating the use of either CAM or orthodox medicine.

XIV: Researcher Bias

Jack was the only participant who asked me what my husband's job entailed. I told him he was a general practitioner. This fact could be construed as producing a bias in me towards orthodox medicine. However, such a statement would imply that orthodox general practitioners do not have sympathies with CAM therapies and as my research shows, there are a growing number of GPs who are now combining orthodox medicine with some type of CAM modality. I also know many people, including members of my family, who attend CAM practitioners and are positively enthusiastic about the treatment and benefits they receive from these types of treatments.

Throughout the course of my research I encountered many layers of discourse. I accepted some of the things I was confronted with and was definitely challenged by others. For instance, in an interview I held with a CAM practitioner, which was unremarkable in many ways, I left her consulting room with an unmistakable feeling that just being in the same room as her would make a person feel better. I know this probably sounds very mystical, and I certainly never expected to feel that way, but I believe this practitioner possessed some unique 'gift'. Similarly, while attending the MindBody Conference Christiane Corbat presented a paper on her work in the field of body sculpture, especially with cancer patients. She exuded an aura of tranquillity and healing. While I struggle to explain these impressions in concrete terms, I accept this is how I feel. In my interview with Brian (Dr-CAM), I was taken aback by the strong racial prejudice and class discrimination clearly evident by some of the things he said. While the anthropologist in me wanted to challenge his statements, I opted to remain focused on questions relating to the research topic. The majority of patients I talked to described feelings of discontent, and sometimes anger, towards the medical profession. These events challenged my perception of doctors as generally hard working and committed professionals who feel genuinely concerned about their patients and the way they treat them.

Feminist research points to the “analytic use of feeling and experience of the ‘personal’” (Stanley and Wise 1993:174) and in this way my research describes both the feelings and experiences of the people I interviewed as well as my own. By adopting a reflexive stance I am aware of any prejudices I may have and know that I must take these into account when constructing research findings.

XV: Researcher Responsibility and Reflexivity

The theme of this thesis – responsibility - constantly haunted me during the research process. The topic set the tone and I felt it was incumbent upon me to be as *responsible* to the participants as possible. They had invested considerable time and energy into agreeing to talk to me, often divulging intimate details about certain aspects of their lives, and as a researcher I was responsible for portraying that information as accurately and as sensitively as possible. In moments of doubt about the whole research process, and my abilities to complete the thesis, I also reflected on the responsibility angle and this, in part, kept me motivated to finish my work. As Rice and Ezzy (1999:69) eloquently conclude, the privileges of interviewing participants are intertwined with responsibility:

The time, emotional energy, and trust that the participants of in-depth interview studies invest in the project confers a responsibility on the researcher to publish well-written and scholarly works that honour that trust.

Of course responsibility to complete research is not solely confined to the participants – I also had responsibilities to the academic institution, my supervisors and colleagues.

The research process is both interesting and dynamic, especially when it involves interviews with participants, but I also found it fraught with ambiguities. As Rice and Ezzy point out, the relationship between researcher and participant is an odd one because even although a rapport can develop between the two parties and intimate knowledge gained, “the mutual trust developed during an interview [has] no place in an ongoing relationship” (ibid:51). There was almost a feeling of emptiness or incompleteness at the end of an interview and to me, this was particularly evident with the interviews I held with patients. As I mentioned above all but two of the interviews were held in the participant’s home and after saying farewell on the doorstep we parted company with no mention of further contact, other than to check details from the transcription if necessary. This lack of contact

following interviews made me feel a little uncomfortable and somewhat bereft. In a belated effort to overcome these feelings, following the interviews with the remaining categories of participants, I sent a small card thanking each participant and offering them the chance to contact me about the research if they wished. However, I only set this regime in place for the last two of the seven patient category participants, and regret not sending thank-you notes to all of them. I hope to make amends by sending all these participants an executive summary of this thesis.

Researchers should view in-depth interviewing as a privilege (ibid:52) and I certainly concur with this sentiment. One particular interview left a vivid impression with me. Jack was my first participant and all I knew about him was that he had been treated for cancer. When I arrived at his house he greeted me warmly, making his way around on crutches as one leg, I noted with shock, had been amputated above the knee due to an osteosarcoma. He shared a great deal of information with me during the interview and was a good-humoured participant. At one stage I asked him, when it came to looking after his own health, what sort of areas did he want to have control over? He replied:

I just don't want to be sick again...I just want to be well but I don't want to go overboard about looking after diets and stuff like that...I just want to live a little...if someone could tell me what causes osteosarcoma I'd avoid that like the plague.
(Jack)

Following the interview, while sitting in my car outside his property, I wrote in my research diary:

Jack has deep purple shadows under his eyes. Makes me wonder how well he actually is – very pale as well.

A further diary note reads:

Jack was diagnosed with lung cancer in June and he died at home, surrounded by his family, on 15 July 2003.

Qualitative research is, by its very nature, a subjective process and adopting an objective stance in light of the participants' utterances, such as Jack's above, would be, I contend, virtually impossible. Whether the researcher likes it or not, you become inexorably caught up in the lives of your participants. I liked many of the participants I talked to and even if I had not faced their health problems or been confronted with the anguish and frustrations patients and practitioners expressed towards our current health system, I could often empathise with their feelings. I

found that the ‘lived experience’ often referred to in qualitative research is as much related to the researcher as the researched.

In terms of both the researcher and the interviewees being ‘co-participants’, qualitative research cannot be seen as a ‘parasitic’ enterprise, with the researcher taking and the participant giving. Many of my participants said they enjoyed the chance to talk about their experiences and on one occasion I was able to provide a patient with advice about Accident Compensation entitlements. The Bowen therapist I spoke with said she was very nervous prior to the interview and felt she would have nothing much to offer me in regard to my research topic, but at the end of the interview she said she had really enjoyed the experience and felt she had gained a lot out of it.

I had occasions to reflect upon my topic in its wider environs – that of the impact of ill health on both patients and practitioners. Of course, much of the literature I have read during this research project relates to topics about ill health and people’s reactions to it but at one particular juncture I felt overwhelmed by ‘illness’. I had been working solidly on my thesis and was, metaphorically, impregnated with the topic and had occasion to attend a General Practitioner Continuing Medical Education (GPCME) conference. I listened to a number of medical practitioners and politicians grapple with both the political environment of medicine as well as the nuts and bolts of dealing with people’s illnesses: a neurosurgeon explaining about head, neck and arm pain; a physician talking about how difficult it can be to manage hypertension; and a dermatologist showing graphic pictures of melanoma. When I was not attending the conference I had my head buried in *How We Die* (Nuland 1994), which paints a fairly pragmatic picture of what happens to our bodies as we age and decay and, ultimately, die. After the conference I accompanied my father to hospital where he underwent radiotherapy treatment. It was a sobering experience indeed to sit in first the radiotherapy waiting room and then the oncology foyer and be surrounded by so many people suffering from cancer. Not only was it the sheer volume of patients that was startling, but in particular the number of young women receiving treatment for breast cancer.

I reflected on this feeling of being overwhelmed. I have chosen to inhabit this archipelago of illness and healing. The research topic was not forced on me. But

sadly for many of the patients and practitioners I have met or just observed those choices have been made for them. While practitioners choose their careers, I have no doubt that if they find exposure to ill health overwhelming, the time, money, knowledge and commitment already expended makes looking for an alternative career difficult. However patients rarely have a choice. The life they led changes; the landscape becomes unfamiliar. Judith Zaruches (cited in Frank 1997:1) says of her experiences with illness “the destination and map I had used to navigate before were no longer useful”. I hope this research will provide opportunities for new maps to be created because it has enabled patients and practitioners to tell their stories. As Frank (ibid:17, emphasis in original) says:

Ill people’s storytelling is informed by a sense of responsibility to the commonsense world and represents one way of living *for* the other. People tell stories not just to work out their own changing identities, but also to guide others who will follow them. They seek not to provide a map that can guide others – each must create his own – but rather to witness the experience of reconstructing one’s own map. Witnessing is one duty to the commonsensical and to others.

In sum, reflexivity adds to the learning experience of the researcher: “It is a conscious experiencing of the self as both inquirer and respondent, as teacher and learner, as the one coming to know the self within the processes of research itself” (Denzin and Lincoln 2003:283).

XVI: Quantitative Research

In contrast to the ‘thick descriptions’ available through the use of qualitative methodology, quantitative methods involve “the measurement and analysis of causal relationships between variables, not processes” (Denzin and Lincoln 2003:13). Quantitative methods are positivistic and grounded in the hard sciences. Quantitative research is often deductive and “deals with ‘hard’ data” (Davidson and Tolich 1999:19). The objectivity and impartiality of the researcher and the research design is considered paramount, as is the ability to replicate experiments. I do not propose to give a detailed analysis of this research method as it was only used fleetingly. For instance, I was able to count and compare data, such as the number and types of CAM therapies available in New Zealand, the number of and type of complementary and alternative therapies patients used. The range of therapies practised by individual practitioners was also investigated, together with demographic information concerning their patient base.

XVII: Conclusion

By being a *Bricoleur* this research project has utilised a variety of research methods, both quantitative and qualitative, in order to capture data relating to belief systems. The medical anthropology and critical medical anthropology paradigms highlight the relevance of qualitative methods because it is through this methodological approach that prominence is given to the voice of research participants. The range of methods used: a literature review; correspondence; attending seminars and meetings; and the interviewing of participants, enabled opinions to be sought from a number of participant categories over diverse geographical locations. My reflexivity meant it was permissible to amend the question guides as interviews progressed or to ask participants if they had anything in particular they wanted to talk about. It also provided me with an opportunity to reflect on my role in the project and consider any prejudices or biases I may have. It underscored the necessity for me to remain grounded in the realities of daily life because I was dealing with the lived experiences of people as they coped with ill health, either as a patient or a health practitioner. This methodological *bricolage* also set the scene for the development of the central framework and themes for this thesis as described in the following chapters.

CHAPTER THREE

RESPONSIBILITY

“Responsibility is such a weighty thing.”

(An intern on *Interns* TV One 2 August 2004)

“Sick persons are understood to be responsible for incurring their illness, usually by their lifestyle, stress, or feelings of unresolved anger and depression, and they are also responsible for getting well again.” (Hawkins 1999:129)

I: Introduction

Responsibility is a concept replete with meaning. It can be considered a contested term; open to interpretation from individuals and bureaucracies as well as being viewed from a more dispassionate perspective and enshrined in legislation and codes of ethics. As my research progressed I found that the ideas I was looking at in relation to the notion of responsibility possessed an intangible quality; there were no aspects I could quantify and no pithy sentence that explicitly stated ‘this is what responsibility is’. This provided me with a challenge. I knew that I wanted to learn what responsibility meant to the different groups of participants I talked to and how these ideas manifested in their daily lives. I was also curious about what responsibility means to government agencies and health bureaucrats, and how this influences or impinges upon their policies and actions? And what about the literature – who discusses the topic of responsibility and which perspective is used, and what do the authors have to say about the subject?

Literature¹ that was particularly insightful about responsibility so far as the use of CAM and orthodox medicine is concerned is mentioned throughout this chapter. While none of these authors specifically discuss responsibility in the way I do, there are similarities. Ursula Sharma (1994) examined the question of United Kingdom CAM practitioners’ therapeutic responsibilities. However she did not report patients’ views about this topic in any significant detail. Kahryn Hughes’ (2004) research, also based in the UK, focused on people with HIV/AIDS. She compared the way biomedicine, through the framework of the National Health Service (NHS), and CAM, perceives the role of the patient/user/client, especially as it relates to individuals taking responsibility for their health. June Lowenberg’s (1992) account

¹ I found particular resonance in the work of Buckman and Sabbagh (1995); Cant and Sharma (1999); Coward (1989); Crawford (1978; 1980); Farsides (1994); Morreim (1995); Lantos (1997); Lowenberg (1992); and Sharma (1996, 1994, 1992).

of health practitioners working within a holistic framework in the United States described responsibility in terms of attribution of illness and empowerment in the healing encounter. She concluded that this genre of medical practitioner continued to absolve patients of responsibility for either their illness or their recovery.

In this chapter I discuss several categories of responsibility that are pertinent to my thesis. While responsibility is discussed specifically in relation to my fieldwork throughout Chapters Six, Seven and Eight, this chapter foregrounds the concepts discovered during analysis of the participant transcripts and the literature reviewed.

First, in Section II a range of definitions is discussed in relation to the term ‘responsibility’ and I emphasise the fluidity of meaning and interpretation that can be ascribed to this word. Second, the central focus of this research encapsulates and analyses ideas about responsibility when patients and health practitioners combine orthodox and CAM modalities. However, it is important to understand that CAM therapies are predicated on the notion of personal responsibility (see Section III), especially in relation to the patient’s role in health and illness, and this is discussed in detail in Section IV. Third, responsibility also relates to those individuals who work within the health sector and Section V discusses the therapeutic responsibility of both CAM and orthodox practitioners. And fourth, health funding impinges on those people who work in the sector and the individuals who want or need access to health care, as well as the funding providers, which in New Zealand, is mainly the state. Responsibility from a financial perspective is discussed in Section VI. But first, how is responsibility defined?

II: Defining Responsibility: Multiplicity of Meaning

What does responsibility mean? An initial search of library databases revealed little in the way of relevant information pertaining to patient responsibility or that of CAM practitioners. I concluded that this research strategy was unhelpful and a more useful method of investigation might be through examining dictionaries, both hard copies and those on-line. My search for a definitive meaning began with an investigation of the etymology of the word *responsible* and I found the website www.etymonline offered a comprehensive history of the term. The origin of the words *respond*, *responsible* or *responsibility* are found in the Latin root word *respondere*, and by the 1600s the word had evolved to the spelling and

pronunciation we use today - *respond*. As far as the meaning is concerned, the Latin root word included a sense of obligation, and this is still evident in contemporary definitions. In the 1300s *respond* meant: “answer to, promise in return”; by 1599 the word *responsible* related to being “answerable (to another, for something)”, and by the mid-1800s connotations included being “morally accountable for one’s actions”. The Collins Compact Dictionary (1989:423) provides a contemporary definition of *responsible* in which the original Latin and French meanings still resonate: “liable to answer (for)...dependable...of good credit or position. The Collins Dictionary describes *responsible* in the following terms “being *accountable* for one’s actions and decisions...being the agent or cause [of some action]...able to take rational decisions without supervision; accountable for one’s own actions” (1994:984).

The word *responsibility* was incorporated into our general vocabulary from 1787 (www.etymonline) and current definitions describe the word in the following terms: “the state or fact of being responsible...authority; the ability to act independently and make decisions...the person or thing for which one is responsible” (Collins English Dictionary & Thesaurus 1994:984; Concise Oxford 1990:1026). It seems therefore that responsibility invokes ideas about status, autonomy and agency, and accountability. For instance the definitions as outlined suggest that people endowed with responsibility are perceived to be of high moral standing and can be relied upon from a financial or personal perspective. Personal responsibility also involves independent action and the ability to make decisions, as well as accepting responsibility for someone or something else. Responsibility can therefore relate to either the self or acting on someone else’s behalf. However the dictionary meanings are obscure when it comes to responsibility where unintended consequences, good or bad, are involved.

I became curious about the way the words *responsibility* and *accountability* appear to be interchangeable. For instance, the New Zealand Nursing Council defines *accountability* as “the acceptance of personal *responsibility* for the decisions and actions taken or not taken by a nurse or midwife” and includes “being answerable, chargeable, culpable, liable and *responsible*” (Irvine 2004, my emphasis). *Responsibility* is further defined as “a charge which is given to a registered nurse and accepted by that person, to enable them to carry out an action. It includes

knowing both the external and internal sources from which this is derived” (Irvine 2004). However, I came across three opinions which caution against the malleability of these terms. I believe these views are well worth noting as they illustrate the tensions between health practitioners on the one hand and bureaucrats on the other. The first opinion comes from Dr Peter Roberts, the then President of the New Zealand Association of Salaried Medical Specialists (NZASMS), during his address to their 1999 conference.

Citing Professor Allen Schick², he argued that the words responsible and accountable

...lead down very different paths. Responsibility is a personal quality that comes from one’s professional ethic, a commitment to do one’s best, a sense of service. Accountability is an impersonal quality, dependent more on contractual duties and information flows. As much as one might wish for an amalgam of the two words, the relentless pursuit of accountability can exact a price in the shrinkage of a sense of responsibility (Schick 1996:84-85).

While Schick made these comments in relation to the public service as a whole, Dr Roberts contended they were especially applicable to the health sector because people who initiated, controlled, motivated, and performed certain actions needed also to be concerned about attendant consequences, and this is what he believed responsibility meant. As I noted previously, dictionary meanings remain stubbornly silent on the question of *unintended* consequences. Dr Roberts (1999) argued that the commercial model adopted by health managers, as directed through government policy, often ignored social and moral responsibilities towards the greater community, and that within the hospital environment, responsibility was seen as achievable through a “tic [sic] box form of accountability”. This sense of frustration experienced by medical practitioners, when their clinical and moral responsibilities conflict with fiscal and bureaucratic policies, is also eloquently summarised by John Lantos (1997:131-132), who believes

² In 1995 Allen Schick, a Professor of Public Policy at the University of Maryland and a Visiting Fellow at the Brookings Institute, carried out a review of state sector reforms in New Zealand. One of the main points noted in his Report (1996) was that the reforms differed from those undertaken in other countries because in New Zealand public sector managers were held accountable through contract-based arrangements. Schick argued that although the idea of accountability was laudable, because of the way government services were delivered (not in a true ‘market’ environment), there was a temptation by chief executives to adopt a “check list mentality” towards the tasks and goals they were required to comply with. This meant that in certain situations managers overlooked or disregarded responsibility towards non-specified items. According to Schick, this situation needed to be addressed in order that any model of accountability “encompass[ed] responsibility, based not solely on greater specification of results, but based as well on values, judgment and leadership”.

Doctors are no longer responsible for patients in the way they used to be. Each clinical decision is scrutinized and reviewed, doctors are curtailed by utilization reviewers, clinical pathways, nursing protocols, and informed consent. Financial arrangements make them accountable to their colleagues, to large health delivery organizations, and to anonymous decision makers in invisible offices reachable only by toll-free telephone calls. The system for identifying and punishing mistakes, is, in essence, a system for defining accountability, but every other aspect of current arrangements hides or diffuses accountability. One of the last remaining roles for the doctor may be as the accountable fall guy for the sins of the stockholders.

Similarly, Calliope Farsides (1994:52) believes that to be responsible is of greater significance than being accountable:

To be accountable is to be answerable for one's actions to another person or body...to be responsible is to be prepared to own one's actions in a fuller sense. It implies that I understand them as actions I have freely chosen to perform, and that because of this I will answer fully for the consequences of the action I take. To be accountable allows for the possibility of 'carrying the can' for actions which you were forced to take; to be responsible can entail vetoing demands which require you to perform actions you would not happily call your own.

Accountability can be demanded of those who have little or no real responsibility, but if individuals operate within a system which denies, or does not encourage them to take, personal responsibility for their actions, a valuable sense of autonomy might well be eroded.

As demonstrated above, *responsibility*, within the context of this research project, is imbued with a sense of moral and ethical behaviour, of a person responding *to* a particular situation in a positive, helpful, and trustworthy manner. These ideas reflect society's expectations of health practitioners and, to a large extent, form the basis of codes of ethical practice. In order to ascertain whether responsibility, as an ethical consideration, is viewed differently by CAM and orthodox professional bodies I compared the New Zealand Medical Association (NZMA) Code of Ethics and Recommendations and the New Zealand Charter of Health Practitioners Code of Ethics, which outlines ethical behaviour and codes of practice. In essence I found the two codes share many of the same features; namely that practitioners' first priority must be the health and wellbeing of their patients. Respecting patient autonomy, including his or her right to choose treatments as well as practitioners, and ensuring patient confidentiality were also included as standard clauses in the codes. Responsibilities to patients included the non-exploitation of patients either through physical, sexual, emotional or financial means; non-discrimination with respect to a patient's race, colour, religious or political affiliations, and ensuring

that patients be as fully and truthfully informed as possible about the state of their health and treatment options available to them. Despite these similarities there were notable differences in the codes as well. The NZMA considers that part of a doctor's responsibility towards his or her patients is to provide continuity of care and after-hours cover (albeit delegated in certain situations). In contrast, the NZ Charter does not require their practitioners to provide similar services. However there is an expectation that in the case of an emergency situation, CAM practitioners should provide assistance commensurate with their professional abilities. Both codes also advocate practitioners taking responsibility, in general terms, towards the promotion of healthy and safe communities.

One facet I particularly noted in the codes is the requirement of both orthodox and CAM practitioners to adhere to the doctrinal base of their modality. This means that orthodox practitioners are expected to follow scientific practice, whereas CAM practitioners follow the principles intrinsic to a range of natural medicines.

Another viewpoint about responsibility in relation to this research topic is to do with the difference between social and individual responsibility. Mike O'Brien (1998) argues that social responsibility and individual responsibility are terms that should not be conflated. This is because society needs to offer an environment where there are adequate resources, opportunities and support systems in place in order for people to be able to make "meaningful choices". According to O'Brien it is "only then [that] personal responsibility become possible, personal responsibility which can be enforced" (ibid:i). Nesta Devine (1998) contends that the neo-liberal environment views social responsibility differently. For instance 'social' is just the "aggregation of individuals" and 'responsibility' relates to an individual "respond[ing] to their own circumstances" (ibid:47). If a person is unable to look after themselves then it becomes someone else's 'business' to step into the breach (ibid:47), with the emphasis being on *business*. This means that from a neo-liberal perspective we are no longer just involved with a "market *economy*" but in fact inhabit a "market *society*" (Gledhill 2004:340) where all facets of our daily lives, including health and social and individual responsibilities, have become commodified. My research revealed that neo-liberal discourse has permeated the political and health-care sectors, as well as society at large, and this in turn has led to a questioning about the roles and responsibilities of individuals, health

practitioners, and the state, in relation to the provision and management of health-care services. Another noticeable feature of this discourse is the attribution of responsibility for sickness and health. What I have found is that the rhetorical strategies adopted by the various participant groups I interviewed show there is considerable confusion and debate over whether individualistic or collectivistic ideologies best reflect the way health services should be delivered in New Zealand.

So far in this chapter I have demonstrated that responsibility is a complex concept and, within the context of this thesis, a palimpsest of meaning is revealed. For example, responsibility involves ideas concerning power, authority, agency and autonomy, in turn affecting decision-making processes and their consequences. Responsibility impinges on all our lives. Whatever the facets, it is evident that responsibility has different connotations in relation to a myriad of circumstances. This situation is further complicated, as I have outlined above, because responsibility is construed as having interpretative qualities. For example, what responsibility means to patients, practitioners and health bureaucrats can be linked to professional, personal, and fiscal ideologies. Patient interviews reveal that many of them have attempted to adopt a 'healthy' lifestyle and these choices are construed as accepting responsibility for their health care. However, the situation is not straightforward as patients also transfer responsibility for their health onto practitioners (as discussed in Chapters Seven and Eight). Also, health practitioners often choose to work within a therapeutic modality that best incorporates their beliefs about illness, health and intervention strategies, and the levels of responsibility they want to contend with. For example, CAM therapists invoke an ethos of patients being largely responsible for their own health-care whereas medical practitioners view responsibility from a different angle – as an intern said, "I have learned to take on a lot of responsibilities and be accountable for the things I do" (*Interns* TV One 9 August 2004). Concern about financial responsibility is evident in government policies and was also voiced by the practitioners and patients I talked with. These views tend to reflect a preference towards *either* individualistic *or* collectivistic ideologies: the championing of individual responsibilities, or alternatively state provision of health services, and I discuss these views further in my fieldwork chapters.

As I demonstrated above, responsibility can also be construed as having a dispassionate quality such as when it is imposed on individuals or professional groups (as shown by the Nursing Council editorial). It can be enshrined in legislation governing the compulsory registration of practitioners (as I detail in Chapter Six), as well as in codes of practice and codes of ethics.

Despite the variety of ideas relating to responsibility canvassed in the above discussion, the theme of responsibility for illness and healing being left to individuals to exercise remained constant with the CAM practitioners I interviewed. To my surprise I found that CAM practitioners were less inclined to consider the causes of illness and healing within a holistic framework than the biomedical practitioners I talked with. The rhetoric from the CAM practitioners was heavily imbued with neo-liberal ideas about individual responsibility. In general these practitioners were disinclined to countenance a patient's social circumstances as a 'cause' of illness and the tenor of the interviews suggested that it was up to individual patients to overcome any socio-cultural barriers that impacted on their health (such as low income, poor diet and so on). On the other hand the biomedical practitioners I spoke with were more prepared to consider the social circumstances of their patients as being a factor in their health problems and were supportive of collectivist policies to ensure better standards of health and health care. Patients generally attempted to negotiate between the different discourses: when they were well they found it relatively easy to support neo-liberal ideas espousing self-responsibility and the use of CAM therapies. However, when faced with serious health problems they demonstrated a change in attitude where they sought out orthodox intervention and often wanted to relinquish at least some responsibility for their health care to a medical practitioner.

III: CAM and Biomedical Views on Health and Illness

Put simply, within the context of this research project, illness means different things to different people but all my participants, whether health professionals or patients, find resonance with ideas that incorporated both biological and socio-cultural aspects. A biomedical perspective defines illness as:

An unhealthy condition of the body. The symptoms that a patient experiences are a consequence of that disease which *may* have a pathological and/or psychological basis (Brooks 1998:3-4, emphasis in original).

An anthropological or sociological viewpoint places considerable emphasis on a person's socio-cultural background when defining illness (see for example Brown 1998:1; Parsons 1951:431), because all societies have developed ideas about who or what is to blame for ill health (Douglas 1994), and there is ambiguity as to what even constitutes 'disease' (Seedhouse 1990:41)³. Disease categories change depending on the cultural construction of illness. For example, in the nineteenth century the diseases Drapetomania and Dysaesthesia were attributed to Negro slaves. Drapetomania related to a disease causing slaves to run away, and Dysaesthesia caused slaves to behave as though "half asleep" (Caplan et al 1981:320). As Turner (2000) points out, people in certain societies believed that sickness occurred when social rules or mores were broken. Foucault (1971) demonstrated that a historical review of 'madness' revealed inconsistent definitions and that by labelling a person 'mad', a strategy to control certain sectors of a population became a bureaucratic tool. In the West, the construction of what constitutes disease, illness, and sickness is likely to be strongly influenced by whether a person is a health practitioner or a patient (McElroy and Jezewski 2000). And as McGuire (1988:5) points out, middle-class Americans who use CAM do so because they see this type of healing providing them with "a totally different definition of medical reality, an alternative etiology of illness, and a specific theory of health, deviance and healing power". McGuire states that orthodox medicine and its 'reality' is also "socially constructed" (ibid:5).

Because of orthodox medicine's preoccupation with science and technology a strong bias towards pathogen-based etiology is now prevalent. The prime task of medical practitioners relates to halting infections and disease through the use of

³ Wendy Stainton-Rogers (1991) suggests eight criteria that encapsulate beliefs about the causes of health and illness. These include, for example, the 'body as machine, the 'health promotion' approach, and 'robust individualism' (see pp. 209-226 for a detailed account of these categories). The 'body as machine' relates to scientific discourse where the biomedical model and its reliance on technology is perceived as being able to mend bodies/parts of bodies and overcome the "scourge of disease" (ibid:209). Belief systems that incorporate the 'health promotion' perspective focus on the need for social change, especially in relation to the adoption of healthier lifestyles. While this approach can result in positive outcomes for some sectors of the community, neo-liberal politicians have used this perspective to shift responsibility for health from governments onto individuals. Such a shift denies the "structural and politico-economic causes of ill health" (ibid:217). The 'robust individualism' perspective points to the importance of autonomy and embodiment. Health is viewed as a commodity that individuals can choose to 'buy' into; and individuals have the right to act as they see fit (for example, smoke cigarettes). However all consequences of such behaviour is the responsibility of the individual. Interference by a "Nanny state" is perceived as a gross intrusion on individual autonomy (ibid:220).

medications or surgical intervention (Hafen and Frandsen 1984:2)⁴. This focus on disease, according to Deborah Saltman (1998:220), means that the biomedical approach perceives patients as “disease carriers”, and thus diminishes the likelihood of practitioners and patients adopting a more holistic approach to health care. In contrast, CAM therapies are based on symptom models and it is the patient’s description of his or her illness that helps a practitioner decide what illness(es) a person may have (ibid:220). The importance of this approach lies in the “validation” of a person’s symptoms and experiences, enhancing their autonomy and control over healing encounters (ibid:220-221), and by inference, accepting responsibility for the state of their health.

Within the context of CAM, health and healing is achievable from two angles. First, as mentioned above, one of the central tenets of CAM is that individuals are viewed as being largely responsible for their own health. This especially relates to lifestyle factors that cause ill health, such as smoking or excessive alcohol intake, lack of exercise and stress. Second, the body, with the assistance of a CAM practitioner, is also viewed as being able to heal itself and therefore, in Thomsonian⁵ terms, a patient can be his or her own doctor. I will now outline both these points in more detail.

i: What makes you ill?

Are we responsible for our own illness? As I have outlined above, illness can be traced, in varying degrees, to biological, psychological or socio-cultural causes. There is also the pragmatic view, especially contained within some of the biomedical literature, that poor health results quite literally from the ageing process. As we grow older the cells and organs in our bodies deteriorate, not necessarily through disease, but everyday usage (Nuland 1993:74). For example, heart failure, according to Nuland (ibid:53), can be explained in the following terms:

As the pump [heart] ages, its inner lining and valves thicken. Calcifications appear in the valves and muscle; the color of the

⁴ This view of orthodox medicine is, I believe, open to debate. As David Peters (1994) notes, GPs in particular deal not only with patients who present with specific disease-related conditions, but also problems that have a significant psycho-social component. See also Sharma (1992:108-110) for comment regarding the holistic approach of orthodox medicine.

⁵ Samuel A. Thomson (1769-1843) developed a system of vegetable-based therapies, and promoted the concept of ‘every man his own doctor’. He believed that “every man [sic] ought to hold himself intelligently responsible for his own health and that of his family, and that years of medical study were unnecessary in the treatment of sickness once you had grasped the basic principles of health in all their astonishing simplicity” (Griggs 1997:164; see also Porter 1999:393).

myocardium changes somewhat as a yellow-brown pigment called lipofuscin is deposited in its tissues. Like the face of a weather-beaten old man, a heart looks its age. There is no need to invoke a disease to explain its failure.

Illness can also be imbued with a moral component. Talcott Parsons' (1951) functionalist perspective viewed illness as 'deviance'. By according an ill person a 'sick role', they would not be blamed for their illness. However, this role was allocated by society on the proviso that the sick person sought medical intervention. By doing this, according to Parsons, the sick person could legitimately temporarily withdraw from the expectations and obligations society incurred upon them, such as going to work or caring for a family⁶. According to Lowenberg (1992:115), the sick role advocated by Parsons meant that doctors absolved patients from having to accept responsibility for causing their illness(es). Lupton (1994:89-92) offers another perspective regarding Parson's sick role. She argues that the Parsonian viewpoint placed individuals in 'innocent' or 'deserving' categories. As such people who contracted a sexually transmitted disease were seen as *deserving* their illness, whereas someone who was afflicted with a contagious virus such as measles, was presumed *innocent*. Lupton (ibid:89) also contends that chronic illnesses do not fit within Parsons' sick role model. Therefore the chronically ill or those who *deserve* their ill health run the risk of condemnation not only from health professionals but society in general.

Both biomedical and CAM practitioners acknowledge that the lifestyle choices people make impacts on their health. Drug taking, including cigarette smoking and alcohol, poor diet, environment (such as overcrowded or damp accommodation), and a sedentary existence are all factors that can have a negative effect on a person's health.

Despite these shared beliefs about the reasons for ill health, there are important differences that underpin biomedical and CAM philosophies. While much of the biomedical model is based on scientific evidence-based disease etiology, the majority of CAM therapies describe ideas about the necessity of energy flow around the body: illness occurs when this flow is disrupted (Buckman and Sabbagh 1995:77-79; Coward 1989:24; Fulder 1996:7). In other words, illness happens

⁶ This idea is evident in the work of Anne Chambers and Judy Macdonald (1987). Some of the women interviewed described how being ill gave them the excuse they needed to withdraw from domestic obligations.

when the body is not maintained in a state of harmony or equilibrium. The individual is held to be responsible for their own healing. These ideas are widely advertised as can be seen by extracts from leaflets and publicity material collected from a number of CAM practitioners:

Perfect health means: perfect harmony. Any perceived lack of health demonstrates a disharmony in the make up of the individual (Spiritual Surgery).

REIKI is Self-Help. You take control of your health and well being. You learn how to use the energies already present with you to heal you MIND, BODY and SOUL (Reiki).

You know more about your body than anyone else, so why not choose your positions of comfort? It is simple yet not simplistic. It is deep, interconnected work, yet very subtle. It reconnects you with parts of yourself you may have forgotten existed. It gives you a bigger picture so that you have more choices (Ortho-Bionomy).

An unhealthy nervous system does not allow functions of the body systems or organs to work normally and can create sickness and pain. STRESS CAN ASSIST IN CAUSING DISEASE (BOWTECH, the Bowen Technique).

The principles of reflexology help to activate the natural healing processes of the body, which keeps it working at peak efficiency (Reflexology Clinic).

Illness is often the result of the obstruction of energy flow, called blockages; they prevent energy from circulating freely through the body's energy channels [and] the body loses its balance and depletes the life energy required for the nourishment of our vital organs and immune system. As a result, our body becomes weakened and we are more likely to become sick...For every emotional state there is a physical response in the body...The mind strongly influences our body and our vital energy (LI Energy Healing Centre).

[Kinesiology] can identify where the imbalance of energy is and with a variety of corrections can release stresses that are blocking or sabotaging personal growth and affecting well-being...At a deeper level, it can be used to identify and clear subtle stresses, which if not released, can lead to physical manifestations of disease (ByZantine Wellness).

The constant flowing movement [of holistic pulsing] stimulates the tissues and fluids of the body improving function. This awakens the body's immense intelligence....Where separation from deep values and spirituality has happened body, mind and spirit can re-integrate into their natural state (Holistic Pulsing).

Bowtech empowers the body to heal itself...It stimulates energy flow, which activates the body's own resources for healing (BOWTECH, the Bowen Technique).

According to Fulder (1996:4) the central focus of CAM is the “restoration of health rather than the removal of sickness”, and much of the responsibility for healing lies with the individual⁷. As I have already mentioned, the message that people need to be responsible with regard to their health keeping behaviour is not solely the domain of CAM therapists. For example, at the 2004 GPCME Conference I attended a physician presented a paper about hypertension and made the point that one of the best strategies a hypertensive patient can adopt is to control their salt intake. Medications can assist in certain situations but the responsibility for lifestyle changes rests with individual patients.

Accepting responsibility for illness can be liberating for some patients. Anne Hunsaker Hawkins (1999) describes how patients who turn to CAM therapies, often as the result of a cancer diagnosis, find it helpful to consider their illness as stemming from “repressed and denied negative emotions (ibid:175). This does not mean that patients want to indulge in self-blame. Instead it offers them an opportunity to reassess their lives and make positive changes to their lifestyles, such as re-evaluating relationships, employment, and unfulfilled goals. Some of the therapies these patients find particularly useful are visualisation, meditation and spiritual healing.

However just as some patients find the idea of accepting responsibility for illness a cathartic and empowering experience, Hawkins (1999) also gives examples of patients who become disenchanted or angry with CAM because of its message that somehow individuals “can be ‘responsible’ for acquiring or recovering from a disease such as cancer” (ibid:175). Hawkins outlines the experiences of a woman, Christina Middlebrook, whose treatment for breast cancer involved surgery, chemotherapy, radiotherapy and a bone marrow transplant. Unfortunately none of these treatments were successful and Christina turned to the approaches advocated as ‘healthy-minded’ – such as meditation and visualisation - of “Pacman figures eating up her cancerous cells” (ibid:175). This approach reflected New Age philosophies because they supported the premise that the “primary locus of authority” should be vested in the individual and that each person needs to take responsibility for their own life (Heelas 1996:169). However Christina recoiled against what she called the “tyranny of New Age” arguing that these approaches

⁷ See also Coward (1989); Crawford (1978, 1980); Freund (1982); Hafen and Frandsen (1984:2); Hawkins (1999:129) and Micozzi (1996:6).

only make her feel “inadequate, worried, and guilty”. She said, “dying is difficult enough without having to achieve a pleasant attitude” (Hawkins 1999:175). As described in Chapters Six and Seven, patients and practitioners I interviewed offered divergent opinions about whether individuals were to blame for their ill health but generally most patients felt that extenuating circumstances existed.

Buckman and Sabbagh (1995:75) argue that complementary practitioners trade in health and that many of their patients are concerned with “enhanc[ing] their health” as opposed to looking for specific cures for specific problems. They go on to say that CAM promotes the idea that “full health is not only within the power of everybody, but that it is also his or her *responsibility* to achieve maximum health” (ibid:76-77), and they protest against the “stigma of blame and failure” (ibid:77) that attaches itself to those people who are ill. Unlike some proponents of CAM, Buckman and Sabbagh do not believe that individuals are able to control all disease processes: “personal responsibility for health is a two-edged sword – one edge is a catchy slogan for the healthy, the other edge cruelly transforms the patient into a scapegoat” (ibid:77). This situation is poignantly illustrated by a widower’s recollection of his wife’s visit to a CAM therapist after she had been told her cancer was no longer responding to chemotherapy. The therapist asked the wife why she had cancer and she replied that she did not know. The therapist then asked the location of the primary cancer and was told - in the ovaries. The response from the therapist was “what does that suggest? Eggs, life, creativity. Have you been denying your creativity?” The husband reported that:

We were amused by this idea until its implication sank in: *you are responsible for your own disease....It is unnecessarily cruel to tell people they may be dying because they have failed to live, love, work, relax, or eat properly, whatever ‘properly’ means. We might be able to do these things better, but what right does anyone have to say that these factors might kill us? Where is the evidence* (Buckman and Sabbagh 1995:236-237, my emphasis)?

Another critic of CAM ideology and personal responsibility for illness is Rosalind Coward (1989). She argues that new belief systems are emerging about health because, under the rubric of CAM, being healthy does not equate to an absence of disease but it is more about “feeling good” (ibid:43). Preventative medicine, especially as promoted by CAM therapists, exhorts individuals to “avoid illness altogether” (ibid:44). This, according to Coward, is achieved by “work[ing] for health just as you have to work for most things in life” (ibid:44). Hughes (2004)

and Power (1994) make the point that it is difficult for both patients and practitioners not to collapse responsibility into blame. However Lupton (1994:90) believes that the biomedical model is also underpinned by an “implicit moral evaluation” regarding the etiology of ill health and this causes some practitioners to negatively judge their patients.

ii: Who or what makes you well?

If we believe that the individual is largely responsible for his or her illnesses, what ‘work’ do we do to make us well? If, as Coward (1989:43) contends, CAM is predicated on the philosophy that “natural health is locked within us” and it is up to the individual to ‘unlock’ our healing potential – how do we do this? Is it enough to just think positive thoughts and try to achieve a ‘balanced’ lifestyle?

As the extracts in the above section indicate, it would appear that from a CAM perspective good health can be achieved in many cases by ensuring that the energy flows around the body are working and any imbalances, whether physical, chemical or spiritual, restored. Wellness can be achieved if individuals are prepared to commit to “hard work and personal transformation” (ibid:45) with or without the assistance of a CAM practitioner. The majority of CAM therapies invoke ideas about the self-healing capacities of the body and many of these can be used to ‘kick-start’ the patient’s own healing resources, such as acupuncture or manipulative therapies like osteopathy, or ‘natural’ products used by herbalists or homoeopaths. These techniques and therapies are also individualised because the idea of ‘one size fits all’ is incompatible with CAM philosophies. The apparent “normalization, standardization, and generalization” of the biomedical approach is not relevant because, as Micozzi (1996:7) states:

If the body heals itself, has its own energy, and is uniquely individual, the focus is not on the healer but on the healed...it is liberating to realize that in the end each person heals him or herself.

The individual, it would seem, is heavily implicated in the success or otherwise of CAM interventions as well as the ability to achieve ‘natural’ or ‘perfect’ health. As Coward (1989:42) argues:

If ‘natural health’ is thought to be innate in each of us, rather than something acquirable from the outside by the use of medicines then, logically, it follows that the individual becomes responsible for his or her own health.

Continuing this theme, Clare Baker (2005), a natural health columnist for the Waikato Times states: “it’s important we look at our health as our own responsibility”. Readers are encouraged to transform their lifestyles because “a bit more effort on your part – a change of diet, a shift in attitude, a shifting of the butt off the couch” can help you gain “a lifetime of good health”. While acknowledging that orthodox medicine can be “lifesaving in emergencies” Baker recommends that good health can be achieved if we are prepared to spend “15 minutes every morning imagining our bodies are perfectly healthy, that every cell is functioning perfectly and every breath we take fills our body with good health”.

It would be incorrect to assume that it is only CAM practitioners who espouse personal responsibility when it comes to illness and healing. During the interviews I held with medical practitioners who practise CAM I found they too place a strong emphasis on patients accepting responsibility for their wellbeing. As Robin Kelly (2000:26) argues, when doctors “interfere with...personal responsibility, the patient’s confidence and ability to heal are often eroded” and this induces patients to become dependent upon medical intervention. Kelly believes that doctors and patients have to share responsibility and information in order for healing to occur.

As I have already stated, I do not intend to debate the efficacy of either CAM therapies or orthodox medicine in this thesis. However there are several observations that I think need to be made in relation to CAM and its focus on ‘perfect’ health and individual responsibility. As Coward (1989:14) points out, many industrialised societies are facing a changing episteme in relation to beliefs and attitudes about the body, health and nature. One of the messages CAM promotes is that nature and natural therapies are synonymous with a perfect body and perfect health. It seems to me that in doing this there is a subliminal message being conveyed that, first, nature is sublime and, second, the body is invincible.

Ideas that humans become ill because they remove themselves from their natural environment and can only regain their health by reacquainting themselves with nature have existed throughout history. As shown in the extracts above many CAM therapies invoke the use of products or techniques that will return the patient to a state of ‘natural’ or ‘perfect’ health. However, as Rene Dubos (2001:5) points out, this type of relationship with nature is an “abstract concept” because it lacks the

reality of “the flesh and blood of life”. In other words there is no ‘real’ or ‘perfect’ natural world that we should aspire to because it does not exist. What humans do, to paraphrase Dubos (2001:5), is to manipulate their external world in order to create what is ‘natural’ according to individual taste. And this, as Coward (1989) argues, is what occurs throughout the CAM industry. If we are prepared to dedicate ourselves to maintaining all facets of the self in relative harmony then, according to CAM ideology, we can ward off ill health or at least engage the services of CAM therapists to help restore us to some type of bodily nirvana.

Nature is not unreservedly benevolent. As I have pointed out already, one of my participants died of cancer not long after I had interviewed him. All the other patients I spoke with described a history of various illnesses and pathology. It is quite possible that lifestyle choices contributed to some of their health problems but the one thing they all have in common is that they are ageing and, as such, nature is not always a benign mistress. And it is this aspect, “the body is no longer viewed as degenerate” (Coward 1989:50), that I argue is stunningly absent from much of the CAM discourse. Scant regard is paid to the idea that, as corporeal entities, humans are prone to a vast range of afflictions which may incapacitate us for a short time, or longer, and even if we manage to ward off ills and accidents, ultimately we all age and die. By promoting the “avoidance of illness altogether” (ibid:44), and the reality of ageing and its affect on our bodies (Nuland 1993), I believe we are denying the very essence of our humanity. Certainly our lives may be more pleasant if we adopt a healthy lifestyle but there is no guarantee that we will not contract a terminal or disabling disease or die suddenly at a young age. Denying the ageing process will not postpone it. I only have to look in the mirror myself to see that despite a reasonably healthy lifestyle and genes that, to date, lean towards longevity, my skin is not as smooth as it used to be and my hair is greying.

It is not only CAM practitioners who confront a ‘degenerating’ clientele. Many of the problems medical professionals have to deal with are conditions directly attributable to the ageing process. In industrialised societies our life expectancy is longer than it used to be and our expectations that doctors are able to deal with the degenerating body are high. Longer life expectancy is the result, in part, of the

scientific and technological advances made following the Second World War⁸. The increased availability and use of antibiotics, such as penicillin, meant that the incidence of acute serious illnesses diminished. However in its place we now see an increasing prominence of chronic conditions such as arthritis, back pain, skin cancers, depression and so on (see Fulder, 1996:36-39; Porter, 1999:633 and Sharma, 1992:201-202). But despite the prevalence of chronic illness Budd and Sharma (1994:12) state, “we expect to be well in old age in a way that previous generations did not. Wellness is ‘normal’ in an almost moral sense”. And so even if we accept that it is natural for our bodies to age and that certain parts will either wear out or not work as well as they used to, where do our responsibilities lie with regard to maintaining our health or seeking intervention?

IV: Patients and Personal Responsibility

There are many reasons why patients believe they become unwell and therefore the attribution of responsibility for illness is also complex and varied. As I mentioned above, June Lowenberg’s ethnographic research of a holistic health centre and a holistic dental practice in the United States revealed that practitioners involved in the study did *not* blame or condemn their patients for non-compliant behaviour in regard to recommended treatment regimes, such as diet or exercise programmes. Lowenberg was surprised at these findings because she believed that much of the rhetoric surrounding CAM therapies supports patients taking responsibility for their illness and healing. Lowenberg stated (1992:171):

Not only did [the practitioners] continue to absolve patients from direct responsibility in creating their disease state, but they often warned me about the dangers in attribution of blame and guilt...informing me of the ‘pitfalls’ of going overboard on self-responsibility.

Attribution for illness affects different sectors of society in a myriad of ways. For example, people belonging to Christian healing groups see ill health or therapeutic failure as a sign of either a lack of faith or divine punishment for sins (McGuire, 1988)⁹. For individuals involved with human potential groups or the psychic and occult realms, responsibility for illness and healing is connected to lifestyle choices, in particular the role of the mind and an individual’s emotional state (ibid:108,141).

⁸ Illich (2001), McKeown (1998) and Tesh (1988) argue that increased life expectancy of people in the West owes more to improved public health measures and better standards of living through economic growth than the use of vaccines and antibiotics.

⁹ See also Jaye, C. (1998) for a discussion regarding the attribution of illness by Pentecostal and Christian Scientist congregations. This study also included the views of medical professionals from these congregations along with secular practitioners.

As already detailed, and although seemingly repetitive, when I asked my research participants (patients) what their responsibilities were when it came to health care they all unequivocally described three main areas they needed to manage: their diet and weight, an exercise programme, and reducing stress through a balanced lifestyle. This ubiquitous mantra litters much of the discourse about individual responsibility. Even in 1977 the then President of the Rockefeller Foundation's wrote in his editorial for *Science*:

Prevention of disease means forsaking the bad habits which many people enjoy – overeating, too much drinking, taking pills, staying up at night, engaging in promiscuous sex, driving too fast, and smoking cigarettes – or, put another way, it means doing things which require special effort – exercising regularly, improving nutrition, going to the dentist, practicing contraception, ensuring harmonious family life, submitting to screening examinations (Knowles, 1977a:1).

However, as I point out in Chapter Seven, although many of the patients I interviewed acknowledge the strategies they need in order for them to be healthy, actually incorporating these facets into their day-to-day existence proves extremely difficult. The reasons for this are multifarious but lack of time and lack of money are important factors.

One of the reasons many patients turn to CAM is that it offers them more of an “active...role in the healing process” (McGuire, 1988:201), ultimately encouraging patients to “take on more responsibility for his or her own health care” (Sharma, 1994:88). The aspect of using plural healing modalities is discussed in detail in Chapters Seven and Eight, but it is important to point out here that patients believe they are able to take a greater degree of responsibility for their healing by using CAM therapies as opposed to orthodox medicine. This in part relates to expert knowledge where patients feel confident about diagnosing their own illness and then choosing a health practitioner or type of treatment they feel is appropriate (Miskelly 2005). Acting responsibly under these circumstances includes buying natural remedies at health shops instead of making an appointment with a doctor and relying on the practitioner's expertise and perhaps obtaining a prescription for medication. This type of behaviour subtly alters the power dynamic within the healing encounter because patients feel in control. They choose how *they* want to deal with their health problem(s) and also select a timeframe that suits. They can buy a remedy almost instantly, as opposed to, for example, having to *wait* for a prescription.

While it sounds laudable that patients accept responsibility for their health and that practitioners encourage them to do so, there is criticism of this approach because of its linkage to individualistic ideologies and the increasing obsession with, and surveillance of, the body. These ideas are discussed in the following chapter.

V: Therapeutic Responsibility

When we consult a medical practitioner or CAM therapist what are their responsibilities from a therapeutic perspective? Are they different from one another? And what do health practitioners expect of patients with regard to following advice or treatment options? Are the expectations of all these players realistic? Again, these questions are answered in my fieldwork chapters, but a broad overview of the subject is given in this section.

Ursula Sharma's work on the subject of therapeutic responsibility has been very relevant to my research topic. She asks some very pertinent questions as the following extract outlines:

I shall contend that the popularity of complementary medicine raises crucial questions about the balance between the degree of responsibility which patients may be expected to take for decisions about their own treatment and the degree of control over the therapeutic process which therapists, whether orthodox or non-orthodox may claim. Orthodox medicine, as practiced in the National Health Service, is organized on the assumption that the doctor has prime responsibility for therapeutic decision making; this responsibility may be delegated to another practitioner, as when a patient is referred to a specialist, but in general the patient merely 'complies' or 'fails to comply'. But where a plurality of therapeutic systems exist and people exercise deliberate choice in using one system rather than another, a degree of self-responsibility on the part of patients is surely implied....In the end, who has the right of power to decide who should exercise control or who should take responsibility? The medical profession? The state? The market (Sharma, 1992:2)?

The therapeutic responsibilities of medical and CAM practitioners are similar in many ways. CAM practitioners I interviewed outlined their main responsibilities as ensuring safe practice; educating their patients; encouraging patients to become independent healers; referring their patients to either orthodox or other CAM practitioners when necessary; and for themselves, participating in continuing education. The GPs I spoke with described their responsibilities as making a correct diagnosis; referring on as necessary; providing continuity of care; receiving informed consent from their patients; providing an after-hours service; educating

their patients, and, like their CAM counterparts, continuing with post-graduate education. The GP-CAM practitioners offered similar views of responsibility to their orthodox colleagues although they described the importance of adopting a holistic attitude towards consultations while retaining an orthodox approach to diagnosis to ensure that serious pathology was not present. The biggest difference between this group and their orthodox colleagues was their belief that patients were largely responsible for both their health and healing. The differences between the groups are subtle and, I believe, important. For instance orthodox medical practitioners believed that continuity of care was an intrinsic part of their therapeutic responsibilities and thus an after-hours service was seen as essential component of patient care. Some GP-CAMs personally offered an after-hours service but many did not. Generally CAM practitioners did not believe it was part of their 'job description' to provide after-hours care because patients who needed this type of service had usually suffered an accident or were experiencing acute conditions and therefore orthodox medicine was best placed to deal with these.

As Crawford (1980) states, the therapeutic encounter is a socially constructed one. A person with an illness or an injury adopts the role of patient and forms a relationship, albeit on occasions brief and superficial, with a health practitioner. As much of the literature notes, the relationship between doctors and patients appears to be based around ideas of power, autonomy and expert knowledge. Crawford (*ibid*:373) argues that the role ascribed to patients is a passive one as it involves understanding illness as portrayed by a medical practitioner and accepting both the diagnosis and treatment plans. This is often not perceived to be the case within the context of CAM or Dr-CAM practitioner consultations because patients are encouraged to take a larger degree of responsibility for their health and healing processes. However, one of the criticisms of this approach, as I mentioned above, is that by promoting responsibility as the prime locus of the patient, there is a possibility that CAM practitioners are able to distance themselves from their treatment outcomes and hence, by inference, their therapeutic responsibilities. Certainly there was evidence of this behaviour amongst some of the CAM practitioners I spoke with (outlined in detail in Chapter Eight). Power (1994:196) argues that practitioners need to "examine their consciences and improve their accountability" to ensure that this situation does not occur. This view is also

apparent in the MACCAH (2004:4) report where the Committee includes in its guiding principles the idea that patients and practitioners share responsibility.

However it is not only practitioners within a CAM environment that face criticism relating to their therapeutic decisions. Patients are becoming more sophisticated and educated and challenging the status quo of medical knowledge. One result of this questioning attitude is the rise in litigation against orthodox practitioners. As Lantos argues, we live in societies these days that “like to look for villains” whether it be governments, bureaucrats, businesses or individuals and that one of the results of this change in attitude may be that “we don’t need many of the things that doctors used to do” (Lantos 1997:3). It may be argued that we live in an environment that is intent on blame – whether this relates to health problems, examination results, violence, floods and resulting damage to property and so on. Who is responsible for unexpected or unwanted outcomes, and if they occur who can we blame? Part of this blame ‘culture’ I believe, in relation to the health environment, can be attributed to our lack of acceptance of ill health. This of course ties in with the ideologies underpinning many CAM therapies relating to the healthy body as a ‘natural’ state. Also, our more secular societies seem less accepting of death as a natural and inevitable part of what it means to be human (Nuland 1994).

Lantos (1997:3) puts up a compelling argument that the change in views as outlined above has often left doctors in a quandary because nobody in fact appears to be responsible. With the fragmentation of the health service and the rising status and apparent autonomy of other health care professionals, such as nurses, dieticians, CAM therapists and even administrators, orthodox practitioners are no longer perceived to be in charge and the consequence of this is that “they are no longer the locus of responsibility for decisions and outcomes” (ibid:5-6). If, as Lantos argues, politicians, bureaucrats, researchers and lawyers are going to have to shoulder some of the responsibilities that used to be vested in the medical profession, then to who will these individuals be accountable to? What mechanisms will be put in place to ensure that they are in fact held to account? As Lantos (ibid:40) says:

We play a shallow game with responsibility, foisting it onto committees, courts or corporate boards, but we don’t talk about what it means to anyone, be they doctor, nurse, parents, judge...[when we] care for someone who is incurably sick, interminably dependent, or dying....

Lantos points to contradictions that are occurring where orthodox practitioners' authority is being constantly challenged. He believes that on the one hand society as a whole wants to preserve those areas of the medical profession which relate to the healing and saving of lives, but at the same time feels a need to retract professionals authority (ibid:27). Morreim (1995) discusses patient and practitioner autonomy (which I outline in more detail in Chapter Four) but I believe she makes a point that is worth including at this juncture. Morreim argues that patients within an orthodox medical environment have wanted the freedom to make their own decisions but, concomitantly, the freedom to *not* make decisions, instead conferring that responsibility onto doctors.

To put the matter more starkly: while we castigate the physician whenever he would purport to 'play God', we nevertheless require him to 'play Christ' (Morreim 1995:136).

Responsibility for making therapeutic decisions was fraught with contradictions for the patients I interviewed. I was also made aware of the dilemmas people faced when discussing my research socially or 'after-hours (so to speak)'. One example of this happened when I was having a drink with a few colleagues and an acquaintance of theirs talked to me about his experiences when making decisions about his diabetic condition. As I recorded in my research diary:

Paul told me that he had been diagnosed with diabetes some years ago. For several years his diabetes was managed by his doctor and nurse at the medical centre he attended. His blood sugar levels were taken, and the medication he needed, and how often it was required, was prescribed. However more recently he has been expected to manage his own condition. He told me that he found this level of responsibility daunting and much preferred being 'told' what to do by his doctor or nurse. (March 2005)

Paul's experiences, along with those of my patient participants, highlight the quandary many of them face. At one level they want and enjoy the autonomy responsibility for therapeutic decision-making brings, but at another level this type of responsibility can produce anxieties.

Another factor with regard to therapeutic responsibility has been an increasingly vocal consumer movement. Over the past thirty years consumer groups have called for a more accountable health sector, while at the same time increasing the expectations and demands of health professionals (Taylor 1985, cited in Vincent and Furnham 1997). This, according to Taylor, has had a negative impact on patient-doctor relationships in five key areas:

1. Doctors face increased threats of litigation (and negative publicity in the media) therefore they do not trust their patients to the same extent they used to. As a result, consultations take place in a less relaxed atmosphere.
2. There is a worldwide shortage of medical personnel. One impact of this is that doctors have become an increasingly mobile workforce and, as such, long-term therapeutic doctor/patient relationships are unlikely.
3. Doctors still want clinical autonomy, but this is often perceived by patients as an unwillingness to share information.
4. The increasing health care bureaucracy makes patients feel more like a statistic as opposed to an individual with problems that require treatment.
5. The ever-increasing costs of health care and rationalisation of services means that both patients and practitioners are concerned about what services will be available in the future.

On the whole participants I interviewed share Taylor's views. While none of the patients I spoke with expressed very negative opinions about the relationship they had with their GP, concern was raised about the 'conveyer-belt' environment of general practice. This related to full waiting rooms and ten-minute consultations, and the lack of a holistic approach by some practitioners. The refusal to accept patient expertise was also a factor in patients' disgruntlement with their medical encounters. Patients generally articulated positive comments about their relationships with CAM therapists, although reservations about the efficacy of some treatments, and the querying of practitioner expertise, were exhibited.

All categories of practitioners I spoke with revealed some levels of anxiety over whether they could 'trust' their patients nowadays, given the increasing trend towards litigation or publicity about perceived errors and ensuing 'trial by media'¹⁰. The increasing level of bureaucratic intrusion into clinical practice through aspects like best practice protocols, general form filling, as well as increasing post-graduate education requirements, were construed as constricting elements in the therapeutic relationships practitioners had with their patients. This related in particular to the amount of time these 'extramural' activities take.

¹⁰ For example, the Medical Council case against Dr Richard Gorringer received considerable media coverage, as did the manslaughter charge brought against midwife Jennifer Crawshaw, who was found not guilty by a jury in the High Court in March 2006.

I decided that I might glean further information concerning patient rights and responsibilities by attending a Patients Rights Advocacy Group meeting. One such meeting was advertised in the town where I lived, so I took the opportunity to attend. I was very surprised by the invited speaker's vitriolic presentation strongly criticising the medical profession. Information presented by the speaker was factually incorrect, for example she said that doctors were not required to pay Accident Compensation Corporation (ACC) levies. However doctors, if they are self-employed, do have to pay levies as invoiced by the Corporation. A note in my research diary (28.07.05) following the meeting reads:

The advocate started off by outlining what her group can do for patients – such as help write letters of complaints, accompany patients to consultations, initiate complaints through the Health and Disability Commissioner, deal with ACC and that sort of thing. However she made some outlandish claims against doctors saying “doctors can still do *anything* they want to you” and “doctors make mistakes *because* they can cover up their mistakes”. The advocate made it sound like a very adversarial relationship where the medical profession definitely doesn't have the patients' interests at heart. She also criticised drug companies and said patients should be very wary of what they were taking because doctors are still prescribing medication that had been banned years ago.

While I am well aware that mistakes do occur with therapeutic intervention and not all doctors are honest and reliable I was astonished both at the tone and the content of this presentation. Not one positive word was said about the medical profession. It would, of course, have been interesting to know more about the advocate's personal background (she had been a nurse and a theatre sister) because it may have revealed why she expressed such negative attitudes.

In tandem with the consumer movements, the women's liberation movement and patient rights groups, we have seen a proliferation of “complex regulatory framework(s)” (Lantos 1997:47) within the health sector. One of the results of this has been an attempt by bureaucrats to shift the responsibility for therapeutic decisions away from health professionals to more nebulous agencies such as committees or institutions, or enshrine them in laws and regulations (Lalond 1974; Lantos 1997; and Lillis 2000). The argument against this move is that it decreases patient accessibility to a reasonable standard of health care (Lantos 1997). However, as the health sector is still largely funded in most industrialised nations by the state, and costs are increasing all the time, it is not unexpected that governments

and health bureaucrats are demanding a greater say in the way the health dollar is spent.

VI: Financial Responsibility

All the participants I talked with expressed opinions about where responsibility should lie when it comes to the provision and payment of health care and, as I explain in subsequent chapters, there is a divergence of views. Some patients believed that the state should fund all our health needs but then qualified those statements by saying that they did not expect CAM treatments to be paid for out of the public purse. Other patients protested against the lack of funding for CAM therapies and described the impact of having to meet the cost of consultations and products out of their disposable incomes, which in some cases was extremely limited. Health practitioners were also divided in their opinions. Orthodox doctors were generally supportive of state funding for health care provided under the biomedical model, but were largely opposed to such funding being available for CAM consultations. One Dr-CAM practitioner was vehemently opposed to the state having a role in either orthodox or CAM funding, except for the provision of a pared down public hospital system, while other CAM practitioners thought the government should meet the cost of CAM consultations because they believed it would lower the cost of the health vote. The way the Dr-CAMs practised revealed that some still opted for part payment through state patient subsidies while others relied on their patients to meet the full cost of consultations.

Whatever beliefs are held, it is an inescapable observation that governments in industrial societies are faced with burgeoning health care costs. The demands for health care, both CAM and orthodox, are insatiable. As I point out in Chapter Five, the health sector in New Zealand has undergone considerable reforms since the 1970s. The reasons for these reforms were largely because of “the need to control and contain expenditure and to improve the efficient use of public health resources” (Salmond et al 1994:2). Doctors, both here and overseas, have been implicated in the increasing cost of health care delivery, and criticism was levelled at a system that did not encourage the medical profession to choose treatments that were “most appropriate and cost-effective” (Upton 1991:17). While society in general may believe that doctors should be imbued with a moral and ethical commitment to do

everything possible for patients, the other side of this argument reflects the financial cost to society.

One way to try and stem the demand for health dollars is through government policies now requiring fiscal accountability from both doctors and the organisations they work for (Hunter 1994:2-5). This has resulted in a *cultural* change within the health sector, where an alteration in the balance of power between doctors and managers has occurred (ibid:4). One of the effects of this reform process has been the curtailing of medical practitioner autonomy through cost-control measures (Leicht and Fennell 2001:172) and senior managers within the health sector are now viewed as the recipients of the “autonomy and prerogatives that [medical] professionals once enjoyed” (ibid:216)¹¹. This cultural change was also envisaged to bring about a user-pays philosophy and a ‘client-centered’ approach to medicine that would enable patients to outline the types of health services they wanted (Hunter 1994:6-7) and this of course would include both orthodox and CAM modalities¹².

The cost of providing a health care service is also relevant within the CAM sector. Some of the CAM and Dr-CAM practitioners I spoke with suggested that state funding of CAM would reduce the overall cost of health care but as Cant and Sharma (1999:46) point out, it appears that the increasing popularity and use of CAM has not diminished demand for, nor therefore the cost of, orthodox medical services. Certainly all the patients I interviewed utilise plural healing systems incorporating both CAM and orthodox modalities.

In some quarters, it is believed that state intervention in the provision of health care protects patients from the realities of costly procedures, medications and other interventions (Morreim 1995; Lantos 1997:61; Knowles 1977b). And so the debate is ongoing as to whether it is the state’s responsibility to provide health care, and if so, what level should this entail? Or is it reasonable to expect that the financial responsibilities presently shouldered by the state should become the province of

¹¹ I discuss practitioner autonomy and the effect this has on their responsibilities in the following chapter.

¹² This assumption that the consumerist role would provoke a change in attitude by patients towards their use of the medical profession and services was found wanting by Lupton et al (1991). This is because patients generally trusted their doctors and showed little inclination to challenge the status quo. See also Cant and Sharma (1991:21-50) for a discussion regarding the patient/consumer dichotomy.

individuals? In an effort to stem the rising costs of medicine controls have been put in place which result in a tension between medical practitioners, patients and health bureaucrats (Lantos 1997:162) and this has influenced the way responsibilities are defined and acted out.

As can be seen above, individuals and health practitioner groups have different, and at times, contradictory ideas about what responsibility means to them with regard to the provision of health care services and the role of individuals. Whatever these views health remains one of the major concerns of governments the world over.

This is because:

One of the main reasons for [governments' participation in the health sector] is that individuals cannot look after all aspects of their own health. They may not have the financial means and knowledge to do so and rarely are they in a position to exercise full control over those aspects of their lives known to affect health such as where they work and live, the air they breathe and the food they eat. Moreover, it is in the interests not only of the individuals themselves, but also of the community at large, to maintain the health of all its members. In other words health carries external benefits. Therefore it falls to government to ensure that all citizens have access to a reasonable standard of care (Wall 1996:186).

Wall's sentiments are, arguably, laudable. However this ethos has been challenged by a move away from ideologies promoting collective social responsibility to more individualistic focused societies trumpeting self-responsibility. Since the 1990s both National- and Labour-led governments have implemented changes that have changed the direction of state health care funding. While taxpayers are still the major contributors of the state provided health care system, because of waiting lists for surgery and outpatient clinic appointments, and the removal of some elective surgery procedures, such as vasectomies or varicose vein removal, individuals are being subtly encouraged to accept an increasing level of commitment to pay for their own health care.

New Zealanders were told that the health reforms would give them more choices and make more explicit what they could expect from the state funded health sector and what they could expect to fund themselves...The changes in the health sector were motivated by the need to reduce state spending on health, and transferring responsibility for both choice and funding from the state to the individual was a strategy employed in this process (Gower 2000:96).

It is possible to argue that this system penalises taxpayers who, if they also pay for treatment out of their own pocket, are in the invidious position of paying for their health care 'twice'.

The debate surrounding whether or not the government should pay for CAM treatment continues. In the face of a recommendation from MACCAH (cited below) it will be interesting to see if any changes are implemented in the future.

Where there is evidence of safety, efficacy and cost effectiveness, specified CAM modalities should be considered for public funding [and] The Ministry of Health should encourage the District Health Boards to establish pilot studies to identify the practicalities, costs, benefits and health outcomes that would accompany CAM and biomedical practitioners working together (MACCAH 2004:6).

VII: Conclusion

From a social constructionist perspective, the ideas we have about health, sickness and healing arise from our day-to-day experiences and these include an amalgamation of ideas generated from both orthodox and CAM modalities. Although the predominant discourse of the biomedical model continues to strongly influence our health-keeping practices this situation is changing because the rhetoric of individualism now pervades New Zealand society. One of the most noticeable areas of influence within the health sector can be seen in the way the discourse surrounding CAM works in concert with neo-liberal rhetoric. This has resulted in a highlighting of personal responsibility for health and illness as opposed to collective responsibilities. CAM largely disregards a person's individual circumstances, including ethnicity, gender or social class, and advocates that people can change aspects of their lives, including their health, if they want to. All it requires is motivation. As Devine (1998) argued, changing a person's circumstances, whether in relation to their health, (education or economic background and so on), is, in neo-liberal terms, tantamount to a business transaction - the task of a market society (Gledhill 2004). If an individual cannot change his or her circumstances then, as Devine remarked, it becomes someone else's *business* to do so. And as such, over recent years, CAM has positioned itself to capture an increasing market share of the health sector. We are constantly exposed to ideas about being healthy, that it is our 'natural' state, and it is our responsibility to be well. There is the implication that by literally buying into CAM, we can buy health.

The biomedical model does not discount individual responsibility for illness and healing but the literature reviewed and the practitioners I spoke with largely supports, I believe, a more holistic viewpoint of responsibility. There is a tacit agreement that the reasons for ill health are multifactorial and it is not just disease etiology that has to be considered, but social, cultural, psychological and economic circumstances as well.

It could be stated that, at best, much of the literature I have reviewed, especially relating to CAM therapies, is biased, either in a positive or negative vein. Certainly there are examples of extreme or intransigent views (see Glymour and Stalker 1989 and Griggs 1997). However there is much common ground as well, especially as I have noted when it comes to recognising that the choices people make about their lifestyles impacts on their health. But in reality the situation is much more complex than what people chose to eat, or drink, or smoke, or whether they exercise or not. The social milieu, especially from economic, cultural and environmental perspectives, has a significant bearing on people's health and wellbeing and, importantly, the resources they can access.

I acknowledge that in many ways I am sticking my neck out in proposing that it is orthodox medicine that offers a more holistic view of health and sickness and attendant responsibilities than CAM. However, as I discuss in the following chapter the role of the individual, especially within the neo-liberal environment, has, I believe, been pivotal in narrowing CAM's focus, and as a consequence I found that many practitioners I spoke with, both CAM and Dr-CAM, expressed views which were generally unsupportive of collective responsibility and social obligations and more inclined to be centered on the self. This situation is further complicated because all my research participants live in a world of different and contradictory discourses: neo-liberalism, collectivism and individualism to name a few, and they are constantly having to move between them. The rhetorical devices they use to make sense of these different discourses are often strongly influenced by how they view the role of the individual.

CHAPTER FOUR

THE ROLE OF THE INDIVIDUAL IN A NEO-LIBERAL SOCIETY

“I am my own authority”

(in Heelas 1996:21)

“No man is an island”

(John Donne)

I: Introduction

Along with responsibility the other major theme that developed from the literature I reviewed together with the discussions I had with my research participants was that of the role of the individual. This particularly related to ideas pertaining to individual responsibility and the notion of autonomy. What proved a revelation to me was that during the interviews I undertook with CAM and Dr-CAM practitioners, and much to my surprise, I encountered a discourse steeped in neo-liberal philosophies. I believe that this philosophical bent certainly influenced the way in which these practitioners regarded their roles and responsibilities, as well as the expectations they have of their patients. While some of the rhetoric voiced by patients and general practitioners also contained neo-liberal ideas I found that in reality their behaviour and expectations echoed a more collectivistic ethos.

Individualistic and neo-liberalistic discourses privilege the individual and question the role or even existence of society and community. This chapter details the background of these bodies of knowledge (Sections II and III) and shows how these discourses now influence individual, professional and state rhetoric relating to responsibility and autonomy.

I believe that my research participants' views reflect the complexity that exists between rhetoric and reality. Of particular importance, from this research project's perspective, are the *political* ramifications of neo-liberalism with its emphasis on individual as opposed to collective responsibility. One of the paradoxes of neo-liberalism is the rhetoric of surveillance advocating the monitoring and control of individuals, either through bureaucratic channels or by individuals themselves (see Sections IV and V). While both the biomedical and CAM models are complicit in this surveillance rhetoric, it is more overt in the rhetoric underpinning many CAM therapies.

What has occurred, under the auspices of individualistic and neo-liberal discourses is the emergence of a *blame* culture where responsibility for ill health is often attributed to a particular individual's lifestyle choices, such as a poor diet or lack of exercise. I believe this attitude patently ignores the realities of living in the West and its preoccupation with consumerist activity. What we have is a socio-cultural environment that actively encourages autonomy (Section VI), freedom of choice and consumerism, which often results in a lifestyle at odds with 'wellness'. Then when people become unwell they are blamed and punished for making unhealthy choices. The rhetoric of freedom of choice, autonomy, state and self-surveillance, and blame, are the central paradoxes of neo-liberal discourse. It is this environment of mixed messages that many of my research participants, both patients and practitioners, find themselves constantly negotiating.

II: Individualism – Its Beginnings and Application

The role of the individual has been one of the cornerstones of modern western civilisation and as a consequence a vast array of scholarship has been compiled concerning its inception, its attributes and its weaknesses. Individualism is a social and political philosophy advocating liberty and freedom of choice for individuals as opposed to supporting collective interests or demands. Individualism supports the notion that it is the individual who is of primary importance and value. Within an individualistic environment, individuals are considered to be solely responsible for the decisions they make and cannot hold the state or other individuals accountable for their actions.

An understanding of the role of individuals and their relationship with other individuals, together with their socio-cultural environment, has influenced political, economic, religious, ethical, epistemological and methodological doctrines (Lukes 1973). For example, many of the sentiments underpinning these doctrines are reflected in the American Declaration of Independence and in the Universal Declaration of Human Rights adopted in 1948 by the United Nations General Assembly, which supports "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family" (ibid:49). As can be imagined, these doctrines have also influenced contemporary ideas about responsibility in western societies. While out of necessity I describe the germination of individualistic and neo-liberal thought and their subsequent influence on belief systems surrounding health and illness within biomedical and

CAM environments, providing a comprehensive and detailed history of the development of individualism and neo-liberalism is beyond the scope of this thesis. Nor do I intend to delve into the significant body of psychological literature on this subject. What follows is an outline of the way individualistic and neo-liberal thought has come to play such a predominant part in the contemporary New Zealand socio-cultural landscape, as is mirrored in other western democracies. But to begin, where did the idea of individualism come from?

Locating one coherent history of individualism is problematic. For instance Hayek (1949), Lukes (1973), Macpherson (1962) and Turner (1988) all provide varying interpretations of the development of individualism based upon their own doctrinal persuasions. There is some consensus of opinion that it was in early Greek society that ideas about individualism took root. Christianity endorsed these sentiments because of the idea of the “individual’s supreme worth” (Lukes 1973:45), although this related more to the “individual-in-relation-to-God” (Dumont 1985:98) as opposed to a person’s relationship with society. During the Middle Ages individual aspirations were replaced with ideas relating to the “common good” and collectivism became the predominant value (ibid:46). This was due in part to the influence the Church had over all laws and the belief that the cohesion of society rested on adherence to religious doctrines, as opposed to the fragmented self-interest of individuals (ibid:46). The Church and state continued to suppress the value of the individual until their authority was challenged during the Reformation, Renaissance and Enlightenment where the importance of the individual was once again emphasised (Green 1985:5). Two key figures in this re-assertion of individualistic philosophies were Thomas Hobbes (1588-1679) and John Locke (1632-1704). It was at this time that a new way of thinking emerged about the “place, capacity and potential of the individual and their relationship with and place in society” (Gower 2000:39). Hobbes believed there were two forms of autonomy. First was intellectual autonomy – individuals being capable of gathering and disseminating information; and second moral autonomy – individuals having the right to make their own decisions (Ryan 1988:81). Kant and Spinoza also associated autonomy with ideas about intellectual freedom (Lukes 1973:54-55).

However, despite these changes supporting the notion of individual supremacy and worth, the industrial revolution in the nineteenth century foreshadowed further

changes, mainly because of concerns raised about the health and welfare of workers (Green 1985:6). It should be noted that these concerns were not entirely philanthropic because it was the demand for a fit and healthy workforce required to work in the expanding industrial and manufacturing sectors that was considered to be important, as opposed to more altruistic motives. Up until the mid-twentieth century western governments supported policies which valued community and social ties, hardly surprising after the experiences of both world wars. However, as those memories dimmed and the political and economic landscape changed, so did the ideological direction of politicians and policy-makers.

The political and economic aspirations of governments are closely intertwined. Right-wing parties tend to promote policies reflecting individualistic ideologies that advocate voluntary collaboration as opposed to state and bureaucratic intervention (Hayek 1949; Lukes 1973). This often means that right-wing governments attempt to devolve fiscal responsibility for some services, such as health and education, onto individuals. For example, individuals are encouraged to provide for their own health care and retirement income (superannuation) through private insurance schemes. Left-wing administrations, on the other hand, while usually supporting the basic tenets of capitalism, espouse a more collective ethos and support legislation and state spending to assist certain sectors of society. New Zealand has experienced both individualistic and collectivist political regimes, and for just over half a century (1920-1980) collectivist policies saw the provision of universal benefits such as those supporting the unemployed, widows or those too ill to work. Universal coverage for health and education was also provided (Goldsmith and Kingfisher 2003:331). It was not only the so-called disadvantaged who benefited from the welfare system; as Goldsmith and Kingfisher point out, governments also adopted interventionist policies supporting market and price protection for local industries, especially the farming and manufacturing sectors (ibid:331). Emphasis on individual responsibility was thus tempered by the influence of the state, with assistance being available to those in need despite their personal background (such as a student's parents' income).

However, the late 1970s heralded a change in direction. This was due to a number of factors. The oil shocks of the late 1970s and subsequent rampant inflation were catalysts for changing economic and social policies. Britain's entry into the

European Community produced uncertainty about a previously relied upon export market for much of New Zealand's primary produce (ibid:336). The economy also faced new pressures because of New Zealand's closer relationship with Australia, which in turn influenced the labour and commodity markets. In recent years these areas have been put under further pressure due to the effects of globalisation and competition from East Asian markets (ibid:336). All these factors triggered a change in policy direction by both National and Labour governments in an effort to forestall New Zealand's spiralling current account deficit. To this end neo-liberal policies incorporating individualistic philosophies were introduced in the hope they would control a state sector perceived to be unwieldy and inefficient, and by doing this, an environment would be created encouraging economic growth. Heelas talks about this era in the West as promoting 'enterprise values' which consist of:

...individualistic values, all held to enhance productivity: exercising responsibility, initiative, energy, creativity, self-reliance; standing on your own feet rather than being dependent on others...of doing away with dependency cultures: of liberating people from restrictive ego-routines; of encouraging self-responsibility (Heelas 1996:168).

This change in policy direction meant that many sectors of New Zealand society were subjected to restructuring and these changes reflected a move away from the collective ideologies of previous administrations. These changes were especially evident in the social welfare sector. During the 1990s a number of reforms were implemented which saw the introduction of targeted assistance. The criteria for benefit and allowance eligibility were tightened (see Goldsmith and Kingfisher 2003:337 for a comprehensive description), and 'part charges' for health care and education were introduced.

These changes to the health sector coincided with challenges made by the general public to authority and expert knowledge. One manifestation of these challenges was a growing disenchantment towards biomedicine and a resurgence of interest in alternative and complementary therapies. These factors were an integral part of the move to shift responsibility for health care onto individuals and, I contend, a culture of blame permeated much of the discourse. A report released from the Canadian Minister of National Health and Welfare, Marc Lalonde, influenced the direction of health care policies in western countries.

i: The Lalonde Report

In the mid 1970s the Canadian Liberal Party's Minister of National Health and Welfare, Marc Lalonde, released a working paper, *A New Perspective on the Health of Canadians*, which pushed for individuals to take more responsibility for their own health care. The report said:

If government is, at least in part, a mirror of the people's collective will, then the people collectively must *accept the blame* for any causes of sickness arising from the deterioration that has taken place in the environment...In addition to the health care system and the people collectively, *individual blame* must be accepted by many for the deleterious effect on health of their respective lifestyles. Sedentary living, smoking, over-eating, driving while impaired by alcohol, drug abuse and failure to wear seat-belts are among the many contributors to physical or mental illness for which the individual must accept some responsibility, and for which he [sic] should seek correction (Lalonde 1974:26, my emphasis).

In the report Lalonde highlighted self-imposed health problems that Canadians faced caused mainly by drugs (alcohol addiction, excess alcohol consumption, cigarette smoking, abuse of pharmaceutical drugs, social use and addiction to psychotropic drugs); poor diet and exercise patterns (over-eating leading to obesity, fad diets leading to malnutrition, high-fat and high-carbohydrate intake, lack of exercise and recreational activities leading to stress and related health conditions such as ulcers and hypertension); as well as risky driving habits (not wearing seat-belts, speeding, driving while under the influence of drugs or alcohol) and promiscuity and 'careless' sexual behaviour (ibid:16-17). Lalonde also touched on environmental risks such as pollution, urbanisation, poor working conditions and rapid social change. These risks, the report concluded, created "... a far greater threat to health than any present inadequacy to the health care system" (ibid:18). However, and somewhat ironically, the report also recognised that "Canadians have the right to choose their own poison" (ibid:6). This type of rationalisation can be seen as concurring with the basic tenets of individualistic thought - the right of the individual to make their own decisions and any attempt by the state to dictate lifestyle choices is paternalistic and breaches individual autonomy.

The report also examined the cost of maintaining services and pointed to a lack of incentives to contain costs within the health care sector. It suggested that if patients and practitioners are able to access care relatively easily because only minimal financial barriers are in place, then demand for services will always remain high (ibid:29). The report went on to suggest that some of the work done by

doctors and dentists could in fact be carried out by other health care workers “often at a lower cost” (ibid:30) and concluded that, because there will always be limited funds, individuals, governments and the general public will have to ultimately make choices with regard to which health care services they wish money to be spent on (ibid:73).

This report was embraced by conservative governments in the West as a means of introducing cost-cutting measures into the public health sector. For example, the Thatcher government in Britain promoted the concept of community care because it was seen as a means of saving state funding in the health and social sectors. This created an opportunity for the state to shift the burden of responsibility for providing services from the state onto individuals, as well as providing a platform for private enterprise to become involved in health care (Baggott 1994:221-222).

In New Zealand similar sentiments were expressed and over the past thirty years policies promoting collectivism have increasingly been criticised by both politicians and the business sector, such as the Business Roundtable. As an example, in a 2005 address to the electorate, the leader of the National Party, Don Brash (2005, my emphasis), stated:

We need to remind ourselves that this country was pioneered by people of enterprise, some who crossed the Pacific in small craft, others who much later travelled half way round the globe to carve out a land of opportunity. They would be aghast if they could see what has happened to the attitudes of *personal responsibility*, self-reliance, and independence which have been the essence of the Kiwi character.

Not only did Brash’s speech outline ideas to do with personal responsibility, it also indicated there was a need to monitor people on benefits to ensure that they were not ‘using or abusing the system’. For instance, one of the measures announced related to women who were on the Domestic Purposes Benefit (DPB) being financially penalised if they gave birth to further children while receiving state funding, or that they would not be entitled to receipt of a full benefit if their children were not immunised.

As can be seen from the above discussion, individualistic discourse is redolent with rhetoric concerning the responsibility of individuals to ensure their own well-being and not rely on the state, or other agencies, to intervene or make decisions on their behalf. In such an environment the role of any government would be restricted to

protecting individual rights, especially those relating to property (Lukes 197?:84). Not surprisingly, individualistic philosophies are open to criticism. This is particularly so in the debate surrounding whether it is society, or the individual, who has - or should have - precedence.

ii: Society versus the Individual

Macpherson (1962:263-264) criticised the theories of Hobbes, as amended by Locke, calling them *possessive individualism*. He maintained that this type of individualism contained the following seven propositions:

- (1) What makes a man human is freedom from dependence on the will of others.
- (2) Freedom from dependence on others means freedom from any relations with others except those relations which the individual enters voluntarily with a view to his own interest.
- (3) The individual is essentially the proprietor of his own person and capacities, for which he owes nothing to society.
- (4) Although the individual cannot alienate the whole of his property in his own person, he may alienate his capacity to labour.
- (5) Human society consists of a series of market relations.
- (6) Since freedom from the wills of others is what makes a man human, each individual's freedom can rightfully be limited only by such obligations and rules as are necessary to secure the same freedom for others.
- (7) Political society is a human contrivance for the protection of the individual's property in his person and goods, and (therefore) for the maintenance of orderly relations of exchange between individuals regarded as proprietors of themselves.

These propositions expose the fundamental beliefs of Hobbes and Locke that while they accept individuals are influenced by their social surroundings, it is the individual and his or her right to property and the ability to be involved in 'market relations' that take precedence over obligations to the society they live in. The individual is, in effect, *larger* than the society they live in. Macpherson found these beliefs problematic because he believed they ignored the reality of individuals living within a community, of being part of a society or social grouping. Similarly Louis Dumont's (1984) theory of 'individuals-inside-the-world' and 'individuals-outside-the-world' recognised the importance of some type of society. Dumont

observed, during his fieldwork in India, that even the individuals who distanced or removed themselves from everyday life in order to undertake religious contemplation, still needed to belong to a group of fellow devotees.

Papers¹ released in 1998 following the ‘Social Responsibility: Whose Agenda’ Conference held the previous year in New Zealand also strongly supported the notion of society. This is evident through rhetoric highlighting the importance of society and social interaction, and collective responsibility. Devine (1998) concluded that even for the term ‘social responsibility’ to be used, the existence of a society or community is implied. This contradicts supporters of individualism, such as Margaret Thatcher, who famously stated ‘there is no such thing as society’.

Further endorsement of the importance of society was revealed in recent correspondence in the *NZ Listener* focusing on the prevalence of depressive illness in New Zealand society. Philip McConkey, a counsellor, wrote that one reason for depression is the lack of recognition that humans are social beings; they *need* society:

...the primary human need [is] for connection. We live in a universe that is based on connection, on relationship. Everything that exists does so only by its relationship with everything else. Humans are part of that law. But so much of our western value system appears to deny that. The values of independence, self-reliance, individual autonomy and choice are espoused as important to our individual and collective well-being...We are relational beings, but our western lifestyle and values create separation, isolation, alienation and soul loneliness. Our basic need to belong and feel connected is denied. Why wouldn't we be depressed (McConkey 2006:6)?

Of course anthropologists have long recognised the importance of society and consider it a more durable entity than individuals, hence their interest in the work of French philosopher and sociologist, Emile Durkheim (1858-1917). Durkheim challenged the utilitarian concept of society: that it exists only inasmuch as individuals maintaining relationships with other(s) for the sole purpose of securing “individual advantage” in an environment based on “exchange relations” (Poggi 1972:168). To paraphrase Poggi (ibid:169), Durkheim believed that individuals act in specific ways *because* social processes preceded the existence of individuals as opposed to it being behaviour causing processes to be implemented. Further, Durkheim argued that the expansion of authority and regulation in modern societies

¹ These papers reflect the importance of society and criticise the implementation of neo-liberal policies by National and Labour governments in New Zealand (see O'Brien 1998).

also confirmed the existence of society (Durkheim1933:212-220). Shared meanings through language, cultural identity and traditions are the hallmark of all societies or social groupings. Thus, unlike proponents of individualism, anthropologists consider society to be *larger* than the individual². This attitude, which in essence privileges society over the individual, goes against the central tenets of neo-liberal discourse.

III: Neo-liberalism

Neo-liberal discourse is imbued with individualistic rhetoric. The roots of neo-liberalism can be found in the liberal economic philosophies promoted by Adam Smith (1723-1790). He believed that governments should have a very limited sphere of influence over economic matters and that free trade would encourage and enhance the development of national economies. However it was not until the signing of the Bretton Woods Agreement in 1944 and the influence of twentieth century economists such as Friedrich von Hayek and Milton Friedman that the foundations of neo-liberal thought became firmly established in the policies of western governments. These policies included the disbanding of many state-owned corporations, the removal of trade protection regimes and a freeing up of labour and business markets through deregulation. Financial institutions such as the International Monetary Fund, the World Bank and the US Treasury still subscribe to neo-liberal philosophies and encourage moves towards a globalised economy.

Critics of neo-liberalism point to a *selective* freeing up of world trade, as currently illustrated by the way access to export markets is denied to many third world nations by countries such as the USA. New Zealand is also experiencing the consequences of selective neo-liberal policies because of the restrictions it faces in being able to export goods, especially its primary produce, to places like the USA, Australia and Europe. In New Zealand neo-liberal philosophies adopted by

² As a graduate of the discipline of English Literature, as well as Social Anthropology, I have experienced great difficulty coming to terms with the concept of individualism. While Anthropology, of course, has made me acutely aware of the nature of society, English Literature provides endless evocative examples of human beings need for relationships, social order and social contact – in essence their need to belong to ‘something’. I was struck by this while reading Doris Lessing’s *Dialogue* where she describes how being part of a community, even as an observer, makes her protagonist feel comforted and joyful: “Well-being, created because of the small familiar busyness of the street, filled her. Which was of course why she had spent so long, an hour now, loitering around the foot of the tall building. This irrepressible good nature of the flesh, felt in the movement of her blood like a greeting to pavements, people....She could feel the smile on her face. Because of it, people going past would offer jokes, comments, stop to talk, invite her for drinks of coffee, flirt, tell her the stories of their lives....” (1996:28-29).

successive governments resulted in rising unemployment during the 1970s to 1990s. Public sector deregulation saw the loss of many jobs and, with the lifting of trade restrictions, manufacturers had to compete with cheaper imported goods. Many industries, such as shoe, garment and automobile manufacturers have been decimated or not survived.

One of the ironies of neo-liberal discourse, according to Peck and Tickell (2001, cited in Gledhill 2004:332) is that it was a “starkly utopian intellectual movement” that became “aggressively politicized by Reagan and Thatcher in the 1980s”. In other words neo-liberalism was a *theoretical* discourse than became transformed into a *political* discourse, and *political action*. Politicians emphasised individualistic ideologies (Tickell and Peck 2003:163) and supported the primacy of the individual using the rhetoric of personal responsibility (Davies 1985:21). Neo-liberalism, according to Giddens (1996:229), is often considered synonymous with the “self-seeking, profit maximizing behaviour of the marketplace”. Within the context of this thesis this type of attitude means that individuals acting as autonomous beings are free to choose whatever health services they want (such as orthodox and/or complementary therapies) and pay for them themselves. As I show in Chapter Seven at first glance my patient participants appeared to embrace this attitude, but as I discovered, they do so rather selectively. While they wanted the freedom to be able to choose which health service or health practitioner(s) they wished to consult, a consensus was not reached as to whether the state or the individual should pay for treatment. And, like scratching off a layer of paint, the question of responsibility was never far from the surface. Was it the patient or practitioner who should be responsible for health and healing outcomes?

These views were also reflected amongst the practitioners I interviewed. Although supporting the right of patients to choose a healing model, the majority of CAM and Dr-CAM’s were explicitly more in favour of patients meeting the cost of treatments as opposed to the general practitioners who supported state intervention, especially for orthodox medical consultations. And as I discuss in Chapter Eight, practitioners expressed divergent opinions regarding their responsibilities and those of their patients. Those who followed a neo-liberal approach supported the concept that patients must ultimately accept responsibility for their health. On the other hand practitioners who held collectivist views expressed a more holistic attitude and

believed that responsibility had to be shared amongst patients, practitioners and the state.

As I have already suggested, neo-liberal discourse is also underscored by blame rhetoric³. As well as supporting freedom of choice, neo-liberalism also tolerates inequality. Under the neo-liberal paradigm responsibility lies with the individual. Therefore, it is up to the individual to weigh up risks, make decisions, and ultimately live with the consequences of those decisions. As Ericson et al (2000:554) state:

If one ends up poor, unemployed, and unfulfilled, it is because of poorly thought-out risk decisions.

In other words, the poor, the uneducated, or the ill are considered to be authors of their own destiny.

The irony of neo-liberalism, according to Foucault, is that its economic and political philosophies have now infiltrated into the “social sphere” (Lemke 2001:197), to a point where neo-liberalism is synonymous with every day life in contemporary western societies. But paradoxes abound. Despite advocating minimal state involvement in the minutiae of daily life, the neo-liberal environment has, ironically, seen an increase in state regulation and surveillance (Ericson et al 2000; Gledhill 2004; Lemke, 2001; Tickell and Peck 2003). So while the rhetoric continues advocating for trade and financial market liberalisation, labour market deregulation, and reduced government spending, a whole raft of policies and regulations occur contemporaneously to supervise and oversee these changes. As O’Neill (1997, cited in Tickell and Peck 2003:167) argues:

Neo-liberalism is a self-contradictory theory of the state....it is a political discourse which impels rather than reduces state action.

The theoretical discourse of neo-liberalism has now been absorbed and transformed into the social sphere. This practical manifestation of neo-liberalism is evident through the increased surveillance of individuals, both privately and professionally, and is one further example of the competing discourses we now have to negotiate.

³ Ericson et al (2000:537) argue that within a neo-liberal environment the concept of “pure accidents’ is disappearing. In their study of the private insurance industry in the USA Ericson and his colleagues found that when people made a claim against their insurance policies they were considered to be at least “partially at fault” despite circumstances which might indicate otherwise.

IV: Bureaucratic Surveillance

Not only do bureaucratic societies define what constitutes illness, disease and health, but they also dictate who are 'acceptable' health providers. Because the biomedical model is both dominant and powerful in such societies, Foucault argued that it was given the power to label bodies as deviant or normal, hygienic or unhygienic, or controlled or requiring control (Lupton 1994:23). This labelling was a catalyst for institutionalised surveillance, or the threat of it – Foucault's (1977) panopticon - and has increasingly become a part of contemporary society and a prevalent form of social control (Lupton 2000:53, White 1999:27). For example, in recent years in New Zealand, the speeding motorist has been seen as behaving in a deviant manner and the advent of hidden speed cameras alongside roads is being used as a surveillance mechanism whereby the fear of being photographed speeding and subsequently fined is used as a tool to modify the general public's driving behaviour. Similarly, video cameras are now installed in many central business districts in an effort to curb unruly behaviour and burglaries. The use of surveys at local and national government levels, such as the five yearly national census, is a form of surveillance, albeit under the auspices of policy and planning requirements. The health sector is also increasingly used as a site for surveillance.

As societies have become industrialised and sophisticated, the site of disease and illness has moved from the domestic realm to a hospital-based one (Foucault 1973:17). According to Bryan Turner (1988:60):

As the demands for individual rights grow on an equal basis there is correspondingly an increase in state surveillance. The more individual rights expand, the more the individual becomes subject to centralised control and regulation.

Turner refers to this as the 'Foucault Paradox', which relates to equality for all individuals, including their access to resources. However the only way that this equality can be achieved, especially regarding access to scarce resources such as health care, is through government regulation and control. This move has in essence medicalised much of modern society and paved the way for bureaucratic growth and power together with strategies that seek to "conduct the conduct of others" (Rose 1996:3). Kevin White says that Foucault's central argument regarding bureaucratisation is based on the premise that

[m]odern medicine is one aspect of an administered society in which the centralization of information and citizens is essential for social planning. In a fundamental sense modern societies are bureaucratic societies, and information needs to be generated, monitored, evaluated, and used as the basis for administering society (White 1999:27).

Within the health sector there are a plethora of surveys and systems to monitor both patients and practitioners. This is part of what has become known as the ‘audit culture’ (Arnason and Hafsteinsson 2003:52) and, as Shore and Wright (1999) contend, many aspects relating to the finance sector are now being applied to other working environments, such as health. These aspects include public inspection, submission to scrutiny, quality assurance, accreditation, accountability and responsibility (ibid:559). Advocates of audit believe it to be an empowering process where

...individuals and institutions [are able] to ‘monitor’ and ‘enhance’ their own performances and quality, and to be judged by targets and standards set by themselves. This suggests that audit is an open, participatory and enabling process; so uncontentious and self-evidently positive that there is no logical reason for objection (ibid:559).

However critics of this phenomenon point to increasing paperwork for limited gain. Despite the contention that auditing should be seen as an empowering and positive process, some doctors no longer feel they can trust their patients. One Dr-CAM practitioner described some of his patients as “fair-weather sailors” and said dealing with them could be stressful:

They say I don’t want to take drugs, I don’t want to do this, but cure me anyway, fix me anyway. Yes, some people do make it tough and they may want to own their health but then if it goes wrong, who owns it? Well they rapidly discharge their responsibility and point the finger....I guess in the long term you have to believe that most humans – that human nature is basically good and hopefully after all these years, touch wood, your antennae goes up if you have someone who is particularly stropy and somebody who is particularly difficult, you sense trouble....You wonder if they really just want another doctor’s scalp on their belt. We get a few people like that, but fortunately they are few and far between and you kind of sense it. (Ernest, GP-CAM)

And it is not difficult to imagine that patients may also feel they are under scrutiny and the healing encounter has changed from one of support and co-operation to one where monitoring and judgment are an overt part of each consultation (Arnason and Hafsteinsson 2003:52).

This audit culture is evident within New Zealand’s health sector. For example women requesting smears now have their details automatically entered on the

National Cervical Screening Programme (NCSP) Register unless they specifically request otherwise. Information from the Register is open to scrutiny in order to check how well the programme is working and women are sent reminders, depending on previous smear results, as to when their next examination is due. Similarly, once women reach the age of 45 years they can register with BreastScreen Aotearoa, a national database. This entitles a woman to mammography screening once every two years and, like the cervical programme, reminders for follow-up appointments are sent out at regular intervals. Certain diseases, such as Hepatitis B, Campylobacter and HIV are classified as 'notifiable', and medical personnel are required by law to inform the Health Department of patients with these conditions. While the choice to immunise a child in New Zealand is still voluntary, there is an expectation that for the greater public good this will be undertaken. Parents who choose not to immunise their children are sometimes perceived as irresponsible and their pre-schoolers may not be able to attend certain daycare centers. Immunisation rates are scrutinised through a web of bureaucracy incorporating general practice, public health nurses and so on⁴.

Governments and bureaucrats are also not exempt from scrutiny as was evidenced during the Gisborne Cervical Screening Inquiry. The Report released in 2001 criticised various aspects of bureaucratic ineptitude, including the lack of quality control and accreditation processes in relation to laboratories carrying out cervical cytology readings; a less than optimal National Cervical Screening Register, and a failure by health authorities to learn lessons from the problems encountered by screening programmes in other countries⁵.

Scrutiny of the health sector is also maintained because it is the state and bureaucrats who largely control the general public's access to health providers. Through legislation and regulation the state has indicated support, albeit obliquely, for the biomedical model. As outlined in Chapter Five, only certain categories of health professionals are required by law to be statutorily registered, and it is usually these practitioners who can access patient subsidies. Therefore, patients wishing to visit practitioners who do not receive subsidies, often those included under the CAM rubric such as colour therapists, naturopaths or homeopaths, are often obliged

⁴ For further information about the influence individualism has had on childhood immunisation in New Zealand see Gower (2000).

⁵ For a more comprehensive analysis of the Committee's recommendations see www.csi.org.nz/publications/TairawhitiHFAPFinalReport.pdf.

to meet the full cost of consultations and therapies themselves. With the advent of Primary Health Organisations (PHOs), patients wishing to avail themselves of cheaper state subsidised consultations with a GP have to register with a particular doctor. This information is available on a national database and could arguably be used for surveillance purposes. Health agencies such as the Accident Compensation Corporation (ACC) are increasingly able to access patient notes because patient consent is mandatory⁶.

As can be seen surveillance of individuals is now carried out by a number of agencies, including health officials and practitioners working under the biomedical model. CAM discourse also is particularly potent in the way it encourages individuals to survey and monitor their own bodies. Individual surveillance is discussed in the following section and I describe how the surveillance undertaken or promoted by the various factions mentioned above means that the individual body has now become a site to inscribe blame for illness or failure to heal.

V: Individual Surveillance of the Body

If we view patients as being autonomous individuals who have certain responsibilities, then - in terms of the neo-liberal paradigm - this means individuals have a responsibility to ensure they do their utmost to maintain a high standard of health. This includes factors such as:

1. Eating a healthy and moderate diet.
2. Not smoking or using other 'recreational' drugs.
3. Avoiding an excessive alcohol intake.
4. Maintaining an exercise programme.
5. Reducing stress.

In order to achieve and maintain good health, individuals are becoming increasingly reliant on self-surveillance and regulation (Shilling 1993:76). Changes to the focus of surveillance strategies and individual agency have been influenced by capitalism and the commodification of the body (Jagger 2000). In order for bodies to achieve an 'acceptable' image, the body has been cast in the role of body-as-project (Shilling (1993). We can see manifestations of this in the gym culture and the plethora of reality shows, such as 'The Swan', which pepper our television viewing

⁶ When a patient lodges a claim with ACC they automatically give consent to the organisation the right to access notes relating to that specific case.

and focus on individuals changing or improving their body image, or being improved. Diet programmes constantly appear in popular media publications and image presentation businesses also create pressure on us to submit to self-examination⁷. With all these factors exhorting us to improve or change, individuals are increasingly burdened with trying to conform to society's norms with regard to the constitution of a healthy body and mind. This challenges the agency of the individual. It also confirms that individuals do not exist in a social vacuum. Individuals construct beliefs and expectations about their bodies, and what constitutes health and illness, through social interaction.

Underlying the points made above is the sub-text that it is individuals who should monitor their health and accept that it is their responsibility for ensuring they do not succumb to illness, or injury through negligent or careless behaviour. Crawford (1980) and Coward (1989) argue that health and well-being have become a major cultural obsession in western societies and it is alternative and complementary medicines that often encourage individuals into making improvements or changes to their lifestyles; but it is an improvement which centres on the self as opposed to trying to change systems, such as reducing hospital waiting lists or improving the plight of the impoverished.

The majority of complementary and alternative healing modalities are predicated on neo-liberal ideologies: it is the *individual* who needs to be responsible for his or her well-being as opposed to devolving that responsibility onto the state or health practitioners. The body's natural state is viewed as being 'healthy' and able to heal itself (Coward 1989; Fulder 1996; Heelas 1996; Sharma 1992). While diagnosis and treatment may still to some extent be the realm of a healer, it is incumbent upon patients to embrace their "inner doctor" in order to "effect well-being" (Heelas 1996:84). Individuals can achieve an acceptable self-image if they monitor their diet, exercise and make life-style choices that promote good health. Another facet

⁷ I was given the opportunity to be a participant in a 'makeover' for *NEXT* (2006, July issue), a New Zealand women's monthly magazine. With great trepidation I agreed to take part and wondered if I would feel myself under surveillance and falling short of society's expectations of a woman (too old; too grey; too frumpy and so on). Interestingly I found many of the experiences quite fun and not too daunting. I did not feel under surveillance by the hairdresser, the make-up artist or the stylist. However, the most uncomfortable aspect of the process for me was the photography session – I did feel very exposed and under surveillance. Talking to the editor of the magazine following the makeover she said that the participants the previous year had felt very scrutinised and under surveillance and it is possible the tone of the sessions this year were changed to make us all feel relatively at ease.

of surveillance is to undergo regular check-ups, such as mammograms, cervical screening or prostate tests. If illness occurs, individuals may be considered to have neglected their responsibilities (Lalonde 1974) and punishment for non-compliance occurs in the form of medical or CAM consultation fees, loss of earnings and so on.

Foucault (1973) viewed the state and its handmaiden, biomedicine, as partners in defining and controlling individual bodies. However, I believe that in most western societies CAM should also be considered a partner in this ideology. Alternative medicine should not be construed as alternative to the dominant biomedical model because it too largely supports the status quo in relation to power dynamics and philosophies about self-responsibility. While CAM may be considered alternative to biomedicine because it still occupies a minority share of the health sector market and offers different worldviews about healing and illness, the actual dynamics of healing approaches are not so fundamentally different as to support completely alternative philosophies when it comes to the provision of health care services. Coward contends CAM in essence supports existing structures because it promotes self-responsibility and transforming the self as opposed to questioning health policies. Transformation through the use of CAM is achieved through lifestyle changes that promote “an individual without conflict...an individual who has expressed and got rid of anger and envy” (Coward 1989:205). Sharma supports some aspects of Coward’s argument, but she believes that orthodox medicine is also implicated through its lack of support for social changes that would bring about improved health to some sectors of society (Sharma 1996:251). Biomedicine also supports individualistic ideologies through procedures such as cosmetic surgery and preventative medicine programmes (ibid:251) where the focus is very much on the individual and not society as a whole. Heelas (1996:142) argues that when individuals focus on themselves this can be seen as a form of self-sacralisation. However, he contends that this behaviour may in part be due to an anxiety about global events and individuals participate in self-improvement activities because “if one cannot change...society, at least one can change oneself” (ibid:142).

The reluctance to pursue more collectivist policies is evident in the relationship between science and individualism. Sylvia Tesh (1988:168) surmises that individualism and science share similar ideologies – a reductionist analysis of the world and events. What this means as far as science is concerned is that

...it reinforces the political assumptions that impugn structural analyses of causality. Even when the demographic data and historical research indicate that a disease is a consequence of poverty, the search for the causes of illnesses readily gets reduced to the identification of toxic agents. If no agents can be identified, analysis moves to personal behaviour, frequently studied in isolation from its social context...(ibid:168-169).

An example of this can be seen in New Zealand with the recently instituted meningitis immunisation programme. Science may provide an ‘answer’ to disease prevention by way of vaccines, but the social context of the problem continues to be ignored. In other words, if more resources were devoted to solving poverty in areas such as South Auckland, then the types of diseases associated with overcrowding and poor living standards would not be as prevalent. A society that adopts an individualistic viewpoint is unlikely to mount a collective challenge to the status quo (Coward 1989:205). This invariably means that the likelihood of debates about existing health systems and possible changes are severely compromised. Governments and bureaucrats are notoriously selective when it comes to listening to concerns raised by various interest groups and, as Sharma points out, in Britain patients will remain relatively powerless unless major changes are made to the way health care is delivered under the NHS system (Sharma 1992:78). Hence existing power structures, including those contained within the realms of science and technology, remain in place.

Much of the above discussion concentrates on the idea of conflicting rhetoric: freedom of choice as opposed to laws and regulations, and the role surveillance has in achieving these. As I have mentioned before, we are confronted with a paradoxical environment where the central ideologies of neo-liberal discourse promotes individual choice and personal responsibility and yet the society we live in exposes us to increasing amounts of bureaucracy, often through surveillance. This highlights the question of autonomy. Is autonomy the same as freedom of choice? Within an individualistic and neo-liberal environment is our autonomy guaranteed or threatened? How does autonomy affect us as patients or practitioners?

VI: Autonomy

Within the context of a society that promotes neo-liberal and individualistic ideals, the notion of autonomy is important. But what exactly is autonomy? By looking at the etymology of the word autonomy I began to make sense of the difference between it and the concept of freedom of choice. *Autonomy* was formed from the Greek word *auto*, meaning self, and *nomos*, meaning custom or law. In other words autonomy is not synonymous with unfettered freedom but relates to an individual's ability to govern the self and be independent. As Farsides suggests, autonomy is about "control and rational choice" but does not correspondingly equate to freedom, "I can be free but not autonomous, autonomous and unfree" (1994:43). What is important, according to Farsides (ibid:43), is the idea that autonomy is a positive and valued moral quality because it signifies an individual's ability to influence the direction of his or her life⁸. In contrast, Lindbladh et al (1998:1018) suggest that autonomy be viewed within the current climate of individualization⁹ as a moral viewpoint for those who occupy "an advantaged social position". This social status enables individuals to pursue "free choice".

Although contemporary western societies are constructed around a neo-liberal discourse that encourages individual freedom and autonomy, our day-to-day lives, paradoxically, are subjected to an increasing amount of monitoring and control. Examples of this can be seen within the public health arena where regulations and legislations 'force' us to behave in certain ways. Hayry (ibid:16-17) outlines four areas where this situation occurs: first there are laws which aim to protect us against behaving in a way that may cause us bodily harm, such as requiring us to wear seat-belts while in a motor vehicle, or crash or cycle helmets when riding a motorbike or bicycle. The manufacture and sale of certain items of mechanical equipment, dangerous and toxic substances and the production, sale and prescribing of certain pharmaceuticals are also controlled or outlawed. Second, legislation defines the types of people who should be incarcerated (in prisons or other institutions) – such as people who are in danger of inflicting harm on either themselves or others. Third, the practice of 'social medicine' has seen the implementation of vaccination

⁸ See Jackson 2001:101-103 for a philosophical discussion regarding patient autonomy.

⁹ cf. Beck and Beck-Gernsheim (2002). They state that individualization is not the same as individualism. Their discussion on individualization relates to the way structural transformations impact on the relationships individuals have with their society. New structures may mean a change in people's roles and living conditions, but at the same time new forms of social control are created.

programmes, the fluoridation of water supplies¹⁰ and regulations relating to the manufacture, production and supply of certain foods, alcohol and tobacco. The fourth area of these seemingly paternalistic measures relates to more covert areas of control, such as health education programmes and screening for certain diseases, such as those attributable to smoking or sexually transmitted diseases. But it is not only intrusion into matters pertaining to public health that challenges the autonomy of individuals. Taxation, restrictions on the importing and exporting of goods, and legislation covering working conditions and such like all impact on and influence the day to day lives of individuals (Hunt 1996:183-184). While these methods may seem intrusive and against the principles of neo-liberal and individualistic discourse, Lindbladh et al (1998) suggest that the provision of *information* is one way governments and bureaucrats attempt to influence public health measures without seeming to compromise individual autonomy: “the aim becomes to help the individual choose correctly without restricting his [sic] freedom of choice” (ibid:1019).

Despite the amount of regulation and legislation impinging upon our freedom, the rhetoric surrounding the notion of autonomy, especially as described to me by the patients I spoke with and the majority of the CAM and Dr-CAM practitioners I interviewed, is that it is used in the context of self-government *as well as* freedom of choice and individual responsibility. Self-government was a feature with regard to the choices practitioners made about the way they wanted to practice their craft (the type of patients they wanted to treat, the way they want to run their practice: solo practitioner or group practice; provision, or not, of an after-hours service; patients to pay full fees or use government subsidies and so on)¹¹.

Patient self-government is reflected through the choices one makes about daily life: diet, exercise, smoking (or not) and a host of other decisions about their lifestyles¹².

¹⁰ The fluoridation of water supplies in New Zealand is currently a topic of contentious debate. In January 2006 the result of the Wanganui City Council’s referendum on this issue supported the withdrawal of fluoride from the public water supply. Earlier this year Hamilton City Council held a binding referendum about this issue and seventy percent of the population voted for continued fluoridation of the city’s water supply.

¹¹ I only touch on ideas about practitioner autonomy here. In Chapter Six practitioner autonomy is discussed in detail, especially in relation to the changes faced by many health workers. These changes include the de-professionalisation and proletarianisation of the medical workforce.

¹² Governance of the self within this context also mirrors many of the aspects discussed above under the heading of neo-liberalism and self-surveillance. The body is constantly under surveillance: its weight is monitored, what goes into it and out of it is observed, the amount of exercise it gets is noted, stress levels are scrutinised, and so on.

As Sarah explained

Just taking note of my own physical responses and, things like peanuts, which I love to eat but give me the most horrendous stomach-ache. So I just find things out...and am happy to avoid what makes me feel uncomfortable.

Making decisions about the type of treatment you are prepared to countenance is an important aspect of self-governance. Sarah recounted how she underwent menopause at the age of thirty-seven, and her doctor was very concerned that she may develop osteoporosis and wanted to commence her on hormone replacement therapy (HRT). However Sarah was reluctant to pursue this line of action and she and her GP had a heated discussion, where, according to Sarah, her doctor became very “angry” with her for disregarding her advice¹³. Although Sarah did not have the ‘freedom to choose’ whether or not menopause occurred, she retained her sense of autonomy by responding in the following way:

I tried to compromise with her [the GP] and I said I'm going to go away and have a read about this because I don't know anything about it and I agreed to go back in a week's time. I did a bit of reading and I found that there was quite a discussion happening and HRT wasn't necessarily indicated. I went for a bone density scan and my bones were great so that settled the question. But it was an interesting experience. She [Sarah's GP] really just wanted to deal with what she saw as a problem for me, a future problem.

This quote from Sarah demonstrates the paternalism the biomedical approach is often criticised for, compared to CAM which is perceived as protecting the autonomy of patients and empowering their decision making processes. As Sarah commented about her experiences with CAM practitioners:

I've never really found alternative people quite so keen for you to do something you weren't comfortable about.

Autonomy-as-freedom-of-choice was also a consistent theme exhibited by the patients I interviewed, and this usually related to the type of practitioner a patient wanted to attend as well as treatment options. Elizabeth explained freedom of choice in this way:

Whether I go to the doctor or whether I don't go to the doctor and what I have done and what I don't have done. I'm not going to undergo an operation if I don't think it's necessary...the decision is ultimately mine and not the practitioners. It's your body that they're messing with.

¹³ Murtagh and Hepworth (2003) concluded in their study about the construction of menopause and the use of HRT treatment that although general practitioners believed they were empowering women to make decisions about the use of HRT, because the discourse was constructed solely within a biomedical framework, the concept of autonomy and freedom of choice was illusory and in reality only served to “intensify power relations” between patients and doctors (ibid:1650).

Another patient, who had considerable nursing experience, expressed an opinion where she equated autonomy with the freedom to demand certain medical procedures when she wanted them.

One of my children was really ill...I still say he got a bowel bacteria from eating a pie, but you know for three days I treated him as you would normally treat a child with food poisoning on basically supportive fluids and things like slippery elm and goodness knows what else. But when that child got very sick, and I could see he was very sick I actually wasn't getting the support....until I just popped something [a faeces sample] under the face of the doctor and said I demand you get me to a specialist now with this child. He is so ill. And I'd been saying he's losing weight I'm really worried. And I was right - he'd lost kilos. (Stevie)

The underlying discourse here is one of power. The sick role concept, as proposed by Talcott Parsons (1951), meant that medical practitioners were in a position of power through their role of defining and treating illnesses/injuries. The patient fulfilled his or her obligations by seeking out the advice of a doctor and co-operating with treatment plans. In this way patients were absolved of responsibility for being ill, as well as, temporarily, their social obligations. However Talcott Parsons' ideas are now no longer widely accepted by the academic community¹⁴.

Information is seen as a key component of patient autonomy and the concept of informed choice. Prior to the mid-twentieth century biomedicine was considered paternalistic in its mode of delivery, often operating under the rubric of 'doctor knows best'. However, with the second-wave of feminism in the 1970s and New Age discourse espousing a rhetoric of self-responsibility challenges were made to the traditional bastions of authority, such as those found within medicine and orthodox religions (Heelas 1996). The patriarchal gaze dominating these areas was also subjected to scrutiny and critique. Feminist literature called for a more patient- and female-centred approach to the practice of medicine and for the autonomy of patients to be encouraged and respected. Jackson (2001) provides an excellent background to autonomous practice and informed consent and is worth quoting here at some length. She states that questions began to be asked about the way health care was delivered, particularly

...what information was owed patients out of respect for their right to autonomy; their right to decide or at least participate in deciding, questions of treatment and care. Deceiving patients, even keeping information

¹⁴ Research carried out by Dixon-Woods et al (article in press) questioned whether Talcott Parsons' analysis of the doctor-patient relationship should be revived because their findings mirrored many of the roles Parsons' described, including the idea that "doctor knows best".

relevant to the decisions they were taking from them, hindered their exercise of rightful autonomy. Thus, deceiving and concealing have come under a cloud indirectly, not because of a sharpened antipathy for untruthfulness as such, but mainly as a knock on effect of the new enthusiasm for patients taking more control and having more of a voice in decisions about their treatment and care...[and what has happened as a result of these changing attitudes]...is the idea that patients should be encouraged to participate in reaching decisions as to what treatments or procedures are appropriate for them. It is this right to participate in deciding what is appropriate that spurs the call for full and frank information-giving. Since the idea of patients' rights to be involved in deciding what treatment is appropriate has emerged and has taken hold, the duty of doctors and nurses to speak and act truthfully has been largely perceived as derivative from the duty to respect autonomy (ibid:10).

The concept of autonomy-through-information was one described by the patients I spoke with. What they wanted from their health practitioners was a diagnosis (particularly when consulting an orthodox practitioner) and advice about how to improve or cure their condition. In particular they wanted information conveyed to them in a way they could understand. Doctors in particular came in for criticism about the way they imparted information and patients resented being spoken to in what they perceived as patronising language. Comments were made such as doctors 'think they're gods' or 'they think they know best' and patients were resentful that the expertise they possessed in relation to their own bodies was often ignored or discounted. As one participant said, she wanted to be spoken to "as if I have a brain in my head" (Elizabeth).

One way to avoid this type of criticism is for medical practitioners to change the way they behave by adopting what is termed a 'patient-centered approach'; a relationship viewed in more egalitarian terms (Ong et al 1995:904). The "ideal" consultation paves the way for "shared decision making" because it

...integrates the patient-centered and physician-centered approaches: the patient leads in areas where he is the expert (symptoms, preferences, concerns), the doctor leads in his domain of expertise (details of disease, treatment) (ibid:904).

Restoring autonomy to patients can also be achieved through a consumerist model. By adopting the role of client as opposed to patient, individuals attempt to establish a relationship based on equality between the consumer and provider and as a result, regain control of the consultation process. Part of this control can relate to paying for a service: if I pay for something then I can make demands/requests/expectations of the person I am paying to see; or if I pay for something I am investing in my

health and therefore adopting a responsible attitude towards my care (Hughes 2004, Sharma 1992). Patients I interviewed displayed agency in the way they chose to consult health practitioners. Relying on the expertise they possessed about their own bodies and diagnosis, they were confident in their ability to choose the practitioner best suited to their needs on any particular occasion (Miskelly 2005).

From a biomedical point of view Lillis (2000:21) points out that adopting a consumerism approach to a medical consultation means doctors are expected to cooperate with patient requests for investigations and treatment and perhaps, even a diagnosis made according to a “patient’s interpretation of events”. If a patient does not receive the treatment, tests and so on that they want, then they are inclined to consult other practitioners until they find one who is ready to comply with their wishes. Certainly the CAM practitioners I spoke with recognised this behaviour amongst their patients and I suspect that all health practitioners could provide examples of patients ‘doctor/therapist-hopping’.

Expert knowledge and who ‘has it’ is a complex question and one permeating much of the discussion on autonomous practice. As one of Lillis’s (2000:64) participants complained, there is plenty of information available to patients these days, but one of the problems is that of interpretation. Lillis notes (ibid:73):

Absolute equality in terms of knowledge, experience or the ability to make decisions about medical matters is not possible in many medical consultations. The doctor usually has more knowledge and experience of the disease process. However, the decision as to the most appropriate investigation or treatment is also dependent on the belief system of the patient...the requirement of doctors, therefore is acceptance and acknowledgement of a variety of belief systems held by patients that may conflict with his or her own belief system.

Relationships between patients and doctors are complex because, whether we like it or not, they involve “interaction between individuals in non-equal positions” (Ong et al 1995:903). And this is where the question of patient autonomy and expert knowledge raises questions about informed consent. While the patients I interviewed were adamant that they possessed expert knowledge about their own bodies and felt they were often capable of making a diagnosis and taking responsibility for their health care, they also described conflicting situations where they were reliant on information and intervention from health professionals. Faye

revealed the complexity of attempting to retain autonomy while conceding to a 'superior' authority when she said:

I have to put my faith in them [doctors] because I don't know enough to know if it's right....they have that responsibility to ensure that I'll be okay and to give the best possible care and advice.

This scenario does not necessarily mean that patient autonomy is compromised (Farsides 1994) because Faye, in this case, is still self-governing in that she chooses to delegate responsibility to someone else. To illustrate the notion of information and informed consent further, during the term of this research project I had informal conversations with a wide range of people about either their health problems or their thoughts on the provision of health care in general and ideas about autonomy, expert knowledge and informed consent were dominant themes. One woman I spoke with told me that soon after she had been diagnosed with breast cancer an operation was scheduled for a partial mastectomy. Prior to the surgery the surgeon told her he was ethically obliged to explain what was going to happen during the operation, as well as pointing out things that could go 'wrong'. The irony, according to this woman, was that she felt she had little choice in the matter – even taking into consideration the things that could go wrong - either she underwent the operation and post-operative radiotherapy treatment in an effort to cure or at least stave off the spread of the cancer, or she did nothing and died. She believed that the process aimed at securing her informed consent became one of *too much information* and in fact only added considerable pressure and anxiety to an already fraught situation¹⁵.

If, as Giddens (1991) suggests, humans are capable of knowledgeability and capability, and the reflexive self makes decisions which individuals accept responsibility for, then informed consent seems unproblematic. But, as Lantos (1997:64) and Ong et al (1995:905) point out we like to think that patients, no matter how ill, are capable of rational decision-making. However at times the

¹⁵ Interestingly, Titia van Kleffens et al (2004) found in their study of patients undergoing (and refusing) treatment for cancer that medical information was *not* the pivotal factor patients relied upon when making decisions about their treatment. While medical information did "have a serious effect on patients' experiences of having a choice" (ibid:2331), patients were influenced more by their own experiences or those of others who had undergone cancer treatments, as well as ideas generated from friends and family. The physicians who treated them, on the other hand, perceived that information was the key element to patient autonomy because it was believed that it allowed patients to make 'informed' choices. The possibility of *no* treatment was rarely presented as an option, thus it could be concluded that patient autonomy was compromised through this option being overlooked or ignored by medical personnel.

situation is not straightforward and patients (or their families) want health professionals to make decisions on their behalf (Dare 2004:11). What we want when we are well compared to what we want when we are in the throes of a severe illness or are in pain can be two very different things. Studies have shown that while some patients want to have access to medical information, they still want to vest responsibility for medical decision-making in their doctor (Ong et al 1995:905). In the case of patients with cancer, one study showed that only sixty-nine percent of patients wanted to participate in decisions relating to their treatment and sixty-three percent of patients thought that the “primary responsibility” for decision-making should rest with doctors (ibid:905). One of the reasons given for this lack of autonomy could relate to the possibility of recurrence, “if the disease recurs, patients may feel that they have made the ‘wrong choice’” (ibid:905).

Another facet of autonomy and the imparting of information is that of equality. Are patients and health practitioners equal partners in the consulting and decision-making process? And if patients are not considered to always understand and interpret the information given to them, is it possible for them to give informed consent for treatment? Dixon-Woods et al (article in press) assert from their study into women consenting to obstetric or gynaecological surgery in a British hospital, that the idea of informed consent is problematic because it involves relationships of power. Women-as-patients were found to demonstrate reduced agency because they found the hospital environment mirrored social hierarchies (see also Murtagh and Hepworth [2003] for a discussion on autonomy and power in patient-doctor relationships). Surgeons and other medical and nursing staff were perceived as ‘higher’ class compared to patients. This meant that patients often demonstrated compliant behaviour and signed consent forms for surgery while in reality they were unsure as to whether this was the course of action they actually wanted. Dixon-Woods and her colleagues concluded that the consent process does not in reality protect patients from making uninformed or wrong decisions.

My research showed that patients resent their own expertise being discounted and view this as an attempt to establish a hierarchy of knowledge placing them in an inferior position to that of the medical profession. Calls for autonomy reflect a desire to introduce equality into the relationship between patient and practitioner.

Despite these misgivings about whether or not equality is either possible or desirable, CAM appears to support autonomous behaviour and gives patients a sense of control over their healing processes (Kelly 2000:163; McGuire 1988:257; Murray and Shepherd 1988:513; Sharma 1992:56; Vincent and Furnham 1996:41-43). This is due in part to the type of person who seeks out this sort of medical intervention – they are keen to be part of the healing process – and see CAM as a way they can take responsibility for their health care. However it is the relationship between patient and practitioner that is the most pivotal factor in this area of control because the patient is seen as partner in the healing process (Fulder 1996). Patients believe they are treated as *equals* in the consultation process and their feeling and beliefs are not ignored. Further, because CAM is based around the philosophy of individual treatments for individual patients, it is more likely that a patient's autonomy will remain protected.

One aspect of autonomy that is absent from CAM discourse relates to transference of responsibility. As far as my patient participants were concerned, autonomy represented the chance to take charge of healing encounters whereas practitioners viewed autonomy in terms of patient empowerment and freedom to choose treatment options. Associated with these beliefs was the idea that self-responsibility was somehow the lynchpin of being autonomous and that transferring control to someone else disenfranchised the patient. However, as Farsides (1994:59) argues

...if one decides to hand over a degree of control, forego some independence, or give another power to act on your behalf, one may still be considered autonomous if the decision was based on a rational evaluation of the reasons for doing so.

I asked patients about this point and they said that in some circumstances they may want to vest responsibility for healing in someone else (as I noted in Faye's comment, p.109). Patients said they would relinquish responsibility if they had a serious illness or injury; the implication being that they required someone else's expertise to help solve the problem. Sarah said that she was generally in very good health and as I illustrated (p.105) she obviously wanted to control the encounters she had with health practitioners. However she was pragmatic about the possibility of changing her stance – "If I was very unwell I might have a different answer". Stevie also believed that circumstances might force her to change her ideas about wanting to retain control and responsibility, however she believed that health

practitioners had to remain aware of *who* a patient was and what their expectations were.

I think that we do have the responsibility to try and accept help. I also think that the person giving us the help... whether it can be from our allopathic doctor or alternative practitioner, that the person giving it also has to realise who we are, and what we're asking for, and how we're asking for it. And I don't expect to be judged and be pushed into a corner....and I don't want them to tell me, no you're not going to take that, or as the doctor did when I took my father who had gross jaundice and said well what medications do you take. He said I take garlic capsules and the doctor said it must be the garlic causing the problems....He had a tumor that was so huge the surgical specialist said I don't know how he's alive. I don't know how he's even managed to get one morsel of food down because he had this much gut left [indicated a tiny amount]. And here's a doctor telling us we shouldn't take garlic capsules and I was staggered. I thought 'excuse me - garlic's a food'; and yes, garlic can change your clotting profile but does that mean we shouldn't eat it? (Stevie)

As noted by Stevie's comments, while she recognised that seeking help was in some way impacting on her independence and ability to completely control a healing encounter, she also displayed the complexity and contradictions apparent when negotiating different discourses. Under the banner of individualism and neo-liberalism the decision about which type of healing modality Stevie, or in this case her father required, is up to them as reflexive knowledgeable beings (in this case they sought out a medical doctor). The rhetoric of autonomy means that the independent decisions Stevie, and presumably her father, made about his diet and the use of garlic, should be valued. However, Stevie believed her decisions were being challenged by the doctor, (who of course was also acting autonomously), and conflict ensued. The ability to hand over a degree of control is therefore fraught with ambiguities because perceptions can arise that patient autonomy in particular is being compromised.

If patients want the freedom to choose plural healing systems then they have to be prepared to take responsibility for their decisions and subsequent consequences: "if it turns out that a complementary practitioner has failed to diagnose a serious illness or has prescribed inappropriate treatment, then such patients have only themselves to blame" (Sharma 1992:57). Is autonomy a two-edged sword then? Sharma (ibid:58) sums up by saying:

Many people are demanding more responsibility for their own healthcare, more say in decisions about what treatment they receive and wider options for treatment. If they go about making such decisions armed with adequate information about the strengths and weaknesses of the different kinds of therapy available to them (including orthodox medicine) and knowledgeable about screening facilities for serious illness, then taking

responsibility for their own choice of healthcare should expose them to few risks...their safety will also depend on the orthodox and non-orthodox practitioner each being well informed about the other's modes of diagnosis and treatment and their preparedness to communicate with each other quickly and amicably where they is cause for concern.

VII: Conclusion

Neo-liberal discourse, which had its beginnings as an economic and political philosophy, has been captured by the political and bureaucratic sector and now infiltrates all facets of contemporary western societies. This discourse promotes the primacy of the individual as opposed to that of a collective: be it a nation, a state, a society, or even a class of people. In essence, individualism holds that the individual is the primary unit of reality and the ultimate standard of value. The fluctuating fortunes of neo-liberal policies and the role of the individual can be related to the ever-increasing expansion of capitalism, hence support for individualistic policies is likely to be found amongst higher-educated and higher-income groups (Lindbladh et al 1998). This is because these are the people who can withstand changes from welfare-based collectivist policies to those requiring individual input (such as paying for the cost of private health care as opposed to relying on state funded treatments). Despite changes to the political landscape in many western countries from right-wing conservative administrations (such as Thatcher and the Tory party in Britain and Reagan and the Republican party in USA) to left-wing socialist parties, neo-liberal policies have remained largely intact¹⁶. This can be attributed to an expanding middle-class who have benefited from a period of increasing and sustained affluence in the West. While there has been some paring back of neo-liberal policies in New Zealand, such as the removal of hospital part-charges and the implementation of increased patient subsidies for some general practice consultations, there remains an expectation that individuals should not expect the state to fund all health care. And so we see procedures such as vasectomies or varicose vein surgery largely unavailable through the state sector, or patients requiring expensive cancer drug therapies having to meet the cost themselves.

¹⁶ The situation in New Zealand was slightly different to their western counterparts. Many of the cost-cutting measures made to the public sector were implemented by the 1984 Labour Party led by David Lange. Roger Douglas, the Finance Minister, was instrumental in changing the collectivistic ethos that had been the cornerstone of left-wing politics until this time. When the Party lost the 1990 election the National Party, more usually associated with right-wing ideologies, reinforced the neo-liberal direction of government policies.

Contained within neo-liberal discourse and the rhetoric of individualism is the inference that individuals should embrace autonomy and exercise freedom of choice. This is particularly pertinent to the health sector and the choices individuals are now faced with in regard to the range and types of modalities on offer, as well as their own health-related behaviour. The neo-liberal environment encourages individuals to question and challenge traditional bastions of authority. There is now a continual appraisal and critique of the way biomedicine delivers health care and a manifestation of this questioning is also seen through the increasing use of alternative and complementary therapies. The biomedical model has been criticised for being both paternalistic and patriarchal in focus. This has resulted in changes in the way health care is delivered and can be seen through processes that have been instituted, such as obtaining the informed consent of patients prior to treatment commencing. This patient-centered approach considers protection of patient autonomy as paramount. However, the construction of the doctor-patient relationship as one of equal partners in the consultation and treatment process remains problematic. The reasons for this are varied but include concepts surrounding expert knowledge as well as social hierarchies constructed both inside and outside the medical domain.

The notion of autonomy also remains a contested space: at its most simplistic it is considered within a neo-liberal and individualistic context as individuals engaging in freedom of choice. However, as Farsides (1994) contends, autonomy is more about an individual's ability to self-govern rather than being totally free. This ability to self-govern includes the choice to transfer responsibility onto someone else (Farsides 1994).

The idea of transferring responsibility is anathema within the context of most alternative and complementary medicines, which are imbued with individualistic philosophies. However, while the patients and practitioners I interviewed espouse many individualistic ideals about the individual being responsible for his or her health, it is at this level that a potent complexity of behaviour and beliefs is exhibited. Although many patients say they want to take responsibility for their health, at times they clearly wish to pass that responsibility onto someone else¹⁷. As I also show in later chapters, similar situations occur amongst the health

¹⁷ I discuss this idea of patients wanting to transfer responsibility in much more detail in Chapter Seven.

practitioners I spoke with – especially those who practised CAM. I am not implying that this transference of responsibility is a negative trait, but I do believe that it is an area needing fuller recognition and discussion by the many users and providers of our health system.

Transference of responsibility is also evident through the surveillance and monitoring occurring within our neo-liberal environment. One of the notable paradoxes of neo-liberalism is the increasing bureaucratisation of society. Within the biomedical field this situation is evident as we see certain sections of the population being encouraged to participate in health screening or prevention programmes (such as childhood immunisation or breast cancer screening). National databases are being set up to follow and monitor the individuals who use these services. CAM also promotes self-examination (for example, what makes us ill? What changes can we make to our lifestyles to make us better?). We live in a society that emphasises the ‘self’ – and this is encapsulated through the increased use of many ‘self-improving’ regimes: the fitness industry, plastic surgery for aesthetic and cosmetic purposes, a huge range of dietary advice now available, life-coaching and so on. All these areas focus on the individual and what can be done to make us ‘better’, and they all paradoxically require some type of monitoring or surveillance – either by individuals or an external agency.

I believe there are problems with an adherence to neo-liberal discourse and the rhetoric of individualism. This is because the neo-liberal economists (for example Hayek and Friedman) and politicians (such as Lalonde, Thatcher and Douglas), as well as the health practitioners who also embraced individualistic philosophies, have failed to understand the impact society has on individuals. The *blame* culture that has arisen through neo-liberal philosophies ignores the way our society is predicated on capitalism; the cornerstone of capitalist economies involves the production and consumption of material goods as we can see by the array of products and devices available to purchase. Turn on a television, read a magazine or newspaper, listen to the radio and it is almost impossible not to be confronted with advertisements encouraging you to buy many items that are *not* considered compatible with a healthy lifestyle. Big screen televisions, home theatre and entertainment systems, apartment living and smaller sections are also contributing factors to New Zealanders more sedentary existence. Consumerism has

undoubtedly given us more choices, but those choices can impact on more than one individual. People have to balance their own needs with, for example, those of their family, commitments to work or study or leisure activities, financial resources and religious beliefs. In other words, individuals rarely make decisions or give informed consent in a vacuum – some rarified atmosphere where it is only the individual who matters.

If politicians and health practitioners who abide by individualistic ideals support the individual and his or her right to ‘choose’ what is best for them, the collective needs of our society will be increasingly ignored. For example, adherents to neo-liberalism point out that health care needs paying for and believe that the cost should be borne by the individual, not the state. Individuals should be able to use their discretion as to the type of health practitioners they wish to consult; orthodox doctors, alternative or complementary practitioners, or information and therapies purchased from health food shops. But the reality is, as many of my patients and practitioners stated, that CAM is too expensive for many people to utilise. This narrows patient choice and therefore individuals from lower socio-economic backgrounds are more likely to opt, whether they want to or not, for a consultation with an orthodox practitioner because they may be able to secure a government patient subsidy.

One thing is obvious: no matter whether we live in a society built on individualistic or collectivist ideals there remains a need for someone to respond to disease, illness, injury and death. Who that person is, a doctor, a shaman, a priest, or a complementary practitioner, is largely dependent upon the socio-cultural values of the society (Lantos 1997:155). Perhaps surprisingly, given that over the last few decades questions have been raised about the way health care is delivered, and both patients and practitioners have called for less intervention and increased patient autonomy, whenever the state attempts to change the way medicine, in particular, is delivered, the public voices disquiet (Sharma 1996:252). What we are seeing is the “enthusiastic use of complementary medicine” alongside the “increasing use of orthodox medicine” (ibid:252). Hence there are many factors that continue to shape our health sector and I discuss these in the following chapter. The health system we have today has been influenced by the discourses of neo-liberalism and

individualism and the rhetoric of self-responsibility together with the collectivist policies adopted by previous generations of New Zealanders.

CHAPTER FIVE

THE NEW ZEALAND HEALTH SECTOR: A BACKGROUND

I: Introduction

New Zealand's health sector currently comprises a diverse array of health care options that have, as Iain Hay (1989:1) suggests, "emerged as the result of a conjunction of broad social processes with local characteristics". These processes and characteristics include the evolving of plural modalities and today traditional healing systems such as rongoa Maori, Ayurvedic and Chinese medicine sit alongside western orthodox medicine and CAM. However, despite a range of cultural influences and a burgeoning CAM sector, the dominant modality remains the biomedical model. Orthodox medicine's status is due, in part, to the tacit approval it receives from the state, which in tandem with biomedicine supports the privileging of science and technological knowledge over the supposedly more metaphysical philosophies underpinning alternative and complementary modalities. However this situation is changing. Over the last three to four decades industrialised societies such as New Zealand have re-evaluated the role of both the state and individuals, for example, in education, housing, superannuation and health, and as a result there is now an increased emphasis on individual as opposed to state responsibility. These attitudes have helped revitalise interest in alternative and complementary medicines by patients and practitioners, as well as government and bureaucratic agencies. There has always been a plurality of healing modalities available and in Section II of this chapter I trace the early development of the New Zealand health sector while Section III discusses contemporary developments. An outline of the range of health services now available is described in Section IV and their mode of delivery, portrayed in Section V, completes the background of the contemporary New Zealand health sector. The role science and technology has played in securing the dominance of the biomedical model is discussed in Sections VI and VII.

II: Early Development of the New Zealand Health Sector

During the early period of European settlement in New Zealand there was a variety of health care options available. These contained components of both alternative and orthodox genres, but were not specifically organised in any coherent form, nor

did any public health system exist. Those practitioners in the 1800s who offered some type of healing service did not practice under clearly demarcated professional boundaries. For instance, doctors were not a cohesive profession and, as Belgrave outlines, they were made up of a mixture of “itinerant street vendors, folk physicians and regular practitioners...[who] possessed no organization and no common medical knowledge” (Belgrave1985:3-4). However, even if there was little homogeneity among orthodox practitioners during the early stages of colonisation they, along with druggists¹ and chemists, were the only healers who possessed a distinct occupational status, with chemists also diagnosing and dispensing patent remedies (ibid:289-290). Other occupational groups such as dentists, opticians, masseurs and public health officials emerged during the 1870s and although not all doctors were resistant to the idea of alternative therapies, by the 1890s a more pronounced demarcation between orthodox and alternative modalities was evident (ibid:294-306). Practitioners such as herbalists, hydrotherapists, chiropractors and osteopaths were viewed as providing a different range of healing options compared to those offered by more orthodox systems, which at that stage included homeopaths (ibid:294). However while homeopathy was a popular alternative to orthodox medicine doctors discouraged its use by distancing themselves professionally from this group of health practitioners (ibid:299).

Despite the availability of both orthodox and non-orthodox healing systems it was the biomedical model that became increasingly predominant. Three factors contributed to this situation. First as scientific knowledge and technology became more widespread, orthodox medicine gained in status and popularity. Second, doctors transformed themselves into an increasingly homogeneous and powerful profession (see Chapter Six) and third, having to a large degree garnered support from the state, the medical profession attempted to limit the practice of alternative and complementary medicines (Dew 2003:29). This in part occurred through legislation marginalising alternative medicine, for example the Tohunga Suppression Act 1907 and the Quackery Prevention Act 1908.

In tandem with what are now construed as alternative modalities, the early European settlers brought with them traces of the British health system they had left behind which, although pluralist, privileged orthodox medicine. Along with the

¹ According to the 1874 New Zealand Census (p.155), the occupational classifications regarding health workers during the 1870s included “druggists and their assistants”.

health system another important factor transplanted here was the continued adherence to the individualistic ethos prevalent in Victorian society. In Britain health care was predominantly the responsibility of families, and individuals were not encouraged to seek the services of health practitioners or to expect assistance from the state. However, this mode of health care proved unsustainable in the colony because of two main factors. First, New Zealand's economy was based around agricultural production and because of the size and geography of the country many people worked in sparsely populated and isolated areas (Hay 1989:5). Second, the early settlers were predominantly single men hence there was an absence of families, especially females, to provide health care and advice (ibid:32). This meant that people became reliant on healers or doctors when they became sick or were injured, although choices were constrained by their ability to meet consultation and treatment costs.

In Britain the wealthy upper classes had provided some charitable health care for the poor, however migrants to New Zealand were mainly from the lower middle classes or upper working classes and as such were not in a position to fund private hospital care (Fraser 1984:56; Hay 1989:17). During the 1800s doctors in New Zealand offered health care on a fee-for-service basis but for many people these costs were prohibitive. This meant that many people found it difficult to access orthodox medical care; doctors were too expensive and there was no public health system they could utilise. This situation led to the formation of Friendly Societies; the Societies employed doctors, and financial members and their families were able to avail themselves of medical treatment through the payment of an annual subscription (Hay 1989:17; Wright-St Clair 1989:15).

The state gradually became involved in the provision of health care during the mid 1800s when Governor George Grey arranged for the establishment of public

hospitals to treat both Maori² and poor Europeans, although the latter were asked for some financial contribution towards their care (Fraser 1984:56; Hay 1989:18). This involvement transgressed the *laissez-faire* attitudes of the time, especially those relating to “work, thrift, respectability and self-help” (Fraser 1984:54). Concern was raised in some quarters about state intervention interfering with the concept of individual responsibility, resulting in a general public who lacked qualities such as self-reliance and thereby increasingly dependent upon the state to provide services such as health care (Sutch 1966 cited in Hay 1989:19).

Despite these misgivings the state continued to increase its role within the health sector and its support of orthodox medicine was fundamental to the growth and dominance of the biomedical sector. Both private and public health services became more readily available and during the late 1800s repeated attempts were made at securing government funding for hospitals and primary care. As New Zealand society became urbanised the expanding labour-force became increasingly vociferous in their demands for an adequate health care system (Hay 1989:30). Technological advances together with the advent of a more professionalised medical work-force made hospitals an attractive place to seek medical treatment (ibid:31-32). The Hospitals and Charitable Institutions Act 1885 provided hospital funding through general taxation and local body rates. Because of this people no longer considered public hospital treatment akin to seeking charity and consequently an increasing percentage of the population sought hospital-based care (ibid:32). In 1900 The Public Health Act created a Ministry of Health and a Department of Public Health thereby confirming the increasingly dominant role of the state in New Zealand’s health care system (ibid:42). This shift in government policy heralded

² While it is beyond the scope of this thesis to discuss Maori healing methods in any detail it is worth mentioning here that many policies implemented at this time placed Maori in an invidious position. Although colonial authorities advocated Maori using western medicine, and in fact legislated against their use of traditional healers through the Tohunga Suppression Act 1907, Maori exposure to orthodox healing methods remained limited. This was because the majority of Maori lived in rural areas whereas Pakeha doctors worked in towns and near European populations (Lange, 1999). Hospitals were reluctant to admit Maori patients because of their inability to pay for medical services and Maori were reticent about using western medicine for the same reason (ibid:36). However, most importantly, the Maori worldview about healing was considerably different to that of western medicine. The orthodox approach was seen as “alien, part of a strange Pakeha world where there was no comprehension of the spiritual sphere so important to the Maori” (ibid:37) and it was for this reason that many Maori continued to consult tohunga. Treatments by tohunga during the 1800s usually consisted of herbal preparations accompanied by karakia or Christian prayers (ibid:48). Lange (ibid:50) also maintains that tohunga were important to Maori because they “represented a link with the past”. Maori faced decimation of their cultural practices through the process of colonisation as well as depletion of their population through disease, and maintaining links with tohunga reaffirmed cultural beliefs and traditions (ibid:50). For further reading about Maori health development see Dow, D.A. (1999), Durie, M. (1998) and Lange, R. (1999).

changes that would become prevalent over the next few decades, especially those pertaining to responsibility. There was a gradual move away from ideologies espousing individualism to those reflecting a more collective ethos.

The most significant impact on the delivery of health care in New Zealand was the election of the first Labour government in 1935. Under the leadership of Michael Joseph Savage a social security system was introduced which promised assistance from 'the cradle to the grave' (Wright-St Clair 1989:24). In 1938 the Social Security Act was passed legislating universal provision for free mental and general hospital care, maternity services and general practitioner subsidies (Hay 1989:113). However, the medical profession mounted a protracted and determined campaign against government interference in the general practice arena and it was not until 1941 that doctors finally agreed to the implementation of a general medical services benefit (GMS), with the proviso that they could still charge patients a fee additional to the GMS if so desired (ibid:112-122).

This collectivism was not only evident within the health sector; the Reserve Bank was nationalised, old age pensions were restored and increased, children could attend primary and secondary schools free of charge and a state-owned broadcasting system was introduced. Farmers were paid a guaranteed price for dairy products, union membership became compulsory, a forty-hour working week was introduced, and a state housing scheme launched (King 2003:355-356).

III: Contemporary Development of the New Zealand Health Sector

Since the mid-twentieth century New Zealand's health system has undergone considerable reorganisation (see Blank 1994; Fougere 1984; Fraser 1984; Hay 1989; Scott 1994). During the 1970s New Zealand, along with many industrialised nations, experienced an economic downturn due to the oil shocks. One of the consequences in New Zealand was rampant inflation. At the same time there was a demographic shift in New Zealand's population base with an increasingly ageing population (Hay 1989:149). Urban populations were also expanding and many of these areas lacked adequate medical resources (ibid:150). These factors contributed to an increasing demand being placed on the government to provide more funding for medical services. Since that time, successive governments (both National and Labour) have instigated a number of reports, for example in 1974 the Labour

Government produced *A White Paper: A Health Service for New Zealand*, in 1981 a supplementary report relating to population based funding formula was put forward for discussion and in 1991 the National Government promoted its *Green and White Paper: Your Health and the Public Health*³. These reports all offered 'solutions' to the burgeoning costs of health care, and as Laugesen and Salmond (1994:21) comment, many of the suggested reforms were based on theoretical models as opposed to the more pragmatic options favoured by health professionals. The emphasis of the reforms was on the *economic* ramifications and administration of the health care sector as opposed to the views of the individuals who required *access* to health care or those who *worked* in predominantly front-line roles, such as doctors and nurses. This is evident in the way the reforms set out to temper people's expectations in regard to what the state would provide in the way of health services, such as the introduction in 1992 of part-charges in hospital outpatient clinics and increasing the cost of prescriptions (due to the unpopularity of this policy by the general public, part-charges for hospital visits were removed in 1993) (ibid:17). In spite of policies which have attempted to shift responsibility for health care onto individuals (Scott 1994:30), New Zealanders still expect that at least part of their medical and health requirements will be met by the state (Hay 1989:149). However this increasingly individualistic environment has, in part, set the scene for a resurgence of alternative and complementary medicine.

IV: The New Zealand Health Sector Today

Despite the early obstacles practitioners faced in establishing and practicing alternative and complementary medicines, these are now well established in New Zealand and are part of a burgeoning health care industry. Patients can access a veritable smorgasbord of CAM therapies such as radionic and psionic medicine, colour therapy, herbal medicine, naturopathy, homeopathy and Bach flower remedies through to practices involving spiritual surgery or attendance at New Age awareness weekend retreats.

According to the New Zealand Government's Ministerial Advisory Committee on Complementary and Alternative Health there are at least seventy CAM modalities available in New Zealand at the present time (MACCAH 2002:15). CAM products can also be purchased from a variety of outlets such as health food shops,

³ For detail about these reports see Hay (1985:170-172) and Laugesen and Salmond (1994:15).

supermarkets, chemists, CAM practitioners (such as herbalists or naturopaths) and also by using the internet or mail order catalogues (MACCAH 2003:2).

Patients interviewed for this research project reflect these findings, combining orthodox medicine with a wide variety of CAM therapies. For example, one participant (a male in his late 60s) had over the past twenty years used Buteyko⁴, naturopathy, acupuncture, Chinese herbal medicine and electro-therapy in order to treat a variety of health problems and has also continued to consult orthodox health practitioners. A woman (in her mid 30s) who suffered continual back pain had attended neurologists and orthopaedic surgeons as well as undergoing CAM procedures such as a rhizotomy⁵, acupuncture and osteopathy. She had also visited a colour therapist for other health problems.

Research on the health-keeping behaviour of women in central Auckland (1987) noted that respondents consulted a wide range of health professionals: doctors, nurses, chemists, naturopaths and homeopaths. Respondents were also active in attending health-related courses which ranged from first aid training to studying Bach flower remedies, rebirthing, meditation, Shiatsu massage and holistic healing (Chambers and Macdonald 1987:88-92).

Despite the apparent increasing popularity of CAM treatment to date there is insufficient data available within New Zealand allowing the number of CAM practitioners, CAM therapies and CAM patients to be exactly quantified. In 1987 a Ministry of Health survey indicated:

We simply do not know what proportion of the New Zealand population seeks alternatives in health care, and we do not know what provision is made for such care at national level. But if overseas trends are any indication, then it is likely that use of complementary therapies will be substantial (Leibrich et al 1987:19).

A number of surveys lend some weight to this claim. For example, a survey of Dunedin and Auckland residents found that 13.2 percent of patients or their families

⁴ A special breathing technique devised by Professor Konstantin Buteyko to control the way asthmatics over-breathe.

⁵ According to *Dorland's Medical Dictionary*, this procedure involves "Interruption of roots of spinal nerves within the spinal canal...[carried out for] relief of essential hypertension...relief of intractable pain" (p.1188).

had utilised the service of ‘non-medical’ doctors⁶ with the majority consulting an orthodox doctor before seeking an appointment with a complementary therapist (Dixon et al 1977). In 1986 the Department of Health report into CAM usage revealed that no definitive figures relating to either CAM patients or practitioners was available but it was suggested that if New Zealand followed overseas trends then it was prudent to suggest that up to a quarter of the population had consulted with a CAM therapist (Leibrich et al 1987).

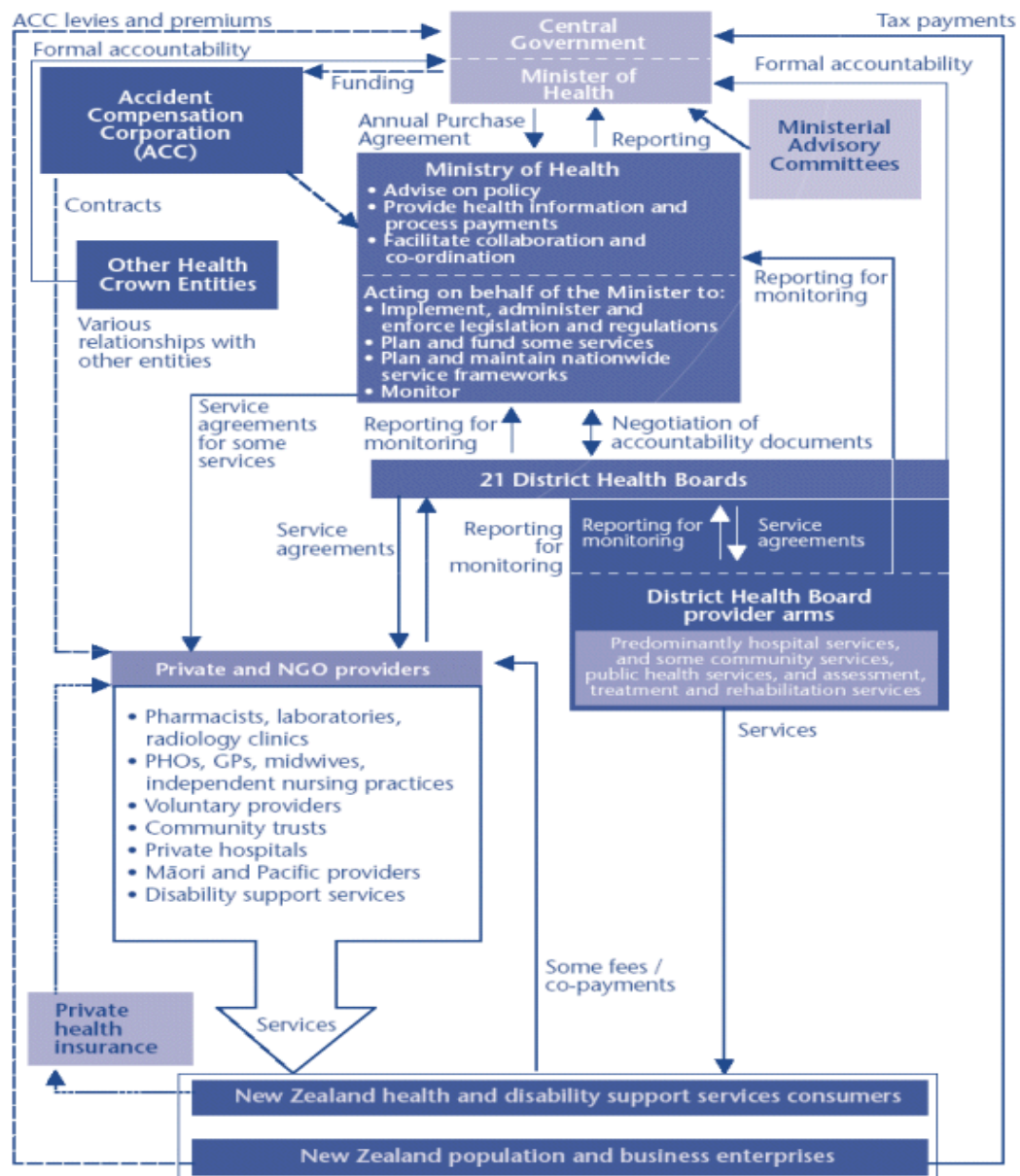
In 1997 a NZ Consumers’ Institute’s random survey of its members found that just over 50 percent of respondents reported using non-conventional therapies and of these, herbal medicine, chiropractic and homeopathy were the most popular (*Consumer* September 1997:20-27)⁷. In the same year a Ministry of Health survey found that 6-7 percent of its respondents had visited a chiropractor/osteopath; up to 6.5 percent had visited therapists who could be categorised as naturopaths, homoeopaths, iridologists or acupuncturists; and between 1-2 percent had received treatment from a traditional healer (such as a tohunga or fofo) (Ministry of Health 1997). Again in 1997 the NZ Charter of Health Practitioners’ Survey found that 74 percent of New Zealand households used some sort of CAM product – from vitamins to herbal remedies (McIver 1997). Provisional data obtained by MACCAH in relation to the 2002/03 New Zealand Health Survey shows that during the previous twelve month period 9.1 percent of New Zealand adults consulted, at least once, a massage therapist, 6.1 percent a chiropractor, 4.9 percent an osteopath, 2.6 an acupuncturist, 1.8 percent a herbalist and 1.4 percent a traditional Chinese medical practitioner (MACCAH 2004:13).

⁶ The term ‘non-medical’ doctor in the survey meant “a person who is not a registered medical practitioner within the meaning of the Medical Practitioners Act, but who practices some form of primary medical care (generally) not in association with a medical practitioner” (Dixon et al 1977:1).

⁷ This survey data was compiled from a random sample of 12,000 *Consumer* members. It should be noted that these respondents were likely to be upper/middle class (they can afford to subscribe to *Consumer*) and therefore more able to meet the cost of CAM therapies, as opposed to people from low socio-economic backgrounds.

V: Delivery of Health Care Services in New Zealand

Table II: Diagram showing structure of New Zealand Health System



(Diagram sourced from Ministry of Health website <http://www.moh.govt.nz/moh.nsf/> downloaded on 29.07.05)

Health care is delivered through both public and private avenues but the state remains the dominant provider. As the above diagram illustrates it is central government, through the Minister of Health, that defines the mode of delivery. Government funding to the sector is provided through the collection of taxation and Accident Compensation Corporation (ACC) levies and premiums. The Ministry of Health advises the government, via the Minister, on a range of matters including policy and health information. It also oversees the implementation and

administration of policies as well as ensuring that legislation and regulations are complied with. Twenty-one District Health Boards report to the Ministry and are charged with providing a range of health services to the general public, both at the tertiary level (hospital) and primary and secondary services (GPs, midwives, specialist services). Private health providers are also subject to state regulation and legislation.

The New Zealand Health Workforce Survey (2002) estimated that approximately 67,000 individuals work in the health sector with a further 30,000 providing informal health support roles. It also estimated that 10,000 people were providing some sort of CAM service.

As I mention above, although I discuss the combining of orthodox and CAM modalities by patients and practitioners in greater detail in Chapters Nine and Ten, it is worth noting here that many of the services within the health sector are pluralist in nature, sometimes combining aspects from both orthodox and CAM modalities. There are many reasons for this. One CAM practitioner I talked to illustrated this point by saying:

Often people who come into the shop don't have a GP and they need to have one so I will refer them to GPs who refer people to us because I know they're not going to get a hard time about using natural therapies. (Lorna, herbalist)

A biomedical doctor interviewed stated that his reasons for utilising both orthodox and CAM therapies within his practice was because:

I found that my training and the drugs available did not cope with the kinds of things that were coming through so naturally you reach out for other possibilities...I think I was one of the first GPs in this area who did acupuncture and I was one of the first batch of GPs in this area who did manipulation with medicine...[in our clinic] we had massage, psychology, counselling, acupuncture, a herbalist, an osteopath, physiotherapists...we had all those paradigms working under one roof, working together. (Ernest, GP-CAM)

The majority of research for this thesis has been carried out in the Waikato region and a survey of the 2005/06 Waikato/King Country Telephone Directory Yellow Pages was undertaken in order to ascertain the number and variety of CAM therapies available. These are outlined as follows:

**Table III: CAM Therapies/Therapists
Waikato/King Country Yellow Pages
2005/06**

Category - 'Natural Therapy'	Number of Therapists
Ayurveda	1
Bioptron Light	1
Colour Therapist	1
Herbal Medicine	7
Hypnotherapist	1
Iridology	2
Kinesiologist	4
Doctor/CAM	1
Natural Health Therapist (eg: naturopathy and homoeopathy)	10
Nutritionist	1
Osteopath	2
Spiritual Healing	3
Therapeutic Massage; Reflexology; Bowen Therapy; Shiatsu	6
Traditional Chinese Medicine	1
Other	21
Category – Therapies	
Acupuncturists	14
Herbalists	7
Homeopaths	16
Hypnotherapy	8
Massage – Health and Fitness	48
Naturopaths	1
Osteopaths	17

NB: Crossovers in many of the therapies apply, for instance a herbalist also advertising iridology, naturopathy and homoeopathy.

CAM practitioners and members of the public also use holistic health festivals as venues to both advertise and seek out information about a diverse range of therapies. My attendance at festivals in Cambridge in 2002 and 2003 revealed the following stalls and displays: Reiki, herbal creams and essential oils, Ki Energy, Ortho-Bionomy, massage, Hemaview analysis, yoga, holistic healing therapists, medical herbalist, The Angels Clairvoyants, homeopathy, 'OM', tarot card sessions, aura vision, aromatherapy, Mystic Madness – Soul Play, Feng Shui, bioptron light therapy, crystals and meditation. An entry in my research diary noted the following impressions:

One of the stalls was offering Ortho-Bionomy and the man who was running this suddenly asked if he could hold my arm and he gently started to turn it, saying that their treatment would allow me to dictate 'how far I wanted it

[the arm] to go'. He didn't explain what the treatment was for, but I picked up a pamphlet which stated it 'focuses on the bones, where they fit together and the stress and tension at the joints. It looks at flexation, movement and stuck patterns or places'. The next stand was dramatic, a Korean man demonstrating Ki Energy. A middle-aged woman was receiving treatment and this seemed to involve her sitting on a chair, with the healer (dressed in a cream 'karate' suit) running his hands down the woman's back and at intervals giving out loud 'chooo' noises. A young Korean woman told me this treatment helps unblock the flow of energy that can accumulate which makes people ill. Such treatment would prevent me having to go to hospitals and having surgery. (Research diary note 06.04.02)

It is apparent that a diverse range of CAM therapies is available in New Zealand and currently, under Common Law, all modalities are permitted to practice here. However, with the recent advent of the Health Practitioners' Competence Assurance (HPCA) Bill and recommendations from MACCAH, it is envisaged this situation will change. For instance the HPCA Bill requires osteopaths to be statutorily registered and other CAM practitioners I have spoken with, such as herbalists, also expressed an interest in being incorporated under the statutory umbrella (the regulatory environment is outlined in the following chapter). A more regulated environment has the potential to alter CAM practice within New Zealand. For example, one herbalist I spoke with said she was concerned that within a more regulated environment training establishments may have to include a larger biomedical component in their courses and she was worried that the *essence* of herbalism would be lost if such an approach was adopted. How CAM is practiced, who can practice it, training and qualifications, patient safety, and disciplinary measures are all integral to the focus of this thesis as they encompass the notion of responsibility. These topics are discussed in greater detail in subsequent chapters.

As noted, both alternative and CAM therapies have now secured a place in the New Zealand health sector alongside more orthodox modalities. However friction still exists between the biomedical and CAM models and much of this relates to the debate surrounding the legitimacy of science over the legitimacy of clinical practice (Willis 1994:64). Even although CAM is increasing its share in the healing market-place it still faces opposition from orthodox practitioners (see Beaven 1989; Cole and St George 1993; Hadlow 1989), and questioning about the therapies themselves (such as homeopathy), their efficacy or otherwise, and place in the New

Zealand health system is also evident in the popular media⁸. An excellent illustration of this tension is evident in the well-publicised case of the Medical Practitioners Disciplinary Tribunal's findings against Dr Richard Gorringe. According to the Health and Disability Commissioner, "a registered medical practitioner cannot discharge his or her responsibility to treat patients appropriately simply by claiming the particular treatment was 'alternative' or 'complementary'" (Paterson 2003:10). The tribunal was especially concerned at Dr Gorringe's use of a procedure called peak muscle resistance testing and found that it was

...not a plausible, reliable or *scientific* technique for making medical decisions. It was unacceptable and irresponsible of Dr Gorringe to rely on muscle testing to the exclusion of conventional diagnostic methods (Paterson 2003:10, my emphasis).

It is this reference to scientific knowledge that has contributed to biomedicine's continued ability to dominate the health care sector because of its critique over claims about the validity of CAM and lay knowledge.

VI: Asserting the Role of Science and Technology

Challenges to the orthodox medical model are evident because people are demanding a choice of health care options incorporating both CAM and orthodox modalities. However, as previously mentioned, the current status of biomedicine compared to CAM is largely due to the privileging⁹ of scientific and technological knowledge over the more metaphysical philosophies underpinning many CAM therapies, for example the importance of the mind, body and spirit as a single entity together with an individual's relationships with both the self and society (see Fulder 1996:4-7 for a detailed description of these philosophies). The growth of scientific knowledge and its impact on the biomedical model is briefly outlined as follows.

During the nineteenth century knowledge about the human body expanded because of a range of scientific discoveries and technological advances. For example, laboratory research techniques were refined enabling the exploration of body tissues and as a result knowledge was gained about matters relating to respiration, nutrition, the digestive system and endocrinology. With discoveries by Louis Pasteur (1860) and Robert Koch (late 1800s), an understanding of infectious

⁸ See letters and editorials in the *New Zealand Herald* (2004, 2005) *New Zealand Listener* (2002, 2005 a&b); *Waikato Times* (2002).

⁹ Kevin Dew (2003:24-26) observes that this privileging of orthodox medicine should not be seen entirely as a 'modern' phenomena. Medicine was considered a distinct occupational group and enjoyed state support during the era of 'heroic' medicine (1780-1850).

diseases was made and new cures developed. The use of antiseptics greatly advanced operating room conditions and improved anaesthetics significantly enhanced surgical outcomes. Public health regulations also came into force. In the twentieth century technological discoveries have seen the advent of x-rays, computed tomography (CT or CAT), and magnetic resonance imaging (MRI). This has aided in the detection of diseases and the possibility of surgical or chemical intervention. Pharmacology has been revolutionised with the advent of antibiotics. In the 1920s insulin treatment for diabetes became available; in 1977 small-pox was eradicated; and during the same decade the first heart transplant surgery took place. Such was the confidence of orthodox medicine that in 1969 the US Surgeon General, Dr William Stewart, announced that infectious diseases were a thing of the past. However, such extolling of the virtues of biomedicine has its critics. Illich (2001:265) argues that biomedicine and its practitioners should not be credited with the “elimination of old forms of mortality and morbidity” because there is considerable evidence to support the premise that it was the improving living standards in many western-style societies during the eighteenth and nineteenth centuries that was responsible for diminishing rates of infectious diseases as opposed to the use of vaccines and antibiotics (McKeown 1998:71-74; Tesh 1988:38). And it is important to note that diseases such as polio, yellow fever, plague, cholera and typhus are still prevalent in many Third World countries today (Tesh 1988:69). Of concern is the reappearance of some of these diseases in First World countries. Suzanne Gower (2000) provides a comprehensive discussion on the failure in New Zealand to eradicate vaccine-preventable diseases such as measles and whooping cough because of less than optimal immunisation rates.

As technological and pharmacological advances have been made medicine has become more specialised and secondary and tertiary services commonplace. Modern technology such as the stethoscope, x-rays, laboratory findings, CAT and MRI scans means knowledge about the body is no longer predominantly the domain of the patient because others now have access to information that is often internal and unavailable to the person concerned. By the turn of the twentieth century patients' views concerning their bodies and ill health were often discounted because the “responsibility for discovering and labeling illness had become the preserve of the medical practitioner” (Lupton 1994:86). Knowledge about health and illness also led to theories concerning the medicalisation of society together with concepts

relating to the construction and surveillance of the body and the way social problems have come under a medical gaze and control (see Annandale 1998; Foucault 1973; Nelkin and Tancredi 1989). An example of this is the prescribing of Ritalin for children diagnosed with Attention Deficit Disorder (ADHD), antidepressants given for a broad spectrum of psychiatric conditions, and drugs such as Viagra or Cialis promising males a lifetime of sexual activity. The role of pharmaceutical companies and their marketing strategies in relation to the medicalisation of social problems also needs to be noted here (Singer and Baer 1995).

So-called scientific and technological advances have also raised questions about *iatrogenics* or doctor-made diseases. For example, Illich contends that “technical medical intervention” inflicts considerable anguish and suffering on populations because patients suffer complications from medications and surgical procedures (Illich 2001:266-267).

Despite concerns about the medicalisation of society and iatrogenic disease, generally, in western-style societies, people enjoy better health than their forebears and because of this members of the medical profession continue to be valorised for their scientific and technological prowess and are still accorded high social status (Lupton 1994:84). This status is a major factor in the gap that remains between the lay patient and their personal experiences and knowledge and the orthodox practitioner armed with scientific knowledge.

Although scientific and technological advances have been major contributors to the dominant position biomedicine has gained in the West, alternative and complementary therapies have also maintained and increased their presence. Why has this situation occurred?

VII: Questioning Science and Technology

As I discuss in detail in Chapter Four, individualism is a philosophy that advocates the primacy of the individual. It is a mode of thinking that encourages the right of individuals to make decisions about their own lives as well as to bear the consequences, good and bad, arising from those choices. Individual freedom is

only constrained by obligations and rules that ensure all individuals are able to access the same freedoms (Macpherson 1962).

One of the ramifications of individualism has been a questioning of authority and the role of *experts* and *professionals* and this attitude profoundly affects attitudes to do with health, illness and responsibility. CAM therapies promote the individual as a major force in the healing process:

The healer clearly cannot have the kind of authority exercised by the conventional science-informed doctor, the person who draws on an established body of knowledge...it seems that the healer must – crucially - be the patient (Heelas 1996:82-83).

Much of the debate between lay and expert knowledge concerns the values of subjectivity and objectivity. Scientific knowledge is largely viewed as being objective and support for this paradigm within the health sector continues unabated. As Glymour and Stalker (1989:21) boldly state:

Medicine in industrialized nations is scientific medicine. The claim tacitly made by...physicians, and tacitly relied on by their patients, is that their palliatives and procedures have been shown by science to be effective. Although the physician's medical practice is not itself science, it is based on science and on training that is supposed to teach physicians to apply scientific knowledge to people in a rational way.

This view is somewhat tempered by those who work within the biomedical sphere. For instance a seventh year surgical registrar muses:

The thing that still startles me is how fundamentally human an endeavor it [medicine] is. Usually, when we think about medicine and its remarkable abilities, what comes to mind is the science and all it has given us to fight sickness and misery: the tests, the machines, the drugs, the procedures. And without question, these are at the center of virtually everything medicine achieves. But we rarely see how it all virtually works. You have a cough that won't go away – and then? It's not science you call upon but a doctor. A doctor with good days and bad days. A doctor with a weird laugh and a bad haircut. A doctor with three other patients to see and, inevitably, gaps in what he knows and skills he's still trying to learn (Gawande 2002:4-5).

Robin Kelly (2000:208), a New Zealand general practitioner (GP) who now concentrates on mind-body healing, believes:

Medical technology will not answer all our health problems. It will, I am sure, do much that is wonderful. Keyhole surgery and designer drugs will continue to help us 'get a life' – we will recover more quickly from medical and surgical procedures and have fewer side effects. The cautious use of molecular engineering techniques, will, with the right intent, ease suffering, and save lives...But for many this will not be enough. For these people,

healing answers will not be found in chemical laboratories or operating theatres...answers will be found in society, in loving relationships, in their own past and hopefully in their own futures. They will be helped by health professionals who understand their own roles, their strengths and their limitations, who match their skills with compassion, their knowledge with humanity. Professionals who take time to guide and listen before prescribing and operating, professionals who allow patients the freedom to heal.

The components of art and science within the biomedical paradigm remain precariously balanced. As Gordon (1988) writes, there is a move to introduce more 'science' into biomedicine. The reasons for this are many: there is a desire to minimise the 'uncertainty' and 'risk' implicit in medical encounters; to placate increasing demands for medical accountability; and both medical practitioners and lay individuals are becoming increasingly reliant on the use of digital computers to provide information and answers to health problems (ibid:262). Gordon argues that by privileging the scientific encounter a preference for 'formal' knowledge is evidenced as opposed to knowledge systems reflecting 'practical knowledge' which is derived from clinical experience encompassing the "senses of sight, sound, touch, smell, as well as emotions and more general senses, such as...a gut feeling" (ibid:269).

While this humanistic approach alerts us to the *art* as opposed to the *science* in medicine, the subjective perspective as opposed to the objective, critics of empiricism such as Karl Popper strongly support and advocate scientific knowledge.

Scientific knowledge is based on an objective perspective: a theory is proposed, exhaustively tested, and either proved, modified or discredited. This way knowledge progresses or is achieved (Popper 1994:13). Scientific theories achieve their status by "falsifiability, or refutability, or testability" (Popper 1972:37). Popper argues that the theoretical underpinnings of disciplines such as psychology (as described by Freud) and Marx's view of history are found wanting because "it is easy to obtain confirmations, or verifications, for nearly every theory – if we look for confirmations" (ibid:36). Popper maintains he is not disputing the importance of psychological or historical interpretations, but he believes they cannot be viewed as scientific. While Popper accepts that empirical evidence is an important component of scientific endeavour, he argues it has to be backed by rigorous testing as opposed to mere observation (ibid:38). And it is the reliance on empiricism that

is often central to arguments by the biomedical community towards CAM and lay knowledge (see Beaven 1989; Chalmers 1989; Green 2000; Hadlow 1989:21).

Criticism of CAM focuses on two main areas. Firstly, the unproven nature of many therapies and secondly, many of the remedies and preparations used do not face the same rigorous testing that biomedical medications undergo (Furnham and Forey 1994:459; Micozzi 2002:398; Radner and Radner 1989:151; Saunders 1996:108-113; Willis 1994:64-69). CAM proponents counter this argument by stating that the methods and results used and obtained by CAM therapies are not testable within the framework of conventional medicine because treatment is based on a case-by-case basis (Fulder 1996:9; Furnham and Forey 1994:459; Saunders 1996:111-113).

As Willis (1994:64-65) surmises, biomedical opposition to CAM is premised on the lack of scientific evidence to support the “paradigms of knowledge that these practitioners use” and knowledge gained from “anecdotes, testimonials and single case studies”. Biomedical knowledge, on the other hand, is formed through scientific methodology: double-blind randomised trials, replication of tests, peer reviews and the publishing of results in professional journals (ibid:65). This methodology embraces scientific doctrine. However it also ignores the increasing body of scientific literature supporting CAM therapies (see for example Berman and Spicer 2002; Katz et al 2006).

Willis (1994:62) does make the point that many CAM practitioners incorporate some scientific or medical techniques into their repertoire of diagnostic practices, such as taking a full history or blood pressure readings. I found evidence of this during my research. For example, Joseph, a homeopath I talked to said when an adult consulted him he took a comprehensive history:

For an adult I'd sit down for a whole hour and get them to talk about their symptoms as well as their past health history, their family history and then I'd look at what the symptoms were, what is the body showing me, why is the person feeling this way?

And Lorna, a herbalist, told me “I look at the tongue, I look at medical tests. Sometimes I ask for medical tests to be done, a whole combination of things”. She also made the point that, “sometimes all the medical tests in the world won't tell you what's wrong”.

Another herbalist, Margaret, said she used the following techniques to help make a diagnosis:

Mostly we talk. People will tell you what's going on with them. I do iridology as well and if I need to I do a physical examination like listen with a stethoscope, measure blood pressure, listen to the chest, feel around their gut if there's something wrong, just fairly basic because I haven't had extensive medical training. But I can feel if there's something different.

While it would be incorrect to see the 'flight from science' towards CAM as a wholesale rejection of orthodox medicine, there is an argument that dissatisfaction with biomedicine's preoccupation with scientific and technological expertise has been caused because of our inability to use this type of knowledge wisely (Hawkins 1999:6). As Gawande, a surgical registrar remarks, doctors "believe the world to be decipherable and logical, [and they deal] with problems we can see or feel or at least measure with some machine" (Gawande 2002:116). However, if doctors are confronted with problems they cannot account for then the profession is often "dismissive...we're apt to conclude [it's] all in the [patient's] head" (ibid:116).

In her excellent account of patients' and caregivers' experiences of ill health, Anne Hunsaker Hawkins states that patients who turn to CAM do so as a reaction against "perceived inadequacies in the current biomedical model...[they turn to CAM because of] disillusionment, frustration, or anger at orthodox medicine" (Hawkins 1999:125). She goes on to say:

...the many forms of alternative medicine are characterized by what orthodox medicine is not. If the model of patient-hood in biomedicine is one of passivity, in alternative medicine the model is one of agency – the patient is expected to be a fully involved participant in his or her own therapy. If in biomedicine specific treatments are verified by statistical evidence, in alternative medicine verification is arrived at by anecdotal evidence – the fact that a given therapy has worked for some people. In biomedicine, it is the disease that often seems to be the focus; in alternative medicine, the individual with the disease. Biomedicine is allied with technology; alternative medicine is associated with natural agents and processes (Hawkins 1999:126).

CAM supports the self-healing capacities of the body, aligning itself with *natural* remedies and the power of positive thought. The values of "self-reliance, individualism, and perhaps most important, activism" (ibid:129) illustrate a move away from scientific and technological expertise and explanation for illness to one where individuals develop an explanatory model that makes sense to them. Orthodox medicine tries to make sense of ill health from an etiological point of

view: what disease or illness a person has, what are its origins, what can be done about it and so on. However, lay perspectives are concerned not only with the reasons why disease has occurred but also the experience related to illness (see Lupton 1994:79; Pill and Stott 1986:269-271; Williams and Popay 1994:123). Patients often feel the biomedical approach does not address or adequately answer their concerns. One of the phrases repeated to me constantly during my interviews with patients was that ‘doctors only treat symptoms not causes’. Put simply, patients and their families want to know why things happen to *them*. One research participant, a woman who had put on a lot of weight over a relatively short time-frame, said to me that she believed her problem was caused by a fatty liver:

Who has fatty livers – is it just a fat problem? Which comes first, the fat, because I've put on 15kg just like that – it was boom – over a period of probably four to six months – so when did I get this fatty liver? I've asked my husband and I've said, do you think I ate more?...I felt so depressed...[doctors say] it must be your gall-bladder and I've had three tests and there's nothing wrong with my gall-bladder – but because I'm fat they think I must have a wonky gall-bladder! (Stevie)

The focus on scientific explanations of illness has replaced patients' own interpretations of what is happening to them and they feel increasingly detached from the process that is meant to help them. To this end they construct meaning which makes sense to them.

While the debate about CAM versus orthodox medicine can be divided into arguments about subjectivity or objectivity, or the value of lay as compared to expert knowledge, or art over science, I believe that to reduce this complex matter into such binaries is simplistic and unhelpful. As Micozzi (1996:3) states:

Some of the central ideas of biomedicine are very powerful, but are becoming intellectually stale. The study of dead tissue cells, components and chemicals to understand life processes, and the quest for “magic bullets” to combat disease are based upon a reductionist, materialist view of health and healing. We have made tremendous advances over the past hundred years by applying these concepts to medicine. However, the resulting biomedical system is not always able to account for and use many observations in the realms of clinical and personal experience, natural law, and human spirituality.

The scientific community argue that they are the rightful arbiters of what can and cannot be either included or excluded from a scientific paradigm (Pickering 2004:167). However, Pickering makes the point that evidence based medicine (EBM) utilising randomised clinical trials (RCT) is not a completely objective or neutral process. Clinical trials testing for a single variable may include the choice

of a 'wrong sort' of variable or ignore variables that are perceived as 'non-scientific', such as patients being able to talk to someone about their illness (ibid:174). In other words, RCTs are a value-laden process that can be seen as subjective. Pickering believes that scientific endeavour has to be placed within a social context and ultimately both biomedicine and CAM will have to be subjected to some form of testing. However the methods used will need to encompass a framework that takes into account the plurality of therapies and their varied ideological base.

While some supporters of individualism may express dismay at a challenge being mounted to the privileging of rationalism and science, free choice is a central tenet of this ideology. To this end a health sector offering a range of healing modalities incorporating lay and professional expertise can be seen as adhering to individualistic ideologies.

VIII: Conclusion

The development of New Zealand's health sector can be traced through several epochs; from the self-sufficiency required of early European settlers to a more paternalistic and benevolent state, and nowadays, although the state is still the major provider, a mixture of both private and public health care exists. Alternative and complementary medicines have become increasingly popular over the last two decades and have secured a foothold in the health sector, but biomedicine remains the dominant medical modality, largely because of its adherence to science and technology and evidence-based medicine. This situation is far from static because the prevalence of neo-liberal and individualistic discourses, and their rhetoric of individual responsibility, influences the way health care is being delivered. One aspect of these discourses is evident in the way individuals are being encouraged to take greater responsibility for their health and CAM certainly provides a vehicle enabling patients to do this. These discourses also influence the regulation and training of health practitioners as outlined in the following chapter.

CHAPTER SIX

THE REGULATION AND TRAINING OF HEALTH PRACTITIONERS

I: Introduction

Medical pluralism in New Zealand has flourished within a neo-liberal environment that encourages therapeutic freedom of choice. The accompanying rhetoric of individual responsibility and autonomy has helped complementary and alternative modalities secure an increasing share of the health care market. This has occurred from both inside and outside the still dominant biomedical model. As mentioned in previous chapters one of the paradoxes of this situation has been a society (including a health sector) that has become increasingly subjected to scrutiny and regulation. However, contradictions abound. Despite rhetoric supporting increased monitoring of CAM, the sector, as a whole, still remains largely unregulated. One result of this situation is that the training and qualifications of CAM practitioners and doctors who practise integrative medicine remains obscure. This obscurity about the training regimes undertaken and qualifications gained by individuals involved in the CAM industry has important implications with regard to practitioner and patient responsibility and is examined throughout this chapter. In comparison the training and qualifications required by medical doctors is well prescribed through both their academic institutions and regulatory body, the Medical Council of New Zealand, and I will not be exploring this avenue further in this thesis.

It is clear that patients and practitioners are compelled to act in certain ways because health services are delivered through a variety of regulatory frameworks. Section II and III outlines the government's role in establishing and maintaining the regulatory environment that health professionals are required to adhere to, while Sections IV, V and VI describe the regulatory processes orthodox and CAM modalities adhere to.

As I set out in Chapter Four, autonomy is an important feature of a neo-liberal society. While much has been made of the rights of patients to be treated autonomously, health practitioners have also been used to working within an environment where their clinical autonomy has been respected. CAM therapists are

arguably better able to practise autonomously than orthodox practitioners because they operate in a less regulated environment. However they, along with their medical colleagues, increasingly experience threats to their autonomy through attempts to de-professionalise and proletise the medical workforce. This situation is examined in Section VII.

Intrinsic to this chapter are the insights proffered by my research participants (see Sections VIII, IX, X, XI, XII). During the interviews I conducted with both patients and health practitioners I asked them for their views on responsibility from a bureaucratic and governance perspective, as well as their ideas about the training and qualifications health practitioners should have. Although many different opinions were voiced, the general consensus from all participants was that health care should be delivered through some sort of regulatory environment that encompassed both orthodox and CAM modalities.

II: Regulation

In New Zealand the state plays a pivotal role in the regulation of health practitioners. The government enacts legislation, such as the Health Practitioners Competence Assurance (HPCA) Act 2003. However, it is the Ministry of Health that oversees the day to day running of the health sector. The Ministry of Health's executive team currently comprises eight deputy director-generals and a Principal Medical Advisor who all report to the Director-General of Health. In turn these bureaucrats are responsible to the Minister of Health who is the government's key spokesperson on matters pertaining to health. It is the government that retains responsibility for policy relating to the health sector. As well as the government and the Ministry of Health, various practitioner organisations are involved in the regulation of health practitioners. For instance, organisations such as the Medical Council of New Zealand (MCNZ), which is a statutorily registered body, and the New Zealand Association of Medical Herbalists (NZMH), which is self-regulating, have responsibility for compiling professional registers that set out the requirements for practitioner registration. These requirements may include minimum standards for training and qualifications, codes of ethics and codes of conduct, complaints procedures as well as processes to discipline practitioners in cases of negligent or

inappropriate conduct¹. The difference between these two examples is that one is required by law to ensure all practitioners are registered whereas membership of the NZMH is voluntary. In the case of medical doctors and practitioners such as osteopaths and chiropractors, their regulatory bodies are now also required to define scopes of practice (discussed further in Section VI). The Health and Disability Commissioner's role includes defining patient rights and ensuring these are upheld and his/her office has legislative authority to investigate and initiate proceedings against health practitioners and health bureaucrats, such as hospital boards.

Regulation also affects the way the health practitioners are remunerated. The state, Accident Compensation Corporation (ACC) - which is a Crown entity, and private medical insurance companies, all meet at least some health care costs. Predominately they cover modalities occurring under the biomedical paradigm but increasingly also support some CAM consultations, (for example, Southern Cross offers a policy which includes "preventative, allied and natural healthcare services"). These agencies dictate the requirements practitioners must meet in order to be considered a provider. For instance, ACC funds consultations with registered health professionals such as doctors, chiropractors and pharmacists as well as what they term 'treatment providers', for example, acupuncturists, counsellors and osteopaths. ACC sets out criteria that practitioners must have, including their qualifications, registration and certification standards. In other words a counsellor who is not registered with the appropriate body will not be accepted as a treatment provider and therefore any patient of that practitioner will be ineligible for ACC funding. Private insurance companies, such as Southern Cross, use similar guidelines. An insurance company, depending upon the type of policy held, will cover consultations or procedures carried out by a particular category of registered medical practitioner (such as a GP or a surgeon). Consumers can also take out policies covering acupuncture, osteopathy and homeopathic or naturopathic consultations. Again, these providers must be registered with a particular

¹ Some of the CAM practitioner organisations offer comprehensive and informative web-sites which outline registration requirements, codes of ethics, disciplinary procedures and so on. I recommend the following as organisations that have good web-sites, the NZ Council of Homeopaths and the NZ Association of Medical Herbalists. The NZ Register of Acupuncturists' site is also worth viewing although it does not detail disciplinary procedures available. A link to their Australian counterpart, the Australian Acupuncture & Chinese Medicine Assoc. (AACMA) outlines Codes of Ethics and Codes of Conduct. The NZ Health Charter site is disappointing given that it purports to represent 70 affiliate organisations with approximately 7000 members. There is no information available concerning ethical standards or disciplinary procedures. The MCNZ and the Health & Disability Commissioner web-sites are very informative and user-friendly.

professional body and be in private practice. For example, acupuncturists must be registered with the New Zealand Register of Acupuncturists and osteopaths registered with the New Zealand Register of Osteopaths².

III: Regulation of Medical Practitioners

As I set out in the previous chapter the evolution of New Zealand's health system has largely mirrored that of the United Kingdom, and so it has been with the regulation of medical practitioners. Therefore it is worth first briefly reviewing the history of practitioner registration in Britain prior to describing the New Zealand situation³. The regulation of doctors did not happen quickly and was in fact a drawn-out and complicated process. Reasons for this are varied but importantly include the rivalries that existed between different occupational groups such as physicians, apothecaries and surgeons, as well as reluctance on the part of parliamentarians to become involved in legislating professional activities (Fulder 1996:70-71). The regulating process can also be seen to mirror the prevailing discourse of the time: individualism backing practitioners' freedom to practice how and where they wanted to work, while collectivism encouraged greater participation by the state in the provision of health care services and defining the role of practitioners.

In Britain, after repeated attempts at legislation, the 1858 Medical Act was passed and with it the establishment of the General Medical Council (GMC). This august body was able to control who practiced medicine through a professional registration process (Dew 2003:23; Fulder 1996:71; Porter 1997:355-356; Wright-St Clair 1989:4-5). The Act also meant the GMC was able to restrict the professional aspirations of other healing modalities and this aided orthodox medicine to cement its relationship with the state and influence health policy (Cant and Sharma 1999:84-85; Dew 2003:23). Doctors attempted to use the act as a tool to debar colleagues who practiced alternative therapies, but politicians thwarted this action (Fulder 1996:71). Homeopathy was a popular therapy and despite attempts to forestall the practice of non-conventional therapies, the 1858 Act ensured the continuation of this modality, which still operates in Britain today under the National Health Service (Dew 2003:24).

² For more information on the types of treatment and practitioners Southern Cross will fund I suggest reviewing their web-site. ACC's web-site is also very informative.

³ For a history of the professionalisation of medical practitioners see Porter, R. (1999).

In New Zealand it has been compulsory for doctors to be registered since 1868, but under common law⁴ anyone was, and still is, able to treat patients providing they do not claim to be a registered medical practitioner (Wright-St Clair 1987:59)⁵. In the past the NZMA has voiced concern about this situation citing the need to ensure patient safety and the lack of a professional medical board and qualification standards of alternative therapists (ibid:59).

Prior to legislation registering the medical profession under one national body, the registration of medical practitioners was carried out on a provincial basis. Under the New Munster Ordinance in 1849, practitioners in the South Island as well as those who worked in the North Island but south of the mouth of the Patea River, were required to be registered (Dew 2003:27; Wright-St Clair 1987:2, 1989:13). At this time the New Ulster province tried unsuccessfully to pass legislation requiring all practitioners to be registered, noting that the Government had a duty to “protect the life and property” of its citizens (Wright-St Clair 1987:2). In 1864 the Otago Province enacted legislation requiring all practitioners to be registered and also provided for deregistration in circumstances reflecting “disreputable or infamous conduct in any professional respect” (ibid:2). As in Britain, the regulation of orthodox medical practitioners on a national scale in New Zealand was fraught with political agendas and practitioner misgivings. Politicians in New Zealand reflected the concerns of their British counterparts because they too were wary of doctors’ motives for wanting registration, viewing their attempts as ‘patch’ protection as opposed to altruistic concerns about professional competence (ibid:60). Pharmacists and supporters of homeopathy expressed opposition to the proposed legislation, which they considered would impinge on their ability to practice their particular modalities (Wright-St Clair 1987:60, 1989:13-14).

⁴ The Common Law right is well outlined in the House of Lords’ Science and Technology Select Committee’s Report (2000 Section 5.9). It states, “anyone can treat a sick person even if they have no training in any type of healthcare whatsoever, provided that the individual treated has given informed consent. (Treatment without consent constitutes an assault.). Persons exercising this right must not identify themselves by any of the titles protected by statute and they cannot prescribe medicines that are regulated prescription-only drugs. This means that, as long as they do not claim to be a medical practitioner registered under [appropriate legislation] then anyone can offer medical advice and treatment and can purport to treat a range of diseases, provided that they do not claim to cure or treat certain specified diseases as proscribed by law. The Common Law right to practise springs from the fundamental principle that everyone can choose the form of healthcare that they require. Thus, although statutory regulation can award a therapy protection of title, it cannot stop anyone utilising the methods of that therapy under a slightly different name.”

⁵ For a detailed history of the development of the New Zealand medical profession see Belgrave (1985); Wright-St Clair (1987; 1989).

In 1867 the New Zealand parliament passed the Medical Practitioners Act, and a consequence of this was the establishment of a Medical Board. The Board had the power to decide who could be a registered practitioner (Belgrave 1985:51) as well as the ability to discipline doctors but the registration process did not run smoothly. According to Wright-St Clair (1987), the Medical Practitioners Act 1867 provided for the appointment of local assessors to the Medical Board on a provincial basis. However, these assessors were not Board appointments, but were made by the Governor. When Dr F.W. Irvine was appointed as assessor in Nelson the Board reacted strongly. Irvine, although qualified as a medical doctor (MD) from Edinburgh, practiced as a homeopath and this angered his colleagues. A majority of the Medical Board resigned in protest at his appointment and in 1869 Parliament passed the Amendment Act abolishing the Board and registration of practitioners became the province of the Registrar-General. It was not until 1914, after numerous attempts at legislation, that the Board was reinstated (Wright-St Clair 1987:3). In 1924 the Medical Practitioners Amendment Act changed the name of the Medical Board to the Medical Council and powers were given to the Council to decide whether practitioners with foreign qualifications could gain registration in New Zealand (ibid:62). To qualify for registration the Board, practitioners had to satisfy the Board that they had attended an approved university or medical school for five years and they were required to provide evidence of a diploma in medicine and surgery (Belgrave 1985:62).

Today the Medical Council is the body administering the registration of medical practitioners in New Zealand. Registration requirements are contained within Section 16 of the Health Practitioners Competence Assurance Act 2003, which provides for registration as a health practitioner within a “scope of practice” (HPCA Act 2003:24). Sections 11 and 12 of the Act give the Medical Council authority to define the qualifications deemed acceptable for practice in New Zealand and these include the following principles:

1. the qualifications must be necessary to protect members of the public;
2. the qualifications may not unnecessarily restrict the registration of persons as health practitioners;
3. the qualifications must not impose undue costs on health practitioners or the public.

Registration can be granted on a provisional basis under Section 22 of the Act, which allows applicants to practice under supervision. This provision is waived however for graduates of New Zealand and Australian medical schools who have completed their internships in either of these two countries (MCNZ 2004:1). Amongst other criteria, applicants have to satisfy the Council that they are proficient in the English language and, with the exception of New Zealand graduates, intend to work in New Zealand. Doctors are not able to practise medicine unless an annual practicing certificate is issued (MCNZ 2004:2).

IV: Regulation of Complementary and Alternative Practitioners

As previously noted it has never been illegal for unqualified people to practice medicine. While legislation provides for the registration of qualified practitioners it also

...provides penalties for anyone who pretends to be qualified but who is not. It defines certain things which only a registered practitioner can do, but it *does not forbid the practice of medicine* by herbalists, colour therapists, or any who can persuade the public to believe in their methods. Medicine is not a closed shop (Wright-St Clair 1987:4, my emphasis).

Again a brief historical examination of what happened in Britain is warranted here, as the New Zealand CAM milieu reflects many similar features. Kevin Dew (2003:24) argues that, apart from homeopathy, the 1858 Act “had a dramatic impact in excluding alternative medical therapies in Britain”. Homeopathy, by contrast, has always occupied a unique place in Britain’s health care sector. The 1858 legislation ensured the continued practice of this therapy despite opposition from some orthodox practitioners, and today licensed homeopaths are able to practise within the NHS system (ibid:24). Homeopathic hospitals exist as part of the NHS and those medical doctors trained in homeopathy treat patients utilising both their orthodox and homeopathic skills. However, the situation has come under considerable pressure with some hospitals closing, although recently there has been a revival of this type of care (Dew 2003:24; Fulder 1996:79).

Fulder (1996) offers a more optimistic viewpoint than Dew with regard to the practise of alternative therapies in Britain. Under common law, there is freedom to practise any modalities apart from veterinary surgery, dentistry, midwifery, or to treat people with venereal diseases (Fulder 1996:71). Further, CAM therapists, like all health practitioners, are subject to criminal and civil laws (ibid:72).

Registration of complementary practitioners is still a contentious matter: osteopaths and chiropractors campaigned for and have now achieved statutory registration (Cant and Sharma 1999; Fulder 1996)⁶, whereas naturopaths remain dubious about the benefits of following a similar path (ibid:73).

The situation in New Zealand, as I have mentioned, has mirrored the British experience. However homeopathy does not enjoy the same status or state support as occurs in Britain under the NHS. During the early period of New Zealand's colonisation, homeopaths were considered part of the registered medical profession, unlike herbalists and hydrotherapists (Belgrave 1985:294). But when the 1867 legislation was enacted in New Zealand, homeopaths found themselves excluded from hospital practice (Belgrave 1985:41, Dew 2003:28). Despite support from some medical practitioners the practise and popularity of alternative medicine, including homeopathy, declined, while the power and status of orthodox practitioners expanded. However pockets of resistance to the hegemony of orthodox medicine did exist and a few medical doctors continued to practise alternative modalities, particularly homeopathy (Dew 2003:30). Throughout the 1880s and 1900s debate continued between the orthodox and unorthodox camps where science was championed over supposed quackery (ibid:31). However continued scientific advances changed cultural views of health keeping practices and orthodox medicine became the preferred healing modality (ibid:32). Although biomedicine has remained the dominant and preferred healing modality, governments in New Zealand have been reluctant to impose statutory registration requirements onto CAM therapists. In 1986 the then Minister of Health stated that his government, with regard to CAM therapies, was

... philosophically opposed to further restrictions in trade or professional practices and is unlikely to support any restrictive legislation unless the need for changes are adequately demonstrated (Hon Michael Basset as cited in Leibrich et al 1987:70).

This statement reflects the political ideology of the time, which was heavily imbued with a neo-liberal bias. However, the situation became increasingly complex because while the rhetoric of individual choice was being championed by politicians, health practitioners and members of the public, moves towards statutory

⁶ For discussion regarding the history behind the statutory registration process for osteopaths and chiropractors in the UK see Cant and Sharma (1999:89-92;144-155) and Fulder (1996:73-76).

registration of some modalities was occurring. Following the 1978 Commission of Inquiry into Chiropractic, the Chiropractors Act 1982 was passed which allowed for the statutory regulation of chiropractors. Similarly, repeated approaches to various governments from the osteopathic profession finally resulted in their inclusion as a statutorily registered group under the HPCA legislation from September 2004.

There are obvious advantages to statutory registration. These include strategies for protecting the public by ensuring certain entry standards are required and maintained for people wishing to train as health practitioners. Statutory registration also gives governing bodies the ability and means to enforce standards of practice and disciplinary action against members if required (Leibrich et al 1987:71). For practitioners, belonging to a statutory register can be construed as attaining “improved status; protection of titles; official recognition, government subsidies...and better referral networks” (ibid:71). However, despite all participants interviewed agreeing that CAM should be regulated in some form or other, there was recognition that such an environment brings with it the spectre of bureaucratic interference, the potential loss of professional autonomy, higher compliance costs, and the fear that CAM training and practice will become subsumed by a biomedical approach (see Cant and Sharma 1999; Dew 2003; Sharma 1992). One of the main concerns expressed was that the current scope of practice enjoyed by many CAM therapists would be eroded as government agencies, such as ACC, attempted to narrow the clinical areas practitioners could work in⁷.

Hugh, an osteopath, had dealings with health bureaucrats at a high level and he expressed the concerns of many CAM practitioners in the following way:

I personally think with legislation and ACC that osteopaths will be pushed towards a physio-type role. They'll [health bureaucrats] try and say that you just deal with musculoskeletal aches and pains but osteopaths will push for more than that. I mean we treat infertility, children with colic and glue ear, bowel disorders, the whole range....It's not that in any way we're going to cure cancer or infertility, but there are a lot of people who you can definitely directly help and I think ACC will just want us to give a few treatments for a sprained ankle and that type of

⁷ Kevin Dew (2003) describes how the chiropractic profession in New Zealand limited its worldviews in order to gain acceptance from the medical profession. Instead of promoting chiropractic as a “therapy that treats disease”, it reduced its parameters to one that “manipulates vertebrae” (ibid:56). In other words, in the process of seeking recognition and acceptance from both the medical profession and the state, CAM may experience “greater limitation and regulation of those practices” (ibid:57). See also Cant and Sharma (1999:65-68) regarding the limiting of “knowledge claims” by various CAM modalities in order to moderate concerns lay people and medical professionals may have about their practises.

thing....The services we provide are being market driven – less cost to the government and even though ACC would deny that and they say it's not about money it's about patient care, I believe that's rubbish. They're trying to get osteopaths into an endorsed provider network. They're trying to get all of us - GPs and chiropractors and physios, to write treatment profiles. If a person comes in with such and such a condition - how many treatments should they get? What should the practitioner be treating? What kind of thing should you be looking at? And then produce a book of osteopathic treatment for every condition. But look at the other ones that have been done: the doctors, the physios, the chiropractors - they all outline the maximum number of treatments ACC will allow. Eventually it will say you are only allowed to give three treatments for a certain condition...and once you get to be part of the endorsed provider network you will not be allowed to charge patients. So organisations like ACC will decide how many treatments you can give a certain patient because that is how many they will pay for...people come in from all walks of life with conditions or injuries and you can't treat one specific injury. The body is a unit; the person is a unit. And that's what I mean; the government has to be answerable. Yes, I like the HPCA Bill, practitioners have to be culpable and answerable...they have to be accountable...but what the government is doing is pushing down the practitioners who are working really hard to try and offer a good level of health care.

Despite such misgivings, in the West there have been increasing calls for regulation of the CAM industry and investigation of how this could be implemented has been undertaken for example, in Britain and New Zealand⁸. The Ministerial Advisory Committee on Complementary and Alternative Health's report sums up regulation of the CAM sector succinctly, pointing in particular to the need for risk management (see MACCAH 2004:8 for detail relating to common and inherent risks):

Regulation is a key means of containing the risks involved with CAM. The main forms of practitioner regulation relate to authority setting and maintaining the rules and directives. They are:

- self-regulation, where a professional body sets and maintains regulations. This body can have either a modality-specific or multi-modality focus.
- statutory regulation, where a statutory body is responsible for setting regulations and ensuring that practitioners comply. Because statutory regulation is enforceable by law, this is generally regarded as a stronger form of regulation (MACCAH 2004:11).

Although arguably the majority of CAM practitioners can practise within an unregulated environment in New Zealand because of their common law status they still remain subject to the laws of the land, for example the Consumer Guarantees Act 1993, the Fair Trading Act 1986, and the Health and Disability Commissioner Act 1994. There are also restrictions on the dispensing and sale of medicines and

⁸ Information relating to the investigations in Britain and New Zealand can be found in House of Lords' Select Committee on Science and Technology Report (2000); MACCAH (2004).

claims about the efficacy of treatments. For example practitioners are not allowed to claim they can 'cure cancer' (Leibrich et al 1987:68). Section 7 of the HPCA Act 2003 also prohibits people from using descriptions, such as the title 'Dr', or any other names, words or initials that imply a person is a particular type of practitioner, such as a doctor or an osteopath, when they are not (this aspect is discussed further in Section XII).

The findings from MACCAH (2004) and the House of Lords Select Committee (2000) support greater regulation of CAM practitioners but certainly do not advocate statutory registration for all modalities. The recommendations from MACCAH (2004:9) in relation to the regulation of New Zealand CAM practitioners are as follows:

1. Practitioners of complementary and alternative health should be regulated according to the level of inherent risk involved in the modalities they practice.
2. The process of regulating practitioners of high-risk CAM modalities should continue under the Health Practitioners Competence Assurance Act 2003.
3. Practitioners of low-risk CAM modalities should be encouraged to self-regulate through their professional body.
4. Practitioners (either biomedical or CAM) who practise one or more CAM modalities should undertake training and monitoring that is appropriate to the risk of each CAM modality.

V: Practitioner Regulatory Bodies

All the health practitioners I interviewed, both CAM and orthodox, are affiliated to professional organisations. Of course, as already outlined, statute requires practitioners such as doctors, osteopaths and physiotherapists to be registered and they have no choice in the matter. The CAM practitioners I spoke with, other than osteopaths, have no legal requirement to be registered but they all were affiliated to at least one professional body and these are self-regulatory.

Because there are a plethora of CAM organisations, it can be difficult to ascertain their exact status (see Leibrich et al 1987; Sharma 1992). An example of this situation can be illustrated with regard to naturopaths. I wrote to the NZ Society of Naturopaths (NZSON) requesting, amongst other things, information about their membership criteria and they replied as follows:

Graduates from the following institutions meet the requirements for membership:

- The South Pacific College of Natural Therapeutics
- Naturopathic College of NZ
- Wellpark College of Natural Therapeutics

(NZSON, personal correspondence)

The NZSON is also an affiliate member of the New Zealand Health Practitioners Accreditation Board and The New Zealand Charter of Natural Health Practitioners. The NZSON Secretary advised that there are a number of organisations naturopaths can belong to and if a practitioner is qualified in more than one modality, such as massage and herbal medicine, then he or she may decide to belong to several associations. A practitioner is not able to state they are a member of a professional register or organisation unless they have applied for membership and been accepted, and that acceptance is usually reliant on a candidate meeting certain educational requirements. The NZSON confirmed that people are currently able to practise naturopathy without legally having to undergo specific training (however such a practitioner would not be eligible for NZSON membership).

I also enquired in my letter about disciplinary procedures and was informed that the NZSON had a disputes procedure in place. My next question asked how enforceable decisions were in relation to disciplinary matters and I was advised that there were “too many variations to answer this question”.

The response I received from the New Zealand Council of Homeopaths (NZCH) mirrored many aspects described above with regard to requirements for registration but was more forthcoming regarding disciplinary proceedings. Members registered with the Council must of course act in accordance with all laws of the land, such as the Privacy Act and the Health and Disability Act and...

...members of the Council must abide by the Council Code of Ethics and Rules of Practice....Members of the public may make complaints to our organisation under our Complaints procedure....As yet we have received no complaints from the public which have resulted in a disciplinary procedure (NZCH, personal correspondence).

The Council has at its disposal the ability to re-educate, suspend or withdraw membership from practitioners found guilty of misconduct. However, as with the NZSON, the Council cannot prohibit a therapist from continuing to work as a homeopath provided they do not claim to be a registered member of the NZCH.

This situation is very different from that of a registered medical doctor. If the Medical Council removes a practitioner from the Medical Register (for disciplinary, retirement, or other reasons), then that practitioner is *unable* to practice as a medical doctor in New Zealand. It is against the law to do so. However, as the case of Dr Gorringer highlighted, although his name was removed from the Medical Register by the Council he has continued to practise as a ‘natural health practitioner’ despite having no formal qualifications in this area⁹.

To some extent practitioners operate in a sort of twilight zone with regard to regulation/self-regulation/un-regulation within the CAM environment. While the CAM and Dr-CAM practitioners I interviewed were generally in favour of a more regulated environment, many stopped short of advocating total statutory registration of all practitioners. The HPCA Bill, and the recommendations from MACCAH reflect this ambivalence. The Health Select Committee received thirty-three submissions from healing modalities wanting either to be covered by the new legislation, or at least expressing an interest in doing so. These groups included acupuncturists, audiologists, herbal medicine practitioners, homeopaths, hypnotherapists, medical herbalists, natural healthcare practitioners, naturopaths, psychotherapists, remedial body therapists and traditional Chinese medicine practitioners (HPCA Bill 2003:see page 9 commentary). Despite this level of interest, the Committee stated it did “not recommend that any of these groups be included at this time” (ibid: 9).

VI: The Health Practitioners Competence Assurance Act (2003)

The HPCA Act came into force on 18 September 2004. Two hundred and sixty five submissions were considered by the Health Select Committee and following these the Committee (2004:1-2) reported:

The Health Practitioners Competence Assurance Bill is intended to provide a framework for the regulation of health practitioners in order to protect the public where there is risk of harm from the practise of the profession.

⁹ Because Dr Gorringer’s surgery was on the route I took when travelling from home to university, I became aware of changes made to the hoarding outside his rooms during the time of the disciplinary hearing and its subsequent decision. The first sign, which replaced a rather tatty and worn one, was painted bright yellow and had a large silver stethoscope mounted on it. Dr Gorringer’s name and the title ‘Dr’ were clearly evident on the sign, along with his qualifications. The morning after the Medical Council’s public announcement of their decision to strike Dr Gorringer’s name from the Medical Register a new sign had replaced the previous one – still bright yellow - but without the stethoscope. The sign now reads “Hamilton Health Clinic Ltd. Ricky Gorringer. BSc. Dip.PhysEd. DipTchg. MBChB MRNZCGP Dip.Obst. Bioenergy & Natural Health Practitioner”.

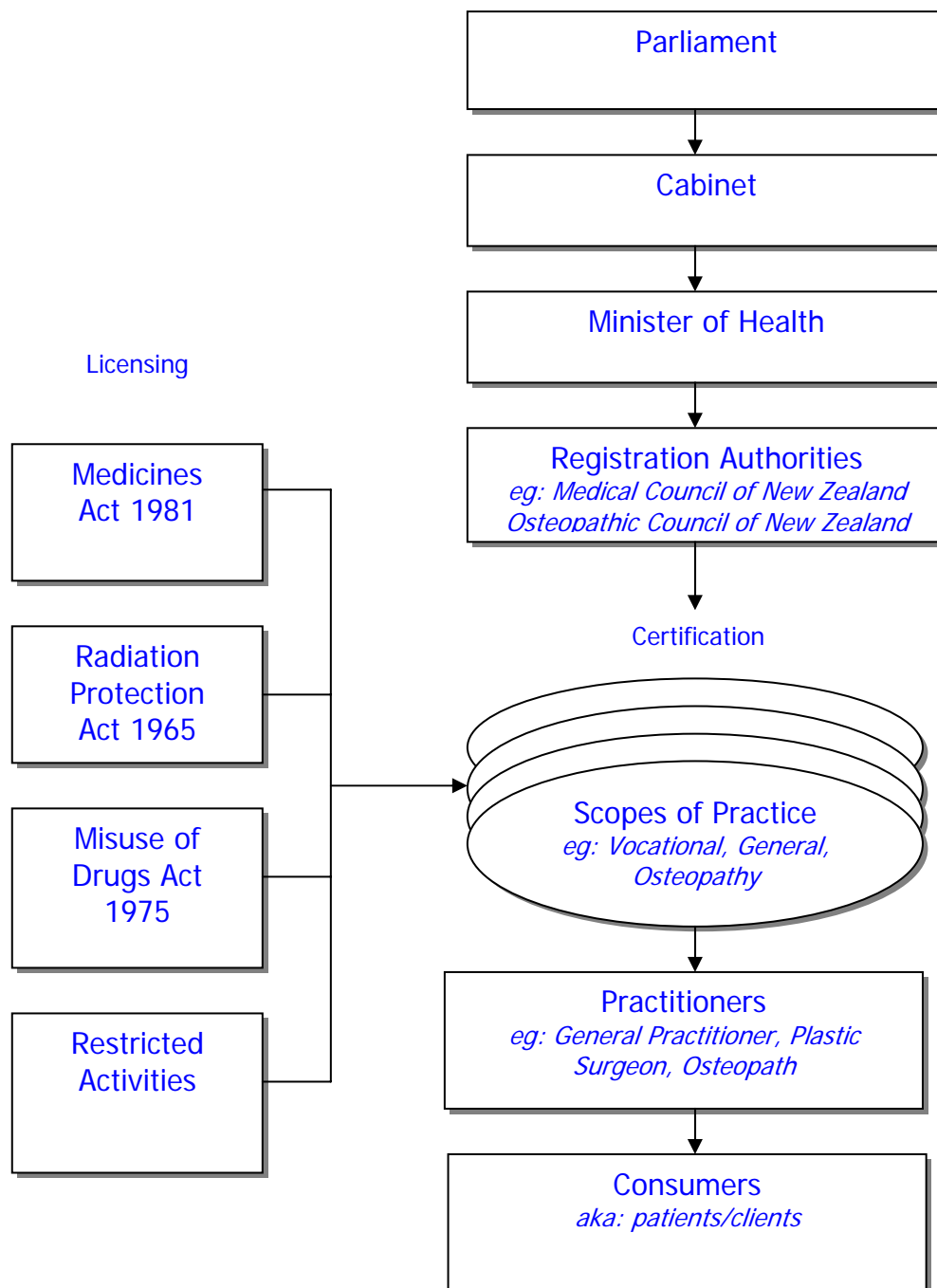
It includes mechanisms to assure the public that a registered health practitioner is competent to practise. It also includes consistent procedures across the professions for handling complaints against health practitioners, co-ordinated with the provisions of the Health and Disability Commissioner Act 1994. It is intended to provide a positive and professional working environment, where complaints can be dealt with in an open and transparent manner.

This Bill replaced eleven existing regulatory statutes and created registration authorities for all of the professions covered under the legislation. As mentioned previously, one facet of the Bill was the establishment of 'scopes of practice' (see Part 2 Clause 10 of the Act). This in essence means that practitioners covered under this legislation can only practice the modalities listed as their particular scope of practice. For instance general practitioners' scope of practice is delineated as "Vocational, General" and their vocational branch is defined as "General Practice". A plastic surgeon's scope of practice is also stated as "Vocational, General" and his or her vocational branch listed as "Plastic and Reconstructive Surgery". The scope of practice is not set by government but by regulatory authorities, such as in the case of medical practitioners, the MCNZ. Clauses 11 and 12 describe how each authority must detail the qualification or qualifications necessary for each scope of practice, such as a degree or diploma from particular educational institutions. Practitioners are not permitted to carry out another 'scope of practice' unless, under Section 8 (3) where there is an emergency, during training, or in an examination.

Another important component of the legislation is that it sets out a 'chain of authority' as demonstrated on the following page:

Figure IV: Health Practitioners Competence Assurance Act 2003

Chain of Authority



Sourced from www.moh.govt.nz/moh.nsf. (I have added some explanatory descriptions as well, such as scopes of practice and names of registration authorities.)

An important aspect of this legislation, not illustrated in the above diagram, is the role of the Health and Disability Commissioner (HDC). Under the legislation there is provision for complaints to be brought against health practitioners and investigated through the office of the Health and Disability Commissioner. Complaints can be instituted by members of the public or practitioner organisations

(such as the MCNZ) or, alternatively, the Commissioner can him- or herself decide to make enquiries into areas of concern, such as the outpatient services at a public hospital. The HDC's Office has two Tribunals for dealing with complaints and these are outlined below.

i: Health Practitioners Disciplinary Tribunal (HPDT)

The Health and Disability Commission's website (www.hdc.org.nz/proceedings) outlines very clearly the role of this Tribunal, and the information below has been largely paraphrased from this site. The HPDT is charged with the function of hearing disciplinary charges brought against *registered* health professionals. In other words practitioners such as doctors, nurses, midwives, physiotherapists and chiropractors, are required under the Health Practitioners Competency Assurance Act to be on a professional register. The HPDT comprises five members: a chairperson (who is a lawyer), a lay person representing public and community interests and three people from the same profession as the person being prosecuted (for example, if a general practitioner is being charged then three general practitioners will be on the Tribunal). Charges brought to the Tribunal are not criminal but relate to alleged professional misconduct and this means: "the provider's care fell below accepted standards and is serious enough to warrant the formal disapproval of his or her peers" (ibid). If a practitioner is found guilty the following remedies are available to the Tribunal:

1. cancellation of the practitioner's registration;
2. suspension of the practitioner's registration;
3. ordering that the practitioner can only practice under certain conditions;
4. censuring the practitioner;
5. fining the practitioner;
6. ordering the practitioner to pay some or all of the costs of the investigation and hearing.

Registration authorities, such as the MCNZ, are not able to take their own disciplinary action against members until the Health and Disability Commission has completed its investigation. However, this does not preclude professional bodies from intervening if they consider a practitioner is unfit to practice because of health problems or there are queries about a practitioner's professional competence.

ii: Human Rights Review Tribunal (HRRT)

This Tribunal has been set up under the Human Rights Act and is available to hear cases when a health practitioner is *not* a registered health practitioner, for instance

practitioners such as naturopaths, homeopaths, massage therapists or acupuncturists. However this Tribunal can also hear complaints against registered practitioners and other providers such as rest homes or district health boards. There are three Tribunal members: a lawyer (who is the Chair), and two other people. Complaints involve areas such as privacy and human rights issues or breaches of the HDC Code of Consumers' Rights. If a practitioner is found guilty the following kinds of recourse are available to the Tribunal:

1. declare the Code has been breached;
2. order the practitioner to cease the conduct that has breached the Code;
3. order compensatory damages to the aggrieved party (except if covered by ACC);
4. order exemplary damages be paid to the aggrieved party;
5. order the redress of any loss or damage ;
6. other remedies as the Tribunal deems appropriate.

The regulatory and governance framework outlined above supports the contention, as discussed in Chapter Four, that neo-liberal philosophies are now firmly embedded within New Zealand's social sphere. However, within this environment contradictory elements are apparent. Although neo-liberal and individualistic discourses encourage autonomous behaviour and freedom of choice, the reality is that society is increasingly restrained in those choices because of bureaucratic interference. An example of this is CAM practitioners being subjected to greater controls (although they are not as regulated as their orthodox counterparts). Surprisingly this call for a more regulated environment comes from both the practitioners themselves, and their patients. The discourse of neo-liberalism and individualism is, ironically, being threatened by the rhetoric of responsibility and accountability. One aspect of this situation is the effect this has on practitioner autonomy.

VII: Professional Autonomy

Prior to the neo-liberal era and particularly during the 1950s and 1960s, medical doctors occupied a dominant and powerful place in both society and the workforce. One aspect of this dominant position was that doctors (whether employed in hospitals or private practice) were 'self-directing' in the way they worked. In other words they were able to define and control many facets of their work environment: their roles at work, the tasks they, or others were allocated, as well as ensuring that any performance assessments were carried out by their peers (Foucault 1973; Freidson 1970; Kelleher et al 1994:xii-xiii, Leicht and Fennell 2001:27-28).

Professional autonomy also included aspects such as the gaining and use of esoteric knowledge which is controlled through entry qualifications, education, and the ability to apply the knowledge gained; legal or political recognition of occupational groups that require both licensing and disciplinary facilities; professional collegiality; a code of ethics or similar document; and finally public acceptance of a profession's claim to "expertise and altruism" (see Farsides 1994:43, Freidson 1970:134, Haug and Sussman 1969:153, Leicht and Fennell 2001:26). An important aspect of a health practitioner's professional practise is their right to clinical autonomy; this means a doctor having the "right and responsibility to decide about appropriate diagnosis and treatment" (Stacey 1994:121) for their patients. Although some health workers, such as nurses or radiotherapists, claim professional status these groups exist in an environment comprised of a "hierarchy of institutionalized expertise" and thus remain dominated by the medical profession (Freidson 1970:137). However, as Farsides points out in her discussion regarding obstetric care, one reason for this is that it is often medical doctors who bear ultimate responsibility for clinical outcomes and hence they may be "cautious about sharing control with others", such as midwives (1994:55).

The status and power of doctors began to diminish once neo-liberalism became embedded into the social sphere. This environment challenged the medical profession's dominance of the health sector because of its "heavy emphasis on 'liberalising' the economy, abolishing the 'dependency culture' and encouraging business values and the discipline of the market" (Kelleher et al 1994:xiv). Private sector involvement in the health sector expanded, while the state's role diminished and, significantly, a cultural shift took place where consumers of health services were constructed as clients or customers, not patients (Hunter 1994:26). The neo-liberal climate, with its focus on the role of individuals, questioned traditional authority structures. One consequence of this was the challenges mounted to the medical profession from a variety of sources, including nurses and other healing modalities such as complementary and alternative therapies. Further, during this period management became a dominant and powerful sector, and it was argued that responsibility within the health sector shifted from the realm of individual practitioners onto bureaucrats (Lantos 1997). It is this change that has stimulated research and argument about the de-professionalisation and proletarianisation of the medical profession (see Hunter 1994; Kelleher et al 1994; Leicht and Fennell 2001;

Saks 1994) However, Hunter argues against a blanket acceptance of the de-professionalism and proletarianisation of the medical profession because he believes that doctors are adept at deflecting management-led reforms (Hunter 1994:1). An example of this is evident in New Zealand. During reforms to the health sector started under the 1984 Labour-led government, and continued by successive administrations, general practitioners formed independent practitioner associations (IPA's). These associations were used by GPs to collectively negotiate with health sector managers, and were generally successful in protecting the autonomy and status of general practice (see Barnett et al 1998 for a comprehensive discussion about this situation). Barnett et al (ibid:203) suggest there is little evidence, at present, to support the notion that general practice in New Zealand is undergoing proletarianisation on a large-scale¹⁰.

Despite this apparent protection of GP autonomy, as I discussed previously, autonomy should not be considered synonymous with freedom, despite neo-liberal rhetoric to the contrary. For example, practitioners who belong to autonomous professional organisations are required to adhere to the rules and regulations of those bodies, and thus it could be argued that a practitioner's autonomy is therefore compromised (Farsides:48-49). General practitioners' autonomy is also curtailed in areas such as prescribing and referrals, as well as through the use of evidence based medicine (EBM). EBMs relate to "the process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions" (Rosenberg and Donald 1995:1122)¹¹. Many medical practitioners feel constrained by the expected use of EMB and this situation is eloquently summarised by a doctor interviewed during Jon Adam's (2000:250) research into the use of integrative medicine by GPs:

Evidence-based medicine and me are in a pickle. I don't believe in it. I find it incredibly threatening to the way I conduct my business of being a GP because I don't conduct it in that way. I might treat your asthma totally differently from that asthma....I also like to feel that's possible to

¹⁰ Doctors working in public hospitals have not been as fortunate as their GP colleagues and have been subjected to "extreme forms of corporatisation" (Barnett et al 1998:204). See also Kitchener et al (2005) for a discussion on the bureaucratisation of the medical workforce in the United States.

¹¹ EBM, according to Armstrong (2002), is one way "elites" within the medical profession have attempted to exert control over individual practitioners. Through the use of randomised controlled trials, knowledge is transformed into clinical guidelines and protocols, and doctors are encouraged to follow these in terms of best practice. However, Armstrong argues that by adopting an EBM focus, practitioner autonomy is compromised. Patient-centered consultations are also put under pressure because the individuality of patients is ignored in the interests of doctors following best-practice guidelines.

do with allopathic medicine and guidelines and evidence-based medicine and the rest of it, they make a mockery of the individual relationship.

Although New Zealand GPs have managed to retain their autonomy in many areas, the medical profession has experienced changes to its status and authority. As mentioned previously, this has been provoked, in part, through a resurgent CAM industry. It is therefore reasonable to question whether CAM and Dr-CAM practitioners view autonomy differently than their orthodox colleagues.

Autonomy-as-self-government manifested itself amongst the CAM and Dr-CAM practitioners I interviewed in the way they chose to practise their therapies: sole or group practice, working from home or consulting rooms elsewhere, full- or part-time hours, qualifications and training undertaken, control over fees charged, and the types of patients treated. An example of this occurred when one practitioner spoke about the category of patient he chose to avoid:

I don't tolerate idiots, I don't tolerate the alternatives [lifestylers], nor those who can't afford to pay. (Brian, Dr-CAM)

While Brian certainly appeared less-than-tolerant of certain types of individuals, neo-liberalism supports his right to choose to run his business this way. He appeared to have no compunction about wanting to treat only a certain class of patient. However if he had been working under a strictly orthodox model of medicine and receiving patient subsidies from the state, he would not have been able to be quite so choosy about his patient-base. This is because a more collective ethos still underlies state-funded medicine, especially within general practice

Practitioners also talked of autonomy in terms of adopting a patient-centred approach to consultations and encouraging patients to be responsible for their own healing. Julian (Dr-CAM) said

The process involves a lot of letting go of a certain amount of control that we've been conditioned as doctors to have....Obviously if somebody collapses in my waiting room I have to take control....But the people I'm seeing are in chronic conditions where often their selves have been overridden by other people....So any healing has to take that into account. And if you, in an autocratic way, want to, even if you're doing it for the right reasons, take control and guide them, it won't work....It's a matter of almost joining someone in their chaos.

While these are very general ideas relating to practitioner agency and control, as I have already noted, there are certain characteristics that define professional

autonomy. However, as Sharma (1992) notes, these characteristics are not collectively applicable to CAM therapists. This is because CAM remains largely unregulated. Therefore not all CAM practitioners are under the control of a parent body and they can therefore escape sanction or disciplinary action; and even for ones who are members of a self-regulating authority, they are quite able to set up 'shop' somewhere else if they are 'struck off' their association's register (ibid:115-116). This means that practitioner responsibility and accountability remains somewhat oblique. Practitioners I spoke with were very aware of this situation and believed that regulation would better protect the public from practitioners whose ethics were questionable. At the same time it would provide 'ethical' practitioners with the professional status they desired. The CAM and Dr-CAM practitioners I spoke with were well aware that the gains they made as far as professional recognition was concerned would equate to a loss of their individual autonomy and the freedom to practise the way they wanted to. As Fran (Dr-CAM) said:

...registration can become a tool for conventional medicine or adversaries who want to quash, to kind of squash people.

This situation reveals the contradictions and complexities inherent in a socio-cultural environment professing to support the tenets of neo-liberal and individualistic philosophies. While freedom of choice is part of the rhetoric of these discourses, it would seem that for all health practitioners, orthodox and complementary, professional autonomy is congruent with a regulatory framework.

VIII: Patients' and Practitioners' Views on Regulation

All patients interviewed believed they required protection from charlatans and poorly trained practitioners and that some form of regulation was necessary. However, patients were divided in their opinions as to whether regulation for CAM practitioners should be similar to that of the medical profession or whether it should offer greater flexibility to cover the diversity of CAM therapies and therapists.

I think they need to belong. I don't think they all need to belong to the same body because they do different things but there should be different groupings, different bodies or something. At the moment you don't know who you're dealing with. I used to know someone who said she was a therapist and she had no qualifications at all and I don't know if it was psychotherapy, something similar to that, and I thought how could she do that? I thought that's really unethical because she's got the responsibility of people's minds... The situation needs to be regulated. The government should have control over things to make sure that we're safe.
(Faye, patient)

Phyllis said she felt that regulations may be needed to protect people from charlatans but she was unsure as to the best way this could be achieved. She spoke of a friend whom she held in very high regard. This woman had practised herbal medicine for thirty years despite having no formal training or qualifications, although according to Phyllis she continued to study "minerals and vitamins". Phyllis did not believe this woman would ever harm anyone and thought that any legislative attempts to enforce training and qualifications onto such a person would mean that her friend would not be able to continue her work.

Other patients also echoed these concerns, saying on the one hand that they saw a need for CAM practitioners to be regulated in order to protect patients, but on the other hand also believing that insisting on statutory regulation could see the more metaphysical component of CAM therapies being replaced with a biomedical focus.

I can see the need for CAM practitioners perhaps belonging to their own society but my concern is that I think we're trying to slot them into a slot that is actually foreign to where they should be. We're trying to slot them into an allopathic slot.
(Stevie)

Genevieve described a couple of occasions where she had felt uneasy about practitioners' competence and ethical behaviour. Genevieve believed one therapist she attended just "didn't know what she was doing", and during a consultation with another practitioner his behaviour had unnerved her. She described it as:

...on the margin of some sort of sexual thing and as soon as that came up I was wow – no way! There's no way he's in this for *my* health, he's in it for something else.

Despite her misgivings about these situations Genevieve believed it was *her* responsibility to be "discerning" about the practitioners she chose to consult. This attitude reflects the discourse of neo-liberalism. Individuals are encouraged to value their own judgments and experiences and not blindly accept the so-called expertise of professionals. Individuals decide on the course of action best suited to them, and accept responsibility for any resultant consequences, good or bad. Patients and practitioners used the mantra of 'buyer beware' when talking about the choices patients made with regard to their treatment options, and the consequences of those choices.

Genevieve said that if society in general wanted to be able to have a range of therapeutic modalities at its disposal then

...we have to take the risk that the odd one or two will be a bit questionable. I don't mind taking that risk and what it comes down to is patient responsibility.

Genevieve also compared her experiences with CAM practitioners to those she had had with orthodox doctors:

I've been to plenty of so-called registered doctors who've been quite inappropriate in their advice and even harmful in one instance...people go to the doctor and they don't get a satisfactory treatment or advice and no-one really questions that.

Genevieve's point is perfectly valid. However, according to Lowenberg (1992) ideas such as these can also underlie concerns about therapeutic efficacy. Lowenberg proposes that patients might confuse cure with care. If health is not restored or improved following intervention, patients may construe the lack of a cure with a lack of care. This may mean patients then query the therapeutic competence of practitioners.

As mentioned, the CAM practitioners I spoke with generally supported some form of regulation.

It brings us into line with England and Australia and the aim is to have an international standard....There is commonality and educational standards and agreement on principles of disseminating knowledge to the public about what we do. (John, osteopath)

What osteopaths want with regard to patient safety is that people will now know if they come and see an osteopath, they will know they're answerable, they're culpable. I mean you've got an example of an osteopath accused of serious sexual misconduct, raping a patient at the same time as a doctor did. They both served prison time. The doctor was struck off, unable to practice medicine in this country, and the osteopath, after prison, went straight back to work. Currently there's nothing to stop them doing that. In the interests of patient safety that's an extreme example....In terms of medical differential diagnosis, as a primary health care practitioner it is very important if people assume you'll be able to diagnose when they walk in off the street. They might have serious crush fractures in the spine from osteoporosis to anything - and some of these people practicing as osteopaths aren't trained. They just watch someone do it and decide they're going to do a manipulation. That's serious. We've been saying that for years; we've been lobbying, we've been pressuring. And we are very, very pleased at the outcome of the HPCA Bill. (Hugh, osteopath)

Margaret, a medical herbalist, said that she felt her profession should be regulated because

herbs are powerful and it can actually be really dangerous if someone doesn't know what they are doing....There's a lot of herbs and drugs that you do not prescribe together. When you do your qualification you learn about different medications and what herbs you cannot prescribe with which drugs.

This statement belies the beliefs of some patients I interviewed who believe that CAM therapies are not harmful. However this practitioner also displayed contradictory beliefs about regulation when she said:

Some practitioners don't actually want to register. They would rather just work as herbalists without registering. And I'm really torn on that because I think if we want it to be a profession then yes, we do need to take regulation seriously. But I do agree with those who don't want to register. It doesn't necessarily mean they're not good...and the cost of registration - that's going to put people out who are only practicing part-time. (Margaret, herbalist)

Margaret went on to voice her concerns about health food shops because she said they

don't even ask if someone is pregnant or on medication or anything like that. They'll just sell the products, they don't really know any different and they're not qualified.

The positive aspects of health food shops related to her beliefs concerning responsibility.

I feel that people are responsible for their own health, which is why I think health food shops are a good thing, but I also think that health shops should have qualified staff and there should be a quality assurance, so to speak, on the products as well because there's a lot of stuff in health food shops which is just a load of crap. (Margaret, herbalist)

Dr-CAM practitioners were also in favour of some regulation of the industry. This is not surprising given their experiences of already being statutorily registered medical practitioners. However they too were somewhat ambivalent about the need for a 'heavy-handed' approach in regulating non-medical CAM therapists although some concern was expressed at the minimal training standards of some practitioners and questionable ethical behaviour.

It's always a tricky situation. I think people should have their own bodies they relate to, whether you're a chiropractor or an osteopath or whatever you do, there should be a professional body which has minimal standards and so on. So the answer is yes, there needs to be more regulation or the professional bodies need to be stronger. But at the same time the patient must take some responsibility there too....We get a lot of people who obviously try out several therapies and I'm quite surprised sometimes when the person they've gone to I personally wouldn't have. Some of these therapists have done a few weekend courses and then they use some sort of machine and say it does all these wonderful things. People who over-claim always worry me because some people are very impressed by that - that they can cure this and that and everything. If people say they can cure cancer that's just not on, not in this day and age, but you still hear that claim being made. (Peter, Dr-CAM)

Another Dr-CAM practitioner said the current situation of self-regulatory or unregulated CAM therapists needs monitoring and he was in favour of a more

regulated environment. However he urged his patients to retain ‘control’ of therapeutic encounters because he felt this type of attitude would help people discern whether or not particular therapies or practitioners were beneficial.

My goal...is to make sure that there are not controlling elements coming from [other] healers. And in most cases I’m usually happy that there isn’t, but sometimes there are. So, it’s a very fine balance of you encouraging patients to follow their intuition but also to keep in control. And that’s not always easy because they’re not very well. To be assertive is something that’s quite difficult if you’re feeling tired and weary and in pain and need support....Ultimately I advise patients when they’re going to a complementary therapist, including myself, that they need to feel in control. If they feel there is another agenda: is a person is pushing a particular philosophy or religion that they’re not happy with or there are ego issues and things involved then they should stop going. Because ultimately those things are not helpful, sometimes destructive....There are good, well-trained non-medical people in the complementary field who have had good training in defined areas....But unfortunately it’s a fairly unregulated environment and I believe there are people out there who it would seem to the public that they’ve had training but they haven’t...we need a better regulating system for complementary practitioners.
(Julian, Dr-CAM)

The GPs I interviewed also saw a need for a more regulated CAM environment. The reasons given reflected a variety of viewpoints and encompassed ideas relating to patient safety and the need for minimum standards for the training and qualification of practitioners. Interestingly, many of the doctors described the need for a system that was ‘fair’, requiring the same standards for both orthodox and CAM practitioners. One doctor said because he had been trained overseas, in order to practise medicine under the rules set by MCNZ, he had been obliged to undergo an exam process and retraining because his specialist qualifications were not recognised in New Zealand. He felt there were double standards because CAM therapists faced little in the way of regulatory obstacles:

CAM therapists should be responsible to the same standards that we have, like Medical Council registration. At the moment there are no checks and balances. I’m a foreign doctor and I had to go through all the exams and all that but if I was a complementary practitioner I could just come and practise any time.
(Ravi, GP)

Another GP described the need for CAM practitioners to adhere to standards of practice that may not be construed as medical or clinical, but were just as important in the consultation:

[CAM] practitioners should have a responsibility for safe practice so they should have enough checks and balances not to harm anybody and they need to meet certain minimum standards which society has already set – like privacy and appropriateness of care and facility and all those things which are already regulated around in medicine, that aren’t strictly medicine related but are health and safety type standard. There doesn’t seem to be any of that type of requirement for alternative health providers and they just seem to slip through

the net on that, they are just seen as individuals basically helping someone else out.
(Andrew, GP)

A GP in the same practice described the way that regulation can be seen as intrinsic to establishing levels of accountability. He believed there is a difference in the way the public perceived the role of doctors and CAM therapists and this is integral to the way complaints against practitioners were handled. He also thought the medical profession should be wary of advocating compulsory regulation of CAM therapists because this would just play into the hands of critics of the medical profession who see doctors as paternalistic and arrogant:

...as a rule the medical profession is held to account in a different way than alternative therapists are. The public view us differently and they expect a higher standard and maybe rightly so, therefore they are more inclined to be unhappy if they are treated in a way they think they shouldn't have been and I think they are far less likely to complain about an alternative therapist because their expectations are different. Maybe also they aren't aware they can make a complaint [against an alternative therapist]. I also think there is a bit of the big brother thing in that the medical establishment is seen as being a bit of an overbearing culture because doctors have an interest in maintaining the status quo and there's a bit of antagonism there that makes us more of a target, whereas alternative therapists are almost like a minority group who are really trying to survive against all the odds and are somehow friends with everyone...they provide a treatment which is sort of frowned on by orthodox medicine and are therefore seen as an ally of the ordinary person...and people sort of gravitate towards that. They sympathise with it; they side with the under-dog.
(Scott, GP)

This last quotation from Scott reflects the main difference in attitude between practitioners of orthodox and CAM modalities. I found patient expectations of CAM surprisingly low (Miskelly 2005) and I believe it is this factor that permeates belief systems and influences ideas about the regulation of health practitioners and their responsibilities. Because patient expectations of CAM are low compared to their expectations of orthodox medicine, they are prepared to allow some latitude with regard to compulsory regulation of complementary and alternative practitioners.

IX: Qualifications and Training

Within the context of responsibility, the questions of training and qualifications are pertinent¹². The Health Practitioners Competence Assurance Bill (2003) aims to ensure higher and more consistent standards amongst health professionals. However, the Bill does not restrict lay practitioners who are not on a register, such

¹² The qualifications and training of all health practitioners are detailed in Appendices XIV, XV and XVI.

as those involved in some complementary therapies, from practising as long as their treatments contain no risk of harm to the public. While it is beyond the remit of this thesis to conduct an in-depth investigation into specific training methods and courses, some comment is necessary. A very important part of this research has been to ascertain whether there is a link between the qualification of practitioners and the level of responsibility expected by patients. The research undertaken also demonstrates, from the practitioners' perspective, what degree of responsibility they adhere to, whether by choice or through legislation.

The training and qualifications of CAM practitioners is a contentious matter because standards are so variable, even within the same modalities (see Fulder 1996; House of Lords Report 2000; Leibrich et al 1987; Sharma 1992)¹³. In New Zealand there are a large and diverse number of CAM training courses available. These are offered through a variety of educational and training providers, such as tertiary institutions and private establishments. I began my research into the training of CAM practitioners by looking through local newspapers, as well as brochures gathered from health festivals and in health food shops, and sent away for prospectuses from a number of institutions including the Wellpark College of Natural Therapies, the Bay of Plenty College of Homeopathy and the Waikato Institute of Technology Nursing and Health Studies. The Wellpark College of Natural Therapies is based in Auckland and its 2002 Prospectus offered Diplomas in Naturopathy, Herbal Medicine, Ayurvedic Medicine, Therapeutic Massage, Holistic Sports Therapy, Aromatherapy and Yoga, with Certificates in Remedial Massage, Ayurvedic Lifestyle Counselling, Aromatherapy, Herbal Studies and Nutrition. Six of the training programmes were New Zealand Qualifications Authority (NZQA) approved, three were in the process of being approved, and three had not, as yet, been approved. An example of a training programme is the Diploma in Naturopathy. Full-time, the course can be completed in three years, and part-time courses are also available. Subject modules span anatomy and physiology, chemistry, herbal fundamentals, naturopathic philosophy and principles, massage, iridology plus others. It is possible to gain entry into a number of Australian institutions through Wellpark College and, for instance, complete a Degree in Naturopathy. Entry criteria to all courses are as follows:

¹³ It is interesting to note that MACCAH's report (2004) expressed views about the need for some regulation of practitioners who used CAM therapies, but made very little worthwhile comment about standards of training and qualifications (ibid:17).

For students over 18 years of age there is open entry to all courses, provided a Course Advisor is satisfied that the academic course requirements can be met. For students under 18 years, 6th Form Certificate, preferably in Chemistry and Biology, is required. There will be tutorials available in Chemistry and Anatomy & Physiology for students who are weak in these areas (Wellpark College of Natural Therapies Prospectus 2002:47).

Entering the keywords 'NZ natural therapy training' into Google in August 2005 resulted in a total of 451,000 hits and a vast number of courses and institutions offering training in alternative and complementary therapies was revealed. For example a government career website (kiwicareers) outlined twenty-one different institutions where training in CAM could be undertaken: these included a number of polytechnics and the Wellpark College mentioned above as well as the Auckland College of Natural Medicine, Canterbury College of Natural Medicine, New Zealand School of Acupuncture and TCM (Traditional Chinese Medicine), Naturopathic College of New Zealand, Christchurch College of Holistic Healing, Aromaflex International Aromatherapy School, Australasian College of Herbal Studies, NZ College of Massage, Whitcliffe College of Art and Design, South Pacific College of Natural Therapeutics, Wellington School of Massage and the Wellington College of Homoeopathy. Some of the courses involve up to four years of training (full- or part-time) while others comprise a few months. Many of the longer courses advertised a biomedical component, such as anatomy and physiology, as well as modules in biochemistry and first-aid. Qualifications ranged from degrees in disciplines such as therapeutic and sports massage or art therapy to diplomas and certificates in modalities such as acupuncture or herbal medicine. A number of the courses were New Zealand Qualifications Authority (NZQA) approved, or had the backing of regulatory bodies such as the New Zealand Association of Medical Herbalists (NZAMH) or the NZ Charter of Health Practitioners (NZCHP).

As well as the courses mentioned above, which perhaps can be seen to fit into a more 'conventional' paradigm as far as training methods and qualifications are concerned, there are also a seemingly infinite number of informal courses available. Many of these contain a metaphysical bias: some examples I came across include yoga, a natural remedies cooking school, spiritual surgery, emotional metamorphosis, vision empowerment, "the dreaming body", a body casting

workshop and “BodySense” (sic) therapy. The majority of these courses involve only a few hours participation.

Defining qualifications can be problematic. As Leibrich et al (1987) and MACCAH (2004) discovered during their research, concerns were expressed about both the quality of training and the meaning and value of qualifications in relation to practitioners of complementary therapies. Also there was a level of obscurity in some of the qualifications practitioners cited (Leibrich et al 1987:63). I also came across this situation during a perusal of the Waikato 2005-06 Telephone Directory. The Yellow Pages Natural Therapy Section listed the qualifications of some therapists as: B.S.SC (HONS) psych. DHM. CTS; Dip, Hom (NZ); ND, Dip Herb.Med; N.D.S.P.A.N.T. Further investigation of the directory revealed a number of practitioners advertising themselves as 'Dr', but their qualifications are listed as B.Sc.(Hons) OST London (osteopaths); and CNBCE (USA) BappSc (AUS) Member NZCA (chiropractor).

X: Qualifications and Training: Patients' Perspective

I asked patients for their views about the training and qualifications of CAM practitioners and was surprised that many of them seemed taken aback by my question and appeared somewhat ambivalent about the qualifications of therapists they consult. Their body language indicated to me that few of them had actually considered this situation in-depth. However, given time to consider the question some of their responses belied my initial impression. I believe this ambivalence can be related to ideas that CAM is ‘natural’ and therefore patients do not consider they will be harmed by treatments. For instance Jack said:

Well I sort of think they aren't going to do anything that can do me any harm but they might do something that will do it some good...I've always felt that what they're [CAM therapists] prescribing is, what would you say, passive drugs and they're not aggressive drugs and therefore I don't feel scared but if they were prescribing real drugs, if you like, then I'd be worried. Mainly supplements is what they do, what they prescribe. They may not do much good but I doubt if they'd do any harm.

The participants described the qualifications as visible, “hanging on the wall” (Phyllis), and implied that it was their responsibility to decide whether or not the qualifications mattered.

The people that I've been to have always displayed their certificates so you can see where they've gone. But I tend to find that if it [the treatment] doesn't work for me, as in if the person doesn't appear to me to be competent, I don't

return, but that hasn't happened to me very often at all. Maybe I've just been lucky. (Sarah, patient)

Faye said she always asked CAM practitioners about their qualifications. She had found the naturopaths she had dealt with “very professional” and said they were very forthcoming about their background and training prior to a consultation taking place.

Another participant said she relied on word of mouth referrals and the reputation of practitioners before consulting them and was also prepared to spend time checking into their backgrounds and therapeutic options:

I would be very concerned about who I went to and I would certainly go on reputation and on people who had had good success and not just go to anybody. I would certainly check out a lot of things before I went to a particular therapist...they have different training regimes and believe in different things and you've got to decide on what you prefer and what's going to be to have the best success for you. (Elizabeth, patient)

Genevieve talked about the unregulated environment CAM practitioners work in and while this concerns her she feels that qualifications are only a guide and it is her responsibility to decide whether or not the practitioner is a person she feels is competent to deal with her health problems:

It's quite a difficult field to navigate the alternative health field because it's so unregulated and some health practitioners have their favourite little pet treatment and they think they can treat everything under the sun with whatever they do and I think that's quite unrealistic. I think qualifications can be a guide. Sometimes they have overseas qualifications which you don't know a lot about. I think on the whole if they act in a professional manner and if they belong to the local association or professional group you can be reassured.

However Genevieve then went on to say that:

Sometimes qualifications aren't a good guide. Word of mouth is important. I look for someone who is obviously really interested in and has a real depth of knowledge of whatever it is that they've specialised in. They haven't just done a weekend course in it or, you know, if they say they do homeopathy they are real experts in that field. You can tell from the way they speak. I usually talk to them on the phone or face-to-face before I make an appointment and you can usually tell whether they came from a really in-depth base of knowledge. I tend to prefer to go to practitioners who do only a small range of things so that you know they've really built their knowledge up in those particular areas so they perhaps only do massage or one other thing. They don't try to do everything.

The training of some CAM practitioners is becoming more *mainstream*. This is because an increasing number of institutions are offering courses that include a biomedical component, such as papers on anatomy or pharmaceutical interactions. Some of my participants believed this will bolster public and biomedical confidence

in the sector because practitioners who do not meet required standards will not be eligible for inclusion on therapeutic registers and this may eventually force them out of business:

The more people who are training through the colleges that offer natural therapy training, the more possibility there is that people may not be meeting a standard, so I think that the register is a good idea. (Sarah, patient)

It will be interesting to see if this situation does occur. Even although there are a greater number of CAM courses now available, the CAM industry remains largely unregulated and therefore it is still left to individual practitioners to decide whether or not they want to meet the eligibility criteria for inclusion on professional registers.

Even if patients have researched practitioners and their qualifications the consultation process can remain fraught. The following quote, from which I have previously used a small extract (see page 160), clearly illustrates this point.

It can be a bit hit and miss really but you generally know after one visit whether or not to continue - so it really is a gamble. I do as much research on the person as I can beforehand but I've sort of resigned myself to the fact that I may at times go to an appointment and it may not be what I'm looking for and they may not be able to offer me advice really that is suitable to my health needs and therefore I need to discontinue with the treatment. There's one lady I went to and I just thought she was quite off the mark with her advice, I just thought it was quite off-beam, well I sought a second opinion and realised that I don't think she knew what she was doing! (Genevieve, patient)

The above comments outline a variety of opinions regarding the qualifications and training of CAM practitioners. While patients were genuinely concerned about the competence of practitioners, they also demonstrated a willingness to experiment with therapies and therapists. Patients certainly wanted to retain the ability to make autonomous decisions about the practitioners they wished to consult and these choices related to the confidence they had in knowledge about their own bodies and making a diagnosis (Miskelly 2005). However, despite an environment professing tolerance and some ambivalence about practitioner training and qualifications, there were patients who believed that if a biomedical component was included in CAM courses, then the skill base of practitioners would be enhanced. For instance Jack said:

I think I'd feel happier if they did [have medical training]. An acupuncturist I consulted is extremely confident and I don't know whether his confidence was quite justified.

Jack then made a comment about this particular practitioner's previous occupation, which I believe highlighted reservations he had about the acupuncturist's competence.

He was a painter – a house-painter before he took this course. He went to China and did this acupuncture course and he's got all the certificates for acupuncture and he looks up the book before he puts the needle in, you know looking for the various points, and yeah, I think he's done his best to be qualified....I've never felt that their [CAM practitioners] therapy could be harmful except with [acupuncturist] with his needles in my bad leg cause once I came home after visiting him and the lymph fluids wouldn't stop flowing out of the holes that he'd made and I thought this can't be good so I don't think I went back after that.

XI: Qualifications and Training: Practitioners' Perspectives

i: CAM Practitioners

The CAM practitioners I interviewed described an interesting variety of occupational backgrounds prior to embarking on their present careers in complementary and alternative medicine. As mentioned above, one osteopath had been a carpenter and other practitioners talked about previous careers in teaching, physiotherapy, social work, nursing, research science, and working in the hospitality industry as a chef. Their change in career direction was often marked by a desire to help people or, having undergone an illness themselves or observing friends and family cope with ill health, subsequently developing an interest in healing.

While only one of the CAM therapists I talked to appeared overtly market-orientated in her choice of career (she described the CAM sector as a "growth industry...all I see is opportunity" [Lorna]), some of the Dr-CAM's had also carved themselves a niche market amongst upper and middle-class patients. Their consultation charges and practice locations were clear evidence of the socio-economic demographics of their patient base and this could be construed as a possible reason for their move into CAM therapies. Consultation charges were varied. At the 'top' end, one of the Dr-CAM's I interviewed charged \$260 per hour, plus patients had to pay extra for any remedies or medications they purchased. Another Dr-CAM charged \$150 per hour, plus remedies. One Dr-CAM, who involved a greater degree of orthodoxy into his CAM practice than some of his integrative colleagues, charged what he termed 'normal' consultation fees as his practice was eligible for state funded patient subsidies. However he said that if a patient wanted to focus mainly on the CAM side of his practice, an initial consultation may cost the patient in the region of \$70.00 and he would spend about

forty-five minutes with that person. The osteopaths I interviewed charged non-ACC patients between \$65.00 and \$110.00 an hour. Subsequent consultations usually attracted lower fees, around \$60.00 per hour. One herbalist I spoke with charged up to \$90.00 per hour for an appointment, while other therapists in her practice charged \$70.00 an hour. The Bowen therapist I interviewed described her fees:

My prices for Bowen are \$25.00 a time. Homeopathy, for an hour and a half I charge \$40.00 and that includes the remedy. And massage, because that's physical work I charge \$27.00 for a half hour session, \$32.00 for three-quarters and \$40.00 for an hour and I've just put it up to \$50 for a full body which takes an hour and twenty minutes, or usually a bit more....I should be putting the Bowen therapy charges up. We're not supposed to be charging under \$30.00...but that is a lot of money for some people if they need to come for five or six weeks. (April)

The qualifications obtained by the CAM practitioners demonstrate the diverse range available. Some practitioners had undergone courses comprising an extensive biomedical component, such as Hugh, who had obtained his osteopathic degree in Britain:

I've got a Bachelor's degree in Osteopathic Medicine from the British School of Osteopathy in London. It was a four-year fulltime course in osteopathic medicine...we had basically the same lecturers as the medical students from Guys Hospital...and studied anatomy and physiology...we did a basic pharmacology course, so you know when people come in, what drugs they're on, and why they're on them.

Steven had also undergone his osteopathic training in England, obtaining a Diploma. He said

The tools we work with are a working knowledge of anatomy and physiology so all the time when someone's coming to you you're asking what's the anatomy involved here. So our knowledge of anatomy needs to be fairly good.

A medical herbalist I spoke with has a Masters of Science degree and after several years working as a research scientist she went on to obtain a Diploma of Herbal Medicine. This course took four years and she said that even although the qualification has the status of a diploma, when compared to her university degrees, she felt that the amount of training and study required was "pretty much equivalent" to a degree course. As far as post-graduate education was concerned, Margaret went on to say that:

To be a member of the New Zealand Association of Medical Herbalists you do need to do continuing education and different companies that sell medicinal herbs put on seminars a couple of times a year... there are also other post-graduate diplomas and degrees you can get in herbal medicine.

However Lorna, another herbalist was scathing of post-graduate requirements. She said

You only have to do ten hours a year which is a pathetic amount. I go to seminars because I like to go. But I must say that over the last few years there hasn't been much new...it's like I just hear the same old, same old.

Lorna was also cynical about qualifications saying that patients need to be very wary of...

...pretty bits of paper on the wall. Half of them mean nothing...You can buy certificates over the Internet, you can buy degrees over the Internet. It means nothing.

Glenda utilised massage and bio-energy in her CAM practice and described her training as "...esoteric and metaphysical so it's quite a different approach". She said that her nursing training and extensive clinical experience added to the healing experiences she offers patients, especially from a diagnostic point of view. As well as massage, light therapy and nursing training, she had also completed a diploma in herbal medicine (including Bach Flower remedies). Glenda believed she had a responsibility to ensure her qualifications are visible to her patients:

I think it's the same as the doctor having his certificate on the wall...I mean I wouldn't practise if I didn't have it. I don't think you can. You've got to have credibility and be answerable to those things. I mean I've studied in lots of things over a long period of time....there are certain protocols to stick by and that's to protect the public as well as yourself.

Another practitioner described the commitment she had made to study alternative medicine. This initially involved

...one year going to Auckland [from the Waikato] to study massage and then I heard about homeopathy and once a month, for four years, I'd travel to Tauranga for a weekend (April, Bowen therapist)

While April was rather vague about her qualifications and requirements for professional affiliation she described the post-graduate study she was required to undertake for Bowen therapy as involving

Twenty-one hours every two years and that's not hard. You want to do it because Bowen's very exacting. They say Bowen done badly still works but you strive to do it exactly right.

John, who had studied osteopathy in New Zealand and overseas, believed the standard of many CAM courses had been low. He thought there was still some improvement needed before their academic content would be acceptable to universities.

The courses are improving...if you train in naturopathy you now get taught anatomy and physiology at polytech but there are no degree courses in naturopathy...at the local polytech here we've achieved a shift from a certificate

level of tuition to a diploma...but as far as getting universities to teach natural therapies, I think that's many years away.

While the CAM practitioners interviewed had all undergone fairly extensive training in their fields, and the majority of them were also keen to continue with their post-graduate education, they voiced skepticism about the standard of training Dr-CAM's have received. While not denigrating their medical qualifications or training, the CAM practitioners believed that many doctors attended little more than "weekend courses" in a variety of therapeutic modalities.

ii: Dr-CAM Practitioners

As suggested by Leibrich et al (1987), the competence of doctors who decide to incorporate CAM into their therapeutic armamentarium is open to question because their level of training and competence is often unknown. The CAM practitioners I spoke with made the following points about their medical colleagues:

There's a doctor practising out there who's been struck off the [medical] register, but a lot of people believe he's a naturopath because he calls himself a naturopath - but he's done no naturopath training. (Joseph, homeopath)

Lorna said she would like to see regulation of all practitioners' training and qualifications because

...you should not be able to practise anything after doing a weekend course, and that includes doctors who study acupuncture in the weekend and then use it in their practice on Monday. You need as much as four to five years training.

Similar concerns were stated by Steven, an osteopath:

You get doctors who do a wee bit of acupuncture – because they've all done weekend courses on it – and that's the scary bit. They do weekend courses – a while ago sports medicine was the rage so we had all these doctors doing manipulation and that was scary because I was getting all their mistakes. You get these frantic phone calls can you see so and so, mumble, mumble and the treatment procedure they'd used was inappropriate...the problem is the view that if a doctor has done a wee bit of training in this area then that's okay because he's a doctor. The big thing should be patient protection and these practitioners need more skills in the therapies before they're allowed to use them. Should they inform the patient that hey – I've done a weekend course in acupuncture – and I just look at my book and put the needles in!

A herbalist said she felt that doctors should be wary of prescribing herbs because "they don't know them as well as they should" (Margaret).

Despite concerns raised by these practitioners about doctors lacking CAM qualifications, I did not find specific evidence of this amongst the Dr-CAM

practitioners I interviewed, although certainly at times it was very difficult to ascertain what particular qualifications they did possess. One doctor said when he first became interested in acupuncture the only courses available to medical practitioners were part-time and although he utilised this therapy for some years he came to realise that its world-view and techniques would require him to practise acupuncture full-time and he did not want to take that route.

When I started there were courses which GPs did where you could go and do a two week course or a three week course and there were various other weekend things where you could learn medical acupuncture. I had a number of years doing that and it was very successful but as I went to more conferences I began to see that it was a whole area of medicine in itself and to do it really really well you would have to be a full-time acupuncturist....I limited what I did to certain situations...I didn't go into the whole areas that acupuncturists did and that applied to herbal medicine or anything else. (Ernest, Dr-CAM)

What is worth noting is that the Dr-CAM participants interviewed all developed an interest in CAM early on in their medical careers. For example, Peter's particular interest lay in anthroposophical medicine and he said he decided to travel overseas and train for eighteen months in this modality. However, he also retained a strong desire to improve and expand on his orthodox medical knowledge and at the time I interviewed him, he was in the throes of completing a Masters of General Practice. All the Dr-CAM's interviewed described a strong interest in post-graduate education and this related to both orthodox and CAM modalities.

Doctors who practised metaphysical therapies, such as mind-body and anthroposophical medicine are less likely to have a formal qualification as opposed to doctors who use modalities such as acupuncture, manipulation or homoeopathy and naturopathy. For instance Julian, who was originally interested in acupuncture and Chinese medicine, now practises a therapy known as mind-body medicine. As well as teaching this therapeutic approach to other health practitioners, which requires him to keep up-to-date with reading and research in this area, he also attends courses overseas. However he did say that many of these courses fall into an unregulated environment.

There isn't a bio-physics course for doctors although it is certainly being introduced now into medical schools in the States as a spirituality. It's been more of a growth process. The formal education is part of it but to be honest it's more driven by people who come to see me. You're actually involved then in a conscious growth which is being fed to you by the people who are coming with the problems. They're the ones that actually lead the way. (Julian)

Bob, who also practised a range of therapies said his training had involved

...classical acupuncture training in the UK which spread over three years and I've subsequently studied with a Japanese acupuncture group which required twenty days training, post-graduate acupuncture training and I also go to their summer school so maintain my acupuncture skills pretty actively. The Chinese herbs I did as part of the original training as a sort of add-on. Nutritional medicine I've really just picked up from seminars and reading and likewise the mind-body medicine and I've also got an interest in anthroposophical medicine.

While I accept the concerns of both CAM practitioners and patients that there may be some Dr-CAMs who have little in the way of formal CAM qualifications, I believe there is no current evidence available to suggest that this situation presents a threat to patients who choose to consult integrative practitioners. All the Dr-CAM practitioners interviewed said they adhered to orthodox diagnostic methods in order to exclude serious pathology *before* deciding to utilise alternative or complementary therapies. Reservations about the standard of qualifications and training is not only focused on Dr-CAM practitioners as was evident by the concern all health practitioners and patients interviewed showed towards people who, after little or no training, set themselves up as CAM therapists. This point was made apparent to me when I attended a holistic health festival. I stopped at a booth advertising spiritual surgery and the 'surgeon' explained a little about his therapy and offered me the chance to participate in a weekend course costing in the region of \$800.00. He hurriedly assured me that I could recoup my money "very quickly" because after such a course I would be able to set myself up as a practitioner and charge my 'patients' at least \$80.00 a session.

When considering the regulating of CAM practitioners, MACCAH recommended:

Practitioners (either biomedical or CAM) who practise one or more CAM modalities should undertake training and monitoring that is appropriate to the risk of each CAM modality (MAACA 2004:9).

It remains to be seen whether or not government and/or the professional bodies of doctors and CAM practitioners will decide that the current situation with regard to training and qualifications of complementary and alternative therapies needs to be amended.

XII: Patients' and Practitioners' Views Regarding Title

The establishment of biomedicine as the predominant healing modality saw the medical profession's status enhanced. This situation gave doctors certain privileges

and responsibilities. Despite traditional structures of authority, such as medicine, experiencing considerable criticism over the past five decades, doctors remain endowed with certain responsibilities and authority. Because of this I asked participants whether they thought practitioners, other than medical doctors, should use the title 'Dr'. While scanning the Yellow Pages phone directory, as I already mentioned, it was apparent that some non-medical CAM practitioners use this title, although they were not advertising themselves as medical doctors.

Generally patients felt that if CAM practitioners used the title 'Dr' then they could be accused of misleading the general public about their qualifications and training and they were not in favour of therapists doing this. The following quotation sums up patients' beliefs about this matter:

I don't think it's right because it misleads people, particularly people that are not well educated and they are the people that I feel sorry for because they are the ones who are usually taken advantage of. People who are educated can usually look after themselves, it's the others that I worry about, that are misled by people calling themselves doctors because they will think they are the same as a medical doctor and they are far from it. (Elizabeth)

CAM practitioners on the whole were also not in favour of non-medically qualified practitioners using the title 'Dr'. A herbalist explained why she did not think the use of the title 'Dr' appropriate for alternative and complementary practitioners:

The term ND is naturopathic doctor. And I don't like it. Even though I've studied all the things that are required to be a naturopath I would not call myself a doctor because I'm not a doctor... would not put doctor in front of my name if I had the choice of doing it or not...I guess I think like this because I haven't done the full medical training. My father was a doctor and I've got a few friends who are doctors as well and their training is enormous compared to ours. And so, if someone like a naturopath calls himself a doctor, I know they have not done nearly as much as training as a medical doctor has and so no I don't think they should call themselves doctor...If I did a five-year intensive course in herbal medicine training although with a hospital apprenticeship, so to speak, as doctors do, internship or whatever, then I could put doctor in front of my name with a fairly confident approach. But not without it. (Margaret)

However osteopaths showed some ambivalence about this matter. One, who did not use the title, said that he felt members of his profession calling themselves 'Dr' did so because they had been trained overseas and these establishments had a tradition of bestowing the nomenclature 'Dr' onto their graduates. He was not prepared to commit himself during our interview as to whether this was a desirable thing or not to do.

Another osteopath interviewed did use the title 'Dr'. When I asked him why he replied:

Because basically doctor is a title and it's also a job description. It's not there as a job description, it's an honorary title bestowed by the NZMA upon osteopaths in this country, chiropractors, everyone, so really it comes down in terms of a decision. Osteopaths around this area all called themselves doctor and so I decided to as well. The ruling here, in terms of the New Zealand Medical Council, is that if you make it absolutely clear that you are an osteopathic doctor then you are in no way misleading anyone in terms of you being a medical practitioner. (Hugh)

Dr-CAM practitioners interviewed also felt that non-medically trained therapists should not use the title 'Dr' because they felt this had the potential to confuse patients about a practitioner's qualifications and clinical abilities:

I think it's confusing if chiropractors and doctors of oriental medicine use the title [Dr] – I personally don't like that very much. (Bob, Dr-CAM)

However all this category of participants utilise the title 'Dr' themselves, as they are entitled to, because they are registered members of Medical Council. As discussed in the following two chapters the doctors who practise integrative medicine are welcomed by patients for a number of reasons. First, patients were reassured by the practitioners' biomedical training and perceived ability to diagnose potentially serious conditions. In other words, patients trusted these doctors. Second, patients were aware that general practitioners act as gate-keepers to other medical services and as such referrals to secondary and tertiary medical services can be enacted, as well as referrals to other CAM modalities. Third, because these practitioners had embraced another worldview of health and sickness through their use of CAM, their healing armamentarium was considered to be multi-faceted and thus beneficial to patients. And fourth, patients saw Dr-CAM practitioners as offering individuals the chance to accept responsibility for their own healing, and yet, significantly, these practitioners did not transfer all responsibility to the patient (see Lowenberg 1992). This is because practitioner responsibility is implicit within the orthodox medical model.

XIII: Conclusion

The regulation of health practitioners in New Zealand has evolved since early colonisation. Originally few restrictions applied to the practice of orthodox or alternative medicines. However as those modalities with a scientific focus became more predominant, practitioners lobbied politicians with a view to restricting

practice to certain individuals who had undergone specific training and gained qualifications from particular institutions. Thus we now have a system that legally requires all medical doctors and allied professionals (such as nurses, dentists and physiotherapists) to be statutorily registered. This process largely marginalised alternative and complementary practitioners, but under common law they were not disbarred from practising their therapies. Governments have until recently been reluctant to become involved in regulating alternative and complementary practitioners. However, as the popularity of CAM therapies has increased so have calls for a more regulatory framework to underpin non-orthodox modalities.

Unequivocally all the patients and practitioners I interviewed believed that regulation of all health practitioners should be mandatory, though there was some variance as to whether statutory regulation, as opposed to self-regulation of CAM practitioners, was required. There is little evidence to suggest that CAM therapists present a significant danger to the health of the general public and although some concerns were raised about the possibility of patients being 'ripped off' by unscrupulous practitioners there are still remedies available through civil laws or the office of the Health and Disability Commissioner. The current situation where many CAM therapies are self-regulating appeared satisfactory to many of the patients and practitioners I spoke with, although certainly some therapists, such as the medical herbalists, expressed a strong desire to become members of a statutorily registered profession.

I contend that the current regulatory environment of health practitioners reflects the paradoxes of neo-liberalism. On the one hand individualism is encouraged, while conversely, surveillance and regulation of individuals involved in certain occupations is increasingly sought. Autonomy, that much vaunted rhetoric of individualistic and neo-liberal discourses, is under threat. Practitioner individuality and the freedom to practise without regulatory constraints have been a hallmark of CAM practice, and this is now being tempered in an effort to create 'orthodox' non-orthodox practitioners. While this may have some significant benefits for practitioners in regard to raising their status in the eyes of both the public and the medical profession, greater bureaucratisation of their modalities is likely to occur. However, one aspect that I believe has been ignored by practitioners and academics is that a more regulated environment will mean practitioners will face greater

expectations from their patients as well as the wider social community. Currently CAM practitioners attempt to vest responsibility for healing in their patients, but under a more regulated environment this situation will change and they will have to accept more responsibility themselves. This has been evidenced in my research through patients expressing higher expectations of medical doctors compared to their non-medical CAM colleagues. As detailed in the following two chapters, these expectations have ramifications for the responsibilities of both patients and practitioners.

CHAPTER SEVEN

THERAPEUTIC PLURALISM: PATIENTS' VIEWS OF RESPONSIBILITY

At first I did want someone to solve my health problems for me and there would've been nothing nicer than if someone had said to me well this is what you need to do, take this pill and you'll be better...but I realised that ultimately it's all just down to me. I can go to other people for advice and I can choose to like that advice or not like that advice, but it's completely up to me. (Genevieve)

I: Introduction

One phrase I have been repeatedly confronted with throughout this research project is the ubiquitous '*I want to take responsibility for my health*'. Not only is it a phrase that crops up in academic texts (see for example Chambers and Macdonald 1987:97; Fulder 1996:34; Kelly 2000:208; Leibrich et al 1987:44-45; McGuire, 1988:248; Sharma 1994:58; White 1991:20), during social conversations and in the popular media, but it was I found, also uttered by the patients I interviewed. Despite an apparently universal usage and understanding of these words within a western social context I could not locate any research that has attempted to analyse what *taking responsibility for my health* actually means. As I pointed out in Chapter Three, various authors have examined the topic of responsibility from a variety of perspectives. However, these authors did not provide an in-depth investigation and analysis of patients' views of responsibility within the context of everyday life, especially in relation to their utilisation of CAM and orthodox modalities (in social constructionist terms this relates to developing an explanatory schema to understand the meaning of illness as well as reasons why certain healing methods are used). One of the core tasks I set myself at the outset of this thesis was to ask my research participants what the word 'responsibility' *meant to them* with regard to their health keeping strategies, health care requirements, and their expectations. What I discovered was that the notion of responsibility from a patient's perspective is both contradictory and complex. Certainly patients described their responsibilities for keeping healthy in terms of lifestyle choices, however, underlying this discourse were ideas about attributing responsibility for illness and I discuss these in Section II. Section III investigates why patients integrate healing methods including whether patients still require a diagnosis, and if

so, which diagnostic model they prefer. At the nub of this thesis is the question of how responsibility manifests itself in the lives of the participants, and the patients I interviewed all described this aspect in terms of the lifestyle choices they made. These choices are outlined in Section IV. Of course ideas about responsibility in healing encounters involve practitioners as well as patients and the health practitioners' views about patient responsibility were canvassed and are described in Section V.

II: Responsibility for illness – Why do you get sick?

From a social constructionist perspective individuals require explanations about social phenomena. This includes looking for reasons why they (or others) become ill. Some individuals adopt a fatalistic approach to ill health while others strongly emphasise individual responsibility for being receptive to disease processes (Goldner 2004:15). One question I asked patients is “why do you think you get ill?” The most poignant reply came from Jack, who had cancer:

I'm very mystified as to why, for example, one gets cancer. Why does one get a cancer in the leg? In the bone? I really think it was caused by an injury but no-one else seems to think that. I got a big thorn in it about 20 years ago, it hit the bone, the thorn hit the bone and I was laid up for a couple of weeks afterwards. But then it gradually came right and I carried on, but it seemed too much of a coincidence to me that the sarcoma came up in exactly that spot. The doctors don't seem to think it was relevant.

I think this response is an excellent illustration of an individual constructing meaning for his predicament. Jack needed to know *why* he had cancer and the medical profession was not able to provide an answer so he created his own explanation. Although Jack said the medical profession did not concur with his viewpoint, as far as he could see it made sense to link the previous injury to the tumour because they were both in “exactly that spot”¹.

Another participant, Elizabeth, initially recounted a fatalistic viewpoint of her experiences of ill health by saying that

...it's just the luck of the draw. I guess I'm fatalistic in that sense, if something is going to happen it's going to happen. You know if I'm going to die tomorrow that's what's going to happen. I can be careful, I can do everything I'm supposed to do or try and do and make sure I'm doing my bit, but if it's meant to happen it's going to happen.

¹ Attributing meaning to illness is clearly demonstrated through the classical anthropology of Evans-Pritchard (1976). The Azande believed nearly all sickness was caused by witchcraft or sorcery. While they recognised the causative factors of some conditions, such as when a person received a burn, the Azande believed it was witchcraft that caused the patient's pain.

However after thinking about the question for a bit longer Elizabeth offered the following opinion introducing the concept of self-responsibility:

I think you have to be responsible. It's just like anything else in life you've got to take responsibility for the things that you do and responsibility for your actions and for the consequences of those actions...I mean you've got to take responsibility and not be stupid about things. There's only certain things that you can do as far as taking responsibility and sometimes you get run down because you have been working a bit hard or whatever and you don't listen to the warning signs and you pick up a bug and it's irritating, but you know that you could have probably looked after yourself better and so you try and remember for next time.

This statement illustrates the complexity of ideas about responsibility. On the one hand individuals should behave in a responsible manner in order to prevent ill health, but conversely there are some factors beyond the control of people that may impact negatively on their health.

Faye talked about being unwell for quite a long period and despite consulting orthodox practitioners no diagnosis was made. In desperation she consulted a naturopath. The naturopath asked Faye about her lifestyle and it was here she admitted that

I used to drink a lot when I was a teenager and when I was 21 I used a lot of drugs.

The naturopath believed Faye's former behaviour had led to problems with her liver and gall bladder and recommended a special diet lasting two years, including abstinence from alcohol. Faye said that even although she only managed to adhere to the diet for five months the consultation changed her perception of the healing professions, her body, and her responsibilities

I started realising that we really control all of our bodies; we've got to take responsibility for it; we can't just rely on a medical profession that sees you for 10 minutes.

Faye felt let down by orthodox medicine: they failed, in her eyes, to diagnose what was wrong with her. She appreciated the holistic approach of naturopathy where she felt able to talk about her previous lifestyle and how this might have contributed to her current situation. Although patients offered harsh criticism of '10 minute consultations' with their GPs, there are reports of patients not wanting doctors to initiate conversations about lifestyle choices or preventative medicine into the

consultation (Parry and Pill 1994:12-14)².

Other participants discussed the importance of emotional equilibrium in maintaining good health. For instance Sarah said

I'm quite sure about this. My emotional state tends to put me into a state of being unwell physically.

Phyllis and Stevie also believed that emotions and health were closely interconnected

Well I do believe that your thought patterns produce what happens to you. A refrain that runs through my head is: 'be careful what you ask for because you might get it'. (Phyllis)

Well I think you go back to the holistic person - your food and your nutrition, your spiritual nutrition. That's that's probably the most missing link of all our society at the moment in western society and we have a lot of people out there searching. My personal belief is that they're searching for all these other things because they've actually lost track along the way. Mental health is interesting because that also ties in with spiritual health because your emotional health can tie with your spiritual health very much and when you're very grounded spiritually...your emotions may be more settled because you know who you are and where you're going. (Stevie)

While all patients believed their emotional wellbeing might be a causative factor in their health status, there was some reluctance to attribute total responsibility for ill health to this aspect:

...the type of illness you end up with seems to be connected with what sort of emotional state you've been in and things that happen to you, but I don't have that huge leap of faith to just believe in that aspect so it's a hard thing, it's hard to know. (Faye)

In order to elicit further views on the aspect of why they got ill, I also asked patients if they felt anyone or anything could be held responsible for their health status. Responses again showed a divergence of opinion. Faye talked about the responsibility she felt we should possess towards our emotional or, as she described it, our 'internal' health, but she believed that external factors sometimes exonerate us from liability for poor health.

We are responsible for ourselves for a start, so we are responsible for how we react to people's actions so you can't completely blame others. With regard to your emotional health you can't completely blame someone else because it's how you take it on board. Usually you are in control of your body and mind... When it comes to external actions from things that have happened to you, you don't have

² Parry and Pill (1994:12-14) believe that in situations such as these patients want doctors to retain their 'traditional' roles whereby they retain control of medical encounters. By introducing lifestyle and preventative strategies into the consultation process there is an expectation that patients will be expected to take more responsibility for their own wellbeing.

much control over that, but internally, how you look after yourself and that sort of thing, that's your responsibility like if someone else is controlling you and I'm thinking of things like women who are being controlled by their husbands or something like that. (Faye)

The power of emotions, often invoked in mind-body medicine, was discussed and certainly patients generally felt that while a positive approach to life was helpful, it was not sufficient in itself to produce miraculous cures. For example, Sarah expressed some skepticism of this philosophy when she said

I think lifestyle has a lot to do with how well people are and, if for instance I ate a very poor diet for any extended period I would expect that I wouldn't be very well so it has more to do with a whole range of how you look after yourself....However I couldn't really say that I believed that certain cancers can be turned around just because of strength of will.

These comments present a counter-argument to the rhetoric of individual responsibility that underlie neo-liberal and CAM discourses. While the patients interviewed did not specifically discuss feeling *blamed* by CAM practitioners for their health problems, they were wary of attributing total responsibility for illness solely onto themselves. Patients, I contend, are prepared to accept partial responsibility for their health status, while also believing that there are other mitigating factors to be considered:

All through my younger years I was always 'why me?' Why is everyone else healthy and why aren't I able to enjoy the things everyone else seems to enjoy? Life's never been a straightforward path, and there was a long time where I felt completely disempowered by my health....Looking back now I guess there's all sorts of explanations. I think there's definitely been environmental factors. They are very, very hard to pinpoint. You can't prove any of them, but there's definitely been correlations with times when I've been exposed to a heavy dose of pesticides when I worked in a nursery garden centre and people use to spray right next to where I was working. A sort of insidious type of illness. The same with a head injury that I had when I was younger which brought about the onset of periodic headaches and spinal problems and depression. Now the link seems to be there but I didn't see it at the time. I mean there's traumas, well that's part of life... most people in life get some sort of physical or emotional or environmental stresses on their system and we all react in different ways to those stresses. So if you don't respond well you end up getting diseases which can be emotional or psychological, which they definitely were in my case. That's why now with my health I look at all those levels and what's within my power to do in terms of, for example, my environment. I try and reduce the amount of nasty chemicals I use in my house when I do housework. But I can't do much about the arsenic in the water...but you try and do what you can. (Genevieve)

Attributing responsibility for illness to any particular person or factor is far from straightforward. This was apparent in Lalonde's (1974) report. Although the report focused on behaviour that was considered to be detrimental (such as smoking or not wearing seat-belts in cars) to good health outcomes, acknowledgement of the role unemployment, pollution, urbanisation, overcrowding, and other environmental

factors play in people's health was also made. However, the report laid the blame for all these potential sources of ill health with individuals both solely and collectively. The state appeared to be a somewhat amorphous being and escaped censure. My participants, when it came to ascribing responsibility, were well aware that certain behaviours were likely to impinge negatively on their health, such as taking drugs, eating a poor diet or becoming emotionally overwrought. While being aware of these factors, patients also recognised that, for them, there are elements beyond their control, such as environmental toxins or having a genetic predisposition for a disease such as cancer. In contrast to the rhetoric promoted by Lalonde, and since utilised by western governments and health bureaucrats, the patients I interviewed believed that ill health was not solely attributable to the individual. They also drew on collectivist expectations that other individuals and agencies have roles to play in sharing the burden of responsibility for health care.

III: Mixing and Matching Modalities

There is a large body of literature available describing patients' increasing use of alternative and complementary therapies in western societies³. The reason for this upsurge of interest in CAM by patients is multifaceted but common features include concern about biomedicine's increasing use of technology, invasive procedures such as surgery⁴ and the toxicity of medications; long hospital/specialist waiting lists; the lack of time given to patients during consultations at primary and secondary levels; disillusionment with orthodox medicine's ability to treat chronic conditions; plus the desire for a patient-centered approach as opposed to a doctor-centered one which often invokes ideas about medical paternalism and lack of patient autonomy⁵. Central to this discontent is a perceived lack of holistic care by orthodox practitioners towards patients.

³ See for example Baer 2002; Coward 1989; Dew 1998; Douglas 1994; Fulder 1996; Furnham and Beard 1995; Furnham and Forey 1994; Furnham and Kirkcaldy 1996; Kelly 2000; McGuire 1988; Micozzi 2002; Murray and Shepherd 1988; Saks 1994, 1996; Sharma 1992, 1996; Vincent and Furnham 1996; White 1991; White 2000.

⁴ I recall looking at my father just after he returned from theatre for surgery to remove a facial tumour and thinking how brutal biomedicine was. Not only were the scars of surgery very visible, but he also had numerous tubes inserted into different parts of his anatomy. In one way I was able to marvel at what could be done, but in another way I was horrified at the way the body could be so drastically cut into, rearranged, and changed forever.

⁵ For information on these topics see Kelly (2000:211-212) for a discussion regarding power and autonomy in healing encounters. Furnham and Forey (1994:458) and Vincent and Furnham (1996:38-39) describe skepticism about the efficacy of orthodox medicine. Patient desire for a holistic health care is outlined by Furnham and Forey (1994:467-468), Hughes (2004); (Lowenberg (1992); Sharma (1992). Sharma (1992) points to the inadequate funding of the public health system in the UK as a reason why patients turn to CAM, as well as patients dislike of orthodox medicine's

Despite the criticisms leveled at the orthodox approach to health care it is important to note that patients have not abandoned their use of biomedicine. Studies have revealed that even if patients are dissatisfied with orthodox medicine it does not necessarily drive them to seek alternative or complementary interventions (Furnham and Forey 1993:468) and for those who do use CAM but find it of little benefit, their consultations are mainly ‘one-offs’ and no long-term encounters with alternative and complementary therapies are established (Murray and Shepherd 1993).

The reasons patients mix-and-match healing modalities can be categorised as follows: CAM ‘fills gaps’ that exist under the biomedical model (see Adams 2003); CAM therapies are more benevolent than those offered by orthodox medicine; CAM offers patients alternative paradigms relating to diagnosis and healing options; and finally, the holistic focus of CAM therapies appeals to patients. I discuss these ideas below.

i: ‘Filling Gaps’⁶

When I asked patients why they chose to mix-and-match therapies their replies reflected much of the literature reviewed. At its most poignant, some of the patients I talked to said the main reason they use CAM is because of *desperation* or *hope*. Desperation occurs because patients believe that the orthodox approach is unsympathetic to their particular condition, even to the extent of discounting their symptoms or labelling the patient a hypochondriac. Desperation occurs because sometimes the biomedical model is simply unable to offer a definitive diagnosis or treatment for particular health problems and patients unsatisfied with this response look for other healing options to fill this void (see Adams 2003). CAM offers hope to patients who feel that the orthodox system has failed them. Patients using CAM are often confronted with different worldviews regarding the etiology of illness than those that underlie orthodox medicine and CAM enables them to construct new

preoccupation with an objective stance to illness as opposed to CAM therapies which offer a “subjective and social experience of illness” (ibid:201). Reilly (2002:408-409) argues orthodox medicine has become ‘dehumanised’ because attributes such as kindness, respect and empathy are more likely to be found in practitioners who practice CAM than those who work within a biomedical environment. CAM is considered more receptive to patients’ psychosocial background (Furnham & Kirkcaldy 1996:60; Sharma 1992:24) and offers a “spiritual dimension that is not seen as important in orthodox medicine” (Vincent & Furnham 1996:38-39).

⁶ Although Adams (2003) uses the ‘filling gaps’ analogy in relation to Dr-CAM practitioners’ use of a variety of therapeutic modalities, I believe it is useful in describing why patients mix-and-match orthodox and CAM therapies. In the following chapter I elaborate on the concept of ‘filling gaps’ in conjunction with the interviews I held with Dr-CAM practitioners.

meanings in relation to their health problems. Such a process is patient-centered and affirms their autonomy.

I would say that most of my life I have had chronic health problems. When I was younger I was taken to the doctor by my parents and had various examinations done and tests done and they never found anything. I guess the feeling was that maybe I was just sort of a bit of a hyper-sensitive or a bit of an overactive or hypochondriac type of personality and it was more emotional or psychological grounding for the problems I had. [In my late teens and early twenties] I went into a health crisis and developed a whole lot of problems, most of them were psychological - eating disorders and the rest of it - and first of all I was going to conventional doctors and became really lost with how to proceed. Nothing was really working so at that point the option seemed to be medication, ongoing medication and that didn't work very well either. So that frustration with not having my physical symptoms recognised as a definable illness alongside the type of psychological treatment I was receiving which was quite ineffective was I guess the impetus for me to look for other health options....No one therapy solved the problems, but certainly at least with the natural therapists, there was a recognition that the fact that I was coming there to see them and saying that I was unwell, meant that there was something not right for me and it wasn't just something in my mind. There was less effort to define my illness *as* something, and more about supporting myself holistically. (Genevieve)

According to Furnham and Forey (1994:468-469) CAM patients usually possess a “wider belief system” than patients who do not use plural therapies and they are therefore prepared to try a variety of healing modalities.

Before I had my [back] operation I did try other alternatives, like using needles [acupuncture] and I did all the Chinese techniques and visited therapists who used various energies. It's quite weird how it works; I don't know how it works but I've been willing to undergo everything....I've been to all sorts of different therapists and tried different things because I don't think you should block yourself off to any sort of treatment. People have been using, you know, chiropractic medicine for years and have had some success with it. A lot of these techniques are from China and I think western people kind of block their minds off to it because it's foreign, it comes from the East and it doesn't come naturally to what they would normally think of when going to the doctor or getting a cure or looking for relief. (Elizabeth)

Because the biomedical model is not able to meet all the needs of these participants, by choosing other healing options such as alternative and complementary medicines, patients see themselves as taking responsibility for their health-care by plugging the gaps that exist within the dominant paradigm.

ii: Side Effects

Many patients interviewed were wary of orthodox medications and their long-term effects, especially in terms of toxicity. Phyllis told me she had never used oral contraceptives because she believed they adversely affected women's health. She was also very concerned at the way antibiotics are used:

I do believe that over the last 20 years or so the dishing out of antibiotics has been criminal...they've built these super-bugs now that they can't cope with. I

believe it's because the doctors didn't tell people that you should always take vitamins afterwards because antibiotics kill the bugs as well as the other stuff. I believe drug companies are multi-million dollar businesses that are into the business of making money rather than making people healthy. (Phyllis)

Another patient said that she felt that products that are *natural* should be used much more than orthodox medications:

I think there would be a lot more natural healing if [doctors] prescribed things that were a lot more natural...I'd have more confidence in them if they tried these different things rather than feeding us up on chemicals. (Faye)

During her first pregnancy Faye was under the care of a midwife who recommended massage. She said that with the natural oils and the pleasing aesthetics of the room she was in she had felt completely pampered. The actual birth proved difficult and Faye had been given a piece of amethyst to hold onto as well as undergoing continual massage. Although specialist intervention was eventually needed, including the use of "too many drugs", Faye believed the combination of modalities helped the overall experience and outcome.

Jack suffered from a multitude of health problems, including asthma and rheumatoid arthritis and he expressed concern about the toxicity of the orthodox medications he had been prescribed. One reason he had been drawn towards CAM was because of the natural therapies used by practitioners.

I felt that the drugs were doing me more harm than good actually...[with regard to his rheumatoid arthritis] the only thing they put me onto was anti-inflammatories. They said you'll probably have trouble with your stomach and I thought if it's going to fix my leg I don't really want trouble with my stomach...[and I liked natural medications because] I sort of think they aren't going to do anything that can do me any harm but they might do something that will do me some good. (Jack)

Despite patients expressing some concern about the possible side effects of orthodox medications, none of the patients interviewed have discarded the biomedical approach. Faye said a naturopath told her that people should have a number of healing modalities at their disposal:

You can only heal so much using naturopathy and homeopathy and all that sort of thing...sometimes you do have to go the hospital and doctors.

When we spoke about using orthodox medications Faye said her beliefs have changed and she can now see, after working in the mental health sector, that at times orthodox intervention was required. However, she also felt that other therapies, such as counselling, were important:

I had this belief that maybe we don't need medication, but I can see how medication is important but it's not the be-all and end-all. If you just do that it's just bandaging. (Faye)

Patients contend that one way they take responsibility for their health is by refusing to take medications that they believe are toxic or likely to compromise their health in some way. Jack refused to take the anti-inflammatory medication suggested by his GP that may have alleviated his rheumatoid arthritis symptoms because he was concerned about the possibility of side effects causing him stomach problems. One of the belief systems prevalent amongst users of CAM is that therapies offered by alternative practitioners are natural and therefore harmless. Notwithstanding these beliefs, there is an increasing amount of evidence to the contrary (see note 8, p. 199). MACCAH (2004) recommended further research to ascertain both the safety and efficacy of CAM products.

iii: Diagnosis – Orthodox or CAM?

One of the contradictions my research reveals is in the area of diagnosis. Patients believed they were capable of making a diagnosis because they are *experts* when it comes to knowing their own bodies (Miskelly 2005). Despite being vocal about their own expertise it is important to note that the patients I interviewed also expected medical doctors and Dr-CAM practitioners to diagnose those same bodies and recommend appropriate treatment options. However patients did not display the same expectations towards CAM practitioners and were unconcerned as to whether or not a diagnosis was proffered (see Chapter Eight for a discussion about this aspect from a practitioner perspective). Although one of the main reasons patients consult doctors is because they are looking for a specific diagnosis, one facet of the consultation process they appeared dissatisfied with was summed up by their use of the ubiquitous phrase 'doctors treat symptoms not causes'. What patients appear to want is for doctors to attribute meaning to their ill health; that the symptoms they are experiencing are a manifestation of something occurring at a sub-clinical level, perhaps relating to the psycho-social environment of the patient. Patients may look for therapists and therapies that suit their particular worldview, such as viewing illness as an "opportunity" to reassess one's life (see Lowenberg 1992:35-37), as opposed to remaining reliant on "factual understanding" (Murray and Shepherd 1988:513).

Phyllis said she used CAM in preference to orthodox medicine because she believed medical doctors had poor skills when it came to diagnosing:

I decided that *they don't treat what's wrong with you*, they treat the symptoms that's what's wrong with you produces, which to me doesn't seem right...Well when you go to a doctor he says and what's wrong with you – so you tell him how you feel and he guesses that perhaps you might have such-and-such wrong with you so he'll suggest you use either this or that which is used to treat these particular things. And basically it's guess-work it seems to me.

However Phyllis went on to contradict herself later on in the interview because she said one of the reasons she goes to orthodox practitioners is to obtain a specific diagnosis.

As previously mentioned when people feel unwell they generally search for an explanation. The biomedical model “explains sickness in terms of pathophysiology – abnormal structure and function of tissues and organs” (Weston and Brown 1989:79). However patients do not view ill health so much in terms of a label but rather in relation to the experiences they have that might be construed as illness. In other words, “many people can have the same disease, but the illness experiences of each person are unique” (ibid:79). In light of these subjective experiences of ill health, lay people develop explanatory models for themselves combining a range of information gleaned from, for example, the electronic mass media, ‘home doctor’ books, novels, medical advice columns found in magazines, personal experience and discussions with other people. All my participants described talking to other lay people, usually friends and family, about their physical or psychological symptoms. Armed with knowledge from a variety of sources, patients then felt able to make a diagnosis. For instance, Genevieve said

...when I have a health problem what I do is really becoming as educated as possible myself on what the issue is and what I think might lead to a good pathway for dealing with the health problem.

Another participant recounted how she felt a bit ‘down’ and diagnosed depression, which she felt was due to “my situation at the time”. She also talked about living in Australia where her son was bitten by a spider

...I saw two marks you know, like fang marks from a spider...and the way he was reacting it was just like something real bad [but by the time they got to the hospital the marks had disappeared] and doctors don't believe what you are saying, what you know...[they said] Kiwis are so paranoid about spiders...and I felt really silly. (Faye)

This patient was extremely upset and disappointed that medical staff at the hospital had not agreed with her diagnosis and she felt humiliated in the process.

Sarah explained diagnosis in the following terms; if she thinks she needs a blood test then she consults a doctor. However, if she perceives her problem to be nutritional in origin, she consults a CAM therapist of some kind. Consultations with CAM practitioners are preferred, according to this participant, because she receives “a more negotiated answer to a problem”. This attitude related to the lack of hierarchy patients perceived in the relationship between themselves and CAM practitioners as opposed to those encountered in the doctor-patient consultation (Hughes 2004:29; Sharma 1994:85). The patient and practitioner in the CAM environment are considered to be partners in the therapeutic process, as opposed to the patient being a canvas on which a biomedical practitioner can inscribe his or her expertise. This means that patients often feel in control or empowered through the CAM consultation methods and this redresses power imbalances that may occur within the biomedical environment where knowledge ‘gaps’ may be evident.

All participants described making diagnoses but also expressed contradictory statements in regard to their expectations of health practitioners when it came to their diagnostic skills. For instance, when visiting an orthodox practitioner Genevieve said

I guess the things you ask for is a diagnosis and tests and things like that.

Stevie was less conciliatory in her approach because she felt she should be able to visit a doctor and request specific tests. Because of previous experience with epigastric discomfort she expressed confidence in her diagnosis and therefore believes

I should be able to go to my doctor and say could you please do a blood test for helicobacter.

Genevieve had different views about the need for a diagnosis and said when she attending a CAM practitioner

...[a diagnosis] is not always necessary...because I've had so many different diagnoses by natural health practitioners that you could say that doesn't make any sense...but the thing is that's not the emphasis...it's on what's going to work to make you feel better and I generally find the diagnosis can be quite unimportant.

This patient described security in knowing that she had been to a Dr-CAM and received a diagnosis of gluten intolerance, but said “I don't actually need that diagnosis anymore”.

As illustrated by these examples expertise in diagnosis can be problematic. Some respondents admitted to being *surprised* by a medical diagnosis they have received, indicating there are discrepancies between what they perceive to be the cause of their ill health and the views of practitioners. Patients were not unduly concerned if CAM practitioners did not make a diagnosis or treatment was unsuccessful whereas they appear very unforgiving of orthodox medicine if a misdiagnosis was made or treatment was not to their liking. CAM treatment was usually described in a more positive light and often because of the perceived holistic approach adopted by practitioners.

iv: Holism

The rhetoric of holism is at the very heart of CAM discourse. It is, of course, also at the very heart of the anthropological discipline. Holism within the CAM environment is not just about a body being constituted as comprising a mind, body, emotions and a soul. According to Lowenberg (1992:19, emphasis in original) holism relates to “the *interrelation of the physical, mental, emotional, spiritual, and social dimensions* of the human state”.

And it is this interrelationship between a myriad of components that is at the core of anthropological cultural studies: kinship and marriage patterns, religious beliefs, ritual practises, political and economic structures, gender roles, environmental factors and so on. Within the CAM sphere, this holistic approach is also integral to the treatment individual patients receive because, as Hughes (2004:29) points out,

By approaching the individual holistically...the individual is constituted as combining mind, body, spirit and social location, where both pathology, and therefore treatment, must be unique to that individual.

However, as Sharma contends, it is incorrect to assume that holism is synonymous with CAM therapies because good health care requires both orthodox and CAM modalities treating the “whole person” (Sharma 1992:108). Certainly GPs are the orthodox health practitioners most likely to adopt a holistic approach because their relationships with patients often endure over many years although, as Sharma points

out, the “over-specialization” occurring under the biomedical model, especially in the secondary and tertiary sectors, run counter to developing a holistic approach to patient care (ibid:109). Further, Cant and Sharma (1999:100) suggest that biomedicine’s stated adherence to holistic practice appears to coincide with criticism of CAM by the medical fraternity. This understandably raises questions about whether there is a real and genuine commitment to holistic practise.

Despite debates about whether holism is central to the biomedical, CAM, or integrative approaches, it is evident that some patients are drawn towards non-orthodox modalities because of their holistic focus. As I have already stated, patients want to be able to establish reasons for their health problems - why something is happening to them in particular - and CAM’s holistic approach offers an opportunity for the meaning of illness to be explored. Patients I interviewed also saw this approach as gratifying because the focus was on them as an individual and contextualised within their own socio-cultural environment. During CAM consultations many aspects of their life are taken into consideration while working out the most appropriate therapeutic approach to their health problem(s): for example, their work, social and domestic environment; social and family relationships; spiritual beliefs; as well as their physical symptoms. This, they argue, is unlike the biomedical approach that appears to consider them more as a specific organic entity where it is only their physical condition that is of interest to the practitioner. Patients described CAM’s holistic approach in positive terms:

They include your whole: what you’re doing...factors and stresses in your lifestyle and particularly emotional and psychological areas - what’s going on there? For me anyway, it’s such a fundamental indicator of my health. (Genevieve)

Well I think with the naturopath they’re looking at the cause, really the root of the problem. I think a lot of it is talking over who *you* are. (Faye)

Yeah, [CAM practitioners] say we don’t treat the complaint we treat the whole body, so I say go to it, treat the whole body. (Jack)

One important aspect of the holistic approach surrounds the rhetoric of responsibility. The autonomy of the patient is considered paramount and therefore it is implicit upon patients to accept responsibility for decisions they make and the resulting impact these may have on their health (Lowenberg 1992:37). Genevieve described to me how she found the expectations from holistic practitioners

empowering as the balance of responsibility shifted away from the practitioner to herself:

Over time there was a shift in awareness of me looking for answers to my health problems...a shift of me taking control of my health. Seeing it as something I had to create - a lifestyle and work towards health. I guess the problem is when you are in a health crisis you are very vulnerable and there can be times when you either look for someone to give you all the answers and take responsibility or you end up with people who feel they want to do that to you.

However, even although Genevieve and the other patients interviewed embraced and enjoyed the holistic style of CAM, they all continued to mix-and-match modalities. As Genevieve stated, despite her reservations about orthodox medicine, she continued to consult both orthodox and complementary practitioners because she believes both modalities

...have a role. With more acute things or infectious things I definitely go to see a doctor, but the things that don't fit easily into any kind of diagnosis or are more long-term chronic sort of ailments I look to alternative practitioners.

There is no doubt that holism is an attractive concept because it is patient-centered in its approach and recognises humans as complex and multi-dimensional and who need understanding in accordance with their whole being. However, despite this testimony Sharma (1992:109) makes the valid point that while patients seemingly endorse holism, their behaviour often runs contrary to their beliefs. One aspect of mixing and matching modalities, especially with regard to the use of CAM therapies, is that patients have a tendency to 'therapy-hop' and as a consequence a long-term association with a practitioner and continuity of care is unlikely. A therapeutic relationship based on the principles of holism is therefore likely to be thwarted (ibid:109), and this can have consequences with regard to practitioner responsibilities which I discuss in the next chapter.

IV: Responsibility – Patients' Perspectives

i: Lifestyle

During my interviews with patients I specifically asked them what they did with regard to taking responsibility for their own health care. All research participants describe three main areas that can be summed up as *lifestyle choices*. Patients believed that being responsible for their health meant eating a healthy diet, maintaining a regular exercise programme, and leading a balanced lifestyle to reduce stress in their lives. These themes mirror responses given by practitioners

of all modalities I spoke to in regard to their ideas of patient responsibility, and are also evidenced in the wide body of literature surrounding CAM therapies.

With regard to eating a healthy diet, participants offered the following views:

...and so we eat pretty well, we don't eat junk and I'm not allowed chocolate....I just want to be well but I don't want to go overboard about looking after diet and stuff like that. I don't want to be on faddy diets or anything like that - I just want to live a little. But what we eat is good food. (Jack)

I make sure that I eat the right foods or have supplements so that I'm putting the right things into my body, drinking enough water every day. (Elizabeth)

Well I try and eat well and because we don't eat meat. I sort of started wondering if, because of my lifestyle, it's hard to have time to have really good meals and things all the time so I thought I'd start giving the kids multi-vitamins and they have those every day. I think you are what you eat⁷. (Faye)

One participant I talked with was a sprightly woman in her seventies. Phyllis mentioned that, as she has aged, she reduced the amount she eats:

I'll just have something light. I don't think that hurts as you get older because your output of energy decreases as the years go by. That's where a lot of people make a mistake; they continue to eat like they've always eaten.

She was also adamant that one of the things people could do in relation to their health and especially their diet was to grow their own vegetables. She described the number of large homes on large sections being built in the town where she lived and lamented the absence of vegetable gardens on these properties. Phyllis felt that a vegetable garden not only provided better nutrition, but also exercise. She looked after fifteen acres by herself and believed the exercise she received from this was of great benefit to her overall good health.

Another participant reiterated the importance of lifestyle choices, pointing out that diet, exercise and stress management are integral to the way she managed her health. The strategies she adhered to are illustrated below:

Diet is important. I've had all kinds of weird diets, finding out specifically, rather than reading a whole lot of books, but actually finding out specifically what does and what doesn't work for my body, that's such a hard thing to figure out because there is no one rule....Yeah, diet is really important but it's not the only thing. Exercise and just general trying to balance work and stress. I use relaxation, meditation techniques. I find that really, really effective for

⁷ The comment 'you are what you eat' made by Faye is an excellent example of holism in action. Food is no longer just fuel because the body becomes a site for personal and social inscription. Vegetarianism (in some cases) is such an example because it can represent an individual's worldview eg: environmental and health concerns, religious views, statement about cruelty to animals, and so on.

depression and anxiety type problems. I do a lot of supplementation. I've had all kinds of varying theories on that but I guess I've come to understand it more now and I just acknowledge that even if you're eating a really healthy diet, which I do most of the time, that there are certain elements that I'm not getting and I need to supplement. (Genevieve)

While a good diet is pivotal to the notion of accepting responsibility for one's health, patients I spoke with acknowledge that preventative strategies are also important.

I suppose I try and avoid getting sick for a start and I think that helps. Walking - I should do more exercise and I don't do that but that's a time factor as well. And resting - I don't go out partying all the time or anything like that, so it's sort of I look after myself in that way and then when something's wrong I have to try and decide what I'm going to do about it. (Faye)

Another participant, who suffers from serious back problems, also outlined the strategies she puts in place, under the guise of preventative medicine, in order not to aggravate her condition. She said she made sure

I dress very warmly every day because if I'm cold my body tenses up and I'm in pain. I try and do the right things as far as my back is concerned by changing my position every few minutes and not sitting in the same position for too long. (Elizabeth)

And this was certainly the case, as I noted in my research diary (29 April 2003) following our interview: "I can confirm that the participant certainly did this during our interview - changed her position frequently in the chair she was sitting in".

Sarah talked about her desire to adopt a lifestyle that removed things that impacted negatively on her wellbeing. These included a realisation of what it is that actually made her feel unwell and the steps she was prepared to take in order to overcome these feelings

Lifestyle I think has a lot to do with how well people are and, if for instance I ate a very poor diet for any extended period I would expect that I wouldn't be very well so it has more to do with a whole range of how you look after yourself....Well some stuff dawns on me. At one stage in my life I had a partner who always had a glass of wine in the evening and I was happily joining in and I got tired and tired and it occurred to me at one stage that maybe that was overload for my system and so that formulated in my mind so, it's not that I'm a non-drinker, but I definitely don't drink alcohol every day because I know it makes me tired and I don't want to feel tired. So these things just evolve really. The food thing is again a little bit of a process - just listening to and taking note of my own physical responses and things like peanuts, which I love to eat, give me the most horrendous stomach-ache so I just find things out like that, and I'm happy to avoid what makes me feel uncomfortable. (Sarah)

One of the complaints rendered at CAM therapies are the difficulties patients have in complying with treatment advice – such as diets which may exclude products like

wheat or dairy products, as well as exercise regimes and so on. The participants I spoke with certainly echoed many of these sentiments. For instance Elizabeth stated there is only so much in the way of preventative strategies she felt capable of undertaking

There's only so much you can do, like having a good diet and exercise. I know that I push myself too hard but that's a problem I have with me and I put myself under unnecessary stress as a result 'cause I'm a bit of a perfectionist. I've kinda cured myself to a certain degree, not altogether, but I have got better.

Faye also spoke of the difficulty she had in maintaining a diet she knows is good for her, both in terms of content and cost

I'm a vegetarian so that's always been a thing with me, sometimes I just crave greasy things and not eating the right foods and that's another thing when I think about it with the natural foods and stuff - you know diets and things. You know what's good for you and that but it's being able to afford it. It's a tricky situation and often I think I should be eating more of this and that and I just can't really afford it and I look for the cheaper options that aren't as good.

Similarly, other participants also mentioned that it was not always easy to adopt a responsible attitude, especially when disease processes are not clearly evident.

My father had heart disease, he was born with a leaky valve so he always had a bit of a problem with his heart and he had a heart attack at 56. So there's the potential for some heart problems for me and my mother had strokes. So I've been told that I must take aspirin on a daily basis and I bought a packet of Cartia and I suppose it took me about two and a half months to take the packet because I forgot. You know if you've got a sore foot or a sore knee or something it reminds you, but if you feel fine then nothing reminds you. (Phyllis)

Even although participants acknowledge the importance of exercise, many felt it was a facet of their lives that was often sidelined because of family, employment or study commitments. Time was their biggest enemy. One participant confessed she simply did not enjoy exercising and was therefore faced with the dilemma of knowing what she should do to try and stay healthy but actually disliking the process

...and of course with your physical comes exercise and that sort of thing. And I am really bad. That is the one thing I am the most recalcitrant about and I acknowledge that and I am actually not a person who loves exercise, I just don't. (Stevie)

While there is no 'one size fits all' scenario, most New Zealanders need to earn a living in order to provide for their daily requirements. This often produces conflict and tension in people's lives as they juggle multiple roles: raising children, paid employment, maintaining house and garden, relationship with partner, relationships with extended family and friends, and so on. In many industrialised

societies women in particular find themselves not only working full or part-time, but also having to undertake the majority of the household's domestic tasks. Stress can become a common feature of their lifestyles, which in turn impacts negatively on their health. Genevieve summed up the situation in the following way:

I think the whole notion of full-time employment for everyone in the country is just complete unreality and it doesn't make us good citizens. It doesn't make us active in our communities, it doesn't make us good parents and it doesn't mean we have the time to spend on our own well-being. For me I think making money and having a full-time job isn't really of any value if I'm not well. I mean I've had such a lot of health problems that I value my health more than that....I used to think well maybe it's me, maybe I just can't hack the pace of full-time work, maybe I'm somehow less able than other people and I got to the point where I thought maybe I had a type of disability. But actually I think that the expectations of most people now in the labour market are completely unrealistic. People do it but at a huge personal and family cost and cost to their health and you can find all sorts of crutches to cope - and in my case that will probably have to be being permanently on anti-depressants - but that's not a long-term wellness strategy, it's a survival mechanism that has consequences over the long-term. So yeah, my ideal situation would be to have flexible working hours or to work part-time and maybe have less income but at least be able to maintain my health a bit better. So it does come down to time and it's imperative that we do take responsibility for our health, but that's almost impossible for most people because they haven't got the time to do that. (Genevieve)

It is one thing to know that the lifestyles we adopt may produce negative affects on our health, but participants eloquently demonstrated that they do not find it easy to integrate *healthy* options into their lives. As I have already suggested, the politicians, policy makers and health professionals who adopt a neo-liberal focus make it sound plausible that individuals have a responsibility to both themselves and society to be well. However, as Baer (2003), Coward (1989), Crawford (1978, 1980), Galvin (2002); and Tesh (1988) point out, western socio-cultural environments are replete with paradoxes where individuals are both encouraged to and chastised for participating in the global consumerist economy. As my participants aptly show, *knowing* what they should do to implement and retain good health is only one (and possibly the easiest) side of the equation; it is *maintaining* the aspects of healthy diet, exercise and a stress-reduced lifestyle that remains problematic. As Genevieve, quoted above, notes:

... it's imperative that we do take responsibility for our health but that's almost impossible for most people because they haven't got the time to do that.

This is the lived reality of the patients I interviewed; knowing the preventative measures required but confronted by a lack of resources and a lack of time to implement them. The discourses of neo-liberalism and individualism that underlie some healing modalities, despite their rhetoric of holism, ignore these factors and

continue to promote the development of policies and treatment strategies which are anathema to my participants because they bear little relationship to the realities they experience on a day-to-day basis.

ii: Information Sharing

Sharma (1992:55-56) states that one area of concern to her is that many patients appear reluctant to inform their GP that they are consulting alternative and complementary practitioners. This happens because patients believe their doctor is unlikely to condone the use of CAM therapies and may express disgruntlement or even anger towards this behaviour. This reticence to honestly disclose all therapeutic treatments may compromise patient safety in certain circumstances⁸. However condemnation of the use of plural healing methods is not solely the preserve of orthodox practitioners. Sharma (ibid:58) also reveals that there are CAM practitioners who are averse to their patients' use of orthodox medicine and this may manifest itself through recommendations to stop particular treatments or medications (in the following chapter I discuss in detail practitioners' perspectives regarding the mixing and matching of modalities).

I specifically asked patients whether they kept practitioners, both orthodox and CAM, informed about the range of treatments they are receiving. Genevieve said if she is attending more than one practitioner at a particular time, she always points this out during a consultation. I asked her about the reactions she receives from the practitioners concerned and she said that the last doctor she had seen ...

...sort of really frowned and sort of thought that it was all quackery and why would I want to do that when he was offering perfectly good treatment. I guess he still respected my choice, but he thought it was a foolish choice, that was quite clear.

This reaction was in contrast to CAM practitioners who did not voice their opposition to other modalities, including biomedicine, to the same extent. In general Genevieve said that when she consults a CAM therapist they usually

⁸ St John's Wort is a herbal remedy used, although not exclusively, as an antidepressant. Some of its ingredients are thought to lead to "reduced absorption and increased metabolism" when combined with a variety of orthodox medications, including warfarin. Ginseng, another herbal remedy thought to help cognitive function, also interacts with warfarin. Because Ginseng is also known to lower blood sugar levels this could compromise a person taking conventional diabetic medication, resulting in hypoglycemia. Toxic substances such as mercury and chromium have also been found in herbal remedies (Smith 2004). See also Chrystal et al (2003) who describe the potential interactions caused between CAM remedies and chemotherapy agents as well as other herbal remedies.

...always ask whether you're on medication and what treatments you're undergoing and I guess there is just a general acceptance that most people do have a GP who they go and see and yeah that's the status quo so I guess they don't really question it that much....On the whole they do try to move you towards reducing your reliance on drugs. I guess some practitioners would see that as being counter-productive to the healing process that they are trying to foster but they will just say that. Like very few of them have ever said to me you shouldn't be taking these drugs or whatever.

Only one of the patients I interviewed specifically described being warned by a CAM therapist about the quality of some people working within the CAM industry. This therapist had been particularly concerned about the training and qualifications of some practitioners who were working within the counselling sector. This is another example of the contradictions inherent in our neo-liberal landscape. Individual freedom and resourcefulness are encouraged by challenging orthodox medicine's authority through the use of non-orthodox therapies (for example, rebirthing), which are available to the public by way of a business transaction. At the same time there is a demand for regulation (to protect individuals who are supposed to be autonomous agents capable of making their own decisions). This situation reinforces the complexities of multiple discourses and multiple realities. Despite the veneer of neo-liberalism that permeates our social sphere, the collective spirit, I believe, still underscores much of New Zealand society. In the interest of the public good it would seem reasonable to expect some oversight and regulation of people who are dealing with individuals who may have their autonomy compromised through a depressive illness or personal circumstances.

Stevie revealed another perspective relating to the sharing of information. She works as a nurse in a hospital but is also passionate about CAM. Stevie acknowledged that using a variety of healing modalities is

...a bit of a conundrum for me because here I am, really keen on natural health stuff and historical health modalities and yet I love intensive care work. I know there's a place for intensive care work when you've got to help somebody stay alive and we need that, but we don't always need to go and take an antibiotic for a cold.

As well as trying to reconcile the different worldviews offered by CAM and orthodox medicine, Stevie had received negative reactions from orthodox practitioners when she had attempted to introduce aspects of CAM into hospital clinical practice (such as using iridology as a diagnostic tool), or when she

disclosed to a GP or specialist that she used alternative therapies herself⁹. While she used to be very open about her predilection for CAM, now, after feeling rather emotionally battered and bruised by her encounters with orthodox practitioners, she, unlike some of the other patients I spoke with, was very wary about disclosing her use of CAM to doctors. Stevie talked in terms of being 'judged' by the medical profession and, as Genevieve illustrated above, being made to feel foolish for believing that alternative or complementary modalities might help her health problems.

I find as a health professional it is really, really frustrating that I actually am inclined not to tell them [orthodox doctors] because of judgment. I am inclined not to tell them that I take herbs. (Stevie)

While all participants said they generally kept their orthodox and CAM practitioners informed about the healing modalities they were using, analysis of the transcripts revealed that this is done on a selective basis, especially in regard to their consultations with the medical profession. Interestingly, the GPs I talked to all said they assume many of their patients are using CAM. What they want from patients is honest disclosure about these treatment regimes. All the CAM and Dr- CAM practitioners interviewed said they encourage their patients to be frank and open about the healing modalities being used.

One question I asked all groups of participants: if patients choose to mix-and-match therapies, whose responsibility is it to keep practitioners informed about this? All practitioners believe that the responsibility rests with *patients*, although GPs said they feel one of their clinical responsibilities is to at least 'ask the question' about what therapies a patient is using. Gratifyingly perhaps, in the interest of their own safety, all patients interviewed echoed these beliefs by saying they are responsible for informing all practitioners about the treatments they use. Despite this apparent symmetry of opinion I believe the reality is more complex than these answers suggest. My research indicated that when patients presumed a practitioner would be unhappy or censorious about their use of particular therapeutic modalities, either CAM or orthodox (although usually CAM), they were unlikely to honestly reveal

⁹ Part of the hostile reaction Stevie purported to receive from orthodox practitioners could be attributed to her very forceful personality and the confidence she exhibited towards her own clinical and diagnostic abilities. While these comments may seem contradictory in the face of her reluctance to now discuss her use of CAM with doctors, I wondered if the situation she was confronted with had more to do with the question of power relating to the hierarchies of knowledge implicit in the doctor-patient and doctor-nurse relationship, as opposed to tensions over her use of plural healing modalities.

these treatments. Further, patients believed orthodox practitioners to be more negative about their use of alternative and complementary medicine than CAM therapists are about their use of conventional medicine. Conversely while practitioners of all modalities purported to be reasonably open-minded about the therapies their patients used, orthodox practitioners were less likely to show overt support for CAM than CAM and Dr-CAM practitioners showed towards the biomedical model.

One ramification of this situation means that while patients purported to act responsibly in regard to keeping practitioners informed about their treatments, in reality this does not occur. This happens because within the western socio-cultural milieu there is still skepticism about the use and benefits of alternative and complementary medicines, as well as condemnation of patients and practitioners who practise or use these therapies. As a result an environment exists where full and frank disclosure of therapeutic interventions remains unlikely. This muddies the waters with regard to responsibility. Patients will be able to pick and choose whether they want to accept responsibility, or as Lowenberg (1992) outlined and I discuss in detail in the following chapter, it may mean patients ultimately are absolved of their responsibilities.

iii: Paying For Health Care Equals Responsibility

One facet, which I had not expected in relation to my enquiries into patient responsibility, was the rhetoric that introduced the concept that paying for health equated to being responsible for health. It was those CAM and Dr-CAM practitioners who adopted a strong individualistic tone who said they believed that patients paying for consultation fees and remedies as being part of the equation of accepting responsibility for one's health. For example, below is an extract from an interview I had with John, an osteopath whose patients were not, at that time, eligible for government subsidies. He believed patients accept responsibility for implementing and maintaining therapeutic regimes because they pay for it:

John: Well they come to us for help so they're going to listen. And they're paying for it. The state's not paying so it's in their best interest. And if they're not prepared to listen they can go somewhere else. I won't carry people who aren't prepared to help themselves.

Me: So do you think people having to pay for treatment actually enforces that message of responsibility?

John: It's an incentive.

Joseph, a homeopath and physiotherapist said he felt that one of the positive features that has resulted from New Zealand's "under-funded health system" is that people who turn to CAM see paying for their health as an investment strategy especially with regard to preventative medicine^{10 11}:

Because they have to pay I think people say 'hey – if I stay healthy it's a good investment because I don't get sick as much and I feel healthy'...people are taking more responsibility.

April, a Bowen therapist, also believed that payment and patient responsibility go hand-in-hand:

If the state paid too much of a subsidy to people's healing then they wouldn't be inclined to take responsibility for themselves.

Ernest, a Dr-CAM practitioner, offered views synonymous with the individualistic philosophies espoused by politicians such as Marc Lalonde:

...I don't believe in handouts. I think people should be able to manage their own affairs...I don't believe in the [government] subsidy system...I think there are better systems which could be used to encourage people to be more discerning when it comes to looking after their health....Because when you subsidise there is a large mass of people who think – hey – somebody, that is the government...will take care of [health]...I don't think it encourages people to take responsibility and I'm really hot on this responsibility thing, I'm really hot on this idea that if you don't take responsibility then there are consequences. If you are obese, I mean like it's not a medical condition, if you want to get obese there are consequences....Perhaps the role of government in the area of public health is to point out to people...if you continue to smoke, if you continue to be obese or pig out on foods then we're not going to be here to pay for everything like your bypass or your stomach stapling – we're not going to be there for you...I think [the system] has to be designed to get people back to being responsible for what they do and understand that if they don't do these things then there are consequences to those things – how else do we learn? If you've got somebody always there to fall back on, there's always a hospital, a government or a service...nothing changes.

¹⁰ Thomas McKeown's (1979:192) viewpoint challenges the assumption of health being used as a personal investment strategy. Within the biomedical sphere he argues that doctors should not be held responsible for maintaining the health of "well people". This statement reinforces concerns that wellness is now seen as each individual's moral right or duty, resulting in a class of individuals known as the 'worried well' (see also Lupton 1994; Scott 2002).

¹¹ Professor Des Gormon (Head of Occupational Medicine, Auckland Faculty of Medical Health Sciences) spoke during the 2002 GP CME Conference of the way "normal life events" were being medicalised and how this situation has been responsible for creating an expanding medical market in the West. Social expectations, he stated, were predicated on the idea that we "[expect] to live forever well". Gormon maintained that many of the problems that have been medicalised, such as Occupational Overuse Syndrome, related to unsatisfactory work environments and poor management practices, but these were not 'medical' problems. It could therefore be argued that in cases such as these investment strategies by *management* to secure a good workplace environment could have prevented these problems occurring. This view offers a counter-argument to Joseph's neo-liberal and individualistic rhetoric that it is the individual who should be the sole investor in their health.

While the above sentiments appear unequivocally individualistic, contradictions became evident because the majority of practitioners (six out of eight CAM and four out of six Dr-CAMs) said they felt state subsidies should be available for CAM consultations. The main reason for this is the recognition that many people in low socio-economic brackets cannot afford CAM consultation and remedy fees. Some practitioners considered patients using CAM as being pro-active in accepting responsibility for their health and thus should be 'rewarded' for their effort through state subsidised consultation and remedy fees. However this support for subsidies was qualified because practitioners acknowledged that higher standards of training, qualifications and regulating practitioners would be required if taxpayer funds were spent on CAM consultations. In essence practitioners believed that if the state subsidised CAM consultations government interference within the sector would increase. One result of this could be practitioners losing their ability to practise autonomously.

Not all Dr-CAM practitioners believed that paying for consultations equated with self-responsibility. For instance Julian said:

It concerns me that the care I can give is not affordable to some people whose conditions have drained their resources, their financial resources as well. The chronically ill are often having to pay quite a lot for their health care to get good quality care especially if they don't want to just be given medications all the time.

The GPs interviewed were generally not in favour of the state subsidising CAM consultations unless practitioners were required to "undergo the same rigorous process that we have to go through" (Alison) and the efficacy of the therapies themselves was determined scientifically. This viewpoint reflects the role science and technology has played in establishing biomedicine as the dominant paradigm, as previously outlined.

Patients, surprisingly, were ambivalent about state funding for CAM. Certainly the majority of patients interviewed said that attending CAM practitioners could be expensive and this did act as a deterrent to using it as an ongoing health-keeping strategy.

One deterrent for going to alternative medicines is the cost. Everything is dear. I was paying \$50 a time to go to this woman in Auckland plus the running costs of getting there so it was blimmin' dear and when I was going to another therapist I think it was costing me about \$80 a visit and that's 20 years ago.

(Jack)

I went to a naturopath and I was meant to go back regularly. She gave me cell salts and things like that I could take but I couldn't afford it. The thing with the medical system is that they are subsidised, but natural therapists aren't and that's really the worst thing because I would have liked to have gone back more but we just couldn't afford it. (Faye)

It's been a huge financial cost to me over the years to find solutions to my health. There was a short time when I received a Disability Allowance which did help a bit but most of the time it's just come out of whatever I could earn at the time...there's definitely been periods in my life when I've had to reduce my reliance on alternative healthcare because I haven't had the money and I've resorted to going to the doctor, the GP and getting drugs because they are subsidised and I was only paying \$3 for anti-depressants so that was a lot cheaper than going to a naturopath or a homeopath. But I used those as a short-term stop-gap measure while I improved my financial situation. (Genevieve)

However not all patients believed that CAM was expensive. Sarah said she found the costs of CAM and orthodox consultations very similar and reasonably affordable, though her view was at variance with the other patients interviewed.

Research points to a cross-class interest in seeking CAM treatments (see Fulder 1996; Sharma 1992). However because of the costs associated with these modalities the demographic who use CAM tend to be largely upper and middle-class individuals.

Patients also echoed the concerns of GPs regarding the CAM industry being required to prove treatment efficacy if the state funded CAM:

I think the government should subsidise alternative medicines. I know they've got to look into whether it works but that goes back to the positivist point of view – you know – we've got to have proof - instead of saying well look it's worked, who cares how it happened but it's worked. But the government has to think of the money and cost-benefit analysis and all this sort of thing and I know it's difficult but if people see good results does it really matter? Does it really matter that we haven't got absolute proof if we can see that it's making a difference. (Faye)

A major concern patients describe is that if CAM is subsidised then practitioners would need to be much more accountable, and therefore higher standards of training could be demanded in tandem with a more rigid regulatory system.

How would an alternative practitioner make application? There'd have to be some sort of monitoring body. (Jack)

I would say that if CAM therapists have good structures and registration that [state funding] is a viable possibility, but I really wouldn't like to see everybody who decided to set themselves up being able to tap into that 'cause I think

accountability is very important if you are going to be receiving funds...it would be an ideal world if everybody who was offering some sort of service had the best interests of the person or patient in mind - but sometimes - well it's conceivable that people might think they can make a fast buck out of the gullible public.
(Sarah)

Patients considered it was the state's responsibility to ensure that public health received priority. At the heart of patients' concern was quick and effective access to a well-funded well-resourced orthodox public health system as opposed to taxpayer input into CAM.

I think there's more pressing things that [the government] have to deal with first. Like hospital waiting lists.
(Phyllis)

While most patients supported a collectivist ethos with regard to funding for health, Genevieve spoke in more individualist terms about some individuals meeting the cost of their own treatment:

I guess it depends on your income. I think if you are on a reasonable income then I see no reason why the state should subsidise you. I think that's just a question of resources and people shouldn't go unnecessarily, even to the doctor. The problem is that if you get everything for free then you maybe don't appreciate it as much. I think when you are under financial pressure it is important to get appropriate assistance and a GP may not be the best assistance, but the argument may be that well with natural practitioners we don't know what they can do or what they can offer or how good they are....Natural health practitioners definitely need to have some kind of way of identifying the people who are genuinely skilled, knowledgeable or have lots of qualifications.

As is clearly evident from these extracts, patients meeting the cost of health care can be interpreted in a variety of ways. CAM and Dr-CAM practitioners portray individualistic ideas that equate patients paying consultation fees as one form of taking responsibility for their health care. Deciding to seek and pay for health care was seen as a key component in preventative medical strategies. However these ideas are part of the competing discourses because the majority of these participants also said they would be prepared to accept state subsidies provided certain criteria are met, such as the increased regulation of CAM practitioners. Patients on the other hand did not conflate paying for their own health care with personal responsibility. They presented a collectivist stance when it came to the provision of health care services, preferring the state to accept responsibility for funding an easily accessible public health system and, on the proviso that there is 'spare' money available, then subsidising some CAM therapies. Further, patients believed that if the state is to fund CAM then there will have to be increased regulation of both CAM therapies and therapists, including 'scientific proof' that the therapies

work. These findings mirror MACCAH's recommendation to the Minister: "Where there is evidence of safety, efficacy and cost effectiveness, specified CAM modalities should be considered for public funding" (2004:6).

V: Patient Responsibility – Practitioners' Perspectives

All practitioners shared similar beliefs about how patients should act responsibly with regard to their health with the patients themselves. Four main themes arose from the interviews: meeting the cost of health care (discussed above); eating a healthy diet, exercising, and reducing stress.

It's probably as basic as exercising, drinking enough water and eating the right foods. Not drinking too much alcohol and trying to stay as stress free as possible. (April, Bowen therapist)

I just see it that they've got to do whatever they can to keep their family healthy...I think there are people who've decided to take responsibility, and they do. They will do what you tell them to do, they will take their herbs and they'll keep coming back until whatever it is has changed...they will definitely take responsibility for their health because they want to be well enough to live, not just exist, and they don't want to die young. So there are a lot of people who do take responsibility and I'm just here to offer them advice of what they can do and given them the herbs that help them and it's a really good working relationship. (Margaret, herbalist)

Patients certainly have a responsibility in terms of what they're doing to improve and to help themselves. (Hugh, osteopath)

There are basic areas: hygiene, diet and exercise. (James, GP)

It makes a lot of sense to treat your body very well (Julian, Dr-CAM)

We should be eating appropriately, exercising, but I also think we need to do things for the soul. It's really important to try and balance ourselves more. (Bob, Dr-CAM)

While all practitioners believed it was up to patients to change modes of behaviour that ran contrary to a healthy lifestyle or therapeutic advice, I found CAM and Dr-CAM practitioners were generally more intolerant of 'deviant' behaviour than GPs. However, all practitioners expressed frustration towards patients who took little or no responsibility towards their health care.

They want an instant cure. People who are overweight are wanting a tonic that will melt the fat away from them. They won't change their diet, they won't go for a walk around the block, they just expect a miracle from the herbs and supplements. And I find that quite frustrating but ultimately it's their responsibility. It's their health problem and it's them that are going to have to do something about it. (Margaret, herbalist)

Change is always difficult. I've actually thought about having a sign above my door, haven't done it yet but I've thought about it – 'Unless you are prepared to take responsibility for yourself don't bother coming in!' (Lorna, herbalist)

If you want to get obese – I mean it's not like it's a medical condition – if you want to get obese there are consequences...if you continue to be obese or you continue to pig out on foods then [the state] is not going to be here to pay for everything like your bypass or your stomach stapling – we're not going to be there for you!
(Ernest, GP-CAM)

Patients have total responsibility – you have to look after yourself – why look after the rest of the world. You choose your own path, right or wrong, and it's your own responsibility.
(Brian, Dr-CAM)

There are some patients who don't want to be responsible for anything; their health, their life – they expect someone else to do it.
(Simon, GP)

As is evident these practitioners expressed ideas strongly imbued with individualistic and neo-liberal rhetoric, placing the burden of responsibility for health and illness with the patient. It should be acknowledged, however, that not all practitioners interviewed offered such stringent views, although there was a consensus that self-responsibility was an attribute patients should strive for. One way in which self-responsibility could be constructed was through the use of education as a conduit to self-responsibility. Practitioners believed that if patients were given information and the opportunity to educate themselves about both preventative health strategies as well as any health problems they may be afflicted with, then they would be able to take more responsibility for their own wellbeing and healing.

I mean probably the most difficult part is that they want to take responsibility but they have to know how to take responsibility [and it comes down to information and education].
(Joseph, homeopath)

I think people lack fact and education...we could have a lot more health education starting in schools for instance talking about what is proper nutrition.
(Steven, osteopath)

Much of the rhetoric above confirms that many health practitioners, especially those who work within the integrative and CAM paradigms, consider self-responsibility as pivotal to patient wellbeing and management. As previously highlighted, under the biomedical model, and supported by Parsonian sick-role theory, the patient was largely exempted from responsibility and was entitled to care and attention from doctors and society at large without fear of being condemned or punished for being unwell. What I wanted to know - was the same sick-role model of care invoked within the integrative and CAM models? The rhetoric implies that it is not, but is this a true reflection of the lived experiences of patients and practitioners? During

her ethnographic research Lowenberg (1992) found that the holistic physicians¹² she observed and interviewed maintained similar paternalistic behaviour patterns as are evident under the traditional biomedical model. She argued that despite many commentators describing a shift in the doctor-patient relationship to one where the primary authority became vested in the patient, in reality “it has *not* gone that far, despite the prevalent ideology and rhetoric” (1992:131, emphasis in original). The situation, as Lowenberg perceived it, was one of “mutual participation” (ibid:131). And yet, in seeming contradiction, Lowenberg (1992) then argued that although the integrative rhetoric ascribed responsibility to patients, the consultation process was constructed on the basis of practitioners absolving patients of their responsibilities. What I discovered is that my Dr-CAM participants, despite their individualistic rhetoric, portrayed a more humanistic approach towards their patients. For example, Fran, a GP who practises mainly homeopathic remedies, spoke about why she thinks people become unwell:

My belief is that disease is really the sum total of, of course, our constitutional vulnerabilities, be they genetic or developmental, but really it's about how we live our lives, that's what disease is reflecting. And we are responsible for how we live our lives, not somebody else. So I think that people need to take a lot of responsibility for their illness.

So I probed further and asked:

So if a person who's been fit, hasn't smoked or drunk, and gets cancer – do you feel they're responsible for their disease?

Fran's response contained the rhetoric of absolution:

No, not in a blaming way. And how people live their lives may also mean they're living in an environment where they grew up exposed to toxins and pesticides. You know, I don't mean taking responsibility means that it is totally their creation, and we do live in a toxic world. In terms of cancer, there is a toxic influence. However, I think people, when they're confronted by cancer or any disease, what I try and encourage them to do is to look, you know – this is a major kind of shake-up and what is the meaning of this and what are all the – I like to use the word 'recipes'. What are all the interacting factors that have led me down to this, what is the pathway? And I want to get off that pathway, what do I need to do? From a spiritual point of view as well, what is the meaning, this is a major challenge, what is it that I need to change here, what do I need to learn? So it's kind of more of that rather than 'you didn't do this so you caused your own disease'. I don't really think that's very helpful.

Another Dr-CAM, who often spoke in terms weighted towards neo-liberal and individualistic philosophies, conceded that it would be unreasonable to attribute

¹² Holistic physicians are the equivalent of GP-CAM practitioners in New Zealand.

patients with full responsibility if they lacked knowledge or understanding about their condition or treatment.

Responsibility is dependent on knowledge and if a patient has very little knowledge on a subject – not only their condition but possibly treatments both CAM and mainstream, then the responsibility probably falls quite heavily upon the practitioner to advise accordingly. (Ernest, GP-CAM)

The contradictions between patients being wholly responsible for their health care or doctors absolving them from that role were very apparent when Bob (GP-CAM) said his patients either

...run the show, they can be the ultimate overseer of the whole thing, or I'll take up that role if they don't want to.

Another practitioner said

I think it's all right for them [patients] to be rescued. (Julian, GP-CAM)

Lowenberg's research revealed similar findings. She said holistic practitioners "essentially take responsibility when they assess that patients are ready, or do not want, to take full responsibility....Thus they extend, rather than restrict, absolution from responsibility (ibid:177)". Should we see this as an attack on patient autonomy? As I pointed out in Chapter Three, Farsides (1994:43) argued that autonomy is about "control and rational choice" and one aspect of this can be that patients choose to vest responsibility in another agent. But what remains unclear is whether patients are choosing to relinquish some or all responsibility during their consultations with integrative practitioners, or is it being taken away from them.

This situation highlights the complexity of our socio-cultural environment. Society is a palimpsest of competing and conflicting discourses where the roles of patients, practitioners and the state remain blurred. The rhetoric underpinning neo-liberalism and individualism supports patient self-responsibility, and yet my research reveals that the lived experiences of patients and practitioners indicates that a key role in the GP and Dr-CAM-patient relationship is that of absolution. The state is also involved in the absolution process through its provision of a publicly funded health service. CAM practitioners were also party to the absolution process, but not, I believe, to the same extent that their medically trained colleagues were. As I discuss in the following chapter, I found that absolution is not the sole preserve of the health practitioner-patient relationship. It is also pivotal to why Dr-

CAM and CAM practitioners choose to practise the type of healing modalities they do.

VI: Conclusion

My interviews with patients revealed a complex web of beliefs where ideas ranged from claiming expertise and responsibility for therapeutic decisions to uncertainty about their role in the healing encounter and conflicting expectations of health practitioners. Claiming responsibility for health invokes individualistic philosophies that assert patient autonomy in the therapeutic encounter. Patients mix-and-match healing modalities largely because they are dissatisfied with aspects of the biomedical paradigm but this has not resulted in a decrease in the number of orthodox consultations and instead has seen patients adding a variety of therapies to their healing compendiums. Patients considered such behaviour to be an example of affirming their autonomy by looking for treatment options that most suited their individual worldview. Choosing to align themselves with practitioners who shared their belief systems, such as using 'natural' medications or adopting a holistic approach to ideas about illness and health, meant that patients took responsibility for the way in which they wanted to be healed. As Farsides (1994) argued, autonomy is about self-government and making choices rather than unlimited freedom. The patients I interviewed showed ample evidence of being *selectively* self-governing. This is because I found many of their beliefs were tailored to specific situations as opposed to forming a more embodied framework that shaped all their lived experiences.

This selective self-government was apparent in the way patients talked about the manifestation of self-responsibility through their lifestyle choices. All participants I interviewed, both patients and practitioners, considered that the prime responsibility of patients related to the decisions they made in relation to their lifestyle: in other words diet, exercise and stress reduction. These choices promoted are seemingly feasible for middle and upper class individuals, and even although many of my participants fell within this classification, they described conflict in achieving many aspects because of financial pressures, time constraints and difficulty in managing exercise or diet programmes. This meant that these so-called 'choices', which have become heralded as pre-requisites for a healthy life and are part of the mantra of self-responsibility, were selectively adopted. The result of this selectivity is that

within the context of neo-liberal and individualistic discourse, when individuals fail to meet these expectations they become tainted by the blame culture that now permeates our society.

This may convey a rather negative view. However one of the Dr-CAM practitioners commented to me how *change* can be “scary”. Fran was not talking about change at just an individual level, but more at institutional and societal ones. She recognised that the gap between the rhetoric of self-responsibility and the reality of everyday life for many people could be related their socio-cultural environment:

A lack of resources, and don't forget that a lot of disease is linked directly to poverty. And that impoverishment of poor diet and housing, just all the opportunities that are lacking, and that's really difficult sometimes for people to change, that's where we need to change at societal and governmental level.

(Fran, GP-CAM)

This comment is an example of a more collectivist approach to our social sphere than those contained within the neo-liberal and individualistic discourses. However paradoxes remain because Fran, along with many of her colleagues and CAM therapists, also talks about patients in terms of accepting the majority of responsibility for their healing. And so how do patients enact their responsibilities in such a conflicting environment? I found that they negotiate between these different discourses by using a simple and effective strategy. When they want to express their individualism and self-responsibility they seek the services of a CAM or Dr-CAM practitioner. When patients want to divest themselves of some, or perhaps all of their responsibilities, they then choose to consult an orthodox practitioner, and sometimes a Dr-CAM. The question is, what are the implications for the practitioners involved, and, most particularly, those who practise integrative medicine? Chapter Eight investigates this situation.

CHAPTER EIGHT

THERAPEUTIC PLURALISM: HEALTH PRACTITIONER RESPONSIBILITIES

Well, at the end of the day everyone is responsible for their own health care....It's your body, you're responsible for it. I can only support you in taking away the part that is blocking, but it's not my responsibility to do it for you, you have to do it yourself....I never take on the responsibility of a person.

(Joseph, homeopath)

It's most definitely the patient who has responsibility [when they mix and match therapies].

(Julian, Dr-CAM)

I: Introduction

As I have already noted the integration of healing modalities is not a new phenomenon. However, as western societies privileged the biomedical approach the use of alternative and complementary therapies had, until fairly recently, remained on the margins of healing practices. There has been a resurgence of interest in, and practise of, CAM by not only non-medical health practitioners but also medical doctors, especially those who work within the general practice environment.

This chapter analyses the responsibilities of Dr-CAM practitioners. The data has predominantly come from the interviews I held with six Dr-CAM practitioners as well as literature reviewed. To put these practitioners' responsibilities into a meaningful context I also investigated how other health practitioners (CAM and orthodox GPs) viewed their responsibilities, as well as those of the Dr-CAM's. Patients' views of practitioner responsibilities were also canvassed and analysed.

To locate the reasoning behind the integration of biomedicine and CAM I briefly outline in Section II why doctors have chosen to mix-and-match healing modalities. Responsibilities, as I have already stated, are difficult to define, but one aspect of healing that seems intrinsic to responsibilities is that of making a diagnosis. Section III describes the way Dr-CAM practitioners view their diagnostic responsibilities and how they reconcile the differing philosophies that underpin the orthodox and CAM modalities they use. Section IV details responsibilities using the perspective of the Dr-CAM respondents and Section V reveals how non-medical

CAM practitioners and general practitioners (GPs) view their responsibilities. Patients were also asked for their views on health practitioner responsibilities and their comments and expectations are revealed in Section VI. The central theme of this thesis relates to the question of responsibility when a mixing-and-matching of therapeutic modalities occurs and the views of all participant groups are outlined in Section VII. In the previous chapter I noted that despite the neo-liberal and individualistic rhetoric of self-responsibility, health practitioners were shown to absolve patients of responsibilities. The absolution process is an important feature of why practitioners choose to practise CAM and integrative medicine. I contend, in the final section of this chapter, that practitioners choose to work with CAM modalities because they believe it moderates the responsibilities they have towards their patients.

II: Mixing and Matching Modalities

It is not only patients who are disaffected with orthodox medicine; many doctors are also voicing concerns about the direction the biomedical model is taking them with its reliance on technology, pharmaceuticals, managed care and the increasing intrusion of bureaucracy into daily practice, not to mention the inability to practice 'holistically' because of time and financial constraints (Coward 1989:11; Lowenberg 1989; Murray and Shepherd 1988:511; Pizzorno (Jnr) 2002:407; Reilly 2002:408; Winnick 2005:41). One reaction to this disenchantment has been the co-opting of CAM therapies into orthodox practice, especially for doctors who work in the general practice arena¹.

The integration of CAM and biomedicine has brought a variety of responses from orthodox professional bodies, such as the British Medical Association (BMA) and the New Zealand Medical Association (NZMA), not to mention practitioners themselves. Views have ranged from indignation at the integration of CAM into orthodox practice (see for example Hadlow 1989) to a more generalised acceptance and calls for doctors to be better educated about CAM therapies and their usage (Brooks 2004; Cohen 2004; Coulter and Willis 2004; Lewith 2000; Lewith and Bensoussan 2004; Zollman and Vickers 1999). General practitioners, such as

¹ See Adams (2000a,b; 2001, 2003); Adams and Tovey (2000); Cant and Sharma (1999); Fisher and Ward (1994); Kelly (2000); Pirota et al (2000); Saks (1994); Taylor (2003); Tovey and Adams (2001).

Philip White (2000), describe the attributes of CAM (longer consultations, patient-centered consultation styles, and so on) and while not advocating a move away from the principles of orthodox medicine, encourages doctors to incorporate these positive features of CAM consultations into general practice.

Despite growing usage of CAM by the medical profession, and GPs in particular, there is some cynicism about its uptake into orthodox practice. Claims have been made that doctors who incorporate CAM into their practice do so in order to carve out a niche market where the ‘worried well’, those people who inhabit the middle and upper classes, can have their health concerns pandered to (see Baer 2002:405; Kelleher et al 1994; McGuire 2002:410; Saks 1992; Scott 2002; Sharma 1992). It has been argued that therapies that are “readily translatable into commodified medicine...goods and services to be bought and sold in a medical marketplace [such as] herbalism, acupuncture, osteopathy and similar therapies” (McGuire 2002:410), are the ones that CAM doctors are now embracing². This situation was made evident to me when I talked to an administrator from Swinburne University in Australia. The Swinburne University Graduate School of Integrative Medicine (Melbourne) offers medical practitioners the chance to obtain qualifications in integrative and nutritional and environmental medicine. In 2003 they had a representative attend the annual General Practice Continuing Education Conference in Sydney and I arranged to talk to her. I asked Ms Fraser for information about the demographic make-up of those who attended their courses and she echoed the sentiments mentioned above. As a note in my research diary (16 May 2003) reveals:

Carolyn said that more women attend their courses than men and they tend to be from a ‘younger’ age-group, in the 30-40 bracket. They also mainly come from practices in city areas that are located in the more affluent areas. The reason for this was given that the need for further education in this field is ‘patient-driven’ in that patients tend to be well-educated, affluent and have themselves shown interest in CAM. I asked whether this could relate to doctors attempting to ‘meet a market’ or buy into the ‘whims of the worried well’ but no answer was forthcoming.

² Sharma (1992:166) also speculates that consumerism may be one reason egalitarian relationships are found within CAM patient-practitioner encounters. In other words market forces dictate the relationship. To ensure the continued purchase of CAM, it is in practitioners’ commercial interests to create a consultative environment that patients want to return to. As Sharma points out, setting the scene for patients to continue with treatment regimes also involves a degree of “client control” by practitioners. This is an interesting observation, although as Sharma admits, perhaps a very cynical one. I could not find any direct evidence in my research that suggests practitioners promote patient-as-partner for commercial reasons only, although there was a strong market orientation among the majority of CAM and Dr-CAM practitioners interviewed. (cf. Goldner [2004] where she examines CAM as a consumer movement.)

Despite this querying of the motives behind the integrative approach New Zealand doctors reflect the growing trend in western societies to integrate CAM into general practice. To date no data are available which exactly quantify the prevalence of general practitioners who integrate CAM into their practice but Taylor (2003:106) reports that thirty percent of general practitioners now use some type of CAM, with acupuncture being the most commonly practiced therapy.

So why do GPs decide to use CAM? Adams (2003) identifies three main themes relating to the integration of CAM into general practice. These are, first, doctors are able to offer therapies to patients who feel they are not being helped by orthodox approaches. Adams refers to this as “filling gaps” (2003:157). Second, doctors were concerned about the iatrogenic aspects of orthodox medicine and are drawn to CAM therapies because of safety aspects and the likelihood of reduced side effects from treatment. And third, CAM offered these practitioners a chance to expand their interests in healing methods. This was found to increase their job satisfaction.

All the Dr-CAM practitioners I interviewed had been integrating CAM into their orthodox practice for many years. They all remarked that it was either during their medical training or fairly soon after establishing careers in general practice that they started questioning the constraints of the biomedical model. As one practitioner noted:

I wasn't actually very happy with regular general practice. I wanted to be able to do something more positive for people's health instead of just the illness reaction, which a lot of general practice is about. (Bob, Dr-CAM)

This attitude led practitioners on a quest for other therapeutic options and ultimately their use of CAM. The majority of practitioners interviewed, five of the six, were almost solely focused on the use of CAM in their practice, although all said they would prescribe orthodox medications if required and that they still used the biomedical model for diagnostic purposes.

The Dr-CAM practitioners I interviewed mirrored Adams (2003) findings in two areas and I describe these below. They integrated CAM into general practice because the therapies ‘filled gaps’, and the methods used were also largely free from side effects.

i: 'Filling gaps'

The doctors I interviewed talked about their integration of CAM into general practice as allowing them to 'fill in gaps'. In other words, it provided them with a wider range of therapeutic options for those patients who feel that conventional medicine does not meet their particular needs. These practitioners spoke about orthodox medicine in terms of being able to offer a 'band-aid' for acute conditions. Practitioners felt that the approach offered through CAM modalities was especially preferable for patients who suffered from chronic conditions or psychosocial problems.

I've always seen them [biomedicine and CAM] as an integrating process....I see the areas where they are best linked together...it's not to say that there aren't sometimes conflicts but in general they sit alongside very well...it makes sense to me....When I started general practice I became very concerned very quickly about the amount of people walking around the street who looked healthy but who were on a vast number of medications, particularly hypertension medications and sleeping pills...what's happened since then is that I've not only adapted Chinese medicine but I've seen how it's fitted in with the whole growth, the paradigm of mind-body, spiritual areas that have grown around the world in the last fifteen years or so. In other words, it's making it very relevant to see illness as part of people's emotional, physical and spiritual growth. And so it's looking at a deep healing process that is caring, what is somewhat not so much tied into the symptoms but lurks around at a deeper level. (Julian, Dr-CAM)

I was never really convinced that allopathic medicine was really the answer – there are so many things which I found that it just did not have the answers for...in some respects it was just sticking plaster medicine – patch up stuff. In some areas it is superb...but I found that my training and the drugs available did not cope with the kind of things that were coming through my medical practice so naturally you reach out for other possibilities...[got involved with acupuncture and manipulation]...and I found them extremely useful tools to have other than prescribing wretched drugs all the time which I really absolutely refused to do. If I had to, I had to of course and sometimes you did and I recognise their value but not to the exclusion of everything else...There are some things that orthodox medicine is not good at like back-ache, digestive problems, a lot of hormonal issues...children with allergic problems and things like autism...chronic fatigue...time and time again [the patients] say their GP says there's apparently nothing wrong with them and they generally put them on Prozac.

(Ernest, Dr-CAM)

There's quite a lot of medicine where medicine says we can't do any more for you and that's when people tend to seek out complementary people like me and yes, we can usually go further and help them feel a lot better. (Peter, Dr-CAM)

I have basically abandoned the strict biological model of conventional medicine. Not that I don't pay attention to the pathology and pathological cross-systems but in terms of treatment I don't use it any more because my philosophical stance is really a homeopathic model. However, sometimes because of a patient's wishes or because we're doing a temporary emergency band-aid I will then revert to some of the conventional medical role for treatment...I think there is a place for conventional medicine in an acute trauma situation, car accident or broken bones and I don't have any qualms about patient's needing to be hospitalised and treated, although I sense there is still a role to help them

stimulate their healing facilities alongside the conventional treatment and I think most things really can be looked at in a more holistic way. (Fran, Dr-CAM)

[General practice] doesn't give you a way of actually assessing health in a pre-symptomatic phase. Acupuncture answers that for me. If somebody came along and said I'm just feeling unwell and I couldn't really put a finger on and you'd do all the medical things and you know nothing turned up which is often the way, you were pretty much stymied. At least with acupuncture diagnostic assessment you can actually figure some of those ones out. (Bob, Dr-CAM)

As can be seen by the above comments these practitioners saw gaps in the orthodox model, especially in relation to chronic conditions as well as the social and emotional aspects of patient care. While these doctors agreed that biomedicine was often best practice in the treatment of some cancers, high blood pressure, infections and trauma, the CAM therapies provided them with a diverse range of diagnostic and treatment options that were usually non-invasive and non-toxic. CAM also provided these practitioners with a wider scope to explore the etiology of illness:

Basically complementary medicine extends what you can do within orthodox medicine and the other thing you can look at are the questions 'why' – which you don't often do in orthodox medicine. (Peter, Dr-CAM)

ii: Side effects

Another very important aspect for these Dr-CAM practitioners was their concern about the use of medications and other invasive techniques favoured by the allopathic model and their possible side effects and safety. One doctor talked about the furore caused in 2003 by the New Zealand Food Safety Authority's (NZFSA) recall of dietary supplements and vitamin products manufactured by Pan Pharmaceuticals Limited in Australia (see media articles in New Zealand Herald 2003; Waikato Times 2003) and his anger towards the publicity which ensued, which had questioned the safety of CAM compared to that of orthodox medication and iatrogenic disease:

Nobody died, nobody got affected, somebody had a side effect....It's quite an interesting thing to see when [the Health Department] talk about the so-called dangers of health therapists – give me a break! You've got more chance of having reactions by having medical drugs and yet that's okay – it's got the big stamp of approval. It's alright to have a bleeding ulcer after taking an anti-inflammatory...people die with drugs...drug related deaths in US hospitals is the fourth highest cause of deaths...misadventure from drug side effects, drug interactions – the fourth highest death rate below cancer and heart disease. How many deaths from alternative medicine? Probably zero. How many bad side effects? Rare. (Ernest, Dr-CAM)

Another practitioner said he had become increasingly concerned at the number of medications patients take for chronic conditions, including those relating to pain,

illness and fatigue, and he believed that clinical investigations required a more holistic focus:

People were faced with having to take increasing drugs, mixing up medications, being on steroids, getting osteoporosis – I felt we've got to start looking at this....When I see people who live with chronic pain they may well have been in certain pain clinics or whatever where the focus has been on how you are best to cope with this pain...My focus on what is happening relates to is there a block in the healing process, is pain in fact an initial stage of healing like it is when we stub our toe and things are held up there? What is your potential to heal? And if there are blocks, if there are things that have happened in your life that is holding this process up, maybe we should become aware of these and see if there's any way we can help that. (Julian, Dr-CAM)

Peter proffered an interesting insight as far as side effects and safety are concerned when he said that reliance on biomedical tests, instead of listening to patients, could lead to misdiagnosis:

Blood tests and x-rays don't tell you that much in reality, not about why things are or aren't functioning. And most GPs put things down to depression if they can't find an answer but that's also a cop-out and a lot of patients know that and they can find the answer themselves. I think you ignore a patient at your peril quite honestly.

While the practitioners I interviewed all expressed very positive feelings about their use of CAM none of them talk specifically in terms of this as being a factor in helping them maintain their job satisfaction (Adams 2003:159). However because they were all enthusiastic about working in this field I am sure this has influenced their continued use of complementary and alternative therapies.

III: Diagnosis – Orthodox or CAM?

One aspect of integrated practice and responsibility that interested me was whether or not Dr-CAM practitioners rely on orthodox or CAM diagnostic methods. Certainly the CAM practitioners I interviewed did not consider their responsibilities included making a specific diagnosis and they tended to concentrate on eliciting information about a patient's social and emotional world and looked to see if lifestyle changes can improve a person's health:

I usually try and not diagnose so much as say I think it could be this, this or this, we'll do this test to rule out that ...and we sort of narrow it down. Sometimes you just don't know, sometimes all the medical tests in the world won't tell you what's wrong. (Margaret, herbalist)

The majority of Dr-CAM practitioners recognised that their integration of the biomedical and CAM models can mean they are confronted with conflicting world-views relating to diagnosis, disease and healing paradigms, and that at times these

can be difficult to reconcile. Fran described it as a “big conflict. It’s a daily problem that I run into” and her way around this was to adhere closely to the homeopathic model as opposed to biomedicine. Julian said that

I think it’s perfectly possible to practise both and honour both but I think there are certain philosophies that don’t fit with a hierarchical medical model and that’s where there is a big conflict.

However Peter said that he did not see difficulties with integrated practice because “it is just extending the biomedical model”.

Despite their concerns about conflicting philosophies, all of the Dr-CAMs I spoke with believed that because of their medical training, it was incumbent upon them to ‘keep their doctor hats’ on during the diagnostic process (see also Adams 2004:146-147). They described this aspect of the consultation process in the following way:

It always starts with the orthodox. Let me give you an example. If a patient has got high blood pressure most ordinary GPs will do things like ECGs and look at the kidneys. Now that’s fine and most of the time those things are fine – most blood pressure problems are what is called idiopathic which means there’s no cause. Now we sit down and go through a whole lot of other questions as well – looking at things like the liver, the energy of the liver, the energy of the kidneys and these are sub-clinical areas. A blood test won’t show them but the patients have little symptoms that might add up to some meaning – so if you like that’s a second level diagnosis. The first one is hypertension – you’ve gone through the orthodox approach but the second one is the anthroposophical one saying maybe your liver is too congested, maybe your energy isn’t strong enough...They are different levels. But you sort out the orthodox – you make sure that’s clear before you go to the other one. (Peter, Dr-CAM)

One of the good things about the biomedical model is it grounds me. With everyone who comes to me, because I’m a medical doctor if I don’t do my medical doctor diagnosing I’m in trouble. They’ll be in trouble as well. (Julian, Dr-CAM)

I do still follow the conventional model in terms of I take responsibility to take a proper history, do a physical examination, do any other tests that I feel may define if there is actual pathology, anatomical or functional pathology, you know to try in as much as possible to define the disease process. (Fran, Dr-CAM)

I always keep my doctor hat on. It’s surprising the amount of pathology you turn up because I think with your medical training you are always a doctor first. You have to be very clear about that – you do things that other GPs do. But acupuncture has its own diagnostic system and I use that extensively. (Bob, Dr-CAM)

Ernest offered a slightly different opinion, he said he

still use[s] the terminology of my orthodox training...but I’m careful not to create labels. If somebody’s got chronic fatigue for example we will just discuss the fatigue and all its attendant symptoms and treat that rather than say a diagnosis is such and such.

The importance of making a diagnosis is also contained, as Adams (2004:147-149) points out, within the rhetoric of safety and risk prevention. This is evident when Dr-CAM's compare their consulting style to that of non-medical CAM practitioners. As the practitioners I interviewed explained, using their allopathic diagnostic skills meant they were taking responsibility for staying alert to the possibility of discovering serious pathology. A risk they associated with the use of CAM by non-medical practitioners is that these therapists might miss symptomatology that requires further investigation.

In terms of diagnosis, if a person came with a breast lump and went to a naturopath who told them one thing, and then came to me, I would certainly carry the responsibility of making the correct diagnosis. (Fran, Dr-CAM)

Ultimately the safety issue is very important. For instance, if somebody has a back pain, for me to maybe diagnose say a tumour in the back, is very important. There are very real reasons why we have to be very accurate with diagnoses....There are good, well-trained non-medical people in the complementary field who have had good training in defined areas...and I think that's fine. But unfortunately it's a fairly unregulated environment and there may well be people out there, and I believe there are, who haven't got the appropriate level of expertise. (Julian, Dr-CAM)

However, unlike Adams' (2004) findings, the Dr-CAMs in my study did not overtly discuss the use of CAM by non-medical therapists as "deficient and potentially highly dangerous" (ibid:145). Any concerns they had were contained within the rhetoric of qualifications and training, regulation, responsibility and accountability.

What can be seen from these viewpoints is that these respondents were very mindful of the expectations their patients had of them in relation to their clinical practice. While there was much they did not like about the biomedical approach, all practitioners continued to see the body in scientific terms as well as adopting a more metaphysical approach to illness. Diagnosis was considered an integral part of their clinical responsibilities, but as noted below, the rhetoric of individualism and neo-liberalism were a consistent trope when discussing a more comprehensive view of responsibility.

IV: Responsibility: The Dr-CAM Practitioner Perspective

In terms of the discussion above, developing an understanding of *why* doctors choose to integrate CAM into general practice does not initially appear to raise questions about their responsibilities beyond that of diagnosis and therapeutic integrity. Research by various authors who have investigated the effect of

integrative practise (see Adams 2000, 2003; Adams and Tovey 2000; Cant and Sharma 1999; Tovey and Adams 2001) does not explicitly discuss Dr-CAM practitioners' responsibilities. As I have mentioned, research that has considerable resonance with my study is that of Lowenberg (1992) and Sharma (1992;1994), and to a lesser degree, Hughes (2004). Lowenberg's research focused on the attribution of responsibility and whether the contemporary sick role ascribed to patients has led to them being blamed or stigmatised for their ill health. Further, she looked at how ideas about responsibility influence the patient-provider relationship. Sharma investigated whether the relationship between patients and practitioners within the CAM setting was different from that found within orthodox medicine. These relationships were contextualised against a backdrop of therapeutic and information sharing responsibilities. Hughes' study concluded that both orthodox and CAM models share ideas in relation to patient responsibility, although important differences were also noted. One of these is that CAM practitioners and patients are more likely to collapse responsibility into blame (ibid:44).

Analysis of the interviews I held with Dr-CAM practitioners revealed several further themes relating to responsibility and these can be framed within two main categories. First, respondents believed that one of their principal responsibilities was to act as a conduit to healing and this included educating patients and referring to other practitioners, both orthodox and CAM, as required. Second, these practitioners adopted a patient-centred approach to healing in order to encourage patient autonomy. While this approach also involved patient education, Dr-CAM practitioners were keen that patients question therapeutic options and be encouraged to take responsibility for their own healing.

i: Conduit to Healing

Practitioners described their role in terms of facilitating healing through either the transfer of energy or personal input into consultations. For example, one Dr-CAM who practised a diverse number of therapies ranging from those steeped in Eastern healing philosophies to homeopathy and chelation therapy, described his role in terms of transferring energy, while another practitioner believed that acting in a caring manner helped the healing process.

You are an energy person conveying energy from the universe into the patient.
(Brian, Dr-CAM)

Maybe what we're doing is just setting in motion things that should be done anyway by taking care of people, by giving something positive, by helping processes. (Ernest, Dr-CAM)

Other doctors talked about what they did in terms of healing as acting more as a conduit of information. This was done through educating patients about various treatment options and lifestyle changes that would enhance their healing prospects:

After I've done the [orthodox] tests to see what they divulge then my responsibility is to look at what they're eating, what they're drinking, how they're sleeping, what are the physical stresses they're having and look at what emotional stresses are going on – sort of see if we can look at the whole picture. *And to educate them* and make suggestions. I will often write up a prescription but it will be a prescription to say they need to go to bed earlier and exercise and look at this relationship stress they're having. (Fran, Dr-CAM)

You provide support. You're very much a co-ordinator and a facilitator...the patient actually becomes the expert. (Julian, Dr-CAM)

Peter was particularly enthusiastic about imparting information to his patients and in his own practice he described how they spend considerable time teaching parents how to look after their children at home:

We have a mothers' group here which all kids under one are invited to and their parents and we put them through things like nutrition, what is your kid's immune system, tender loving care, how do you support the child's development and so on. Quite a wide range of speakers all coming from a more or less holistic point of view and then when I see patients I will teach them the difference between a virus and a bacteria and when antibiotics should be used and when not and I would say that we don't see those kids as much as others because we encourage them [the parents] to take responsibility, by in large, for their kids at home and basically use us as a sounding board....We teach quite strongly when to panic – what you can do at home and when you should call a doctor....Because we are interested in kids we do this [education] but it's very hard to do this across the board for every illness with adults. We run biography groups where people look at different stages in life and why they get ill and what they're going through at this point in their lives.

However Peter also said that one of the principles of education and information was to encourage patient autonomy by making them less dependent on health practitioners:

I just make [patients] aware that there are those options and make sure they have explored the orthodox world well enough, that they have got good opinions on what the illness is about, and I think people should stop being dependent on doctors! [followed by laughter]. (Peter, Dr-CAM)

Acknowledging gaps in their therapeutic armamentarium or diagnostic abilities and referring to other therapists, either orthodox or CAM, is one way integrative practitioners demonstrated responsibility.

I need to make sure that [patients] are clear on the diagnosis and different options and if I can't help someone complementary-wise I may well suggest they try someone else. I don't see myself as the be-all and end-all of complementary medicine.
(Peter, Dr-CAM)

However practitioners at times felt pressured by patients who demanded specific treatments, and especially in cases involving cancer, many doctors expressed reluctance to completely forgo orthodox medicine.

Some people say I don't want to have chemotherapy – they go to a herbalist and say I want to be treated with herbs. Now it may be obvious to the practitioner that the cancer is not going to respond, it may be too advanced so what does the practitioner say to the patient – no, I think you're wasting your time! It's all about a balanced decision between what patients' demand or expect as opposed to how you counsel them and sometimes their expectations may not be in line with what the therapy can offer and I think they have to be guided on that and I think that's what any practitioner, CAM or otherwise, should be doing. It's to be able to say to someone – your condition is beyond what this therapy can offer.
(Ernest, Dr-CAM)

While acting as conduit for healing appears as an act of responsibility on the part of the practitioner, if it also encourages patient autonomy and decision making, does a situation develop where responsibility for healing becomes blurred? Even if practitioners want patients to be less dependent on them, the status they have achieved through western society's privileging of orthodox medicine means that who they *are*, as a doctor, still carries with it certain expectations and ethical implications implicit in the biomedical model. This produces contradictions and paradoxes because Dr-CAM practitioners clearly stated that they wanted to divest themselves of the constraints offered under the orthodox model of health care to those that, amongst other things, encouraged patient responsibility. However, working in this way can mean putting more of 'yourself' into the consultation process and this raised questions about the responsibility the practitioner had towards him or herself as well as their responsibilities to patients. Julian, who practiced mind-body medicine, outlined some of his concerns about this aspect of his work:

Some of us will be working at a deep philosophical level...and I think that's one of the reasons we have to be quite cautious. Just because the therapist, him or herself, puts so much of themselves into the therapy, in fact it's usually the biggest part of it. So their attitude, their philosophy, their spirituality inflicts on the treatment...so much of being a complementary therapist is about personal development.

At the same time, Julian saw himself as an intrinsic part of the healing process, a conduit to wellness, and therefore felt not only therapeutically responsible for his

patients' wellbeing but also morally responsible. This revealed a paradoxical situation because Julian spoke of patients "actually own[ing] their own healing".

Our responsibility is to conduct ourselves in a way that is conducive to them [patients] healing. On that level our moral responsibility is huge, when you're starting to use things like acupuncture and homeopathy and other things, you're very much a part of the treatment. You have a huge responsibility to honour that process and not be dictating and controlling...But I think when it comes to owning and controlling the outcome it is somewhat different. In the healing paradigm, the healing mode you tune in to and become committed to is in some ways a paradox because you release attachment to the outcome....So the responsibilities are one, to do your best, to open, to share, to allow that person to actually own their healing. But it also requires quite a bit of letting go of outcomes...you're withdrawing your ego from the situation. (Julian, Dr-CAM)

This point of view highlights the complex and contradictory nature of responsibility, which this practitioner recognised. Julian described healing as involving, on the practitioners' part, a moral responsibility towards a patient's wellbeing, and yet he also talked about practitioners distancing themselves from therapeutic and personal responsibilities in the patient-healer encounter. These dichotomies are constructed through the privileging of patient autonomy on the one hand, and, as I discuss in Section VIII, practitioner absolution on the other.

ii: Patient Autonomy

Although I have discussed patient autonomy in Chapter Four, further elaboration is warranted here. Dr-CAM practitioners dislike the paternalism often associated with the biomedical approach where patients are perceived to be receptacles awaiting input from the 'expert' doctor. Practitioners described their relationship with patients in egalitarian terms and the importance this facet plays in encouraging patient autonomy and has been one reason why CAM has increased in popularity (Hughes 2004:29; Sharma 1992:80). While Dr-CAM practitioners acknowledged their responsibilities in terms of patient education, they believed that one way to encourage patient responsibility was for patients to develop an 'enquiring mind'. In other words, patients should ask about treatment options and be prepared to learn as much as possible themselves about health and illness.

[Patients should] become informed. I think people have to ask doctors more questions...and if there are two or three options for treatment they've then got what is the preferred option. (Peter, Dr-CAM)

Even although the majority of the Dr-CAM practitioners eschewed the biomedical model in favour of CAM, except where diagnosis was concerned, they were at times reluctant to disregard a patient's request for a more orthodox approach, thus

ensuring the autonomy of the patient stayed intact. For instance, Fran said that although she had all but abandoned her use of conventional medicine

...sometimes because of a patient's wishes...I will then revert to some conventional medical role for treatment.

Despite this attitude Fran certainly did not comply with all patient requests because she believed some would result in negative outcomes as far as the health of the patient was concerned. Another practitioner said that while he adopted what he considered to be a patient-centred consultation style, he did not necessarily agree with all treatment options canvassed by patients. Peter said he believed he maintained the integrity and autonomy of patients by making sure that if

...I don't agree with them then I've got to explain very carefully why.

Autonomy, as previously outlined, can be seen in terms of patient self-governance and one important facet of this relates to patient control of healing encounters. One practitioner said that patient control was the reason he had encouraged his maternity patients to adopt natural childbirth techniques as opposed to orthodox interventionist methods. This approach, he believed, produced positive results:

If a woman felt in control of everything then in medical terms we were basically just hangers-on hovering around just not part of the big scene. Women tended to handle things better and there was less intervention. (Ernest, Dr-CAM)

This worldview runs counter to the paternalistic model biomedicine has so often been criticised for where control is the province of the medical practitioner and patients, largely, adhere to their advice. With rhetoric now emphasising the role of the individual, patients and practitioners are constructing different control paradigms. Julian stated one result of this change might mean:

...letting go of a certain amount of control that as doctors we've been conditioned to have.

Despite the rhetoric of respecting patient autonomy contradictions were apparent. As previously mentioned, Brian clearly identified the type of patient he wanted to deal with and this could be construed as compromising the autonomy of those patients (Maori, those on welfare benefits, 'alternative' lifestylers) that he turned away³. The expert knowledge possessed by both the patient and practitioner also tested the so-called egalitarian relationship promoted under the CAM and integrative banners. Although practitioners believed that knowledge and informed

³ Of course the situation is even more complex because Brian's autonomy is also at issue here. An argument could be mounted that he is quite entitled to choose the type of patients he wants to treat.

consent assisted patient autonomy research within the biomedical setting suggests this situation is fraught with contradictions and misunderstandings (see Dixon-Woods et al article in press; van Kleffens et al 2004). While it may be possible to argue that power and control rests more with patients under the integrative and CAM models, patients remain reliant on practitioners for information and therapeutic advice. The situation is further complicated because, as Lowenberg (1992) points out, despite the rhetoric of individual responsibility considered so integral to CAM and integrative medicine, the reality of the patient and Dr-CAM encounter suggests that patients continue to be absolved of their responsibilities. If, as Farsides (1994) suggests, patients willingly delegate their responsibilities, patient autonomy remains intact. However, if responsibility is covertly eroded on the basis of expert knowledge, then an argument could surely be mounted that patient autonomy becomes compromised. This means that ascertaining *who* is actually responsible for healing outcomes remains unclear. In order to gain as comprehensive as possible overview of this complex situation I asked other practitioners for their views on the subject.

V: Responsibility: Other Health Practitioners' Perspectives

Although the focus of my research relates to patients and practitioners who *combine* healing modalities I felt it was important to gain an understanding of responsibility from other practitioners' points of views. As mentioned in my methodology chapter I chose to interview both CAM practitioners and orthodox GPs as this provided me with the opportunity me to compare and contrast belief systems. I was especially interested to see whether there were any significant differences in the way both 'arms' of the type of integrative medicine that form the focus of this study, orthodox and CAM, viewed their responsibilities. Certainly analysis of the interviews with all practitioner respondents has highlighted the complexity of this topic.

i: Responsibility – CAM Practitioner Perspective

When I interviewed CAM practitioners I asked them all specifically "as a practitioner, what sort of responsibilities do you think you have?". Practitioners described their responsibilities generally in terms of 'doing the best job I can'; referring patients to other practitioners (orthodox or CAM) as required; patient education; and supporting patient autonomy. Individualistic ideologies were a

prevalent theme throughout the interviews, manifesting themselves particularly as practitioners qualified remarks about their own responsibilities with comments on patient responsibilities. Such an example was evident during the course of an interview I had with Margaret, a medical herbalist. She answered my question on her responsibilities by saying she should “do the best job I can” and then immediately outlined how she views patient responsibilities. She also detailed her frustrations at patients who wanted a “magic cure”, such as when they were overweight just wanting a pill to “melt the fat away” without being prepared to change their diet or embark on an exercise programme. I mulled this idea over during the interview and asked:

Me: It might be a circular question but how much responsibility as individuals do you think we should take for our health? Is it all in our lap?

Margaret: No, that's why there are people like me here. It's [the patient's] responsibility but if you can go to somebody who can help you to put the responsibility back in your lap, then ideally that's what people want I think. I can't carry everyone's health problems on my shoulders, that would be too much for me. So it's like I deal with them while they're here and when they leave they take [their problems] with them.

Another herbalist interviewed also spoke of her responsibilities in terms of treating patients to the best of her ability, as well as therapeutic responsibilities when prescribing herbs:

My responsibility...is to make sure I don't do anything that will be harmful; like if they're on drugs I'm very careful what herbs I give. I always err on the side of caution rather than take risks.
(Lorna, herbalist)

But like Margaret, this practitioner also distanced herself from responsibility. She said:

I believe in people taking responsibility for their own health. I'll be totally honest in that I'd say to people this is what I think you need to do, this is what I think will help you, we can go about this in lots of different ways, lots of different treatment options and I will set them on track – dietary advice, lifestyle options, herbal medicine, whatever. But at the end of the day it's up to them – to take the medicine, to make the changes and change is not easy. But at the end of the day if they don't take up my suggestions I don't lose any sleep over it...it's up to them.
(Lorna, herbalist)

Lorna also said that she thought patients' expectations of health practitioners were unrealistic. She said she disliked it when patients put the onus of responsibility on her when she outlined a range of therapeutic options and said

...it places too much responsibility onto the practitioner and [patients act this way] because they're used to the medical model where if you're sick you go to the GP and the GP says blah blah blah do this and you take a magic pill and you're better. People think if they go to a natural therapist the same thing will

happen. That we'll have all the answers and we don't. I believe a lot of the time...people know within themselves not only what's wrong but what's caused their problems and what they need to do – they know they shouldn't be drinking a lot, or having 20 cups of coffee a day, or smoking.

Responsibility for healing was clearly seen in terms of being in the domain of patients.

Responsibility comes back to the self. Being an adult means being responsible for your actions and suffering the consequences otherwise. Health is [the patients] responsibility, no-one else's. (Glenda, Biopton therapy)

...When [the patient] has left the room [following a consultation] I really don't spend any time thinking about them because I don't go out to establish dependency...I provide a service, I don't provide responsibility. (Steven, osteopath)

To do my work as well as I can. When I say I don't take responsibility – I do take responsibility for what I do, probably too much quite honestly, but at the end of the day the person who comes to me has to heal themselves and all I can do is share my knowledge and ideas and give them things that I think are good for them up to an optimum....I've got a patient at the moment who broke her wrist and is in plaster and she is still playing the drums and she says to me my wrist still feels painful and I don't think it's healing properly. So I told her to have a break from playing the drums. I'm not taking on that responsibility, she has to change because I can't do that for her. (Joseph, homeopath)

Interestingly the practitioner whose views are most in concert with his orthodox colleagues are those of an osteopath, Hugh, whose training in Britain meant he shared many of his first years of study with orthodox medical students. He talked of his responsibilities in terms of diagnosis and also expressed anxiety about treatment regimes he put in place.

My responsibilities lie in terms of differential diagnosis and informed consent, and in explaining to [patients] what I am going to do them osteopathically....Responsibility lies in honesty and communication between the patient and the practitioner....It depends on the amount of responsibility you feel. If someone comes in with something very simple and they do all the exercises and do everything they're told and you've done as much as you can with treatment and you're getting no progress then my anxiety feelings, in terms of responsibility are quite high. What am I missing?....So that way as a practitioner you feel a massive amount of responsibility. (Hugh, osteopath)

Although Hugh described the need for patients to take responsibility for their healing he said that when treatment does not work out because of a patient's inability to follow instructions or enact lifestyle changes it is important "never to blame the patient". Compared to the other CAM practitioners interviewed Hugh was a lone voice in not trumpeting the rhetoric associated with individualistic or neo-liberal discourses.

ii: General Practitioners' Views of Responsibility

When I asked the GP focus groups what “the concept of responsibility with regard to health care means to you as a general practitioners” the central themes arising from the ensuing discussion revolved around best practice including continuing diagnosis, post-graduate education, offering patients guidance and education about therapeutic options.

It's providing the patient with the necessary treatments based on the diagnosis and giving them the options...discussing with the patient to try and get them to agree to what in my view is the answer for them. Whether they take my advice or not, that's *their* responsibility. (Simon, GP)

Your primary responsibility is to make sure that the patient hasn't got something that needs some sort of immediate attention and where medical treatment can make a difference, and then we tend to deal with the other things maybe at a slightly lesser level. (Scott, GP)

I see that we have a responsibility to present options to patients that involve them in the decision making...to make sure that our patients are informed and as safe as possible. (Cynthia, GP)

The concept of expert knowledge was also raised when these GPs described their responsibilities. One doctor said he felt that some of his patients made “dead-end” choices when it came to therapeutic options and this was sometimes caused by their own diagnosis of the problem.

I think it's becoming more imperative that we offer guidance because medicine's becoming so complicated...Having lots of choices is often the problem, people don't know where to go or how to access all this marvellous medicine out there....I think as a primary doctor you're often trying to help [patients] understand their condition in the first place and once we have that right and it's not what they think is wrong with them. The classic situation being that they are actually depressed. (Andrew, GP)

GPs also talked about being held accountable for their actions. For instance Jeanette said:

If a patient has taken my advice and something's gone wrong, then yes it is my responsibility.

Another GP poignantly described the weight of responsibility he felt towards his patients and how this manifested itself as guilt when not everything went as well as expected. However, he said that it was important to overcome these feelings as much as possible because the realities of daily practice, especially in a rural area, meant that GPs had a large number of patients to see with a wide variety of conditions, and consultation styles had to meet those circumstances.

Well as a doctor you've just got to get used to feeling guilty and eventually you get over it and you get on with the job. Well I can remember feeling guilty about lots of things and I've still got these little ghosts sitting on my shoulder about the lecturer medical school saying you must do this and you must do that...but you finally get rid of them because you realise that you've got to get on and get practical about things. (Scott, GP)

Other aspects of responsibility as far as these GPs were concerned, was the provision of an after-hours service and continuity of care. In the city areas it is possible to delegate after-hours care to Accident and Emergency (A&E) clinics and the practitioners in one of the focus groups were all required to work in such a clinic on a rostered basis. Because the other practice was in a rural area the doctors said there is nowhere else they could delegate after-hours patient care to, hence they covered both their own patients and the local hospital. Describing the difference between their responsibilities for after-hours care and those of CAM practitioners:

There is a big difference between conventional medicine providers and alternative providers – they certainly don't generally see [the provision of after-hours care] as their responsibility. It's very rare for them to be seeing people after-hours and there's certainly patient expectation of 24-hour care [from general practitioners]. (Andrew, GP)

Another doctor expressed some resentment about CAM practitioners not providing 24-hour cover:

I think it's hard to not become a little bit cynical about it now that other types of health providers are given sort of full credibility with doctors...You still feel that responsibility but at the same time cynical that society is saying well someone else can do your job during the day but we still need you at night! (Cynthia, GP)

However Cynthia went on to say that this expectation from society was understandable because:

The bottom-line is that doctors are the ones that do make a difference and save lives and...the other groups don't. I think we do feel that responsibility to society but I do think it's a service that society takes very much for granted and it's not properly valued.

Simon said he didn't feel it was doctors' responsibility to be providing "free care either!"

While all the GPs interviewed agreed, albeit reluctantly for some, that after-hours care was part of their responsibilities, it was a subject that aroused much debate especially with regard to what type of service should be offered to patients and what should be considered an acceptable remuneration. While I did not pursue this topic

beyond the bounds of responsibility I believe it is an area that is ripe for further investigation⁴.

The most striking difference between GPs and their CAM and Dr-CAM counterparts was their appreciation of the social, economic and cultural milieu that their patients inhabited and how these facets impact on an individual's health and wellbeing. In other words, these general practitioners described responsibility from a collective perspective and they considered their role as one where responsibility is implicit in its construction, both morally and therapeutically. And it is here that the *lived* experiences of individual responsibility are most at odds with neo-liberal and individualistic discourses. Although rhetorics decrying medical paternalism and power at the expense of individual autonomy and responsibility are prevalent within our social milieu, my study revealed a complex web of beliefs that belie this situation. What I discovered was a significant gap between the individualistic rhetoric and the expectations and behaviour of patients and the different genres of practitioners.

VI: Patients: Their Views on Practitioner Responsibility

The patients I interviewed displayed different expectations relating to practitioner responsibility depending on whether the health professional involved was a CAM therapist, a medically trained CAM practitioner, or a GP. These responsibilities are summed up below in Table V below. The main differences occurred in the area of diagnosis, clinical competence and follow-up, and the provision of acute/emergency medical services.

⁴ See Chapter 9, page 252 where I set out possible future research topics.

Table V: Patient Views of Health Practitioner Responsibilities

CAM Practitioners	Dr-CAM Practitioners	General Practitioners
Non-specific diagnosis	Less specific diagnosis	Specific diagnosis
	Clinical competence	Clinical competence
		Clinical follow-up
		Provide acute-emergency medicine
Prescribe therapies as required		Not to over-prescribe
		Respect patient autonomy
Professionalism	Professionalism	Professionalism
Honesty	Honesty	Honesty
“Enquiring mind”	“Enquiring mind”	“Enquiring mind”
Advise therapeutic options	Advise therapeutic options	Advise therapeutic options
Maintain up-to-date knowledge	Maintain up-to-date knowledge	Maintain up-to-date knowledge
Accept limitations	Accept limitations	Accept limitations
Refer as necessary	Refer as necessary	Refer as necessary

The most significant disparity with regard to practitioner responsibility occurred in the area of diagnosis. As previously outlined, the majority of patients I spoke with did not expect a specific diagnosis from a CAM practitioner, but they were adamant that medical doctors should be able to diagnose their health problems and were very critical if this was not done or mistakes were made. Genevieve made the point that while she expected a GP to make a specific diagnosis she was often looking for different ideas with regard to the etiology of her illness from CAM practitioners:

I guess what I'm looking for is different ideas...outside of the square. How to manage my health and possibly things I may not have thought of. My doctor – I guess the things you ask for is a diagnosis and tests and things like that...a diagnosis from a natural therapist is not always necessary because I've had so many different diagnoses by natural health practitioners that you could say that doesn't make any sense...but the thing is that's not the emphasis. The emphasis is what's going to work to make you feel better and I generally find that the diagnosis can be quite unimportant.

When describing consultations with a particular Dr-CAM practitioner, Genevieve said she was reassured by his medical background in excluding any obvious pathology, and liked the diverse range of therapeutic options she was offered:

I had confidence in his abilities because he has that knowledge and those other things to draw on if he does see something sinister like cancer...he's got all the diagnostic tools of conventional medicine which are really useful...he does a lot of blood tests and he picked up something that no other doctor or alternative health practitioner had ever picked up...and it was just his way of interpreting the blood test...and it was encouraging to get this piece of paper, a result, rather than just some naturopath telling me you should do this or that.

Another respondent talked about expecting her doctor to make a diagnosis:

That is my motivation for doing to a doctor. If I think that I'm not feeling right and I don't know why then I'll go and see if they can put their finger on whatever is making me feel like that. (Phyllis)

However Phyllis's expectations of CAM practitioners and their diagnostic abilities was at considerable variance to the expectations she had of her GP. She described visiting a therapist who adopted a 'hands-off' approach to making a diagnosis. In fact it was not the therapist who made the diagnosis but a computer system that was able to detect viruses and parasites. A cure was affected through transmission of a "reverse electrical impulse" into the patient (which the patient could not feel). Phyllis said that the diagnostic and healing process

...worked on the electrical impulses from your body and all the things that it finds in you...it picks up any viruses that you have, any parasites that you have and deals with them because the reverse electrical impulses kills parasites and deals with the viruses...the diagnosis on the computer screen is totally unrelated to [the therapist]...it's the most amazing treatment because [the therapist's] input into it is totally unrelated.

The patients interviewed also expected clinical competence from practitioners with orthodox training and expressed some concern and anger when they felt this had not occurred. There was considerable expectation that the biomedical model was necessary for serious conditions, such as cancer, accidents, and acute conditions. Follow-up was considered an important component of GP responsibilities but did not feature in conversations about the role of Dr-CAMs, nor was it evident in their behaviour as many consultations were 'one-offs'. Patients demonstrated ambivalence about their relationship with CAM practitioners. If treatments or therapies suggested by CAM practitioners were not successful patients showed little sign of resentment; they simply either stopped going to a certain practitioner or looked elsewhere for treatment, including sometimes returning to the orthodox model. There was a sense that CAM was worth trying but if it did not work out – so what!

Jack, as previously mentioned, had been diagnosed with an osteosarcoma and his leg was amputated when the cancer spread. He said that even although he considered medical doctors as a "last resort",

...when the tumor starts to grow I'm too scared not to have it surgically attended to because I can't think of any other way [to have it dealt with]...I wasn't in a position to argue.

Faye acknowledged that she had different expectations towards doctors and CAM practitioners.

I don't have complete faith in [CAM practitioners] whereas with a doctor I suppose we think we do have the backing of the government and things and because we've lived in the medical model for so many centuries it's just that we do put more into them and if they do something wrong or unethical it's huge compared to natural remedies...but I think there's a lot more riding on alternative medicine as far as ethics and things like that go because they're being watched...but doctors have got a lot more pressure on them to get it right. I suppose we put a lot more faith in them too.

Faye admitted that although she preferred naturopathic treatments, if her condition "got really bad then I would go to a doctor". The perverseness of this behaviour was not lost on the patients themselves. As I illustrated in the Introduction (page 3), Faye spoke about the dilemma of responsibility; in particular the expectations she has of herself and the expectations she has of practitioners:

I want [practitioners] to give me informed options and then it's up to me what I do with that. But if I decide on something I have to put my faith in them because I don't know enough to know if it's right so I suppose I have to take the responsibility for that. Whatever they suggest and whichever option you take if it's the one they specialise in they have that responsibility to ensure that I'll be okay and to give the best possible care and advice. (Faye)

Faye went on to say that she felt sympathetic towards the contested space doctors worked within:

I don't know why people ever want to be a doctor because the responsibility is huge and they have to let go at some stage.

These views reflect the dichotomy between patients' use of orthodox and alternative models and their ascription of responsibility. It is apparent that despite the rhetoric of individual responsibility, patients exercise it selectively. My study reveals that patients expressed little in the way of expectations with regard to CAM practitioner responsibilities but expected high standards of responsibility from medical practitioners, including GPs who integrated CAM and orthodox medicine. One aspect of this disparity was evidenced by the minimal confidence patients displayed towards the efficacy of CAM therapies, whereas they retained high expectations towards the effectiveness of biomedical treatments. Although patients I spoke with grumbled a little about some of the CAM therapies not working for their particular conditions, there was no overall feeling of resentment or concern about this. Conversely patients expressed high expectations of the efficacy of the biomedical model and remained heavily reliant on science and technology and orthodox

practitioner expertise to find answers to their health problems, and thus placed greater weight on the responsibilities of doctors and Dr-CAM practitioners⁵.

Patients enjoyed their consultations with CAM practitioners because they were offered a service that allowed them to spend considerable time with therapists who operated in a largely non-hierarchical environment where an exchange of ideas was encouraged. Patients believed their ideas were valued by practitioners and described relief that the causes of their health problems were investigated as opposed to just receiving symptomatic relief which is what happened, in their opinion, with orthodox medicine. However, I think it is erroneous to assume that enjoyment of the consultation style, the *natural* remedies, and the rhetoric of individual responsibility, can be translated into trust of the CAM model. The patients I interviewed, despite voicing real concerns about the technology, invasiveness and toxicity of biomedical therapies and procedures, and the fear of losing their autonomy, still demonstrated a high degree of trust in the orthodox model. This is, no doubt, partly attributable to the position orthodox medicine retains in the West, with its status as the preferred healing model. Implicit in its position is the support it receives from the state, both financial and legislative. Further, the legislative weight of orthodox practitioner bodies adds to feelings of trust, reassurance and competence about practitioner abilities and their levels of responsibility. Patients talked about biomedicine being “real” medicine and described practitioners as “proper” doctors. Dr-CAM practitioners were also viewed as ‘proper’ doctors, but ones who offered a service combining multiple worldviews. However, despite worldviews that contained contradictory rhetorics regarding responsibility, patients’ expectations of Dr-CAMs mirrored many of those they held towards orthodox practitioners. In particular they expected a diagnosis, and importantly, they expected these doctors would remain alert to any serious pathology. In essence, my research revealed that despite rhetoric portraying biomedicine as a model of healing predicated on ideologies of paternalism, patriarchy, and the inhumanness of science and technology, when patients were seriously concerned about their health, they vested responsibility in orthodox

⁵ I am not suggesting here that the biomedical model is able to prove efficacy for all its treatments. For example, not all surgical procedures have been subjected to randomised double-blind trials (this would be unethical). Patients’ reactions to medications and other interventions are also varied; for example, Penicillin may prove an effective antibiotic for one patient, but can produce an allergic reaction in another.

medicine as opposed to seeking out or continuing to use what they described as the “natural” therapies utilised under the CAM rubric.

VII: Mixing-and-Matching Modalities: Who is Responsible?

At the crux of this thesis is the question of patients and practitioners mixing and matching both orthodox and alternative and complementary therapies and where responsibility lies when this happens. The previous chapter, together with Section VI above, has considered this question from a patient perspective. Although patients described wanting to accept responsibility for the decisions they made, a close analysis revealed discrepancies where responsibility was often foisted back onto general practitioners. The interviews I held with health practitioners exposed a similar theme. Dr-CAM and CAM practitioners, as earlier described in this chapter, espoused individualistic ideologies with regard to patients accepting the majority of responsibility for their health and healing choices, yet contradictorily they also spoke in terms of a more collectivist ethos where they depicted the general practitioner playing a central role in managing patient treatments.

During one focus group I asked the GPs what they thought about their medical colleagues who practised alternative and complementary medicine, and the following discussion ensued:

Simon: I'm frustrated because a patient comes and says I've been to Dr-so-and-so and he's given me this and he's told me I've got this condition and he's cleansing up my veins with chelation therapy and I feel so much better. And I think this guy knows that this stuff doesn't work and he's selling it to them.

Jeanette: I don't like them basically. I don't have any time for them whereas I have a lot of time for osteopaths.

James: I feel reasonably comfortable with Dr X for instance, mainly because he's a registered medical practitioner and if something goes wrong he's responsible. He is still on the medical register.

Jeanette: I don't go along with his practice at all...I think it's slightly scary that patients go to these doctors because they feel safe and they will pay exorbitant amounts - that's what I don't like. I get frustrated that these guys got out of general practice because they weren't making enough money and now they are making a heap of money and fleecing the patient.

It was apparent these GPs felt a degree of frustration and resentment towards some Dr-CAM practitioners. This related to Dr-CAMs use of unscientifically proven therapies and the amount of money patients were expected to pay for treatments. It

was assumed that doctors who resorted to this type of medicine were in it for money as opposed to benefiting the health outcomes of their patients. The GPs also commented that patients needed to accept responsibility for their therapeutic choices and not foist that responsibility back on to them, especially if the therapy has been unsuccessful.

If they've chosen something different and they come back to me I don't feel it's my responsibility to necessarily accept whatever may have been caused by their choice. I can say – you chose that, I didn't necessarily agree with that – but I won't accept that's my fault.
(Simon, GP)

The appeal for patients attending Dr-CAMs is fairly obvious. They get to consult a practitioner who has expert knowledge of the dominant medical paradigm, and patients feel confident that any serious pathology will be diagnosed. They also believe that Dr-CAMs will be aware of possible drug or therapy interactions, as well as being able to offer a considerable range of therapeutic options spanning both orthodox and CAM modalities. Implicit in all these advantages is the level of diagnostic and treatment responsibilities Dr-CAM practitioners adhere to because of their orthodox training. While not all the patients I interviewed have consulted a Dr-CAM practitioner every one of them spoke enthusiastically about such a combination, describing it as 'the best of both worlds'.

You would have the best of both worlds. You know you have their diagnostic training with the alternative therapies.
(Phyllis)

I think it's highly advantageous because they have the medical background that they can combine with alternative therapy so I think that's the best kind of mix you can have. It's a more holistic view and I certainly think you have the best of both worlds and you've got a lot more available in the choice of treatments for the patient.
(Elizabeth)

The Dr-CAM practitioners I interviewed were mindful of their clinical responsibilities and said they would not advocate patients changing biomedical treatments without full consultation with their orthodox practitioner.

I will never take people off drugs of my own account...I'll say to people in the event that [my treatment] is going to work you might decide you can reduce your blood pressure tablets so go and see your doctor and reduce them.
(Ernest, Dr-CAM)

However Ernest acknowledged that sometimes he was put in an invidious position because patients did not want to return to their doctor to discuss their use of alternative medicine. He believed that responsibility for changing a therapeutic regime ultimately lay with patients.

In 2005 the Medical Council of New Zealand issued a *Statement on complementary and alternative therapies*⁶. This document supports doctors who choose to either utilise CAM therapies within their practice or refer patients to CAM practitioners as long as the therapies concerned “have demonstrated benefits for the patient and have minimal risks”. The Council endorsed the decision made by the Medical Practitioners Disciplinary Tribunal’s (MPDT) in relation to its proceedings against Dr Gorringer, where it stated:

There is an onus on the practitioner to inform the patient not only of the nature of the alternative treatment offered but also the extent to which that is consistent with conventional theories of medicine and has, or does not have, the support of the majority of practitioners...

Doctors are advised to regard informed consent as “particularly important” when proposing CAM treatment or referrals, especially if the therapies utilised are not supported by scientific evidence. Doctors who wish to practise integrative medicine are reminded that physical examination and diagnosis should reflect a “standard of practice generally expected of the profession”. In other words, Dr-CAMs are expected to adhere to the principles of the biomedical model in many regards: obtaining a case history, undertaking a physical examination, making, or attempting to make a “generally recognised diagnosis”, outlining treatment options and obtaining informed consent.

I asked GPs if they had experience of a patient who consulted both them and an alternative or integrative practitioner, and if so - where did they believe the responsibility for treatment lay. One GP recounted the following experience:

A lady of this community, a well-to-do woman who frequently visits alternative therapies was given a whole list of vitamin supplements that had been recommended by an alternative therapist who I think may have been a fringe doctor and she brought me the list to check whether it was all safe. There were all sorts of supplements and vitamins and her expectation was that although prescribed by this other person, she obviously saw it as my role to advise her if all of this was safe and whether the quantities were correct. I said there was no way I could. I actually did make an attempt; I went to the *New Ethicals* and another book we've got on vitamins and I made an attempt to go through it and check doses for her, but as usual they were really small doses and it probably was quite safe but there were a lot of things on the list I had no information on. I just said to her it wasn't a fair expectation of me. I just haven't got this sort of information and it's not my field and I suggested she do it herself by looking on the internet. (Alison, GP)

⁶ According to Fulder (1996) in Britain doctors who wished to refer their patients to non-registered CAM therapists were allowed to on the basis that it was the doctor who “retained clinical responsibility and accountability” (ibid:18). Medical practitioners who wanted to practise integrative medicine were required, by the British Medical Association, to undergo “recognized training in that field approved by the appropriate regulatory body, and should only practice the therapy after registration (ibid:19).

The doctors in this focus group described the time and effort it would take to keep informed about CAM treatments and how they did not perceive this to be feasible with their current workloads. I had sympathies with these practitioners because some of them felt they were being forced to accept a worldview they are at odds with. While it can be argued that this is not unreasonable because the scientific paradigm offers what may be perceived as a narrow view of health and illness, these practitioners have studied and continue to work within a healing modality which complements their belief systems. This is not to say that they do not question the biomedical model or the efficacy of treatments or ideas about best practice.

An interesting facet that arose from the interviews with Dr-CAM and CAM practitioners was that despite the rhetoric that patients should retain responsibility for their health choices, the general practitioner was cast in the role as having *overall* responsibility for patient care. The following interview extracts sum up many of the views expressed about this topic:

I like my patients to go back to their GP because I think the GP should be the overall person who is familiar with the whole case otherwise you get such fragmented care that there's nobody who has an overall global views of that and the GP should. The ideal GP should be the one who, whilst they don't have to understand all these other therapies, they should at least respect that they exist, at least respect the fact that there are things they don't understand that might work...There are times when I initiate a therapy that may be controversial and it's an awkward area and I don't really know fully how to work though but in the end as long as I discuss it with the patient and I do rely on them sometimes to discuss it with their doctor. Sometimes patients put you in an awkward position because they say I don't want my doctor to know this...I guess if it was something quite significant, not so much life threatening but could seriously jeopardise their health, if I was to do something quite off my bat without anyone else knowing I think that would be a limit I would not cross. There are some areas that you have to be careful about and sometimes I think you've got to say you have to see your own doctor and advise them. (Ernest, Dr-CAM)

I believe that the primary caregiver will always be the GP...At the end of the day, when push comes to shove, the primary caregiver is their GP and I think it's very wise for natural therapists to work in with GPs...I don't think we would at all ever take over their role. I don't think we should. (Lorna, herbalist)

...general practitioners run the show, they are the ultimate overseer of the whole thing, although I'll take up the role if they don't want to. (Bob, Dr-CAM)

However the GPs I interviewed were not necessarily prepared to accept this mantle imposed on them by Dr-CAM and CAM practitioners. They argued that it was not

their responsibility to learn specific details about CAM therapies, although they believed they should know enough to be able to act as a guide for patients.

I don't think our responsibility includes getting involved in alternatives, we shouldn't have to do that, but I do think we have a responsibility to know that our patients are involved in alternatives, to at least find out what they are up to in terms of what they're trying to use alternatively so that they can get some information. (Andrew, GP)

Another GP said he felt it was his responsibility to be confident about referring patients to practitioners, either orthodox or CAM, but he did not feel compelled to offer advice about other treatments if he does not believe in them.

We have a responsibility to be competent that we recommend a treatment we believe will be practised in a safe way and so it's actually irresponsible to recommend any other treatments or practitioners unless you feel confident that they are going to be used appropriately and properly and therefore once you start advising alternative health practitioners you can be treading on reasonably dangerous ground unless you feel confident that a person can do something you feel comfortable with. (Scott, GP)

Most of the doctors interviewed conveyed some desire to at least consider other healing paradigms. However there was resentment that patients, CAM and Dr-CAM practitioners, together with their own regulatory body, the Medical Council, should expect this of them. The Medical Council's *Statement on complementary and alternative medicine* (2005) advises doctors to indicate to their patients any limitations they have with regard to their knowledge about CAM therapies. However, the *Statement* recommends that patients who are in the process of deciding between orthodox and CAM treatments should receive from their doctor information about the different options, including "an assessment of the expected risks, side effects, benefits and cost of each option".

VIII: Absolution of Responsibility

What I have described so far is indicative of the tensions and complexities that surround the attribution of responsibility when plural healing modalities are utilised. In the previous chapter I mentioned that Lowenberg (1992:171) maintained that integrative practitioners absolve patients from responsibility in similar ways as their orthodox colleagues. However she also made, what I considered to be a very telling comment, when she stated that doctors become integrative practitioners because they want to "give up, or at least lessen, their responsibility for patient health and illness and direction of cure" (ibid:200). She quoted practitioners describing their relinquishing of responsibilities:

That's why I left (traditional) medicine...I couldn't handle the responsibility. I couldn't handle it. It was very clear. (ibid:201)

The other thing basically was the gradual concept or willingness on my part, or realization that it's very freeing to the physician to turn over the responsibility to the patient for their health and well-being...it's very burdensome to carry that responsibility and lonesome, and that sharing it with a patient eased my mind, eased my tensions. (ibid:201-202)

In spite of this rhetoric relinquishing responsibility, Lowenberg said that many of these practitioners found it difficult to put their sentiments into effect.

I believe it is possible to expand Lowenberg's contention that doctors choose integrative practice in order to lessen their responsibilities, to one where Dr-CAMs and CAM therapists choose to work with the therapies they do in order to absolve themselves of responsibility. Although no doubt contentious, I believe that by adopting the mantra of the patient as the prime agent of responsibility and the general practitioner as the main caregiver, Dr-CAM and CAM practitioners' distance themselves from both their therapeutic and moral responsibilities. In similar fashion to Lowenberg's research, some of my participants spoke of adopting an integrative style of practice in order to have an "easier life". Ernest said:

I developed several niche areas which weren't well done in general practice...and I decided when I moved here to take an easier life...

However Ernest found that his practice became well known and very busy and from that point of view, life was not necessarily "easier".

But an easier life in terms of integrative and CAM consultation styles consists of lengthy appointments, utilising mainly non-invasive or non-toxic substances, not being required to offer an after-hours service, or continuity of care. CAM practitioners do not, as a matter of course, undertake a physical examination or feel required to make an explicit diagnosis. In essence this means that practitioners are under less pressure than orthodox practitioners because they do not face on-going responsibilities.

Because I've created more time in my practice, I might be able to find things more readily because I do have more time with them and they have more of a chance to probably ask me questions. There's less pressure than in a more orthodox general practice. (Julian, Dr-CAM)

For new patients coming to see me I have a half-hour standard consultation. My standard consultations are twenty minutes and they often go on to twenty-five to

thirty minutes. It's a little bit of a juggle. My classical homeopathic consultations are two hours long. (Fran, Dr-CAM)

Well some diagnoses are pretty simple to make. For example, if someone's low in energy I'll find try to find out where that lack of energy is coming from and sometimes it's almost like an airy-fairy kind of term, or it's a mixture of different things that are going on with that person. So you can't actually give a diagnosis as such. It's like, this person's got hypoglycemia, they're low in iron and blah, blah, blah, so generally they're lacking in energy. You could call it chronic fatigue if you wanted to but that encompasses so many different causes of lack of energy that it's a nondescript term. (Margaret, herbalist)

With patients, if their problems relate to being overweight, or smoking, or drinking – I haven't got the time nor the interest in working with these type of people. I might point it out to them, but I don't do it in a heavy sort of manner. So I really stay in those areas that's easiest for me. (Steven, osteopath)

I will only see people on average four or five times....I have longer appointments but I don't tend to see people over and over again. (Julian, Dr-CAM)

I see a lot of one-offs. I actually like to see people back at least once, just so that I know how they've got on with it....I kind of try to avoid people coming back and back and back because it means what I'm doing isn't working and there's something else *they* need to be doing instead. It's when people start to rely on herbs to do things which they're not actually doing for themselves that it frustrates me....I sort of wash my hands of it if they're not going to do what needs to be done. (Margaret, herbalist)

No I don't offer an after-hours service....the reality is that I have a family after hours so I've told my patients that I don't want to neglect my family. (Fran, Dr-CAM)

Lorna: No we don't offer an after-hours service. I've thought about it, but at this stage we don't.

Me: Patients' haven't requested this?

Lorna: No-one's ever asked. I've thought about it being a good marketing thing... (Lorna, herbalist)

My day starts at eight in the morning and I quite often finish at six in the afternoon. Come Saturday morning I'm fairly ga-ga and phone- and patient-shy. I will see people who are obviously distressed over the weekend, but I don't encourage it....not in the same way that doctors are available for emergencies. (Steven, osteopath)

As far as an out-of-hours service goes I'm here the whole week, including Saturdays so the only day I'm not here is Sunday and we haven't been able to set up a group that will take on those Sundays. We've tried and it hasn't worked. I think most people who do get an acute have learned to use our remedies and quite often if it's really, really acute – and it usually relates to children – they will get on the phone and say I'm not quite sure what's happening and I will tell them to go to the doctor. So quite often that's dealt with and then they come to me a couple of days later. (Joseph, homeopath)

IX: Conclusion

As is clearly evident CAM and Dr-CAM practitioners develop a style of practice that diffuses their responsibilities. Although Lowenberg (ibid:172) also argues that integrative practitioners can be seen as increasing their responsibilities because they are working with patients who have often been unresponsive to the therapies on offer under the biomedical paradigm, my data suggest otherwise. The doctrines underpinning CAM and integrative medicine are infused with rhetoric of individual responsibility and this responsibility, from the perspective of the practitioners who practise these therapies, lies with patients, not practitioners.

In anthropological terms, integrative practitioners operate in a state of liminality. While the rhetoric of individual patient responsibility underpins CAM discourse, the rhetoric of practitioner responsibility is highlighted through both their orthodox training and the regulatory environment they work within. For example, biomedical training involves attempting to make a diagnosis (and as I have shown, this is what patients expect), whereas the CAM model focuses more on constructing a meaning for symptoms than defining or labelling an actual illness or condition. This means that practitioners have to negotiate between different worldviews and whether they manage to do this successfully is debatable and was not something I was able to unequivocally ascertain. Certainly all the Dr-CAMs I interviewed had practiced integrative medicine for a number of years and appeared to have successful businesses. However, changes in the funding regimes for GPs meant that those practitioners still claiming patient subsidies from the state found themselves under pressure because their orthodox colleagues were now more reluctant to refer patients to them. The successful MCDT disciplinary hearing against Dr Gorrings' use of CAM therapies, and the extensive media coverage which accompanied the case, also made practitioners wary of being interviewed. Brian maintained that some practitioners operated in a more "underground" manner and certainly no longer openly advertised their use of "vega" machines. They were also wary of patients and some had resorted to asking their patients to sign consent forms before commencing specific treatments.

My study shows that patients, together with Dr-CAM and CAM practitioners, consider the general practitioner to be the primary caregiver and the repository of responsibility. Non-orthodox and integrative practitioners accepted responsibility

for the way they practised their therapies on a consultation-by-consultation basis, however, from a holistic point of view, I believe they largely absolved themselves from responsibility. Neo-liberal and individualistic discourses informed their view of their patients' socio-cultural environment, and many of the practitioners were rhetorically dismissive of a more collective perspective towards health care. Despite these factors, the reality of the situation showed a more humanistic approach, and as Lowenberg suggests, some sharing of responsibility.

CHAPTER NINE

CONCLUSION

*Between the idea
And the reality
Between the motion
And the act
Falls the Shadow*

(T.S. Eliot, *Wasteland*)

This anthropological study of responsibility within a plural healing environment has revealed a palimpsest of complexity. Despite a veneer of homogeneity (because the majority of research participants were from a Pakeha middle-class urban background), I found that research participants attributed responsibility when mixing and matching therapeutic modalities in a myriad of ways. While none of the participants' attributed sole responsibility to individuals, CAM and integrative practitioners generally described responsibility in terms of individual patient behaviour, whereas orthodox general practitioners and patients were prone to fluctuate in their views as to whether responsibility should be a collective or individual trait.

Until fairly recently medical anthropologists had concentrated on investigations with an ethnomedical bias and it is only in the past twenty years that their gaze has turned towards their own society's beliefs about illness, health and healing. This study is firmly located within present-day New Zealand society and fills a gap currently untapped. Research has been conducted into medical pluralism: Dew's (2003) sociological study looked at the regulation of alternative therapies in New Zealand and the position of what he termed the 'medical heretic', the orthodox practitioner who chooses to practise unorthodox therapies. Medical practitioners themselves have provided research into the attitudes their colleagues hold towards the use of plural healing methods (see Hadley 1988; Marshall 1990; Taylor 2003). Leibrich et al (1987) undertook exploratory research on behalf of the Department of Health to ascertain the uptake of CAM by New Zealanders, and latterly, the government's Ministerial Advisory Committee on Complementary and Alternative Health (2004) presented an up-to-date picture of CAM usage, whether regulation of therapies and CAM practitioners was required, and the feasibility or otherwise of state funding for CAM. From an anthropological perspective, White (1991)

investigated why people chose to use alternative therapies. However, none of the research mentioned looked at the question of how patients and practitioners attribute *responsibility* when they mix-and-match healing modalities and my study addresses this situation. The reason it needs to be addressed is because the rhetoric of responsibility is becoming increasingly articulated within our social sphere. For example, in the medical sector not only doctors, but also midwives and chemists (and patients by default) have recently had their mistakes and responsibilities publicly scrutinised. And this scrutinisation is occurring within other sectors as well: education, religious and political organisations, and even the building industry. Parents' and children's roles and responsibilities are also debated.

From an anthropological perspective I was interested in discovering beliefs about responsibility from the participant groups interviewed, and I was also interested in whether these beliefs represented a cultural change within New Zealand society. In 1992 Ursula Sharma contended that the assertion made by Rosalind Coward (1989) about the use of complementary and alternative therapies representing a change in western cultural beliefs was premature rather than incorrect (Sharma 1992:87-88). Sharma (*ibid*:87) argued that at that time there was little in the way of empirical evidence to back up Coward's claims. Given the time lapse between those two publications and this research project, I believe there now exists empirical evidence suggesting that such a cultural change, within New Zealand at least, has occurred (and I would speculate that in general the more recent academic literature on the use of medical pluralism indicates these changes would be found in other western societies). The catalyst for these changes can be found in the influence neo-liberal and individualistic discourses have had on our political and social landscapes, and it is within these arenas that the conflicting rhetoric of individual versus collective responsibilities is continually scrutinised and debated.

New Zealand, like other western societies, has undergone substantial changes since the 1970s. The privileging of the individual over the collective has been brought about by changes to the political and economic spheres, where policies have been introduced with the intention of reducing government spending. This has been especially evident with changes to the health sector that have threatened the universal coverage most New Zealanders have come to expect. With the advent of a more user-pays system, attitudes towards individual responsibility hardened and

expectations changed. These expectations have included calls for patient autonomy to be respected by health practitioners, and more therapeutic choices to be available to the public. The increasing prevalence of complementary and alternative medicine is one result implicated through these changes.

The discourses informing the rhetoric of individual versus collective responsibility are found within neo-liberalism and individualism and, as Foucault noted, it is somewhat ironic that the economic and political philosophies contained within these discourses have become embedded within our 'social sphere' (Lemke 2001:197). The irony occurs because what was originally construed to be a theoretical discourse has been transformed into a political discourse and political action. As a consequence, a cultural shift manifesting itself through an increasing rhetoric promoting individual responsibilities has become noticeable. However these responsibilities are revealed through a web of complexity, contestation and contradictions.

The rhetoric of individual responsibility is paradoxically under direct attack from the rhetoric of surveillance, one of the by-products of a neo-liberal society. Although neo-liberalism and individualism promote individuals as being responsible for their own decision-making, and subsequent actions and consequences, we live in a society that increasingly monitors and chastises individual behaviour. Within the health sector surveillance occurs through bureaucratic intervention, intrusion and scrutiny such as through national database and recall systems for breast, cervical screening and immunisation programmes. Legislation protects ACC's right to access patient notes regarding their compensation claims. An audit culture now scrutinises and monitors health practitioners' professional practise through the use of protocols and best-practice guidelines based on an evidence-based approach (Armstrong 2002). Orthodox GPs and integrative practitioners have their roles and responsibilities prescribed through legislation, regulation and oversight by the Medical Council. Ethical and disciplinary standards are clearly defined and enforceable. However, as MACCAH's report (2004) outlined, the situation with CAM practitioners is more complex. At present CAM practitioners are able to operate in a fairly unregulated environment, although this situation is being challenged (which is somewhat ironic given the neo-liberal and individualistic underpinning of CAM discourse). All the

patients and practitioners involved in this study supported *some* regulation of CAM, however the mechanisms to do this, and whether it should be mandatory, were debated and no consensus was reached on this question. It would be fair to say that there has been little evidence produced to show that the current situation is endangering public safety, however many CAM practitioners spoke in terms of regulation providing the industry with an opportunity to enhance the status of the therapies and therapists; of increasing the profile of CAM; securing public confidence in the use of CAM; and the improved likelihood of receiving state funding for CAM consultations.

Individual surveillance occurs through monitoring the body. This includes monitoring the external appearance as well as what goes into (and out of) the body. As a result of this surveillance culture individuals who transgress, for example, by disregarding health screening programmes, or who are obese or smoke, can be subjected to blame and censure, hence the rhetoric of a *blame* culture now permeates social discourse.

Surveillance also tempers the expectations of both patients and practitioners. The patients I interviewed all expressed high expectations towards the biomedical model, which in many ways contradicted their rhetoric favouring the therapies they used under the CAM rubric. The preservation and encouragement of patient autonomy was considered a virtue of CAM, as was the non-hierarchical relationship between patient and practitioner. The fostering of individual responsibility for health and wellbeing further enhanced patient perceptions of CAM. Notwithstanding these attributes of complementary and alternative therapies, patients revealed that they relied on the biomedical model for diagnosis and *effective* treatment regimes. While I am not suggesting that CAM therapies are ineffective, the patients in this study demonstrated ambivalence towards its efficacy. This ambivalence about expectations was further evidenced by the lack of long-term or on-going relationships patients had with any particular CAM practitioner or modality. If the modality did not work patients moved on to either another CAM therapy or therapist, or turned to orthodox medicine. By way of contrast, patients *trusted* their general practitioners and the biomedical model to provide solutions to their health problems and to take responsibility for their health and wellbeing. Furthermore, patients I interviewed knew medical practitioners' responsibilities and

obligations were contained with a regulatory and legislative framework overseen by both the state and professional bodies, such as the Medical Council, and this aided their feelings of trust, security and expectations of the biomedical model. Patients and orthodox practitioners also outlined responsibilities not only in terms of diagnosis and treatment regimes, but also the provision of continuity of care including an after-hours service. These facets were largely absent from CAM models of practice. Moreover, responsibility from a CAM perspective adopted a more consumerist hue than that contained within biomedicine.

Paying for health care, a much vaunted proposal by proponents of neo-liberal and individualistic ideologies (see Knowles 1977 a&b; and Lalonde 1974), is equated with accepting responsibility for health. This rhetoric was prevalent amongst some of the CAM and integrative practitioners, and a minority of the patients, I interviewed. This consumerist approach to health implies that good health can be purchased. As a consequence the cultural change that Coward (1989) alerted us to can be seen in the flourishing gym, health food, and CAM businesses. Critics of this approach refer to these niche markets as pandering to the whims of the 'well-sick' or 'worried well'; a predominantly white, middle-and upper-class set who have disposable income and time in which to try and attain the perfect body or perfect health. My patient participants displayed competing and contradictory rhetoric when attributing responsibility for their health and illnesses. They all talked in terms of trying to make changes to their lifestyles in order to effect good health. The three aspects all patients (and practitioners) agreed upon was the need to eat a healthy and balanced diet; the need for regular exercise, and the need to live a lifestyle congruent with stress reduction. Perversely, the trappings of consumerist society meant that for the patients interviewed, attaining any or all of these goals for a healthy lifestyle proved difficult. If illness occurred, then many patients blamed themselves. For instance Stevie talked about not liking exercise, even although she knew it was good for her, and Faye described the difficulty of providing a healthy vegetarian diet for her and her children while trying to balance work, study and financial commitments. The complexity of the blame culture was apparent because although the rhetoric from all patients was heavily biased towards their own responsibilities, and they did blame themselves for getting ill or not being as healthy as they thought they ought to be, there was still a reluctance to attribute *all* responsibility for their illnesses onto themselves. This was well illustrated by Jack

who believed that his osteosarcoma had been caused by an accident several decades previously and was not directly attributable to his lifestyle choices (although of course it could be argued that by choosing to be out in the bush Jack was culpable for the accident occurring). Similarly Elizabeth viewed her joint problems as 'bad luck' as opposed to attributing herself with blame for her condition. According to Parsons (1951), responsibility for illness is not attributed to individual patients if they seek medical intervention. However, this situation is complicated because the interventions now sought by patients are diverse and absolution of responsibility is not a blanket role adopted by all practitioners.

As my study revealed, health practitioners offered divergent opinions regarding the absolution of patient responsibility for illness and healing. The orthodox GPs I interviewed tended towards a collective acceptance of responsibility. First, these doctors felt a great deal of responsibility about the way they practised medicine. Second, they stated their patients should take responsibility for following medical advice, including taking prescribed medications or enacting changes to their lifestyle if required. Third, they also believed that society in general had a responsibility to provide an environment that catered for the social, cultural and economic welfare of their patients. Integrative practitioners and CAM therapists shared many of these views but their rhetoric initially appeared less likely to absolve patients of responsibility because it was littered with neo-liberal and individualistic ideologies where patients were considered to be largely the authors of their own healing destinies. However this is where contradictions were apparent. As Lowenberg (1992) noted, and I have demonstrated, despite the prevalence of a neo-liberal rhetoric, the reality of the consultation process revealed a much more conciliatory approach because integrative practitioners continued to absolve patients of responsibility. Although practitioners *talked* about how patients should take responsibility for their own healing, the empirical evidence indicated that a more collective ethos was present in their daily practise where responsibility was at least shared. On the other hand non-medical CAM practitioners were more likely to adopt a strongly neo-liberal stance towards the individual responsibility patients should bear and they were significantly less likely to absolve patients than their medical and integrative colleagues. From the patients' perspective, one of the contradictions they face is that under the discourse of neo-liberalism and the rhetoric of autonomy, they are being given the opportunity to accept more

responsibility for their illness and healing. However my research shows that patients still want to share those responsibilities with health practitioners. Paradoxically, because of the surveillance and blame cultures enacted through the use of neo-liberal and individualistic discourses, practitioners' responsibilities are increasingly managed and scrutinised, despite the rhetoric by CAM and integrative practitioners of wanting to give their responsibilities back to their patients.

Research Implications

My study into the use of healing pluralism and the attribution of responsibility revealed significant differences between the rhetoric and the actual experiences of patients and health practitioners. My study is limited by its small size and scope and I do not claim that it is representative of the population at large. However, it does reflect that although much has been made of vesting responsibility for healing and illness with individual patients, there are divergent opinions as to whether this is, or should be, achievable. An expansion of this study could include a large-scale research project incorporating a wider range of CAM modalities as well as patients who do not utilise alternative or complementary therapies. Further research on the concept of holistic practice from biomedical, CAM and patient perspectives would also allow for a more meaningful understanding of expectations between patients and providers to be achieved. Another aspect requiring further investigation relates to the provision of after-hours patient care. The provision of an after-hours service is currently part of ongoing negotiations between general practitioner organisations and the government and remains a contentious issue. I believe it is an area that would benefit from in-depth analysis, particularly with regard to the expectations the general public has of who should provide these services, what services should be available and how the cost of these will be met. If CAM practitioners continue to increase their market-share within the health sector it will also be timely to investigate what expectations we should have of them to provide after-hours care for their patients.

Conclusion

In essence, I am arguing that the holism CAM is much praised for is empty rhetoric. I agree with Baer (2003:240) when he says that complementary and alternative medicine "engage[s] in a rather limited holism in that [it] focuses largely on the individual rather than society and its institutions". The discourses underlying

complementary and alternative medicines largely ignore people's individual circumstances and the effect this has on their health and wellbeing. In other words an individual's ethnicity, social class, gender, economic circumstances, educational background and so on are glossed over because, within the market society promoted by neo-liberalism, people are perceived to be able to change their circumstances (Devine 1998). Further, relationships between practitioners and patients must involve, at some level, responsibilities. By choosing to absolve either patient or practitioner of responsibility is to surely negate the fundamental principles of holism.

I have found that the patients in this study negotiated their way through a contradictory and complex landscape by consulting CAM and integrative practitioners when using the rhetoric of self-responsibility, and orthodox practitioners when adopting a collectivist stance. Integrative and CAM practitioners used the rhetoric of individual patient responsibility in much of their practise, and yet they absolved themselves of responsibility through their adoption of a collective rhetoric when they transferred responsibility for patient care onto orthodox medical practitioners. While criticism can be levelled at the biomedical model and its adherence to technology and invasive techniques, not to mention paternalistic attitudes that are still inherent in the system, this study revealed the orthodox approach to patient care produced a holistic and collective attitude towards patient and practitioner responsibilities. This being the case - where does the ultimate responsibility for health-care lie when patients and practitioners utilise plural healing methods? My study does not unequivocally answer this question, but as T.S. Eliot suggests, the answer lies in the amorphous shadow world of human understanding. The realities we construct do not have to be logically consistent. It is a world of complexity and contradictions that exist in the space inhabited between our rhetoric and our lived experiences.

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Appendix I

Demographic Information Orthodox-CAM Patients Interviewed

Pseudonym	Gender	Age	Occupation	Highest Qualification	Income Bracket \$K
Jack	Male	61+	Self-employed	UE	Not given
Genevieve	Female	31-40	Student	MA	\$21-30
Phyllis	Female	61+	Voluntary Work	Not given	-\$20
Faye	Female	31-40	Student/Gardener	Tertiary Diploma	-\$20
Elizabeth	Female	31-40	Manager	MBA	+\$60
Sarah	Female	41-50	Student/Teacher	Tertiary Diploma	-\$20
Stevie	Female	51-60	Nurse	Tertiary Diploma	-\$20

CAM Therapies Used By Patients

Jack	Genevieve +	Phyllis	Faye	Elizabeth+	Sarah	Stevie
Naturopath	Naturopath		Naturopath		Naturopath	
Electro-therapy(x2)*	Homeopath		Homeopath		Homeopath	Homeopath
Acupuncture				Acupuncture		Acupuncture
Buteyko	Nutritionist	Iphus**	Bach Flowers	Colour Therapy	Bach Flowers	
Uzana			Osteopath	Osteopath		Osteopath
Faith Healing			Spiritualist Church	Rhizotomy		Thermogram
PMRT***			Iridology		Iridology	PMRT***
Chinese Herbal Medicine			Crystals		Herbalist	Magnets
Supplements	Supplements	Supplements	Supplements	Supplements	Supplements	Supplements

+ Both these participants indicated they had consulted with a wide variety of CAM practitioners, however I was not able to get them to specifically identify which therapies were always involved. Genevieve for example said choosing a practitioner sometimes involved intuition “I open the Yellow Pages – there’s about five pages of natural health practitioners – and think I need to try something new, something I haven’t tried before”.

* Jack described these treatments as ‘electrotherapy’ – where he said he had been hooked up to a machine and electrical impulses were meant to rectify his health problem. He had visited two practitioners and received different types of treatment.

** Phyllis described this therapy as Iphus – she was hooked up to a machine and electrical impulses, which she couldn’t feel, detected viruses in her system and removed them. The machine could also tell her about her past life – she had been a serf in Asia.

*** PMRT – Peak Muscle Resistance Testing.

APPENDIX II

Research Questions CAM-Orthodox Patients

I'm interested in why you use a variety of healers. What made you decide to do this?

Background. General opening question

Why types of healers do you use? **The number and variety of healers used**

Are these healers male/female? **Background**

How do you decide which healer to use for which complaint? **Reasons for above**

How long have you been attending a number of different types of healers?

Demographics/return visits?

How often would you say you attend either a doctor or a CAM practitioner?

Demographics. Especially – do patients keep returning to a particular CAM practitioner or is it a one-off situation.

What types of healers/doctors did your family use as you were growing up?

Background. Reasons for use today/Belief systems

Why do you think you get ill? **Belief systems**

Do you think the body can heal itself? **Belief systems**

Do you have any particular religious or spiritual beliefs that relate to your views about health? **Spirituality**

Do you tell both your medical practitioner or your alternative therapist that you are using the other type of medical treatment? **Power/trust/responsibility**

If not, why not? **Power/trust/responsibility**

If not, whose responsibility do you think it is if something goes wrong with your treatment, maybe a reaction to medication or therapies that have been prescribed for you? **Responsibility**

When you are unwell do you feel there is anyone or anything responsible for your misfortune? **Belief systems/to do with ideas about blame**

What do you expect from a consultation with a medical doctor? **Ideas about expectation/responsibility/power/trust**

What are the benefits you've found from attending a medical doctor?

What do you expect from a consultation with an alternative therapist? **Ideas about expectation/responsibility/power/trust**

What are the benefits you've found from attending alternative practitioners?

Would you ever accept that there is no 'cure' for the particular health problem you have? **Belief systems/responsibility**

What happens when you attend an alternative practitioner, for instance is there a physical examination? Do they undertake tests? **Background/responsibility/power/trust.**

Is this consultation profoundly different from a medical consultation? If so, how do you account/reconcile the differences? **Responsibility/power/trust**

Do you have a diagnosis in mind when you consult with either a medical doctor or an alternative practitioner? **Belief systems**

Do you ever attend both a medical doctor and an alternative therapist for the same condition? What happens in these circumstances if you receive conflicting advice as to treatment? **Trust/responsibility**

To you, what are the biggest differences you are aware of between attending a medical doctor and an alternative practitioner? **Power/responsibility/belief systems/qualifications and training**

Do you think there are any advantages in attending a medically trained doctor who also practises alternative medicine? **Qualifications and training**

As you are probably aware, medical doctors all undergo a prescribed period of education and training and have to be registered by the NZ Medical Council in order to practise. To date this isn't the case with many areas of alternative/complementary medicine. What are your thoughts about the type and standard of training alternative practitioners undergo? **Qualifications and training**

Do you ask to see what qualifications they have? **Qualifications and training**

Do you think that there are certain types of illnesses or conditions that either medical doctors or CAM practitioners shouldn't treat? **Qualifications and training/responsibility**

What do you do if you feel dissatisfied with the treatment you've received by either type of health practitioner? **Responsibility/qualifications and training/power**

Have you ever laid a formal complaint about treatment you've received in the past? **Power/qualifications and training/responsibility (panoptic theory)**

What thoughts do you have about the role government agencies and medical authorities have in regard to looking after your interests when it comes to your health care? **Responsibility**

What are the parts of your health care that you feel you want to have control over? **Responsibility/power**

What do you think the government should provide as far as health services are concerned? **State responsibility/availability of CAM to the general public**

Currently some therapies attract government subsidies and some visits to GPs are also subsidized. How do you feel about having to pay to visit a medical doctor/alternative practitioner? **State/individual responsibility**

What are the cost involved of attending a medical doctor/alternative practitioner? **Background information/availability/state responsibility**

Have you ever called your alternative practitioner for an out of hours consultation? **Responsibility**

Do you have access to a computer? If so, do you use it to find out about information relating to your health problems? **Belief systems/future research**

Any other points you'd like to raise?

APPENDIX III

Research Questions CAM Practitioners

Could you tell me how you came to practice (whatever therapy respondent is involved in)? **Demographics/type and number of therapy.**

What did you do prior to becoming involved in (whatever therapy currently involved in)?

Would you describe to me the training and qualifications you've undergone and what qualifications you have received? **Training and qualifications**

What do you think about practitioners who use the title 'Dr'? Do you think the use of this gives patients a correct/incorrect perception of training and qualifications? Will the use of the title still be allowable under the provisions of the HPCA Bill? **Qualifications/responsibility**

Is there a requirement for you to undertake postgraduate study? **Training and qualifications**

Are you affiliated to any parent body or statutory organization? **State and CAM modality responsibilities**

What are your medico-legal requirements, for example confidentiality of consultations, keeping of records and so on? **State and CAM modality responsibility**

If not presently under statutory management, would you like to be and what would be the advantages/disadvantages? **State and CAM modality responsibility**

Under the present regime how accountable are you in relation to the treatment you deliver to patients? (incorporating conduct in patient-practitioner relationship). Disciplinary procedures? **Responsibility/accountability**

Do you think the present situation needs to be changed? **Responsibility/accountability**

What impact has the Health Practitioners Competency Assurance (HPCA) Bill had in relation to the way you practice? **State and CAM modality responsibility**

What are the main ideologies underpinning the type of therapy you practice? **Belief systems/knowledge.**

Do you believe the body can heal itself? **Belief systems.**

Would you say there is a difference between healing and curing? **Belief systems.**

Do you have any particular religious or spiritual beliefs that relate to your views about health and healing? **Spirituality?**

What are the main types of conditions and illnesses that you treat?

How do you make a diagnosis? **Holistic approach (physical examination)/qualifications/knowledge/responsibility.**

The **demographic** make-up of their practice:

Female/male ratio?

Age-group?

I guess many of the people that see you, also use orthodox medicine. Why do you think they combine both types of healing? **Belief systems.**

How do you feel if your patient tells you they are also seeing a medical doctor and perhaps another type of CAM practitioner for the same problem? **Responsibility/Trust/Power (looking for whether patient/practitioner relationship is affected and how does efficacy of treatment be proved).**

Would you like your patients to keep you informed of all the treatments they are receiving? **Responsibility/Trust/Power.**

What would you suggest to your patient if they are consulting with a variety of healers and receive conflicting advice relating to either diagnosis or treatment of their illness? **Responsibility/power/belief systems.**

Who do you think ends up having ultimate responsibility when a patient is visiting several healers? **Responsibility.**

What expectations do you have of patients with regard to their own health care?

Responsibility/expectation

Do the people that come to see you have an idea of what is bothering them, or are they looking for a particular diagnosis from you? **Expert knowledge**

Who do you think is the 'expert' when it comes to knowing about the body – the patient or the practitioner? **Expert knowledge**

(Depending upon response) Some of the patients I've talked to have been emphatic that they are the experts when it comes to their own bodies and have expressed the opinion that they often feel health practitioners, especially medical doctors, don't always accept that concept. Do you think that the lay person can in fact be an expert when it comes to matters relating to health? **Expert/received knowledge**

Are there boundaries that complementary practitioners or medical doctors should acknowledge? What are these? (eg: medical conditions). Have you ever referred a patient to a medical practitioner, or had them referred to you? **Responsibility**

As individuals, how much responsibility do you think we should take for our own health care? And how is this achieved? **Responsibility.**

If you believe that patients have to take responsibility for their own health care, what responsibility, as a practitioner, do you take? **Responsibility.**

What about the State, what sort of responsibilities do you think it has as far as the provision of health care goes? **State responsibility.**

Do you believe that government funded patient subsidies should be available for CAM consultations? **State responsibility/CAM subsidy**

Do you offer an after-hours or emergency service? **Ongoing responsibility.**

Any other points you'd like to raise?

APPENDIX IV

Faculty of Arts & Social Science
Te Kura Kete Aronui
Division of Cultural and
Environmental Studies
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Anthropology Programme
Te Kaupapa Whatu Aho Iwi

Telephone 64-7-838 4030
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The
University
of Waikato
*Te Whare Wānanga
o Waikato*

INFORMATION SHEET

Researcher

Philippa Miskelly (B.Soc.Sc [Hons])

Department of Anthropology
Faculty of Arts & Social Sciences
University of Waikato
HAMILTON

Supervisors

Dr Judith Macdonald
Senior Lecturer
Department of Anthropology
University of Waikato

Dr Michael Goldsmith
Head of Department
Department of Anthropology
University of Waikato

This research project aims to collect information from 20 people who use both orthodox and complementary medicine. Complementary and alternative practitioners, medical doctors and government officials will also be interviewed. As well as finding out what different types of health services are used and why this occurs, the researcher is particularly interested in ideas about responsibility. This relates to patient responsibility, health practitioner responsibility and the responsibilities of the state.

These interviews and their analysis will form part of the data collection towards completion of the research project. The aim of this project is completion of a PhD by the researcher, Philippa Miskelly. The thesis is currently titled 'Patients, Practitioners and Notions of

2.

Responsibility: Orthodox and Complementary Medicine'. Mrs Miskelly is a doctoral candidate at Waikato

University and is supervised by two senior lecturers from the Department of Anthropology at the University. She is receiving funding from a University of Waikato Doctoral Scholarship.

Your participation involves taking part in a face-to-face interview. This interview will last for approximately 1-1 1/2 hours. The interview will be conducted, in private, by Mrs Miskelly, in your home or some other acceptable place, at a time convenient to you. During the interview you will be asked about the type of health services you use and why, ideas about health and illness, and your thoughts about various aspects of responsibility.

The interview will be tape-recorded and will then be transcribed by the researcher. The interview information will be stored on a computer to enable analysis of the data. Once this has been completed the results will be incorporated into the thesis document as part of the requirements towards a PhD. Parts of the thesis material may also be used in articles for publication.

Your confidentiality is assured. Only the researcher and her supervisors have access to the information you provide in the interview. The transcriptions will not reveal your name or personal details that could identify you. The tapes and other information will be kept in a secure location which will only be accessible to the researcher and her supervisors. All information stored on the computer will only be accessible to the researcher via the use of passwords. Your identity will not be disclosed in any publication or presentation, nor to any other person.

You have the right to:

- Refuse to answer any question(s) and to withdraw from the study at any time.
- Ask questions about the research during the course of the project.
- Examine the information you have provided and amend any part you wish, and to ask that certain information not be used.

Thank you for agreeing to participate in this research.

For further information the researcher and her supervisors can be contacted as follows:

Philippa Miskelly (University of Waikato, ph: 856-2889 ext. 8272) home 823-5752 or email: pam10@waikato.ac.nz).

Dr Judith Macdonald (University of Waikato, ph: 838-4466 ext. 8282) or email jmac@waikato.ac.nz).

Dr Michael Goldsmith (University of Waikato, ph: 838-4466 ext. 6426) or email mikegold@waikato.ac.nz

APPENDIX V

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.....2003

UNDERTAKING ON CONFIDENTIALITY OF RESEARCH

I, Philippa Miskelly am undertaking research for a thesis, as part of the requirements for a doctoral degree in anthropology. I am familiar with and agree to follow the code of ethics of the Association of Social Anthropologists of Aotearoa/New Zealand, and the University of Waikato Human Research Ethics Committee guidelines.

I have informed _____ about the purpose and nature of the research and its possible implications for him/her. I have also informed that he/she may withdraw his/her consent to participate in the research or his/her consent to have information obtained from him/her used in any written reports on this research.

I, Philippa Miskelly, undertake not to show transcripts of conversations or field notes made during this project to any person other than the participant or supervisors unless I have the written permission of the participant.

I, Philippa Miskelly, undertake to respect the anonymity of _____ and not to publish any information gained from these conversations or field notes in a research paper/thesis or in other academic media, except in the form of extracts pseudonymously identified, or in the form of numerical data unless the participant agrees or asks to be identified.

Signed:

Date:

(One signed copy to be given to the participant and one signed copy to be attached to the letter signed by the participant and filed in the confidential file held by the Convenor, Human Research Ethic Committee, Anthropology Department.)

APPENDIX VI

From:

Date:

Address:

.....

To: Director
Anthropology Programme
University of Waikato
Private Bag 3105
HAMILTON

Dear Sir

I have agreed to be interviewed by Philippa Miskelly on aspects of my life/my opinions, particularly in relation to thesis research on 'Patients, Practitioners and Notions of Responsibility: Orthodox and Complementary Medicine'.

I have also agreed that this information may be used by Philippa Miskelly as source material for a written thesis. I understand that no personal names or any other information which would serve to identify myself as a participant will be included in the thesis. I understand that if I wish to request that information supplied by me should be omitted from the body of material collected by the researcher I may do so.

I understand that the thesis is likely to include the use of theory and other research to enable Philippa Miskelly to interpret the significance of any findings arising from her understanding of our discussions.

I understand that the thesis will be read by the thesis supervisors and by an internal and external examiner for the purpose of assessment. I also understand that the thesis, or extracts from it, may be published, but that my anonymity will be respected unless I agree or ask to be identified.

I have received a signed undertaking from Philippa Miskelly regarding the maintenance of confidentiality of any information which she obtains from myself.

Yours sincerely

.....

Participant

Release Letter: Two copies to be signed; one to be retained by the participant, together with a copy of the signed undertaking by the researcher, and the other to be given to the Graduate Committee Convenor to be placed on file.

APPENDIX VII

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..... 2003

.....

Dear

I am a post-graduate student with the Department of Anthropology, University of Waikato. I began my research in 2002 and it falls within a medical anthropology paradigm. My thesis topic relates to both patients and practitioners who combine orthodox and complementary medicine and focuses on ideas about responsibility. I am also interested in the state's responsibilities with regard to the provision of health services within New Zealand and aspects concerning training, qualifications and registration of practitioners.

To ensure that I have collected ideas from a range of patients and practitioners, and to present these in a fair and competent manner, I need to understand more about the ideologies behind the different health providers and especially the relationship between provider and patient. I wonder, therefore, whether I could arrange an interview with you to discuss these matters further.

I enclose an information sheet which contains details about my research, together with copies of consent forms. If you are agreeable to an interview, I would be happy to conduct the interview over the phone at a time convenient to you. I anticipate the interview taking approximately one hour. I would like to tape-record the interview.

If you would like to obtain further details about my research please do not hesitate to contact me. My supervisors can also be contacted as outlined on the information sheet. I can be contacted at home on (07) 823-5752 or at university as per the attached details.

I appreciate that you are no doubt very busy with your practice, and would be very grateful for any assistance you could give me. I will phone over the next few days to see if you are amenable to an interview.

With thanks.

Yours faithfully

Philippa A. Miskelly (Mrs)

APPENDIX VIII

Research Questions – Medical Doctors who use CAM

1. I'm interested in the reasons why you've chosen to utilise both biomedicine and complementary medicine in your medical practice.
2. Could you tell me what aspects of complementary medicine you've adopted?
3. Would you describe to me the training you've undergone and what qualifications you've received?
4. How do you reconcile the philosophical underpinnings of biomedicine with complementary medicine?
5. What about making a diagnosis – do you use an orthodox or complementary approach to this?
6. Who do you think is the 'expert' when it comes to ideas about health – the patient or the practitioner?
7. You no doubt see situations where patients are seeing a number of healers. In these cases, who do you think ends up having ultimate responsibility for their treatment?
8. When it comes to utilizing complementary medicine, what are the main types of problems or conditions that you feel benefit from this?
9. Are there any conditions that you wouldn't use complementary medicine for?
10. What are the demographics of your practice?
11. What do you charge for a consultation?
12. Are there boundaries that CAM practitioners and medical doctors should acknowledge (such as conditions they should/shouldn't treat)? What are these?
13. As individuals, how much responsibility do you think we should take for our own health care?
14. One of the catch-cries that appears in much of the literature surrounding alternative medicine relates to people either taking, or saying they want to take responsibility for their health care. From what you see in your own practice, is there a gap between the rhetoric and what actually happens in the 'real' world?

15. If you believe that patients have to take responsibility for their own health care, what responsibility, as a practitioner, do you take?
16. What are your views on complementary practitioners who don't have an orthodox medical training? Do you think their training is sufficient? Should there be any limitations on the way they practice?
17. And what about the responsibility of non-medical complementary practitioners – should they be any different from people like you?
18. Are you affiliated to any parent body or statutory organization with regard to the complementary medicine(s) you practice?
19. How do you feel about the regulation of complementary medicine? (relating to training, qualifications, medicines etc.).
20. Do you think the present situation needs to be changed?
21. Do you offer an after-hour or emergency service?
22. Do you have any particular religious or spiritual beliefs that you relate to your own views about health?
23. Do you think the State should provide subsidies for patients who use complementary medicine?
24. What other responsibilities do you think the State has towards the health care of its citizens?
25. Any other points you'd like to make?

APPENDIX IX

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o Waikato*

..... 2003

Dr ...

Dear Dr ...

I am a PhD student with the Department of Anthropology, University of Waikato. I began my research in 2002 and it falls within a medical anthropology paradigm. My thesis topic relates to both patients and practitioners who combine orthodox and complementary medicine and focuses on ideas about responsibility. I am also interested in the state's responsibilities with regard to the provision of health services within New Zealand and aspects concerning training, qualifications and registration of practitioners.

In view of the fact that you practice a type of healing utilising both orthodox and complementary medicine I feel you would be able to offer me some valuable insights with regard to my research project, and therefore wonder if I could make an appointment to talk to you.

I enclose an information sheet which contains details about my research, together with copies of consent forms. If you are agreeable to an interview, I would be happy to conduct the interview over the phone at a time convenient to you. I would like to tape-record the interview. I envisage the interview lasting between thirty minutes to an hour.

If you would like to obtain further details about my research please do not hesitate to contact me. My supervisors can also be contacted as outlined on the information sheet. I can be contacted at home on (07) 823-5752 or at university as per the attached details.

I appreciate that you are no doubt very busy with your practice, and would be very grateful for any assistance you could give me. I will phone over the next few days to see if you are amenable to an interview.

With thanks.

Yours faithfully

Philippa A. Miskelly (Mrs)

APPENDIX X

Research Questions – Focus Groups Medical Doctors

1. What does the concept of responsibility with regard to health care provision mean to you as a general practitioner?
 - Doctor-patient relationship
 - Diagnosis
 - Ongoing care
 - After-hours care
2. What expectations do you have of your patients with regard to the concept of responsibility for their health care?
 - Follow advice
 - Diet/exercise/stress
3. With regard to CAM practitioners – should their responsibilities towards health care provision be the same as general practitioners?
 - Provider-patient relationship
 - Diagnosis
 - Ongoing care
 - After-hours care
4. When patients and/or medical doctors use or practice a variety of modalities – who do you think has the ultimate responsibility with regard to their health care?
 - My research shows that patients usually want the ‘buck’ to stop with orthodox care.
 - GP who practice CAM also imply that ‘regular’ GP should be the overall ‘facilitator’ and therefore ‘responsible’.
5. Do you think that CAM providers should be funded by the state?
6. Do you think that CAM providers should be subject to legislation in the same way general practitioners are?
 - Statutory registration
 - Disciplinary procedures/strike off register and then unable to practise
7. Any other points you’d like to raise?

**APPENDIX XI
LETTER TO CAM ORGANISATION**

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The
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24 June 2003

The Secretary
The New Zealand Natural Medicine Association
PO Box 36-588
Northcote
NORTH SHORE CITY

Dear Sir/Madam

I am a research student with the Department of Anthropology, University of Waikato. I am looking at ideas about responsibility in relation to patients and practitioners who use alternative/complementary and orthodox medicine. Further, I am interested in the state's responsibilities with regard to the provision of health services within New Zealand and aspects concerning training, qualifications and registration of practitioners. I am also looking at the impact the Health Practitioners' Competence Assurance Bill may have in relation to many of the alternative and complementary modalities currently practised in New Zealand.

To evaluate the information I am currently collecting in a fair, complete and competent manner, I need to understand the policies and ideologies of the many different providers of health services. I have written to various health practitioner organisations requesting information and would also appreciate any input and guidance that the Association could give me in relation to the following questions:

1. Currently, is there more than one national organisation Natural Health practitioners can be affiliated to? If so, what are the differences between these organisations?
2. Do Natural Health Practitioners have to be affiliated to an organisation in order to be able to practise in New Zealand?
3. I understand that under present legislation in New Zealand there is no specific requirement for Natural Health practitioners to be statutorily registered. Does the Association promote compulsory registration of practitioners and what are the reasons behind this stance?

.../2

4. What sort of training are Natural Health practitioners required to undergo before they can practise in New Zealand?
5. What disciplinary procedures exist in relation to the practise of Natural Health modalities?
6. How enforceable are decisions made in relation to disciplinary matters?
7. What impact will the Health Practitioners' Competence Assurance Bill have in relation to Natural Health practice in New Zealand?
8. Does the Association believe that the government funded patient subsidies should be available for Natural Health consultations?

I am aware that I have asked for quite a lot of information and acknowledge that it may take some time to answer my queries. However I would be very grateful for any help that could be given to me. If it is more convenient to email responses to me, or if further information is required, my email address is pam10@waikato.ac.nz. Also, I can be contacted by phone on 07 823-5752. If I'm supplied with a contact name and phone number I am more than willing to phone the Association at a convenient time to discuss these matters further.

In anticipation, I look forward to your assistance.

With thanks.

Yours faithfully

Philippa Miskelly (Ms)
B.Soc.Sc. [Hons]

APPENDIX XII

APPLICATION FOR ETHICAL APPROVAL

**THE UNIVERSITY OF WAIKATO
ANTHROPOLOGY PROGRAMME
HUMAN RESEARCH ETHICS COMMITTEE**

1. **Name of Researcher:** Philippa Miskelly
2. **Department:** Anthropology
3. **Researcher(s) from off campus:** I will be the only researcher involved in this project, therefore no researchers from off campus will be participating.
4. **Title of Research Project:** Patients, practitioners and notions of responsibility: orthodox and complementary medicine
5. **Status of Research Project:** PhD
6. **Funding Source:** This research project is being undertaken for the sole purpose of completing a PhD and is not funded by any organisation.
7. **Name of Supervisors:** Dr Judith Macdonald
Dr Michael Goldsmith
8. **Description of Research Project:**
 - a) **Justification in academic terms**

As outlined in my initial thesis proposal (attached), the main aim of this research project is to ascertain that, when individuals choose to use both complementary and orthodox medicine, who do they ultimately expect to take responsibility for their health care. Current research has indicated that people are using both orthodox and complementary practitioners, and it has been perceived, especially by the orthodox medical community, that this mix-and-matching of therapies is occurring because people perceive “conventional medicine is lacking in some way”¹. This thesis hopes to uncover who, in demographic terms, uses both complementary and orthodox medicine and if these people expect similar levels of responsibility from those who treat them. As outlined in my proposal, this study is important especially in relation to the question of responsibility. There has been much discussion within contemporary New Zealand society about questions relating to responsibility (not only within the health sector, but also education, justice, economic policies and so on) and it is hoped that through this research a deeper understanding will be gained in

¹ White, P. 2000 What can general practice learn from complementary medicine? *British Journal of General Practice*, 50(459) p.821-823, p.821.

relation to what people expect of health practitioners, and whether in fact these expectations are realistic. This research project will also attempt to gain the perspectives of both orthodox and complementary practitioners.

b) Objectives

As outlined in the attached Initial Thesis Proposal, the main objectives of the research project will investigate four main areas:

- (1) Who has the ultimate responsibility for our health care: the individual, orthodox or complementary practitioners?
- (2) The qualifications, legal obligations and ethical standards of orthodox and complementary health practitioners.
- (3) A demographic analysis of individuals using both complementary and orthodox medicine, and their reasons for using both types of medicine.
- (4) To discover whether there is a gender bias related to people using both complementary and orthodox medicine.

It is envisaged that other issues relating to the research topic may be uncovered during the course of the face-to-face interviews and literature review, and if feasible, some of these may also be investigated.

c) Procedures for recruiting participants and obtaining consent

It is proposed to interview 20 people who use both complementary and orthodox medical practitioners; 2 orthodox medical practitioners; 2 complementary practitioners and 2 practitioners who combine both types of medicine within their practices. Because the research is only in its infancy, detailed copies of information that will be given to prospective candidates and consent forms have not yet been prepared. These will be made available to the Ethics Committee prior to any interviewing being undertaken. At this stage it is envisaged that the line of questioning will cover areas as follows:

Individuals using orthodox and complementary practitioners

- (i) A demographic profile.
- (ii) The types of medical practitioners patients have consulted, the reasons for the consultations and the number of visits made over the past year.
- (iii) Patients' views on the practitioners consulted.
- (iv) Expectations of practitioners and their treatments.
- (v) Expectations of practitioners' training and qualifications.
- (vi) Views relating to responsibility for health care.

Orthodox and Complementary practitioners

- (i) A demographic profile.
- (ii) Training and qualifications.
- (iii) Type of medicine practised.
- (iv) Views on patients' expectations of medical care.
- (v) Views on orthodox/complementary medicine – its benefits and disadvantages.
- (vi) Views relating to responsibility for health care.

The individuals who use both orthodox and complementary medicine will be recruited, initially (if approval is granted by shop-owners and practitioners) by way of responses to advertisements placed in health shops, community newspaper bulletins and the waiting rooms of medical doctors and complementary practitioners. It is also anticipated that respondents may be located through indirect association with colleagues and/or friends. Once an initial number of respondents have been found a snowball sampling technique will be used to locate up to twenty individuals.

In relation to the practitioners themselves, initially telephone contact will be made with a number of individual practitioners requesting their participation in the research project.

Once a person has agreed to be interviewed they will be sent a formal letter detailing an outline of the research project. Also included in this letter will be information relating to the taping of the interviews, storage of material, privacy and confidentiality matters and the name and contact details of the researcher's supervisors. Participants will also be advised that they are able to withdraw from the research at any time, and can also request information be withdrawn at any time before completion of data collection.

At the actual interviews the purpose of the interview will be fully explained to the respondents and the researcher will undertake that all person details (such as name or other singularly identifying features) will remain confidential. The respondents will be requested to read and sign a copy of the Consent Form prior to the interview starting. If a participant declines to sign the Consent form then the interview will not proceed. If a participant, at any stage throughout the interview, requests to stop the interview, then their request shall be accepted.

d) Procedures in which participants will be involved

Participants will only be involved in a face-to-face interview with the researcher. The interviews are expected to last between one hour and one and a half hours. Participants will also be asked if they can provide the name(s) of other possible research participants. As outlined above, participants will also be asked to sign a consent form.

Participants will also have the general purpose of the research explained to them. It is to be stated that research findings will be published in the form of a PhD thesis and the researcher will ensure that participants will not be identified in any publication or dissemination of research findings.

9. Procedures and timeframe for archiving data:

Once the thesis has been completed and marked, information containing identification details of respondents will be destroyed. All remaining data will be archived in a locked cabinet at the researcher's home.

10. Procedures and timeframe for storing and maintaining confidentiality of personal information:

During the period of the research project, tapes and transcripts relating to the face-to-face interviews, together with information recording personal details of the respondents, will be stored in a locked filing cabinet in the researcher's office at Waikato University. This office is also locked. Access will only be available to the researcher and her supervisors.

Following interviews, the researcher will transcribe the material verbatim. However, proper names or information that may identify individual respondents will not be included. Pseudonyms will be used to protect respondents' privacy and also the identity of those persons they may talk about during the interview.

The researcher will not disclose to anyone, other than her supervisors, details concerning respondents and those people they may refer to during the interviews.

Once the thesis has been completed, as stated above, data that could identify respondents will be destroyed and all research material stored in a locked cabinet at the researcher's home.

11. Ethical and legal issues:

a) Access to participants. The researcher will initially place advertisements as outlined above and any responses will firstly be made by telephone. The researcher will follow up contacts with a formal letter outlining the nature of the research project and detailing information about the confidentiality of the interviews and the name and contact details of her supervisor. Participants that are found through snowballing will be contacted by telephone and, if they agree to participate, then they too will be sent a formal letter and procedures followed as described above. In relation to the practitioners, it is envisaged that initial contact will be made by telephone and the same procedures as above will be adhered to. Because the researcher has some contacts within the medical profession, it is believed that participants for this section of the interview process will not be too difficult to locate.

Interviews will occur in a place nominated by participants, and it is envisaged this will be either their home or work place.

b) Informed Consent. Participants will be fully informed as to the object of the research and reasons for the interview, and will be requested to sign a Consent Form immediately prior to the interview (one signed copy to be kept by the researcher, one by the participant). If these forms are signed, it will be deemed that informed consent has been obtained.

c) Potential harm to participants. While being aware publication of details such as respondents' (both patients and practitioners) names, occupations, medical conditions, views on medical practitioners they have visited - and their treatments, or practitioners' views about their patients and treatment could harm participants, it is contended that by not revealing personal details about participants and strictly controlling who has access to the tape-recordings and consent forms, no harm should arise. If participants become upset during the interview because of their experiences

in relation to the research topic, the researcher will endeavour to put them in contact with an appropriate person/organisation for follow-up if the participant wishes this to occur.

d) Publication of findings. This research project is being carried out in order to complete a PhD, therefore the completed transcript will be printed and available for scrutiny and marking. If the completed thesis is successful, a copy will be held in the Anthropology Department and Library of the University of Waikato. The researcher may also publish findings to this research topic in other publications together with conference papers and proceedings.

e) Conflict of interest. The researcher is not receiving remuneration for this research project. The researcher does not hold any positions, paid or otherwise, which may affect the impartiality of her research findings.

f) Intellectual and other property rights. The completed thesis remains the property of the researcher. However, all resources used in the research project will be acknowledged.

g) Intention to pay participants. The researcher has no intention of paying participants for taking part in the research project.

h) Any other ethical or legal issue: continuing ethical guidance. The researcher proposes to consult regularly with the Anthropology Programme Human Research Ethics Committee as the research progresses and remains committed to adhering to best practice.

12. Ethical Statement:

As a researcher, I will abide by the University of Waikato Regulations for Researching Involving Human Participants and the Association of Social Anthropologists of Aotearoa/New Zealand Code of Ethics and Ethical Procedures.

Signed: *P.A. Miskelly*
Philippa A. Miskelly

Date: 18.06.02

APPENDIX XIII

**ETHICAL APPROVAL
INTERNAL MEMORANDUM**

Anthropology Programme

To: Philippa Miskelly
From: Keith Barber
Date: 21/6/02
Re: Ethics Application

We have approved your application for ethical approval for the research titled Patients Practitioners and Notions of Responsibility: Orthodox and Complementary Medicine and you may now proceed with the research. We wish you well with it.

K Barber (signed)

Approved

M. Goldsmith (signed)

(Michael Goldsmith,
Director, Anthropology)

Appendix XIV

CAM Practitioners Interviewed

Pseudonym	Gender	Therapy(s)	Qualifications	Affiliations
Lorna	Female	Medical Herbalist; Naturopath; Massage; Iridology; Reflexology	Dip.Holistic Pulsing; Dip.Massage; Dip.Naturopathy; Dip.Herbal Medicine	Assoc. of Medical Herbalists; Assoc. of Natural Therapies
Margaret	Female	Medical Herbalist; Massage; Reflexology; Iridology; Bach Flowers; Diet & Nutrition	MSc; Dip. Herbal Medicine;	Assoc. of Medical Herbalists; NZ Charter of Health Practitioners
John	Male	Osteopath	Dip. Natural Therapies; Dip. Osteopathy; Graduate Dip. Clinical Osteopathy (Melbourne)	NZ Register of Osteopaths*
Hugh	Male	Osteopath	Bachelor of Osteopathy	NZ Register of Osteopaths
Steven	Male	Osteopath	Dip. Osteopathy	NZ Register of Osteopaths
April	Female	Massage; Homeopathy; Bowen therapy	Dip. of Proficiency in Bowen Therapy; Dip.Homeopathy	Bowen Academy; affiliated to a massage 'body'***
Joseph	Male	Physiotherapist/ Homeopathy; Bowen therapy	BA (physiotherapy); Dip.Homeopathy	NZ Council of Homoeopathy
Glenda	Female	Nurse; Bioptron Light Therapy (has also practiced massage; herbalism; Bach Flower remedies	NZRN; Dip.Herbal Medicine	NZ Charter of Health Practitioners

* Joined Register as at 18 September 2004

** This participant was vague about which practitioner bodies she was affiliated to.

Appendix XV Dr-CAM Practitioners Interviewed

Pseudonym	Gender	Therapy(s)	Qualifications	Affiliations
Julian	Male	General Practice*; Mind-Body Medicine**	MRCS (Eng); LRCP (Lond); FRNZCGP	Association of Medical Herbalists; Association of Natural Therapies
Peter	Male	General Practice, Anthroposophical Medicine	MB.ChB; DCH: FRNZCGP; Masters in General Practice***: 15- 18 month course overseas in complementary therapies	European organization for Anthroposophical Doctors; NZ Anthroposophical Doctors Assoc.
Ernest	Male	General Practice, Chelation Therapy, Nutritional Medicine****	MB.ChB; FRNZCGP	
Brian	Male	General Practice, Acupuncture, Homeopathy, Herbal Medicine, Chelation Therapy, Bio-energetic Medicine, Manipulative Therapy, Chinese Medicine, Ayurvedic Medicine	MB.ChB; Diploma in Obstetrics; FRNZCGP;	Registered Medical Acupuncturist, Medical Naturopath & Homeopath, Registered Medical Acupuncturist NZ, Registered Japanese Acupuncturist
Bob	Male	General Practice; Acupuncture; Chinese medicine; Nutrition; Mind- Body Medicine	MB.ChB; Dip. Obst; FRNZCGP; Formal training in classical acupuncture (UK)	Medical Acupuncture Society; Japanese Acupuncture Association
Fran	Female	General Practice; Homoeopathy	MD (Canada); Degree in Counselling; FRNZCGP; Homoeopathic training	Australasian College of Nutritional & Environmental Medicine (ACNEM)

* All doctors interviewed were on the NZ Medical Council Register and listed as general practitioners. However some of these participants said they did not tend to use a biomedical approach in their daily practice (eg: prescribing orthodox medications) but certainly utilised their medical training with regard to ensuring no underlying serious pathology existed when considering a diagnosis.

** Has also practiced acupuncture and developed strong interest in Chinese medicine.

*** This participant was completing his Masters degree at the time of interview.

**** The first 'alternative' therapy this participant practiced was acupuncture and he has developed an interest in a wide range of therapies that include treatments for neck and back pain, ME and chronic fatigue problems and digestion problems.

Appendix XVI

Orthodox General Practitioners* Interviewed

Pseudonym	Gender	Qualifications
Scott	Male	MB.ChB; FRNZCGP
Andrew	Male	MB.ChB; Dip. Obst.
Ravi	Male	MB.BS (India)
Cynthia	Female	MB.ChB; FRNZCGP
Alison	Female	MB.ChB (GB); FRNZCGP
Sunita	Female	MB.ChB; FRNZCGP
Jeanette	Female	MB.ChB; FRNZCGP
James	Male	MB.ChB; Dip. Obst; FRNZCGP
Simon	Male	MB BCh (Sth Africa); FRNZCGP

* All doctors interviewed were on the NZ Medical Council Register and listed as general practitioners.