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UNIVERSITY OF SOUTHAMPTON

Faculty of Medicine, Health and Life Sciences

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A grounded theory study of homeopathic practitioners'
perceptions and experiences of the homeopathic
consultation

By

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Thesis for the degree of Doctor of Philosophy

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ABSTRACT

FACULTY OF MEDICINE, HEALTH AND LIFE SCIENCES

SCHOOL OF MEDICINE

Doctor of Philosophy

**A GROUNDED THEORY STUDY OF HOMEOPATHIC
PRACTITIONERS' PERCEPTIONS AND EXPERIENCES OF
THE HOMEOPATHIC CONSULTATION**

By Caroline Eyles

The apparent success of homeopathy is often attributed to a collaborative, holistic and empathic consultation and to the practitioner patient relationship. However most research into the homeopathic consultation has focussed on patients' experiences although the practitioner is a crucial component of the therapeutic context and may have an important part to play in optimising health outcomes in homeopathy. Therefore the aim of this research was to gain an in depth understanding of homeopathic practitioners' perceptions and experiences of the consultation. An additional aim was to generate a theoretical model to explain the processes that underpin the homeopathic consultation.

A qualitative approach was taken using constructivist grounded theory methodology employing a process of two phases of data collection. Medical and non medical homeopaths were sampled from the registers of the Faculty of Homeopathy and the Society of Homeopaths. Phase 1 involved face to face in-depth interviews with homeopaths. From these interviews a theoretical model of the homeopathic consultation was developed. Phase 2 of data collection involved observations of homeopathic consultations and the use of solicited practitioner reflective diaries in order to confirm, refute or enlarge on the model which developed from phase 1.

The emergent theoretical model entitled "a theoretical model of a UK classical homeopathic consultation" describes how homeopaths view and enact the consultation process. The findings indicate that the consultation consists of processes which are interlinked and dependent on each other. I have labelled these processes *exploring the journey together*, *finding the level*, *responding therapeutically* and *understanding self*. Central to these processes is the core category which I have labelled *connecting*.

This study has highlighted that the whole process of the homeopathic consultation is important and aspects that are unique to homeopathy such as the process of identifying and matching the homeopathic remedy cannot be separated from the rest of the consultation and must be considered as part of the whole process. Additionally the ritualistic and symbolic aspects of the consultation that are embedded in this process are of paramount importance and provide meaning, highlighting the power of the consultation to promote beneficial effects for the patient. This research has implications for all stakeholders and signals many future avenues for research.

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Declaration of Authorship

I, Caroline Eyles declare that the thesis entitled:

A grounded theory study of homeopathic practitioners' perceptions and experiences of the homeopathic consultation.

and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- This work was done wholly while in candidature for a research degree at this University;
- Where I have consulted the published work of others, this is always clearly attributed;
- Where I have quoted from the work of others, the source is always given. I have made clear exactly what was done by others and what I have contributed myself;
- None of this work has been published before submission

Signed:

Date:

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Chapter 1 Introduction and background

1.1 Introduction and outline of thesis

I qualified as a homeopathic practitioner in 1990 and since then have been in private practice. I also teach homeopathy and supervise students who are undergoing supervised case taking practice. I was particularly interested in the homeopathic consultation as my clinical teaching activities lead me to closely examine how I conducted a consultation and the process of it. My interest in research into complementary and alternative medicines (CAM) began when I was doing a Masters degree in Health Education and Health Promotion. It was whilst I was doing my research dissertation, when I explored social support networks and emotional exhaustion in homeopaths, that I realised that research into CAM and particularly the homeopathic consultation from the perspective of the practitioner was scarce.

This thesis describes the background, methodology, methods and findings of research into homeopathic practitioners' experiences and perceptions of the homeopathic consultation. Embedded in this investigation is a reflexive process which describes my development from homeopathic practitioner to practitioner researcher. This chapter will explore background information on the homeopathic consultation; initially the following section provides an outline of the chapters that construct this thesis.

Chapter 1 presents background information to the thesis, beginning with an introduction to my background as a homeopathic practitioner and how this led me to research the homeopathic consultation. Homeopathy and its key principles are then described followed by a discussion that outlines the major paradigm differences between homeopathy and conventional medicine. Contemporary problems that affect research into homeopathy are then considered illustrating how research often focuses on the efficacy of the homeopathic remedy, and largely ignores the process and context of homeopathy as a treatment. As there is scant literature that describes the process of the homeopathic consultation I have described the consultation from my perspective and also outlined training methods for homeopaths in the United Kingdom. I have subsequently reviewed the literature on the homeopathic consultation concentrating on the therapeutic relationship and the concept of holism. The end of this chapter outlines the aims and the specific questions to be answered by this research.

Chapter 2 addresses the research questions that arose out of the background chapter and describes the selection of methodology. This discussion initially starts with a debate on how

the research questions are best answered with qualitative research methods. Following on from this I have justified the use of a constructivist grounded theory approach to data collection and analysis as this investigation was focussed on the process and context of the homeopathic consultation. A discussion on how rigour was maintained throughout this study is followed by an explanation of reflexivity and the challenges that this presented for me as a homeopathic practitioner and how I have addressed issues of assumptions and preconceptions.

Chapter 3 sets out to describe the methods of data collection that I have used, whilst addressing the principles of grounded theory. In this chapter I discuss how I collected the data by conducting interviews with the homeopaths and then subsequently observed homeopathic consultations and asked homeopaths to complete reflective diaries. Included in this is a discussion describing the many challenges that presented themselves to me, for example, as a homeopathic practitioner interviewing and observing other homeopaths. Issues that arise at each stage of the research such as sampling decisions and ethical considerations are also discussed.

Chapter 4 presents a discussion on my methods of data analysis. Here I have shown how I analysed my data by presenting some examples of the processes that I underwent to arrive at my conclusions. This includes showing how I developed my initial codes and subsequently my categories and how the core category finally emerged. Following on from this I have also illustrated how a *theoretical model of a UK classical homeopathic consultation* developed from the initial coding and category formation.

Chapters 5 to 9 are the five findings chapters. Each of the categories that emerged from the data and how they collectively constructed the theoretical model are presented. Each chapter will discuss a category and show how it developed and the concepts that they encompass. Data from the interviews, observations and the diaries was used to illustrate this and relevant literature was used to exemplify and interpret the categories. Additionally memos are also used to show how I have interacted with and interpreted the data.

Chapter 10 is the final chapter and is a discussion and conclusion to this thesis. This chapter presents a *theoretical model of a UK classical homeopathic consultation* with a description of its variations and limits. This chapter also discusses how the model builds on previous research whilst also revealing aspects of the homeopathic consultation that are common to other medical consultations and aspects that are specific and unique to homeopathy. The role of symbols and rituals in the consultation is explored within the perspective of symbolic interactionism, which leads to a discussion of how the placebo argument can be reframed

within a homeopathic perspective. A review of the study follows with a conclusion and the implications of this research with recommendations.

1.2 Introduction to the homeopathic consultation

Homeopathy is a popular CAM and concerns surrounding the lack of information about CAM and its practice have stimulated a need for high quality research in all CAM areas. This is necessary in order to ensure that the treatments that the public are accessing are safe, that the efficacy of different therapies can be proved and that their cost effectiveness can also be established (House of Lords 2000). Despite homeopathy's popularity with the general public (McDade 2008; Samarasekera 2007; Thomas, Nicholl, & Coleman 2001) homeopathy has struggled to gain legitimacy within the medical and scientific communities (Goldacre 2007; Horton 2005). Largely due to funding issues and a political need to meet scientific credibility research into homeopathy has mainly focused on using experimental methodology to investigate its evidence. This principally consists of published reports of RCTs, systematic reviews of RCTs and meta-analyses of RCTs and reviews of systematic reviews. These essentially report on the efficacy of the homeopathic remedies tested against placebo. A handful of these trials have compared homeopathic medicine to orthodox treatment and thus provided information on the comparative effectiveness of homeopathic medicines (Dean 2004). However this evidence does not take into account the effect that the practitioner, and the relationship that they have with their patient, has on the treatment. As such aspects of the whole homeopathic practice and process such as the practitioner patient relationship have been ignored despite evidence that the practitioner's consultative style can have a considerable effect on treatment outcomes (Ong, de Haes, Hoos, & Lammes 1995). In addition, there is also a large body of observational evidence of treatment by homeopaths which has been reviewed (Chanda & Furnham 2008b) consisting of studies of groups of patients and single case studies. The effectiveness of homeopathy in terms of patient and practitioner assessment in these studies was generally high. However, as Chanda & Furnham (2008b) note, although this type of evidence does acknowledge the homeopath's contribution to these outcomes it is subject to substantial biases.

Homeopathy has been termed a complex intervention in recognition of its multiple components (Bell 2005) such as the efficacy of the remedy, the patient's expectations and beliefs, the practitioner's consultation style and the relationship between the patient and the practitioner. There is generally a dearth of literature, especially exploring my area of interest which is the relationship between the patient and practitioner in the homeopathic consultation and the role of the practitioner within that relationship. The recognition that the

consultation is an integral feature of homeopathic treatment has stimulated a shift in focus within the research field to addressing alternative questions about how to research complex interventions.

The rest of this chapter will be concerned with a brief exploration of contemporary problems in CAM research. The homeopathic consultation will then be described from my perspective as a homeopath, leading onto a review of the literature on the homeopathic consultation. Initially however a discussion on the nature of homeopathy and its central principles will be examined by contrasting it with the biomedical model. This is necessary as some homeopathic practitioners are medically trained and others are not, which means that that they enter the profession from differing perspectives and with different training. These different perspectives may impact on the way that the consultation is conducted.

1.3 Homeopathy and its key Principles

Homeopathy is a form of complementary and alternative medicine in which an individualised remedy is deduced during the course of a therapeutic consultation.

Homeopathy can be defined as a holistic system of medicine that aims to assist the natural tendency of the body to heal itself. Homeopaths recognise that all symptoms of ill health are expressions of disharmony within the whole person and that it is the person who needs treatment and not the disease. The holistic approach to medicine takes a wider view of illness, the causes of disease and the ways in which people express their illness individually. Homeopaths do not treat physical, emotional, mental or spiritual illnesses separately, but regard them as intimately connected, since all are aspects of the whole patient's suffering.

Compared to other holistic medicines such as acupuncture, homeopathy appeared on the medical scene relatively recently. Unlike acupuncture which has its roots in an eastern tradition of healing, homeopathy and conventional orthodox medicine both emerged from the Hippocratic tradition of Western medicine. Homeopathy as a system of medicine was developed by Christian Friedrich Samuel Hahnemann (1755 - 1843) a German physician. Hahnemann first coined the word Homoeopathy¹ from the Greek; "Homois" meaning similar and "pathos" meaning suffering. The word homeopathy refers to the first principle of

¹ The word homoeopathy, often because of the lack of proper type on the part of type setters to produce a diphthong (a joined oe), has become "Americanised" to homeopathy. For the sake of consistency I have used the more up to date and common spelling of the word – homeopathy.

homeopathy, which is called the “law of similars”. From this initial development Hahnemann then expanded his system further to develop the key principles of homeopathy. The law of similars is the most important principle of homeopathic prescribing. It states that the symptoms caused by taking too much of a substance are the symptoms that can also be cured with a small dose of that substance (treating like with like). However many of the substances in use were highly toxic so he experimented to reduce side effects of these substances. He found that by repeatedly diluting the remedies he could eradicate any side effects of the medicines. He also discovered that the vigorous shaking of the remedies (which he called succussion) increased the potency (or strength) of the remedy. He called this process of dilution and succussion, potentisation (see Appendix 1, for an explanation of the preparation of homeopathic remedies). Hahnemann experimented on himself and healthy volunteers by repeatedly taking small doses of diluted substances and meticulously recording the symptoms that appeared; he called this method of testing substances, provings. The results of the provings are collected in homeopathic reference texts called materia medicas (or materials of medicine). He believed that only one remedy at a time should be given in the smallest dose possible; this opposed the current medical practice whereby apothecaries tended to dispense concoctions of multiple medicines in high doses. This process of prescribing small amounts of diluted substance as a remedy is another principle of homeopathy which homeopaths refer to as the minimum dose or the infinitesimal dose. Hahnemann proposed that symptoms were elicited from the whole person, and that information is gathered from all levels of the person; mentally, emotionally and physically. These symptoms represent “the totality of the person” and are matched with a remedy ensuring that the individuality of the person is then taken into account. Hahnemann also promoted an immaterial vitalistic view of disease which proposed that vital forces (an animating life force within living beings) are active in living organisms so that life cannot be explained by physical mechanisms alone.

1.4 Differences and similarities between homeopathy and medicine

Although these central principles distinguish homeopathy from conventional medicine, it is the final principles of holism and vitalism which provides a major paradigm difference to mainstream conventional medicine (Coulter & Willis 2004). Vitalism stems from the theory or doctrine that life processes arise from or contain a nonmaterial vital principle and cannot be explained entirely as physical and chemical phenomena. Vitalism is a concept that is found in Eastern and Western medicine traditions. In the Western tradition vitalism was

associated with Hippocrates who identified vital forces which he called the humours. The role of vitalism was eventually challenged in Western medicine when the microscope enabled the development of the germ theory. This resulted in a better understanding of the human body and the concept of vitalism became consigned to the past (Rhodes 1985). However many homeopaths today still recognise that vitalism is an essential principle of homeopathy and refer to the animating life force within living beings as the *vital force* (Vithoulkas 1980). This vitalistic approach affects many areas of a homeopath's practices, such as their outlook on health and disease, their prognosis of the patient's condition and their responsiveness to homeopathic treatment. Additionally it affects the treatment that may be given such as the remedy and potency prescription.

Central to the philosophy and practice of CAM is the notion of holism. CAM practitioners identify holism as an important central theme of their therapies and contrast it with conventional medicine (Barrett, Marchand, Scheder et al. 2003). Holism is associated with treating the whole person, body, mind, emotions and spirit within the context of their environment facilitating the body's innate ability to self heal (Paterson & Britten 2008). It also presumes a participatory relationship between practitioner and client which generates hope and empowerment (Long, Mercer, & Hughes 2000). In contrast to this modern medicine draws its roots from Cartesian Dualism (Rene Descartes 1596-1650) which assumes that mind and body can be treated separately. Explanations of disease became more reductionist as the focus was on biological changes to the neglect of social and psychological factors (Rhodes 1985). Inherent within the dualistic and reductionist philosophy was a mechanistic and materialistic approach to the treatment of the body, which hypothesised that all natural phenomena can be explained by physical causes and that the body was to be viewed and fixed as a machine. This view has led to a conventional biomedical consultation where the focus is on the presenting complaint, largely disregarding other factors, with the aim of providing a drug or specific medical treatment.

Although vitalism and holism provided a major paradigm difference between conventional medicine and homeopathy, it was the practice of diluting remedies that initiated the marginalisation of homeopathy from conventional medicine (Wootton 2006). It is the extreme dilution of the remedies that causes the most controversy and is responsible for scientists to still refer to any clinical effect from homeopathic treatment as a placebo effect. This label was attached to homeopathy soon after its discovery and is still the subject of an ongoing debate where there are both positive systematic reviews of homeopathy demonstrating that homeopathy has effects above and beyond placebo (Boissel, Cucherat, Haugh, & Gauthier 1996; Cucherat, Haugh, Gooch, & Boissel 2000; Kleijnen, Knipschild, &

ter Riet 1991; Linde, Clausius, Ramirez et al. 1997; Linde & Melchart 1998) and negative reviews that conclude that any clinical effect of homeopathy are simply due to a placebo effect (Shang, Huwiler-Muntener, Nartey et al. 2005).

From this background homeopathy developed with many divisions within its community which has manifested in different styles of homeopathic treatment. A principle division was between the “classical” and the more clinical approaches. The “classical” individualised whole person approach proposed by Hahnemann requires an in depth consultation with the patient and tends to be adopted by many non medical practitioners and some medical homeopathic practitioners. The more clinical standardised treatments for certain conditions which required a more medical approach, tend to be adopted by medical practitioners. As a result of this other divisions came, for instance concerning potency choice (see Appendix 2), and method of practice (see Appendix 3). Additionally when Hahnemann first proposed his system of medicine his focus was on a type of consultation that required an objective approach. Practitioners were expected to be the “unprejudiced observer” of their patient and to collect their patient’s symptoms in a methodical and systematic manner. There are now many versions of “classical” homeopathy which run on a continuum of maintaining an objective Hahnemannian stance to a more psychodynamic consultation where the spiritual and emotional symptoms take precedence and are fully investigated, and the subjectivity of the practitioner is a tool in the consultation rather than something to be avoided. These many interpretations of homeopathy which sometimes contradict each other have led to schism and dissent both within the field, and for those outside of the field, (Dean 2004; Vithoulkas 2008). Consequently this has resulted in many different types of homeopathic consultation due to either difference in training, previous clinical experience and also the nature of the practitioner. This raises many questions about the nature of the homeopathic consultation and how it is practiced. Questions also arise concerning the training of the practitioners and whether the divisions mentioned are reconciled during training. Additionally the question of whether the practitioners are prepared during their training for dealing with what is a complex interpersonal consultation is also raised.

These questions highlighted here demonstrate that little is known about the practice of homeopathy and the homeopathic consultation. Homeopathy is a complex intervention and its many multiple components, for example, the role of the practitioner, may each affect outcomes. Additionally the paradigm differences between homeopathy and conventional medicine of vitalism and holism imply that there may be fundamental differences in the approach to the consultation style and the relationship between the patient and practitioner. These issues have implications for how homeopathy has been researched and for the future

approach to homeopathy research. Until recently research into homeopathy has focussed on the question, does homeopathy work? The evidence for the effectiveness of homeopathy has included two areas of research:

1) Studies looking for biological effects from potencies especially ultra-high dilutions. Recently a rigorous European multisite laboratory study on high dilutions of histamine found that they exerted an effect on basophil activity *in vitro* (Belon, Cumps, Ennis et al. 2004). A systematic review of *in vitro* research into the effects of high dilutions concluded that many of the studies reviewed were of high quality and demonstrated effects of high potencies. Some of the studies in the review had been successfully replicated (Witt, Bluth, Albrecht et al. 2007).

2) Studies of the efficacy of homeopathic remedies for particular clinical conditions. Many randomised placebo controlled trials (RCT's) have assessed the efficacy of homeopathy in single medical conditions. The evidence for homeopathic remedies being more effective than placebo is mixed (Jonas, Kaptchuk, & Linde 2003). However when high quality studies have been selected for analysis (such as those with adequate randomisation, blinding, sample size and other methodological criteria that limit bias) a number show positive results (Kleijnen et al. 1991; Linde et al. 1997). Moreover in a prospective observation study to evaluate the usefulness of homeopathy in the real world clinical setting of primary care, homeopathy was found to be at least as effective as conventional medicine (Riley, Fischer, Singh et al. 2001).

However, the strengths and limitations of the use of RCT's to assess the efficacy of CAM have been widely debated. The limitations of RCT's can be categorised as either practical or methodological in nature.

1.5 Contemporary problems in CAM research

The practical challenges facing RCTs in CAM research include inadequate research infrastructure and inadequate funding for research. One of the main practical challenges has been that clinically orientated CAM research does not always research CAM as practiced in a real life clinical situation, but rather is research into some of the “tools of the trade”, such as the remedy in homeopathy. For example the efficacy of a remedy may be tested rather than the whole treatment effect in a natural setting (Cohen 2007). Criticism of the use of RCTs for research into homeopathy was discussed by Weatherley-Jones et al (2004) who suggested that follow up consultations of patients taking part in a RCT may be hampered by

the use of placebo, as the homeopaths do not know if change or lack of change of symptoms may be due to the patient receiving placebo or being on a remedy that is not working. Additionally Bell et al (2004) identified that an increased number of remedies were prescribed by homeopaths treating the placebo group compared to the active treatment group. More studies are needed to confirm or refute this proposal.

There are many methodological challenges facing RCT CAM research. One of the main issues is concerned with the differences in philosophy and paradigm between many CAM therapies and conventional medicine (Mason, Tovey, & Long 2002) because the RCT is based on a reductionist approach, whereas CAM embraces a highly individualised holistic approach to treatment (Thompson 2004). In addition the value of examining the specific effects of a therapy (the remedy) as separate to the non specific effects (the effects from the practitioner patient relationship etc) of a therapy has been questioned. For example, it has been proposed in homeopathy that the specific and non specific effects may interact rather than just being an additive effect of the homeopathic intervention (Weatherley-Jones, Thompson, & Thomas 2004). This view is reiterated in Paterson & Dieppe's (2005) observations on acupuncture research. Additionally RCT's only address whether an intervention works but do not address the process of how it works and the context in which it works best (Verhoef & Vanderheyden 2007).

These and other challenges can be addressed though by thoughtful design in the application of RCT method investigating CAM, for example, the use of pragmatic approaches (Pirotta 2007) and by combining RCT's with qualitative methods (Verhoef et al. 2007). In order to fully understand a CAM intervention research must address the separate components of it whilst allowing the system to remain intact because of synergy between the different components (Verhoef et al. 2007). CAM whole systems research (WSR) is an emerging research framework specifically designed for the investigation of the effectiveness of complex interventions which have many varied components. Verhoef et al (2004) provide a definition of WSR research that:

- Encompasses the investigation of both the processes and the outcomes of complex interventions
- Includes all aspects of any internally consistent approach to treatment (philosophical basis, patients. Practitioners, setting of practice, methods and materials)
- Acknowledges unique patient, family, community and environmental characteristics and perspectives

The aim therefore is to employ appropriate research designs and methods so that all the components of the therapy can be assessed within the framework (Verhoef, Lewith, Ritenbaugh et al. 2005). This WSR framework differs from The Medical Research Council's (Medical Research Council 2000) sequential framework for evaluating complex interventions which does not address the philosophical issues, individualised treatment packages or allow for the evaluation of the context of an intervention.

Although homeopathy has many differences to medicine it has been researched within a biomedical paradigm so that research has focussed on the question of whether homeopathy works but has largely ignored the question of how homeopathy works. The process and context are fundamental to effective treatment and positive outcomes (Verhoef et al. 2007). The process and context of a therapy refer to components such as the relationship between the patient and practitioner, expectations and how an intervention is delivered. The therapists' contribution to these components can only be understood by exploring the consultation in depth from the practitioners' perspectives.

1.6 The Homeopathic Consultation

Although in homeopathy there are hundreds of books referring to the homeopathic materia medica there are only two books which refer to the complexities of the homeopathic consultation and some of the processes that occur within it (Kaplan 2002; Owen 2007). Therefore in this section I will describe from my perspective as a classically trained non medical homeopath what happens in a homeopathic consultation and subsequently relevant literature will also be discussed to show what is known about the homeopathic consultation.

The homeopathic consultation is a lengthy process compared to a conventional medical consultation. The first consultation for a new patient can vary from 20 minutes (for some medical homeopaths) to 1½ hours (for a non medical homeopath). Initially a typical consultation allows the patient to tell the story of their illness with as little interruption as possible. The intention is to understand the patient's subjective and objective experience of their illness. The homeopath not only listens to every word but also to the tone of voice in which it is expressed as it is not only the content of what the patient says that is important but the way it is presented and their body language is also of value (Kaplan 2002). The practitioner may prompt for the following type of symptoms if they are not readily given by the patient:

- Mental, spiritual and emotional symptoms:

For example: fears, anxieties, anger, grief, confusion, memory issues, relationship issues and spirituality.

- General symptoms

For example: sleep, environmental issues such as being affected by weather, food and drink preferences, tendency to be chilly or warm, sweating and energy levels.

- Particular symptoms

For example with pain: location of pain, sensation of pain, what affects pain e.g. heat, concomitants of the pain e.g. pain and nausea,

- Medical history and family medical history

For example: vaccination history, illnesses and operations and family background.

It is considered important for the practitioner to engage with the patient in order to elicit symptoms to choose the remedy (Owen 2007). Owen (2007) proposes that there are five models of looking at illness and health that are relevant to homeopathic practice. One of the models, the relationship model, suggests that the context of symptoms, the patient's relationships and the patient's relationship with the homeopath is central to homeopathic practice. The homeopath may be directed to the importance of a symptom by a sensation or feeling of their own. Within this model the homeopath is using their awareness to explore what is happening in a patient. Therefore the dynamic nature of the relationship between the patient and homeopath reveals important aspects of the case and informs treatment and prescription. Owen (2007) argues that the relationship model requires homeopaths to be self aware and reflect carefully about their physical and emotional reaction to patients.

In my experience there is a parallel process occurring of listening to the patient and evaluating the treatment needed. The intention is to gather as much information that is relevant to the patient as possible and to match this to a homeopathic remedy according to the law of similars. Homeopaths traditionally use books called repertories and materia medicas (available in texts and computerised programmes) to aid them in the remedy selection. The repertory is an index of symptoms running from head to toe with a "Mind" section and a "Generals" section as well. Next to each symptom is a group of remedies (each group of remedies is called a rubric) which are the appropriate remedies that are used for treating that symptom. The remedies in each rubric have been collated from provings, recordings of accidental poisonings and clinical experience. This process of referring to the repertory and narrowing down your selection of remedies is called repertorising. Once the practitioner had identified a small group of remedies that may be useful for their patient they

will then refer to any number of materia medicas. The materia medicas contain all the detailed information relating to each of the four thousand individual remedies that have been collected from the provings, accidental poisonings and from extensive clinical experience. By referring to the materia medicas they can then differentiate between the various remedies and find the one that is appropriate for the patient.

1.7 Training and qualifications of homeopaths

The homeopathic consultation is a complex interpersonal relationship that requires skill and experience. However there is no literature that examines the training of homeopathic practitioners and whether the practitioners are adequately prepared for such a complex interpersonal consultation and relationship. In Britain today homeopathy is practiced by medical and non-medical homeopaths. The homeopaths are trained and governed within different organisations. The Faculty of Homeopathy promotes the academic and scientific development of homeopathy and ensures the high standards in the education; training and practice of homeopathy. Within the Faculty dental surgeons, doctors, nurses, midwives, pharmacists, podiatrists, veterinary surgeons and other statutorily registered healthcare professionals may train in homeopathy and are regulated by the Faculty. The Faculty also ensures that homeopathy is used by these professionals within the bounds of their profession. The Faculty maintains a ‘classical’ or ‘Hahnemannian’ stance within the bounds of a biomedical context. The methods of practicing homeopathy by Faculty members are varied (see Appendix 3, for an explanation of different methods used by homeopaths). The Faculty also publishes the peer reviewed academic journal *Homeopathy* (formerly the British Homeopathic Journal).

Postgraduate courses are taught at six locations in the UK and six overseas. All Faculty accredited courses are wide-ranging in subject matter and the practitioners can choose the level appropriate to their knowledge and experience. Students are encouraged to sit the specialist examinations, which lead to the Faculty’s qualifications; LFHom (for doctors, midwives, nurses and pharmacists), which is at a foundation level, MFHom (for doctors midwives, nurses and pharmacists) which expands substantially on introductory training and is at a more advanced level, VetMFHom (for veterinary surgeons), and DFHom (for dentists and pharmacists and podiatrists) this training is at diploma level.

Non medical homeopaths can practice homeopathy in Great Britain due to Common Law allowing “citizens to do as they like unless expressly prohibited by Law”. The Society of Homeopaths was established in 1970 and was the first non-medical organisation for

professional homeopaths or, otherwise known as lay practitioners, and has the largest membership of all the homeopathic organisations in the UK. The Society of Homeopaths maintains a “classical”, or, “Hahnemannian” stance and its members use a variety of methods in their practice of homeopathy (see Appendix 3). The Society of Homeopaths produces a quarterly publication entitled *The Homeopath*. Many other homeopathic organisations for lay practitioners have been formed over the years, such as the Alliance of Registered Homeopaths founded in May 2001 and the Homeopathic Medical Association founded in 1985. Both organisations have an ethos which tends to be less “classical” than the Society of Homeopaths. Non medical homeopathic practitioners are not statutorily regulated, but most of the lay homeopathic organisations have formed a working committee to attempt to amalgamate and form a single register in readiness for voluntary regulation.

Today there are seventeen colleges of homeopathy established around the United Kingdom, of these colleges thirteen are private institutions and four of those are degree courses (Universities of Middlesex, Thames Valley, Westminster and Lancashire). At the end of their training, lay homeopaths achieve a qualification which is a licence to practice in the form of a diploma, licentiate or a BSc degree. The courses are usually affiliated to one or more of the homeopathic organisations that maintain the educational standards and the code of ethics for the practitioner. Nowadays most of the courses are affiliated to the Society of Homeopaths which ensures a standardised curriculum and achievement level.

The content and delivery of private courses, degree courses and faculty courses have a history of being extremely varied. Medical and non medical practitioners are expected to gain an understanding of the following areas:

- Core principles and concepts of homeopathy
- The historical and philosophical background to the development of homeopathy
- Current scientific evidence, Homeopathic pharmacy and materia medica
- Alternative methodologies in practice
- Consultation and case taking and case analysis skills
- Interpersonal communication, patient centred communications, dynamics in practice
- Research skills and Research in practice (for non medical students only)
- Anatomy, physiology and pathology (for non medical students only)

The Faculty and the Society agree on many aspects of homeopathic training, and yet despite considerable common ground, the two bodies have very little communication over what a curriculum needs to include to give students with no previous knowledge of homeopathy an in depth understanding of the practice and philosophy of homeopathy. This lack of communication between medical bodies and non-medical bodies providing a specific therapy seems quite common. For example, a similar trend was found between the British Acupuncture Council and their medical equivalents the British Medical Acupuncture Society (House of Lords 2000).

Although I have briefly described the training that the practitioners undergo this does not explore whether the practitioners feel adequately prepared for the complex interpersonal homeopathic consultation. Similarly I have described a typical consultation from my perspective as a homeopathic practitioner. However this does not examine in depth what is known about the consultation and the interpersonal relationship between the patient and practitioner. The next section of this chapter therefore, will look at the homeopathic literature specifically focussing on the concepts of the therapeutic relationship and holism which have been identified as key aspects of the homeopathic consultation. References will be made to research into the homeopathic consultation but also to other CAM research as this allows comparison and contrasting of areas of knowledge and understanding.

1.8 Reviewing the literature on the homeopathic consultation

There has been significant debate about how to conduct a literature review in a grounded theory study (Chenitz & Swanson 1986; Glaser 1978; Silverman 2000). Chenitz & Swanson (1986) note that a researcher is often required to present an extensive review of the literature prior to the commencement of the research study in order to provide a rationale for the purpose of the research. Glaser (1978) however, considers that an extensive review prior to commencing a research study may increase the researcher's preconceptions about the topic to be studied. Additionally the researcher may become entrenched with non relevant and unrelated topics that may hamper the process of emergent interpretations. Charmaz (2006) accords with Glaser's view and adds that the literature can be woven into the analysis and interpretation of the data. I therefore decided that I would approach the literature review on the homeopathic consultation in a focussed manner in this chapter so as to not anticipate concepts that may emerge from the data collection. Additionally relevant literature from homeopathic and other therapeutic consultations would be woven into the findings chapters.

1.8.1 Therapeutic Relationship

One of the many reasons that patients turn to complementary therapies such as homeopathy is the value that they place on the quality of the practitioner patient relationship, the “whole person” approach and the possibility of taking a more active part in maintaining their own health (Vincent & Furnham 1996). Also patients who seek CAM hope to get relief of symptoms and improvement in function, advice on self help or other therapies and to gain control whilst improving their ability to cope with their illness and to avoid or reduce medication (Paterson & Britten 1999). Patients who use CAM, including homeopathy, perceive that through being listened to and being heard a trusting and equal relationship develops. This relationship provides social support and reassurance reducing anxiety and enabling individuals to manage their illness (Cartwright & Torr 2005). Homeopathic practitioners tend to not present themselves as experts in the consultation. Therefore patients feel able to express themselves spontaneously thereby allowing a more balanced, collaborative and equal interaction to occur (Chatwin & Collins 2002). Within this equal relationship patients of homeopaths also value the possibility of shared decision making, being treated as an individual and the whole person approach (Mercer & Reilly 2004; Patriani Justo & de Andrea Gomes 2008). The length of the homeopathic consultation is also valued by patients, particularly because there is sufficient time in the consultation for listening and responding to patients’ worries and concerns (Luff & Thomas 2000; McIntosh & Ogunbanjo 2008; Mercer et al. 2004; Patriani Justo et al. 2008). Medical homeopathic practitioners also found that the increased time of a homeopathic consultation allowed for a greater exploration of the deeper problems that each patient presents (May & Sirur 1998). Some homeopathic consultations however conducted by medical homeopaths do have relatively short consultation times but there is no research that identifies whether these shorter homeopathic consultations are perceived to be as satisfying for both the patient and the practitioner. However a study exploring patient satisfaction with the length of a consultation in conventional medicine indicates that it is not so much the length of consultation as the quality of the consultation that is important (Cape 2002).

Practitioners were perceived as being calm, caring, compassionate and empathic (Luff et al. 2000; Mercer et al. 2004). This approach was seen by patients to be therapeutic and supportive (McIntosh et al. 2008). Empathy is an important component of the therapeutic relationship (Davis 2009; Reynolds & Scott 1996). Empathy and sympathy have been explored and compared in both homeopathic and general practice consultations in a study using observation and conversational analysis (Ruusuvuori 2005a). This study found that both homeopaths and general practitioners use personal disclosure as a means to demonstrate

empathy in their consultations and affiliate themselves with their patients, but this occurs more frequently in the homeopathic consultation. The use of empathy by homeopaths was found to help develop and maintain the therapeutic relationship (Mercer et al. 2004). Additionally empathy is particularly important in the initial long homeopathic consultation in order to develop rapport with the patient (Bikker, Mercer, & Reilly 2005). Also the degree of patient's enablement is related to the patient's perception of the doctor's empathy (Mercer, Reilly, & Watt 2002). The importance of the therapeutic relationship in these CAM consultations suggests that the therapist has an important part to play in these relationships and this may have an affect on outcomes. The homeopathic consultation has also been compared with psychotherapeutic consultations. In these consultations the therapist is an important component of the therapeutic context and maybe thought of as a facilitator in the healing process. However this aspect is poorly understood in both psychotherapy and homeopathy (Hyland 2005). Only one study has examined the effect of the homeopathic practitioner on treatment outcome. Bikker et al (2005) found that empathy is strongly related to perceived positive change in main complaint and well being.

It is possible that the approach to history taking could be responsible for developing a good therapeutic relationship as it is considered to be a patient led process in homeopathy (Kaplan 2002; Owen 2007). CAM practitioners tend to ask broad question in the consultation to elicit life experiences. This enables patients to set the agenda for the consultation and express their thoughts about factors influencing either the cause of their disease or action that they need to take to prevent a relapse (Steinsbekk & Launso 2005). These broad question offer a means of understanding the true inner self of the patient and also connect their psychological and physiological problems and offer a safe tool to practice in a holistic fashion (May et al. 1998). Ruusuvoori (2005b) observed this too when comparing homeopathic and medical consultations; in her conversational analysis she identified that patients at the start of a consultation in both medical and homeopathic consultations would present a small narrative of their presenting complaint and mention social and emotional aspects of their illness in the very first description of their complaint. A medical consultation thereafter would focus on the presenting complaint and diagnosing the disease; however in subsequent homeopathic consultations the focus would be on the narrative and the social and emotional aspects of the illness. This then informs patients how to proceed with subsequent consultations. Moreover it is not only the content of what the patient says that is important but of equal value is the way that the information is presented to reflect subjective experiences (Chanda & Furnham 2008a). Additionally patients preferred the communication skills of CAM practitioners noting that body language signalled whether they were interested in the patient (Steinsbekk

et al. 2005). Patients have also noted that CAM practitioners are focussed on empowering patients (Steinsbekk et al. 2005) enabling them to learn more about their own health, become more involved in the process of health care for themselves and explore reasons for the cause of their ill health (Luff et al. 2000; Shaw, Thompson, & Sharp 2006; Thorne, Paterson, Russell, & Schultz 2002). This last point was reflected in a study which found that CAM patients tended to have more control over their lives, indicating a better prognosis and management of their chronic conditions (Sasagawa, Martzen, Kelleher, & Wenner 2008).

However the therapeutic relationship in a homeopathic consultation is not always easy or harmonious for practitioners (Frank 2002a). Some interactions do contain a significant amount of negotiation and disagreement. For example, some practitioners may withhold the name of the remedy given to the patient therefore depriving the patient of power; some practitioners consider the lengths of the consultation draining and challenging; and some find their patients' expectations of their treatment progress unrealistic and difficult to meet. Additionally the passivity of the patient can cause problems along with the issue of payment of fees. Frank's (2002a) study is the only study that explores difficulties that homeopathic practitioners experience in the consultation.

From these studies it is clear that patients who consult with homeopathic practitioners value the consultation and specifically the therapeutic relationship. These relationships encourage and empower the patient to explore their own beliefs about their illness using strategies of collaboration, equality of the relationship, empathy and the whole person approach. The whole person approach has consistently throughout these studies been expressed as a patient preference and as a tool for the practitioners to elicit life experiences.

1.8.2 Holism

The notion of holism is not exclusive to CAM. Some conventional doctors consider they have a holistic approach driven by patient centred and biopsychosocial models (Checkland, Harrison, Mc Donald et al. 2008; Saks 1997). However CAM practitioners and their patients identified holism as a theme that contrasts it from orthodox medicine (Barrett, Marchand, Sheder et al. 2000; Barrett et al. 2003). Comparisons of parents of child patients' experiences of homeopathic and conventional medical consultations have also found that homeopathic consultations were holistic whilst conventional medical consultations focussed on presenting symptoms (Rise & Steinsbekk 2009). Patients are attracted to CAMs holistic approach (Vincent et al. 1996) have a preference for a holistic approach (Ratcliffe, Van Haselen, Buxton et al. 2002) and an expectation that this approach will address the cause of their illness (Richardson 2004).

Specifically within homeopathy patients value the holistic aspect of the consultation as it treats them as an individual and explores how their illness has affected all aspects of their life (McIntosh et al. 2008; Mercer et al. 2004). Health and illness beliefs in homeopathy patients are associated with a “vital” balance of the body mind interaction mediated by physical, psychological, social and spiritual factors. Illness is seen as a process of somatisation that starts in the soul and comes out in the body. Patients also identified that a holistic approach provides them with a philosophy of life, helping them think about behaviours and habits which enables them to maintain treatment (Patriani Justo et al. 2008). This is consistent with CAM practitioners views that they had a role to empower the patient by using holism to educate patients to change belief and behaviour (Barrett, Marchand, Scheder et al. 2004). These studies indicate that holism is not just concerned with symptoms from the whole person but also views holism as being concerned with the practitioners approach for treatment and their role as a practitioner. They may therefore prescribe a package of care, which could include modification of lifestyle, dietary change and exercise as well as a specific treatment (Zollman & Vickers 1999).

Homeopathy was valued by patients because it gave them a broader perspective on the causes of their illness and their underlying susceptibility to asthma. This occurred by the practitioner gathering “constitutional” symptoms which may or may not be related to the asthma, such as sleeping and anxieties. This exploration of views of patients and parents of children with asthma has led to a deeper understanding of holism within the homeopathic consultation (Shaw et al. 2006). This is consistent with Rise & Steinbekk’s (2009) study which adds that the whole person approach was characterised by the type of questioning and eliciting of patients subjective experiences that may lead to mutual understanding between patient and practitioner and connections between symptoms. This may result in the patients experiencing this as finding the underlying cause. These studies add weight to the argument that CAM offers patients new ways of understanding their condition that go beyond “reductionist” explanations (Cant 2005). Thus holism provides a framework for making sense and understanding causal mechanisms for illness as well as how to maintain health and well being (Cartwright et al. 2005). Additionally explanatory frameworks, such as holism, are often concordant with patients own models of illness, moreover patients adopt concepts and terminology from CAM such as “energy” thus expanding their own explanatory models of illness (Cartwright et al. 2005).

These studies are consistent with the “expanded effects of care” described by previous research with acupuncture patients (Cassidy 1998; Gould & MacPherson 2001; Paterson & Britten 2003). Whilst patients may initially seek CAM to treat a specific often chronic

problem, over time the focus widens to include general feelings of well being and illness prevention (Gould et al. 2001; Thorne et al. 2002). Patient centred outcome measures are limited in their ability to record the diversity of change that patients experience after acupuncture treatment. These include changes in strength and energy and personal and social identity (Paterson et al. 2003). This diversity of changes that patients experience after CAM is indicative of complex interventions (Campbell, Fitzpatrick, Haines et al. 2000; Paterson & Britten 2004) and is also seen after homeopathic treatment (Bell, Koithan, Gorman, & Baldwin 2003). Patient's of acupuncture experience holistic care as being dependent on four factors structural factors such as time and setting, the intention of the practitioner, the intention and needs of the patient and the therapeutic theory that underpins the treatment (Paterson et al. 2008). These aspects are consistent with homeopathic patient's experiences of holism discussed in this section.

The whole person approach of homeopathy attempts to understand patients on all levels of the person, physically emotionally and spiritually. However, there is also another dimension to holism within homeopathy that is concerned with a practitioners' evaluation of outcomes from treatment. In homeopathic theory a certain pattern of systemic changes occur throughout the individual in response to long term homeopathic treatment (Bell et al. 2003). The changes identified included changes in; emotions, state of mind, specific physical functioning, general physical changes, perceptions of self, relationships, spirituality, lifestyle, energy, dream content and tone, well being, perceptions by others, life relationships, a sense of freedom of being less "stuck", sleep, coping, the ability to adapt, creativity and the recall of past experiences. Bell et al (2003) provide a more detailed analysis of what holism means in homeopathy showing that attention is paid to a wide scope of life experiences and quality of life of the patient rather than physical symptoms on their own. There were many limitations to this study for instance the data collection involved a written response format rather than intensive individual interviews and this did not allow for the emerging categories to be fully investigated. Nevertheless this is the first study to identify in detail the holistic aspects of the homeopathic consultation. Although there is limited understanding of the concept of holism in homeopathy it is not fully understood how this concept is used in the consultation by practitioners in conjunction with the other skills of developing and maintaining the therapeutic relationship.

1.9 The research aims

Reviewing the literature on the homeopathic consultation in this chapter has highlighted that there are aspects of the consultation which have been largely under researched. This led to establishing the following aims which were broad and explorative.

The aims of this research were to gain an in depth knowledge of homeopathic practitioners' perceptions and experiences of the homeopathic consultation. An additional aim was to generate a theoretical model that would explain the processes that underpin the homeopathic consultation. Within these aims there were some specific questions that needed to be addressed:

- What were the homeopathic practitioners' perceptions of their role within the consultation?
- What were the practitioners' intentions in the consultation?
- What philosophy and rationale do the practitioners' use in their consultations?
- From the practitioners' perspective how do they develop and maintain the therapeutic relationship?
- What difficulties do they encounter in the consultation (from lack of training, from the complexity of the interpersonal relationship)?

The aims of this study needed to be sufficiently broad to allow for exploration (Bluff 2005) of the topic and to ensure that there is enough data to formulate theoretical understanding of the research topic (Glaser 1992). However, as the study progressed the focus narrowed as important issues emerged (Charmaz 2006; Glaser 1992) and the search began for the processes that constructed the homeopathic consultation.

1.10 Conclusion

The many questions that emerged from reviewing the literature in this chapter demonstrated that there were gaps in knowledge concerning the nature of the homeopathic consultation, what occurs in it and the role of the homeopathic practitioner within it. Gaining an understanding of this component of homeopathy was important in order to understand the whole treatment effect of this complex intervention. Therefore a study using an inductive qualitative approach was indicated to address this insufficiency in knowledge and understanding of the consultation from the practitioner's perspective. The next chapter will address the methodological decisions that were made in this study.

Chapter 2 Methodology

2.1 Introduction

This was a broad and exploratory study in an area of homeopathic practice not previously investigated in depth and it was necessary to select an appropriate methodology. In order to fully understand the processes of the homeopathic consultation and the meanings that the homeopaths assign to their experiences an in depth study was required, entailing a methodology that would allow full exploration of the subject matter. A qualitative inductive approach was seen as the best way of meeting these criteria and of discovering meanings from the data and through my interactions with the data.

2.2 Qualitative Research

A qualitative approach in this study allowed in depth exploration of the intentions, experiences and perceptions of how a homeopathic consultation was conducted through the subjective accounts of the practitioners. A qualitative approach also took into account the complexities of homeopathic practice and the varieties of meanings that practitioners attached to their experiences, and how those meanings were formed by the social structures and processes of their practices (Creswell 1998; Denzin & Lincoln 2000). A real world naturalistic approach was considered vital for understanding the context within which the homeopaths conducted their consultations. Therefore data collection wherever possible was conducted in the homeopaths practices to avoid any contrived feelings that were out of context (Creswell 1998; Patton 2002). Naturalism also holds that research techniques should be familiar to those under study and respect their beliefs and where possible have similarities with normal interaction (Patton 2002). The interpretivist paradigm that encompasses many naturalistic methodologies has a resonance with homeopathy, as the practitioners search for the meanings of the illness with their patients, and therefore a qualitative approach helped the participants to feel more comfortable with the research process and that they have a voice in the debates on the nature of homeopathy. Consequently the homeopaths, as participants, were not passive subjects but active contributors to the research process. A feature of naturalism is that a research setting should be left as undisturbed as possible by the researcher who should not attempt to manipulate the phenomenon of interest, for example the group, relationship or interaction (Patton 2002). Nevertheless the very presence of a researcher, prompting and asking questions could have changed and influenced the natural unfolding of the thoughts and processes of the participants (Grbich 1999). Therefore as a

researcher I could not detach myself from the evidence that I was generating and it was important for me to recognise that this research was a social process that was open to interpretation (Avis 2005). The challenges for me as a practitioner researcher, researching participants who were also homeopaths are discussed in more detail later in this chapter.

The open ended and exploratory nature of this study required an inductive approach to sampling that allowed for flexibility so that the research could evolve in unexpected ways as this study progressed (Avis 2005). This flexibility allowed me to develop different sampling techniques and strategies that evolved as the study progressed. The sampling techniques of qualitative research are highly characteristic and often employ the use of purposeful sampling. Small sample sizes are generally used in order to allow in depth inquiry and understanding of a phenomenon, leading to information rich cases for study (Patton 2002). However this also attracts criticism as there is limited generalisability from data collected from a small number of settings (Mays & Pope 1995). However generalisability of this research to a wider population was not a purpose or requirement of this research and small sample sizes were indeed necessary in order to get in depth information from the homeopathic practitioners. Nevertheless theoretical generalisability from one setting to another is possible with qualitative research (Mason 2002). For example, relevant research questions about other therapeutic consultation could be framed using the theoretical model developed from this study.

Having decided that a qualitative approach was necessary, it was then important to decide on the appropriate methodology for conducting the research and for meeting the aims of the study. There were many methodologies within the qualitative paradigm that could have been used to inform the data collection and analysis, for example, biography, ethnography, phenomenology, case study and grounded theory (Creswell 1998). Grounded theory was chosen as an appropriate methodology for a number of reasons. Firstly it was particularly suitable for exploring and gaining insights into a previously unknown area. The focus of my study which was to explore homeopathic practitioners' perspectives and experiences of the consultation fitted this criterion. Secondly grounded theory was also suitable as it was a methodology that aims to develop theory that is grounded in the data through a specific process of analysis that moves the analysis beyond description to a more abstract and conceptual level (Glaser 1992). One of the aims of this research was to generate a theoretical model that would explain, predict and give a deeper insight into the processes that occur in the homeopathic consultation. Theory explains and provides insight into the topic under study and grounded theory was therefore a process that was appropriate to use when there was a lack of knowledge or theory of a topic (Glaser & Strauss 1967). Existing theories of

the consultation do not offer any relevant in depth solutions to the problems of the homeopathic consultation which is a unique process (see Chapter 1). Thirdly grounded theory sought to identify processes rather than static conditions (Stern 1985) and one of the aims of this study was to understand how the practitioners conducted a homeopathic consultation, which is an ongoing process. Finally, grounded theory was drawn from symbolic interactionism which stressed the importance of the context in which people function, the process of their functioning and the roles that they adopt in interactions (Holloway 1997). This makes grounded theory particularly appropriate for this study which was concerned with exploring the context and the process of the homeopathic consultation and examining the roles of the homeopathic practitioners within the homeopathic consultation.

2.3 Grounded theory

Grounded theory, which is rooted in symbolic interactionism, is a sociological perspective which aims to gain an insight and explain how people interpret the responses of others and reorganise their actions in response to those interpretations (Blumer 1969). Blumer (1969) stated that there were three major points that were fundamental to symbolic interactionism. Firstly that human beings act towards things on the basis of the meanings that the things have for them. Secondly the meaning of such things arises out of the social interaction one has with others. Thirdly, that these meanings are formed and modified through an interpretive process. This approach was considered to be suited to understanding the interactions that occur in the context of a healthcare consultation (Bluff 2005). Also this approach reflected the perspective of the homeopath, where meanings associated with the expression of the patient's health or illness arise out of the interaction between the patient and the practitioner. How the practitioners make sense of those meanings and their multiple perspectives and realities can only be revealed by using a methodology that has as its goal the construction of participants' symbolic worlds and social realities (Pidgeon 1996).

Grounded theory, originally formulated by Glaser & Strauss (1967), was a general research methodology for inductively developing theory that was grounded in data systematically gathered and analysed. The theory should evolve through the continuous interaction between analysis and data collection. A central feature of this analytic approach was the process of constant comparison of data with data and then the comparison of concepts to data with the aim of saturating and integrating categories and their properties. Since the origin of grounded theory subsequent publications by the authors have reflected important differences in how these scholars envisioned grounded theory and its use. As a result two distinct

methodologies have evolved (Glaser 1992; Strauss & Corbin 1990) with many debates as to the merits and disadvantages of each approach (Bryant 2003; Charmaz 2000; Glaser 1992).

Reading about the debates in grounded theory and reading research that used a grounded theory approach increased my awareness of the impossibility of separating off the practitioner side of my self from the researcher side of my self. I realised that any research that I conducted into the homeopathic consultation must be a reflection of the amalgamation of those selves. My decision of how I was to proceed with the study gradually evolved with the awareness of my epistemological and my ontological stance. My beliefs were firmly rooted in the interpretivist paradigm in which multiple realities were possible and the researcher and the researched were inseparable and between them a reality was constructed. Mainly because of my background as a homeopathic practitioner I realised that I needed an approach that would embrace my experiences as part of the research and I therefore chose a constructivist approach to this study (Charmaz 2000).

2.4 Constructivist grounded theory

A constructivist approach to grounded theory was proposed by Charmaz (2000) in an attempt to bridge the positivist position of Glaser and the post positivist position of Strauss and Corbin. Charmaz (2006), who studied with both Glaser and Strauss, used both versions of grounded theory making it a very practical approach that stressed the reflexivity of the researcher. This approach captured the creative and dynamic character of the research process and recognised that the categories, concepts and theoretical level of an analysis emerged from the researcher's interactions within the field and questions about the data. The use of grounded theory alone failed to explain the critical role played by a researcher in a study; however a constructivist approach placed priority on the phenomena of study and saw both data and analysis as created from shared experiences and relationships of the researcher with participants and other sources of data (Charmaz 2008; Charmaz 2006). As the researcher in this study it was therefore important for me to take a reflexive stance towards the research process and to consider how the theoretical model was developing within this. In order to be reflexive I needed to have an awareness of my prior assumptions and an understanding of how they affect the research, and my interpretations and the participants' interpretations. Reflexivity can enhance the rigour of a grounded theory as it can help develop theoretical sensitivity and increase transparency of the research (Hall & Callery 2001).

2.5 Rigour in grounded theory

Rigour is a means by which researchers demonstrate the legitimacy of the research process. To ensure that this study was rigorous I needed to tackle the issue of my role in the research as a research instrument and homeopathic practitioner, as this dual role might bring into question my impartiality. As mentioned above and discussed in the next section a reflexive stance was taken throughout this thesis. Reflexivity not only increased the transparency of the research but also enabled a deeper insight into the consultation so that my subjectivity was a resource rather than a problem (Holloway 2005). The triangulation of methods was an additional way of increasing the robustness of the research. Interview, observation and reflective diary data were used in this research to test and increase knowledge concerning the categories in the developing theoretical model. Also triangulation of data sources occurred where interview and observation data were compared with formal and informal conversations that I had with homeopathic and non homeopathic colleagues. Triangulation ensured that different aspects of the consultation were captured and any inconsistencies were then questioned (Patton 2002). Member checking also occurred in this study. This was the process of returning to the participants with a summary of their interviews and observations and the developing theoretical model to establish whether the description or interpretation truly represented their experiences (Creswell 1998). As I had been unable to conduct observations with NHS medical homeopaths I was therefore able to show the theoretical model informally to NHS medical homeopaths so that they could confirm, refute or enlarge upon the model in relation to their experiences. Negative case analysis was also employed in the research. The analysis, of the observations and the diaries which focussed on challenging consultations, explored not only evidence that confirmed the interview data but also evidence of contradictions, which often served to enrich understanding of the categories and their links to each other (Patton 2002). Additionally negative cases were sought in the interview data, for example, Roger a medical homeopath consistently held views that were different to the other participants. These views forced a re-examination of the data and my assumptions both as a practitioner and a researcher.

Researcher bias and the criteria for judging the quality of work was influenced by the underlying paradigm of the research tradition. Within the traditional positivist paradigm the rigour of research is judged by the validity, reliability and generalisability of the research. However within the interpretivist paradigm the role of rigour and the use of these positivist terms has been the subject of longstanding debate (Cutcliffe & McKenna, 1999). As rigour was a means by which researchers demonstrate the legitimacy of the research process, I saw

that aside from the methods of ensuring rigor stated in the last paragraph there was a need to establish other criteria for judging the quality of the research. Both Glaser (1992) and Strauss and Corbin (1990) established their own versions of criteria for judging grounded theory, but I felt uncomfortable with both variations of criteria as they tended to draw on a positivist assumption that the natural world was available for observation and analysis, leaving little room for interpretation of the meanings that have been created between the research and participant (Hall et al., 2001).

Charmaz (2006) also proposed criteria for evaluating a constructivist grounded theory; credibility, originality, resonance and usefulness (see Appendix 4) and provided a full explanation of these terms and how they could be of use in a study. Additionally these criteria were developed from within the interpretivist paradigm to which I identified and positioned myself. Furthermore with a reflexive approach these criteria addressed the inherent actions and meanings in the studied phenomenon, in this case the homeopathic consultation, and the criteria helped analyse how it was constructed. Moreover the question posed by each of the criteria acted as a checklist that I used to constantly challenge my actions, decisions and interpretations as the research instrument.

Many of the questions that each evaluative criterion raised are applicable and useful at different points in the research process, for example within the first criterion of credibility a question was asked “Is the researcher familiar with the setting and topic?” This question was answered where relevant throughout the thesis (for a discussion of how rigor was maintained in this study using the evaluative criteria please refer to Chapter 11). The process of using these criteria to evaluate my interpretations created a transparency both of the research process and of my personal involvement in the research.

2.6 Reflexivity

As the research instrument and a practitioner of homeopathy one of the major challenges for me in this research was to track and constantly be aware of my preconceptions and assumptions. Inevitably my conscious and subconscious biases (Payne 1997) had an impact on the research as my thoughts, feelings, culture, environment, training, experience and social and personal history informed me, as I engaged with participants and as I transcribed and interpreted the conversations and observations that I had with the participants. To counterbalance these concerns, which can be seen as weaknesses of qualitative research, it was necessary for me to constantly be aware that the research was an evolving process requiring me to critically reflect on the decisions that I made during the course of the study,

and to reflect on my own role in the social process of producing the data (Mason 2002). This practice is referred to as reflexivity which can be described as the researcher's capacity to acknowledge how their own experiences and contexts (which may be fluid and changing) inform the process and outcomes of inquiry (Etherington 2004). I therefore recorded the process of the research in a journal leaving an audit trail, which was a record of my decisions, actions and interpretations that were made during the research allowing a transparency that ensured that independent researchers could check my actions and interpretations of the data. Reflexivity offered the opportunity to state my assumptions throughout the process of the research and to examine any judgements that were made by me. As the researcher is part of the final research report it should include some information about the researcher and to report any personal and professional information that may have affected data collection, analysis and interpretation either negatively or positively. For example it should be stated what experience the researcher has had with their level of training and the perspective that they bring to the field (Patton 2002). Therefore to provide transparency of any preconceptions I embedded in this thesis my subjective thought processes and memos presenting an audit trail of my decisions during the data collection and analysis process. For example, in the Method of data collection chapter (Chapter 3) I discussed the challenges that I faced whilst interviewing other homeopathic practitioners.

In this study I observed and recorded two of my own homeopathic consultations with patients and I completed a practitioner reflective diary focussing on difficult consultations. This type of data which used my personal experience as a practicing homeopath to study the homeopathic consultation is a form of autoethnography (Ellis & Bochner 2003). This type of data is consistent with a constructivist grounded theory approach and adds understanding to a way of life or practice through my experiential experience as a practitioner. However, it is also a different form of data to that collected from the other participants, as it includes my self awareness about my experiences and increases the subjectivity of the presentation of the data (Patton 2002). The intentional use of reflexivity in this way can provide a bridge between practice and research and creates a dynamic process of interaction between my self as the researcher and my participants and the data (Etherington 2004). Seale (1999) cautions against the more confessional style of reflexivity in which the researcher presents themselves as achieving a true insider status and where the researcher tells their story rather than that of the research itself. Seale also noted the limits of reflexivity as we cannot be aware of all the sub conscious ways in which our assumptions shape our approaches to research. In order to minimise these challenges I have been transparent in my writing making a clear boundary between data collected from my consultations and diary and those of my

participants. Throughout the research process colleagues and supervisors challenged any judgements and assumptions that I made, presenting me with an opportunity to re-examine my statements and to often deepen my understanding of the research. I formally addressed reflexivity in a presentation to the Research Unit where I was based for my PhD and considered the many challenges that I faced as a practitioner doing research. I also discussed my development from practitioner to practitioner researcher and how this has impacted on my practice of homeopathy. The slides from the presentation can be found in Appendix 5.

2.7 Conclusion

The methodology for this study evolved along with my understanding of my theoretical positioning and of what was required of me as a researcher. Making the leap from being a practitioner to a practitioner researcher was not without its inherent difficulties but the use of reflexivity helped rather than hindered that process. The use of a constructivist grounded theory methodology enabled the research questions in this study to be answered in a manner that took into account the prior assumptions that I had and the beliefs and biases that I inevitably accumulated throughout the research process. This subjectivity became a strength of the research and reflexivity is used throughout the thesis so that the process was documented and therefore transparent. Having chosen grounded theory as my methodology the next chapters illustrate the methods of data collection and data analysis used in this study.

Chapter 3 Method of data collection

3.1 Introduction

The aims of this study were to explore the process of the homeopathic consultation and to explore homeopathic practitioners' experiences, perceptions, roles and intentions within the homeopathic consultation. Central to this process was the use of constant comparison which guided data collection and analysis (Charmaz 2006; Glaser et al. 1967). By making theoretical comparisons I was stimulated to question what was happening in the data. Each step of the process of data collection is discussed in this chapter, and data analysis is discussed in the following chapter (Chapter 4). Although these steps are described sequentially data collection and analysis was not a linear process in and occurred along with sampling as an iterative process where each step informed the subsequent steps. The following figure (Figure 1) is a visual explanation of this process:

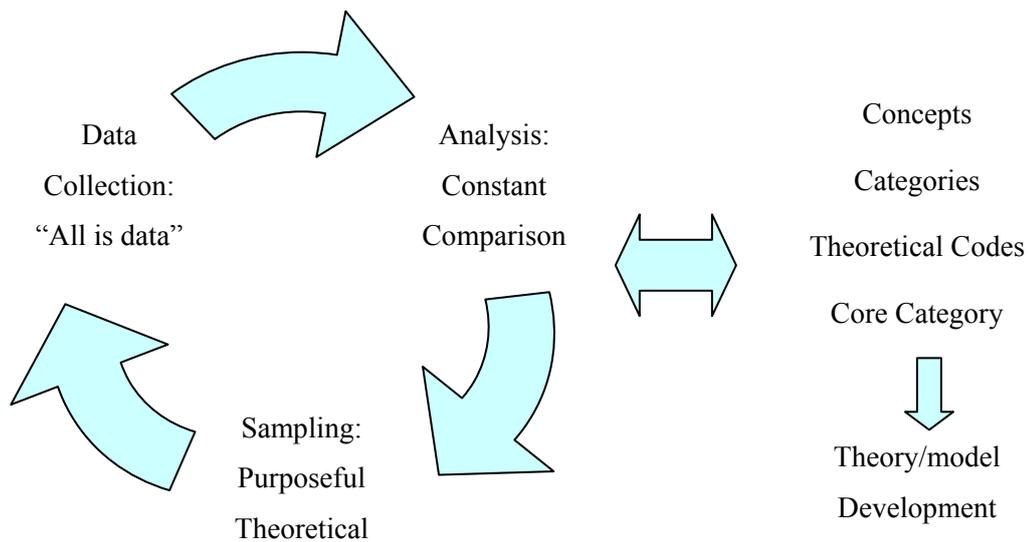


Figure 1: Constant comparison

Initially, however, it was important to consider the methods that were used for data collection in this study. A qualitative approach allowed inquiry into selected topics in great depth taking into account context and details and therefore relied on extensive interaction with the people being studied (Patton 2002). The two primary methods of gathering data when using a qualitative approach include observation and conducting interviews. There were limitations to both sources of data collection. With observation data there was the possibility that as a homeopath I might affect the setting. I might make both the homeopath and the patient that I was observing self conscious and self aware and thereby behave in an

unnatural or atypical fashion. Moreover observation data was limited to focussing on external behaviours and would not enable me to see what was happening inside the participants' minds nor the opportunity to explore their feelings and thoughts (Patton 2002). The limitation of interview data was that the participants could present information that they thought the interviewer wanted to hear, or, they could distort information to protect themselves or their profession (Rubin & Rubin 1995). Additionally with interviews it would also be impossible to tell whether there were any contradictions between what the participants' said they did in practice and what they actually did in practice (Taylor 2008). In order to answer the research aims I decided that interview data would be an appropriate start.

However the interview data could not confirm or refute whether the participants behaved as they reported. Therefore in order to capture a truthful representation of the consultation it was necessary to triangulate retrospective interview data. In order to explore the emerging theoretical model observational data was gathered to substantiate whether the practitioners did what they say they did. Additionally data from practitioner reflective diaries was collected which captured feelings and experiences immediately after consultations and reflected on how they dealt with problems on an immediate day to day basis. Since "all is data" (Charmaz 2006; Glaser 1992) in grounded theory memos, conversations with homeopaths, non homeopathic colleagues, field notes, grounded theory group meetings, literature on consultations and my experiences as a homeopath were all considered.

This chapter will discuss my three methods of data collection which began with interviews and was followed with observations of consultations and collection of practitioner reflective diaries. Each section will describe my justification for using that particular method and will also discuss my sampling and recruitment strategies, how I conducted the interviews, ethical issues and any challenges that I encountered.

3.2 Method 1: Interviewing homeopathic practitioners

The advantage of conducting interviews for the initial data collection was that through their in depth subjective accounts I had immediate access to the "insider perspective" of the homeopaths' experiences and perspectives of how they conducted homeopathic consultations. Interviews had the added benefit of allowing the participants to explore past events, sensitive issues and topics that they may not have revealed through more structured questionnaire methods (Taylor 2008). Having decided that I would commence my data collection with interviews, they were started very early in this research project.

3.2.1 Recruitment and sampling

Some inclusion criteria were put in place before the study started but I did not want the study to be too limited by these criteria as flexibility was needed to allow the research to evolve. The initial inclusion criteria for this study were that participants would be members of the largest homeopathic organisations (the Faculty of Homeopathy for medical homeopaths and the Society of Homeopaths for non medical homeopaths). Selected members of these organisations were approached for recruitment as only a small sample was needed in order to gather in depth information concerning practitioners' experiences. Another inclusion criterion was that the practitioners had peer, group or one to one supervision to deal with any concerns that might have arisen from the process of reflecting on the consultation. Finally the initial homeopaths to be sampled were expected to have at least ten years experience of the homeopathic consultation to allow for a full description of the process of the homeopathic consultation.

A two stage approach to sampling was used. Purposive sampling was initially employed. The goal of purposive sampling was to sample participants in a strategic way, to obtain a sample appropriate for the research question and to ensure that there was a variety in the resulting sample so that participants differed from each other in terms of key characteristics (Bryman 2008). Additionally snowball sampling was used, this refers to when participants suggest other practitioners who they feel may be relevant or interested in taking part in the study (Bowling 1997). The homeopaths that were sampled were chosen because of a range of experience and working conditions. Homeopaths chosen from the Society of Homeopaths were mainly in private practice; additionally some were working or had experience of working within a NHS setting. Homeopaths recruited from the Faculty of Homeopathy were a mixture of both private and NHS practitioners, either working within primary care with a dual role of homeopath and general practitioner or as a homeopath within a homeopathic hospital. All of these practitioners were chosen from Hampshire, London, Wiltshire, Dorset, Avon and Sussex regions. This ensured a certain amount of geographical diversity, for example, some were working in inner city practices and some were in rural areas. Furthermore there was variation in the training that these homeopaths received within these two different organisations as the homeopaths chosen had training from different schools with differing philosophical backgrounds. Initially out of this group of practitioners, homeopaths with more than ten years in practice were sampled.

As the study developed and became more specific, a more focussed sampling approach was needed. Theoretical sampling was the process of data collection where the researcher having

been informed by prior analysis decided what data to collect next in order to develop the emerging theory (Charmaz 2006; Glaser et al. 1967). Theoretical sampling therefore ensured that the sampling was fluid and evolved as needed throughout the study so that questions that arose could be tested along with the developing theoretical model and its categories. Additionally the subsequent use of theoretical sampling to explore views of participants that differed from others was used to provide a balanced perspective. Practitioners with varying degrees of experience were also selected to gain a comparison of experiences. The remaining participants in the study were all selected through theoretical sampling.

All the prospective participants were approached by a letter inviting them to participate (see Appendix 7) in the interviews for this study. Included with the letter was a participant information sheet (see Appendix 8) and a form that they could complete and return to me in a freepost envelope with their contact details (see Appendix 9) and an indication of interest in participating or not. On receipt of this form, if they were interested in participating, I then contacted the practitioner either by email or phone and arranged a convenient time and location for the interviews to take place.

3.2.2 Conducting the interviews

Twenty five interviews were conducted in total (see Appendix 25 for list of participants' pseudonyms) and the conduct of the interviews followed appropriate ethical and research governance guidelines (see section 3.2.3). Before the interviews took place I asked if the practitioners had read the participant information sheet and ensured that the practitioners were fully informed about the nature of the research, and they were encouraged to ask any questions that would give them further information. Clear statements were made regarding the demands on the participant's time and about the general direction of the research. For example, before the interview began it was established that the interviews would last for 1½ hours unless the participant wished the interview to be shorter or longer. They were asked if they would also be willing to participate in a possible follow up interview, phone call or email to investigate any issues that emerged from the initial interview. Whether the participants had any supervisory support or peer group support networks was then identified, as it was strongly recommended that they have this form of support in place. The participants were informed that they were at liberty to stop the recording at any point and were indeed free to withdraw from the research process at any time. They were informed that their anonymity and confidentiality would be maintained throughout by the use of pseudonyms. The participants were also offered the opportunity to read a summary of their interview, in order to indicate if any identifiable material had accidentally been overlooked. Reading a

summary of the transcription not only enabled the participants to remove identifiable information but also enabled them to indicate their agreement or disagreement with the way that they had been represented. Therefore if participants wished that something they said be left out of the data then I would comply with their wishes; however none of the participants took up this offer. Consent was then taken (see Appendix 10) face to face prior to the interview beginning.

I conducted two pilot interviews at the start of the study. For the two pilot interviews I looked for practitioners who had depth of knowledge and insight into the homeopathic consultation and the practitioners who were selected were chosen because they were known to me as homeopaths that had been in practice for more than ten years. Length of time in practice does not necessarily equate with experience or expertise. However these practitioners had managed to sustain busy private practices with good reputations and as homeopathic practices generally receive new patients based on word of mouth recommendations this was a positive sign. The pilot interviews gave a sense of how to conduct future interviews as they gave focus to the study and highlighted the type of questions that I would need to ask, thereby increasing my theoretical sensitivity towards the phenomenon of the homeopathic consultation. Theoretical sensitivity refers to a researcher's ability to have insight, understanding, give meaning to the data and the capability to determine relevance of the data (Charmaz 2006; Strauss et al. 1990).

For the initial interviews an unstructured interview approach was chosen to offer maximum flexibility to pursue information given by the participant in a spontaneous and individual fashion (Patton 2002). This approach also encouraged breadth and variety of the social processes of the consultation to emerge allowing a theoretical understanding of the consultation to develop (Taylor 2008). The digital recorder was switched on and the recorded interview took place. The interviews lasted from one to two hours and followed an open ended narrative style format based on the research questions. The opening question to each interview varied but tended to be an open ended question allowing the participants to guide the interview and to freely express their own perspectives. The following was an example of a question that began the interview:

“I am really interested in your experience of the homeopathic consultation; please could you describe a consultation to me”

The participant was then allowed free rein to speak and only when there was a significant pause in their speech was a question asked. During the interview cursory notes, key words or concepts were noted down to remind myself to prompt them to revisit those topics later in

the interview. I found that as I was interviewing an internal dialogue was occurring throughout the process. I was not only listening but also thinking about what question to ask next and how to ask it. At times the interviews resembled conversations but differed as they tended to be guided to cover a few topics in depth (Rubin et al. 1995). Having an awareness of the dynamics of the interaction also distinguished the interview from a normal conversation (Hutchinson & Wilson 1994). Before and after the interview reflective notes were also taken about the process. This was done to learn from each experience, and to add possible insight to the recorded data.

As the interviews progressed I shifted to more focused questions as the earlier interviews had been analysed and this allowed me to catch sight of patterns and processes amongst subsequent interviews. The grounded theorist begins with open ended, general questions and advances to more specific questions about strategies, processes and consequences (Hutchinson et al. 1994). Analysis started as soon as the initial data was collected and this informed further data collection (see Chapter 4). By the fifth interview it was obvious that many of the same concepts were being spoken about by the participants, this provided an opportunity to question further during subsequent interviews. By the tenth interview the analysis had developed and categories were emerging from the initial concepts, these categories then became the focus for subsequent data collection so that I could further understand the properties for each category and their relationship with each other. The data collection process then became more directed and the questions that I asked in the interviews became more focussed as I was looking for relevant data but also looking to confirm, refute or enlarge my knowledge of the categories. After interview 15 theoretical sampling began in earnest and the search began for alternative forms of data such as literature, conversations with colleagues and media coverage of homeopathy. This was necessary in order to deepen my understanding of the homeopathic consultation and to seek alternative explanations with the use of negative case analysis (see Chapter 4 section 4.5). The need to confirm, refute and enlarge on aspects of the categories led to the decision to collect data using observational methods and the collection of diary data so that aspects of the developing and emerging theoretical model could be tested. Using theoretical sampling as a means to refine ideas and to discover variations amongst the data is a goal of theoretical sampling (Charmaz 2000).

Twenty five interviews were conducted and allowed the development of a tentative theoretical model of the homeopathic consultation to emerge. However, as discussed the limitations of the interview data meant that in order for the model to be robust additional data needed to be collected. A checklist was devised using the categories from the tentative theoretical model and was used as a method for analysing the data obtained from the

observations of homeopathic consultations and the practitioner reflective diaries (see Appendix 6) which will be described in the subsequent sections in this chapter (section 3.3 and 3.4). A checklist was seen to be relevant as a means of analysing the observation and diary data, as grounded theory gives priority to processes rather than a description of a setting (Charmaz 2006). Although the setting provided a context for the observations I was more concerned with confirming, refuting or finding new data which was relevant to the processes already in development.

3.2.3 Ethical issues

Ethical approval for the interviews for this research was received in June 2005 and was granted by the Thames Valley Multi-Centre Research Ethics Committee (05/MRE12/42). The University of Southampton acted as my sponsor and provided the necessary insurance cover. In addition ethical and research and development approval was sought and given by 12 primary care trusts (see Appendix 23) so that interviews could be done with homeopaths who were also general practitioners and worked within the NHS. Ethical guidelines established by Beauchamp & Childress (2001) were followed and ethical issues that apply to all three methods of data collection are discussed in section 3.5.

One of the potential problems with qualitative interviews is the amount of information accessed and whether the information is always pertinent to the study. However, as mentioned above it is a feature of a qualitative interview that it is sometimes difficult to distinguish between normal conversation and data collection. As a result there is always the possibility of the participants introducing issues that may not be related to the subject area, or issues that are very sensitive. I therefore reminded each participant that quotes may be used in the thesis and that they would be anonymised to protect their confidentiality.

I realised that I had to deal sensitively with the participants during the interviews because if the interview was going well then the homeopaths could be disclosing information that could leave them feeling vulnerable. There was always the possibility that sensitive or challenging issues concerning the consultation would arise as participants were asked to reflect and review in depth their experience of the homeopathic consultation during the interview. The participants were advised that if this happened then they could turn off the recording equipment. Prior to the interview I recommended that the homeopaths be in contact with a supervisor or their peer support network should the need arise to discuss any of these issues. As Patton (2002) acknowledged although the purpose of a research interview was to gather data a good interview lays open thoughts, feelings, knowledge and experience. The process of being taken through a directed, reflective process affects the person being interviewed and

leaves them knowing things about themselves that they did not know or were not fully aware of before the interview. Within this there was also a duty to patients and patient care. I therefore ensured that the confidentiality of patients mentioned in the interview was maintained by not mentioning them by name and perhaps changing details so that the patient could not be recognised.

There were no direct disadvantages of participating in this research for the practitioners, although some of the participants were self employed and were therefore giving their time freely. Some of the participants found the process helpful in reflecting and reviewing the consultation process, and it was envisaged that information obtained from the study would be used to enhance therapeutic outcomes and to gain a better understanding of the homeopathic consultation and practitioner skills.

3.2.4 Challenges encountered with the interview

Departmental grounded theory meetings provided a forum for discussing other issues related to the research. These issues included how I as a researcher affected the research process at each stage of the research and ethical issues and dilemmas which occurred continuously through a research study. A reflexive journal was also used during the research to note my thoughts and reflections and issues that could be used for reference later on. For example the following extracts (Figure 2 and Figure 3) were an example of two journal entries which were made before and after interviewing a medical homeopath and showed how prior assumptions could affect the research process:

Figure 2: Journal entry before interview

Journal Entry: November 2005

Tomorrow I will be travelling to M... to visit R.S. This will be my first meeting with a medical homeopath and I am feeling quite nervous as he is aware that I am a non medical homeopath and I wonder how he will relate to me and whether I will feel the urge to constantly justify myself. I am also aware that I have at times colluded in the general assumption within the non medical homeopathic community that medical homeopaths practice a "lesser" version of homeopathy. Therefore I am reminding myself that at present I am primarily a researcher and that it his views that are important and mine can be set aside. Additionally I am reminding myself that these assumptions cannot be used to form an opinion.

Figure 3: Journal entry after interview

Journal Entry: November 2005
<p>I really enjoyed the interview with this homeopath, especially as I was able to put my prior assumptions and prejudices to one side. This allowed me to see that this medical homeopath had all the concerns and issues that many non medical homeopaths have. He was extremely helpful and willing to talk and this made me realise that my insecurities of being a non medical homeopath were unfounded (at least as far as this homeopath goes) and were completely my issue and not his.</p> <p>I was also very aware in this interview of the dichotomy in my position as a researcher and a practitioner. I am part of the construction of this data, but I need to be cautious that I do not influence the participants with my views.</p>

The perspective that I as the researcher brought to this study was part of the context for the findings (Patton 2002). The dual role that I had as both homeopathic practitioner and researcher had inherent tensions and these tensions were most noticeable when I was in conversation with other homeopathic practitioners and with other researchers. I was aware therefore of feeling apprehensive about how I would present myself for the interviews. Was I a practitioner doing research or was I a researcher who also practiced? The difference between these two different stances was subtle, but one of the biggest issues facing practitioner researchers is the way in which their knowledge and identity affect the collection of data (Reed 1995). My practitioner experience could not be ignored and I decided to be completely open about my experience as a practitioner. Moreover many of the homeopaths that I contacted to interview would be aware of me as a homeopath, as the homeopathic community is small. Presenting myself as a practitioner doing research meant that I had to retain a certain objectivity from the practitioner role so that the participants could answer freely and feel able to express their perceptions without the constraints of my preconceptions and assumptions. This was a major challenge for me initially, but became easier as the interviews progressed. As I relaxed into the identity of a researcher it appeared as if my participants also relaxed. Therefore I felt that my dual role was more of a challenge for me than my participants, although two of my initial participants took several moments before they relaxed into the flow of the interview. I recorded an example of this in my reflective journal in Figure 4 below:

Figure 4: Journal entry showing practitioner uncertainty

Journal entry: January 2005
<p>I interviewed Maggie today.</p> <p>This was my first pilot interview I was very unsure of myself as a researcher but excited as well. I think that Maggie was aware of my nerves because she also expressed nerves about the interview. We had a couple of false starts where I had to turn of the recorder and we started again with the interview, the second time made us laugh and I felt that Maggie was more relaxed after that.</p> <p>After the interview Maggie gave me a cup of tea and she admitted that she had felt nervous because of my role as a researcher, she felt judged and unsure as to whether her answers were right or wrong.</p> <p>I was certainly aware of her nerves at the beginning of the interview but I felt that we both relaxed as the interview progressed and Maggie seemed willing to disclose sensitive and personal information in order to illustrate her points. I felt that this interview went well and I am really looking forward to meeting my next few participants.</p>

Although I found the dichotomy between my dual roles challenging I also felt familiar with the process of the qualitative interview. There are many similarities between a therapeutic interview and a qualitative research interview (Hutchinson et al. 1994). Both are open ended, both are guided by the participant or the patient and in both the researcher/therapist and the participant/patient respond and influence each other. Additionally a homeopath's role is to encourage self disclosure, the expression of feelings and emotions and attitudes and likewise a researcher also encourages this disclosure as a means of understanding the perspectives of the participants.

My familiarity with homeopathic practice was at times a disadvantage as I sometimes failed to question that which seemed obvious to me as a practitioner and could have prevented me from seeing practice with fresh eyes. Having supervisors and colleagues question these omissions meant that I had to return to the data, or to collect further data, to elucidate these aspects. On the other hand as a homeopathic practitioner I shared a common language and understanding with the homeopaths participating in this research and therefore I was able to report aspects of practice in depth (Jarvis 1999). As a homeopathic practitioner I had similar practice experiences to the interviewees but had to be constantly aware of the potential for

making assumptions and therefore attempted to adopt a stance of neutrality towards the interview data and the findings with a commitment to understanding the world as it was, to be true to the multiple perspectives as they emerged and to be balanced in reporting both confirming and disconfirming evidence (Patton 2002). I dealt with these concerns by having some of the transcripts of the interviews looked at by supervisors to see whether the interviewing technique was open and neutral as possible. In the following extract (Figure 5) of an interview the homeopath was discussing the moment of clarity that the practitioner and the patient can reach during a consultation and as I recognised the experience I forgot my role as a researcher but instead engaged in this dialogue as a practitioner. As a result I expressed my perception rather than drawing out the participant's perception of the experience:

Figure 5: Interview extract showing researcher effect

Helen: The moment people suddenly see something and is, I think, is that sort of, when I think "Ah ha" you know, this is Crotum Tig or something and in that moment people suddenly... you know.. no this doesn't happen a lot but there have been occasions when I think YES and someone will go... "actually I feel different" and I think "that's it" that is it. But I would never say that to someone who's not a homeopath.

Interviewer:: Yes, because it's hard to know what's going on at that moment isn't it? Sometimes just the energy of your realisation is...

Helen: Yes. Well sometimes you can feel the whole dynamic in the room change in the moment. You know, and even that...you physically have to move because things sort of feel different. And then they do and you just think "we're somewhere else now". I don't think I'm ever brave enough to say "okay well I'll see you in a month's time" at that point, "off you go".

Reflexivity enabled me to remember that although the interviews were social encounters they primarily were a means of gathering data concerned with the topic under exploration and as a researcher I needed to keep this purpose in mind. Etherington (2004) described reflexive interviewing as a process where the interviewer noticed and shared personal experiences of the topic and comments on the unfolding communication between both parties. Although researcher disclosure can encourage reciprocal disclosure I knew that it was important to be wary of inadvertently using disclosure and changing the course of an

interview. Etherington (2004) also saw researcher disclosure as a tactic to encourage respondents to open up, to establish rapport and empathy.

Facilitating rapport and empathy with the participants helped build a relationship that enabled disclosure, but it was also important to balance this with neutrality (Patton 2002). I tried to adopt a stance of neutrality which I understood as being non judgemental. I balanced this with empathy that I believed communicated an interest and caring for the participants. For an interview to be effective the two parties must establish rapport and I felt that for this to occur I had to be fully present in the situation, attentive and responsive to the verbal and non verbal communication of the homeopath and myself as the interviewer. This involved transcending the interview process and observing reflexively myself the homeopath and the interview dynamics (Hutchinson et al. 1994).

3.3 Method 2: Observing homeopathic consultations

The decision to observe homeopathic consultations was made to test and further explore the categories that had emerged and that collectively formed the theoretical model that was developing. Observations of the consultations had several advantages. Through observation I was able to understand and capture the context within which the practitioners operate and interact in the natural environment (Timmermans & Tavory 2007). The practitioners reported that the environment that they created in their clinics facilitated patient disclosure and through observation it would be possible to see how this happened. Observing the consultations allowed me to see the behaviours that the participants had described in their interviews. This enabled a clearer understanding of the participants' verbal reports. Additionally identification of a mismatch between verbal reports or actions and actual actions could occur (Creswell 1998). For example, many of the participants described using empathy in the consultation and it would then be possible to see whether this actually happened through observing the consultation. Moreover, as an observer I had the opportunity to see things that may routinely escape awareness among the participants of the study and to observe actions and behaviours that the participants would be unwilling or unable to talk about in an interview (Patton 2002).

3.3.1 Recruitment and Sampling

The initial inclusion criterion for the observations of the consultations was that the practitioners should be private medical and non medical homeopathic practitioners. The decision to restrict the observations to non NHS practitioners was made because of time considerations, as it would have taken too long to receive ethical approval from all the

relevant Primary Care Trusts. Another inclusion criterion was that the participants had supervisory support. I initially approached the 25 participants who had already been interviewed by me as this would confirm, refute or elaborate on the interview data. However, none of those approached were willing to participate. I also approached new prospective participants, a further 30 medical homeopaths and 50 non medical homeopaths inviting them to participate. These new participants would provide a different perspective to the interview data thus enabling a more complete understanding of the categories and the developing theoretical model. Of these only 2 non medical homeopaths agreed to participate.

I had originally planned that 8 observations would give enough data to further explore the properties of the categories in the theoretical model as I was looking for depth of information rather than quantity. The prospective participants were sent a letters inviting them to participate (see Appendix 11) in the observations. Included with these letters was a participant information sheet (see Appendix 12) and a form to complete (see Appendix 13) and return to me in a freepost envelope indicating their interest in participating in this research. On receipt of the completed form I was able to contact the practitioners to confirm verbal consent and to make arrangements for the observations to take place. These discussions included informing the homeopath about the process of recruiting their patients into the study. I also instructed the homeopaths on the criteria for them to identify appropriate patients. For example patients were not to be recruited if; they were from any vulnerable group (i.e. prisoner populations), they had mental health problems, they had drug or alcohol dependency problems, they were unable to give consent, they had a terminal condition, and if they were under 18.

The homeopaths were then asked to write to a selection of existing patients from their patient list (approximate size of a patient list of a private practitioner of homeopathy was a maximum of 500). New patients were to be asked by the homeopath when they booked their first appointment with their homeopaths if they wished to receive information about the research, which was then sent to them. Both existing and new patients received a letter from their homeopath which enclosed an invite to participate (see Appendix 15) and a patient's participant's information sheet (see Appendix 16). The patients were also sent a form (see Appendix 17) to complete, sign and return either in a freepost envelope to me or in a stamped addressed envelope to their homeopath. On this form the patient could give permission for the researcher to contact them so that if they required further information then they could request it. Additionally they could indicate their interest or no interest in participating. This form could then be returned to me and I then contacted and informed the homeopath that their patient had indicated willingness to participate and we arranged a

suitable time for the observations. If the patients contacted their homeopath directly then the homeopath would then contact me to arrange a suitable time for the observation. I planned that I would use both participant and non participant observation depending on the preferences of the practitioner and the patient, recording the observations with a digital camcorder.

3.3.2 Conducting the observations

In total I observed 5 consultations, 3 consultations from my 2 participants and 2 of my own consultations. Once the practitioner had contacted me to confirm that they had a patient willing to participate arrangements were made for me to visit and record the consultation. At the request of the practitioners I arrived ½ hour before the consultation. On arrival I confirmed with the practitioner that they were still willing to participate and asked if they had read the participant information sheet and if they had any further questions to ask me. I then set up and positioned the digital camcorder on the tripod to face the practitioner. When the patient arrived I asked them whether they had read the participant information sheet and whether they were still willing to participate and whether they had any further questions. They were also asked whether they wished me to be present or not during the recording. Clear statements were made regarding the demands on the participants' time and about the general direction of the research. For example the practitioners knew that there would be a short follow up interview to discuss aspects of the consultation. Participation in this research was voluntary at all stages and the participants were informed that they could withdraw from the research at any point, for example, the recording equipment could be turned off at any point during the consultation and the participant could decide to no longer participate. Both the practitioner and patient were shown the on/off button on the camcorder should they wish to abort the recording. The participants were also informed that their anonymity and confidentiality would be maintained throughout and quotes used in the research would be anonymised. If the practitioner and patient then agreed to participate they were asked to sign practitioner and patient consent forms (see Appendix 14 & 18) before the observation began. The camcorder was positioned so that the back of the patient and the front of the practitioner was in view, thus protecting the anonymity of the patient. Positioning the camcorder in this way meant that the patient's body language and expressions could not be observed but the intention of the observations was to explore the practitioner's behaviours. Both of the homeopathic practitioners and patients expressed a preference for only the camcorder to be present in the consultation and not me. Although I could not be present in the consultations and therefore could not be open to nuances and atmospheres, I am familiar with homeopathic

settings and have observed and experienced many different types of homeopathic consultations. When they were ready to begin the practitioners asked me to switch on the camcorder and I then left the room. The practitioner informed me when the consultation had finished and I came back into the room and switched off the camcorder. In total two of the observations were for new patients and these recordings lasted 1½ hours each and three of the observations were for follow up patients and lasted up to 1 hour each. The opportunity to discuss the observed consultations with the practitioners immediately after the consultation did not arise as the practitioners had busy clinics. We therefore made arrangements for me to return after the consultations were analysed by me to show excerpts of the consultation back to them to gain further insight and disclosure from the participants to assist with the analysis. Due to the difficulties in recruiting practitioners who were willing to be observed I decided to observe my own consultations. I was used to having my consultations observed and could forget the presence of the camcorder and was able to focus entirely on the consultation. I recorded one new patient consultation and one follow up consultation and the conduct of the observations of my consultations followed appropriate ethical and research governance guidelines as discussed in the last section. My patients were also informed that the consultation would be subsequently watched by my supervisor who would then analyse the consultation. These 2 consultations were analysed by my supervisor (SB) using the checklist (see Appendix 6). The process of recording and observing my own consultations however was an illuminating and instructive process. Although I was used to being observed I had not been recorded before and this process offered me an insight into the way that I conduct consultations because I could observe my self. Reflecting on this I realised that observing your own consultation is a good learning tool and I was able to consider enhancing or changing behaviours that I performed in the consultation that I felt needed to be changed.

3.3.3 Ethical issues

Ethical approval for the observations of the homeopathic consultations was received in December 2007 and was granted by the Southampton and South West Hampshire Research Ethics Committee B (07/H0504/184). The University of Southampton acted as my sponsor and provided the necessary insurance cover. Ethical guidelines established by Beauchamp & Childress (2001) were followed and ethical issues that apply to all three methods of data collection are discussed in section 3.5.

One of the challenges with observation of consultations is that participant anonymity and confidentiality are compromised. The patient's anonymity and confidentiality was maintained by having the camcorder focused at the back of their head and they were not

mentioned by name both in the consultation and in the thesis. However, the practitioners had the camcorder focused on them which meant that their anonymity was compromised. However, they were anonymised within any quotes used in the research. A direct disadvantage of participating in this research for the patients was the loss of the privacy of their consultation. During a homeopathic consultation sensitive information is often disclosed by the patient either intentionally or unwittingly due to the process of the homeopathic consultation. During the observed consultations the patients may have wished to disclose sensitive information but felt unable to because of the presence of the camcorder therefore the practitioner and patient were informed that if they wished to turn off the camcorder then they were at liberty to do so. Feedback from these patients to their homeopaths indicated that they were able to forget the presence of the camcorder particularly as it was positioned out of their view. There were no direct disadvantages of participating in this research for the practitioners although the participants were self employed and were therefore giving their time freely. One practitioner commented that it was interesting to see a recording of themselves during a consultation and considered the possibility of using this method as training tool in their practices.

3.3.4 Challenges encountered with observations

Although I was aware of the advantages of observing consultations I also felt apprehensive about it as I had an intuitive feeling that it would be challenging to recruit participants to this part of the study. This was indeed the case and reflecting on my previous apprehension and the reluctance of the homeopaths to be observed I realised that there were several reasons for this. The homeopathic consultation is an in depth interpersonal interaction in which sensitive subjects are often discussed and the patient pays for the undivided attention of the practitioner. The presence of an observer or a camcorder and the process of being observed would affect those persons being observed (Wallace 2005) and may affect the dynamics of the relationship between the patient and the practitioner. As a homeopathic practitioner and a teacher of homeopathy I am used to being observed in my consultations but remember feeling very self conscious when I was first observed. This made it difficult to focus on the patient who was paying for the consultation, and also made it difficult to listen to the patient properly. Additionally as a patient of homeopathy I have experienced having students of homeopathy observing the consultation between myself and my homeopath. I found this an unpleasant experience as the privacy of the one to one interaction between my homeopath and myself was disturbed, in addition I found that I did not behave in a relaxed fashion, almost as if I was putting on an act. Being observed can generate anxiety, self consciousness

and a feeling of being judged (Patton 2002). Two of the homeopaths that I approached commented that feeling judged was the reason for them to not want to participate. This feeling may be compounded by the negative media press that homeopathy has experienced recently (Goldacre 2007b) and the negative postings concerning individual homeopaths on websites (Lewis 2009).

3.4 Method 3: Homeopathic practitioner reflective diaries

The purpose of using solicited diaries was to gather practitioner reflections on difficult or challenging consultations experienced during clinical practice as a method of negative case analysis (see Chapter 4 section 4.5). An additional advantage of the diaries was that they would allow insight into potentially sensitive areas (Milligan, Bingley, & Gatrell 2005) of the consultation relating to behaviour or thoughts that were inaccessible to participant observation and interviews (Bryman 2008; Elliott 1997). The participants were asked to complete their diaries as soon after a consultation as possible, this type of diary data added an immediacy to the data as the reflections were recorded closer to the event allowing more accuracy and immediacy of recall (Mackrill 2008).

3.4.1 Recruitment and sampling

Similar to the inclusion criterion used with the observations I decided to collect diary data from private medical and non medical homeopathic practitioners. The decision to restrict the diary to non NHS practitioners was made because of time considerations, as it would have taken too long to receive ethical approval from all the relevant Primary Care Trusts. It was also important that the practitioners had supervisory support. I initially approached the 25 participants who had already been interviewed by me as this would confirm, refute or elaborate on the interview data. Of these 25 only 2 agreed to participate. I then approached 30 medical and 50 non medical homeopaths who were prospective participants from the registers of the Society of Homeopaths and the Faculty of Homeopaths. Of these only one more homeopath agreed to complete a diary. This new participant would provide a different perspective to the interview data thus enabling a more complete understanding of the categories, the developing theoretical model and to contribute to negative case analysis. I also decided to complete a practitioner reflective diary as I thought it would be useful to compare my reflections with those of my participants. Letters inviting the practitioners to participate by completing practitioner reflective diaries (see Appendix 19) was sent, along with a participant information sheet (see Appendix 20). Included with these documents was a

form (see Appendix 21) that the practitioners could complete and return to me in a freepost envelope indicating their interest in participating or not.

3.4.2 Collecting the practitioner reflective diaries

In total I gathered 4 practitioner reflective diaries. On receipt of the form indicating an interest in participating I was able to contact the prospective participant to arrange a convenient time to meet. During this meeting I asked the practitioner if they had read the participant information sheet and if they had any further questions for me. I then gave them an exercise book which served as the diary and we then discussed how they were to record their reflections of difficult consultations whilst maintaining patient anonymity and confidentiality. For example the practitioners were instructed to maintain the confidentiality and anonymity of any patients mentioned in the diary by using pseudonyms and by changing details. They were also informed that their anonymity and confidentiality would be maintained as pseudonyms would be used with any quotes in the thesis. Clear statements were made regarding the demands on the participant's time and about the general direction of the research, for example, the participants were asked to complete the diary over a limited period and the practitioners were also reminded that I would need to see or speak to them again after the analysis of the diary. The participants had a choice of completing either an audio, electronic or a paper diary depending on their personal preferences. The practitioners were also instructed that the diary was to be completed over a two week period and as immediately after a consultation or series of consultations as possible reflecting on very recent consultations and particularly focusing on difficult consultations. The practitioners were also informed that they could decide to withdraw from the study at any point. If the practitioners then agreed to proceed with the research then consent was taken face to face (see Appendix 21).

The data collection time was limited to a two week period in order to encourage completion of the diaries, as motivation to complete the diaries can decrease over time (Bryman 2008). The participants were asked to complete the diary with an unstructured narrative format to encourage free expression and reflection (Mackrill 2008). After the two week period the practitioners posted their diaries back to me so that I could begin my analysis. I then contacted the participants again to either meet or speak on the phone to discuss aspects of the diary in order to gain further insight and disclosure to assist the analysis.

3.4.3 Ethical issues

Ethical approval for the practitioner reflective diaries was received in December 2007 and was granted by the Southampton and South West Hampshire Research Ethics Committee B (07/H0504/184). The University of Southampton acted as my sponsor and provided the necessary insurance cover. Ethical guidelines established by Beauchamp & Childress (2001) were followed and ethical issues that apply to all three methods of data collection are discussed in section 3.5.

The use of solicited diaries as a research tool is useful as it can elicit valuable insight into often hidden aspects of the practitioners' daily lives and can facilitate collection of in depth data on sensitive issues. The disclosure of these sensitive issues may necessitate the practitioner to seek supervision. For example, one of my participants recorded in her diary disillusionment with the profession and a desire to retire from homeopathic practice. After the diary was analysed we had an informal conversation where it was suggested that she refer her concerns to supervision which she subsequently did. However all three of the participants commented that a benefit of taking part was that it made them reflect on and consider sensitive issues relating to the consultation.

3.4.4 Challenges encountered with diary data

One of the challenges with data gathered from solicited diaries is that although the participants were asked to consider and reflect on difficult consultations the absence of the researcher means that the participants could conceal information, could deviate from the agenda and choose to set their own tone and agenda of what they revealed.

One of the prerequisites of the diary was that they should contain reflections of difficult consultations; however one of the participants sometimes recorded events rather than reflecting on the events. When this was discussed with the participant after the diary was analysed she confirmed that she did at times have difficulty with the process of reflection. This lack of reflexivity is indicative of one of the limitations of diaries as some participants may not have the skills necessary to complete the diary in the required way (Mackrill 2008).

The process of writing my own reflective diary was as instructive as observing my own consultations. I found the process quite difficult as I was constantly trying to avoid completing the diary; this was partly due to time pressures but also due to other factors. One of these factors was a tendency to skim over issues rather than to reflect in depth. Forcing myself to reflect however had a cathartic effect, resulting in being able to resolve issues that

may have appeared irresolvable or to seek help in the form of homeopathic one to one supervision.

3.5 General ethical issues

There were other general ethical considerations which applied to all three studies. Ethical concerns for upholding the rights of the participants was considered at each stage of this research design within the framework of the four main ethical principles which guide health related research (Beauchamp & Childress 2001). These principles are autonomy (informed consent), nonmaleficence (do no harm), beneficence (benefits of research outweigh risks) and justice (research strategies and procedures are fair and just). This entailed being fully respectful of all the participants and ensuring that they were informed of the implications of taking part in the research, which should be voluntary and without coercion. Maintenance of confidentiality and anonymity of the practitioners and the patients was also ensured by having no identifiable information on either the recorded material or any quotes used in the research and pseudonyms were used. The obvious exception to this as discussed was the observations where the camcorder was focused on the practitioner. The practitioners were informed that the only boundary to their confidentiality was if there was any indication or disclosure by the participants during the study that clearly indicated malpractice or illegal activity and that I would have a responsibility to report it.

Not only was the safety of my participants a concern but also the physical safety of myself as a researcher was an issue. Any risks were reduced by employing a safe method of working and by following the University of Southampton's lone worker guidelines, for example, ensuring that interviewing participants was done in a safe locality and by not interviewing after dark. Also by making sure that my whereabouts were known by other staff and by arranging to call other staff on a mobile phone at a pre arranged time to let them know that I was safe.

Original data is stored in the Clinical Sciences Division of the School of Medicine, University of Southampton. Only I, as the researcher, have access to the original recorded interview and observation data and the anonymised diaries and transcripts. The digitally recorded interviews and observations were saved onto compact disk format and along with the typed hard copy transcripts and the handwritten diaries are stored in locked cabinets. The interviews, transcripts and the observations were stored for the duration of the research on my password protected computer.

Emotionally I was able to bring any concerns that emerged from the research to my research supervision sessions at the University of Southampton and my practitioner supervision sessions. These supervision sessions were very important to help deal with the challenges of qualitative interviewing and sampling for the observations and diaries. The many practical, intellectual and ethical concerns that needed to be considered were demanding and furthermore the practitioner researcher issues also necessitated time to debrief and discuss any worries that I had. The research supervision sessions were supplemented by meeting with peers who were also conducting research using grounded theory methodology. These meetings were vital for several reasons. They enabled me to discuss any ethical issues that arose from the interviewing and sampling process. Moreover they enabled me to understand the application of a grounded theory approach to data analysis.

3.6 Conclusion

In this chapter I have sought to describe my methods of data collection, decisions that I have made in this process and the challenges that I have encountered. The use of a variety of data collection strategies such as interviews, observations and diaries added depth and explanation to the concepts and categories that emerged. However creating grounded theory was not a linear process. The techniques that were used for the research question development; data collection, coding, and analysis were applied simultaneously. The next chapter describes the process of data analysis used in this study.

Chapter 4 Method of data analysis

4.1 Introduction

The last chapter described the process of data collection in this study and this chapter describes the process of data analysis, although they are described separately, in practice in a grounded theory study these processes often occur simultaneously. One of the aims of this grounded theory study was to develop a theory or theoretical model that explained and described the processes which were being explored (Glaser et al. 1967). The process of constant comparison assisted in generating this theoretical understanding as it informed data collection and data analysis. Constant comparison enabled identification of a core category which accounted for the variations in the data and explained a pattern of behaviour relevant for those concerned (Glaser 1978). Constant comparison occurred throughout the process of data analysis in this study and assisted the generation of successively more abstract concepts and theoretical ideas through an inductive process of comparing data with data, data with category, category with category and category to concept.

4.2 Open coding

In *Theoretical Sensitivity*, Glaser (1978) distinguishes between two types of codes that can be generated from the data; substantive and theoretical codes. Substantive codes refer to the process of open and selective coding and these substantive codes conceptualise the data from the transcripts or source of data. Theoretical codes conceptualise how the substantive codes may relate to each other as a coherent story of the data, this conceptualisation may be aided by the use of Glaser's theoretical coding families. Open coding is the first stage of coding and is a process of fracturing the data down and assigning a label to portions of text. This is a lengthy process as I initially followed both Glaser's (1978) and Charmaz's (2006) suggestions to label the text line by line, and example of this is shown in Figure 6.

Figure 6: Line by line coding

Portion of interview with Roger	Line by line coding
<i>And often you can get an <u>understanding</u> of their <u>expectations</u> of the consultation, that's what I'm after really.</i>	Understanding Expectations
<i>Then I know whether I can <u>deliver their expectations</u> or not.</i>	Delivering expectations
<i>If they come in and say, "<u>I've got candida</u>" then we're not <u>going to get on particularly well</u> because they're giving me</i>	Giving a diagnosis Getting on with patient

<i>a <u>diagnosis</u> which is not really about <u>why they've come</u>, that's the, sort of, you know, one step <u>removed</u> from why they've come and doesn't help you to <u>understand</u></i>	Reason for attending Understanding attendance
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Although this was laborious the benefits were that line by line open coding prompted me to remain open to the data and to see the nuances in it thereby developing theoretical sensitivity to the data (Charmaz 2006). Even at this early stage constant comparison was used to compare incidents with each other in the data. However line by line coding could not continue throughout the whole process of analysis as it was very time consuming and an unwieldy quantity of codes developed. Therefore as I became more familiar with the data and as I progressed with the data analysis I started to code the data sentence by sentence or paragraph by paragraph depending on the type of information that the homeopaths were talking about. I would look at the data critically and analytically by asking myself questions about the data, these questions in turn enabled me to see the actions of the homeopaths and help identify significant processes which allowed me to generate codes that attempted to portray meanings and actions in the homeopaths' story.

Glaser (1978) emphasises that using words that just describe the data and coding for themes do not reflect the meanings and actions of the participants and encourage the tendency to make conceptual leaps and to develop theories prematurely. In order to enable this process both Glaser (1978) and Charmaz (2006) suggest the use of gerunds (words ending in *ing*) not just in the formation of codes but also in memo writing. I therefore adopted the use of gerunds wherever possible as I found that these words moved me away from fixed topics into processes. Charmaz (2006) adds that the codes should have grab and fit, in other words, they should grab the reader and fit the data. The constructivist stance on this is that we construct our codes because we are actively naming data and our codes arise from the languages, meaning and perspective of both the participant and the researcher (Charmaz 2006).

The following transcript examples (Figures 7-10) shows how using open coding and comparing the data between codes and interviews can enhance a conceptual understanding of the codes which can enable category formation.

Figure 7: Portion of interview showing open coding

Portion of interview with James	Open codes
<i>It's more important, the <u>actual words</u> they use are more</i>	Listening to language

<p><i>important than the actual particular details of the story in this case is I think because they're <u>closer to the actual experience</u>. So sort of from that <u>exploration of presenting complaint</u> it's quite a diverse <u>pattern</u> from then on, it can go in many directions and I think one of the things that I've taught myself to do is to <u>listen for what I'm not hearing</u>. So a good example would be were you not hearing anything about a spouse, say, so the whole history is there but there isn't a history of the relationship with the spouse, and that's either because it's actually so.. is it a good relationship and therefore in a way it doesn't need to have anything said about it, or because it's a sort of big complex floating around in the <u>inner world</u> which they have chosen to avoid, maybe <u>consciously</u>, because they're embarrassed or guilty or because they don't see it or something, you know, but often you'll come in and you'll find, I mean, the sort of worst and strangely commonest are in areas like sexual abuse and things like that where you know you <u>pick up sort of vibes</u> about the family in the background and so on.</i></p>	<p>Getting to experience Exploring (patterns?)</p> <p>Listening for what I am not hearing</p> <p>Exploring conscious or subconscious levels</p> <p>Picking up vibes</p>
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One of the open coding labels that was assigned to this portion of text was “Listening for what I am not hearing”. The word “listen” was changed to “listening” which is the gerund, thereby changing the label from a descriptive label to a label that explained the process.

This label was chosen as it explained how the practitioner not only listened carefully to the words that his patients used but he was also listening for what wasn't being said. This indicated that he was taking careful note of the patient's nuances and non verbal clues and exploring this aspect with them. This was also puzzling and stimulated many questions such how does the practitioner know when something hasn't been said and how do they use this information? A memo was written at this point (the process of writing memos is described more fully later in this section) in which I expressed my interest and puzzlement and determined that if the practitioners did not spontaneously mention this aspect then I would seek to explore it with them. The practitioner's actual words were used for this label as this was the best description of this process. Labels that have been abstracted from the language of the participant are described as “in vivo” labels. Using these “in vivo” labels helped me

to preserve the homeopaths meanings, their views and actions by forcing me to pay attention to their language.

The previous example of the open coding “Listening for what I am not hearing” and the following examples demonstrate how the analysis progressed. By using constant comparison between incidents and interviews an understanding developed that these practitioners were talking about different dimensions of the same concept. In the following portion of text (Figure 8) this practitioner was describing how important it was for a homeopath to be sensitive:

Figure 8: Progression of open coding

Portion of interview with Anne	Open Codes
<i>It is very interesting that you <u>know the unsaid</u> because you can <u>feel the pain</u> and so you know that you're not there and you've <u>got to go further</u> and I think that is just a very interesting thing. Because, you know, some people won't be as <u>sensitive</u> to that but I think good homeopaths are very <u>sensitive</u>. You know, I have that phrase, liar, liar, you're pants are on fire, because you know that the person is <u>not telling you the truth</u>.</i>	<p>Knowing the unsaid</p> <p>Feeling the pain</p> <p>Exploration</p> <p>Being sensitive</p> <p>Knowing a lie</p>

Two of the open coding labels that this portion of text was assigned was “feeling the pain” and “knowing the unsaid”. This practitioner was explaining that for her as a practitioner she was so sensitive that she could actually feel a patient’s pain and this would help her to understand the “unsaid” and therefore sensitively explore this symptom with them. This next practitioner described (Figure 9) this level of sensitivity in terms of being in tune with your patients:

Figure 9: Further progression of open coding

Portion of interview with Peter	Open Codes
<i>you just get in tune with them. I think it's that <u>being in tune</u> with your patients which is so fascinating I think. I think that comes from a personal <u>fascination</u> of what people are about and it sounds a bit daft and it's certainly not a it's certainly not a power thing or a.... sort of catching people out, but I've always felt personally there's</i>	<p>Being in tune</p> <p>Being fascinated</p>

<p><i>a sort of, you know, <u>level of intuition</u> which carries you forward in life. I think personally I'm quite an <u>intuitive</u> person. I think <u>gut feeling</u> is so, so important and in fact I was talking to a chap, my squash partner, last night about two incidences where I had acted on <u>gut feeling</u> about a patient and, you know, if I hadn't done that there would have been catastrophic circumstances. And I think it's that level of <u>being in tune</u> which I think just stimulates the patients to feel <u>they're being listened to</u>. And, you know, just <u>puts them in touch</u> with their own condition.</i></p>	<p>Having intuition</p> <p>Feeling it in the gut</p> <p>Acting on gut feeling</p> <p>Listening</p> <p>Connecting</p>
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Two of the open coding labels assigned to this portion of text were “feeling it in the gut” and “being in tune”. These labels were adding to the picture of practitioners who were sensitively able to know when the patient had more that needed to be said. I then interviewed a homeopath who had also trained as an acupuncturist and a psychotherapist, this interview was a turning point in the open coding process for this particular thread of codes, as I realised that she was explaining quite clearly what the previous practitioners had been describing. This was that homeopathic practitioners use all their senses in their case taking such as, feeling, sensing, smelling, hearing and seeing to pay attention to verbal and non verbal clues this puts them in a very high state of sensitivity.

Figure 10: Open coding leading to category formation

Portion of interview with Julia	Open Codes
<p><i>But you see I don't know what comes with time and practice and what has come through <u>my own sensitivity</u>. Because I used to work with Dr Sharma years ago who's now dead, and he would <u>smell disease</u>, I mean that was his sense, you know, we would talk about.... so... and as an acupuncturist I've been taught to smell disease so I know, you know, what is it, what's my smell sense?</i></p> <p><i>What's my ability to <u>hear a grief in a voice</u> through acupuncture training? What's my sensitivities that I've developed through psychotherapy? I don't know but I think you make it much tougher if you don't <u>develop some</u></i></p>	<p>Being sensitive</p> <p>Smelling disease</p> <p>Hearing grief</p> <p>Being sensitive</p>

<p><i>of these sensitivities. I think it's much harder to <u>pick up what's going on with someone because that's the art of the case-taking...not to miss perhaps something that <u>isn't spoken about.</u></u></i></p>	<p>Picking up on Not missing the unspoken</p>
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These examples in Figures 7-10 demonstrated the process of my dawning realisation that the practitioners were talking about a level of listening to the patient that allowed them to hear what was not being said by the patient and that this unspoken information was very important for the practitioners. This was unspoken information gathered through the use of the practitioners' senses such as kinaesthetic feeling, hearing, seeing and smelling. After the interview with Julia a tentative category was then formed which was labelled "Perceiving". Assisting the process of forming categories is the process of writing memos.

4.3 Developing categories through memo writing

Memos are theoretical notes about the data and the conceptual connections between categories (Holton 2007). The writing of memos takes place from the beginning of the data collection and analysis process and is a core stage of this process. Indeed Glaser & Strauss (1967) suggest that one rule of the constant comparative method is that if the coding process stimulates thoughts and ideas about the data then the analyst must stop coding and record the thoughts into a memo at any point. Glaser (1978) describes how the writing of memos provides the final write up for the thesis as the process of writing conceptually about the codes and categories as they emerge forms the basis for the emerging theory. There is no set formula for memo writing and can range from a sentence, paragraph or a few pages. The benefits of memoing are that it raises the data to a conceptual level; it develops the properties of each category and stimulates thoughts about the relationships between the categories and their properties. Charmaz (2006) adds that memos catch your thoughts, capture the comparisons and connections that you make and crystallize questions and directions for you to pursue. Through conversing with oneself while writing memos new ideas and insights arise during the act of writing.

The following example, in Figure 11, is a very early memo that was written after Anne's interview (see Figure 8) and was stimulated by my thoughts and considerations or what "being sensitive" entailed:

Figure 11: Early memo

Being Sensitive
<p><i>“some people won’t be as sensitive to that but I think good homeopaths are very sensitive. You know, I have that phrase, liar, liar, you’re pants are on fire, because you know that the person is not telling you the truth.”</i></p> <p>I wonder if this quality of being sensitive to patients has anything to do with intuition i.e. what are they sensitive to? I think perhaps they are sensitive to the cues that the patient is giving them and to making their subconscious knowledge conscious. Also I wonder if this sensitivity informs the homeopath about the remedy that they may prescribe.</p> <p>This practitioner also talks about feeling the pain. The downside of this ability to listen very carefully to the patient is that the practitioner gets pulled into their emotional world and they can quite literally <i>“feel the pain”</i>. I wonder about the long term affects of this on the practitioner.</p>

This early memo recorded my questions about the data and provided a foundation for a deeper understanding of the data to develop as the study progressed. However I did not discard my early memos as Glaser (1978) suggests that early memos are not discarded or rewritten but enlarged upon, which I did in the following memo which encompasses my initial ideas relating to sensitivity and intuition mentioned in the early memo. The combination of writing memos and the process of constant comparison led to the formation of the category “Perceiving”. The following memo extract, in Figure 12, represents the ideas that it stimulated at the time:

Figure 12: Memo entitled Perceiving

Perceiving
<p>I have named this memo perceiving as this is the name that some homeopaths use for the process that they go through in order to understand the case and the patient. It is the art side of homeopathic skills as opposed to the science which is the distilling of the information. This is a tentative name for this category at this point, as I’m not sure if it fully expresses the process here. I must discuss this with my supervisor and explore whether homeopaths recognise this term.</p> <p>Perception is the process by which sensory stimulation is organized into usable experience. Homeopaths talk about the process of using all their senses to hear, see, and feel the patient’s</p>

words.

Refer to the memo on intuition here, as this memo mentions much of the information that I need to write about. There is a sense of intangibility about this skill, perhaps because it is something that we all use in everyday conversation and interaction without thinking about it and analysing it. In the homeopathic consultation however the homeopath is highly sensitised and therefore is aware that they are in this state and yet have often not analysed the skills that they are using.

Perceiving is a higher level category to intuition as it also encompasses the personal feelings of the homeopath and other skills that are utilised when the homeopath is in a high state of attention. Anne describes it very well in her interview by talking about “seeing the Gestalt”

According to Gestalt psychology, which gained popularity after World War 1; Perception is to be understood not by analysing isolated units such as single sensations, but by taking into account total configurations (German, *Gestalten*) of mental processes. In this view, the real perceptual unit is the form: a mental structure that takes its attributes from a corresponding structure of brain processes. Experiments by proponents of the Gestalt theory showed that perception of form does not depend on perception of individual elements making up the form.

Thus, “squareness” can be perceived in a figure made up of four red lines as well as in one of four black dots. Similarly, the mind experiences music not as a compounding of individual notes from various instruments and voices, but according to laws of organization by which the individual perceives a single, organized unit from beginning to end. Using sensory “bits” of information we then can construct a “whole” meaning.

The ability to “honour their patients”, to “facilitate the intelligent body” etc. This later being a reference to memo 17. “Being finely tuned” are all references to the process and the state of perceiving.

I think that some homeopaths naturally have the ability to be finely tuned to their senses and others have to work at it, but essentially it is a skill that we all possess in order to have normal communication

Words are symbols for what we perceive with our senses. They communicate what we think, feel and do. The more complex the idea or thought, the more difficult it is to express it precisely in words.

In living our lives and communicating with each other our perception of reality is less

important than reality itself. Some would argue that there is no ultimate reality, only the illusion of our perceptions.

Our perceptions are influenced by:

1. Physical elements - what information your eye or ear can actually take in, how your brain processes it.
2. Environmental elements - what information is out there to receive, its context.
3. Learned elements - culture, personality, habit: what filters we use to select what we take in and how we react to it.

The process of writing a memo captured ideas that occurred and although initially they may have appeared irrelevant it was quite liberating to be able to express ideas without concerns about relevancy. Additionally it helped form ideas about the categories and their relationships, for example, on writing the memo about “perceiving” it became apparent that this related to the process of “distilling” which was the category concerned with the more structured side of the consultation such as looking in materia medicas and repertories and that both of these categories were concerned with “matching”. This was later confirmed when an early version of the theoretical coding story (see Appendix 24, Part 1) was presented to a group of homeopaths and researchers (presentation made to the research group at the Bristol Homeopathic Hospital June 2006).

4.4 Developing categories through delimiting

Coding subsequently became more selective as the collection and analysis of the data became focused on particular codes and memo writing increased the depth and understanding of the data. Glaser (1978) refers to this stage as selective coding and Charmaz (2006) refers to it as focussed coding. Large amounts of data can be sifted through using the most significant and or frequent earlier codes to determine the adequacy of these codes. The data is reconstructed at this stage by grouping the codes into categories and encompassing categories with other categories, this process is called delimiting (Horton 2005). The Memos at this stage become more focused, detailed and relationships between categories become apparent whilst also showing gaps for theoretical sampling. Moving from open coding to focussed or selective coding is not a linear process (Charmaz, 2006) but evolved and developed by studying earlier data afresh and by using the constant comparative method to compare previous codes.

After 25 interviews 127 open codes emerged which I subsequently delimited to 35 categories. Through theoretical sampling and further data collection and analysis some of the categories proved to be higher level categories and could therefore absorb some of the other categories, for example the category “perceiving”, “distilling” and “finding the remedy” were all absorbed by the higher level category “matching” this procedure continued until there were 7 main categories (Figure 13). This process of delimiting or of being selective in the coding helped to manage the vast amounts of data (Glaser 1978). The naming of the categories was under development even during the final writing of this thesis as the process of writing was part of the inductive process and as such was part of the analysis. An example of this was with the category “influences on practitioner”, originally I called this category “modelling” which represented the myriad of models that the practitioners bring to the consultation e.g. models of health and models of practice. However I soon realised that the concept “models” meant different things to different people depending on their perspective additionally the title “modelling” did not sufficiently represent the concepts and categories that it encompassed and so the category title was changed to “influences on practitioner”. This process of cross checking my coding and category strategies and interpretation of the data with my grounded theory group and my supervisors ensured consistency with my coding, that any missed points had been identified, it also encouraged a diversity of viewpoints and ensured that my interpretations were realistic.

Figure 13: Delimiting the categories

Initial categories that emerged out of the open coding and concepts:	Higher level categories that absorbed the original categories to form the final categories:
Actively Connecting Disconnecting Establishing rapport Maintaining presence Energetically empathising	Actively Connecting
Method of practice Training Being influenced Experience Passion/higher calling Belief culture	Influences on Practitioner
Unravelling Disclosing Exploring Travelling together	Exploring the journey together
Perceiving Distilling	Responding therapeutically

Other therapies Finding the remedy Therapeutic consultations matching	
Structure Rationalising expectations vitalising varying flow of consultations levels of consultations wholeness collaborating	Finding the level
Practitioner characteristics Self knowledge Own journey Skills Experience Boundaries Challenging patients Coming up with the goods Energetically tiring Practitioner self care Being rewarded Letting it go	Understanding self
Healing Transformative change Aha moment Getting clarity	Healing

4.5 Theoretical coding

The next stage of coding is called theoretical coding. This is a more sophisticated level of coding that weaves the fractured data back together, by taking the categories that have been selected and showing possible relationships with each other. This allows an analytic story of the data that has coherence, thus moving the story and process in a theoretical direction (Glaser, 1978). The aim of theoretical coding is to raise the substantive codes or categories to a more abstract conceptual level which then form the basis for the final substantive or formal theory (Glaser 1998). There are two types of theory in grounded theory. Substantive theory is the most common and refers to a specific context and area of study. Formal theory is broader and more conceptual, as it can describe a human experience that can be demonstrated across different situations and contexts. Glaser is unclear however, about what a grounded theory should look like, leaving it open to interpretation (Chenitz et al. 1986). In an effort to overcome this difficulty and direct researchers, Glaser presented examples of theoretical codes derived from various contexts that he called “Coding families” (Glaser 1978; Glaser 1998) which form a theoretical framework for the categories to fit into.

However the “coding families” have also been criticised as being confusing for the novice researcher especially if they have no background knowledge into the contexts from which the “coding families” have arisen. A personal communication with Charmaz (2008) confirmed that it was not entirely necessary to use the theoretical codes in order to link substantive categories together but she advised that using the codes as a framework can help organise the data. It is within this confusing landscape that I used Glaser’s 6 C’s family of theoretical codes which refers to the conditions, contexts, causes, contingencies, consequences and co-variants within the data. The 6 C’s framework can assist in the development and organisation of the categories in the theoretical model.

To enable this process I used a technique called diagramming extensively in this study to enable the development of the categories and the theoretical codes. By providing a visual representation of the categories I was able to make sense of the data as a process providing concrete images of my ideas (Charmaz 2006). These diagrams constantly evolved and changed along with my depth of understanding of the data and they facilitated identification of the core category. In this study I developed many diagrams but will present three as an illustration of my process. The first theoretical coding story of the consultation emerged after the first 14 interviews had been completed and analysed (see Appendix 24, Part 1). This was quite a crude model and occurred before many of the categories were delimited. It also illustrated the first stages of understanding each individual category as part of a whole story line and showed how they were thought to relate to each other. Once the story line was completed and I had begun to discuss it with other practitioners I soon realised that it needed to be established whether this was in fact a story that related to other practitioners experience or whether this was just my experience as a homeopath. Continuing Professional Development seminars, teaching meetings, presentations to group of homeopaths allowed feedback which led to refinement of the ideas, delimited the categories and furthered the development of the model. The next model (Appendix 24, Part 2) emerged after the 18th interview and although it illustrated the ongoing process of delimiting the categories it also illustrated that despite the quantity of feedback there was significant uncertainty as to how the categories fitted together and their true relationships. This in part was possibly due to a lack of clarity of the nature of the core category and it retrospect it also indicated that there was more theoretical sampling to be done which indeed occurred. The use of theoretical coding can also guide theoretical sampling as the data is constantly questioned.

4.6 Integrating observation and diary data into the model

Therefore although by the end of the interviews a tentative theoretical model had been developed it was still necessary to answer some of the questions being asked of the data through further data collection. It was at this point as described in chapter 3 that I decided to observe homeopathic consultations and collect solicited practitioner reflective diaries. In order to assist with analysis of the observations and diaries a checklist was devised and developed from the tentative theoretical model (See Appendix 6 and Appendix 24, Part 3). The checklist was a list of sensitised categories that I brought to the data through the previous collection of interview data; the sensitizing categories orientate and focus the data collection and analysis (Patton 2002). The notion of sensitising concepts was developed by Blumer (1969) and is acknowledged as being helpful in analyzing observational data. Patton warns however, that the sensitised categories should not dominate the analysis but rather should facilitate the understanding of the world under study. This was done so that at each analysis of the observed consultations notes were made alongside each category where the observation demonstrated either confirmation of the existing data, discrepancies, contradictions and any new data observed (see Appendix 6, for an extract of one of my consultations analysed by my supervisor, SB, using the checklist). The solicited practitioner reflective diaries were also read to elicit data that confirmed, refuted or provided new data such as data which focussed on difficult or challenging consultations. Figure 14 presents an example of information, obtained from my consultation analysed by my supervisor. This example added to the interview data to give a broader picture of the consultation.

Figure 14: Integrating observation data

Time into consultation	Notes on Empathy
07:26 to 15:00	Noticeable your anticipation of shock before daughters' trauma revealed. Very drained. Very empathic expression leans towards patient.
38:48	Shock apparent about son's train crash. Big swallow – "MORE" Again empathic leaning towards patient.
44:00	Facial expression on hearing about ex husband's autoimmune disease

In the above analysis my supervisor recorded moments in the consultation when my body language and facial expressions demonstrated shock at some information that the patient had disclosed. In addition she recorded empathic body language and facial expression. This information added to the interview data as the practitioners discussed empathy but did not

discuss their body language. The data obtained from both the observations and the diary data did not change the categories but instead deepened my understanding of how they linked and the properties within them. For example Figure 15 presents an extract from Beth’s reflective diary:

Figure 15: Integrating diary data

Beth’s reflective diary
<i>“I find this patient really tricky, she doesn’t speak English well and I struggle to understand her. If I don’t understand her then how can I decide what needs treating and how to treat her? Somehow I have to find a way to connect or I’m not going to get anywhere with her.”</i>

Beth’s extract helped me to understand the links between the categories and specifically a problem that was encountered in practice.

The use of both the observations and the diaries provided a form of negative case analysis which identified data that did not fit in with the existing patterns and trends. Negative cases were also looked for in the literature and the existing interview data. Negative cases should not be ignored and discarded in grounded theory but can be integrated into the sampling and analysis process and the emerging theory or theoretical model (Morse 2007). Patton (2002) suggests that the benefit of negative cases may be that they provide exceptions that prove the rule, cast doubt on the rule or change the rule altogether. Strauss & Corbin (1990) add that negative cases add variation and depth of understanding as the inclusion of negative cases or the views of participants that differ from others provides a balanced perspective. The negative cases that were identified in the data and in the literature provided valuable insight and alternative interpretations of the consultation that may not have been elicited otherwise. An example of this is presented in Figure 16:

Figure 16: Negative case from diary

Extract from Yanisa’s diary
<i>“its such a relief not to care so much, I don’t mean that my patients are getting poorer treatments from me than before. I just don’t really care whether they want treatment or not!!”</i>

Yanisa's extract challenged my preconception and some of the interview data that the homeopaths were highly empathic people who always cared about treating patients with homeopathy. In the findings chapters I have presented and discussed evidence of negative cases and shown how these have challenged my assumptions or contradicted data. For example, throughout the findings chapters I have referred to Roger who, on occasions presents an alternative view to the other practitioners. This alternative view may, at times, have challenged any assumptions that I had about the consultation.

The turning point in my understanding of the process of the consultation came during discussion of my analysis at a departmental postgraduate student grounded theory meeting in which I came to the tentative conclusion that the core category was "connecting".

4.7 The core category

Both Glaser and Strauss agree that the goal of grounded theory is to generate a theory that would account for a pattern of behaviour that is relevant to the participants, and that identifying a "core category" is key to the process of a generating a grounded theory as it has explanatory power (Glaser 1978). According to Glaser the core category is related to all the other categories which proceed to explain how the participants resolve their main concern. The core category is the central category around which all the other categories are linked and is the basic social-psychological process (BSP). This BSP is a process that occurs over time and explains changes in the participant's behaviours, feelings and thoughts. To be effective a core category must have the following requirements:

1. It must be central in the research and should be related or linked to all other categories.
2. It must be stable, and this can be seen if it is a recurrent pattern in the data.
3. It must be complex and take more time to saturate (identify its properties) than other categories.
4. It has more power if it has clear implications for formal theory
5. It emerges naturally without being forced by the researcher and should be discovered towards the end of analysis.
6. It should be able to explain variations in the data.

Although for Glaser and Strauss identification of a single core category is central to a grounded theory, others disagree. Charmaz (2008) for example, considers that a core category could be absent from the analysis or multiple core categories could emerge.

Dey (1999) also questions whether having only one core category as a pivot for the theory may underestimate or exclude the role of other important factors. I was thus presented with a dilemma of whether a core category would emerge and whether it was necessary in order for theory development. Therefore although *connecting* (see findings chapter 9) satisfies all of Glaser's criteria and had been present and central in my diagramming of the homeopathic consultation I realised that I had been reluctant to present it as the core too early so that I did not force the data. Furthermore my questioning of whether a core category was essential blinded me to what was becoming increasingly obvious in the data. Additionally during the analysis it can be easy to make assumptions about the data and there can be several candidates for a core category therefore it is necessary to constantly look for the main problem of the participants (Dey 1999). It was with this in mind that I embarked on the final stages of data collection and analysis with the observations of the consultations and the practitioner reflective diaries.

4.8 Theoretical saturation

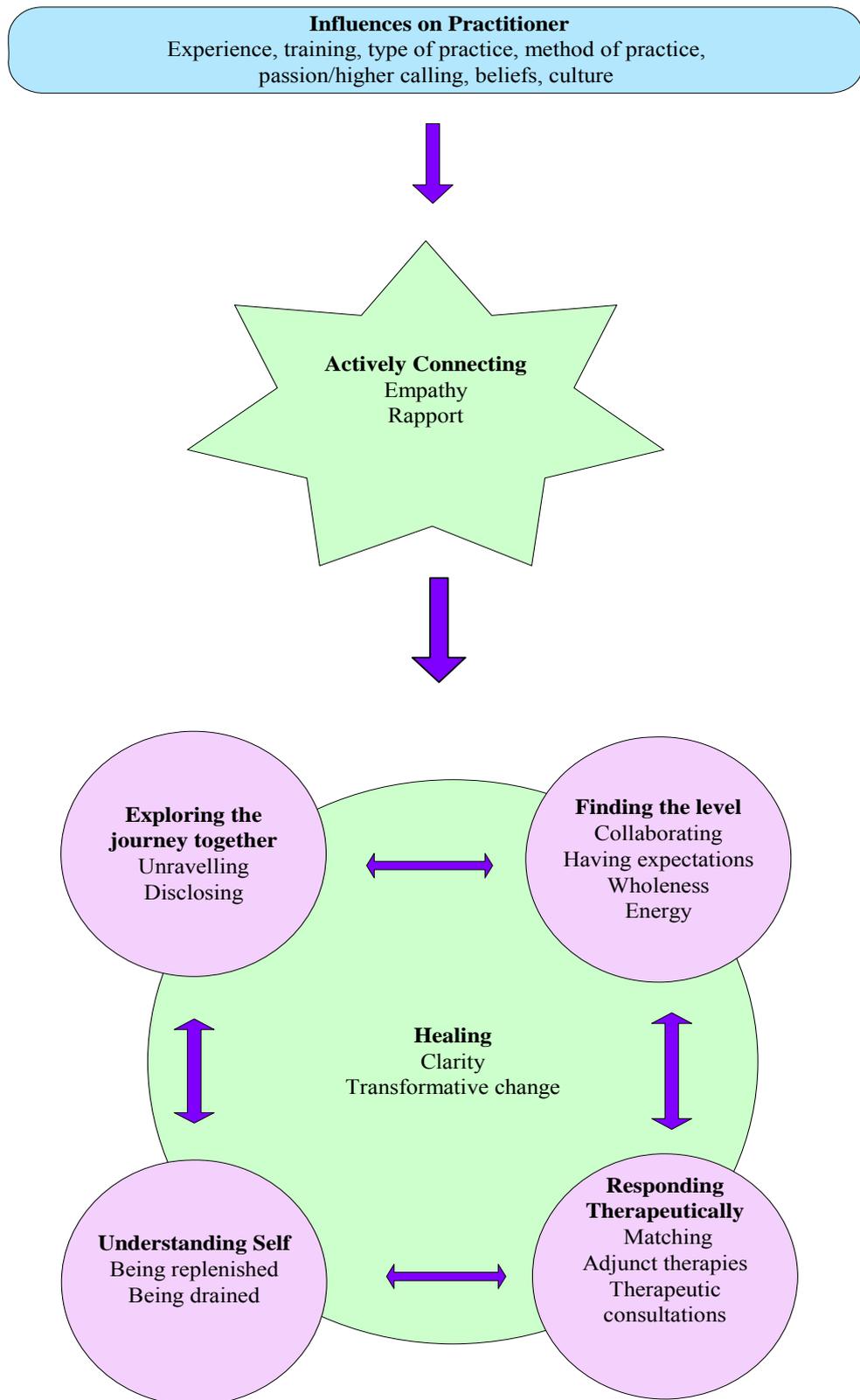
The process of theoretical sampling is supposed to continue until the categories and their properties and dimensions as well as links between the categories were well established, leading to theoretical saturation of the data and the categories (Strauss et al. 1990). Glaser and Strauss (1967) advise that theoretical sampling leads to the researcher being theoretically sensitive to the data as inevitably you become immersed in the data, and I certainly found that the process of remaining open to all sources of data served to increase my sensitivity to the data and added a more complete, if more complicated aspect to the analysis. In addition my role as researcher and practitioner naturally entailed being theoretically sensitive to the topic. Therefore it has been especially necessary throughout to be aware of predetermined ideas and the research journal, supervision sessions and grounded theory meetings have enabled awareness of these ideas. The balance between being so immersed in the data and drowning in the data was difficult to keep and at times I found it necessary to develop a temporary distance from the data only to return to it refreshed. One of the challenges of researching an area of interest that is relatively unexplored was that it was difficult to know when the data was actually saturated. Dey (1999) suggests that it is through the development of a core category that the coding for new data can stop as one of the rationales for developing a core category is to bring the coding for new data to some form of conclusion. Charmaz (2006) explains that saturation is the point where gathering fresh data no longer sparks new theoretical insights nor reveals new properties of the core theoretical categories and it is no longer possible to discover additional data to develop the properties of

a category. However Morse (1989) argues that saturation of the data is impossible if the researcher continues to asks questions of the data and participants as further insights and information will always arise. In this study I certainly reached a point where I was no longer gathering any new information and insights from data collection and it was at this point that data collection ceased. However even during the final writing of this thesis new ideas about the data did emerge through the inductive process of writing about the theoretical model which in turn informed the final theoretical model.

4.9 Conclusion

This chapter along with Chapter 3 illustrated the process of data collection and analysis which was informed and guided by constant comparison of the data. Grounded theory provides a structure to assist the researcher in this process. However at times the structure can vary according to the type of grounded theory applied and navigating this landscape can be challenging for the novice researcher. Despite this the core category *connecting* did emerge from the data and occurred frequently throughout the data. The category *connecting* referred to the practitioner's relationship with the patient and vice versa; it also referred to the practitioner's need for the patient to accept mind body medicine and the practitioner's immersion in homeopathy. The following chapters, chapters 5-9, will present the findings from the data that formed the five main categories that interlinked to form a *theoretical model of a UK classical homeopathic consultation*. This model is shown in Figure 17 (page 67).

Figure 17: A theoretical model of a UK classical homeopathic consultation



Chapter 5 Exploring the journey together

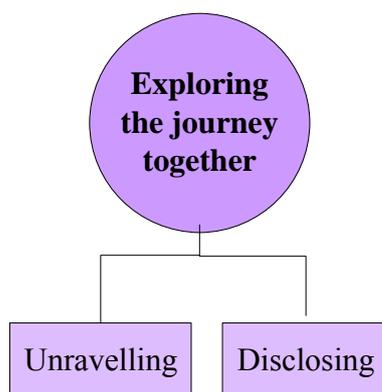


Figure 18: Exploring the journey together

5.1 Introduction

The findings in this chapter and the following four chapters will present each category from the theoretical model (see Figure 17 pg 66) in turn, and will use the data that has emerged from the interviews, practitioner diaries and observations of the consultations to illustrate how this theoretical model of the homeopathic consultation has evolved (see Appendix 25 for a list of participants). This data will also be linked to relevant literature and, where necessary, memos will be included to exemplify the process of constructing the theoretical model.

The category discussed in this chapter is *exploring the journey together*, which evolved from two concepts that will be discussed in the next section; *unravelling* and *disclosing*. These two concepts represent different dimensions of this category and signify the process of the practitioner unravelling the patient's symptoms and the practitioner's need for the patients to disclose their symptoms. Initially, however, I would like to discuss what is meant by *exploring the journey together* and describe the process which this represents. The word "journey" was used by many of the homeopaths to describe the process of patients attending homeopathic consultations. Sarah described how patients may want to attend homeopathic consultations in order to help with life choices:

"we're on this journey and we're getting rid of things and it's great, things are coming up, and you know this can take time...years.... and other people don't want that. Sometimes we're on a crossroads and homeopathy can help us decide and we can gain clarity. But for other people they may just need something for their sore throat and nothing else, for them it's a one-stop journey, in their journey of life."

She explained how some patients may only want to attend one or infrequent consultations for relatively minor complaints and yet some patients may wish to attend more frequently. Helen also described the process of a journey but also related it to the process of exploration:

“They are on a journey and come with the narrative and they... but they don’t always know, you know, what they want treated or what the issue is and it’s a process of exploration between the practitioner and the patient, sort of discovery... we facilitate and there is joint ownership”

In Helen’s extract from her interview she introduced the notion that the homeopath and patient are working together. Yanisa also had a similar explanation *“I just see myself as somebody who they meet on a journey and we travel together for a while”*. Roger, however, had a slightly different approach because, although he concurred with some of the above explanations, he did not describe a process that involved the togetherness that the other participants described:

“Well the patient’s exploring while you’re ... they have to explore really, they have to do the work really. You’re not... you’re just facilitating their journey into working out why they’re ill.”

In Roger’s extract from his interview there was also a glimpse of the meaning of exploring in this homeopathic context. I interpreted it as a process of understanding the patient and their illness through exploration of the patient’s symptoms and therefore related the process of *exploring the journey together* to the process of understanding and interpretation.

In the observations of the homeopathic consultations it was possible to observe this notion of *exploring the journey together* in follow up consultations for both Robert’s and my consultations, where ongoing issues, both emotional and physical, were discussed. However, this was not seen with both my and Clare’s new patient consultations. Clare explained that the type of relationship where ongoing issues could be discussed had not yet been established. Ruusuvaori (2005b) observed this too when comparing homeopathic and medical consultations; in her conversational analysis she identified that patients at the start of a consultation in both medical and homeopathic consultations would present a small narrative of their presenting complaint and mention social and emotional aspects of their illness in the very first description of their complaint. A medical consultation thereafter would focus on the presenting complaint and diagnosing the disease; however in subsequent homeopathic consultations the focus would be on the narrative and the social and emotional aspects of the illness. This then informs patients how to proceed with subsequent consultations.

Although the idea that the consultation was a journey was a reoccurring theme for many of the homeopaths interviewed, this was not always the case. Christine a medical homeopath, when asked directly whether she saw the consultation as a journey, provided a slightly different opinion to the other homeopaths:

Interviewer: "So many practitioners have described the consultation as a journey, would you see it or describe it like that?"

Christine: "Oh I don't think I see that as a journey".

Interviewer: "No?"

Christine: "I think I see the treatment as a journey sometimes. In fact I sometimes say to the patient, you know, well we're just beginning now. A sort of setting off on a process and I hope, you know, that you'll feel better at each stage along the way. I don't really visualise the consultation as a journey"

Christine's opinion that treatment was the journey made me question my original interpretation. Referring back to her entire interview I could see that she, a medical homeopath, was very focussed on treatments rather than exploration. Also she was changing her method of practice to a method that was less focussed on exploration and more focussed on treatment. She described this experience of changing methods as making her "*rather confused*", and making her feel like she was in "*no mans land*", and of feeling "*unsettled*". This different opinion was enlightening and assisted the process of understanding the nature of the theoretical model that was developing as I realised that each practitioner focuses on different aspects of the consultation depending on their individual style and individual abilities, this implied a fluidity and flexibility to the model.

The next section is a discussion that explores the two concepts of *unravelling* and *disclosing* and their relevance to the homeopathic consultation. These two concepts explain how the homeopathic practitioner achieves the understanding and interpretation that occurs in this category. Although these concepts are described concurrently, they may occur at any point during a consultation, as this process depends on the individual patient and practitioner. As observed both in Robert's, Clare's and my own consultations the process of initial disclosure from a homeopathic patient may continue uninterrupted for anything between five to twenty five minutes depending on the patient and practitioner and the patient's familiarity with the homeopathic consultation.

5.2 Unravelling

The concept of *unravelling* the patient's symptoms emerged recurrently throughout the interviews. This concept initially presented itself as open codes that I had labelled often using "in vivo" words to express the process that the practitioners were describing, such as, "*pulling threads*", "*probing*", "*revealing*" and "*exploring*". After several interviews it became apparent that they were describing a similar process which I labelled as a higher level concept of *unravelling* to encompass the meanings of the "in vivo" words. This concept relates to the process that homeopathic practitioners engage in with their patients in order to elicit and understand the patient's concerns. Catherine described it as a process of revealing the patient's perception of their illness:

"every patient is a surprise, every journey with them is different, and what comes out of it is, you know, reveals the patient's perception of their illness, not what I'm trying to find out from them, it's them telling me what's the matter with them, not me asking them. They're telling me".

This process is not passive for the homeopathic practitioners as they appear to be actively engaged in drawing out the patient's version of their illness. Jonathon explained that "*he needs to find a way in*" and in order to do that he used "*open ended questions*". Joanne described it as a process of ferreting around for symptoms and pulling out threads of information:

"... at that point I will then go back over the questions I want, it's like pulling out a thread...he said that I was like a ferret pulling out a thread. I get hold of the end of the thread and you pull it out and I think that's the process of the interview"

Joanne explained that after the patient had finished describing their symptoms she would then pick up on certain concerns that the patient had mentioned and ask further questions. A similar idea to this "*pulling out a thread*" is mentioned by Susan, who talked about this process as "*strategically probing*", and Rosalind who perceived it as "*exploring*":

"If they have somebody they can trust and can open to and preferably somebody that they don't know but in the short space of time if I've made them relaxed enough feel at ease enough then they are able to embrace their higher self and together we can explore"

Observing the process of "*pulling out a thread*" which Joanne had talked about was interesting. In the observation of Clare's consultation there were moments in the patient's narrative when she would interrupt the patient and then pick up on various issues that the

patient had mentioned, asking the patient to clarify and elucidate feelings and motives behind these issues. This was sometimes done by reflecting back language that was used by the patient and then asking what this meant to them. I interpreted this as moments where both the patient and the practitioner were making sense of the patient's symptoms. Yet this process is not always easy for the homeopaths as the reflective diary of one of the participants revealed:

“Saw a patient today whose accent is very difficult and her English is poor, one needs the little nuances of voice and impression to help understand...but what I also find difficult is her story of psychic events in her life, I'm never sure that I understand her correctly... What is cultural and what is the patient?”

Yanisa described how language and cultural barriers in the consultation can make it difficult to understand the patient's narrative. When I discussed this with Yanisa she explained that she rarely felt as if she understood this patient and was often surprised when treatment was successful or when she returned for more treatment. Nevertheless, Yanisa commented that this patient was gaining some benefit from her homeopathic treatment. Yanisa surmised that perhaps the patient was gaining benefit from other aspects of the consultation, such as being heard or the process of receiving and taking the remedy.

My understanding of what the practitioners were trying to elicit from their patients evolved as the interviews progressed. Initially I understood that they were trying to draw out the patient's perception of their illness through an active process. Though, it was not until I interviewed Alan, a medical homeopath, that this process was described as eliciting a “story”:

“sometimes people come in with a very medicalised language, you see people have picked up this lingo. I went to this gastro....and I had a gastroscopy and da de da de da..... and sometimes I might interrupt them and say, well just tell me when you were last well and take me through the process and tell me all the things that happened to you...In other words, to manoeuvre the situation so the patient is telling a story in a subjective way.”

This interview stimulated me to write a memo as I realised that this practitioner had put a name to the process that previous practitioners had only alluded to.

Telling a story

Alan discussed in his interview how some patients attend with a biomedical understanding and language of their presenting condition and he has to manoeuvre the conversation so that the *“Patient is telling a story in a subjective way.”*

This was the first time that a practitioner had mentioned the “story” as being the information that homeopaths require from their patients. It was initially quite puzzling that this had not been mentioned by other practitioners, as throughout my training and subsequent practice homeopaths have always referred to gathering the patient’s history and symptoms as listening to their “story”, so why was Alan the only practitioner who used this word? On comparing and referring to other interviews I realised that all the practitioners that I had interviewed so far were in fact referring to this process when they described the delicate balance of patients revealing their symptoms and of the practitioners exploring and probing for symptoms. Additionally homeopaths use the word “symptoms” to refer to the patient’s entire subjective experience, in other words, anything can be a symptom.

On discussing this with colleagues it was suggested that I look at the literature on narratives and I have started reading a book called “Narrative based Primary Care” by John Launer.

There is an extensive literature surrounding the topic of the use of patient’s narrative in understanding the patient’s subjective experience of illness. In conventional medicine there is currently growing interest in the role that patient narratives can play as a therapeutic resource (Launer 2002; Macnaughton 1998). Launer (2002) points out that, despite this attempt to understand the patient’s perspective, there is still a tension between the patient’s perspective and the need for a diagnosis. There is a sense that the practicalities of modern medicine conflict with the non-technical and open ended process of narratives. From the interviews conducted in this study the homeopathic approach appears to be consistent with a narrative based system. Chatwin (2003) examined the homeopathic encounter using conversational analysis, and found that the patient’s narrative experience of the life world through which they navigate is every bit as important as a therapeutic resource as the more “medical” issues that concern them. Chatwin (2003) found that a key feature of this holistic consultation is the way in which the patient appears to be free to talk at length about virtually anything they care to bring up. This was mentioned in the very first interview with Maggie who stated that:

“I mean it is such a brilliant space for people that consultation because there aren’t many places where you can just go and speak and say what you wanna say and it doesn’t have to lead anywhere necessarily”

These narratives are not only chronicles of events, but they also organise those events into plots that sometimes have chronology. The narratives told by the patients are stories about their experience of the illness rather than the disease process and its treatment (Sakaly 2003). Narratives also attach people to each other and Shapiro (1993) maintains that a narrative is a collaborative joint experience consisting of the act of telling the story and the act of listening and responding to it. It represents the joint effort of the patient and the physician to make coherent sense of a problem within a jointly constructed context (Clark & Mishler 1992). There is an invitation to the listener to join the teller of the story and to enter into the process together (Taylor 2001). This togetherness was implied as early as in the second interview when Rosalind explained that *“together we can explore”*. Alan poignantly described this as:

“In homeopathy a different type of listening is required, a different type of human communication is required altogether because what you want to do...it’s almost as if you want to get a feeling of what it is to live inside that organism that is talking to you.”

This process not only struck me as a method that the practitioners actively engage in, but also as a delicately balanced way of drawing out the symptoms, for example, *exploring, probing and searching* and, as Anne described, of *“allowing the symptoms to emerge”* and as Catherine explained, of *“letting the patient be spontaneous”*. Maggie also said that to be too directive in the consultation was overstepping their role as a homeopath:

“my role is to be the unprejudiced observer and to receive the case to create a space where people feel they can say whatever they want without any judgement coming from me”

Sakaly’s (2003) view is consistent with this, stating that narrative listening is concerned with the patient’s voice and the listener must relinquish judgmental interpretation whilst listening for the patient’s meaning. Only then are questions used to give language and form to the jumble of perceptions and memories in order to unravel the illness experience. However, not all of the practitioners allowed symptoms simply to emerge from the patient, for example, Yanisa described being *“forthright with my questions”* and Julia described her style of consultation as between allowing the story to emerge and being directive;

“frankly if I find..... if I think a patient’s going off on a tangent, I’ll be very directive. And I’ll also use ... also if I feel like we’re going.... If we’ve got someone who’s.....if I’m with someone who’s very loquacious, I’ll stop all talk of emotional states and I’ll just use physical generals, you know, desires and aversions around food because loquacity is just, doesn’t get you anywhere either sometimes... I’ve found over the years”

This interview provoked me to write a short memo to myself on the train back from the interview as I was immediately struck by the dichotomy of being directive and allowing symptoms to emerge:

Being Directive

Julia talked today about how when she has very loquacious patients who go off at a tangent, she will deliberately change the course of the conversation and be quite directive in the way that she conducts the consultation.

Two issues occurred to me. Firstly being directive assumes an agenda to the consultation, the homeopath obviously needs certain information from the patient in order to prescribe and so at some point will have to be directive. Secondly, this practitioner was a very experienced practitioner who had been practicing homeopathy and psychotherapy for over 20 years, so was the ability to be directive in the consultation related to experience?

5.2.1 Style of unravelling

Looking back at the interviews I noticed that the tendency to be directive was related to the style of homeopathy practised. For example, Julia trained with a Greek homeopath famous for his blunt and directive style. Similarly Clare who also had a very directive style in her consultation, also trained with this Greek homeopath. She would allow the patient space to speak, but if Clare wanted more information about an issue she would be quite abrupt and directive in her questioning. Anne described her process of the consultation as *“guiding the patient through the levels of disturbance”*. This relates to a method of homeopathy called the Bombay method:

“The newer methods are about trying to move down into the deeper aspects of this, what we believe is an energetic disturbance of the vital force and so therefore we are encouraged to guide the person into the feeling space after the symptom space and after the feeling space into the space of what we would call delusion, not in the terms

of psychiatric delusion but more how one filters the world, how one sees the world and dream information is really often very, very illuminating within that, round that delusion because you will see imagery or story lines that actually can reflect how the person is viewing the world or what their issues are. And then the consultation, if we have time, moves into what is called the level of vital sensation where the person may actually be able to describe the vital sensation of the disturbance”

This is a very specific method of homeopathy that is less interested in the patient’s story and has a very directive style of finding out about the presenting complaint and is a more structured approach to homeopathic case taking than has been described in this chapter thus far. This method is mainly used by the medical practitioners that I interviewed rather than the non medical practitioners. One possible explanation for this is that some practitioners such as medical practitioners may dislike the degree of uncertainty and lack of structure in the process of homeopathic case taking as they may be used to more certainty and structure in their medical consultations (Thompson & Geraghty 2007). However, despite the differences in style of the homeopathic consultations and the individual practitioners, there has to also be some adjustment for the needs of the patient, greater structure may be needed for a disorganised patient so that coherence in the narrative can be enhanced. The requirements for each patient are different and must be evaluated constantly throughout the interactions with them (Viederman 2002).

In the introduction to this chapter Helen and Roger described their roles as “*facilitators*”. The language of some of the other homeopaths interviewed also indicated this to. For example Peter described what he does as “*giving keys to unlock doors*”, Jonathon talked about “*finding a way in*” and Anne described it as “*gently climbing in the well with them*”. However, this role was not always maintained as Steffie described in her reflective diary:

“She is a nightmare patient....we’re not working together and I feel that I have lost the plot and cant guide this process with her, in our phone consultation today I tried to talk about what a third baby would mean for her family...I was trying to inject some realism and some control back into the consultation”.

Steffie was describing how the role of facilitator that some practitioners described could easily be lost in the consultation leading to a sense of having lost control of the process.

Shapiro and Ross (2002) also view the physician’s role as a facilitator in this process which involves both the patient’s self discovery and the understanding of the physician. This narrative understanding is respectful of the teller’s subjective experience and it requires engagement and action that is based on skills of understanding, recognising and eliciting

narrative (Sakalys 2003). These skills have been described as “narrative competence”. “Narrative competence” is defined as the set of skills required to recognise, absorb, interpret and be moved by the stories one hears or reads. This competence requires a combination of textual skills, creative skills and affective skills: together these skills enable the listener to begin to understand their meanings (Charon 2004). The homeopaths use many strategies that demonstrate narrative competence. Anne, for example, described how the language and the metaphors that the patient uses can help in understanding the patient and prescribing a remedy:

“... I was sure this lady needed an animal, she’d used quite a lot of animal language and gestures, she was very, very fearful of snakes but I didn’t think she was a snake. And she described this dream where... it was a beautiful dream,”

James described a similar experience with a patient and he explained how her idiosyncratic description of her symptoms led him to the remedy:

“There’s a case recently I’ve had of a woman who had a sensation of constriction around her chest and I was thinking of giving her a member of the cactus family... in the end I gave her a fungus because of other factors in the case but they have a sensation of expansion. In fact her constriction was the sense that she was expanding within herself and then these other sort of autumnal fungusy words came through, but that was just by asking her about her presenting complaint,”

Shapiro (1993) refers to one of these aspects of narrative competence as the ability to be sensitive to the patient’s use of metaphor for what it reveals about the patient’s understanding of their illness. To adequately deal with patients’ concerns therapists must be prepared to work with their metaphors as exploring metaphorical language is a way to help the patient develop feelings and associations that otherwise might remain hidden. The use of metaphor has an additional benefit as it creates an atmosphere of closeness and trust and enables the expression of complex concepts relating to illness and health (Konitzer, Renee, & Doering 2003). The danger, however, of relying on the interpretation of the patient’s metaphors to understand their narrative, is if the interpretation of the practitioner contradicts the patient’s interpretation (Brands 2003). This was documented by Beth in her reflective diary:

“Although there are times when I get it right with a patient, I can also get it very wrong. This happened today when I misinterpreted my patient. He referred to a sensation of a constriction in his chest area when his boss came into work. I took this idea of constriction, because he mentioned it in relation to other physical

symptoms, and asked if he was constricted in his life generally. I knew I got it wrong when the patient looked at me blankly and I had to work hard to get the consultation back on track.”

When Beth discussed this event with me she revealed that “*a homeopath has to be careful to not impose their own interpretations or perceptions of the patient’s illness*”. This acceptance of the patient’s perception of their illness and the willingness to actively incorporate the patient’s own reasoning and treat them as valid and relevant is a common thread through the interviews. This process helps reinforce the patient’s own perception of themselves as not only reporter of their symptoms but as someone who can actively take a role in solving the puzzle of their condition (Chatwin et al. 2002).

On reflecting on this concept of *unravelling* it was interesting to note what the practitioners did not say as well as what they did say. Not one of the practitioners referred to or used the word “disease” but used words such as “*journey*”, “*symptoms*”, “*opening up*”, “*patients’ expression*”, “*patients’ experience*” and “*patients’ perception*”. It appears from the data that the practitioners are concerned with the patient’s illness as opposed to the patient’s disease. These views are consistent with Kleinman’s (1988) definition of illness which differentiates between illness and disease. He states that illness is concerned with the lived experience of monitoring bodily processes and the limitations that ensue from disease. Illness is also how the sick person relates to their symptoms, their family and their wider network. Overall cultural background has an important influence on aspects of people’s lives including their beliefs, behaviours, perceptions, emotions, language, educational factors, socio-economic factors and environmental factors which all play a part in the meaning of that illness for an individual (Helman 2007). Homeopathy fits into these frameworks provided by Kleinman and Helman and explains why the use of narrative in homeopathy becomes important.

Although the homeopathic process resembles narrative based therapies there are some differences in the way that the homeopath applies the use of narrative. Some homeopaths feel that they facilitate the process and have less of an input in the narrative, some homeopaths are more exploratory and feel as if they are on a journey with the patient and some are quite directive. This appears to be dependent on the style of homeopathy applied and the experience of the practitioner. More experienced practitioners may feel more confident in being directive, as Julia, Clare and Anne discussed, especially if they are trained in a directive approach to case taking. For homeopaths, there is a purpose to the consultation and the desire to explore the patient’s symptoms arises out of the need to discover the

patient's perception of their illness in order to prescribe the remedy. The homeopaths, therefore, have an investment in the patient's disclosing their experiences and symptoms.

5.3 Disclosing

All the practitioners discussed patient disclosure in their interviews without prompting from me. The concept *disclosing* refers to the homeopathic practitioner's need for the patient to be able to describe their experience of their illness and their symptoms. Catherine described the importance of forming a relationship with a patient that enabled the patient to engage in the consultation:

“Good things. When the patient will engage. That’s quite a challenge isn’t it with homeopathy, that first consultation, particularly if they are brand new to the whole idea, and there are patients who will just bang on about their physical symptoms ... what the doctor said, this test that test and you just have to say I don’t want to hear... you know that’s all very interesting but what I want to hear how you feel about this and what it’s like to have been told you have cancer or you’ve been told you’ve got thyroid problems or whatever. A good consultation is a patient who really will engage and produce the information I want to hear”

The practitioners described this process of disclosure along a continuum of “*allowing the symptoms to emerge*” to “*encouraging*” to even “*challenging*” the patients to disclose. For example Catherine perceived it as allowing the patient to be spontaneous:

“I think if you’re truly going to let the patient tell you what they want to tell you, they need that think time where whatever comes spontaneously next is so important”

This continuum appears to relate to the time in the consultation. At the beginning of the consultation the homeopath allows the patient to begin the story without interruption and then later on comes the process of exploring and probing. This process could be observed in all the consultations I recorded but in particular in the consultations with new patients, where patients would disclose without interruption and then the practitioner would prompt for further information. This process may depend on how open the patient is or how familiar they are with the homeopathic consultation. In Clare's consultation, for example, the patient required very little prompting from Clare and initially talked for 20 minutes before Clare had to prompt for further information. In her interview, Clare explained that the ideal homeopathic consultation is one where the patient needs very little prompting from the homeopath. If this is unsatisfactory, then the homeopath may need to be more challenging to

elicit information from the patient in order to prescribe. For example, Cassie described how she would direct a consultation:

“If I think someone is telling me story to avoid telling me what’s really going on for them, then I might interrupt them. I don’t like doing it, but I might well do. And say, can we just bring this back to you? Or, what’s this really about for you? Something like that. Kind of, trying to focus them back onto their issues. I don’t know about the wisdom of that, you know, I don’t know if I leave out some of the things, if I’m making a judgement that may possibly mean that I cut them off something that I need to know that’s important. But I think all we can do is just use your judgement with it.”

Disclosure is therefore important for the patient in order to express their narrative and for this narrative to be explored by the practitioner. The homeopaths in this study need a degree of disclosure to assist in forming a coherent narrative in homeopathic terms. The whole purpose of the homeopathic consultation is to match the patient’s narrative with the appropriate remedy; one of the ways of doing this is by formulating patterns within the narratives. Sakalys (2003) discusses this idea of discovering patterns in experiences through narrative which then serves as an explanation, and gives meaning and coherence to those patterns. Patterns enable understanding of the patient’s narrative and lead to the remedy required for the patient. It also seems that narrative disclosure is intrinsic to the homeopathic process as the patient’s symptoms and patterns are integrated and embedded in the narrative. Kleinman (1988) refers to this embedding of symptoms in the meanings and relationships that are the patient’s day to day world, he suggests that it is only by understanding the patient that we can understand their symptoms. More recently, Chatwin (2003) found that patients who were familiar with the holistic nature of the homeopathic consultation incorporated and embedded symptoms into accounts of a more general nature, particularly ones that related to their wider ongoing life world experience. These patients were comfortable incorporating psychological or even psycho-spiritual elements into their narrative. Chatwin (2003) also observed that patients less familiar with a homeopathic consultation sometimes had difficulty in adapting from a typical biomedical consultation to the holistic, homeopathic consultation where all symptoms, in any context, are relevant. I did not observe this in any of the consultations observed for this study; however, I have experienced this in practice, particularly with elderly patients who may be unable or reluctant to adapt to a different style of consultation.

5.3.1 Disclosure as a therapeutic tool

Most of the homeopaths in this study recognised the importance of disclosure from the patients, not only as a guide for remedy prescription but also as a therapeutic tool in itself. Joanne described her experience of consulting a homeopath before she became a homeopath, and how that informed her that a patient's disclosure can lead to the remedy:

“The first time I went to see a homeopath it was an incredible experience, I learnt so much about myself. I learnt to grieve which I had never done, I couldn't stop crying and ... he said that's fine. You just have to go in with the remedy, and sometimes you cant get that close with a remedy because they wont open up to you, but they will the next time.”

Pennebaker & Seagal (1999) and Pennebaker (2000) describe disclosure as being at the core of therapy and the act of constructing a story as a natural human process that helps individuals to understand their experiences, to search for meaning and to understand themselves. This process allows one to organise and remember events in a coherent fashion while integrating thoughts and feelings. What is important, however, is that people are encouraged to explore their emotions and thoughts no matter what the content might be and that writing or talking about emotional topics has been shown to have beneficial health effects. In an earlier study conducted by Pennebaker et al (1999), they found that writing about the emotional effects of a traumatic experience over a period of time was also beneficial as the narrative developed over time, in other words, time was needed to develop a coherent narrative in order to develop understanding. This is consistent with the findings from this study, as the homeopaths do not necessarily expect one consultation to deliver the whole narrative and this was described by James:

“I've certainly had plenty of experiences where important things have been said, you know, down the timeline, not at the first consultation.”

As disclosure is important to the homeopaths, they have many strategies that they employ to encourage disclosure. For example, Anne summarised the strategies that many of the practitioners engaged in to encourage the patient's expression of their illness:

“Well, silence is a good way to explore it. Sometimes, you know, in that if you leave a gap the person will be drawn to what they don't want to say...just staying with it, you know, and just coming back to it, you know, tell me more about upset. And then realising the person can't go there and just coming back to it, but tell me a little bit more about the feeling you have when you're upset. So you'd kind of just know that

you needed to return to it. And sometimes I would choose not to return to it, realising that the person's giving you very clear body language or verbal messages that they don't want to go there. But otherwise most people or some people aren't even aware of it and therefore, as you put them in touch with it, it can come as a bit of a surprise and therefore one has to just go very gently and that kind of mirroring language is just very important, I think it's a Rogerian technique but, you know, where you just stay with what they've said and then reflect it and stay with what they said and then slowly but surely they inch closer and closer towards it."

I found that I was puzzled by this concept of disclosure: recognising the importance of it on the one hand for eliciting the patient's perception of their illness for the purpose of prescribing; but also, on the other hand, being prepared to sit and wait for the patient to disclose in their own time:

Disclosure

I am intrigued by the concept of disclosure, as I feel that the practitioners tell me on the one hand that they "*don't expect disclosure*" (Julia), at least not in the first consultation. However, it is evident that they do eventually expect it, as the patients "*eventually do open up*" (Susan).

I find this intriguing as I wonder how they manage this fine balance. The homeopaths narratives revealed that the answer may well be concerned with managing the process of allowing the symptoms to emerge and of being quite directive or, of even challenging the patient to disclose as Maggie described:

"sometimes I'll ask a question and people just trot off an answer and then I... and sometimes it challenges people perhaps. I'm trying to think of examples of that.... yeah sometimes people can get irritated if I'm asking about emotional stuff and you know like well I haven't come here for that why are we taking about that.. I.. which goes back to them not seeing themselves as a whole"

I sense that this can be a frustrating experience for the homeopaths because although they may be taught that they should allow the patient's symptoms to emerge naturally and spontaneously they also talk about "*patients being stuck*" (James), "*guarded patients*" (Maggie), "*having a curtain between us*" (Susan), "*patients that are heavily defended*" (Anne), "*blocked patients wont engage*" (Catherine), "*holding onto symptoms*" (Richard).

Steffie described a consultation in her reflective diary where the patient's reluctance to disclose affected the quality of the consultation leading to her not engaging in the consultation:

“it's hard when you have to drag it out of them, like blood out of a stone, I don't enjoy those consultations, I can't engage and I don't feel that I understand them.”

Despite the frustrations that practitioners may feel with “*guarded*” or “*defended*” patients there is an acceptance that it is often very difficult for some patients to disclose their symptoms. James explained that it can take enormous “*courage*” for a patient to disclose whilst Catherine explained that the patient may need to develop the confidence to expose their feelings:

“you know, there's a huge confidence the patient needs to build up in being able to expose that very vulnerable often part of them and giving them space to do that without keep wiping it with another question”.

Tricia explained that sometimes this is because patients tell homeopaths things that they have never spoken about to anyone else:

“I don't know whether it's specific to me but I've had many people say to me, I've told you things I've never told anybody else. So I think generally I seem to have the qualities that get people to really open up to me, which of course is very useful if you want to get to the bottom of the casean elderly man came to me and at the end of the session he said I've told you things I've never told my priest.”

The difficulties that patients may experience in disclosing their narratives may be concerned with the novelty of a homeopathic and holistic consultation if they are new to homeopathy. It may also take time for returning patients to adjust to these type of consultations as Chatwin (2003) found in his study of homeopathic encounters. Additionally, patients may have trouble revealing their narratives, they may forget aspects of them or, they may be too painful to reveal or, they may conceal aspects of their symptoms or narratives if they want to appear competent or courageous in the eyes of their physicians (Shapiro 1993).

Reflecting on the concept of disclosure, it appears that there is a tension for the homeopaths between needing the patients to disclose and the patient's ability to disclose as disclosing can be challenging and painful for the patient. The homeopath is required to be patient as it can take many consultations to achieve a level of disclosure that enables the practitioner to understand the patient. Prescribing a remedy with confidence entails understanding the

patient's perception of their illness and this can only be done if the patient is ready to disclose and the homeopath can sensitively unravel the patient's narrative.

The language that the homeopaths use when describing the concepts of *unravelling* and *disclosing* is interesting and implies delicate manoeuvring on the part of the homeopath to maintain the balance between letting the patient lead and "*allowing space to open up*", to adopting a more facilitative role and "*encouraging emotional expression*" and being more challenging and "*pushing buttons to open them up*", and "*being directive*". This seems to be a delicate balance and it can go wrong if the practitioner is not sensitively tuned to the patient. The "*togetherness*" of this journey of exploration highlights the importance of achieving a good relationship with the patient. A narrative requires a teller and a listener (Pennebaker 2000). It also offers a way for people, practitioners and patients to connect with each other through the use of story, with the intention of understanding our own and another's beliefs and perceptions about health and well being (Hovey & Paul 2007). The power of this story is located not in the story itself but in the telling and the listening. As humans we construct meaning through language and when a story is revealed it is spoken once by the teller and heard twice by both the teller and the listener (Hyden 1997). Through this revealing of the story there exists an opportunity for meaningful re-evaluation of the understanding and meaning of living with illness (Bury 2001; Frank 1998).

5.4 Conclusion

In the *exploring the journey together* category a process of the practitioner *unravelling* and listening to the patients *disclosing* their narrative, or, subjective experiences of their illness is conducted. Intertwined with this process the homeopath must be able to gauge how much to allow the consultation to be patient lead or how much to direct the consultation and challenge the patient. Central to this process is the relationship that the practitioner establishes with the patient. This relationship is facilitative and at times collaborative, as the practitioner is dependent on the process of unravelling and disclosing of symptoms in order to prescribe a homeopathic remedy. Adjusting and acclimatising the patient to a holistic consultation, if they have been used to a biomedical consultation, is also an important factor in this process. The understanding that the homeopath extracts from this explorative process with the patient enables the next stage of the homeopathic consultation which is labelled *finding the level*.

Chapter 6 Finding the level

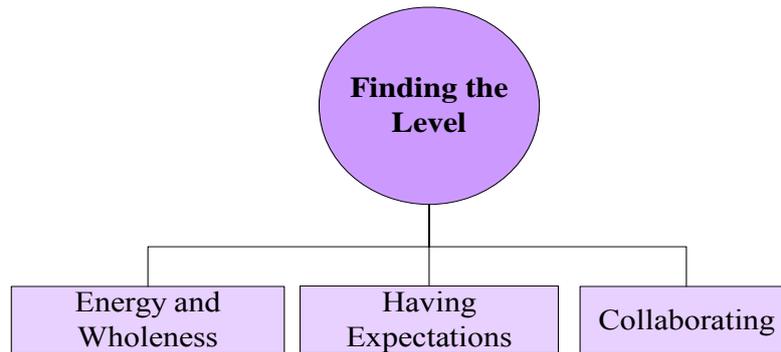


Figure 19: Finding the level

6.1 Introduction

In the previous chapter *exploring the journey together*, I described how the process of *unravelling* and *disclosing* the patient’s narrative could lead to an understanding of the patient’s symptoms: mentally, physically, emotionally and spiritually. This understanding assists the processes that occur in the category *finding the level* that I am going to discuss in this chapter. *Finding the level* refers to an evaluative process homeopaths undergo during a consultation in order to discover how to approach treatment with the patient. This part of the consultation sometimes called case analysis or case evaluation by homeopaths (Owen 2007) consists of evaluating the patient’s ability to heal, the extent of their illness, where the focus of their illness lies and any response to treatment. This process follows on or happens simultaneously to other categories: *exploring the journey together*, *responding therapeutically*, *understanding self* and *connecting*. Encompassed within this category of *finding the level* are four concepts that the homeopaths use as strategies to facilitate this process. I have labelled these concepts: *energy*, *wholeness*, *having expectations* and *collaborating* and will discuss them in this chapter. Initially I would like to discuss in more detail the meaning that I have assigned to *finding the level*.

In his interview Richard described how communicating with patients was an important skill which enabled the practitioner to understand the patient, he referred to it as being a “*chameleon*” implying that the practitioner has to be adaptable to enable rapport with their patients:

“Basically you’ve got to be a chameleon and if you can match your patient and try and understand them at their level, you get a feeling of what that level is... So I think

it's part of the many qualities one needs to communicate with people is to actually perceive that level and to meet them at that level."

What Richard actually meant by "level" is unclear at this point. However, he clarified this later on in his interview when he talked about "getting to the bottom of the problem". Peter also explained it as "getting to the core of their current state". Joanne used the phrase "peeling the onion". They described a process that not only involved *unravelling* and *disclosing* in order to understand the narrative, but also involved searching for the root of their patients' problems, or, searching for where the root lay. The level of the patient's case was, as Tricia related, dictated by the patient's "level of understanding" of their symptoms, and as Richard explained dictated by "the different levels of patients' explanations of their symptoms". Moreover, *finding the level* is also dictated by the homeopath's training and ability to understand the patient and their reason for attending a homeopathic consultation.

Finding the Level

The "in vivo" words from the interviews guided me in understanding and in finding a label for this category. The participants talked about:

"getting to the core", "getting to the bottom of it", "the real problem", "working superficially", "depth of the interview", "working at a profound level", "their deepest, darkest, stuff", "the deeper state".

All the above quotes suggested exploring the depths of a case, but I also understood that the homeopaths were expressing a process of trying to understand on what level a patient's story lay. For example, was this a patient who needed emotional or physical symptoms to be treated and how will they respond to homeopathic treatment?

The processes in this category could happen simultaneously to those in the *exploring* category. This category helped the homeopaths evaluate the treatment options that they could use for the patients which then moved the practitioner through the process to the next category of *responding therapeutically*.

The homeopaths in this study referred to many different options for treatment and approaches to the patient. For example, the "superficial level", "treating constitutionally", "more psychotherapeutic", "keynote prescribing", "working on the level of containment", "pathological", "acute or chronic", "emotional level", "peeling an onion", "it has to be on a spiritual level", "level of dream and delusion", "sensation", and "at the end stage it can be a wonderful modality, as well as the more dynamic processes".

This category is multi-faceted and multi-dimensional.

Do medical doctors undergo this process whilst evaluating their patients' prognosis?

From the memo above it was clear to me that the homeopaths used this evaluative process in order to determine which approach to use in the treatment of their patient, Julia described it colourfully as:

“the rainbow of options in the first consultation that I think experience brings and the connection you make with someone informs all that”

This category could be equated with the idea of prognosis in a medical consultation. Prognosis refers to a physician's estimation of the course of a disease and the outcome for the patient, allowing them the ability to formulate a treatment plan. A recent debate indicated that at times general practitioners focussed on establishing a diagnosis to the detriment of relying on experience and listening to the patient that would inform the prognosis. The debate called for a renewed focus on prognostic research (Dinant, Buntinx, & Butler 2007) and teaching of prognosis in medical schools (Hemingway 2006). This focus on diagnosis can mean that unnecessary laboratory tests are done, particularly for patients with unexplained complaints. The reasons for this have been explained variously as time constraints in the consultation, defensive medicine, diagnostic uncertainty, pressure from an assertive or worried patient and patient expectations amongst others (van der Weijden, Van Bokhoven, Dinant et al. 2002). Notably, although time constraints were mentioned, they were by no means the main factor for the focus on diagnosis rather than on a mix of diagnosis and prognosis. Some of the homeopaths in this study, however, found it necessary to have a diagnosis, as Roger described:

“you want to know really what the diagnosis is, what have people told them, what's the actual diagnosis? If that diagnosis is carcinoma of the oesophagus that has huge implications for what you might or might not do. If the diagnosis is something like reflux oesophagitis or something, it's quite a different game that you're playing with the patient. So diagnosis is very important.”

However Roger, a medically trained homeopath also stated that *“it is almost never the clinical diagnosis that you are actually treating”*. So although the diagnosis was an important part of the information that a patient brought to the consultation as it informed the approach taken, it was not the main focus for the homeopathic practitioner. Their focus was exploring the patient's perceptions of their illness and evaluating the level of treatment.

Although the process of *finding the level* loosely equates to the concept of prognosis it does not fully explain the processes involved in a homeopathic consultation. Examining the concepts that make up this category may go some way to explain the process of *finding the level* as they appear to be intrinsic to the homeopathic process and are strategies that the homeopaths use to assist in the process of evaluation that they undergo in *finding the level* for each patient. The first concepts to be explored in this chapter are *energy* and *wholeness*.

6.2 Energy and Wholeness

These two concepts arose out of the “in vivo” language used by the homeopaths in this study such as “*energy*”, “*vitalistic*”, “*inner energy*”, and “*expression of vital energy*”. Additionally, “*whole person*”, “*not just parts but a whole person*”, “*integrate into a whole*”, and “*mentally physically emotionally and spiritually*”. These phrases and others like them pervade the interviews suggesting an alignment with vitalism and holism, which are two fundamental principles of homeopathy. Although these concepts were at times discussed by the homeopaths in separate contexts they were also often linked by the homeopaths. For example, Sally talked about “*integrating the whole person through the stimulation of the vital force*”. Anne explained “*we look at all levels of the person, it’s an energetic way*”. Richard described it as “*the symptoms from the body or mind are an expression of the vitality*”. The linking of these two concepts stems from homeopathic philosophy (Hahnemann 1833; Vithoulkas 1980). Hahnemann (1833), in line with the orthodoxy of his time, believed in the “*Vis, Medicatrix Naturae*”, the natural healing force which homeopaths call the “*vital force*”. Early homeopaths believed that the “*vital force*” was an energy or “*spirit like force*” that pervaded and linked an organism and was responsible for expressing symptoms; mentally, physically, emotionally or spiritually, as signs of illness. They also believed in the innate tendency of living organisms to self heal and restore health. Nowadays many homeopaths still believe a correctly chosen homeopathic remedy will stimulate the “*vital force*” to facilitate the body’s own self healing mechanism. Homeopaths use both concepts as criteria in evaluating aspects of a patient’s case.

6.2.1 Energy

Anne, a medical homeopath explained how she used the concept of *energy* to help her evaluate the extent of a patient’s illness and where the focus of the illness may lie. Based on this information she then explained that she can proceed to evaluate the treatment that the patient will need:

“You are trying to make tangible something extraordinary which is an energetic vibrational disturbance which no one can see or feel or touch apart from the consequence of that disturbance which is illness in the body, it is this consequence that we look for, is it mental or physical, is it acute or chronic, where do we focus out attention for treatment?”

Anne was describing how homeopaths believe that in ill health the body’s energy is responsible for manifesting symptoms that patients experience. Other practitioners described how they also used the concept of energy to help them evaluate the patient’s ability to heal. Sally referred to *“exploring their vitality shows how they will respond”*. Sarah explained how she would *“look at how vital they are”* and Richard would ask, *“is their expression of symptoms weak or strong, are they frail or vital”*. Susan also explained how she used the concept of *energy* to evaluate the potency (strength) of a homeopathic remedy that she will give to the patient:

“then having chosen a remedy I then look at the patient’s energy and situation in relations to a potency and prescribe that”

Whilst observing one of Robert’s follow up consultations with a patient I noted that he asked his patient some questions relating to *energy*. Robert subsequently explained that this information helped him evaluate the patient’s response to his last treatment:

“Patients should return feeling more robust, more sure of their body’s ability to heal and a general improvement in energy levels”

Although most of the homeopaths in this study had a vitalistic view on health and disease, one homeopath rejected vitalism outright. Roger a medical homeopath stated that *“I don’t agree with the concept of dynamis”*. Here he was referring to *dynamis* as an old expression of vitalism. Yanisa a non medical homeopath with a nursing background was ambivalent about vitalism *“I don’t use words like vitalism I don’t really know what it means myself”*. However, it is particularly interesting that most of the participants, medical and non medical, accepted the concept of vitalism, especially as vitalism is virtually taboo in modern scientific discourse (Fisher 2002). The use of *energy* in assessing patient’s response to treatment has been previously explored in German medical homeopaths (Frank 2002b). Frank (2002b) found that the doctors in his study were able to integrate both biomedical and homeopathic principles into their practices and that the concept of energy was crucial for all their therapeutic decisions, despite them also having a biomedical framework. In contrast a study looking at British medical homeopaths, who acknowledged the benefits of homeopathic treatment for their patients, hardly mentioned homeopathic concepts such as vitalism (May et

al. 1998). The differences between these two studies could be attributed to differences in practising styles between German and British medical homeopaths, or just to differences in the group of participants, or to how the interviews were conducted. Nevertheless, it raises an interesting question of how medical homeopaths reconcile these two opposing paradigms of vitalism and biomedicine and whether it is indeed necessary to reconcile these paradigms in order to practice homeopathy.

6.2.2 Wholeness

The concept of *wholeness* relates to the notion of holism. Although holism is often referred to in different therapeutic contexts it has many common features which includes the interconnectedness of the mind, body and spirit, a positive view of health, the use of low technology or natural remedies and the innate tendency of the body to heal itself (Paterson et al. 2008). The data in this study consistently presents the concept of *wholeness* as a framework that the homeopaths used in their evaluation of how to manage a patient's case. For example, although a patient may present with symptoms that are mainly physical, the homeopath will search for emotional, mental and spiritual symptoms in order to get a complete picture of the patient. Maggie described it as:

“holographic, a part is an expression of the whole, a patient may have arthritis and also be very rigid unbending person...a angry rash can happen to an angry person. she may come with this umm...persistent pain and stiffness,, but... that's been going on for years, but I will also need to know how she is emotionally and how she reacts to her environment, memory, her vitality and all that, I need this whole picture to help find a remedy”

In Maggie's narrative was a description of how she needed symptoms from the whole person in order to understand, evaluate and prescribe, and these symptoms were also interconnected.

I observed the linking of *energy* and *wholeness* in the consultation with Robert and his patient. The patient described an improvement in energy levels and an improvement in emotional symptoms but a worsening of skin symptoms. Robert proceeded to explain to the patient:

“This is a good sign, yes, this is good, energy and emotions are deeper in the person and the skin is the last place for the body to express an imbalance”

Robert referred to this process as “*Hering's law of cure*”, an evaluative tool used by homeopaths to assess patients' response to homeopathic treatment. Hering's law states that, within the process of cure, symptoms proceed from above downwards, from within outward,

from the most important organs to least important organs and in reverse order of appearance (Vithoulkas 1980). Within homeopathic philosophy Herings law does not focus on one individual part of the body but is a reflection of change that flows through the whole person through stimulation of the vitality with homeopathic remedies (Vithoulkas 1980). Yanisa also commented on Hering's law of cure as an evaluative strategy in her reflective diary *"this patient even demonstrated the law of cure, so I'm on the right track"*. I also referred to Herings Law in my reflective practitioner diary:

"(Herings Law) can give you the confidence that the remedy chosen has acted in a curative manner. So if you see a rash or a discharge the body is pushing symptoms out. Or you may see old symptoms returning from the patient's past....."

Like Maggie's use of the metaphor *"holographic"* (above) several of the homeopaths that I spoke to used interesting metaphors to explain the whole person approach to their patients *"peeling an onion"*, *"building a pyramid"*, *"multifaceted like a diamond"*, *"jigsaw puzzle"*, *"concentric circles"*, *"the whole person"* and *"the gestalt"*. I pondered on the necessity for this and realised that for patients new to homeopathy, *wholeness* may be a difficult concept to grasp, especially if they are acclimatised to a biomedical consultation and have difficulty in adjusting to a holistic consultation, as Maggie described:

"I have some patients who will come and they might have lots of physical symptoms and those physical symptoms come and go as they do and there starts to be a kind of demand that those physical symptoms are addressed. And somehow I am not getting over to them or they are not able to take on you know, I am not a GP not just trying to get rid of physical things, I am trying to integrate you as a whole person"

It is interesting that Maggie used the word *"integration"* as Swayne (2005) described *wholeness* as a process of integration. He also likened the search for *wholeness* to doing a jigsaw puzzle which he described as an integrative process. However, as some of the interviews showed this is not necessarily an easy process. As Steffie related, patients react differently to the whole person approach *"for some people it's invigorating, some find it threatening and others don't come back"*, and others, as Roger described, find it difficult to *"express themselves emotionally"*. So although studies show that patients who choose homeopathy like and expect a holistic approach (Mercer et al. 2004; Richardson 2004), these studies refer to a self selected group or patients who are used to a whole person approach. As Swayne (2005) explained, this may be the first time that a patient has been encouraged to think of themselves as a whole.

Roger who is a medical homeopath did not perceive that holism within homeopathy was any different to holism within conventional medicine, and he explained that holism is not just the territory of the CAM practitioner:

“Well, GPs are whole person doctors you know. They’re holistic. So I think the whole person is somewhat an overworked phrase really. You can’t really avoid that in medicine”

One holistic alternative to the biomedical model is the biopsychosocial model (Engel 1977), which seeks to redress the imbalance within the biomedical model and place the patient within his or her psychological and social context. This model adopts a systems theory approach to health and illness which maintains that all levels of organisation in any entity are linked to each other hierarchically and a change on any level will affect the other levels (Taylor 1999). On the face of it this sounds very similar to a holistic approach, however critics of the biopsychosocial model claim that systems theory maintains a dominance of the biological over the social and psychological, and responsibility for deciding the nature of the illness and the method of treatment remains with the doctor (Armstrong 2002). Others state that conventional practice inhibits the task of really understanding the patients as the diagnostic process immediately narrows the field of enquiry, distorting the patients view of themselves and inhibits free expression of the whole nature of the problem (Swayne 2005).

Roger’s experience was not the same as the experience of the other medical homeopaths in this study, who described how holism within homeopathy enabled a deeper understanding for both the patient and practitioner. Richard explained that it enabled patients to “*see wider about their illness*”, Wendy said that “*we want their whole life story really*”. Peter described that “*you have to search...but most people do have issues which are at the core of their current state*”. Anne explained that “*as you move down these levels ... you’re moving closer and closer to the wound*”. This is consistent with May & Sirur’s (1998) study exploring homeopathic medical doctor’s experience of the consultation, the doctors in the study experienced holism within homeopathy as a particular mechanism for connecting different components, such as the psychological and physical, of the patient.

The use of prognostication and holistic medical models such as the biopsychosocial model in the conventional medical consultation certainly have similarities with the category of *finding the level* within the homeopathic consultation but the concepts of vitalism and Hering’s law differentiate homeopathy from the biopsychosocial model in conventional medicine. The evaluation that the homeopaths make using the concepts of *energy* and *wholeness* may occur simultaneously to the process of evaluating both the patient’s and the practitioner’s

expectations. The next section will discuss how in the consultation the process of *having expectations* relates to *finding the level*.

6.3 Having expectations

The concept of *having expectations* was discussed by a few of the homeopaths in their interviews, observed during consultations and reported on in reflective diaries. Some of the homeopaths discussed the impact that perceived patient expectations and the practitioner's own expectations had on the consultation and on being able to *find the level*. From the data, the homeopaths not only recognised the importance of their patients' expectations but also their own. It appeared that they engaged in a sequential process of assessing, managing, adjusting and matching (both patient's and their own) expectations. Beth, in her reflective diary, described a consultation where she had difficulty in understanding her patient's expectations for treatment:

"I'm uneasy because I can't work out what she wants from me, one minute she wants to talk and then next a quick fix."

Later on in the diary, Beth explained that this affected her ability to "*know what to treat*". In my own reflective diary I also noted an occasion where a patient gave mixed messages as to the level of expectations of what homeopathic treatment can achieve for her. Her first words to me in the consultation were "*I am a scientist so I have difficulty with homeopathy and I am sceptical...but I am desperate for help...*". This indicated both low and high expectations from homeopathic treatment. Although I was able to assess her expectations I was unable to go through the process of managing, adjusting and matching her expectations because they were extreme and she was resistant to change. I knew that this patient would be disappointed with treatment and she did not return for follow up. Both examples show how failing to effectively engage with *expectations* in the consultation affects the ability of a homeopath to proceed with the consultation. The next sections will explore the concept of both patient and practitioner *expectations*.

Roger described in the following example a typical conversation with a new patient attending for the first time, where he would seek to elicit an understanding of the patient's expectations:

"Well some of them will know and they'll say "I've come because I've had this problem for x amount of time and I've been to see the doctor and I've been to the hospital and I haven't got better and I know Mrs or Mr So-and-So came to see you or came to the practice and got better so that's why I've come", an answer

something like that. That's the kind of answer you're looking for. And often you can get an understanding of their expectations of the consultation. That's what I'm after really. Then I know whether I can deliver their expectations or not."

The process of assessing a patient's expectations for treatment often starts at the very beginning of the consultation and may continue throughout the ongoing consultations, as expectations can change. However, as Roger explained many patients do not really know why they are visiting a homeopath:

"if you don't know why they have come and they don't know why they have come then how can you know whether they are going to get better and what they are expecting from the consultation"

After this interview with Roger, I puzzled over the concept of expectations as in the following memo:

Expectations

I was intrigued by the idea that patients sometimes do not know why they were consulting a homeopath. To visit a doctor and not know why you were attending seems unthinkable, and yet it is acceptable to see a homeopath under those circumstances. Hidden agendas in a medical consultation are infrequent (Kroenke 1998).

A later interview with Judith clarified this for me as she shared her experiences of trying to understand the patient's expectations, *"It's difficult to know because you often do get people who have things that the medical professions given up on completely"*

Reflecting on my own practice I realised that, of course, many of my patients had medically unexplained symptoms. Therefore the whole homeopathic process of building a relationship with the patient (*connecting*) and of exploring their symptoms (*exploring the journey*) and evaluating (*finding the level*) is a process that is designed for understanding the sometimes hidden nature of the underlying root cause of the patient's illness.

Having assessed a patient's expectations the homeopath may then have to proceed to managing those expectations. As Maggie described, some patients attend with very high or unrealistic expectations *"their expectations are too big to fulfil"* and Tricia explained *"I think a lot of people have too much expectation"*. Managing these expectations involves educating the patient in the homeopathic process as Yanisa said *"I manage their expectation by going through the process and explaining to them..."*, Judith described a situation where she had to *"spend a lot of time"* with a patient managing her expectations of her son's

homeopathic treatment. An observation with Clare and her patient also demonstrated management of expectations. Clare's patient expressed a desire to get better, and then Clare reinforced this desire by explaining what she could expect from homeopathy and the whole person philosophy.

Homeopaths may also have to adjust patient's expectations during treatment, Sarah described this:

"for me that's the key, give them what they want. If someone's come for this, okay, I'll say I can help you but this..... or sometimes someone's come for this and this and this and I say, I think we need to look at this before this will get better. You know. But looking at what they want help with."

Jonathon also explained *"they may think they want their gout better but it's all... the gout and the anxiety that matters"*. The homeopaths appeared to be adjusting the patient's expectations to fit within a homeopathic holistic framework. Joanne described this process of adjustment to a homeopathic model:

"it's like building a pyramid isn't it? It depends what they come with because, you know they will come with a physical, or a physical which is manifested from outside or a mental or emotional state so you have to talk about that physical because they are not going to be happy with you if you don't do anything about what has brought them into the surgery. And if you don't do anything about it they think homeopathy doesn't do anything for me, they won't say it then but they won't come back, and they won't follow homeopathy as a way of healing and that's very evident in lots of cases. You do need to deal with their immediate problem, it's an acute of the deeper state and you have to peel that off and we're back to this peeling the onion"

Joanne described how addressing expectations is crucial to the process of *"peeling the onion"* or knowing what to treat which is the process of *finding the level*. Joanne also explained how important it was for homeopaths to address patient expectations; otherwise patients would not continue with homeopathic treatment.

Common ground can be found between medical and CAM consultations, as both acknowledge the importance of expectations. Expectations are seen to affect outcomes, both in conventional medicine (Mondloch, Cole, & Frank 2001) in acupuncture (Linde, Witt, Streng et al. 2007) and in homeopathy (Launso, Henningsen, Rieper et al. 2007). Ignoring or not dealing with patient expectations in the consultation can lead to dissatisfaction with the consultation, less improvement in symptoms and less adherence to treatment, as unrealistic

patient expectations may not have been explored and dealt with (Bell, Kravitz, Thom et al. 2002).

Steffie explained the process that she underwent when attempting to adjust very high patient expectations to a more realistic expectation: *“I try to be honest with the patient but I try not to remove hope”*. Rosalind recounted an experience with a patient who recovered from a very serious condition with homeopathy. In this case Rosalind believed that being positive for your patient was important *“everyone’s different and I think in some cases it the positive thoughts...she is still alive after 8 years, she didn’t expect to be alive”*. Although most patients look for a cure or improvement in their condition, they also are also looking for hope, reassurance, explanations, advice and understanding (Mitchell & Cornack 1998). A qualitative study that explored potential “active ingredients” of a homeopathic approach found that most patients came away from their initial consultation with a sense of hope that their chronic ailment might be relieved (Thompson & Weiss 2006). Thompson et al (2006) suggest that homeopathy’s ability to engender hope is one of the ways its effects could be mediated. Additionally, a study that examined the links between a positive outlook and an improvement in mental fatigue in chronic fatigue syndrome (CFS) sufferers found that positivity did not play a causal role in the reduction of fatigue but as a result of a caring therapeutic intervention positivity was increased, which eventually was followed by an improvement in fatigue (Hyland, Sodergren, & Lewith 2006). These findings suggested that negative therapeutic expectations such as those found in some general practice consultations may diminish recovery from CFS.

Not only can patients have high expectations but the homeopaths themselves can have high or low expectations of treatment. Matching expectations of both the patient and practitioner was therefore important too. As Julia explained knowledge and experience assisted this process, Julia described this:

“I do know what I can’t do though. I think that’s what I’ve got good at. I think I know when I can’t do something now and I think that’s something that needs to be taught much more to homeopaths because I think sometimes we get ourselves in a big set-up in the first consultation that we’re going to be able to do much more than we can and now, through, you know, all the years of experience, even on the phone I’ll know whether I can do it or not. And I’ll always give somebody a go but I kind of frame it differently now. So I frame it in the first interview, if we’re not sorting this out within 3 or 4 go’s I really do think I’ll give you some other suggestions.”

Knowing the limits of what homeopathy can achieve must be a difficult task for homeopaths as they may often be dealing with medically unexplained symptoms or with patients who have tried every other possible therapy and homeopathy may be their last resort. Whether homeopaths' training equips them to know the limits of their therapy has not been previously explored. Only two homeopaths Julia and James, referred to the practitioner's expectations for treatment, indicating that there is some uncertainty related to this issue.

The process of evaluation that occurs in *finding the level* is assisted by the application of the concepts of *energy* and *wholeness* to each consultation. Effective management of both patient and practitioner *expectations* is central to this process. However, the success of these concepts is dependent on and underpinned by the concept of *collaborating*. If the patient and practitioner do not collaborate then it is difficult to manage *expectations* and to apply *energy* and *wholeness* in the consultation.

6.4 Collaborating

The relationship between the patient and practitioner that was established in the *exploring the journey together* category was described as either facilitative or collaborative depending on the style of the homeopath. The relationship in the *finding the level* category may develop into a more collaborative type of relationship rather than facilitative. This is because homeopaths require the collaboration and involvement of patients in order to apply the homeopathic models of *energy* and *holism* and additionally need a collaborative relationship in order to manage *expectations*.

Sarah described it as an evaluative process where she was matching treatments and patients' expectations whilst also explaining how homeopathy can help them in more ways than they expected.

"I think basically what I do is people come in and they'd say to me, this is where I want help. And sometimes.... And, you know, then sometimes it's very physical. I think the challenge for me and the frustrations that come in are when it's someone who says, "I want help for my stomach, I get these stomach cramps, but I have these drugs from the doctor for my blood pressure, these drugs for this and for that". and I think, okay, so I take all the detailsThen I would say, "oh these are areas that we can work with if you would like to". Some people do, some people don't. But basically for me it's about treating what they want me to treat and telling them the possibilities"

Here she was using her knowledge as a homeopath to evaluate how to approach treatment with a patient using a whole person framework. The difficulty for Sarah in this situation was that the patient was on medication and only discussed physical symptoms. I interpreted Sarah's narrative as an explanation that collaboration was needed in this type of situation in order to educate patients to understand the homeopathic process. Sarah's approach appeared to be collaborative as she explained:

"I work with them.... If they haven't had the experience, I tell them what I'm going to do and I say if you want to talk something over, if you need some support, ring me, they're not on their own"

Her narrative revealed an appreciation of the difficulties that patients encounter in using homeopathy for the first time and so was willing to be supportive to assist them through this process. Judith referred to this also, when she described how she was preparing the mother of the patient for the outcomes of treatment:

"I mean and the good thing I say with this little boy with the sun thing, is that I did set up the prognosis, I was like, oh I don't know about this, and I saidI think his mother expected that it would not come back in the autumn. But I told her right at the beginning that I thought that it was unrealistic that since he's had this since he was three that we're going to get rid of this. I said I think realistically what we can expect is that it will be better than it was, but not..... But I spent a lot of time with her at the beginning, she's a very, very nice lady but knows nothing about homeopathy and they're a very healthy family so this has really come right out of left field for this little boy...."

In the observation of Robert's consultation, collaboration was noted on several occasions in relation to the patient's own insights into their own healing process. Robert affirmed the patient's insights and elaborated on them using *energy* and *wholeness* explanations.

Patient: "I'm ready to go back to work, but I will only go part time as I need time for myself, if I push it now I will end up at square one again"

Robert: "yes that is so good that you recognise that now, your energy is better but if you get stressed again your fatigue might get worse. We can support this process..."

Additionally in the observations of Clare's consultations, the patient discussed her expectations for healing and Clare reframed those expectations within a homeopathic model and then fed back to the patient to see if they could work together:

Patient: "I want to feel stronger, I'm tired of getting these infections, and I'm emotional and want to cry all the time."

Clare: "...once your energy has improved you will be less susceptible to those infections and you won't feel so emotional, but you will have to try not using the antibiotics and see if together we can manage this homeopathically to balance you, what do you think...?"

Patient: "ok...I really want to give this a go..."

The homeopaths appeared to work with the patients to achieve a collaborative relationship from their first contact with the patient and throughout subsequent consultations, as Richard explained *"we work together...continue to persevere to get to a point where that person can move on"*. Endings were also a collaborative venture as Wendy described, *"So we mutually agree.... I will probably say this is the maximum I can achieve with you...and we mutually agree to discharge"*.

The process of choosing a remedy can also be a collaborative process. James regularly fed back his choice of remedy to his patients and he expressed surprise that some practitioners may not do this:

"...if I get excited about the remedy and I'm reading in Scholten it's basically like I've just read the person's biography, you know in another book, and there they are sitting there. My impulse is to tell them about it and I sometimes, I debate with myself whether or not I'm right about that."

Jonathon also shared information about remedies with his patients. He explained that *"it is both ethical and practical and the opposite of a power trip"*. Chatwin's (2003) study which used observational data and conversational analysis to analyse homeopathic consultations also demonstrated that a collaborative strategy was used by homeopaths when evaluating and deciding on treatment options for their patients. The homeopaths used a display of apparent ambivalence towards treatment options as a means of eliciting the patient's perspective. Chatwin (2003) suggested that this was a device to make the patient feel involved in the treatment decision process and also served indirectly to help the balance of the expert/lay relationship between the homeopath and the patient. This collaborative relationship established between patient and practitioner was also noted in a study exploring patients' experiences of a consultation with a herbalist (Little 2007), indicating that homeopathy may have a similarity with other CAM consultations.

This sharing of information in the homeopathic consultation was similar to the concept of shared decision making in conventional medicine, which is one of the treatment decision making models in the medical consultation. Shared decision making is increasingly advocated as an ideal model for making treatment decisions in the medical consultation (Department of Health 2001). The homeopath quoted above, Jonathon, described this strategy that he employed as important for establishing equality in the relationship between patient and practitioner. Similarly advocates of the shared decision making model view it as a means of equalising the informational and power asymmetry between doctors and patients by increasing patient information, sense of autonomy and/or control over treatment decisions that affect their well being (Charles, Gafni, & Whelan 1997). Reflecting on this sharing of information in the homeopathic consultation stimulated some debate as is shown in the following memo:

Sharing of information

Several homeopaths that I interviewed mentioned that they shared information in the consultation and shared the decision as to the remedy that was to be prescribed and this was viewed as collaborating and involving the patient in the process of the consultation. I was intrigued by this as I have also done this in the consultation but never with a new patient. With returning patients who are familiar with homeopathy, I carefully evaluate their desire to be involved in this process. I always inform patients of the remedy name and the substance if they are interested; however, surprisingly, many people are not interested. When I discussed this with some of my homeopathic colleagues, I found that they also tended not to share the remedy decision making process with new patients because new patients were not always acclimatized to the homeopathic process and may have been used to a medical consultation. Additionally, even with long term patients, my colleagues found that some were not interested in the process or the remedy choice, but simply were happy to take the remedy prescribed unquestioningly. However, the process of narrowing down the choice of remedies is one that is shared with the patient as the questions become quite focused and the patient and practitioner share this process. What I realized was that homeopaths use many different strategies to involve their patients and from the perspective of both parties engaging (*connecting*) with the homeopathic process, it seemed to be one strategy out of many that was used to involve patients.

In the homeopathic consultation the practitioner also had to evaluate the patient's preferences for participation in treatment decision making. Patients want information about treatment options but do not always want the responsibility for making treatment decisions.

Additionally both parties have to be willing to participate in this shared decision making; if the physician is willing but the patient is not then the process will not be shared (Charles et al. 1997). Judith, who was relatively new to practice (4 years in practice), gave an example of where the patient had not engaged with the holistic and collaborative nature of the homeopathic consultation, which left her feeling a sense of failure and frustration:

“she came back and she said that her teeth were fine, she wasn’t grinding them. So my dilemma there was, now part of me said, yes well that’s.....you know, part of me would have liked to have said, fine, yeah, but you know, there’s a lot of other things that I can help you with because I have the sense that....you know.....and that’s something that homeopathy can do. But, what really.....what happened was that I didn’t really address that properly in that, you know, I just think I failed with that one. I started to ask her if she’d been feeling any different emotionally. So her teeth grinding had stopped, and I said, “do you feel any sort of difference emotionally” and ended up sort of “do you feel any...” No, nothing had changed at all. But her teeth grinding And, um, you know, that was....I don’t think.....I think I handled that really badly because I felt, okay, she doesn’t.....I’m not sure she wants to go there, so I just let her go really with, you know.....you know, it may come back, please call me”

Judith’s frustration may be based on her being unable originally to evaluate the level on which to treat this patient and therefore being unable to entice the patient into a collaborative relationship. In Yanisa’s reflective diary, she described a consultation with “a nightmare patient” in which she decided to be more challenging and less collaborating:

“Had a patient today who even demonstrated the law of cure, but her husband said she was worse since the remedy....I always find the opinion of a 3rd party difficult. But today I didn’t buy into that, and I gave it to her straight. I said that if she wants to work with me then she must follow my way and that if she wanted to consult another homeopath she could”

Charles et al (1997) in their initial framework of shared decision making, claim that a test of a shared decision is if both parties agree on the treatment option. However, in a later piece of research they revise this framework (Charles, Gafni, & Whelan 1999) suggesting the possibility that decision making approaches can change both within a single consultation and between consultations. This was seen in the interviews where the participants described that at times they shared information with their patients and other times they made a remedy decision on their own. This suggested that homeopaths have to be skilled at evaluating

patient preferences for a decision making model and that the homeopaths must flip between shared, paternalistic and information giving models of decision making both within a single consultation and between different consultations depending on patient preferences.

Sharing of information and decision making takes more time and money than other approaches, as it requires more interaction and consensus building (Charles et al. 1999). Non medical homeopaths have long consultations and can engage in the required type of interaction; however some medical homeopaths may only be able to offer their patients short consultations. They, therefore, not only have to offer a greater variety of treatment options but also have to collaborate and negotiate with their patients, to choose either the homeopathic approach or conventional treatment, as Peter explained:

“So, for example, if I’m dealing with someone who is stressed or depressed, I’ll lay out the options, saying, well, you know, I think you may well benefit from antidepressants or we could perhaps use a homeopathic approach but that takes longer and I’m going to need to bring you back to discuss it. And again I think the response is generally fairly favourable”

Both doctors and homeopaths can experience similar problems with the process of shared decision making if they do not have appropriate communication skills to elicit patients’ preferences. Judith’s experience that was quoted above demonstrated how ineffective communication with the patient stopped a collaborative relationship forming. If a collaborative relationship is not established then the balance of power between a patient and their doctor can be compromised resulting in a patient being reluctant to share their preferences (Say & Thomson 2003). A disadvantage of the process of shared decision making is that it can convey a sense of doctor uncertainty to patients (Elwyn, Edwards, & Kinnersley 1999).

6.5 Conclusion

Finding the level refers to an evaluative process that the homeopaths in this study employ during a consultation with a patient, in order to discover how to approach treatment or to assess prior treatment with a patient. More specifically the practitioner evaluates the patient’s ability to heal, the extent of their illness, where the focus of their illness lies and any response to treatment. The facilitative, and sometimes collaborative relationship that began in the *exploring the journey* category continues into the *finding the level* category in a more collaborative form as the homeopath takes a more active role and keeps the patient involved in the process. In effect this seems to be a process of adapting the patients’ narrative into a

homeopathic model which encompasses the concepts of holism and vitalism. This includes a process of acclimatizing or educating the patients to fit into the homeopathic model, within which the relationship between the patient and practitioner is crucial. In the next chapter I will discuss how the information gathered and then evaluated by homeopaths leads to a process of *Responding therapeutically*, which refers to treatment options.

Chapter 7 Responding therapeutically

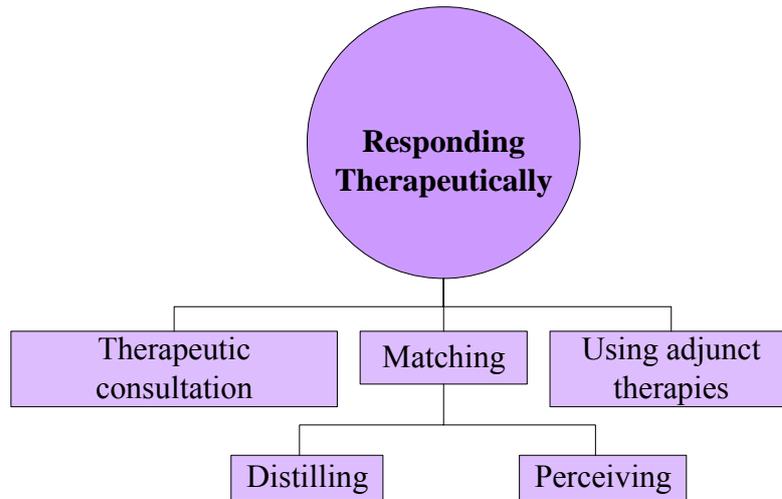


Figure 20: Responding Therapeutically

7.1 Introduction

The previous two chapters *exploring the journey together* and *finding the level* describe processes that emerge out of the data that assist the homeopathic practitioner to understand and evaluate the patient's narrative. The ease with which this occurs is dependent on the formation of a facilitative and collaborative relationship with the patient that enables the development of the therapeutic relationship. This chapter explores the next category in the theoretical model which I have labelled *Responding therapeutically*, and which refers to the homeopath's therapeutic response to a patient. Although this category is described sequentially after *exploring the journey together* and *finding the level*, the process of *responding therapeutically* may begin at any point in the consultation. For example, in the category of *exploring the journey together*, exploring and disclosing a narrative and the act of listening and responding by the homeopath can also enable a therapeutic response (Pennebaker 2000).

Originally, the category of *Responding therapeutically* was labelled "finding the remedy", but discussions with colleagues and participants made me realise that this label limited this category and did not really encompass the range of processes that this category appeared to include. Although all the homeopaths discussed the process of finding a remedy, it became apparent through the interviews, observations and diaries that there were occasions where

referrals to other practitioners, other therapies, conventional medicine, and simply the benefits from a good consultation were also important in provoking a therapeutic response. It was not until the last interview with Helen that I became more aware that this category was not simply concerned with prescribing the closest matching homeopathic remedy; it was also concerned with making an appropriate therapeutic response to the patient, as Helen described:

“This unknown person comes in, you make this case together and then you have to find a response to it. Where do you find that response from? Sometimes it’s a remedy....the homeopathic response might get closer to it in the sense that sometimes your response is watch and wait, sometimes its referral, sometimes it’s education, sometimes it’s, you know naturopathic, you know, or, nutritional.”

Helen’s description enabled me to understand that the homeopath can respond to a patient in many different ways that can all be therapeutic for the patient. This chapter will explore these therapeutic responses to a patient such as the process of *matching* a homeopathic remedy and the giving of an *adjunct therapy*. Initially, however, the next section will explore practitioners’ reports that patients can experience benefit from a consultation before treatment has been given.

7.2 Therapeutic consultation

Some of the practitioners discussed how patients occasionally would report benefit from a consultation before the administration of either adjunct therapies or a homeopathic remedy. Rosalind presented an example of this:

“Um then sometimes on some occasions I’ve even had people phone up and say I’m better and I haven’t even sent their remedy and that has happened, not on many occasions, but it has happened two or three times and I’ve thought my goodness and I’ve sent them their remedy anyway in case their symptoms come back.”

Steffie had also experienced this and explained that the consultation gave the initial *“push for healing, because it was releasing”*. Steffie was referring to the act of disclosure that provided the initial benefit for patients. An informal discussion with Beth, regarding an experience that she had related in her reflective diary, also revealed a similar experience to those of Rosalind and Steffie. Beth was discussing a patient who she had been seeing for over ten years, however this patient only attended once a year:

“She only comes once a year and I think she comes just to talk...and that’s ok, I give her a remedy but I have no idea whether she even takes the remedy. She

always....yes, says that she feels better after seeing me and talking. But it's not just that it's, I also think it's that she feels heard, really heard, as well".

Some of the other participants had similar experiences of the patient reporting benefits from the consultation. Susan for example, stated that it was the “*opening up and talking*” that would provoke a “*healing response*” in a patient. Ruth concurred with this view “*we can all get benefit just from talking and being listened to, and people do*”. Joanne explained that the “*consultation was also healing in itself*”. Catherine described how “*sometimes people say how much better they feel before I've even prescribed*”. These quotes suggest that some of these participants experience occasions when their patients receive positive health benefits from the consultation before a remedy or any other therapy has been prescribed.

Homeopathy is a complex intervention with many non specific effects (effects arising out of the consultation alone). Non specific effects from the consultation have frequently been cited as the reason that patient may receive therapeutic benefit from homeopathic treatment (Ernst 2007a; Ernst 2005b; Reilly 1995; Shang et al. 2005; Zimmermann-Viehoff & Meissner 2007). For example Thompson & Weiss (2006) propose that the homeopath's attention to the patient's expression of their illness including attention to idiopathic and idiosyncratic symptoms, as part of the process of identifying and matching the remedy, is highly specific to homeopathy and may be therapeutic. Thus they consider two aspects of the consultation may be therapeutic for the patients: the action of the correctly matched remedy, or, that the practitioner had developed a very clear therapeutic understanding of the patient and this understanding is reflected in the accuracy of the remedy choice (Thompson et al. 2006). Additionally as discussed (see Chapter 5, *exploring the journey together*) the benefits of the telling a narrative and having it listened and responded to can also be therapeutic as “*meaning*” can be constructed through the interaction (Charon 2004; Frank 1998; Pennebaker 2000; Pennebaker & Seagal 1999). Evidence of this was seen in an observation of one of my homeopathic consultations analysed by my supervisor. It was noted during several occasions in the consultation that the patient acknowledged that the process of exploring the narrative was cathartic.

Patient: “this is so useful, because I can make connections, I noticed that tension makes it worse, its all through my body, its terrible... another connection is that when I eat food I shouldn't eat like wheat...this makes me think about things in my life that I never actually thought about before”

Later on in the consultation the patient both made links and meaning of illness and personal circumstances and reported that the consultation was the only place where she could discuss this.

Patient: “ I’m not fighting for the marriage anymore... I can’t talk to... it’s not easy to talk to anyone, any of my friends, about this, about my marriage, I cant tell anyone, it helps to be able to work it through here....Its such a difficult situation”.

Caroline: “yes it is, you’ve had a difficult time, have you spoken to anyone else about this?”

Patient: “No I can’t, it’s too personal and private, they all know us, you’re the only person I can tell”.

Previous literature has shown that using a whole person approach (Koithan, Verhoef, Bell et al. 2007) and being empathic (Mercer, Watt, & Reilly 2001) is potentially therapeutic.

For some of the participants this appeared to cause a dilemma, Sarah, for example, also described a similar experience of patients benefiting from the consultation:

“I do say that to people, sometimes I say, it’s a combination of you coming and speaking about it, me giving you something to help, everything you’re doing yourself, it all works together. You can’t just pinpoint to one thing. But I think the remedy opens up and I’ll often say, because some people will say I felt better after seeing you and don’t acknowledge the remedy, and I’ll say, oh I’m sure it’s because the homeopathic remedy has really helped to open that up so therefore it’s helped you to see what you haven’t seen.”

Sarah however, was reluctant to acknowledge that the consultation alone was beneficial and perceived that the remedy or adjunct treatments contributed to the patient’s improvements. This indicated to me a desire to believe in the action of the homeopathic remedy. Most of the homeopaths that I spoke to expressed a belief that the remedies contained an active ingredient that was capable of producing change in their patients. Thompson & Weiss (2006) observe that most homeopaths behave as if the remedy is the main active ingredient. Only one homeopath in my study believed that the remedy was inactive, Roger, a medical homeopath, explained that:

“I mean take a 10m of Natrum Mur. There’s not enough water in the universe to make that. You’d have to fill the known universe with water. Or 6×10^{23} . I mean, it’s an astronomical dilution, an exponentially astronomical dilution. You can’t make it. Even a 6c, there’s not a molecule left of the original substance. I mean you give 6c

Arsenicum Album to kids for their skin forever without poisoning them, that's not a physical effect, it's a consciousness manipulation".

When I asked whether he told the patients that he was giving them a placebo he answered:

Interviewer: "So you're actually telling the patient it's a placebo? Or..."

Roger: "I do tell some. But not very many. I'm unlikely to tell a patient in the first consultation they're taking a placebo. It's very unlikely. If they've been coming to see me for a year, if they don't understand that what they're taking is a placebo, then I have failed. That's how I would see it. They have to understand the concept that they're making their own medicine. That they're making their..... you know..... "how long do I take the medicine for?"..... "Until you can make it for yourself". "What do you mean by that doctor?" "Till you can do whatever the medicine does for you, on your own""Ah". And they understand that. And that's a placebo isn't it. That's to say, that's the concept of a placebo, how nothing gets you better. And they say, "is there anything in the medicine?" and I say, "I hope not".(Laughs)"

Later Roger indicated that he thought the remedy was a "a special kind of placebo" which was individual and meaningful to each patient. He explained that if the patient saw the remedy as a placebo this would take the emphasis off the medicine and onto the process of change. He was indicating that the remedy was a symbol or represented the patient's ability to heal themselves. However, he presented his explanation on the remedy as if it was a mystery that the patient would eventually discover. Ruth refers to this element of mystery when she discussed her thoughts regarding the remedy:

"In homeopathy we have another active ingredient which we give and say this has the power....so its got, as well as any, you know, direct properties that the remedy itself might have on the body, it also has that very symbolic power that it stands for something."

Both Roger's and Ruth's revelations concerning the remedy are consistent with views that the remedy is important in the consultation process as it may be part of a healing ritual which contains an element of mystery (Kaptchuk 2002). This is consistent with theories of symbolic healing put forward by Dow (1986) and is discussed further in Chapter 10, Discussion.

As discussed in this chapter homeopathic practitioners have noted that patients can sometimes report that before they have taken a remedy they may experience benefits from the consultation, this has also been noted in the literature (Reilly 1995). However, the

process of eliciting symptoms to match the appropriate homeopathic remedy and choosing the remedy is present throughout the consultation. The next section will discuss and explore the process of matching the homeopathic remedy.

7.3 Matching

All the participants considered that the homeopathic remedy was an essential part of the whole process of the homeopathic consultation. The concept of *matching* refers to a process that the homeopaths undergo when deciding on treatment through prescribing a remedy for their patients. *Matching* is one of the fundamental principles of homeopathy, the principle of “*similia similibus curentur*”, or, “like cures like” (see Chapter 1). This means that a substance that can produce symptoms in a healthy person can also be used to treat those symptoms in a sick person. *Matching* is composed of two concepts that facilitate it and which I have labelled *distilling* and *perceiving*. Although they are described in a sequential fashion in this chapter, they may occur simultaneously, perhaps one concept taking precedence over the others depending on the homeopath’s style. Wendy described matching very succinctly when she said:

“All we’re trying to do is get to know that patient homeopathically to be able to match the picture of the patient’s problems to a picture of the remedy.”

Homeopaths match remedy pictures to a patient’s narrative and then prescribe the remedy that is the closest match. The accuracy of this match has been termed the level of “homeopathicity” (Thompson et al. 2006). There has been very little research into this aspect of the homeopathic consultation, which is notable as this is a central process.

This process of finding and matching remedy pictures to the patient’s narrative is different to biomedical consultations, as the approach is to individualise treatment using the presenting complaint plus all idiosyncratic and idiopathic symptoms of the whole person. This is then matched with a corresponding or similar remedy picture. In a biomedical consultation however the patient’s presenting complaint is matched to a medical diagnosis, a disease category, or the best treatment. The process of *matching* may begin in the category of *responding therapeutically* and may also occur in other categories, or at other stages of the consultation. For example, in the categories *exploring the journey together* the process of exploring the patient’s narrative can sometimes be guided by the homeopath in their attempt to elicit symptoms that are relevant for finding remedies. This process was observed in Roberts’s consultation with his patient where, after initially listening to the patient’s story, he then intervened with homeopathic symptom gathering questions such as “*Have you any food*

cravings? Have you gone off any food?” and “How is your sleep? “Any more strange dreams?” For the homeopaths the desire to explore the patient’s symptoms arises out of the need to discover the patient’s perception of their illness in order to prescribe the remedy, as Joanne described *“you have to probe in a little bit to each of the remedies that you feel are there”*. Building on the information given by the patients enables the next category of *finding the level* to become possible. Richard explained, homeopaths need to be like *“a chameleon and if you can match your patient and try to understand them then you can prescribe”*. I interpreted his explanation to mean that, in order to ultimately match a remedy to the patient the homeopath needs to almost step inside the shoes of a patient to understand at what level to direct treatment. These cumulatively lead to a level of understanding that allows matching and prescribing to occur.

In the next section I will discuss two concepts that I have labeled *distilling* and *perceiving* which facilitate the process of *matching*.

7.3.1 Distilling

The homeopaths described the process of synthesizing the patient’s story and symptoms to find a remedy to match those symptoms. This was usually done with the assistance of “*materia medicas*” and “*repertories*” (books or computer programs containing information on the remedies and an index or list of symptoms that points to appropriate remedies). This process was, as Sally explained, sometimes called the “*science of homeopathy*”. This description combined with the lack of an “*in vivo*” word or phrase that effectively represented this concept led to my label of *distilling*. A dictionary definition of *distilling* “to create something from essential elements” described the process, as I understood it, from the interviews. Ruth described the process of *distilling* and *matching* a remedy:

“finding the right remedy, as we all know, is ...is a very complicated task. Most of us fail a lot of the time to find the right remedy the first time round. And I do think that that makes it a sort of exquisite kind of pressure because we are usually aware of how flawed the information we’ve got about the remedies is and so, whilst we can go through a very systematic process of deciding on the hierarchy of symptoms and the selection of remedies and the justification for one over the other, you know, we’re never 100% clear about whether we’ve perceived the case properly, whether we’ve interpreted it and analysed it properly, whether we’ve matched the symptoms, whether there might be something underneath that we haven’t seen about that person. It’s incredibly complicated and to actually, you know, boil it all done to that

one single tiny little white pill and say this is what I believe is going on, it's.....I always find it an extreme pressure".

Other participants concurred that it was not a straightforward procedure. In her reflective diary, Steffie reported that she had a “*choice of continuing with same remedy or changing – cannot decide so gave two remedies to use sequentially*”. The sense of uncertainty to this whole process was described by others too, as Anne expressed:

“All these newer methods (of homeopathic prescribing) are about reducing uncertainty because its been part of the problem within homeopathy that it can be hit and miss...Your level of uncertainty is high...because homeopathy is about moving on the crest of the unknown”

I understood that Anne was suggesting that the many approaches to the practice of homeopathy could help reduce uncertainty.

Finding a Remedy

As a homeopathic practitioner I am aware of the myriad of methods and approaches that homeopaths use in order to find a remedy, for example, in the interviews the practitioners mentioned “*hierarchy of symptoms, circle method*”, “*bombay method*”, “*using keynotes*”, “*kingdoms and families*”, “*being very directive*”, “*classical prescribing*”, “*miasmatic prescribing*” (please refer to Appendix 3 for an explanation of some of these methods of homeopathic prescribing).

This stimulated some questions in my mind as to why there are so many methods and approaches used. Does the myriad of approaches add to the level of uncertainty or does it help? Are there many approaches because of the uncertainty and the complexity of the process? Does prescribing on an individual basis necessitate many approaches to account for variation of experience? I thought that this also implied that finding the remedy is a very important feature of the homeopathic consultation.

What intrigued me was how the homeopaths distilled the patient’s story: what information do they extract, use or discard? Additionally, how do they choose the remedy out of nearly 4,000 different homeopathic remedies?

Both Ruth and Anne mentioned a level of uncertainty associated with this process and this was highlighted by Roger, who was scornful about the process of distilling:

“Because that leads to repertorisation, which doesn’t work, so, you know, if you’re going to take a homeopathic history and you get all the symptoms down in a long,

long list, you know, I mean, Kent talked about that, I mean talked about patients who would send him by post every symptom in the book, you know, everything there. And then he could repertorise that according to his symptom and you end up with Calc Carb, you know, great. Wonderful. You know, or sulphur, even worse, yes. I mean, it's a pointless exercise, God knows why anyone ever thought that would work. I'm not the first person to discover that, I remember Sankaran saying about this, you know, he said when he first went along to homeopathy you were taught key note, that's what you had to do, get the key note of the case or you got the key note, get the remedy. And somebody said, oh key note doesn't work, you've got to repertorise, you know, get the repertorisation. Well that doesn't work either so what do you do? Where do you go from there? I mean the problem with things like repertorisation is that you're..... if you use Kent's repertory you're forced down Kent's narrow mind set"

Roger's extract explained some of the challenges for the practitioners; indicating that the process of finding a remedy is inherently difficult, possibly explaining the need for many methods and approaches as these may attempt to rectify and structure these challenges.

There is a structure in the flow of the consultation which includes the process of finding the remedy; Susan explained how, in her consultations, there is quite a systematic method to how this is done:

"There's a rhythm to a first consultation that goes something like, five minutes introduction and hour and ten minutes case receiving and taking, then I don't say to people shush while I work out your case, I ask them something mundane, like where are you going on holiday, so they come out of that deep place and I am half listening and also flipping through the case seeing what needs to be healed, what the problem is then repertorise those and run through the remedies and then repertorisation again."

This rhythm and flow to the consultation was noted and mapped in the observations of the consultations. The following sequence of events was observed in Robert's, Clare's and one of my own consultations. The first five minutes were spent with introductions, if it was a new patient, or a chat, if a follow up patient. The next hour for a new patient, and half hour for a follow up patient, was spent with the patient revealing their narrative and the practitioner exploring that narrative. During this time, however, there would be a progressive focus of the homeopath's questions towards eliciting and gathering remedy finding symptoms. In the last fifteen minutes of the consultation the homeopath would then refer to

“materia medicas” or “repertories” to help choose and confirm their choice of remedy. The last ten minutes of the consultation would be spent explaining the remedy choice and prescribing. Only one of the observed consultations did not follow this sequence and that was one of my own consultations with a follow up patient. There was evidence of questions being used to elicit remedy finding information throughout this consultation, however at some point I decided not to prescribe a remedy for this patient in this consultation and therefore did not need to refer to “materia medicas” or “repertories”.

Despite there being a systematic process occurring in the consultation the homeopaths still had difficulty in explaining the steps of exactly how they arrived at a specific remedy choice. There is some evidence that the homeopaths follow a pattern of decision making (Birch & Brien 2008). The PHIR-M decision making model reports on the different cognitive processes which assist the decision making process; pattern recognition, hypothetico-deductive reasoning and intuition. Pattern recognition can be identified, for example, when Wendy explained her process:

“all we’re trying to do in homeopathic consultation, trying to get to know the patient, full picture of the patient and their life story and we’re trying to match that to a remedy.”

Christine also stated that it was *“the closest match in your head, a sort of knee jerk reaction”*, she then elaborated on this by explaining how some practitioners can *“visualise the remedy”* and for her it can *“resonate with my materia medica knowledge”*. Pattern recognition involves the process of making judgements on the basis of a few critical pieces of information and occurs at a conscious level (Manias, Aitken, & Dunning 2004) and its use had been widely reported in the medical consultation (Coderre, Mandin, Harasym, & Fick 2003; Elstein & Schwarz 2002; Offredy 1998) . According to the PHIR-M model intuition can help guide hypothesis generation, Richard described this process:

“And whilst they were talking I’d be beginning to glance through remedies and things...I would say I work intuitively and then I will often talk to them and begin to think there’s a group of remedies which they would be likely to come under”.

The PHIR-M Model also demonstrated that practitioners use hypothetico deductive reasoning also guided by intuition to assist homeopathic practitioners in their final decision on their remedy choice. Jonathon explained that:

“The symptoms bring up some possibilities and that will lead me to more questions so there’s a successive approximation that happens. Or narrowing it down to two or three then I have come back with some more direct questions”.

Hypothetico deductive reasoning (Elstein, Shulman, & Sprafka 1990) has been described as a process that clinicians, regardless of experience, use to help reduce uncertainty.

Hypotheses are generated and then tested by searching for additional information to confirm or refute one or other of the hypotheses. Uncertainty is also associated with intuition (Hall 2002) which is widely accepted as playing a part in clinical reasoning (Benner & Tanner 1987; Macnaughton 1998). Levels of uncertainty were described by Anne, Ruth, Steffie and Roger earlier. This uncertainty may be due to the lack of scientific evidence and clinical guidelines to guide decision making in homeopathy. Additionally the homeopathic materia medica contains 4,000 remedies and choosing between these may be difficult along with the variety and availability of numerous treatment options.

Benner & Tanner (1987) suggests that intuition in decision making is closely related to experience, known as tacit knowledge. The kind of tacit knowing used by practitioners represents a form of clinical knowledge which has been acquired through experience, and is characterised by the way that practitioners know more than they can explain. A person may, for example, be able to do complicated actions, though at the same time be unable to explain their actions (Malterud 2001). This may explain why practitioners had trouble in explaining the specific steps that they took whilst *distilling* and looking for a remedy, as Rosalind described:

“I just have this nagging feeling that this other remedy is right, so I study it, and I realise that it was the remedy that I thought all along, sometimes I don’t know why or how I come to a remedy, I may have used it before... but then I check it in the books and see...”.

Rosalind’s statement indicated a connection between experience and knowledge and demonstrated how intuitive feelings were then validated using a homeopathic knowledge base, this allowed a gap to be closed between the subjective and the objective (Birch et al. 2008).

The discussion on the concept of *distilling* has shown how cognitive decision making processes are used to elicit and match the required remedy for the patient. Intuition is used to guide these cognitive processes, and is a concept that flows through the entire concept of *matching*. The next section will explore the concept of *perceiving*, which encompasses the notions of embodiment and a further discussion of a more subconscious aspect of intuition.

7.3.2 *Perceiving*

Perceiving encompasses another aspect of intuition and also embodiment, which refer to processes which are the less cognitive and analytical and more subconscious components of matching a homeopathic remedy. Initially, however, my first thoughts about this concept came from many “in vivo” phrases taken from the interviews which implied a tacit knowing, for example, “*Listening for what I am not hearing*”, “*Knowing the unsaid*”, “*feeling the pain*”, “*being in tune*”, “*being intuitive*”, “*feeling it in the gut*”. Tricia described it as “*seeing the person as they truly are*” and Julia also described it similarly as:

“when I have clients who can’t speak or name what’s going on, I know about it even if it can’t be spoken about, and gently, maybe over the 2nd, 3rd, 4th, 5th consultation we can go there”.

These phrases, in combination with Susan’s description of the homeopathic consultation as a “*time during which I have the opportunity to perceive what is the problem*” and Helen’s explanation “*it’s not just seeing, it’s perceiving, it’s all the senses*”, led me to label this concept *perceiving*. This only occurred however, after I had fully explored the concept of intuition which appeared frequently in the data.

Some of the homeopaths seemed ambivalent about whether they used intuition or not, some readily referred to it such as Rosalind who stated “*sometimes it’s a completely intuitive process*” and Maggie who explained “*you can have an intuitive feel for the remedy*”. However others, such as Susan, were reluctant to align themselves with intuitive processes. She described her process as being “*more analytical for me... it isn’t intuition. It’s sort of integrated knowledge*”. Anne, a medical homeopath, stated that “*some people can just work at the level of intuition, if you like, but I’ve always been uneasy about intuition*”. This attitude to intuition is interesting as Benner & Tanner (1987) also found that intuitive judgement was consistently devalued by nurses and doctors. Anne uses the Bombay method of homeopathy (see Appendix 3) which is more logical and structured than other methods of practice and this may explain why she viewed her process as being less reliant on intuition:

“The newer methods are about trying to move down into the deeper aspects of this, what we believe is an energetic disturbance of the vital force and so therefore we are encouraged to guide the person into the feeling space after the symptom space and after the feeling space into the space of what we would call delusion, not in the terms of psychiatric delusion but more how one filters the world, how one sees the world and dream information is really often very, very illuminating within that, round that delusion because you will see imagery or story lines that actually can

reflect how the person is viewing the world or what their issues are. And then the consultation, if we have time, moves into what is called the level of vital sensation where the person may actually be able to describe the vital sensation of the disturbance and therefore you are much clearer about the remedy”

This method was employed by most of the medical homeopaths in my sample. Another reason explaining a reluctance to acknowledge the role of intuition may also be due to a misunderstanding of the word intuition. Seventy four definitions of intuition have been reported (Ruth Sahd 2004) which may reflect the complexity, diversity and intangibility of this concept (McCutcheon & Pincombe 2001). Although a precise definition of intuition has yet to be developed the key features of intuition have been described as “a rapid and unconscious process, context sensitive, comes with practice, involves selective attention to small details, cannot be reduced to cause and effect logic and addresses, integrates and makes sense of multiple complex pieces of data” (Greenhalgh 2002). Birch & Brien’s (2008) study showed that homeopaths also use a mix of evidence and intuition, however perhaps the reluctance of some of my participants to admit that they use intuitive processes may be due, in part, to a desire to be seen as more “scientific” and part of a more “evidence based” profession.

Nevertheless the interview data in this study and data from Birch & Brien’s (2008) study indicate that intuitive processes are used by homeopaths. Indeed, one of Dreyfus & Dreyfus’ (1980) six key aspects of intuitive judgment is “common sense understanding” which is described by Benner & Tanner (1987) as a deep understanding of the language of illness which is concerned with emotions and lived experience rather than the language of disease which is concerned with pathology. This concurs with homeopathic practice, which is concerned with the patient’s emotions and lived experience. As Rosalind explained:

“I can sense that there is more to be told, and sometime the telling of the ordinary day to day things and how they feel can help me understand them”

A theory of intuition that emerged from a grounded theory study on nurses’ perceptions of intuition found that it was the synergy that occurred through the interaction of knowledge, experience and expertise that resulted in intuition (McCutcheon et al. 2001; 1999). Nurses, however, do have objective means of confirming their intuitions, for example, with medical tests. Homeopaths, on the other hand, are reliant on the verbal reports and observation of returning patients to ascertain whether they were correct with their intuitions. Additionally, as mentioned in *finding the level*, chapter 6, homeopaths also use an evaluative measure called “Herings law of cure” to determine and evaluate a patient’s response to treatment.

Many of the practitioners spoke about a sense of heightened sensitivity and awareness of the patient's verbal and non verbal communications which assisted them with this sense of the "unknown" or the "unspoken". Anne described this as follows:

Anne: "being in an incredibly high state of attention... and so that sensitivity allows you to pick up and feel, or realize that there something unsaid in the case and to stay with it....to stay with it until it unfolds"

Interviewer: "So how do you explore that with someone, if you have a strong feeling that there's something there that needs to be looked at?"

Anne: "Well, silence is a good way to explore it. Sometimes, you know, in that if you leave a gap the person will be drawn to what they don't want to say. But otherwise, kind of a really, really gentle step by step climb down this well as I sometimes look at it, you know, literally a little hand-hold there and a foothold there, which is just staying with it, you know, and just coming back to it, you know, tell me more...."

Sarah described how she had "always been very sensitive to people... I have a sense of what is going on with people" and how she used this to "go deeper with people". Both Anne and Sarah's descriptions concur with Philipp, Philipp & Thorne's (1999) observation that heightened awareness to cues that will sense what is unspoken, alluded to, disguised, unrecognized or suppressed is necessary to be intuitive.

James spoke about his "schism detector" which could "intuit incongruity". Catherine explained how she would "vibrate....resonate with the sort of energy that comes from the patient". It was not until my interview with Julia who was an experienced practicing homeopath, acupuncturist and psychotherapist that I understood more about how the nature of the homeopath's use of intuition in this study:

Interviewer: "You mentioned, sort of picking up on things when people come in, do you think that's an important skill for a homeopath, that kind of sensitivity?"

Julia: "I think it's very helpful. But you see I don't know what comes with time and practice and what has come through my own sensitivity. Because I used to work with Dr Sharma years ago who's now dead, and he would smell disease, I mean that was his sense, you know, we would talk about.... so... and as an acupuncturist I've been taught to smell disease so I know, you know, what is it, what's my smell sense? What's my ability to hear a grief in a voice through acupuncture training? What's my sensitivities that I've developed through psychotherapy? I don't know but I think you make it much tougher if you don't develop some of these sensitivities. I think it's

much harder to pick up what's going on with someone because that's the art of the case-taking...not to miss perhaps something that isn't spoken about."

I realized that she was explaining quite clearly what the previous practitioners had been describing. Practitioners use their senses such as, feeling, sensing, smelling, hearing and seeing during case taking to increase their awareness to verbal and non verbal cues. This understanding and the knowledge that the five senses contribute to how homeopaths view or perceive their patient's symptoms was a factor in naming this concept *perceiving* instead of intuition. Intuition is linked with perception (Effken 2001). Of the six key aspects of intuitive judgment that Benner et al (1987) observed in "expert" nurses, pattern recognition, similarity recognition and sense of salience are known perceptual skills suggesting that a fundamental part of intuition is perception (Birch et al. 2008; Effken 2001).

Many of the homeopaths that I spoke to also referred to bodily sensations while describing their experiences of intuition and this has previously been reported (McCutcheon et al. 2001). The homeopaths described this in many different ways from "*gut instinct*", "*gut feeling*", "*feeling their pain*", "*feeling their sensation*", "*lump in the throat*", "*feeling it with the patient*", "*its kinaesthetic*", "*felt sense*", "*one's feeling often mirror those of the patient's*". Christine described a response that she may get from a patient:

"I'm also very conscious of just how the patient makes me feel. So, you know, if I'm starting to feel quite sort of down and lethargic andincreasingly I realize that I am picking this up from the patient and that's another clue to their remedy"

Feeling their pain

As a homeopathic practitioner I can understand and relate to the experience that these homeopathic practitioners describe.

Whilst video recording one of my consultations for this study with a new patient I experienced embodiment very strongly. The patient was describing ordinary symptoms to me, and I suddenly experienced a strong sinking sensation in my stomach, similar to going over a hump back bridge. I just knew that something awful was going to be said. The patient started to cry and the emotional pain on her face was extraordinarily poignant, she described how she was left with extreme feelings of anxiety and insomnia since her daughter had been abducted and physically and sexually abused. This resulted in her daughter experiencing psychotic episodes and a diagnosis of schizophrenia. Whilst my patient was relating this I experienced a sense of profound nausea and a sensation of

coldness in my limbs, along with a feeling that I can only describe as panic followed by grief.

Experiences like this are not uncommon in my consultations, and definitely lead me to the prescription.

Literature in conventional medical consultations also shows that nurses had an enhanced sense of a patient's body (Benner et al. 1987). For example, one nurse described, "visualizing the patient's arteries expanding and contracting". However, the homeopaths in this study seem to be describing a slightly different experience where they had actually felt sensations in the body that informed them about the patient. The concept of embodiment in the therapeutic encounter has been explored in relation to psychotherapists. Shaw (2004) demonstrates how therapists use their somatic experiences to help them understand the intricacies of the therapeutic encounter, in doing this they emphasize the importance of their bodily sensations whilst seeing their clients. Shaw suggests that this may have something to do with an intuitive process of empathizing somatically with the client. Judith described an experience that relates to this idea:

"I was listening to somebody talking about a friend and the terrible time they were going through and I thought... gee...you know, I can feel this...so....the sort of lump in the throat thing...and I realized, yeah, Ignatia, that this is the remedy this person might need"

Two of the homeopaths in this study, Alan and Julia, were trained in psychotherapy and both named these processes that occur in the consultation as "transference", "counter transference" and "projective identification". Shaw argues however that to view these somatic experiences within a psychoanalytic and psychotherapeutic lens narrows the concept of embodiment and attempts to make a subjective intangible experience tangible and concrete. The suggestion from Shaw is, therefore, that embodiment is viewed within the lived body paradigm (Merleau-Ponty 1962). The lived body paradigm derives from the phenomenological school of philosophy, which is concerned with an understanding of a person's lived experience of the world. It is certainly possible to see how the homeopath's experiences can be placed within this framework, as the paradigm emphasizes the notion that our perception of the world is crucial to our acquisition of knowledge and that perception is experienced through our bodies and our bodies' senses (Barry 2006). Moreover, this phenomenological framework is opposed to the Cartesian dualistic idea that the mind and body are separate and does seem to fit with the homeopathic holistic viewpoint.

The concept of *matching* consists of both conscious and unconscious processes that assist the homeopath in making remedy choices. However, homeopaths do not limit themselves solely to prescribing homeopathic remedies in their therapeutic response to a patient. The next section will discuss the use of other therapies that homeopaths employ or encourage their patients to use.

7.4 Using adjunct therapies

Although all the homeopaths discussed the process of choosing and *matching* a remedy, it became apparent that there were occasions where referrals to other practitioners or the use of other therapies were also important in *responding therapeutically* to a patient. It became clear to me that all the homeopaths engaged in a therapeutic process that was informed by their individual range of experiences. For example, some of my participants had trained in other complementary therapies such as nutritional therapy and they would consider whether their patients needed homeopathy or nutritional therapy. Some participants were doctors and therefore would consider whether a patient required conventional medicine, homeopathy or a referral to another practitioner such as “*nutritionists, counsellors, neuro linguistic programming practitioners (NLP), osteopaths, chiropractors and independent midwives*”. Steffie described it as:

“Knowing your limitations and that’s why sometimes patients come to me and I am not the right person. There’s a chiropractor in our clinic, aromatherapist, counsellors, physiotherapists.... I’ve actually got quite a broad range of people to refer on to”

Steffie also used western acupuncture and was a medical homeopath so she had a range of therapies that she could use to assist her patients. In addition to this broad range of skills that were typical of the group of homeopaths that I spoke to, they had a variety of different homeopathic methods that they could use (see Appendix 3). There are many different reasons cited by the homeopaths for this array of available therapies, these ranged from, as Steffie described, “*knowing your limitations*”, to the limits of homeopathy itself, as Yanisa explained in her reflective diary “*I spent years and years just doing the classical thing. It’s the ideal but it doesn’t always work*”. Other homeopaths said that it was the job of the homeopath to have a range of options to help the patient. As Tricia said “*you treat the person holistically. You’re not just a homeopath*”. This notion of treating holistically and having available many options to assist one’s patients has some similarity with a description of integrated medicine that has its focus on health and healing rather than on disease and treatment. It may be that the homeopaths are reflecting a view that in order to treat

holistically a range of available therapies may be necessary, and they may also be responding to the popularity of integrated medicine among consumers and healthcare providers alike (Stumpf, Shapiro, & Hardy 2007).

Another aspect of this is that ethically homeopaths are obliged to know when they must refer a patient to another practitioner or back to their general practitioner. For the non medical homeopath this duty of care is listed in the Code of Ethics of The Society of Homeopaths (The Society of Homeopaths 2004). The medical homeopaths would be guided by ethical guidelines laid out by the General Medical Council. This aspect of duty of care was particularly emphasised by all the medical homeopaths in this study. Peter referred to it as having a “*parallel consultation*” occurring where he would be evaluating whether the patient in front of him needed conventional medicine or homeopathy. Steffie viewed herself as “*as doctor first and a homeopath second and that does alter how one treats*”, Roger stated that “*diagnosis is very important*”, Richard acknowledged that at times “*homeopathy is not appropriate and you need the conventional route*”, Alan emphasised:

“I don’t do homeopathic consultations, I do medical consultations but my medical consultations are heavily influenced by the homeopathic approach.”

For these homeopaths legally and politically it was an important that they did not neglect their duty of care to their patients (Hurwitz 1999). This aspect of duty of care was not overtly discussed by any of the non medical homeopaths; perhaps the reason for this is that they do not appear to have the same type of professional scrutiny as medical practitioners. However their tendency to refer patients to another practitioner if necessary is an indication that duty of care may be an issue that they consider.

7.5 Conclusion

The discussions in this chapter explore the many treatment options that are available to the homeopaths so that they can respond therapeutically to their patients. The options that they choose to employ are informed by their previous clinical experiences. This discussion also highlights the difficulties in clarifying where the therapeutic benefits of homeopathy lie. The therapeutic relationship that develops from a facilitative and collaborative consultation can in itself be beneficial. Similarly, therapeutic benefit can also be gained from the process of matching the homeopathic remedy. Finding an appropriate remedy to match the patient’s narrative may signify to the patient that they have been understood. This together with the ritual, symbolism and practitioner belief in the remedy may also be therapeutic. Of course, the possibility always remains that the remedy itself may also have specific therapeutic

effects. This chapter has highlighted the importance of the relationship between the patient and the practitioner that has been established in the previous chapters in enabling a therapeutic response to take place. However, the notion of response implies that the homeopath has been stimulated by the patient to respond, but this response is not only a result of the interaction with the patient but is also as a result of the interaction that the practitioner has with themselves. This aspect will be discussed in the next chapter which explores the category of *Understanding self*.

Chapter 8 Understanding Self

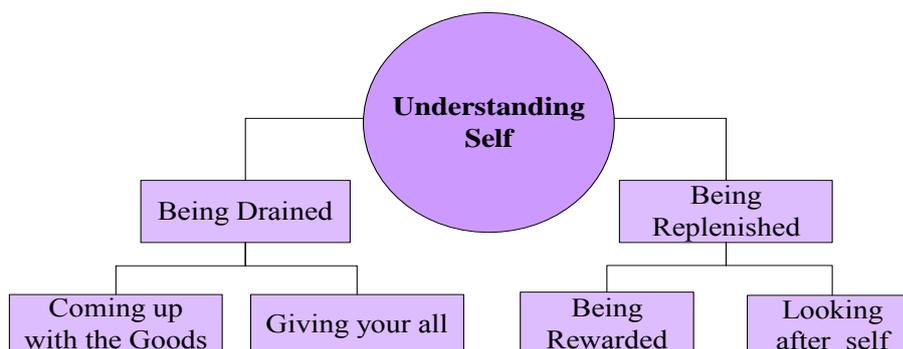


Figure 21: Understanding self

8.1 Introduction

The previous findings chapters have explored processes that can occur within the homeopathic consultation which are enabled by a practitioner patient relationship that is both facilitative and collaborative. This chapter, *understanding self*, proposes that the homeopathic practitioners perceive that they require a degree of self understanding and awareness in order to manage the balance between the challenges and benefits of practice. The challenges of practice are represented by the concept of *being drained* and the benefits of practice and the needs of the practitioner are represented by the concept of *being replenished*. This category was at first difficult to grasp, however, I realised that it was concerned with processes that occur to some extent inside the mind of the practitioner both inside and outside of the consultation. Therefore, the processes in this chapter were not always apparent in the observations of the consultations but were more prominent in the interviews and reflective diaries. There were several “in vivo” phrases which represented a similar process and assisted me in labelling this category *understanding self*, such as “*being aware of myself*”, “*understanding myself*”, “*inner work*”, “*being able to reflect*”, and “*having an awareness*”. The process of constant comparison enabled an understanding of this category to evolve.

I first became aware of the importance of this category whilst comparing the interview data for the other categories for instance James explained that:

“that matching process is confounded by various things, one would be that the practitioner can’t, doesn’t want to, isn’t emotionally capable necessarily of hearing what the patient has to say because when people are talking about... well sexual abuse is a big example”

I understood this as James suggesting that emotional maturity would be a necessary skill in order to listen to and understand another person. Julia described how she could develop that skill by doing “inner work”:

“Developing a rapport with somebody is that I create a space in the room even though I sit behind a desk, where I probably use inner work to make that space feel safe....to develop that energetic connection”

The following extract from Judith further developed my understanding of this category when she explained that homeopaths filter information from others through their own understanding of the world, or, as Alan described, through “our own experiences, knowledge, prejudices and emotional responses”:

“There’s your patient and she’s got her disease, right, but she has to communicate her disease to you through all her stuff, and then it comes out into the ether and you have to understand it through all your stuff”

Roger however presented a slightly different perspective where the practitioner had a less relevant role in the consultation

“The consultation is simply an interface; it’s a meeting between somebody with experience of what might work in triggering a healing reaction. That’s what it is. And its access to a healing system that’s what a consultation is about. And the healing system itself is irrelevant and what the practitioner himself or herself thinks is irrelevant.”

Yanisa also did not state that *understanding self* was important in her consultations and when she was asked about it specifically she stated that “its just not me to get too analytical about it..., they come, I prescribe, and they go”. Yanisa and Roger’s view was not typical of this group of practitioners; however, it would be interesting to study a larger group of homeopaths to assess whether this view was more prevalent than this study reveals.

The dictum of “know thyself” lies within the philosophy of Socrates and has been adopted by the General Medical Council and indicates the importance of this for doctors. This idea has been taken further in the suggestion that the key to being a good doctor is to be able to put themselves in their patient’s shoes (Holmes 2002). Holmes (2002) suggests that if a doctor can recognise their own feelings and reactions to a patient then this will help them understand their patient and enable empathy. In Balint’s (1990) seminal text “*The Doctor, His Patient and The Illness*” he introduced the idea of “Balint” groups to the medical profession as a way of the doctor exploring their own feelings as a means to understanding

their patients. Since then “Balint” groups are used by doctors in general practice to explore their feelings about their patients. Similarly peer group supervision is used by homeopaths this is discussed in section 8.3.2 in this chapter.

Although Yanisa and Roger did not consider that *understanding self* was necessary there is a general acceptance within many of the “talking therapies” that a therapist must have an understanding of self. Rogers (2002), for example, proposed that the therapist must have some self knowledge of personal imperfections and flaws that make them vulnerable people in order to feel secure as a person. It is also proposed in homeopathy that understanding oneself is important in being able to understand others (Cooper 1994; Pool 1991; Ryan 2002). Benefits of understanding oneself as a therapist include being able to distinguish between one’s own issues and those of their clients (Grimmer & Tribe 2001). This was referred to in Judith and Alan’s extracts from their interviews earlier where they described having to understand others through your own experiences. Julia also reflected this view when she described her experience by stating that:

“It’s that internal process of working on yourself and making clear what’s yours and what’s someone else’s”.

This process of understanding oneself increases one’s ability to separate personal and professional issues and enables a better use of “self” in the therapeutic relationship and to understand one’s responses in the consultation (Grimmer et al. 2001). Additionally being able to reflect on oneself as a practitioner helps develop practitioner awareness that will benefit patient’s exploration of their symptoms and develops a deeper connection between patient and practitioner, increasing practitioner confidence and self esteem (Lum 2002). Sarah was one homeopath who reflected this view, she emphasized the importance of her own self development and equated that with the success of her practice:

“I’ve always got a full diary...its what I put into me, its how I live my life and my path, my spiritual growth. This helps me in my practice and to understand where they are coming from.”

Some of the homeopaths felt that their own life experiences contributed to being able to understand others. Cassie for example, reflected a view held by many of the homeopaths that her experience of illness and subsequent treatment with homeopathy, lead her to practice homeopathy and helped her to understand the illness experiences of her patients. Kleinman (1988) explains how a powerful illness experience can lead a patient into a healers role. This notion of an illness experience or trauma that can enable a person’s desire and ability to heal is a concept that emerged out of ancient Greek mythology that is referred to as “the wounded

healer” (Mitchell et al. 1998). Using personal experiences to understand the experiences of others can be a valuable tool in cultivating empathy (Davis 2009; Jackson 2004). However, there is also the possibility that the homeopath’s experiences of trauma or illness can lead them into developing preconceptions or assumptions about their patient’s reactions and condition. Beth described this in her reflective diary:

“Having just experienced the death of my mother within the last year I am surprised that this lady is not grieving, having lost her mother one year ago. But I was very close to my mother. I realise that I mustn’t impose my feelings on this patient...”

Cassie’s description of an experience that led her to become a homeopath was not unique. Maggie referred to the difficulties in growing up with a disabled mother, Anne referred to the death of her brother and Joanne talked about the early and sudden death of her husband. Rosalind spoke about training to be a homeopath after she met her husband who had Parkinson’s disease. Sarah related the reason why she was able to listen and hear the difficult stories that patients told her:

“It’s not that difficult for me at all but I think it’s because, you know, my own background’s been horrendous. I mean if I told you my childhood background It’s like really you know, so I’ve learnt...”

However other participants such as James, Christine, Yanisa and Roger did not disclose difficult experiences that led them to become homeopaths or informed their practices. This may have been because either they had not experienced difficulties such as these or because this was a sensitive issue to discuss. The idea of the “wounded healer” was developed further by Guggenbuhl Craig (1971) who viewed that the physician and patient were both healer and sufferer and that both roles were necessary aspects of healing. The physician could then strive to mobilise the patient’s own healing capacity in order for the patient to contribute to his or her recovery. It is certainly possible to see how a homeopath can fit within this concept as the homeopath and the homeopathic remedy are seen as catalysts for the patient’s own healing powers. The idea that the therapist’s “self” is an instrument in the therapeutic process has been recognised by various therapists as being the single most important factor in developing a therapeutic relationship (Balint 1990; Bandura & Satir 1987; Hyland 2005; Purkey & Stanley 2008; Rogers 2002). Helen reflected this view of the use of “self” in the consultation but also summed this up with other concepts included in this category:

“How I am in the consultation and what I do is vital, I would say, being aware at all time of my reactions, as it can’t help but affect how a patient reacts. Surviving practice is about practitioner know thyself and thyself in relationship to other people...and in that way whatever difficulties comes up for you or the patient or the relationship between you then you have some chance of staying with that experience...and coming out of it, and you know learning from it, with some healing”

Although homeopathy is neither general medicine nor strictly a “talking therapy,” it does have some similarities with both types of therapies and the practitioners may experience similar problems. The next sections in this chapter will explore the concepts that *understanding self* encompasses which are the concepts of *being drained* and *being replenished*. Initially I will explore the concept of *being drained* which refers to the challenges that a homeopathic practitioner may experience in practice.

8.2 Being drained

The concept of *being drained* was derived from “in vivo” comments from some of the participants which I interpreted as encapsulating the end result of many of the problems that homeopaths encountered in practice. Many of the homeopaths discussed the difficulties that they encountered in practice and that if they didn’t take steps to manage these difficulties then this would result in a drain in energy or an emotional drain. Sarah explained how:

“You get caught up in their story or getting caught up in their energy and getting caught up in way that drains you, before you even know it has happened”

Sarah also related a story of another homeopath who had done “*too much*” for her patients to the detriment of her health. Tricia explained how her desire to help was so great that “*it exhausted me*”. She described how she had previously had “*two lots of burn out ...from the practice of homeopathy*”. Richard described how at the end of the day he could be “*totally wrung out...and drained by certain patients*”. Anne explained how she saw it as an “*energetic process because it is very tiring*”. Catherine described how she could hardly manage a half day when she first started practicing as mentally it was “*very exhausting*”. Joanne also experienced *being drained* after a day in the clinic, she explained:

“I don’t tell anybody that homeopathic interviews are easy, they are very hard they are very in depth and you’ve got to be aware of what the patient is saying. Its hard work, its heavy thinking and it does take a lot of energy, your emotional energy and

your mental energy in trying to capture these things in an hour and a half and they are talking about a life time”

The source of the emotional and energy drain that the homeopaths experienced is varied and depends on several factors. These factors are divided into the following two sections which describe the concepts that I have labelled from “in vivo” comments as *coming up with the goods* and *giving your all*.

8.2.1 *Coming up with the goods.*

In the first interview that I conducted, Maggie expressed one of the difficulties that she encountered in practice as “*coming up with the goods*”. Subsequently I found that this “in vivo” phrase encompassed a range of experiences expressed by many of the practitioners as pressures on them to deliver a good service in their homeopathic practice. These experiences included, being judged, being self employed, finding the remedy and dealing with challenging patients.

When Maggie first mentioned “*coming up with the goods*” she was discussing the pressure that she felt as an individual practitioner to be successful:

“Well you know that I’ve got to deliver, that I’ve got to come up with the goods and can I do that? I don’t know. And they paid me money and I don’t want to give homeopathy a bad name and at what point do I say I’m not making any difference here...”

Tricia had a similar experience when she explained “*It’s very exhausting, to get it right...I don’t want to fail homeopathy*”. Both Tricia and Maggie seemed to be equating their personal successes or failures of practising homeopathy with the reputation of the homeopathic profession. Maggie has subsequently retired from her practice of homeopathy and when I spoke to her soon after her retirement she expressed exhaustion and disillusionment with the practice of homeopathy because of these pressures.

In Yanisa’s reflective diary she enlarged upon Maggie’s and Tricia’s concerns implying that they were self imposed by the homeopaths themselves:

“So why do we homeopaths set such ridiculously impossible goals for ourselves? It’s no wonder so many of us are giving up. A consultant colleague said to me recently that if he achieved anything like the 60% improvement that I expect in homeopathy, he’d be thrilled by it”.

When I spoke to Yanisa after she completed her diary she expressed a desire to retire from homeopathy. The reasons that she cited were the difficulties in earning a good living from homeopathy, the media negativity towards homeopathy and the huge expectations from patients and from within the profession which were too difficult to meet. Peter also expressed this opinion:

“You feel that not only are you being judged as a practitioner but to some extent the profession is being judged by our individual successes and failures.”

A recent article written by an experienced long standing homeopath and teacher of classical homeopathy (Vithoulkas 2008) put the concerns of these individual homeopaths into the larger context of a professional schism and what he considers to be outrageous claims made by individual teachers of homeopathy. Vithoulkas (2008) argues that these divisions within the profession can affect the homeopaths perception of their profession and society's perception of homeopathy. Additionally recent scrutiny and media coverage of homeopathy (Bond 2008; Editorial 2005; Ernst 2005b; Goldacre 2007a; Samarasekera 2007) may affect practitioners by highlighting homeopathy's marginalisation from mainstream medicine and adding extra uncertainty for the homeopaths and exposing vulnerabilities. A study exploring both medical and non medical homeopathic practitioners views of homeopathy found that they tended to consistently evaluate homeopathic practice in contrast with conventional medicine thereby continually positioning homeopathy as an alternative to mainstream medicine thus perpetuating homeopathy's marginalisation (Campbell 2008). Moreover the call for more and better evidence to support homeopathic practice (Jonas et al. 2003; Linde et al. 1998) may put pressure on homeopaths to defend their profession which in turn could increase the perception of a loss of control over the once autonomous practice of homeopathy.

The autonomy of being a self employed practitioner was not without its challenges for some of the participants in this study. Many of the homeopaths mentioned patients not turning up for appointments. A patient not turning up represents unpaid fees which can be a problem when there is rent to pay. Steffie described it as *a horrible hazard*”, Alan described it as *“people crossing the line”* and Beth in her reflective diary explained:

“Today I've had a no show. Mrs M, has been several times before and I thought she was reliable. I feel depressed and hate this aspect of homeopathy, it's a waste of my time but I never know if I am right to be cross or whether something awful has happened to her... ”.

Non attendance of patients for a variety of reasons is a problem that exists in many areas of medicine (Stone, Palmer, Saxby, & Devaraj 1999). Having patients pay for their health care represents for some practitioners a conflict of interests as they must identify as carers but also as small business owners (Andrews, Peter, & Hammond 2003). These tensions and dilemmas that homeopaths experience are reflected in conversations that homeopaths recently had on “First Class” a private intranet discussion forum for homeopathic practitioners. In these discussions homeopaths debated the problems of caring for their patients and yet feeling resentment and anger towards patients who don’t turn up for appointments or who refuse or forget to pay. Andrews et al (2003) looked at these dilemmas for complementary medicine therapists and found that they tended to sacrifice their incomes to be good carers and this low income could result in a perception by society that their work is not valuable. This notion of being undervalued and underpaid was reflected in the interviews as Yanisa described:

“I just don’t think we charge nearly enough. You know I don’t....I feel you see we should be doing much more work into that whole thing of valuing ourselves because there’s a huge.... I feel so privileged when people tell me all that stuff, very humbled and I feel we undervalue how much of ourselves goes into an interview like that”

Alan also related that one of the hardest factors in being a homeopath for him was *“making a living...there is a feeling that it should be for nothing”*. Cassie also supported this viewpoint by stating that the hardest aspect for her was the *“financial burden”*. Andrews et al (2003) suggested that if therapists identified as a carer first and a small business owner second then this would be reflected in their business decisions. For example, if these roles conflicted, such as when patients could no longer afford to pay for their treatments, most therapists claimed that they would continue to provide care for these patients either free of charge or at a reduced rate.

The pressure of *coming up with the goods* is also concerned with the *“nuts and bolts of finding a remedy for the patients”* (Tricia). This process of finding the remedy has been highlighted by the participants as being a difficult process. *Matching* the patient’s story to one of four thousand remedies poses some problems (refer to chapter 7 *Responding therapeutically*). Tricia explained how she managed:

“If I don’t get it right I’m failing them...oh homeopathy..I...not homeopathy have failed them because I don’t find the right remedy. And is it one of those weird modern ones that’s just proven”

James also related that even though homeopaths had many successful stories to tell they also had an “*equal number of disappointments, especially when you have gone that extra mile to find the remedy*”. This pressure to find the remedy was expressed by other participants.

Christine described how with being a busy medical homeopath the time constraints of the consultations meant that there were difficulties in finding a remedy:

“very often I don’t know what the remedy is, and we don’t have time to use repertories, with the time constraints...its usually a question of finding the closest match from your head a sort of knee jerk reaction”

Ruth described finding the remedy as a “*very complicated task... that that makes it a sort of exquisite kind of pressure*”. Maggie expressed how there were times that she got “*the feeling like well maybe I’m never going to get this anyway or get the right remedy*”. Wendy also spoke about the difficulties of choosing “*the right remedy*” out of a *materia medica* of 4000 different remedies”. Yanisa described this need to get the “*right remedy*” as “*looking for the pot of gold...the holy grail*”. The metaphor used here by Yanisa of the Holy Grail suggested that the “right remedy” was a worthy but almost impossible quest with an elusive quality particularly as the practice of homeopathy is reliant on the subjective experience and interpretations of both practitioner and patient. Similarly conventional doctors also experience a search for the Holy Grail in the form of Evidence Based Medicine (Lanzafame 2001; Susman 2003). Although many practitioners expressed difficulties with finding a remedy Steffie, for example, in her diary, presented an alternative view where the process of finding the remedy was much simpler:

Its always been easy to treat this family, I just seem to give them the first few remedies that I think of and they do well, it is very rewarding”

In my reflective diary I also commented on the ease with which I prescribed for a particular patient who articulated her symptoms very clearly. Thus it is not always difficult to prescribe and this can be affected by a number of factors, for example, how well the patient and practitioner understand each other.

Meeting the demands of particular patients can be another factor that makes *coming up with the goods* difficult. One of the skills of a health professional is the ability to deal with the different types of patients that are seen in the clinic, some of these patients can be challenging for the practitioner. Richard described how he was “*aware that some patients drain me*”. Susan elaborated on this when she described a particular type of patient that she found difficult:

I do get drained by people in ... in fact the first person I'm going to see this afternoon is very difficult. He's someone who I work with an interpreter with him but he's, you know, he's been tortured and he is, he carries an enormous black cloud around with him, it's so depressing, he wears very dark colours, his face is very morose, his wife has black hair tied back and her clothes are very...they both look so sad. They're exhausting. And why I find them particularly exhausting is because I know there is no way I can address the fact that they're both so exhausting because I'm working with an interpreter and it's really difficult.

This non medical homeopath worked in a NHS practice and was the only one of my participants who worked with patients who needed an interpreter. It struck me as a homeopathic practitioner how difficult it must be to communicate through an interpreter for any health professional. For a homeopath it must present a particular type of difficulty as the practitioner is interested in the patient's narrative. Language is an important part of this process; however, only 7% of emotional communication is conveyed verbally. For the rest of communication we are reliant on non verbal cues (Argyle 1988; Ong et al. 1995) but cultural differences may make it difficult to interpret these non verbal cues (Hargie, Saunders, & Dickson 1999). This was a particular type of difficulty but it also represented an example of patients whose symptoms may not improve but they keep coming back for treatment, as Steffie described "*I think in the end she used to delight in coming back and telling me how much worse she was*". Yanisa had similar experiences where she described giving "*every remedy under the sun*" to one patient with a chronic cough. Roger described how he found patients who didn't really know why they were seeing a homeopath as difficult "*I have to know why they've come and they have to know why they've come*". Steffie said that it was patients who make you feel "*helpless*" that she found difficult along with patients who appeared to gain something out of being ill "*you look and you think what is in their being that makes them need to be ill*". Julia described the "*needy patients...who lock you into a dance*". Several of the homeopaths described aggressive or angry patients as being hard to manage; Tricia perceived that "*people are far more abusive nowadays*". Richard described how he was badly affected by a patient "*who was a bully, his approach is bullying and he is very abrasive*". Joanne explained how she found one of the hardest aspects of practice was not to "*react aggressively if patients are rude to you*". Catherine also found that "*angry and rude patients are the ones that I find hard to deal with*". These experiences were reflected in a study exploring doctors' experiences of difficult patients (Steinmetz & Tabenkin 2001). Steinmetz & Tabenkin (2001) found that rude and aggressive patients were particularly difficult along with needy and dependent patients. Additionally patients who had medically

unexplained symptoms as well as patients who never seemed to be satisfied or get better were also difficult.

Various terms have been used to describe difficult patients in the medical encounter such as hateful (Groves 1978), and heart sink (O'Dowd 1988). The term “heart sink” was coined by O'Dowd (1988) to describe feelings of impending doom or helplessness when presented with certain patients. Medical doctors, as do other health care workers, frequently see patients with medically unexplained symptoms, or, patients who may express psychological symptoms in the form of physical symptoms, this is sometimes termed somatisation. These type of patients are challenging to doctors as they are always in a quest for biomedical causes which can be reinforced by doctors who may recommend unnecessary treatments, referrals and collude with patient's illness behaviour often because they feel ill equipped to deal with these types of problems (Bensing & Verhaak 2006; Chew-Graham, May, & Roland 2004). One study suggests that the type of people who attend complementary therapists, such as homeopaths, were people with medically unexplained illnesses and people who somatised their illness (Astin 1998). Anecdotally homeopaths often discuss how patients consult homeopaths as a last resort, especially if they have undiagnosed symptoms. Some of the participants discussed this, Wendy, for example, described how these are often the type of patients who are referred to the homeopathic hospital that she worked at:

“I mean they're desperate, the patients who are referred in this particular hospital, I would say, they are the patient we get. Patients who have been everywhere, who don't have a diagnosis and who have multiple, multiple problems, got multiple medications, conventional medication, and they're just coming here as a last resort. Oh my God, nothing else works and probably homeopathy is going to be miraculous, so you're having to tell them that's not a miracle pill.”

Dealing with these challenges could be particularly difficult if the homeopaths were tired, unwell or too emotionally involved with their patients, this aspect will be described in the following section *giving your all*.

8.2.2 Giving your all

The label of *giving your all* arose out of an “in vivo” phrase from one of the participants, and it encapsulated the notion that the effort required to practice homeopathy can be compromised by tiredness, being unwell and being too involved with their patients. After observing Clare's consultation she was discussing this issue, and disclosed that she had been tired during this consultation:

“I found it difficult to concentrate; I don’t think it was the camera as I forgot about that. I’m tired and maybe coming down with a cold. You have to be 100% on the ball or you can miss a nuance or something. Usually I prescribe on the spot, but, when I am tired I have to work on the patient’s case and send the remedy on”.

James concurred with this idea as he explained *“our emotional, psychological, spiritual and moral health all contributes to the healing process”*. James illustrated this point when he also described a period in his life when he wasn’t getting much sleep *“I was pretty wrecked and I don’t think that was my best prescribing”*. Susan also stated that her *“emotional health has a part to play, and if I am feeling grim then I find it much harder”*. Peter described how feeling tired and *“If you are feeling a bit down and a bit negative you just think oh well, stuff it”*. Catherine also described how her *“own mood, my own energy level, will dictate how I practice on the day”*.

Links between conventional doctors’ fatigue and depression and lowered patient care have been noted in the literature (McManus, Winder, & Gordon 2002). Not only can mistakes and poor or un-empathic care harm the patient but it can also harm the doctor by increasing stress and depression levels and making the doctor more self critical which in turn can makes them more stressed (Firth-Cozens & Greenhalgh 1997). This was seen in the interviews and diaries where some of the homeopaths expressed a degree of self criticism while discussing their ability to deliver effective homeopathic treatment. In Beth’s diary she reflected that she wasn’t:

“...practicing well today, I have cold and I really should be at home in bed...I would’ve cancelled my patients but thought I would be better today. This patient is very demanding and I feel useless and unable to help her....”

A combination of stress and the tendency to be self critical was seen in several of the interviews but was particularly prominent in Tricia’s. Her desire to raise the profile of homeopathy, her desire to help people, her tendency to over identify with her patients and her tendency to be self critical have lead to a form of emotional exhaustion and to what she has termed *“burn out”*:

“Its very exhausting...how do you raise people’s real understanding that we’re almost what you come to instead of a doctor?”

“my desire to help is probably so great and has been, that its actually exhausted me”

“Exhausted I mean I have had two lots of burn out during the practice of homeopathy... I really a lot of he time, I put too much in”

“if they don’t come back, I’m actually glad they don’t. And I also get hurt. I also..... you’re probably not supposed to personalise, but I think I’m doing really well with somebody and then suddenly, they’ll cancel the appointment. And you’ve got no idea why they did it. And you think, oh, we were doing really well, what’s happened now? I think it’s because we know as homeopaths that it isn’t just so many sessions. You know, the homeopathic path is a.....probably a lifetime’s path really, if you really wanted a..... and it definitely is quite, something that goes on over a period of time, and so if somebody stops like that, you first of all you doubt yourself, you think perhaps they weren’t really right, you haven’t really sorted them out, and they’re dissatisfied and they’re not prepared to tell me and I want to know because I want to learn from any mistakes I’ve made. And I think there’s a great feeling of loss to,....”.

Although Tricia was not representative of this group of homeopaths, the interview extracts describe a particular set of behaviours that have led to stress.

Tricia’s interview extract above also describes an additional set of behaviours that can affect the ability to practice. Over identifying with patients, becoming too emotionally involved and being unable to establish professional boundaries can result in problems for the practitioners. In Tricia’s interview she revealed that she would make herself available to patients when she was not supposed to be working:

“I have to admit I cant resist the phone ringing, even if it is at the weekend and I really want to help and I yes I put myself out and may even see them at times I don’t normally work at, like in the evenings.”

Maggie and Rosalind were also prepared to be available to patients at any time. All three also described strong emotional involvement with their patients; Tricia’s quotes above illustrate this. Rosalind described how she *“gives it your all which I do like to do with my patients you couldn’t just give it a 40 percent you know it would have to be 100 percent”*. Maggie described throughout her interview the tension of being available to patients *“it’s difficult...being there but also having non interrupted time for me”*.

All three of these practitioners were describing difficulties with maintaining boundaries around their relationships with their patients. The process of setting boundaries in the therapeutic relationship is sometimes termed contracting. Contracting with the patient to

establish and maintain clear boundaries within the therapeutic relationship is very important as it structures the work, provides direction to the work and provides safety and containment for both the patient and practitioner. Contracting also deals with issues of accountability and responsibility and clarifies mutual expectations (Page & Wosket 2001). All of the medical homeopaths in this study described very strict relationship boundaries with their patients; however the exception to this was Catherine, a medical homeopath, who explained how she can get caught up with the patient's experiences:

“I can get very drawn into a patient's space and you know... I... you know badly need supervision because I think actually in a lot of occasions this has been quite detrimental to my own health process”

The failure to erect strict relationship boundaries can result in strongly identifying with patients and an unhealthy emotional involvement developing. Kennedy and Charles (1990) discuss the problems of this kind of emotional involvement for those in the caring professions and suggest that it can create imbalances where the professional can feel that they care more for others than others care for them.

The challenges that health professionals such as doctors and homeopaths face can appear overwhelming. For some homeopaths the demands are not worth the benefit, for example, Yanisa and Maggie, two of my participants have given up their homeopathic practice because of the demands made upon them. However, most of my participants remain in practice as they are able to manage the balance between *being drained* and *being replenished* which is described in the next section.

8.3 Being Replenished

The concept of *being replenished* is concerned with both *being rewarded* which refers to the benefits of being a homeopath, and *looking after self* which refers to the action or steps that the practitioner takes in order to maintain the balance between *being drained* and *being replenished*.

8.3.1 Being Rewarded

Although all of the homeopaths discussed difficulties that they had in practice, they also all discussed positive aspects of being in practice. James, a medical homeopath, explained how his successes gave him a sense of reward:

When someone does very well, and that's obviously not for the first consultation but at follow up, that is for me the highest enjoyment in the whole of medicine. And I

can live off it for weeks and, you know you do have fallow periods, I've had a few cases recently which have really been great and great for me. And I think that homeopathy has that, that really is a sort of an addictive side of homeopathy is that you know it can have these results which the most, I don't think even the most sceptical person could ever imagine would have happened by chance but which is always an open question how they did happen, but they certainly wouldn't have happened if they hadn't come for homeopathy. I think I'm confident about that, you know we get cases coming in, wheelchairs, and go back to work and all these sorts of things, they're so unbelievable that you can't even believe them yourself and you were the person that actually was part of it all. And that sort of hooks you in and makes me want to continue to do it, to practice it

Other participants described similar experiences of successes in their practices but also described an enjoyment in the practice of homeopathy and in working with people. Maggie explained how:

“Personally I feel like it's a job well done when you can see people leave with a kind of lightness of step... or when they've had a good response to a remedy....or made a connection that was valuable for them”

Tricia described how with some patients *“it is an absolute joy to have them in the room and work with them”*. Anne described similar experience of working with her patients *“this afternoon I've got my cancer clinic and it may be...but I often get a joy from that clinic”*. Catherine also described *“the buzz”* of working with people and having a good consultation where *“I really feel that I've helped somebody...it makes me feel fantastic”*. Rosalind explained how for her, homeopathy was a worthwhile profession, perhaps not financially, but *“rewarding in other ways, satisfaction and you know coming from the heart and in those nice feeling ways”*.

These comments made by the practitioners were often in reference to particular incidents or consultations with patients that were successful. These successes were not necessarily attributed to successful treatment with a remedy, but were often connected to what the practitioner perceived as a good relationship with the patient. This is consistent with a study that explored what doctor's found meaningful about their work (Horowitz, Suchman, Branch, Jr., & Frankel 2003). The doctors were asked to write a brief account of a work related meaningful experience. The themes that emerged were, achieving a fundamental change in their own perspective, making a connection with patients and making a difference to someone's life. It was notable that often these situations were related to patients who

were medically difficult to treat. In addition none of them wrote about diagnostic or therapeutic triumphs but all wrote about their interaction with their patients. This is consistent with two other studies that also found that when doctors were asked about what was satisfying or meaningful about their clinical work they focused on the non biomedical dimensions of clinical care (Fairhurst & May 2006; Lichstein 1996). This suggests that although the failure to cure an illness may be a frustration for both homeopath and doctor, finding something meaningful about that interaction with that patient can be a source of enormous satisfaction; this sense of meaning seems to centre on a sense of worth, purpose and significance (Horowitz et al. 2003; Lichstein 1996).

Another source of reward that was mentioned by two of the GP homeopaths who have private homeopathic practices concerned feedback that they received from homeopathy that they did not receive in their GP practices, Richard explained:

“Whereas homeopaths because of the nature of the homeopathic....the ongoing consultations you get much more feedback from your patients”

Steffie described a very similar experience:

“I feel better”. And I think well it must be that in homeopathy because it can’t....it doesn’t happen in general practice. People do come back saying that they feel better for having seen you but not in the same way they do when they’ve had the homeopathy.

Although only two participants mentioned this aspect I considered it interesting as a point of comparison between homeopathic practice and medical practice for these two practitioners. Some of my participants who were GPs in NHS practices and who also worked in private homeopathy practices described how homeopathy had enhanced their medical practice. Peter explained how training and practicing in homeopathy has helped his practice:

*“I talk about this with all my medical colleagues who have done it. We just feel that we’re **so much** better doctors as a result because You know... we’re learning about.... Or we’ve learnt how to question patients in a way that that is most relevant”*

Other comments from the participants supported this view; Steffie explained how *“I have better GP consultations now”*. Richard described how he has *“learnt to listen and make connections”*. Christine related that *“Homeopathy has helped all my consultations”*. Catherine explained that she tries *“to bring...It’s not always possible but... homeopathic thinking into all my consultations”*, and Sally described that *“when patients feel that*

someone's taking an interest in them then I think it's a better consultation and that's what I learnt from it,... ". Roger was an exception to this as he did not make this observation. Alan also did not specifically make this observation but throughout his interview he consistently compared homeopathy favourably to conventional medicine.

Consistent with these views was a small qualitative study that explored conventional doctors' use of homeopathy in their GP practices. These doctors found that homeopathy offered a means of connecting their patients psychological and physical problems and enabled meaning to be made from the patients' narratives (May et al. 1998). Although the doctors in this study found homeopathy very useful they considered themselves mainly conventional doctors and viewed homeopathy as an adjunct to their conventional treatments. They also had ambivalent views about lay homeopathic practitioners who they viewed as antagonistic towards orthodox medicine and who turned public opinion against orthodox medicine. Neither of these two viewpoints were reflected in my participants' interviews. All of the medical homeopaths appeared very committed to homeopathy as well as conventional medicine and appeared willing to have dialogue with non medical homeopaths. It is difficult to be sure from my small sample as to why this is; however, it is possible those attitudes have changed over recent years and that the heightened media attention onto homeopathy has drawn homeopaths together. For example, the Society of Homeopaths and the Faculty of Homeopathy now occasionally work together to put out press releases in response to media news concerning homeopathy.

8.3.2 *Looking after self*

All of the homeopaths in this study derived some pleasure and satisfaction from the practice of homeopathy and from encounters with individual patients. Nevertheless, this benefit is not always enough to balance the demands of the job. The Society of homeopaths' journal "The Homeopath" periodically contains articles that acknowledge the demands of the job and support and encourage homeopaths to look after themselves (Pinto 1991; Ryan 1996; Ryan 2002; Wood 2003). The concept of *looking after self* represents the activities that the homeopaths undergo to balance the demands of the job. The activities that the participants mentioned are varied and range from having fun outside of work to continuing professional development (CPD) seminars, peer group supervision and one to one supervision. Steffie described how:

"I've got a horse so I spend a lot of my time mucking out, talking to my horse...its very therapeutic...when you are riding with the horse, you're trying by your body

movements to get them to relax their back so they can put their head down and they do what's called going, you know go what we call 'collected'”

Sarah also enjoyed activity *“I like being outside, I walk a lot and play tennis”*. Anne described how she relaxes *“I sing and I swim and I play with my friends and I really try to come up for air”*. Ruth also liked to *“I like to sing...I have a band and I sing”*.

Whilst having fun and engaging in relaxing and enjoyable activities outside of work is important there also needs to be some way of understanding the practical pitfalls of caring for the health of a patient and all that entails. Helen described the importance of supervision for homeopaths:

“In terms of supervision...we need it, you know, do you care for yourself? Do you value who you are and what you do and what you bring to homeopathy? Do you deserve looking after”

All of the practitioners except for Yanisa, Tricia and Maggie engaged in supervision and it was interesting to note that these three practitioners had difficulty with dealing with the challenges of practice. Some of the homeopaths just engaged in one to one supervision, for example Catherine *“I have one to one supervision...I can cope with it better with supervision”*. Some of them just go to peer group supervision, for example, Peter *“at our group we discuss difficult cases and we look at our own issues”* and some of the homeopaths used a mixture of these to support themselves. Cassie for example used a range of support:

“I do a whole group of things, I see a counsellor for myself, for my own development and I also do back to back mentoring with another homeopath where we just spend an hour each and we can talk about anything we want and the other person listens and tries to help, its great its like a co counselling session and we don't pay. I also go to group peer supervision and a one to one supervisor.”

The impression that I got from these homeopaths was that the support networks that they formed for themselves were a lifeline; this impression may well have been influenced by my own experiences. Early on in this study I wrote a memo about support in homeopathic practice:

Support in Homeopathic Practice

When I first qualified as a homeopath there were very few homeopaths in the country and so it was very difficult to form a successful peer group, also the concept of supervision had

not really been introduced into the homeopathic profession at that time.

After I had been in practice for four years three other homeopaths qualified in my area and we set up a peer supervision group. We met every month without fail for ten years. In the group supervision we discussed difficult patients, remedy choices and case management. Above all we discussed our own processes in order to develop a greater understanding of ourselves to enable us to help our patients but also look after our own emotional and physical health. My peer group was my life line and enabled me to have a very demanding job whilst also bringing up two children. Later on I also used and still use one to one supervision which enables me to understand in more depth some of the processes that occur in the consultation. Since then I have also trained as a supervisor and now offer supervision to trainee homeopaths and homeopaths in practice.

Whilst aware that my views and experience of supervision have been very positive I did not want to impose these views on the participants but was interested to note that the three participants who did not have supervision were the participants who appeared to be struggling with the demands of practice (I later found out that two of them have retired from homeopathy). No one spoke negatively about supervision although Yanisa did view that supervision did not address immediate issues *“by the time you get to supervision it’s kind of irrelevant. There’s no point in saying “the woman that came the other day”, I mean, you need to be able to discharge those kind of irritations now”*.

Supervision is an interpersonal interaction with the goal that one person, the supervisor, meets with the supervisee, in order to facilitate the latter to become more effective in helping people. Supervision is not just for the benefit of the supervisee but is also intended to benefit the patient or client. The task of supervision can have many functions but is often used to develop the skills, understanding and ability of the supervisee (Hawkins & Shoheit 2000). For homeopaths it is seen as an essential part of practice in order to help them identify the over sympathetic homeopath, to understand processes in the consultation such as embodiment (discussed in Chapter 7), thus enabling them to construct effective boundaries to avoid them becoming overburdened and over involved. This can only be done by developing an understanding of ourselves that can help us understand others (Pinto 1991). Pinto (1991) also suggests that in order to counteract the loneliness of working in isolation that regular contact with like minded individuals such as in peer group supervision or CPD (continuing professional development) seminars is helpful. Doctors have a similar process with “Balint groups” which aims to improve physicians’ skills in handling their patients whilst also examining their personal involvement and awareness of their own feelings.

However the popularity of “Balint groups” are waning as the type of group process may not suit everyone (Kjeldmand & Holmstrom 2008). Likewise despite the purported benefits of supervision and peer supervision groups there are still many homeopaths who are reluctant to engage in these activities (Wood 2001). Three of my participants did not attend supervision and two of them did not have a peer supervision group, but relied on individual colleagues that they could phone for assistance. The reasons that homeopaths do not see a supervisor are varied but Wood (2001) explains that seeking supervision can be an admission of failure. Additionally it can be financially expensive for homeopaths if they do not have a very busy practice. Some may also feel that supervision means surveillance or management rather than peer support (Launer 2007).

8.4 Conclusion

Initially there was an elusive quality to this category. Subsequently I realised that this was because the processes that occur in this category are background processes that occur within the mind of the practitioner before, during and after a consultation, rather than as overt actions which take place during the consultations. Maintaining the balance between *being replenished* and *being drained* is a concern of most professionals within the helping professions. For homeopaths this concern is compounded by their frequent working from home and by the necessity of having a deep involvement with their patients whilst not engaging in a detrimental emotional involvement. Media coverage of homeopathy also adds pressure on the homeopath to be seen to be successful. Additionally recent scrutiny of the profession could add to practitioners’ sense of vulnerability. The process of *understanding self* is concerned with the practitioners’ relationship with themselves and how they view themselves in the world. It is also concerned with being able to understand others and relate to them therapeutically. This theme of relationship has emerged out of the data and not only runs through the previous chapter of *understanding self* but also through the preceding findings chapters of *exploring the journey together*, *finding the level* and *responding therapeutically*. The next chapter, *Connecting* will discuss this recurring theme of relationship and show how it is crucial to the practitioner patient relationship and how it links all the processes of the consultation together.

Chapter 9 Connecting

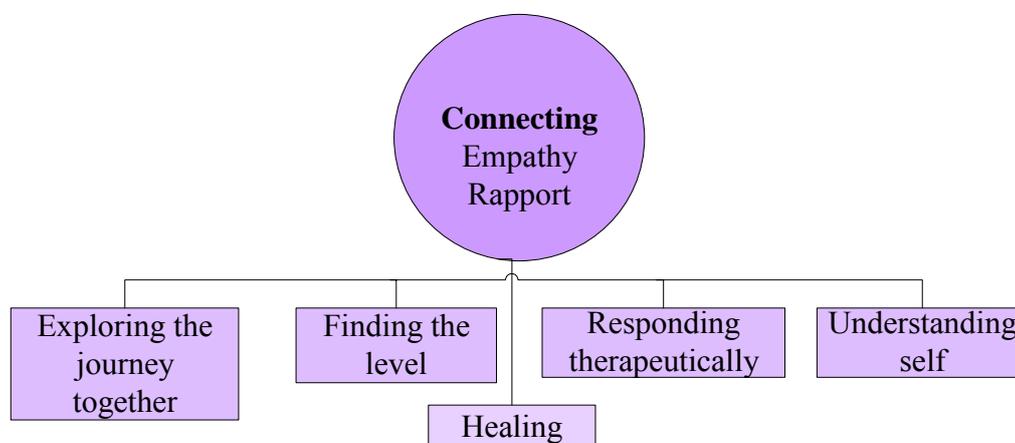


Figure 22: Connecting

9.1 Introduction

This chapter will explore the category that I have labelled *Connecting*, which refers to the theme of relationship which emerged out of the data and flows through and links the other categories discussed in the previous chapters. This chapter will show that the process of *connecting* is central to the practitioner patient relationship and is crucial to all the other processes in the homeopathic consultation as they are dependent on *connecting* and are linked to it. *Connecting* is the core category of this study and meets the criteria of a core category which was established by Glaser (1978) as discussed in Chapter 4 (section 4.7). Glaser suggests that the core category should emerge towards the end of data collection and although this category was seen recurrently in the data from the beginning of data collection it was only towards the end of data collection that it was recognized as the core category. Glaser also suggests that the core category, due to its complexity, should take longer to explore than the other categories. Identifying the properties of *connecting* and understanding how *connecting* linked and explained variations in the data and in the other categories took time as there were possible other contenders for the core category and so it was important to constantly search for the main concern of the participants. The main problem for the homeopaths, it became clear, was to form a connection with their patients, the homeopathic process and themselves so that the other processes in the consultation may occur effectively

including healing which is the ideal, but not always achievable, aim of the homeopathic consultation.

Initially in this chapter I will discuss the meaning that I have assigned to *connecting*.

Following on from this will be a discussion on the notion of *empathy* and *rapport* which are skills and strategies employed by the homeopathic practitioners to facilitate *connecting*. This will lead onto an exploration of how *connecting* links and is central to all the other categories in the findings for this research. Finally a brief discussion will follow on how healing is an ideal but not always possible result of a homeopathic consultation facilitated by *connecting*.

9.2 Connecting

Throughout the data collection words such as “*engaging*”, “*interface*”, “*energetic connection*”, “*relating*”, “*connecting*” “*connect*”, “*relationship*”, “*heart to heart connection*” and “*togetherness*” were used by the participants to explain and describe their relationship with their patients, the process of homeopathy and the relationship that they had with themselves. I therefore labeled the category *connecting* as it appeared to encompass all the concepts referring to relationship. Viederman’s (2002) commentary on engagement in the consultation refers to engagement as being one of the main goals of a consultation.

Christine described how she experienced *connecting*:

“I always hope there’s a connection at each consultation, yeah, I suppose I’m working to it in that sense. I haven’t got an exact route as to how I get there, because it must be different with every patient. But I don’t feel it’s been a good consultation unless I’ve made some sort of connection, you know, I sort of feel that they....that I understand... then they understand me, they feel they’ve been understood”

This was also referred to in different ways; Roger explained it as the “*interchange between the patient and practitioner*”. Richard revealed that for him *connecting* could be “*an energy, it may be an empathy a certain harmony*”. James described it as a “*heart to heart connection of trying to meet the person where they are*”. Anne described it as “*it’s a bit like a dance isn’t it? We come together then we move apart and then come together again*”.

These descriptions of the connection achieved between the patient and homeopath were similar to descriptions that massage therapists used to describe their relationship with their patients (Hyland 2006). Although massage therapy substantially differs from homeopathy Hyland (2006) poses the question as to whether homeopaths, or indeed any other CAM therapists experience a similar form of connection with their patients. My research suggests

that there is a connection that is achieved by the homeopaths that may be comparable to massage therapists. It could be proposed that the connection between massage therapists and their clients takes place mainly through touch, homeopaths appear to rely on speech and observing body language.

Some of the practitioners explained that it was the patients who at times had trouble *connecting*. Yanisa explained:

“If I am stuck with somebody who was that typical English, you know, very abrupt and....I can find that difficult and sometimes I got this...I feel like I’m this person sort of going round a big fortress, you know, banging on the door, can I come in, no, right lets try here then...”

Other practitioners described how they may at times have trouble *connecting* with the patient; James, a medical homeopath, explained *“Sometimes, I do perceive myself as getting a little bored.... that happens when there is no juice in the case”*. James explained that a case with *“no juice”* referred to a patient who was not disclosing. Susan described a similar experience:

“When there’s a curtain between me and them...like with that woman last night I told you about....I wasn’t actually engaged, I just thought I’m bored out of my mind...”

From these quotations there are indications in the data that in order for *connecting* or a relationship between the patient and practitioner to occur in the homeopathic consultation it must be a mutual process. This perspective of the process of mutually connecting has been discussed in relation to the medical consultation (Matthews, Suchman, & Branch, Jr. 1993). Matthews et al (1993) discuss moments in the consultation when there are powerful and mutual experiences of shared understanding, they refer to these moments as *“connexional”*. Additionally the practitioners frequently commented that the lack of connection with their patient resulted in the least successful consultations. For example, Ruth suggested that *“people who can’t connect and are unable to reflect on their own emotional processes make a difficult consultation”*. Catherine explained that *“bad consultations are patients with blinkers on, they don’t connect...not engaged”*. Maggie described how *“its hard to connect with them if they don’t see the mind body connection and see themselves in parts...yeah, those consultations are hard”*.

As I looked more closely at the data I realized that there was a balance that had to be kept between *connecting* appropriately and over *connecting* for each patient. The depth of

connecting to the patient varied along a continuum, where practitioners such as Tricia, a non medical homeopath, seemed to over identify with patients which seemed to leave her vulnerable to stress (this is discussed in Chapter 8 *understanding self*) and Roger, a medical homeopath, managed to remain very detached from patients “*we interact, but I don’t get involved on any level...why would I?*”. In the middle of the continuum Christine was able to engage and connect with patients during a consultation and yet able “*to not take it home with me*”.

Steffie described an experience where she misjudged how much to try and connect with the patient: “*they found it threatening and....they’re the ones that often don’t come back because they’re not prepared for that*”. Julia, who also trained in psychotherapy, described how over *connecting* could affect the ability to prescribe

“sometimes to have the bigger connection means you just cant get the remedy, you get lost in a kind of rapport, and the seduction of it. And you can use the word seduction because I think you’ll find a lot of people are seduced into the kind of transference counter transference energy that happens”.

During the interview Julia referred to the words transference and counter transference several times, I asked her to explain what she meant by these words:

“Well... transference is concerned with a projection of feelings for one person onto another, so for example it can refer to the patient’s feelings towards the practitioner and counter transference is about the therapist’s feelings towards the patient.”

Tim, a medical homeopathic practitioner, referred to over-*connecting* when discussing how he would offer homeopathy to patients in his NHS practice. If they were reluctant “*a shutter would go up*”. Susan referred to it as patients “*building a wall around themselves*”. Here she was describing what would happen if she tried to engage some patients in talking about mental and emotional symptoms. Anne also described over-*connecting*: “*if you over-identify you actually lose any potential you have to maneuver in that space. It is a fine line*”.

Forming connections with patients therefore can be problematic if the practitioner has not understood the needs of the patient and if there is too much closeness or too much distance in the relationship (Fredriksson 1999). Patient unwillingness to connect may also arise if the patients are used to seeking help from a “dualistic” medical system in which symptoms are either physical or mental in origin. They may not consider that social and emotional issues are relevant or feel the implication is that the problem is “in their mind”. Viederman (2002) also proposes that engagement with a patient must be tailored for each individual patient’s needs and personality. This aspect is also discussed in section 9.4 in this chapter.

The observations of the consultations showed that the homeopaths behaved as if they were engaged and connected with the patients. This was clearly seen by the way that the attention and body language was focused intently on the patients. For example, throughout the observation of Clare's and Robert's consultations they would lean towards the patient, mirror body language and frequently used encouraging nods. However, I noted that they wrote down almost verbatim notes during the consultation and I considered whether this process affected the patient's perception of whether the homeopath was engaged or connected with the consultation. I also considered whether the homeopath despite looking as if they are engaged in the consultation had trouble engaging in the patient whilst writing down notes. Clare explained that:

“you get very used to doing the writing and the listening, but I don't know how the patient views it”.

A study using conversational analysis to explore displays of engagement in doctor patient interaction found that when doctors looked away from their patients to study medical records patients were puzzled as to whether the doctor was engaged and this was demonstrated by a lack of fluency in the patient's speech patterns (Ruusuvuori 2001). In the observations in this study no lack of fluency was noted until the last five or ten minutes of the consultation when the homeopaths tended to consult their *materia medicas* to decide on the appropriate remedy to prescribe. I would be interested to explore if patients at this point considered note taking and referring to *materia medicas* to make a decision and act of dis-engagement; however this was beyond the scope of this thesis.

The next section will discuss empathy and rapport which emerged from the data as two strategies that the homeopaths employ to facilitate *connecting* with their patient. The subsequent sections in this chapter will then explore all of the categories described in the previous findings chapters and show how they are dependent and linked to *connecting*.

9.3 Facilitating connecting – empathy and rapport

Many of the homeopaths referred in their interviews to *empathy* and *rapport* as skills that they used in the consultations to facilitate *connecting* and thus enable the other processes in the consultation to take place. Wendy described *empathy* as having an understanding of another person:

“how can I say it....without...well, I think I empathize with them which I think is understanding another person's being, emotional state or whatever”

Ruth also described *empathy* as an understanding “*I try to get inside their head and understand what they are telling me*”. Roger concurred with Wendy and Ruth’s descriptions of *empathy* as being a kind of understanding of the patient; he also discussed how *empathy* was also related to sharing with the patient:

Roger: “actually the patient shifts and isn’t ill anymore”

Interviewer: “What do you think is the skill that they’ve got then that enables them to do that?”

Roger: “Empathy. Understanding what....why....having a relationship with the patient. Understanding why they’ve come and just being there and sharing that sort of distress in that moment and being open to it I think”.

Both listening skills and achieving an understanding of the patient were, according to this group of practitioners, essential components of *empathy*. In Chapter 1 *empathy* was briefly discussed in relation to a study exploring patients views of the homeopathic consultation (Mercer et al. 2004). Mercer et al (2004) found that *empathy* was one of the skills that homeopaths used in the consultation and this was demonstrated to a patient by a caring and compassionate demeanour of the homeopath. It has also been suggested that *empathy* is particularly important in the initial long homeopathic consultation in order to develop *rappport* with the patient and encourage the development of the therapeutic relationship (Bikker et al. 2005). Norfolk, Birdi & Walsh (2007) present *rappport* as being the most basic element in making a connection with a patient and being able to empathize; they consider that *rappport* can be expressed in words and behaviour and conveys a caring attitude towards the patient. Leach (2005) highlights strategies that practitioners can use to establish and enhance *rappport* in the consultation, of these he mentions making the patient welcome, comfortable, being warm, being open, being sensitive, being empathic and awareness and mirroring of body language. In the observations there were often occasions where the practitioner’s body language mirrored the patient’s body language, especially during emotionally charged moments but also during comfortable conversation. In the interviews many of the practitioners described in quite a lot of detail how they would make a patient feel welcome in the beginning stages of a consultation. Rosalind described this at the beginning of her interview:

“I would like to sort of have my room ready... so its clean, the airs right umm everything, they’ve got a nice warm room to sit in something that they are comfortable with so they can find, so its easy to talk to me umm I want to make them feel at ease...”

Joanne described a similar experience to Rosalind “*you have to make them feel welcome...so that they feel comfortable to open up to you*”. Jonathon explained that he may use humour to make people feel welcome “*I make them comfortable and I offer them this chair, which looks like a throne, and I say “do sit on the throne” which gives them a royal welcome*”. Yanisa also liked to use humour “*um people who heard me say there’s always a lot of laughing going on, so it’s not strained*”. Cassie described how she may “*go to some lengths to make them feel comfortable*”, in her interview she described the seating arrangements, providing a drink and being relaxed. This process of welcoming is consistent with the views of patients of herbal practitioners who found that the environment and initial demeanour of the practitioner was intended to make them feel welcome (Little 2007).

Empathy can be an initiating factor in moments of connection between the patient and practitioner (Davis 2009; Matthews et al. 1993). This process of “*connecting*” which is facilitated by the skills and strategies of empathy and rapport can lead to a collaborative relationship (Leach 2005) and can assist patient disclosure and the practitioner in correctly identifying the patients’ perspective (Norfolk, Birdi, & Walsh 2007).

However, the practitioners did not always find it easy to have an empathic relationship with their patients. Helen for example, stated:

“empathy is a bit over rated (laughs), yeah we do need it, but sometimes you really cant get in touch with that person It does make it difficult to connect with them and the consultation doesn’t feel good”.

Cassie for example, described how “*some people I just can’t feel for... there is no rapport*”, when asked to elaborate on this she said:

“it’s the ones that don’t help themselves, they seem helpless and no matter what you say or do they wont do anything to help themselves”

Cassie’s statement suggests that for some practitioners being able to empathize can be dependent on certain factors such as the judgment of the practitioner or criteria that the patients must fulfill. There is an assumption derived from Rogers (1995) that the ability to empathize should not be affected by prior attitudes or judgments. However, this view would require holding presuppositions and knowledge in abeyance. Alan described in his interview how he used his prejudices, knowledge and subjectivity in order to develop an empathic understanding of his patients:

“To me it’s a joke to say all that’s required of you is to be unprejudiced, you are prejudiced, someone walks into the room and says something or whatever, you’re

going to have a reaction to it, we're human beings, we're not computers that can just absorb information and be completely unprejudiced and I have taught my students that the best thing is to be aware of your prejudices and even use them..."

In contrast to Rogers (1995), Pederson (2007) presents an alternative view of *empathy* that reflects the idea that understanding and interpretation is always affected and contributed to by the physician's presuppositions, experience, practice, knowledge and culture.

Definitions of *empathy* vary, but many agree that *empathy* is comprised of both cognitive and affective processes (Davis 2009). In the clinical context it has been described as "the ability to communicate an understanding of the patient's world and to act on that understanding in a therapeutic way" (Reynolds et al. 1996 page 363). Certainly most descriptions and definitions include some aspect of "understanding" and there is a consensus that *empathy* is important for the practitioner patient relationship and medical practices (Pedersen 2007). The diversity in understanding of what *empathy* actually is was reflected in the interviews. For example *empathy* is sometimes seen as a tool or skill that can assist the physician in gaining an understanding about the patient (Halpern 2003) as James described: "*some people who actually used those feelings as part of their diagnostic equipment*". This was demonstrated in the observations of the consultations, where empathic behaviours noted in Robert's, Clare's and my consultations stimulated further disclosure from the patients. For example, in Robert's consultation:

Patient: "being bullied at work has a stigma, especially in a hospital and I felt so angry with him that he could do...it"

Robert: "Yes I know how hard it's been for you" (Robert leans towards the patient listening very attentively)

Patient: "it's been really difficult to sort of you know think of myself in a different way like I'm not that victim anymore..."

Empathy is sometimes seen as a means to assert that the information gathered about another person, using *empathy*, yields direct or even accurate knowledge about that person (Keefe 1976). Sarah expressed this idea "*you really feel it with them...and then you can see the whole of them and that, well, for me it doesn't lie*". Sarah's statement also implies that *empathy* is present if you share the same emotional state as the patient. Catherine also discussed this aspect in her interviews "*I can't help but vibrate and resonate with the energy that comes from a patient, I can cry with a patient, I can feel angry with a patient*" This idea of empathically sharing the same emotional state as the patient is also reflected in the

literature (Gladstein 1983). Halpern (2003) also discusses this aspect of feeling with the patient and refers to it as emotional attunement, another facet of this which is more subtle but equally as powerful is non verbal attunement where the practitioner used non verbal signals to indicate empathy that will then encourage disclosure. This aspect was observed in the observations of the homeopathic consultations. During Clare's, Robert's and my consultations body language with frequent nodding and leaning towards the patient at poignant moments in the consultation indicated focused attention on the patient. These behaviours and others such as being silent, using smiles and maintaining eye contact have been described as attentive and active listening skills (Branch & Malik 1993) which signify to the patient that the clinician is listening intently.

These attentive listening skills have been equated with an empathic style of communication (Du Pre 2002). Moreover the pattern of *empathy* appeared to follow a cyclical pattern of expression and responding between the patient and practitioner (Barrett Lennard 1981). This cyclical pattern is assisted by the use of, what has been termed empathic opportunities in the interactions. Missed opportunities for empathy are termed empathic terminators, and they usually occur when a clue has been given by the patient which the practitioner misses or ignores (Suchman, Markakis, Beckman, & Frankel 1997). Both empathic opportunities and empathic terminators were observed in all the observations in this study. However this aspect could not be fully observed as the video camera was mainly focused on the practitioner and the patients' responses could not be fully observed. An example of an empathic terminator was seen in Clare's consultation with her patient. The patient was describing her intense and difficult relationships that she had with the people that she cares for in her job:

Patient: "I feel too much, as a carer I have to feel, but sometimes I can't cope with the feelings that I get of sorrow for this person that has a difficult life..."

Clare: Looks away from the patient and starts writing, after a short pause asks:

"How many people do you care for?"

Patient:" umm, I don't know, too many."

This exchange between the patient and the practitioner appeared stilted in the observation. Clare did not maintain eye contact with the patient after this disclosure and then did not ask a question that appeared relevant to the disclosure as the patient's ambivalent reply indicated. Julia also described a situation where empathy was difficult in her consultation:

“I couldn’t connect or empathise with her at all and I gave her a fantastic prescription, but then maybe that’s saying something about the remedies...it was china, china is hard to find and they don’t make connections”

Julia was describing how she used the lack of connection and *empathy* with her patient as information which informed her as to which remedy (china also known as chinchona or Peruvian bark is a homeopathic remedy) to prescribe. *Empathy* has been cited as one of the reasons for any success attributed to homeopathic treatment (Ernst 2005a), however Julia has described an experience with a patient where successful treatment occurred despite a less empathic than usual consultation. Later in her interview Julia explained that she had described it as a “*fantastic prescription*” because the patient returned for follow up feeling much better. Thompson & Weiss (2006) in their study that explored homeopathic consultations also noted there was no good outcome without satisfactory *empathy*, but good *empathy* was not itself sufficient for good outcome. This was reflected in my informal discussion about *empathy* with homeopathic colleagues, where there was a consensus that it was possible to have an empathic consultation but the patient does not necessarily get better. This suggests that *empathy* is an important part of the consultation but not necessarily exclusively important for achieving a good outcome.

However the precise meaning of *empathy* is unclear in the literature and in the interviews where the practitioners reflect this lack of clarity and diversity of understanding of the concept of *empathy*.

9.4 Exploring the journey together

Through the process of narrative exploration described in Chapter 5 a relationship develops between the homeopath and the patient. Steffie described how through the process of exploring her patient’s symptoms and narrative she was able to achieve a “*connection*” with her patient. This in turn facilitated the process of further exploration of the patient’s narrative because of a perceived enhancement in the relationship with her patient:

“I think sometimes you just know when to ask the question. I remember having one lady who come in to see me and at one point she was talking about her hysterectomy and I looked at her and I just said “how did that make you feel” and she just burst into tears and it all came out....It was one of those seminal moments in the consultation when suddenly the patients on your side and they’ve really connected with you and you’ve just got this huge packet of information that they have just given

to you and you have to look after it very carefully, like a basket of eggs. And sit with it and not prod it too much but allow things to come”

The process of exploration offers a way for practitioners and patients to connect with each other through the use of story, with the intention of the practitioner gaining an understanding of the patient’s beliefs and perceptions about health and well being (Hovey et al. 2007). A narrative requires a teller and a listener and the power of the story is located not in the story itself but in the telling and the listening (Frank 1998). As humans we construct meaning through language and when a story is revealed it is spoken once by the teller and heard twice by both the teller and the listener (Hyden 1997). Through this revealing of the story there exists an opportunity for meaningful re-evaluation of understanding and meaning of living with illness (Bury 2001; Frank 1998).

How long this process of establishing a relationship through the narrative can take is not clear, but seems to depend on a number of variables such as patient ability, openness to holistic style consultations, practitioner ability and experience. For some of the homeopaths, like Steffie, it can be “*instant engagement*” but for others this process of *connecting* through a patient’s narrative does not always happen immediately in the first consultation. Julia explained how it can take time to connect:

“so when I do have clients who cant speak or name what’s going on, I know about it even if it cant be spoken about and gently maybe over the 2nd, 3rd, 4th, consultation we can go there. And the other thing I think with the first consultation is, I don’t expect them to tell me their whole life, I don’t worry about it any more, I don’t care if we only do a very superficial start, I don’t see that it’s a time related thing. It’s an energetic connection that you have with someone and so over a period of time that connection unfolds itself through the interviews.”

Like Steffie, Roger also found that the process of “*exploring*” assists the development of the relationship between the patient and practitioner but also can assist in forming an engagement with the process of a homeopathic consultation:

“So there’s an opening and changing of the way they relate to natural therapies, you know, which is part of engaging in the process. I think they open up inside themselves. I think.....its like as if there something in them that opens that can listen on a different level”

As discussed already, engaging in a homeopathic consultation can be difficult for patients who are used to a biomedical consultation (Chatwin 2003). Chatwin’s (2003) conversational

analysis of homeopathic consultations identified that the homeopaths had to socialize patients who were used to a medical consultation to a homeopathic consultation. Thompson & Weiss (2006) found that being open to a mind body consultation and connection was necessary in a homeopathic consultation. This was not necessarily because it predisposes a patient to respond to the remedies but rather that such openness gives the practitioner the insights necessary for accurate remedy selection. *Connecting* the patient to the process of homeopathy appeared to be quite an important part of the procedure for the homeopaths in this study. Beth described this in her reflective diary:

“I had a new patient today and it was quite difficult to make them understand the connections between the mind and the body and how homeopathy can help with that....I can understand that for patients not used to this, that it can be confusing but its important to stick with it and get them to see themselves as a whole”

The requirements for engagement are different for each patient (Viederman 2002). This can make it difficult for practitioners to gauge how to connect with some patients. Judith described an experience with a patient where the relationship between herself and the patient was unsatisfactory:

“We didn’t really, you know, click and she was very closed...it wasn’t that easy a decision what to give her, but that’s what I gave her in the end because, you know, when I traced it back I realized that, you know, she’d been bullied quite badly as a teenager and she’d never shared it with anyone and whatever, and this is when the grind, the teeth grinding started. And it sort of.....so then I felt that what I have to do is draw the link for her and she’d never put two and two together, and that”

Judith implied in her interview that because she did not “click” with the patient they then did not make connections and patterns in the narrative, forcing Judith to make those connections for them. Ruth also described how during the exploration of the patient narrative insight and connections can be made as to the meaning of a patient’s illness. However Ruth’s experience differed slightly from Judith as Ruth stated that patient’s can make these connections themselves simply through the process of exploration:

“the questions that we ask as homeopaths can often lead people to some new insights into the connections between their emotional states and the physical states. And I think that we don’t have to tell people that there necessarily is this connection, but that simply by asking them questions then people will come to an awareness themselves”

What Judith had described was a connection that she had formulated and that did not resonate with the patient's experience, resulting in Judith's discomfort at the end of the consultation. However, Ruth's perspective is consistent with Hovey & Paul (2007) who observe that patients may achieve their own meaning and connections through the telling of the narrative and the response of the listener to that narrative. Viedermann's (2002) perspective differentiates between a successful construction of a connection made by the practitioner and patient and an unsuccessful construction of a connection. Compliant acceptance in the form of intellectual agreement does not indicate a successfully constructed connection; however emotional responsiveness or meaningful associative connections made by the patient validate a successful constructed connection. This is what Ruth described, but this does not always happen in practice, as Judith described earlier. Consistent with these perspectives presented in this section is the exploration by Fredriksson et al (2001) of the idea that narrative understanding depends on the level of personal understanding with which the health professional meets the patient, and the level of personal understanding of the patient. If they are situated at different levels then a meeting seems difficult. A successful connection that develops at the exploration stage of the consultation can facilitate and enable the other processes that are seen in each category. Once the homeopath has developed an understanding of the patient through this connection they can begin to evaluate the level at which treatment should be aimed.

9.5 Finding the level

The initial facilitative relationship that is established between the patient and the practitioner provides the context for a more collaborative relationship to be established. Within this category the practitioner evaluates the patient's ability to heal, the extent of their illness, where the focus of their illness lies and any response to treatment. This is done through *collaborating* and assessing, managing, adjusting and matching *expectations*. The principles of holism and vitalism are applied practically in the consultation and also provide a philosophical underpinning for these processes to take place. The following quote from Jonathon described the importance of "*getting on well*" with the patient and he also summed up all the concepts of "*collaborating*", "*having expectations*", "*wholeness and energy*" which were described in chapter 6 *finding the level*:

"Well...I try to, you know, get inside their mind. If we have got on well and the energy is there then I can work out what the patient needs, what we are going to treat, on what level. Am I going to be able to get further than the physical with this

patient, can we discover the emotional side....? If it's just physical then that's what we do. We have to work together or it doesn't happen"

Yanisa also described in her interview how she needed a connection, or to sense a connection, with the patient in order to challenge the patient to form a collaborative relationship with her:

"we've tried this and we've tried that and I really feel there's something going on for you, I totally get that you can't discuss certain..., I totally understand that, but for this to work I'm sorry I need a little bit more. You know....because I feel very much it's a two way process and there's no point in coming in here and just sitting there and saying nurse can I have a pill. But I feel I can only do this if we are connecting"

An example of setting up a collaborative relationship was seen when I observed one of Clare's consultations, where she was clarifying with the patient what the symptoms or condition the patient wanted treated. When they had reached an understanding then Clare asked the patient to confirm if this was what she wanted from homeopathy. When this was discussed with Clare after the observation she stated:

"You know you can work together because it is very much a two way thing its not just me getting them better they have to put their input in as well they have to put in and yeah um they have to want to get better, to work with me...and we need to have to get on well"

The practitioners above were describing the importance of *connecting* with their patients so that they could form a collaborative relationship with the patient. From the analysis of the observations of the homeopathic consultations it was observed that as the patient related their narratives the homeopaths appeared passive, as the patient would take the lead in the consultation. The homeopaths response was often with minimal verbal and non verbal encouragement to the patient to continue talking. The homeopath would then become more involved and the collaborative side of the relationship would become more evident. The purpose of this collaborative relationship appeared to be to assess expectations within the parameters of wholeness and energy and to educate the patient to view their illness within a holistic and energetic framework, allowing an evaluation of treatment to begin. The impression here is of the practitioner trying to establish a commitment to homeopathy and the homeopathic process. In Maggie's interview she discussed a particular incident of a patient connecting to a holistic framework. Maggie was using this example to explain how a patient's connection to holism made it a more satisfactory consultation for the practitioner:

“and she has been so great to work with because she has really taken on the connection between the mind and the body in the way that some people although they say that they understand that its sometimes seems like they don’t actually see that and they still see themselves in parts and this particular woman I think because she has seen that connection so clearly and she’s got much more respect now for her physical body and she’s made great progress and I’m sure that has contributed to her progress along with the remedies and so it....I do find that people who are interested in what homeopathy is about”

Chatwin (2003) discusses how the development and maintenance of a person’s commitment to the healing process and the supporting role of the practitioner can be seen to be particularly relevant in homeopathy because of the degree to which the therapy regards the stimulation of the patient’s own healing abilities as underpinning the therapeutic process. In my reflective diary I had provided an example of a patient with whom collaboration was difficult:

“Her first words to me were “I am a scientist I have difficulty with homeopathy, I am very sceptical...I am desperate there is nothing medicine can do for me” My difficulty with this patient is that she was not open to engaging with the homeopathic process, we did not connect and I could not manage her expectations and I did not expect her to return for further treatment.”

In the medical consultation it is also recognized that a good therapeutic relationship enables collaboration between the patient and practitioner so that patient preferences and expectations can be explored (Murray, Charles, & Gafni 2006). Stewart’s (2005) reflections on patient centred consultations highlight six interactive components of the patient centred clinical method; exploring both disease and the patient’s illness experience, understanding the whole person, finding common ground, incorporating prevention and health promotion, enhancing the doctor patient relationship and being realistic. Elwyn et al (1999) suggest that finding the common ground is central to this process, they describe steps for achieving this which involve the practitioner and the patient working together, sharing of information and eliciting preferences and expectations. Although this does loosely equate with *finding the level* in the homeopathic consultation there are some differences as the homeopath has to, in some cases, acclimatize the patient to a holistic consultation and has less technical or medical information to impart.

Having established through a connection with the patient on which level they require treatment the process of *responding therapeutically* to the patient can begin.

9.6 Responding therapeutically

The previous two sections described how the relationship between the homeopath and the patient develops, facilitating other processes such as an understanding of the patient's narrative, which can then be evaluated within a homeopathic framework. It is within the context of this relationship that the homeopath is able to respond therapeutically with a variety of options as Helen explained:

“Sometimes it's a remedy.... watch and wait, sometimes its referral, sometimes its education, sometimes its, you know naturopathic, you know, or, nutritional”.

However as discussed in Chapter 7 (*responding therapeutically*) the therapeutic response can also be part of, and a result of, the interaction between the patient and the practitioner that can produce a beneficial health outcome for the patient. This is described by Cassie:

“I always feel a consultation has gone well if a patient makes a connection about their case that they've never made before. Or developed a connection that they already knew about, during the consultation. If we have got on really well and I think that that makes me feel a consultation has gone well, if I do that. If I can get enough information to feel confident about a remedy choice to help with that issue, then great. But sometimes I find I get to the end of what I consider to be a very, very good consultation and if the patient feels better before I have even given a remedy then... I don't worry too much about that”

Some of the participants experienced patients receiving therapeutic benefit with just a consultation but did not experience this with every patient and with every consultation. As discussed in Chapter 7 *responding therapeutically* the benefits received by patients could be to do with possible specific effects from the remedy or could also be concerned with the ritual or symbolism of the homeopathic remedy and the interaction between the patient and practitioner (see Chapter 10, *Discussion*). Additionally the combination of the consultation plus the matching of the correctly chosen homeopathic remedy could also be of benefit (Thompson et al. 2006).

Some of the homeopaths expressed the importance of *connecting* to their patients, as this helped them to successfully decide on treatment. James explained that:

“To help me understand the remedy better it would be more like a kind of perhaps heart to heart connection, or trying to meet the person where they are rather than the remedy diagnostic chase.”

Later on in James' interview he elaborated on the importance of forming a good connection with the patient:

“Where we run into challenges is where there is a mis-match, various types of mis-match.... Where the homeopaths' world, which is the knowledge of remedies and principles of homeopathy and you have the life world which is the patients lived experience on the other and the two ideally get sort of matched to each other”

Jonathon expressed a similar idea, *“I use the relationship to try and understand the patient and find the remedy”*. This idea was also present in Steffie's reflective diary:

“I really connect with this patient and more importantly she seems to connect with me. I feel that this is really helpful in finding a good remedy for her, I think this is to do with our mutual understanding.”

This process could be observed in Robert's consultations with his patient. Robert's consultation was with a follow up patient who he had already established a relationship with:

Patient: “I have had trouble with that person before, as you know, and although I can manage the situation better now, I still feel that anger, I feel that it is important to tell you about it,”

Robert: “Yes, it helps me understand what is happening for you right now, and I think that I will give you staphysagria (a homeopathic remedy), like you had before, as it fits, with all this happening”

Patient: “It really helps being able to talk to you and, you know, you... I can talk here”

The data in this study indicates that the practitioners observe that *connecting* is important in the process of *responding therapeutically* to a patient. However it is noteworthy that there are only two books that have been written on the therapeutic relationship in the homeopathic consultation (Kaplan 2002; Owen 2007). In contrast to the hundreds of books that have been written about the homeopathic materia medica and homeopathic philosophy. Owen (2007) states that the relationship is the key because understanding the patient is connected to the understanding of homeopathic philosophy and the homeopathic remedies. Kaplan (2002) also states that it is the conversations that patients have with their homeopaths and their listening and empathic skills that are the most important part of the whole process of the consultation as this then helps the homeopath find a remedy.

In the preceding three sections I have discussed how the homeopaths' relationship that develops with the patient is central to the other processes that occur in the consultation. In the next section I will discuss how the relationship that a homeopath has with themselves as a practitioner both personally and professionally affect their relationship with their patient.

9.7 Understanding Self

In Chapter 8 I discussed how the process of *understanding self* enabled the practitioner to maintain the balance between the challenges of practice represented by *being drained* and meeting their needs by *being replenished*. Peter described how his experience of *understanding self* assisted the process of understanding others:

“I think it’s that level of being in tune with myself and with them which I think stimulates the patients to feel they’re being listened to. And you know it puts them in touch with their condition. I guess you are sharing your own humanity with them rather than just rising above them as bigger”

Julia described a similar experience and explained how an understanding of self and doing *“inner work* could help develop *“that energetic connection”* with a patient. Alan described it in terms of being yourself when entering the consultation *“take yourself in there...and drop the mask”*. Sally revealed that she needed *“to know who I am, to know them”*

However Yanissa, in her reflective diary described a personal crisis, where she documented her thoughts about the negative aspects of the homeopathic profession and her place within it. The dilemma that she faced forced her to examine her motivations for continuing to practice and this led to uncertainties in her practice:

“Its such a relief not to care so much, I don’t mean that my patients are getting poorer treatment from me than before. I just don’t really care whether they want treatment or not!! I am left with an uncertainty though, and I’m not sure if this is me or my patients. I think if I loose a sense of myself in the consultation then maybe I’ve lost the consultation.”

Beth also described (see Chapter 8 *understanding self*) a consultation in her reflective diary where illness affected her ability to connect with her patients.

As previously discussed, patients have reported to some of the participants that they have received benefit from the consultation even before the remedy has been prescribed. This would suggest that the therapist is an important part of this process and can influence the therapeutic relationship. Yanisa, in her interview related an example of a consultation where she negatively influenced the relationship:

“I did lose it with a patient once. A small child. That was several years’ back, who was a brat. I hate brattish children. You know, smirking, you know, his mum.....and his dad you who, who like, runs a huge company and couldn’t even get this kid to fill the bloody dishwasher, you know. We try and we tried to get him to do his jobs.... And I’m sitting there thinking..... Anyway, one day this kid was being a nightmare and I just... and he had done well on some new ... some funny remedy....I don’t know how I got to it.....anyway, and mother said he got headaches and we looked at his food and you know, he’s eating chicken nuggets, that was all he’d eat, and she said, they are organic chicken nuggets, and I was thinking, oh.... And anyway he wouldn’t eat this and I said to her, I’d lost it at 6 o’clock in the evening, I said if you were my child you’d eat...”

Although Yanisa apologized to this patient the connection between her and her patient was broken and she was referred to another practitioner. It is evident from Yanisa’s example that she perceived that she could personally affect the consultation. Ackerman et al has identified therapists’ personal attributes can influence the therapeutic relationship both negatively (2001) and positively (2003). It follows then that practitioners require a level of self awareness in order to actively employ characteristics and techniques that would affect the relationship either positively or negatively. Julia expressed this view:

“how we are and how we feel during it is so important, and we need to understand...if so and so makes us angry, why? What does it mean?”

Doctor’s self awareness has been shown to be important in the medical consultation. If doctors connect to their own emotions that they experience during a consultation by naming, accepting and reflecting on their emotions then they can form better relationships with their patients, improve patient care and improve doctor wellbeing since unexamined emotions can lead to distress, disengagement, burnout and poor judgment (Meier, Back, & Morrison 2001). Alan also expressed this perception that *understanding self* and one’s reactions to a patient can assist in *connecting* the practitioner to the patient and remedy to the patient:

“someone comes into the room and you think, there’s an unconscious process that says, this reminds me of another patient that did really well on Nux vomica and I get something of the feeling, something of the vibes of that. It’s a subtle human relationship we’re talking about now. You know, people can sit here and they can make me uncomfortable, people can sit there and make me feel very comfortable, and all that needs to be processed, so what are we dealing with again now, we’re

dealing with subtle processes...which can be translated into prescribing a remedy.”

This is consistent with Charon's (2001) observation that there are multiple narrative situations that interact; for example the situation between the practitioner and the patient, the practitioner and him or her self, the practitioner and colleagues, and practitioner and wider society. Through engagement with their patients the practitioners can identify and interpret their own emotional responses to patients.

In an informal discussion with Beth after the completion of her diary we discussed this issue of understanding one's reactions to patients, which can assist in prescribing, Beth related an experience with a patient and said:

“I can't get on with.....she is a bully and I always feel bullied when I see her, when I can stand back from that I can prescribe with confidence which is why I gave Lycopodium this time”

Beth was describing how her reaction to this patient assisted her in prescribing the remedy Lycopodium which can be prescribed for people who can bully or who were bullied.

This is consistent with the proposition that there are five models of looking at illness and health that are relevant to homeopathic practice (Owen 2007). One of the models, the relationship model proposes that the context of any symptoms and the relationships of the patient including the relationship with the homeopath are central. The homeopath may be directed to the importance of a symptom by a sensation or feeling in their own body (see Embodiment in Chapter 7). Within this relationship model the homeopath is using his or her reflections or awareness of this to explore what is happening in a patient. Therefore the dynamic nature of the relationship between the patient and homeopath reveals important aspects of the case and informs treatment and prescription. (Owen 2007) suggests that the relationship model requires homeopaths to reflect carefully about their physical and emotional reaction to patients and to know themselves well, as whatever they perceive is influenced by their own emotions, culture and race. Helen reflected this in her narrative:

“I can't help but be influenced by what I already am, so if I look at that and look at myself I think it helps me engage with them. Even if I feel dislike for them I try and look at myself and I think it helps me to put it to aside where I then engage”

Roger on the other hand in his interview described the importance of the interaction with his patients in his interview; however he did not once in his interview refer to the process of self knowledge or understanding self in the consultation.

“The consultation is simply an interface, it’s a meeting between somebody with experience of what might work in triggering a healing reaction. That’s what it is. And its access to a healing system that’s what a consultation is about. And the healing system itself is irrelevant and what the practitioner himself or herself thinks is irrelevant”.

Roger’s narrative challenges my proposition that *understanding self* is important in the consultation and indeed that *connecting* is a core category and opposed the viewpoints of all the other homeopaths in this sample. In context, Roger who is a medical homeopath had received traditional medical training that had not encouraged reflexivity. Without observing his consultations and talking to his patients it is impossible to gauge how much this affects his consultations or the quality of his relationship with his patients, if at all. In his interview Roger claims to have successful encounters with his patients and it is therefore possible to surmise from this that Roger may use other skills and strategies in the consultation that are equally as potent, and he may have an alternative way of *connecting* with his patient. Certainly there is plenty of literature to indicate that a reflexive practitioner is more able to employ skills that can enhance the therapeutic relationship (Charon 2001; Halpern 2007), and no literature that has explored the impact of a lack of reflexivity in the consultation.

This discussion has explored how the category of *connecting* is core to this theoretical model of the homeopathic consultation as all the other categories are dependent on it and it links all the other categories and processes in the consultation.

9.8 Healing through connecting

Although some homeopaths may argue that the homeopathic remedy is the major factor in promoting therapeutic change in their patients some of the homeopaths also perceived that *connecting* and forming a good relationship with their patient was also therapeutic. Roger’s narrative did not describe reflexivity as an issue however he does reveal how important the relationship between the homeopath and the patient is and how through that relationship healing can occur:

“It’s the interchange that takes place between the practitioner and the patient which produces a shift in that patient’s way of functioning, they’ve moved away from deciding to be ill and they’ve decided not to be ill anymore...if it was conscious or a subconscious change, they’ve shifted. They’ve changed the ground that they stand on, that healing if you like, that’s what healing is when you move your consciousness to a point where you don’t want to be ill anymore”

Roger perceived that healing represented a “*shift*” or a change. Julia also referred to healing as “*a shift in consciousness, which can be quite spiritual*”. Tricia also stated that it was a “*spiritual process of enlightenment, of raising consciousness*”. Maggie explained that it was “*getting clarity*” about some aspect of their lives. Wendy revealed a more mundane version of healing as an “*improvement on all levels and in quality of life*” and Jonathon “*health is not just absence of symptoms, it is wellbeing, feeling well on all levels*”. Ruth described healing that summarized many of the participants’ narratives on healing:

“The questions that we ask as homeopath can often lead people to some new insights into the connections between their emotional states and their physical states, not necessarily in a causative way, but just making the connections between well you know, every time I go and see this difficult person my duodenal ulcer gets worse or whatever, and we don’t have to tell people that there is a connection, but by simply asking them questions in order to clarify the exact details of their problems then people will come to an awareness themselves. The narrative needs to be heard but some people get stuck telling the story over and over again and healing is about moving to a point where the narrative changes or you no longer need the narrative... its people’s journeying from that point of distress to the point of resolution which may involve no changes whatsoever in their physical state but that what we as homeopaths would see clearly a difference in their vital force which would be reflected in less distress, less anxiety, less depression, better sleep pattern, more appetite....”

Ruth was describing that the relationship or “*connecting*” with the patient could enable the patient to form “*connections*” about some aspect of their life. Both of these forms of “*connecting*” were capable of facilitating change or clarity which could provoke some form of healing. In Ruth’s interview she clarifies her explanation by saying “*of course this is the highest ideal, as healing does not occur with every patient*”. As discussed in the earlier chapters the impression that I received is that homeopathy is difficult and that as Helen explained “*healing is always aspired to but not always achieved*”.

The homeopaths’ views of health in this study clearly bears some resemblance to the World Health Organisation’s (WHO) definition of health; “*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*”. However, the homeopaths emphasize health as being concerned with change on a spiritual, emotional and energetic level as well as physical, mental and social. The WHO’s definition has not changed since 1948, but does attempt to offer a holistic understanding of health. This is in

contrast to medical literature which does not offer an operational definition of holistic healing and the focus tends to be on prevention and cure. Nevertheless there has been some research within conventional medicine to attempt to produce a working definition of healing. For example a qualitative study explored the notion of healing within medicine, three main themes emerged; the theme of wholeness, narrative and spirituality (Egnew 2005). They concluded that it is through the “connexional” relationship that a physician forms with a patient that a narrative can be shared to produce a transformative change to wholeness on a physical, social, psychological and spiritual level. A more recent focus group study that included patients as well as conventional physicians found the same themes emerging, but also found that healing was a process and a journey to recovery and restoration (Hsu, Phillips, Sherman et al. 2008). Another qualitative study that explored both practitioners’ and patients’ experiences of CAM found that the notion of wellbeing was characterized as a sense of self, empowerment, a subjective sense of health, meaning making and awareness (Sointu 2006).

As shown with the quotes above all of the homeopaths in this study revealed a similar notion of healing as being changes that can occur on any level be that mentally, spiritually, emotionally or physically. Additionally many of the homeopaths indicated, as Ruth and Helen mentioned that healing was an ideal that could not always be achieved. None of the homeopaths discussed the idea that if the relationship could heal it also had power to harm. Dossey (2002) discusses the negative side to healing and poses the question that health practitioners can help and heal through the therapeutic relationship and from our thoughts and intentions towards others then it is possible that we can also harm through the power of the relationship and thoughts and intentions.

9.9 Conclusion

This chapter has explored the core category of “*connecting*” which is concerned with relationship in particular the relationship of the practitioner to the patient and of the practitioner to self. The category of *Connecting* is linked to all the other categories described in this thesis, which are also dependent on *connecting* for developing a relationship with the patient. Collectively the finding chapters represent a *theoretical model of a UK classical homeopathic consultation*, which will be discussed in the next chapter.

Chapter 10 Discussion and Conclusion

10.1 Introduction

The previous chapters have presented the findings of this study. A key issue that has consistently emerged from these chapters is that the patient practitioner relationship is central to all the processes in the homeopathic consultation, which is represented by *connecting*, the core category. Moreover, all these processes are linked including the process of identifying, matching and prescribing the homeopathic remedy, which is a crucial and inseparable part of the homeopathic consultation.

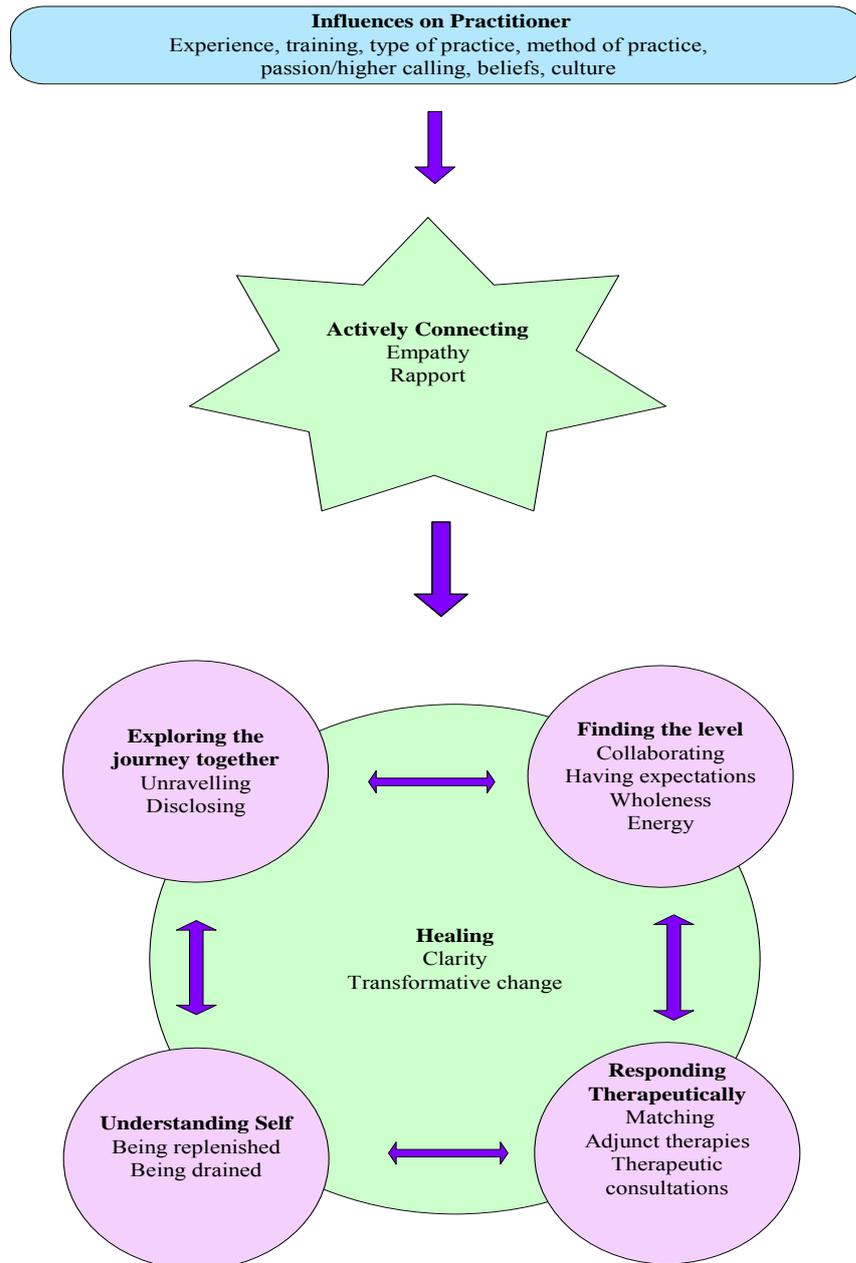
These processes have been presented as *a theoretical model of a UK classical homeopathic consultation*. This chapter will offer an explanation of this model and a description of variations within the model and its limits and boundaries. This chapter will then discuss how the model builds on previous research whilst also elucidating aspects of the homeopathic consultation that are common to other medical consultations and aspects that are specific and unique to homeopathy. The role of symbols and rituals in the consultation will be explored within the perspective of symbolic interactionism, which will lead to a discussion of how the placebo argument can be reframed within a homeopathic perspective. A review of the study will follow with conclusions that will lead into the implications of this research with recommendations for future research.

10.2 A theoretical model of a UK classical homeopathic consultation

The resulting theoretical model represents a process that relates to a classical homeopathic consultation from the practitioners perspective (see Figure 23 below). From the interviews, diaries and the observations, a common process emerged. This process could be seen to equate with the medical process of investigation, prognosis and treatment. However, medical processes are focused on disease and homeopathic practice is focused on the individual. The homeopathic process starts by establishing a therapeutic relationship with the patient that enables a shared journey (*connecting*). This explorative process involves the practitioner getting to know the patient in order to reach a shared understanding of their problem and their therapeutic needs (*exploring the journey together*). The theoretical model shows that the homeopath seeks to look beyond the superficial or presenting problem to evaluate and assess the needs and expectations of the patient within a homeopathic model (*finding the level*). Once a coherent or consistent pattern emerges the homeopath is able to respond in a

therapeutic way. This includes giving a remedy but may also include a variety of other therapeutic strategies (including listening) depending on the training and experience of the practitioner (*responding therapeutically*). The model shows that the homeopathic practitioner seeks to maintain an awareness of aspects of the consultation that are challenging and aspects that assist the processes of this shared journey (*understanding self*). The intention of the homeopaths is to use the entire process to promote healing.

Figure 23: A theoretical model of a UK classical homeopathic consultation



10.2.1 The variations and limits of the theoretical model

Although this model represents a common process that emerged out of the data, there were variations in practice styles, which the model encompasses. Influences on the practitioner affected how they conducted a consultation. For example, some practitioners were therapists of another therapy before they became homeopaths, and some trained in another therapy or method of practicing homeopathy whilst they were practicing homeopaths. Both of these situations would affect how a consultation would be conducted. This was seen, for example in Chapter 8, *Understanding self*, where a practitioner with a more psychotherapeutic background was more focused on exploring the patients' narrative than prescribing. Prior influences such as a practitioner's beliefs and training, all contribute to the way a consultation is conducted (Helman 1986). Within the sample of participants, there were medical and non-medical homeopaths and certain aspects of their practice would distinguish them, for example, length and depth of consultation and framework such as whether they approached the consultation with a more holistic or biomedical focus. Some of these homeopaths worked in private practices, NHS practices or NHS homeopathic hospitals. Finally, individual practitioner characteristics also affect the way a consultation is conducted. These variations are accounted for and encompassed within the theoretical model so that the focus of a consultation can vary according to practitioner skills and patient requirements. Therefore, although the model presented in Figure 23 appears as a static model it is fluid and flexible allowing it to reflect patient and practitioner needs and practitioner influences which may vary between patients and from consultation to consultation with the same patient.

However, there are limits and boundaries to the model and I do not propose that the model is definitive, encompassing all homeopathic consultations. It represents one type of homeopathic consultation conducted in the UK that is called "classical". In Chapter 1 (Introduction and Background), I described a typical classical homeopathic consultation that is underpinned by homeopathic philosophy established by Samuel Hahnemann (1833). This philosophy relates to four principles, the law of similars, the minimum dose, holism and vitalism. However, there are many methods of practicing homeopathy (see Appendix 3) although most of these methods arose out of the classical foundations proposed by Hahnemann. There are debates within the homeopathic community as to what constitutes a classical homeopathic consultation and whether the application of these different methods is still a classical consultation (Dean 2004). For the purposes of this research, I have presented a broad and inclusive definition of a classical homeopathic consultation as one that abides by the principles established by Hahnemann, but also allows the use of different methods according to practitioner preferences and patients' needs. The model represents an example

of classical homeopathic consultations that are practiced in the UK, and is a reflection of the consultation that the practitioners that I interviewed and observed used. In other countries there are variations in applying a classical approach, for example in India, homeopaths may see up to 40 patients a day, consultations may take only 10 minutes and the focus will be on the presenting complaint; however these consultations will still be called classical. As described by my participants the theoretical model applies to treatment in chronic complaints. However, the model has not been tested for acute consultations where there is a one off illness such as chickenpox. Additionally the model is only representative of practitioners' perspectives and does not account for patients' experiences, perspectives and views of the consultation.

Although there are limits to the theoretical model, it does build on previous research and broadens understanding of the homeopathic consultation. Through exploring each category in turn the next section will discuss how the model builds on previous research and will elucidate aspects of the homeopathic consultation that are common to other types of consultations and aspects that are unique and specific to homeopathy.

10.3 How this theoretical model adds to present knowledge

In the core category *connecting*, (Chapter 9) empathy and rapport were discussed as important components of the homeopathic consultation. This is consistent with research done at the Glasgow Homeopathic Hospital (GHH) which demonstrated the importance of empathy and rapport in the homeopathic consultation (Bikker et al. 2005). Additionally both empathy and rapport are recognized as being important components of other therapeutic consultations and for the development of the practitioner patient relationship (Pedersen 2007). However, the model proposed in this thesis builds on the knowledge presented by the GHH by showing that empathy and rapport are both strategies and skills that are crucial to the homeopath establishing a relationship with the patient, and for facilitating all the other processes in the consultation (see Figure 23). There are many aspects of empathy that are poorly understood in the medical consultation such as the relationship between empathy and medical understanding (Pedersen 2007). My study does not elaborate on or elucidate these aspects in the homeopathic consultation and further research would be necessary to explicate this.

The processes in the category of *understanding self* (Chapter 8) are also common to other therapeutic consultations such as psychotherapy and biomedical consultations. Although this aspect has been discussed and explored by homeopaths in homeopathic journals (Ryan 1996; Ryan 2002) and books on the homeopathic consultation (Kaplan 2002; Owen 2007) it has

not been systematically researched in the context of homeopathy, as only one study has looked at the challenges of homeopathic practice (Frank 2002a). This study builds on previous research into the homeopathic consultation and reveals benefits and challenges in the practice of homeopathy not previously known or understood.

The narrative aspects of the homeopathic consultation which are seen in the *exploring the journey together* category (Chapter 5) are also seen in other consultations, such as narrative based medical consultations and in some family therapy consultations (Greenhalgh & Hurwitz 1998; Launer 2002). However, as is already noted by Thompson & Weiss (2006), the narrative aspect of homeopathic consultations have some unique elements that are specific to homeopathy. The type of unravelling and disclosing that occurs in the consultation also probes for specific information and is a central part of the process in finding the correct homeopathic remedy for the patient. For example, the homeopaths in this study were interested in peculiar and idiosyncratic bodily and psychological symptoms to a level that would not have any relevance in conventional medical practice. Thompson & Weiss (2006) pose the question as to whether it is the revelation of information that is in itself curative, as the patient may feel heard and may be able to make connections and meaning of their symptoms, or the fact that such revelations allow the homeopath insight leading to a more accurate prescription. Chanda & Furnham (2008a) suggest that it is the conversational or narrative aspect of homeopathy that provides the beneficial effect, much like a counselling consultation. However, the data in my study indicate that although the narrative aspects are important to the consultation this is only one aspect of the homeopathic consultation. The data in this study also demonstrates that the type of symptoms that are gathered in a homeopathic consultation makes it specifically different from psychotherapy and counselling consultations, with which homeopathy is often compared, as the consultation can be guided by the practitioner towards remedy identification.

Within the *finding the level* category (Chapter 6) common ground can be found between medical and CAM consultations as both acknowledge the importance of patient and practitioner expectations. Expectations are associated with treatment outcomes, both in conventional medicine (Mondloch et al. 2001) in acupuncture (Linde et al. 2007) and in homeopathy (Launso et al. 2007). In my study the practitioners were shown to engage in a sequential process of assessing, managing, adjusting and matching (both patients and their own) expectations. This process, which may change in sequential order and according to patient needs, resembles a process of negotiation that has not been noted previously in the literature on homeopathy. It has, however, been noted that it is important for expectations to

be negotiated and agreed in a patient practitioner relationship and that this can have positive effect on the relationship (Kaptchuk 2002).

The concept of collaboration was discussed in Chapter 6 as a desirable attribute of biomedical consultations and it was also demonstrated in this study. My research also showed that homeopaths collaborated with patients in order to socialize them to a more holistic type of consultation. Both of these aspects of collaboration have been noted in previous research. Chatwin & Collins (2002) observed homeopathic consultations and noted that homeopathic practitioners work collaboratively with the patient in order to understand the patient symptoms and to decide on treatment. Additionally Chatwin (2003) noted that homeopaths use this collaborative relationship in order to socialize their patients to a homeopathic consultation. This was seen recurrently as an issue in this study and could be considered as specific to homeopathy and other CAM consultations such as an acupuncture consultation (MacPherson, Thorpe, & Thomas 2006). Thompson & Weiss (2006) make the observation that openness to the mind body connection and a holistic consultation may be important for some patients and may predispose some patients to respond to treatment, but it is also possible that such openness gives the homeopath the insights necessary for accurate remedy selection. The data in my study shows that the homeopaths believe that openness to a holistic consultation is important as it encourages insights necessary for remedy selection and that open patients are more likely to respond to treatment. However, it would be necessary to explore patients' views of this aspect to elucidate this fully.

The holistic philosophy, fundamental to the homeopathic approach, is also seen in both medical and other CAM consultations. Most, but not all, of the homeopaths had a vitalistic view which underpinned their practice of homeopathy; and it is this together with holism that adds to the paradigm difference between homeopathy and biomedical consultations. The concept of vitalism, taught at homeopathic colleges, is a philosophical paradigm that is used in conjunction with holism to evaluate the health of the patient both with respect to treatment and the analysis of the effect of treatment (Bell et al. 2003; Bell, Lewis, Lewis et al. 2004). In this study, most of the medically trained homeopaths described their consultations using language that implied a vitalistic approach, but also maintained a biomedical focus on the patients' health. They were not specifically asked how they reconciled these different paradigms but for future studies, it would be interesting to see how medical homeopaths reconcile the paradigm differences in their homeopathic consultations.

In Chapter 7 *Responding therapeutically*, the different strategies that the homeopaths use to respond therapeutically to their patients are explored. For example, the practitioners in this

study reported that sometimes their patients described benefits from a homeopathic consultation often before they have received any treatment. This indicates that there are aspects of the consultation, other than the remedy, that are therapeutic, such as listening to the patient and being empathic. This phenomena has also been observed in medical consultations too (Di Blasi, Harkness, Ernst et al. 2001). The use of adjunct therapies in the homeopathic consultation has not been reported or explored before in previous research, however most of the practitioners that I interviewed and observed used other therapies or techniques such as lifestyle advice in the consultation. This research shows that the use of adjunct therapies is often a result of previous clinical experience of the homeopath. For example, an acupuncturist who subsequently trains as a homeopath may also use acupuncture knowledge and techniques in the homeopathic consultation. I have concluded from this that the use of adjunct therapies and advice indicates that the homeopaths apply a varied approach to treatment that is drawn from outside of the homeopathic model and that they are not totally dependent on their remedies. Additionally, although this is not supported by my data, I have surmised that there is also a possibility that the use of adjunct therapies and advice indicates the limitations of homeopathic treatment. An important aspect of the homeopathic consultation that appears to be unique and specific to homeopathy is the process of identifying and matching the homeopathic remedy. The homeopath gathers the subjective and idiosyncratic symptoms that the patient presents with, and then prescribes a homeopathic remedy based on the whole person. This differs from the medical consultation, which fits the drug or intervention to the presenting complaint regardless of the patient's idiosyncratic symptoms with the aim of treating the disease.

This discussion has shown were this study has built on previous research and has explored similarities and differences between the homeopathic consultation and other therapeutic consultations. It has also identified aspects of the homeopathic consultation that are unique and specific to it. The type of narrative unraveling that occurs in the consultation seeks to identify and match the correct homeopathic remedy. Thus, the process of finding the remedy is embedded in the consultation and this process is unique and specific to homeopathic practice, highlighting that the whole process of the homeopathic consultation is interconnected.

The observation that the remedy is inseparable to the whole consultation has been noted previously in relation to both homeopathy (Milgrom 2005; Weatherley-Jones et al. 2004) and acupuncture (MacPherson et al. 2006; Paterson & Dieppe 2005) and has a direct implication on research trial designs. It is not feasible to separate the consultation with a homeopath from treatment with a homeopathic remedy, as they are all part of an interpersonal process

that interacts and facilitate each other's actions. For example, in my study, several of the participants cited examples of re-evaluating remedy prescriptions where initial prescriptions were unsuccessful. Often in these circumstances, a different approach to the exploration of the narrative was required, and hence could shift the nature of the practitioner patient relationship as the practitioner needed to change their approach. As shown in the data, if the homeopath could not connect with their patient or over connected with their patient this could affect the choice of remedy. The question as to whether a homeopathic remedy mediates the activity of the therapeutic relationship or whether the therapeutic relationship mediates the activity of the remedy was deliberated in a case study by Van Hootegem (2007). In relating the case of a woman with chronic fatigue syndrome, the author described how the initial remedies had little effect; however, when he changed the way that he related to the patient and then re prescribed, the patient received significant improvement in her symptoms. He concluded that the homeopathic remedy was part of the relationship that he had with this patient. However, some published homeopathic case studies tend to focus on the process of identifying and matching the remedy whilst ignoring how the whole consultation affects this process (Sevar 2007). I have surmised from this that homeopaths may often either be unaware of the role that the consultation has or that there is a genuine belief and focus on the therapeutic action of the homeopathic remedy. Both of these situations and Van Hootegem's (2007) conclusions are evident in the data in this study and this may assist in explaining why the use of different methods and skills by a practitioner will show variance in the reliability of prescribing decisions. Three studies have assessed homeopathic inter-rater reliability and found it to be poor, as the methods used do not reflect true clinical practice. For example the homeopaths were unable to connect with their patient because they were not consultation based assessments and they may not be true reflections of homeopathic practice (Aghadiuno 2002; Cornu, Poitevin, Lion et al. 1995; Vickers, van Haselen, Pang, & Berkovitz 2000). A fourth study also explored inter-rater reliability and additionally explored how homeopaths make decisions in their practice (Brien, Prescott, Owen, & Lewith 2004). Brien et al (2004) also found poor inter-rater reliability but also found that their raters used intuition to varying degrees in making decisions. These studies indicate, and are consistent with the data in this study, that homeopaths use knowledge and intuition in order to make a prescription.

The practitioners in this study revealed their commitment to homeopathy and that the homeopathic remedy was a vital part of the process, regardless of their personal belief in whether the remedy was "active". Thompson & Weiss (2006) also found a commitment to the remedy in homeopathic practitioners and Moerman (2002) suggests that practitioner

belief and commitment to their therapy is equally, if not more important, than the patient belief. Hyland (2005) also purports that belief in one's therapy, or therapeutic allegiance, affects outcome, and effective therapists need to believe in what they are doing. The data in my study demonstrated that this commitment was present even if the practitioners expressed ambivalence about whether the homeopathic remedy contained any active ingredient. Only one homeopath in my study expressed a belief that the remedies were ineffective yet despite this he still cited examples of matching the appropriate remedy to patients' symptoms according to principles of homeopathy such as "like cures like" (Hahnemann 1833). This commitment to the remedy could be because of the training that is received on homeopathic courses. A large proportion of teaching time on the curriculum of homeopathic courses are taken up with teaching materia medica (remedies) and different frameworks for matching the appropriate homeopathic remedy (see Appendix 3). Additionally there are many postgraduate seminars, conferences and workshops devoted to using old and new remedies. Furthermore new remedies are constantly being "proven" (tested according to an established procedure, see Chapter 1, section 1.3) and added to the body of homeopathic information which is the homeopathic materia medica. The data in this study identified different beliefs regarding how the homeopaths saw the remedy; whether they viewed it as a real active treatment, or symbolic, as a representation of the patient.

10.4 The role of symbols and ritual in the homeopathic consultation

According to homeopathic theory remedies can be presented in some materia medicas as archetypal representations of individuals (Coulter 1998; Whitmont 1993). The practice of identifying through the patient's narrative a remedy archetype and then matching the patient to this archetype is a process that some practitioners in this study revealed as holding some symbolic significance and meaning for both the practitioners and their patients, which they considered, may play a part in provoking a healing response. This type of healing is referred to as symbolic healing (Dow 1986). Dow (1986) formulated a universal explanation for all forms of symbolic healing, to understand how belief in a particular pill, potion or procedure is actually created in the consultation. He identified key stages in this process and I have shown how homeopathy is suited to each stage in this process. First a healer or doctor must have their own coherent explanations to explain the origin and nature of the patient's condition such as biomedical explanations or, in the case of homeopathy holism or vitalism. Second this explanation must include a symbolic bridge between personal experience and social and cultural meanings. Patients must be able to understand their symptoms within this explanation, in homeopathy this is achieved through the telling and listening of a narrative as

described in Chapter 5 *exploring the journey together*. Patients new to homeopathy may have had to be socialised to this process. Third the healers or doctors aim to activate this symbolic bridge, a doctor may use a drug or procedure and in the case of homeopathy this could be represented by the remedy or other symbols of the consultation. In Dow's (1986) fourth stage of the process the healer must get the patient emotionally and intellectually involved or attached to this explanation, such as the reason for the disease whether biomedical or holistic. Within homeopathy power may be given to the remedy by the expectations applied to it and the minutiae of the prescribing regimen. Additionally the more that the homeopath explores the patients narrative with the patient the more pertinent the symbol will become and the more powerful the healing response (Thompson et al. 2006). The fifth stage of this process involves the healer helping the patient to reframe or reinterpret their recent experience in the light of the healers' explanation. Within homeopathy this would involve the patient viewing their treatment within this holistic context and by also identifying with the archetypes represented by the remedies. The sixth stage involves the patient's acquiring a new way of conceptualizing their experience in symbolic terms as a new narrative, this process of acquiring a new narrative is also described by Frank (1998). Within homeopathy this is achieved by the patient becoming or feeling healthier as a result of change and thereafter viewing their health within a holistic framework.

Dow's (1986) description of symbolic healing includes an explanation of the importance of the symbols of a therapy being coherent with a patient's belief systems. This is consistent with Hyland, Whalley & Geraghty (2007) and Hyland & Whalley (2008) studies which conclude that the benefits that a patient may receive from a therapy is dependent on how much the treatment accords with the patients own preferences and motivations. From the data in my study many of the homeopaths interviewed revealed the importance of socialising the patient to a holistic consultation and this was also noted by Chatwin (2003) in his observations of homeopathic consultations. Chatwin did not elaborate on the importance of socialising a patient to this new consultation. However the data from my study indicate that it is important because in order to find a homeopathic remedy the patient's narrative must be explored through the symbols of the patient's language and demeanour (Owen 2007). The patient must be a willing participant in this process which, if successful, may lead to common meanings constructed between the patient and practitioner. This may lead to a new identity for the patient within that consultation and possibly for the patient outside of the consultation. My study did not explore unsuccessful attempts to socialise patients to the homeopathic consultation. However, participants in this study made references to patients

who did not return for follow up homeopathic consultations and it is possible to speculate that a reason for this may be an unsuccessful attempt to socialise the patient to homeopathy.

Other aspects of the homeopathic consultation could also be considered as symbolic. For example, from the interviews and observations it was discovered that homeopaths designed the setting of a homeopathic consultation to be relaxed, comfortable and welcoming, and homeopaths paid attention to creating rapport. They described how numerous books would often be displayed and used during the consultation. These aspects of the consultation such as the setting, objects, dress, demeanour, expression, even smell and especially language are the most important sources of symbolic meaning in human social life (Helman 1986). Their purpose may not always be practical, but they are usually symbolic and create the ambience and a catalyst for a healing response and enhance the patients own belief systems (Helman 2007). All of these aspects of the homeopathic consultation are consistent with symbolic interactionism (SI) which is a theoretical perspective that provides a framework through which symbolism in homeopathy can be viewed (See also Chapter 2 Methodology) (Blumer 1969; Charmaz 2006). SI professes that the purpose of symbols in an interaction such as a consultation is to enable and facilitate rituals to occur, and in most forms of healing interactions a strong ritual component is part of the process of the therapy (Helman 2001; Helman 2007).

A key aspect of a ritual is that it is a form of repetitive behaviour that does not have any overtly technical effect (Helman 2007). From this definition all therapeutic consultations including the homeopathic consultation have elements of rituals, both task orientated and patient centred, that are embedded in their practice. In homeopathy the process of identifying, giving, acceptance and payment of the remedy is a task orientated ritual. The process of giving and receiving a narrative is a patient centred ritual. Both are part of the ritual of the consultation and therefore have meaning for the homeopaths and their patients. According to Goffman (1967; 1971) when a ritual offering occurs, or when one individual provides a sign of involvement in and connectedness to another, the recipient then needs to show that the message has been received and demonstrates appreciation and gratitude, thereby affirming the worth of the giver and signifying that the relationship actually exists. These actions serve to connect individuals in a relationship and to also shape behaviour (Goffman 1967). Helman (2001) adds that the relationship formed by the ritual helps to validate the healer and the power of their methods of healing. Kaptchuk (2002) suggests that these rituals provide an exotic and mysterious element to practice and that CAM interventions may rely on the power of belief, imagination, symbols, meaning, expectations, persuasion and relationship which may all enhance therapeutic benefit. However, it is

possible to argue from this that the degree of ritual in homeopathy may hinge on whether the remedy is considered to be a placebo or not. If it is considered to be a placebo then the action of a patient taking the remedy is a ritual as it is having no technical effect. If the remedy is considered to have a physical effect on the patient then the action of taking the remedy has a technical effect and is not ritual.

Finding the balance between task orientated and person centred rituals in the consultation has been discussed in the findings (see Chapter 7) as an issue that relates to experience, or length of time in practice. Participants who were new to practice or, struggling with methodological issues focused on a task orientated process of finding the remedy to the detriment of other patient centred rituals. Whereas homeopaths that had been in practice for longer tended to focus mainly on patient centred rituals in the consultation such as listening and understanding the patient's narrative whilst also attending to decisions about the remedy. The role of rituals in nursing care has shown that as a nurse develops from novice to expert nurse they have knowledge embedded in their nursing practice, which allows them to transcend task orientated scientific techniques and rituals to focus on patient centred care and rituals (Benner 1984; Benner 2000). The task orientated rituals that are embedded in nursing practice such as taking vital signs can become an effective healing catalyst as they can open doors into patients' stories and life worlds. This is mirrored in the homeopathic consultation where the process of exploration of a narrative happens concurrently with the process of finding a remedy.

Thus although finding the balance between task orientated and patient centred rituals is important in the homeopathic consultation the data in my study also shows that they cannot be separated, and mediate each others actions as discussed earlier in this chapter, highlighting the interconnectedness of the consultation processes. Additionally exploring the role of symbols and rituals in the homeopathic consultation has emphasized aspects of the homeopathic consultation that can act as powerful mediators of beneficial therapeutic outcomes for the patient. Both these factors, that the remedy is inseparable to the consultation, and that the consultation can be of therapeutic benefit to the patient has implication for the way that homeopathy is researched. This will be explored in the next section.

10.5 Reframing the placebo argument

Research into homeopathy has consistently attempted to find specific effects of homeopathy from the remedy alone, treating the remedy as if it was a biomedical drug with specific physiological effects. This focus on the remedy in research mirrors homeopathic

practitioners focus on the homeopathic remedy in every day practice, this was seen in the data in this study where participants discussed their commitment to Continuing Professional Development seminars in order to learn about old and new remedies. Additionally the focus on the efficacy of the remedy has lead to conflicting evidence about its efficacy, with both positive systematic reviews demonstrating effects above and beyond placebo (Boissel et al. 1996; Cucherat et al. 2000; Kleijnen et al. 1991; Linde et al. 1997; Linde et al. 1998) and negative systematic reviews suggesting clinical effects of homeopathy are simply due to a placebo effect (Ernst 2002; Shang et al. 2005). It has been purported that the benefits that some patient can experience after homeopathic treatment are probably due to the therapeutic encounter that is experienced in the consultation (Ernst 2002; Ernst 2007a; Reilly 1995; Shang et al. 2005; Zimmermann-Viehoff et al. 2007). However this is still conjecture, as no formal study has yet attempted to prove this is the case. Studies have shown that the use of placebo in many therapeutic encounters can have therapeutic benefit (Ernst 2007b; Ernst 2007c; Kaptchuk, Kelley, Conboy et al. 2008; Koshi & Short 2007). Recently a study investigated placebo effects, examined the effects of placebo acupuncture in circumstances that involved observation only (evaluating a “Hawthorn effect”), sham acupuncture alone, and sham acupuncture with an enriched relationship with the treating doctor. The group with the greatest relief of symptoms was the one that received the sham acupuncture and the supportive patient practitioner relationship. The conclusions of this study were that the non specific effects of treatment, of which the patient practitioner relationship is an important part, can produce beneficial effects for patients (Kaptchuk et al. 2008). These beneficial effects that patients can receive from the therapeutic encounter have been described in the literature with various terminologies: placebo effects, non specific effects and context effects, often used interchangeably but having different meanings.

The term “placebo effect” refers to changes or any beneficial effects that occur after administration of a substance or treatment thought to be inert or without therapeutic effect or as if it was a real treatment. The term “non specific effects” refers to benefits that occur through no direct causal relationship with a specific drug or intervention and may be related to factors other than the placebo medicine such as spontaneous remission, the natural course of symptoms or through some psychological mechanism activated by the therapeutic encounter. Although placebo effect is a common phenomenon in medicine and research its mechanisms are not well understood and conflicting and paradoxical descriptions of placebo and non specific effects has stimulated debate as to the nature of placebo (Ernst 2007c). For example, if an intervention causes a real beneficial change in outcome then the placebo effect must work by some specific mechanism and therefore placebo treatments are not

absolutely inert or non specific (Miller & Kaptchuk 2008; Walach 2001). Misuse of these terms has contributed to the assumption that any benefit derived from homeopathy is due to placebo effects and is non specific. This is not consistent with the theoretical model that has been developed in this research, because the model shows that it is the whole process of the consultation that is crucial and that the remedy is an integral part of that consultation and is unique and specific to homeopathy. Additionally aspects of the consultation that have been surmised by this study as specific to homeopathy, such as the process of drawing out idiosyncratic symptoms through narrative or matching a homeopathic remedy, may be considered non specific in the biomedical context. This demonstrates that what can be non specific in one system of medicine can be specific in another system of medicine (Paterson et al. 2005). The model demonstrates that the process of identifying, choosing and giving the homeopathic remedy is specific to homeopathy as it has a central role in the homeopathic consultation and may therefore play an active part in promoting therapeutic benefit. My findings corroborate a previous theoretical explanation by Weatherley Jones (2004) that the homeopathic remedy is synergistic to the effect of the consultation, and hence it is meaningless to separate out the remedy from the consultation. This has also been noted in relation to acupuncture (Paterson et al. 2005).

The terms placebo and non specific effects are therefore inadequate in explaining the nature of the catalyst for the specific mechanism that is activated in homeopathy. However, a recent review of the placebo effect has led to a shift in focus from the inert substance or treatment to examining the psychosocial context surrounding the patient, leading to the concept of a “simulation of an therapeutic intervention” (Price, Finniss, & Benedetti 2008). Although this definition is inclusive of context in the intervention it assumes that the therapeutic intervention is in some respects sham or mimicry of a real intervention. The term “context effects” is an alternative explanation that has been proposed to refer to healing that results from the clinical encounter and the practitioner patient relationship (Miller et al. 2008). A review of studies has shown that the context of a consultation can influence the outcome of treatment, doctors who adopt a warm reassuring manner as opposed to a more formal manner tend to observe better health outcomes in their patients (Di Blasi et al. 2001). To some extent the explanation of context effects is consistent with the theoretical model presented in this thesis as it has been demonstrated that the homeopathic consultation is concerned with context and all the processes involved are linked. However it also assumes that the healing is distinct from a specific efficacy of treatment interventions, but as has been discussed the homeopathic remedy is a specific part of the homeopathic consultation.

Therefore an alternative explanation is needed. A framework that sits comfortably within the theoretical model described in this chapter is Moerman & Jonas' (2002) concept of the "meaning response" which relates to the response that people experience as a result of the meanings that they attach to their interventions or treatments. An important part of the homeopathic consultation is the narrative aspect which elucidates connections and meanings (Pennebaker et al. 1999) and these may be symbolically represented by the homeopathic remedy (Coulter 1998; Whitmont 1993). This framework takes into account the different meanings of the terms placebo effects, non specific effects and contexts effects and delivers an understanding of these terms within a cultural context that allows for the complexity of meanings, rituals and symbols that are attached to the objects and activities that contribute to the homeopathic consultation.

Through uncovering the complex worlds constructed by their patients and developing a joint meaning and understanding of these worlds including their patients' illnesses, a relationship between patient and practitioner can develop, which also provides meaning. This process of constructing meaning can influence health for better or for worse (Moerman 2002). Creating meaning can activate biological processes, for example, enhancing the action of drugs and also making drugs considered inert to have significant clinical effects. Two important aspects of the "meaning response" are firstly the commitment of the practitioners to their own therapy and secondly if there is concordance between the philosophy of the therapy with that of the patients'. The practitioners in this study all demonstrated commitment to homeopathy and reported the importance of educating patients towards a vitalistic and holistic philosophy. The "meaning response" framework is appropriate for the model presented in this thesis because from the practitioner's perspective they are committed to their therapy this aspect is seen throughout the interviews where practitioners report their commitment. Also they consider that the process of developing meaningful relationships with their patients does have clinical effects. This can be seen in the findings where practitioners report that patients get better with homeopathy regardless of whether this is through the symbolic nature of the remedy or through the connecting with their patients.

The discussion has presented *a theoretical model of an UK classical homeopathic consultation* and has explored how this model builds on previous research and elucidates aspects of the homeopathic consultation that are common to other consultations and aspects that are specific to homeopathy, such as the process of identifying and matching the homeopathic remedy. This discussion leads to an exploration of the symbolic and ritualistic aspects of the homeopathic consultation, which demonstrated that the consultation can be a powerful mediator of therapeutic benefit for the patient. Both of these processes, of

matching the remedy and the consultation are inseparable and it is within this context that placebo, non specific effects, context effects and meaning response were discussed. Meaning response was acknowledged as a framework that is consistent within the theoretical model presented in this thesis. The next section will be a review of the study exploring methodological issues and considerations about the model.

10.6 Review of the study

Constructivist grounded theory offered me a philosophical positioning that was consistent with my role as a practitioner researcher using interpretive methods to explore a previously unexplored area. This approach allowed me to address my first and most prominent issue which was how I was to gather and interpret the data without imposing my views as a practitioner. The inherent use of reflexivity in this approach provided a means to reconcile my dilemma. Not only did reflexivity allow me to question my own biases and opinions but it also made me ask questions of the data (Charmaz 2006; Patton 2002). For example, in one of the first interviews the motivation of one of my participants was questioned by my supervisor, my initial response was to rush to the participants defence as a fellow practitioner. However being able to reflect on this allowed me to also question their motivations and to then seek clarification in subsequent interviews and frequent discussions with colleagues. This not only enabled me to realise my biases but also enabled a deeper understanding of the data through further questioning. This was not an easy process, however as it required constant self questioning and seeking of clarification through further data collection.

Constructivist grounded theory proposes that the researcher constructs the data with the participants (Charmaz 2006) and therefore my experience as a homeopath has contributed to the findings in this research. It is possible that if a non homeopath had conducted this research they may have reached similar conclusions, but I think it may have taken them longer to grasp the complexity of homeopathic practice and the relationships of the categories. However, the disadvantage of being a practitioner is that the tacit understandings that inevitably occur through my experience as a practitioner may have lead to biases, as there can be an assumption that the participant and myself as the researcher can have the same understanding. Reflexivity has enabled recognition of these biases, but where they have been missed by me they have been seen by others through the process of constantly checking my developing analysis and theory with colleagues. Checking my interpretations and questioning my assumptions was done constantly throughout the process of this research, with presentations, for example to the Bristol Homeopathic Hospital Research

Group and to my own research group; the Complementary and Integrated Medicine Research Group within the Medical School at the University of Southampton. Additionally formal discussions with supervisors, groups of colleagues (homeopathic, non homeopathic and academic) and informal personal communications with colleagues (homeopathic, non homeopathic and academic) were also done. The use of other methods in the study has also helped in reducing these biases, as the diaries and observations of the consultations assist in corroborating or refuting the interview data. For example, my interpretations of the interview data could also be observed in the consultations and noted in the diaries. However, I have also noted where my interpretations or interview data differed from the observation and diary data. Additionally the diary data added a temporal and reflective aspect to the data that could not be gathered through interview and observation.

An issue for me as a researcher and homeopath was the process of observing homeopathic consultations. I was initially very apprehensive at the prospect of approaching homeopaths in order to observe their consultations. My apprehension was drawn from my knowledge and experience of the homeopathic consultation, both as a practitioner and as a patient. From my experience, the consultation is a one to one interaction and the presence of a third party can affect that interaction. The homeopath may change from their normal behaviour and the patient may not feel comfortable to reveal all their symptoms. I was not surprised therefore when there were not many responses to my invitation to participate, and when there were participants, that they insisted on the presence of the camera and not myself. Recording two of my own consultations was instructive as I realized that I completely forgot about the camera after a few minutes into the consultation. Talking to the other participants also revealed that they forgot about the camera. I also completed a reflective diary on difficult consultations and found that it documented my increasing understanding of the consultation. It also, however, documented an alienation from the homeopathic profession, which is possibly an artifact of my dual role as a researcher and homeopathic practitioner. A conversation with a colleague who is also a researcher and another CAM therapist also expressed an alienation from their profession as a result of their research. Fortunately, the feelings of alienation are lessening as the dilemma of having a dual role is being resolved through the process of reflection.

In this section I have reviewed how using reflexivity has assisted and at times negatively affected the development of the model. In the next section I will discuss how my research meets the criteria for evaluating rigor in a constructivist grounded theory. These criteria were introduced in Chapter 2 (Methodology) where I discussed and presented Charmaz's (2006)

suggested criteria for evaluating a constructivist grounded theory (see Appendix 4), these criteria were credibility, originality, resonance and usefulness.

10.6.1 Rigour in grounded theory

The first criterion of credibility is met because my familiarity with the setting and the topic has enabled a sufficient quantity and variation of data to be gathered. For example, apart from the interviews, diaries and observations, I have been privy to conversations with colleagues both in person and on our Society of Homeopaths (SoH) intranet. This has made it possible to further explore the categories and the links between the categories. From these other discussions the categories appear to cover the range of experience of the homeopathic consultation. In the findings strong links between the gathered data and quotes from the participants and observational data and analysis are presented. Any claims that I have made about the data have been checked with homeopathic colleagues, academic colleagues and with my supervisors.

The criterion of originality is met by the new insights that have been made into the homeopathic consultation. As described in the findings chapters and outlined in this chapter this research builds and extends current knowledge of the homeopathic consultation. For example I have shown how there seems to be a cycle of managing expectations in the homeopathic consultation, which has not been previously described in the literature. Also this research presents the whole process of the consultation showing individual aspects as part of an interrelated whole and supports the notion that the homeopathic remedy is inseparable from the consultation. This has previously been mooted but it is the first time that there is a body of evidence to support this notion. This research challenges many current ideas about the homeopathic consultation. For practitioners of homeopathy their focus on the homeopathic remedy may have to shift by also providing a strong focus on the practitioner patient relationship if they want to improve their practice. For researchers of homeopathy this research reinforces the need to develop relevant strategies for research. For patients this work hopefully will enable improvements in practice and patient care.

The criterion of resonance is met as the categories portray the fullness of the studies experience. The observational data in this study reinforced the relevance of the categories as it was possible to see them brought to life. Any tacit meanings in the data have been revealed, this was important as my experience as a homeopathic practitioner meant that it was at times difficult to recognise a tacit meaning. Revealing tacit meanings was facilitated by the reading of my findings and confirmation of my analysis by others. When this

theoretical model has been presented back to participants and to other homeopathic colleagues they have confirmed that the model is meaningful and reflects their experiences.

The fourth criterion of usefulness is also met in this research. The findings and theoretical model will be disseminated in the form of journal articles, conference presentations and lectures at homeopathic colleges and will therefore have an impact on the practice and teaching of homeopathy. Being able to explicitly explain to students what is being done in a homeopathic consultation will better prepare them for practice. Additionally homeopaths who are already in practice may be able to regard the model as the baseline for a consultation and if they are having difficulties with their practice it may enable them to better reflect on their consultations. The next section will discuss some strengths and limitations of the study.

10.6.2 Strengths and Limitations

One of the major strengths in this study was the use of constructivist grounded theory to develop the theoretical model of the homeopathic consultation. I have already discussed the reflexivity implied in this method, the strength of which is that the process is transparent. Additionally this method is both rigorous and flexible. The rigor is found within the framework that guided me as the researcher through the process of coding, conceptualising, constant comparison and theoretical sampling. Additionally Charmaz's criteria for judging the rigor of a grounded theory (as described in the last section) provided guidelines for what would be expected at the end of the research process. The flexibility of this method is mainly seen in the process of data collection, where it is acceptable to use a variety of methods including informal conversations to contribute to the theory. The use of different methods is a form of triangulation (Patton 2002) and has contributed to ensuring that the theoretical model is robust.

However, a limitation of the study is that the observations of consultations (as described in Methods of data collection, Chapter 3) did not include observations of NHS doctors. The difficulties in recruiting participants for the observational part of the study was discussed in Chapter 3, additionally the time available to get ethical approval from various research and development offices in different primary care locations was limited. The implication of this limitation is that the theoretical model may not be recognisable to NHS homeopathic practitioners. However I have attempted to minimise this limitation by discussing and showing the model, during the data collection process phase 2 (observations of consultations), to medical and non medical homeopaths who work within the NHS. Aspects of the model that they concurred with or challenged are reported and discussed in the findings chapters.

An additional limitation of this study was the use of data from the observation of my consultation and my reflective diary. Although I attempted to adopt an objective stance whilst conducting the consultation, completing the diary and assisting in interpreting the data inevitably results in biases and assumptions. However I attempted to minimise this as the data was analysed by my academic supervisor (SB) who could therefore challenge my assumptions. As discussed in Chapter 2 (section 2.6) this type of data could be considered a different type of data to that gathered from my other participants and although this could be judged a limitation it can also be strength if there was complete transparency of the data. Through reflexivity I have been fully transparent maintaining a clear distinction between data gathered and analysed from my consultations and diary and those of my participants. Although the model has been discussed and presented to many different types of practicing homeopaths there is a large diversity in the methods that homeopaths apply in practice. This model is a reflection of a classical homeopathic consultation (see Background Chapter 1) as practiced within the United Kingdom. However practitioners of other types of homeopathy have also been shown the model and where they have challenged or concurred with the model has been discussed in the findings sections.

10.6.3 My reflections as a practitioner researcher

The transition from a homeopathic practitioner to a researcher homeopathic practitioner was not an easy process. One of the difficulties for practitioner researchers is when existing research does not fit with their experience (Reed & Procter 1995). Much of the research into homeopathy has focused on the efficacy of the remedy. The findings have not all been positive and yet my experience tells otherwise. However, homeopathic practice also mirrors the focus on the remedy as homeopaths place a lot of importance on the remedy. Although, as a practitioner I acknowledge the importance of the consultation, experience indicates that the remedy also has a part to play in the treatment package and effect.

When I began writing this chapter, I happened to have a telephone conversation with a homeopathic colleague who is also a researcher into homeopathy. During our conversation I asked her opinion of the homeopathic remedy, she said:

“I believe absolutely in the power of the homeopathic remedy, even if there was incontrovertible proof that the remedies were inactive I would still use them in my practice”

When I started this research project, I also had an unshakeable belief in the activity of the homeopathic remedy. I also felt that the consultation was important but the focus was on the

homeopathic remedy. This focus on the remedy was initiated by the training that I received as a homeopath, like other practitioners the training focused on the process of matching remedies to patients. Four years later and with more knowledge about research into homeopathy and ultra high dilutions, my opinion has changed and the focus has shifted from the remedy to the power of the consultation. As a homeopathic practitioner, I now believe in the power of the homeopathic consultation, of which the remedy is an important and inseparable part, to stimulate a persons own healing powers. Although I am aware of the lack of conclusive evidence to either prove or disprove the action of a homeopathic remedy, I would find it inconceivable to practice homeopathy without the remedy. As a homeopathic practitioner, I now view that it is not the belief or conviction in the remedy that is important but the belief or conviction in the process, which includes the remedy.

As a result of being a researcher and practitioner I am now constantly aware of any media or research attention that is focused on homeopathy. This is a double-edged sword; most of the media attention over the past four years has been very negative. Maintaining enthusiasm and a sense of worth and commitment in a therapy when it is constantly devalued in the press is difficult. As I have discussed commitment is important and this has therefore had an affect on my practice, and I have been temporarily reluctant to take on any new patients.

Furthermore prescribing homeopathic remedies has been described as a deception (Ernst 2007a), but homeopathic practitioners belief in their remedies and the process of matching a homeopathic remedy is specific to homeopathy (Thompson et al. 2006) and is part of the whole package of homeopathic care and as such cannot be separated out. Therefore, an alternative argument can be that it would be unethical to deprive patients by not enhancing the consultation with the remedy. However, the benefits of being aware of media attention and research into homeopathy are that I am developing a deeper understanding of my own therapy, other therapeutic interventions and the clinical encounter along with a critical approach to research. The process of rationalizing and resolving the dichotomy of my beliefs and experience and the research evidence is a sometimes disillusioning but also an illuminating process.

These are biases that I acknowledge and realize that as a researcher I must be open to challenging my biases. However, as a practitioner, these debates left me on shaky ground and recovering my equilibrium and confidence in practice has been difficult. There have been times when I have thought, “Does it really matter which remedy I prescribe?” This is like thinking homeopathic heresy and has separated me out from my peers when there have been long and involved discussions about the appropriate remedy to prescribe for a particular

patient. Additionally this has also affected my teaching of homeopathy, as I now prefer to be teaching consultation skills rather than materia medica.

10.7 Conclusions

This area for study was identified through a personal interest in the homeopathic consultation and an observation that there were no studies that explored the consultation in depth from the practitioners' perspective. This led to the aims which were to gain an in depth knowledge of the homeopathic practitioners' perceptions, intentions, prescribing strategies and experiences of the homeopathic consultation and their process of engaging with the patient. The overall objective was to generate a theoretical model of the processes that underpin the homeopathic consultation. The development of the theoretical model which has *connecting* as a core component has highlighted that the whole process of the homeopathic consultation is important and that it is meaningless to separate the remedy from the rest of the consultation and hence the remedy must be considered as part of the whole process of the consultation. Isolating an active therapeutic agent (remedy or any other aspect of the consultation) would not benefit homeopathy and would be meaningless as this can vary from consultation to consultation, patient to patient and practitioner to practitioner and requires the interaction of the whole process to enable and facilitate this. Paramount in this process is the ritualistic and symbolic aspects of the consultation that are embedded in this process that transcend technical expertise, such as finding the correct remedy. These ritual and symbolic aspects highlight the power of the consultation to promote beneficial effects for the patient. This research has implications for all stakeholders and signals many future avenues for research.

10.8 Implications of the study

10.8.1 For practitioners of homeopathy

A recent Radio 4 program that was broadcasted in two parts (Goldacre 2008a; Goldacre 2008b) was an attempt to educate people about the placebo and placebo response. However, there was a tendency to mystify the placebo response received by conventional medicines and medical procedures and to devalue the placebo response received by alternative therapies such as homeopathy. For example, it was suggested that homeopaths deceive patients by their conviction in the remedy, knowing that the remedy may well be inert. However as I have discussed in this research it appears that most homeopaths have some belief and commitment to their remedies (Thompson et al. 2006). This belief and commitment to ones therapy is considered by Moerman (2002) as necessary. In my research

the only participant who did not believe in the homeopathic remedy still believed in the process of matching a remedy. This is because the remedy and remedy matching process are integral to the whole consultation. The consultation is built round establishing which remedy type the patient may represent, even if a remedy is not eventually prescribed. Additionally when I explored the curriculums of homeopathic courses I could see that focus on the remedy is ingrained in the training of a practitioner. Training into the interpersonal skills in a consultation also focuses on how to draw out relevant symptoms from a patient in order to match a remedy. There are only two books that discuss and describe the homeopathic consultation (Kaplan 2002; Owen 2007), in comparison with hundreds of books on the remedies, thus this belief and conviction in the remedy is a result of the training that homeopaths receive. This in turn originates from the philosophical underpinnings that were developed by the originator of homeopathy; Samuel Hahnemann.

A recommendation from this research is that the training of homeopathic practitioners is now re-evaluated to change the focus of the training to include predominantly consultation skills, which also demonstrate that the remedy is an inseparable part of it. Most of the homeopathic practitioners training courses had components that involved interpersonal skills, communication skills, practitioner personal and professional development. However, the quality of these courses varies enormously. Some courses provide only a superficial understanding of interpersonal and consultation skills and other courses provide a program, which emphasizes interpersonal and consultation skills. Therefore, whether a homeopathic practitioner is adequately prepared for the type of consultation that they engage in may be at times questionable. This would be an appropriate subject for future research as practitioner effectiveness is an important issue to explore. For teachers of homeopathy this theoretical model of the homeopathic consultation could provide a tool to improve the teaching of interpersonal skills for their students. The impression I gained was that the practitioners did not really appreciate the power that a good consultation could have and conversely there was no discussion about nocebo effects and if the consultation could be beneficial then it could also be damaging to patients as you could induce expectations that they will experience adverse symptoms.

On a more personal note, seen through my eyes as a homeopathic practitioner this current atmosphere of attacks and criticism of homeopathy must appear very threatening to other homeopathic practitioners. Certainly, this is very noticeable on the Society of Homeopaths intranet conferencing facility (First Class) of which I am a member. Homeopaths feel disempowered by the negative publicity, the threat to their livelihoods and the paradox of a therapy that they observe helps people and yet the wider scientific community devalues. This

research may help them feel empowered by the knowledge that the consultation is in itself a powerful therapeutic tool, with features that are both generic to other consultations and also unique to homeopathy.

10.8.2 For researchers into homeopathy

The theoretical model demonstrates it is meaningless to split the remedy from the consultation, as they are inseparable. Paterson & Dieppe (2005) question whether three underlying assumptions of placebo controlled trials apply to research into acupuncture; but these can also be extrapolated to homeopathic placebo controlled trials. The first assumption is that the diagnosis process takes place before the trial. Similar to acupuncture research, in homeopathy trials, the biomedical diagnosis that takes place before the trial is not the theoretical understanding that guides homeopathic treatment. This is seen in the *Exploring the journey together* category which is a process of the homeopath unravelling and the patient disclosing their subjective experience of their illness which leads to the *Finding the level* category as the practitioner evaluates the patient. The homeopath does not make an objective biomedical diagnosis, but understands and evaluates the patient's subjective illness according to homeopathic principles.

The second assumption is that non specific factors are generic and are not linked to any particular therapeutic theory. Some non specific factors such as talking and listening are generic, however, there are aspects of the talking and listening that are specific to homeopathy. As already mentioned the patient can discuss any aspect of their subjective experience and idiosyncratic symptoms and this is all considered relevant for homeopathic prescribing. Additionally the homeopath probes for information that specifically helps lead to a homeopathic prescription. Moreover, the underlying explanations of health and disease that a homeopath may discuss with their patients within a homeopathic consultation are based on a holistic and vitalistic framework. There is a collaborative aspect of this that is trying to get the patient socialized to this type of framework and holistic consultations.

The third assumption is that specific and non specific effects are distinct and additive. Paterson & Dieppe (2005) point out that in acupuncture the needling and the consultation are specific to acupuncture and therefore cannot be separated. Likewise, with homeopathy the matching process and prescribing the remedy are specific and integral to the whole consultation process and cannot be easily separated from other non specific factors such as empathy. As Paterson & Dieppe (2005) note these assumptions highlight inconsistencies in acupuncture trials that could also be related to homeopathy trials. First they may explain why homeopathy is still popular despite its lack of definitive evidence of efficacy and second

it may also explain why remedies may not perform better than placebo in RCTs, because the remedy is dependant on the consultation.

It is apparent that research into homeopathy has to take into account that homeopathy is a complex intervention with multiple components (Medical Research Council 2000; Verhoef et al. 2005). Moreover as my study has shown these multiple components are interrelated and part of the whole process of the consultation. There have been several attempts to suggest alternative research strategies for CAMs (Bell & Koithan 2006; Fonnebo, Grimsgaard, Walach et al. 2007). Bell et al (2006) suggest a model for the study of whole systems using complexity theory which takes into account the holistic and vitalistic paradigms of different CAMs such as homeopathy. Complexity theory recognizes that individual symptoms are an expression of a global disturbance rather than a local disturbance. Also the focus of treatment is on the patient and improvements involve well being, energy levels and other biopsychosocial changes. Fonnebo et al (2007) also view that all aspects of the CAM modality must be explored and their strategy does not contain new methodological elements but organizes existing elements in a way that is tailored to pragmatic clinical practice. For example, they suggest that phase 1 of a research strategy for CAMs should be exploring the context, paradigm, philosophical understanding and utilization of the therapy rather than investigating the biological or chemical mechanism of the therapy as a first step. Attempts to reconceptualise placebo effects and non specific effects into context effects or a meaning response, and to have alternative research strategies for CAMs, are helpful as it enables a greater understanding of the individual therapies. This understanding enables sceptics of homeopathy to appreciate that there is more to homeopathy than the remedy and that the whole process of the consultation is equally as important.

10.8.3 Recommendations for further research

It is inevitable that when searching to answer a question more questions arise. Throughout the findings and analysis of this thesis I have pointed out areas that would benefit from further research. This research developed *a theoretical model of a classical homeopathic consultation* in patients with chronic disease. It would be relevant to compare and test out the emergent theory in this study with other therapeutic interventions and therefore demonstrating the wider applicability of the model. Any similarities and differences found may elucidate aspects of those therapies that are specific to that therapy and aspects that are common to therapeutic consultations. This would not only add to knowledge about individual therapies but would also add to knowledge about therapeutic consultations per se.

Patients value many factors in the homeopathic consultation such as aspects of the patient practitioner relationship (Mercer et al. 2004) the holistic approach to the consultation (Barrett et al. 2000) and taking an active part in their healthcare (Vincent et al. 1996) therefore other professions may be able to learn from homeopathy. For example, the way that homeopaths use empathy may be instructive to other therapies.

The question as to whether homeopaths are adequately trained to conduct in depth interpersonal consultations arises from this research. I have already discussed how much of the training focuses on remedies and the quality of interpersonal training varies from college to college. The use of adjunct therapies by the homeopaths in this research has not been noted in previous research on homeopathy, it may be relevant to explore how and when homeopaths use adjunct therapies in their practice as this suggests that homeopaths are not solely dependent on their therapy and it may also add to the understanding of a holistic approach to treatment and the perceived limitations of homeopathic treatment.

Earlier in this chapter I discussed how this model builds on previous research, inevitably further questions arise out of these. All of these can be developed into research questions that would further elucidate the process of the homeopathic consultation. For example, how exactly is holism and vitalism used in the consultation and how do they differ when used in other consultations? It would be relevant to explore whether patients' experiences of the consultation reflect this *theoretical model of a classical UK homeopathic consultation* developed from practitioners' experiences.

This research has demonstrated that the methodology used was applicable for answering the research question and realising the aims of this research which was to explore the practitioner's experiences and perspectives of the consultation and from this to develop a theoretical model of the homeopathic consultation. This thesis presents the first in depth theoretical model which can be used in training and in the practice of homeopaths and can also be used to inform research. This study has built on and extends previous research on the homeopathic consultation drawing out aspects of the homeopathic consultation that are common to other consultations and aspects that are specific to homeopathy, such as the process of identifying and matching the homeopathic remedy. The concept of "meaning response" was acknowledged as a framework that is consistent within the theoretical model presented in this thesis as it accounts for the meaning that is attached to the remedy and rituals and symbols of the consultation as well as the context of the consultation. The exploration of symbols and rituals in the homeopathic consultation have highlighted that the consultation has aspects that are powerful mediators of therapeutic benefit for the patient.

Moreover the model presents a process where the therapeutic relationship is crucial to the practice of homeopathy, as it links all the processes in the consultation. Thus the process of identifying and matching the homeopathic remedy which is embedded in the consultation is linked and inseparable to the whole consultation.

Appendices

Appendix 1 Preparation of homeopathic remedies

Homeopathic remedies are made from many substances from the animal (such as bee sting) vegetable (such as deadly nightshade) or mineral (such as calcium carbonate) kingdoms and homeopaths refer to the remedies using their Latin names. The original substance is processed into a form suitable for dilution, for example plants are prepared into a mother tincture (liquid extraction from the substance) and metals are triturated (ground down with milk sugars to enable solubility). Homeopathic remedies are then prepared through a process called potentisation which involves a series of systematic dilutions and succussions (a forceful shaking action) until the desired potencies (strengths) are made.

The more dilutions and succussions a substance undergoes, the higher the potency will be. Any homeopathic remedy diluted beyond the 12c potency (e.g. diluted 12 times) has reached Avogadro's constant (6×10^{23}) and therefore past the point that molecules of the original substance would be measurable in the solution.

Dilution	Dilution Ratio	Succussion	Designation
1 part mother tincture or trituration + 9 parts carrier liquid, this makes 1X. Take one drop of 1X and add to 9 parts carrier liquid to make 2X etc. 10 times X (or D or D9 parts carrier liquid	1/10	Ten times	X such as 2X, 6X, 12X etc (Sometimes called D or DH e.g. 2D or 2DH*)
1 part mother tincture or trituration + 99 parts carrier liquid, this makes 1C. Take one drop of 1C and add to 99 drops of carrier liquid to make 2C etc.	1/100	One hundred times	C such as 6C (Sometimes called CH or CK e.g. 2CH or 2CK*)

1 part mother tincture or trituration + 1000 parts of carrier liquid to make 1M.	1/1,000	One thousand times	M, 1M, 10M 50M etc,
All remedies are prepared up to a 3C triturated potency (1:1,000,000). 1 grain (0.05gms) of the 3C is dissolved in 500 drops of carrier liquid. 1 drop of this solution is added to 100 drops of alcohol to make LM1. LM2 is made by taking a LM1 granule and adding it to 100 drops of alcohol and succussed 100 times.	1/50,000	One hundred times	LM 1, LM2 etc. up to LM 30 (Sometimes called Q potencies)

*The H and the K designations refer to the method of preparing the remedy which was either according to the Hahnemann method or the Korsakovian method (named after a student of Hahnemann's General Korsakoff from Russia).

The Hahnemanian method uses 1 part of the homeopathic potency to 99 parts of alcohol in a new flask and succussed to make the next higher potency on the Centesimal scale. The Korsakovian method is simpler and quicker and often employed to produce the higher potencies of 200C and above. In the Korsakovian method the same container is used for each succession of the dilution step.

Appendix 2 Potency selection

Low Potencies	High Potencies
Used if the focus of the symptoms is physical or organic, at least at the beginning of treatment.	Used if the emphasis of the symptoms is psychological or emotional.
Can be repeated more frequently.	Tend to be repeated less frequently, if at all.
Tend to be used in most acute cases.	Used acutely with frequent repetition during labour. Can be used to treat the result of an acute that happened a long time ago e.g. head injury.
Often used in conjunction with patients on conventional medicines.	LMs are often used with patients on conventional medicines. Or, to minimise aggravations.
Can be used to facilitate the response to the same remedy in a higher potency.	
Tend to be used on the Frail, elderly the very sick or “slow reactor’s” in preference to higher potencies.	Used on patients with stronger vitality levels. Hyper reactive people can have higher and LM potencies
Mother tinctures and low potencies are used as “organ” remedies.	Some substances are highly toxic in their undiluted state and need to achieve a higher state of dilution e.g. Lachesis (bushmaster snake poison) may produce nosebleeds if given below the 8X potency due to it containing haemolytic enzymes.

Appendix 3 Methods of homeopathic prescribing

Method	Description of method	Potency
Constitutional prescribing (or, Kentian, Classical, Essence)	<p>This involves taking the whole person into account as far as this is possible and treating the person simultaneously on all levels; physically, mentally, emotionally and spiritually. Homeopaths refer to “treating the person and not the disease” in this case.</p> <p>Disease is thought to flow from the innermost regions of a human being to the outermost producing a hierarchy of symptoms to be treated for example mental and emotional symptoms take precedence over common physical symptoms in a disease such as weakness.</p> <p>J.T.Kent developed Hahnemann’s ideas and blended it with his vast homeopathic experience and with the teachings of Swedenborg. This method is very widely used in Britain, India and the United States</p>	<p>Centesimal</p> <p>30, 200, 1M, 10M, 50M, CM, DM, MM</p>
Physical Generals	<p>This is a variation on constitutional classical prescribing differing only in that physical general symptoms are graded highest in the hierarchy of symptoms, above mental and emotional symptoms and physical particular symptoms. Physical general refers to physical symptoms of the patient as a whole and not just to one part. This method was originated by Boeninghausen (1785-1864) and further refined by C.M Boger and Phatak.</p>	<p>Various, often centesimal</p>
Layers	<p>A Method based on the assumption that certain patients have distinct levels of disease which require separate prescriptions to be given in appropriate sequence in order to bring about a complete and lasting cure. A coherent working model of this method was developed by Dr Eizayaga of Argentina. The model has four main categories of layer to be considered 1) Miasmatic layer, 2) constitutional layer, 3) Fundamental layer, 4) Lesion layer.</p>	<p>Depends on layer. Ie. Lesion Layer 3C or 6C. Constit. Layer 30C</p>

	This methods is considered appropriate in cases with advanced pathologies and confused cases.	upwards
Sankaran/ Kingdoms/ Bombay method	Indian Homeopath Rajan Sankaran developed an approach to case taking and analysis of cases that revolved around the “delusion” and “sensations” that the patient reported during case taking. He later developed this method so that there is a more structured approach to analysis as patients were classified into kingdoms of remedies e.g. plant, animal or mineral kingdoms. The approach to case taking could also be quite structured and involves finding out the patient’s symptoms through the use of “levels”; such as the symptom level, feeling level, delusion level and vital sensation level.	Various
Kingdoms/ Sholten	Dutch homeopath Jan Sholten also proposed looking at the kingdoms of remedies such as each mineral family using a process he calls group analysis. By extracting the symptoms common to all the remedies in a family, he composes themes that can then be applied to the various remedies in that family. He also describes the characteristics of remedies that are elements, based on their position in the periodic table.	Various
Miasmatic prescribing	This method is based on the assumption that there exists in virtually everyone an inherited or acquired energy blockage producing a predisposition towards a recognizable pattern of illness. Hahnemann originally formulated the idea that it is impossible to fundamentally and permanently cure a chronic disease state unless treatment is directed towards the underlying miasms. There are five major miasmatic nosodes (remedies made from disease product) Psorinum, medorrhinum, syphilinum, tuberculinum and Carcinosin.	Various often high
Organ Remedy	This method is based on the assumption that a) certain remedies have a specific affinity for certain organs and b)	Tincture & low

	there are patients in whom it may be necessary to treat specific organs or systems in order that the whole person may be properly cured. James Compton Burnett took up the work of organ prescribing in England in the late nineteenth century and placed it in a homeopathic context. French homeopaths Nebel, Vannier, Julian and others have contributed much to this field by introducing the concept of drainage whereby organs or systems are detoxified and toend up before giving constitutional remedies.	
Sarcodes	Organ prescribing that incorporates potentised healthy organs and their secretions e.g. thyroid gland. 3X or 4C arouses organ function, 7C regulates and 9C inhibits	Tincture & low
Polypharmacy	The method encompasses any prescribing technique in which two or more remedies are prescribed simultaneously either in alternation with each other or as a combined formula. The prescription can be individualised or disease based. This system was originated by J Ellis Barker a homeopath in the 1930s and 40s. Medical and European homeopathy use many polypharmacy compounds following on from the French homeopath Jacque Jouanny.	Various often low
Genus Epidemicus	A prescription based on Hahnemann’s observations that during a true epidemic of acute disease a majority of cases will respond to the same remedy.	30c upwards
Aetiology	This is when a prescription is based primarily on some past trauma, illness, or event rather than on the presenting symptoms. The stronger the cause and effect relationship between the trauma and the presenting state the more an aetiological prescription is indicated. For example, Arnica can be given for a head injury that occurred 12 years ago if there appear to still be symptoms resulting from the injury such as headache	Usually High

Isopathy	This is the prescription of a remedy made from the supposed causative agent or products of a disease to a patient suffering that same diseases e.g. pollen to a hayfever sufferer. Also sometimes used as an adjunct to other homeopathic remedies. Hahnemann was very against the idea of Isopathy.	Various often low
Tautopathy	Tautopathy refers to a prescription of a potentised drug or toxin that a person has ingested some time previously and that may have caused them some problems.	Various often low
Specifics	A remedy is prescribed on the basis that it nearly always works when given in similar circumstances such as Arnica in physical injury.	Often centesimal

Appendix 4 Constructivist criteria for grounded theory

Credibility	<p>Is the researcher familiar with setting and topic?</p> <p>Are the data sufficient to merit claims? Have systematic observations been made between categories? Do the categories cover a wide range of observations?</p> <p>Are there strong links between the gathered data and the argument and analysis?</p> <p>Is there enough evidence for the claims to allow the reader to form and independent assessment and agree with the claims?</p>
Originality	<p>Are the categories fresh and offer new insights?</p> <p>Does the analysis provide a new conceptual rendering of the data?</p> <p>What is the social and theoretical significance of this work?</p> <p>How does the grounded theory challenge, extend current ideas and practices?</p>
Resonance	<p>Do the categories portray the fullness of the studies experience?</p> <p>Have taken for granted meanings been revealed?</p> <p>Where the data indicate have links been drawn between institutions and individuals?</p> <p>Does the grounded theory make sense to the participants and give deeper insights?</p>
Usefulness	<p>Does the analysis offer interpretations that people can use in their everyday worlds?</p> <p>Do your categories suggest any generic processes? Have these generic processes been examined for tacit implications?</p> <p>Can the analysis spark further work in the substantive area?</p> <p>How does your work contribute to knowledge and improving the world?</p>

Appendix 5 Presentation made to CAM research group

A qualitative study of homeopathic consultations

Reflecting on the Journey

Caroline Eyles

Complementary Medicine Research Unit
Primary Medical Care
University of Southampton



University of Southampton

Aim and overview

- The aim of the presentation is to give a reflexive overview of my journey so far through this PhD.
 - My background
 - Reflexivity
 - Methodology
 - Practitioner/researcher issues
 - Findings



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From homeopathic practitioner to practitioner/researcher

- Joining the CAM research meetings
- Desire to push the boundaries with new challenges
 - To develop my own CPD
 - To help develop the profession
- Have specific interest in the homeopathic consultation.
- Belief in the homeopathic remedy



University of Southampton

Practitioner reflexivity

- Has been defined as a “turning back on the self” :
 - Reflect on the “active self” i.e. looking at self as part of the process.
 - Reflect on the “inner self” i.e. self awareness

(Rennie, 1992)



University of Southampton

Researcher reflexivity

“The capacity of the researcher to acknowledge how their own experience, thoughts, feelings, culture, environment, social history, personal history and contexts (which may be fluid and changing) inform the process and outcomes of inquiry.

(Kim Etherington, 2004)



University of Southampton

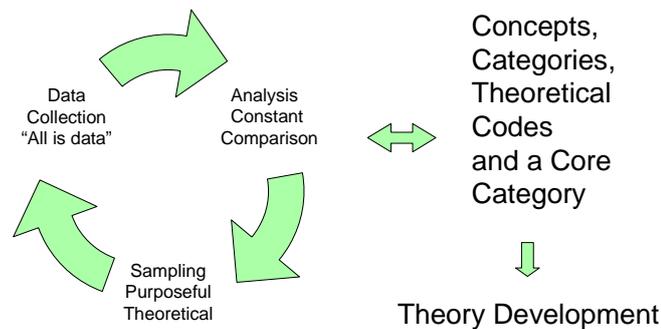
What reflexivity means to me now

- Many ways of understanding reflexivity
- Self awareness and a dynamic process of interaction within and between ourselves and our participants and the data that informs decisions, actions and interpretations
- Reflexivity challenges us to be more fully conscious of our own ideology and culture.
- Reflexivity in research creates transparency
- Reflexivity adds rigour in research by providing information about the contexts in which the data are located.



University of Southampton

Grounded theory



University of Southampton

Challenges with grounded theory

- Conducting the literature review after analysis.
 - Advantages and disadvantages
- The methodology
 - was chosen for this study when I started the PhD therefore when I started writing my chapters I was retrospectively justifying the choice of method.
 - Choosing which branch of Grounded theory I belonged in Glaser, Strauss or other.



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Glaser vs. Strauss

Constructivism



- Sees both data and analysis as created from shared experiences and relationships with participants and other sources of data.

(Charmaz, 2006)



University of Southampton

Doing the interviews

“I am really interested in your experience of the homeopathic consultation, please could you describe a typical consultation to me”

- Interviews were started before literature review
- Interviews were started early in transition from practitioner to practitioner/researcher
- How do I present myself in the interviews



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Influence on interview

H: The moment people suddenly see something, is when I think ah ha. You know this is croton tig or something and in that moment they may say “actually I feel different”

I: Yes, because its hard to know what is going on in that moment isn't it? Sometimes just the energy of your realisation is.....

H: Yes, sometimes you can feel the whole dynamic in the room change in the moment



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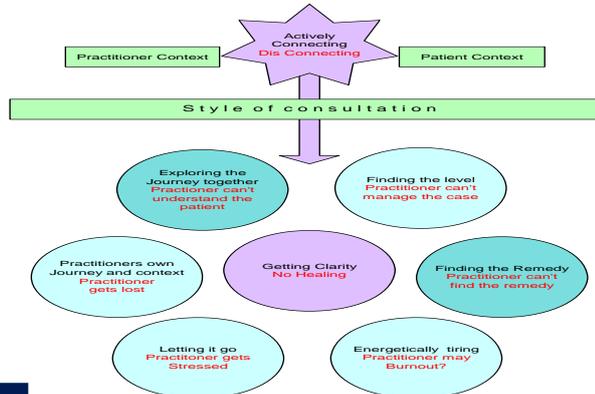
Influence on interview

H: There is something very important going on there. Not necessarily well but he had a response, a big response. It may well be that it was too potent?
 I: *Maybe he is very sensitive and.....*
 H: I've a feeling somewhere I did actually use Phatak's repertory and I think, um, material medica, and I think there was something about red vision, very small print. I'll look at it whilst we're talking (*getting book*)...
 I: *It's not as though he's proving Rhus tox.*
 H: That was the thing I'd hoped he might be proving but it wasn't.
 I: *Unless it's an old symptom or something but he would have mentioned that wouldn't he?*
 H: I'd like to ask him more about.....I find this.....I remember patients sometimes years later, possibly because someone else has done something that triggers it, and I want to then just look it up...
 I: *Sometimes if people produce a symptom like that in.....it's sometimes an indication of it being not quite a simillimum or a partial simillimum isn't it?*
 H:.....Yes



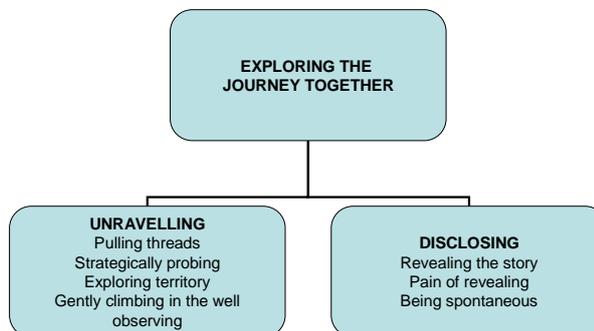
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Theoretical codes



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Writing the findings chapter



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Practitioner/Researcher

- Transition from practitioner to practitioner/researcher
 - Between two worlds
 - Issue of placebo
 - Change in practice
 - Skills are more focussed
 - Negative media on homeopathy



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Acknowledgements

- Pre-doctoral and post doctoral funding supported by the DH-National Co-ordinating Centre for Research Capacity Development (NCC RCD).
- Supervisors:
 - Dr Sarah Brien, University of Southampton
 - Dr Jan Walker, University of Southampton



University of Southampton

Appendix 6 Checklist to analyse observations & diaries

Blank checklist form

Exploring the journey together

Journey	
Unravelling	
Disclosing	

Finding the level

collaborating	
Having expectations	
Energy & Wholeness	

Responding Therapeutically

Using Adjunct Therapies	
Therapeutic consultation	
Matching <i>Perceiving</i> <i>distilling</i>	

Understanding self

Taking Care <i>Looking after self</i> <i>Being rewarded</i>	
Being drained <i>Having boundaries</i> <i>Coming up with the good</i>	

Connecting

Empathy,Rapport,Presence	
Exploring the journey	
Finding the level	
Responding Therapeutically	
Understanding self	

Healing

<i>Clarity/change</i>	
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Example of a completed checklist form after an observation

Exploring the journey together

<p>Journey [6]</p> <p>15:10</p> <p>20:21</p> <p>21:00 – 25:00</p> <p>28:00</p> <p>42:00</p> <p>46:56</p> <p>49:00</p> <p>50:00</p> <p>70:00</p> <p>72:00</p> <p>83:00</p>	<p>Start to be more focused/mover from story to her. But then flips back to story and not herself</p> <p>You look distracted and impatient to start the process. Its then becomes more focussed and you write a lot when she starts talking about herself</p> <p>Back to story again</p> <p>Back to focus with specific questions asked</p> <p>Mainly focussed and “Red Alert” reflected to patient – start of identifying the remedy</p> <p>Caroline asks specific questions to identify the remedy</p> <p>Identify issue – control</p> <p>Move consultation to addressed physical level</p> <p>Consultation around emotional level</p> <p>Medical history taken</p> <p>End of journey – Caroline gets material medica out to check remedy</p>
<p>Unravelling [2]</p> <p>04:00 -5:00</p> <p>5:00→</p> <p>60:00</p>	<p>Anxiety issue re sleep disturbance discussed</p> <p>Questioning about daughter.. focus mainly on daughters story</p> <p>More traumas disclosed</p>

<p>Disclosing [1]</p> <p>→ 3:00</p>	<p>First 3 mins telling problem to you. You are not interrupting – active listening</p> <p>Continues on and off through consultation as one issue expressed over time</p>
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Appendix 7 Interview: Invite to participate

Printed on University of Southampton headed paper

MREC No: 05/MRE12/42

Date

Dear

Invitation to take part in the Research Study entitled "A qualitative study of homeopathic consultations".

I am writing to you to invite you to participate in this research. I am a Department of Health funded Research Fellow at the Department of Primary Care at the University of Southampton, and am a homeopathic practitioner with 16 years clinical experience. I am in the process of doing a PhD to explore the role of homeopathic practitioners in the complementary and alternative medicine consultation, and specifically to examine their perceptions of what makes an effective homeopathic consultation. This research is funded by the Department of Health and supported by the DH-National Co-ordinating Centre for Research Capacity Development (NCC RCD).

I have enclosed an information sheet for participants, a contact details form and a FREEPOST addressed envelope. If you choose to take part in this research please read and keep the information sheet and return the completed contact details form to me in the enclosed envelope. I will contact you to arrange a convenient interview time and location.

If you require any further information regarding this research then please contact me at the above number, or, you could visit my website at: www.som.soton.ac.uk/staff/cge/

Yours sincerely

Caroline Eyles

Appendix 8 Interview: Participant information sheet

Printed on University of Southampton headed paper

INFORMATION FOR PARTICIPANTS

A Qualitative study of homeopathic consultations

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what is involved. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Additionally Consumers for Ethics in Research (CERES) publish a leaflet entitled 'Medical Research and You'. This leaflet gives more information about medical research and looks at some questions potential recruits may want to ask. You may obtain copies from CERES, PO Box 1365, London N16 0BW.

Thank you for reading this.

What is the purpose of this study?

This study is part of a larger project that seeks to identify how complementary therapy consultations benefit patients. My aim is to explore factors that homeopathic practitioners perceive to be important in promoting a satisfying and therapeutically effective consultation with their patients.

Why have I been chosen?

You have been asked to take part in this study because you are a homeopathic practitioner with considerable knowledge and experience of conducting homeopathic consultations.

Do I have to take part?

Whether or not you take part in the study is entirely your choice. If you do decide to participate please keep this information sheet and sign and return the attached contact details form, or alternatively telephone me on the above number. If you do decide to take part you will be free to withdraw from the study at any time and without having to give a reason.

What will happen to me if I take part?

Interview: Participant information sheet v1 27/04/2005 MREC Number: 05/MRE12/42

Once I have received your details, I will contact you by telephone or email to arrange a convenient time and place for us to meet for interview. Before the interview starts I will ask you to complete a copy of the enclosed consent form. I anticipate the interview to take about 1 hour of your time, and expect, where relevant, that this will not take place during NHS time. During the interview I will ask you to describe the process of a “typical consultation”, and also to tell me about your experiences of the homeopathic consultation in some depth, focusing on things that have gone well and those that you feel did not go so well. With your permission, the interview will be audio taped and later transcribed. You will be free to turn off the tape recorder at any point during the interview, or subsequently to request the deletion of recorded information. I would expect this interview to last approximately one hour. I will then listen to, transcribe and systematically analyse the interview using a qualitative methodology called grounded theory. As part of this process I will also compare your interview with other interviews I have conducted so I can identify common codes and categories that capture commonalities and differences among homeopathic consultations.

Following the analysis of your interview, I will share preliminary findings based on your interview for your information and comment if you wish. With your consent, I may at that point contact you to arrange a follow-up interview to discuss these findings and address any additional issues that have emerged since interview or during the data analysis. This subsequent interview will not normally last longer than one hour but could take place using email, telephone or letter, should you prefer this.

What are the possible benefits and disadvantages of taking part?

There are no direct benefits to you of participating in this study, although you might find it useful to have the opportunity to reflect on your practice. The process of reflection might equally raise issues that you find difficult or challenging. I therefore recommend that you are in contact with either a supervisor or member of your peer support network to help you resolve any such issues, if they should arise.

Will my taking part in this study be kept confidential?

If you consent to take part in the research, all recorded data, transcriptions and notes will be retained in a secure place and remain strictly confidential. Your anonymity will be assured throughout through the use of pseudonyms and the alteration of identifiable details prior to

Interview: Participant information sheet v1 27/04/2005 MREC Number: 05/MRE12/42

reporting. Other members of the research team, who are not homeopaths, may need to read transcriptions, but all references to your name and location will have been removed at that stage.. You will have the opportunity to review preliminary findings to check that your personal confidentiality has been adequately preserved.

What will happen to the results of the research study?

The findings from this study will form part of my PhD thesis. They will also be shared at conferences and published in academic journals. A summary of the overall findings of the study will be available on my website or you can request these to be sent to you if you would prefer. You may also request a copy of the published findings by writing to or emailing Caroline Eyles at the Complementary Medicine Research Unit at the School of Medicine (see address above).

Who is organising and funding the research?

This study is funded by the Department of Health and coordinated as a PhD project by **Caroline Eyles RSHom, M.A.**, a research fellow, at the Complementary Medicine Research Unit at the School of Medicine, University of Southampton. The University of Southampton are the sponsors of the study and indemnity cover for negligent harm has been provided.

Who has reviewed the study?

The study has been subjected to peer review and approved by the Thames Valley Research Ethics Committee.

Contact for further information?

If you require further information please contact the chief investigator, Caroline Eyles at C.G.Eyles@soton.ac.uk or telephone 023 8024 1072 or visit my website at www.som.soton.ac.uk/staff/cge/

Thank you for making the time to read this Information Sheet. This is a copy for you to keep for your reference.

Interview: Participant information sheet v1 27/04/2005 MREC Number: 05/MRE12/42

Appendix 9 Interview: Contact details form

Printed on University of Southampton headed paper

CONTACT DETAILS

If you wish to participate in the research please complete this contact details form and return in the freepost envelope enclosed.

Dr, Mr, Miss, Mrs (*Please delete as applicable*)

Name of Practitioner.....

Practise Address

.....
.....
.....

Telephone.....

Convenient contact time.....

Email

How long have you been practising homeopathy?

Years

Do you have a supervisor?

Please tick:

Yes

No

Do you have a peer support group?

Please tick:

Yes

No

Interview: Contact details form v1 27/04/2005 MREC Number: 05/MRE12/42

Appendix 11 Observation: practitioner invite

Printed on University of Southampton headed note paper

REC Ref No: 07/H0504/184

Dear

Invitation to take part in Phase 2 of the Research Study entitled “A qualitative study of homeopathic consultations”.

You are being invited to take part in the second phase of this research study. The first phase of the study involved in depth interviews with homeopathic practitioners. In this second phase of the study with your permission I would like to observe in person and video record some of your homeopathic consultations. After I have had an opportunity to look at the recordings I would then be seeking to interview you to gather your reflections and further data on the consultation.

I have enclosed an information sheet for you, a FREEPOST addressed envelope and a form for you to complete and return to me indicating your interest in participating in this research, or, a request for further information. If you choose to take part in this research please read and keep the information sheet and return the completed form to me in the enclosed envelope. I will then contact you to arrange a convenient time for the research to take place.

If you require any further information regarding this research then please contact me at the above number, or, you could visit my website at: www.som.soton.ac.uk/staff/cge/

Yours sincerely

Caroline Eyles

Study A Practitioner invite to participate. 24/10/07 v1 REC Ref No: 07/H0504/184

Appendix 12 Observation: Practitioner information sheet

Printed on University of Southampton headed paper

REC Ref No: 07/H0504/184

INFORMATION FOR PARTICIPANTS

(Homeopathic Practitioners)

A qualitative study of homeopathic consultations (Phase 2, Study A)

You are being invited to take part in the second phase of this research study. The first phase of the study involved in depth interviews with homeopathic practitioners. In this second phase of the study I would like to observe in person and video record some of your homeopathic consultations. After I have had an opportunity to look at the recordings then I would be seeking to interview you to gather your reflections and further data on the consultation.

Before you decide, it is important for you to understand why the research is being done and what is involved. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. My contact details are at the top of this headed note paper.

Thank you for reading this.

What is the purpose of this study?

This study is part of a larger project that seeks to identify how complementary therapy consultations benefit patients. My aim is to explore factors that homeopathic practitioners perceive to be important in promoting a satisfying and therapeutically effective consultation with their patients. The interviews provided insight into the homeopathic practitioners' perspectives providing information that cannot be observed such as feelings, thoughts and intentions. However in order to test out aspects of this emerging theory it will be necessary to conduct some observations of some homeopathic consultations.

Observation of consultations has several advantages, first, through direct observation I will

Study A Practitioner information sheet. 24/10/07 v1 REC Ref No: 07/H0504/184

be able to understand and capture the context within which you operate and interact. Second, being able to observe the consultation will allow me to see the behaviours that have been described in the interviews in phase 1 of the research, enabling a clearer understanding of these verbal reports. Thirdly observing gives the opportunity to see things that may routinely escape awareness and are therefore not reported or described. I will be seeking to interview you after I have had an opportunity to see the recordings as this will enable both yourself and myself to reflect on the consultation and to clarify and gather further data.

Why have I been chosen?

You have been asked to take part in this study because you are a homeopathic practitioner with considerable knowledge and experience of conducting homeopathic consultations.

Do I have to take part?

Whether or not you take part in the study is entirely your choice. If you do decide to participate please keep this information sheet and sign and return the attached form, or alternatively telephone me on the above number or email me at the email address above. You can also indicate on the form that you require further information before you decide whether to participate. If you do decide to take part you will be free to withdraw from the study at any time and without having to give a reason. Similarly if the patients wish to withdraw from the study, they are at liberty to do so at any point and without having to give a reason. Patients will have been informed that not wishing to participate or withdrawing from the study will not affect their relationship with their homeopath or their treatment.

What will happen to me if I take part?

If you respond by either using the enclosed form or by telephone or email, I will then contact you to explain the process of how you identify and recruit either new or existing patients who are willing to be observed and video recorded in the consultation. The criteria for you to identify and select your patients are as follows:

Patients will not be recruited if:

- They are from any vulnerable group (i.e. prisoner populations)
- They have mental health problems
- They have drug or alcohol dependency problems

Study A Practitioner information sheet. 24/10/07 v1 REC Ref No: 07/H0504/184

- They are unable to give consent
- They have a terminal condition
- They are unable to have face to face consultations
- They are under 18

Patients can be recruited if:

- They are a new or existing patient
- They have any chronic complaint

We will also discuss the arrangements for the day and the process of setting up the video recorder. We will then be able to arrange a convenient date for me to record and observe your consultations. During this initial discussion we can also decide how long I will spend with you; this could be from one consultation to several consultations depending on your availability. I will then be able to give you some information to send to your patients, this will be an introductory letter, patient information sheet, patient consent form and a form that the patients can complete and return to me indicating an interest in participating, or, a request for further information.

Before the recorded and observed consultation takes place I will obtain written informed consent from both your patient and yourself. During the consultation I will sit behind the patient so that a clear view of yourself, the homeopathic practitioner, is enabled. The camera will focus on the front of the homeopath and the back of the patient's head maintaining the anonymity of the patient. Additionally this will enable me to elicit information regarding how you as the practitioner affect the interaction and this will be used to provide a visual record of activities and responses during the consultation that validate and supplement the verbal reports given by homeopaths in their previous interviews from phase 1.

During the observation and video recording I will be taking field notes. You or your patient will be free to turn off the video recorder and to suggest that I leave the consultation at any point during the consultation, or subsequently to request the deletion of recorded information. Should this occur the patients will have been informed that this would in no way affect their relationship with their homeopath or their treatment. Subsequently after I have had the opportunity to view the recorded information I will contact you to arrange an interview, during which we will playback clips of the video recording and discuss aspects of

Study A Practitioner information sheet. 24/10/07 v1 REC Ref No: 07/H0504/184

the consultation. I would expect this interview to last approximately one hour and will be audio taped. Neither the video recording nor the audiotape of the interview will be transcribed or subject to detailed analysis as the primary aim of the video data is to use it to selectively contextualise and confirm verbal reports of the experiences of the consultation. Notes taken from the observation of the consultation and the videotapes will be used to supplement the original data and to confirm or refute the emerging theory of the homeopathic consultation. These notes will be available for you to view if you wish.

In view of your time commitment to the study we would like to make a contribution of a book token.

What are the possible benefits and disadvantages of taking part?

There are no direct benefits to you of participating in this study, although you might find it useful to have the opportunity to reflect on your practice. It is possible that you may feel that my presence in the consultation is intrusive and yet you are happy to be video recorded. In this case I would record the consultations but not be present in the consultation. Alternatively you can request that you wish to have the researcher present in the consultation and to not have the consultation recorded. The process of reflection might equally raise issues that you find difficult or challenging. I therefore recommend that you are in contact with either a supervisor or member of your peer support network to help you resolve any such issues, if they should arise.

What if anything goes wrong?

If you have any concerns or complaints about any aspects of how this research has been conducted by the researcher then please contact, Dr Martina Prude, Research Governance Manager, University of Southampton, Room 4009, Legal Services, Building 37, Highfield, Southampton, SO17 1BJ. Telephone: 023 8059 8848/9 or email: mad4@soton.ac.uk

Will my taking part in this study be kept confidential?

If you consent to take part in the research, all video and audio recorded data, and Field notes will be retained in a secure place and remain strictly confidential. Your anonymity will be assured throughout through the use of pseudonyms and the alteration of identifiable details prior to reporting. Other members of the research team, such as the researcher's

Study A Practitioner information sheet. 24/10/07 v1 REC Ref No: 07/H0504/184

supervisors, who are not homeopaths, may need to view video clips, but all references to your name and location will have been removed at that stage. You will have the opportunity to review preliminary findings to check that your personal confidentiality has been adequately preserved. Please note that the researcher has a responsibility to report any disclosure by participants during the study that clearly indicate malpractice or illegal activity. All data will be stored in accordance with research governance for 15 years but only myself and my supervisors have access to the data. After 15 years all audio data, video data and field notes will be destroyed.

What will happen to the results of the research study?

The findings from this study will form part of my PhD thesis. They will also be shared at conferences and published in academic journals. A summary of the overall findings of the study will be available on my website or you can request these to be sent to you if you would prefer. You may also request a copy of the published findings which will be available by Spring 2009 by writing to or emailing Caroline Eyles at the Complementary Medicine Research Unit at the School of Medicine (see address above).

Who is organising and funding the research?

This study is funded by the Department of Health and coordinated as a PhD project by **Caroline Eyles RSHom, M.A.**, a research fellow, at the Complementary Medicine Research Unit at the School of Medicine, University of Southampton. The study is being supervised by Drs Sarah Brien and Jan walker, who are based at the University of Southampton. The University of Southampton are the sponsors of the study and indemnity cover for negligent harm has been provided.

Who has reviewed the study?

The study has been subjected to peer review and approved by the Southampton and South West Hampshire Research Ethics Committee B.

Contact for further information?

If you require further information please contact the chief investigator, Caroline Eyles at C.G.Eyles@soton.ac.uk or telephone 023 8024 1072 or visit my website at www.som.soton.ac.uk/staff/cge/

Thank you for making the time to read this Information Sheet. This is a copy for you to keep for your reference.

Study A Practitioner information sheet. 24/10/07 v1 REC Ref No: 07/H0504/184

Appendix 13 Observation: Practitioner form

Printed on University of Southampton headed paper

REC Ref No: 07/H0504/184

A qualitative study of homeopathic consultations – Phase 2

Please complete this form and return to me in the FREEPOST envelope provided.

I would like to participate in this research which involves the
researcher observing and video recording homeopathic
consultations with my patients.

I am not sure if I would like to participate in this study which
Involves the researcher observing and video recording my
consultations with my patients. Please contact me with
further information by:

Telephone number.....

(Please put convenient time to receive calls).....

Email.....

Address.....

SIGNATURE.....

PRINT NAME.....

Study A Practitioner form 12/12/07 v2 REC Ref No: 07/H0504/184

Appendix 14 Observation: Practitioner consent form

Printed on University of Southampton headed paper

REC Ref No: 07/H0504/184

CONSENT FORM

QUALITATIVE STUDY OF HOMEOPATHIC CONSULTATIONS (Phase 2)

Name of Researcher : Caroline Eyles

Please initial

box:

1. I confirm that I have read and understand the information sheet dated.....for
the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any
time, without giving any reason or my legal rights being affected.
3. I agree to the presence of the researcher during the consultations with my patients.
4. I agree to the use of video recording equipment to video the consultation with my
patients
5. I agree to be interviewed after the consultation has been observed, and for the
interview to be audio taped for subsequent analysis.
6. I agree to take part in the above study.

Name of Practitioner Date Signature

Name of Researcher Date Signature

Copy for practitioner

Copy for researcher

Study A Practitioner consent form. 24/10/ 07 v1 REC Ref No: 07/H0504/184

Appendix 15 Observation: Patient invite

HEADED NOTE PAPER OF HOMEOPATHIC PRACTITIONER

REC Ref No: 07/H0504/184

Date

Dear Patient

Invitation to take part in the Research Study entitled “A qualitative study of homeopathic consultations”.

I am writing to you to invite you to participate in this research. I have been asked by a Researcher at the University of Southampton, to contact patients who may be interested in participating in this research with me. The research is part of a PhD to explore the role of homeopathic practitioners in the complementary and alternative medicine consultation, and specifically to examine homeopaths’ perceptions of what makes an effective homeopathic consultation. This research is funded by the Department of Health and supported by the DH-National Co-ordinating Centre for Research Capacity Development (NCC RCD).

This research will require the researcher to observe a consultation between a homeopath and their patient. This means that they would be present in the consultation room whilst the consultation is being conducted with you to take notes of what goes on in the consultation. In addition, so that they can obtain as much information as they can, they would also like to video the consultation. The video will be placed in the consultation room so that it will focus on the front of the homeopath and the back of the patients head.

I have agreed to participate in this research and to contact patients who may possibly be interested in also participating. If you do decide to participate then please be assured that all data is confidential and anonymous, that you may withdraw from the study at any point and the video will only be viewed by the researcher and their academic supervisors. However, if you do not wish to participate then please also be assured that this does not affect any aspect of the care that you receive.

Study A Patient invite to participate. 12/12/07 v2 REC Ref No: 07/H0504/184

I have enclosed a form and an information sheet for you explaining the process of the research in more detail. If you are interested in participating in this research then please return the completed form in the stamped addressed envelope provided to me indicating your interest in participating, or, requesting further information. I will then contact you and explain the arrangements for this research to take place.

Yours sincerely

Homeopath

Study A Patient invite to participate. 12/12/07 v2 REC Ref No: 07/H0504/184

Appendix 16 Observation: Patient information sheet

Printed on University of Southampton headed paper

REC Ref No: 07/H0504/184

INFORMATION FOR PARTICIPANTS

(Patients)

A qualitative study of homeopathic consultations

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what is involved. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. My contact details are at the top of this headed note paper.

Thank you for reading this.

What is the purpose of this study?

This study is part of a larger project that seeks to identify how complementary therapy consultations benefit patients. My aim is to explore factors that homeopathic practitioners perceive to be important in promoting a satisfying and therapeutically effective consultation with their patients. The first part of this study involved in depth interviews with homeopathic practitioners in order to develop a theory of the homeopathic consultation. In order to test this theory I will need to video record and observe some homeopathic consultations.

Why have I been chosen?

You have been asked to take part in this study because you are a patient of a homeopathic practitioner.

Do I have to take part?

Whether or not you take part in the study is entirely your choice. If you do decide to participate please keep this information sheet and you will be asked to sign a consent form before you attend the consultation to be observed. If you do decide to take part you will be

Study A Patient information sheet. 24/10/07 v1 REC Ref No: 07/H0504/184

free to withdraw from the study at any time and without having to give a reason, and you can request that any or all of the information already collected be destroyed or withheld. Your decision not to participate or to withdraw will not affect any aspect of the care that you receive.

What will happen to me if I take part?

If you do decide that you wish to participate then please complete the enclosed form indicating your interest in participating and return it to me, the researcher. Your homeopathic practitioner will then contact you to make arrangements for the research to take place. Your practitioner will also discuss with you as to whether you are happy for your consultation to be video recorded and whether you are happy to have me (the researcher) present observing the consultation. If you decide that you require more information before you make up your mind then you can indicate a request for further information on the form and return it to me.

Before the observation and video recording starts I will need to obtain signed written informed consent form from yourself and I will also ask your homoeopath to complete a copy of their written consent form. During the observation and recording of the consultation I will sit behind you so that a clear view of your homeopathic practitioner is enabled. The camera will focus on the front of the homeopath and the back of your head to maintain your anonymity. This will enable me to elicit information regarding how the homeopath affects the interaction and this will be used to provide a visual record of activities and responses during the consultation that validate and supplement the verbal reports given by homeopaths in their previous interviews. During the observation and video recording I will be taking field notes. You will be free to turn off the video recorder and to suggest that I leave the consultation at any point during the consultation, or subsequently to request the deletion of recorded information. A decision to not participate in the research or to withdraw from the research will not affect your relationship with your homeopath or your treatment.

Subsequently after I have had the opportunity to view the recorded information I will contact the homeopath to arrange an interview with them which will be audio taped, during which we will playback video clips and discuss aspects of the consultation. Neither the video recording nor the audiotape of the interview will be transcribed or subject to detailed analysis as the primary aim of the video data is to use it to selectively contextualise and

Study A Patient information sheet. 24/10/07 v1 REC Ref No: 07/H0504/184

confirm and supplement verbal reports of the experiences of the consultation taken from the original interviews with the homeopaths.

What are the possible benefits and disadvantages of taking part?

There are no direct benefits to you of participating in this study, although your contribution allows us to understand aspects of the homeopathic consultation which have not been previously researched. It is possible that you may feel that my presence in the consultation is intrusive and yet you are happy to be video recorded. In this case I would record the consultations but not be present in the consultation. Alternatively you may prefer to not be video recorded but you may be happy to have the researcher present in the consultation.

What if anything goes wrong?

If you have any concerns or complaints about any aspects of how this research has been conducted by the researcher then please contact, Dr Martina Prude, Research Governance Manager, University of Southampton, Room 4009, Legal Services, Building 37, Highfield, Southampton, SO17 1BJ. Telephone: 023 8059 8848/9 or email: mad4@soton.ac.uk

Will my taking part in this study be kept confidential?

If you consent to take part in the research, all video recorded data and Field notes will be retained in a secure place and remain strictly confidential. Your anonymity will be assured throughout through the use of pseudonyms and the alteration of identifiable details prior to reporting. This will ensure that any direct quotations or observations published as part of the research findings cannot be traced back to you. Other members of the research team, who are not homeopaths, may need to see video clips, but all references to your name and location will have been removed at that stage. Please note that the researcher has a responsibility to report any disclosure by the homeopathic practitioner during the study that clearly indicates malpractice or illegal activity. All data will be stored in accordance with research governance for 15 years but only myself and my supervisors have access to the data. After 15 years all video data and any field notes will be destroyed.

What will happen to the results of the research study?

The findings from this study will form part of my PhD thesis. They will also be shared at conferences and published in academic journals. A summary of the overall findings of the Study A Patient information sheet. 24/10/07 v1 REC Ref No: 07/H0504/184

study will be available on my website or you can request these to be sent to you if you would prefer. You may also request a copy of the published findings by writing to or emailing Caroline Eyles at the Complementary Medicine Research Unit at the School of Medicine (see address above).

Who is organising and funding the research?

This study is funded by the Department of Health and coordinated as a PhD project by Caroline Eyles RSHom, M.A., a research fellow, at the Complementary Medicine Research Unit at the School of Medicine, University of Southampton. The University of Southampton are the sponsors of the study and indemnity cover for negligent harm has been provided.

Who has reviewed the study?

The study has been subjected to peer review and approved by the Southampton and South West Hampshire Research Ethics Committee B.

Contact for further information?

If you require further information please contact the chief investigator, Caroline Eyles at C.G.Eyles@soton.ac.uk or telephone 023 8024 1072 or visit my website at www.som.soton.ac.uk/staff/cge/

Thank you for making the time to read this Information Sheet. This is a copy for you to keep for your reference.

Appendix 17 Observation: Patient Form

Printed on Southampton University headed paper

REC Ref No: 07/H0504/184

A qualitative study of homeopathic consultations – Phase 2

Please complete this form and return either to your homeopathic practitioner or the researcher, Caroline Eyles, in the freepost envelopes provided.

I would like to participate in this research which involves the researcher observing and video recording my consultations with my homeopath.

I would like more information before I make up my mind. Please could the researcher, Caroline Eyles, contact me:

Telephone No.....

(Please put convenient time to receive calls).....

Email.....

Address.....

SIGNATURE.....

PRINT NAME.....

Study A Patient form to return. 12/12/07 v2 REC Ref No: 07/H0504/184

Appendix 18 Observation: Patient consent form

Printed on University of Southampton headed paper

REC Ref No: 07/H0504/184

CONSENT FORM

A QUALITATIVE STUDY OF HOMEOPATHIC CONSULTATIONS

Name of Researcher: Caroline Eyles

Please initial box:

1. I confirm that I have read and understand the information sheet dated
for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any
time, without giving any reason, without my medical care or legal rights being affected.
3. I agree to the presence of the researcher and the use of video recording equipment
during the consultation with my homeopath.
4. I agree to take part in the above study.

Name of Patient Date Signature

Name of Researcher Date Signature

Copy for patient

Copy for researcher

Study A Patient consent to be Observed. 24/10/07 v1 REC Ref No: 07/H0504/184

Appendix 19 Diary: Invite to participate

Printed on University of Southampton headed paper

REC Ref No: 07/H0504/184

Dear

Invitation to take part in Phase 2 of the research study entitled “A qualitative study of homeopathic consultations”.

You are being invited to take part in the second phase of this research study. The first phase of the study involved in depth interviews with homeopathic practitioners. In this second phase of the study with your permission I would ask you to complete a diary over a two week period recording your reflections of consultations focussing particularly on “difficult consultations”. After I have had an opportunity to look at the diary I would then be seeking to interview you to gather your reflections and further data on the consultation.

I have enclosed an information sheet for you, a FREEPOST addressed envelope and a form for you to complete and return to me indicating your interest in participating in this research, or, requesting further information. If you choose to take part in this research please read and keep the information sheet and return the completed form to me in the enclosed envelope. I will then contact you to arrange a convenient time for the research to take place.

If you require any further information regarding this research then please contact me at the above number, or, you could visit my website at:

www.som.soton.ac.uk/staff/cge/

Yours sincerely

Caroline Eyles

Study B practitioner invite to participate. 24/10/07 v1 REC Ref No: 07/H0504/184

Appendix 20 Diary: Participant information sheet

Printed on University of Southampton headed paper

REC Ref No: 07/H0504/184

INFORMATION FOR PARTICIPANTS

(Homoeopathic Practitioners)

A qualitative study of homeopathic consultation (Phase 2, Study B)

You are being invited to take part in the second phase of this research study. The first phase of the study involved in depth interviews with homeopathic practitioners.

Before you decide, it is important for you to understand why the research is being done and what is involved. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

Thank you for reading this.

What is the purpose of this study?

This study is part of a larger project that seeks to identify how complementary therapy consultations benefit patients. My aim is to explore factors that homeopathic practitioners perceive to be important in promoting a satisfying and therapeutically effective consultation with their patients. The interviews provided data that enabled a developing theory of the homeopathic consultation to emerge. This data has given information such as feelings thoughts and intentions, thus allowing me to enter into the perspective of a homeopath. However in order to test out aspects of the emerging theory it will be necessary to conduct further data collection. This will be in the form of a diary that you will be asked to fill in over a two week period. The aim of the diary is to ask you to focus and report on your reflections of any “difficult” consultations that you conduct. By “difficult” I mean consultations that you felt were not easy to conduct.

Why have I been chosen?

Study B Practitioner information sheet. 24/10/07 v1 REC Ref No: 07/H0504/184

You have been asked to take part in this study because you are a homeopathic practitioner with considerable knowledge and experience of conducting homeopathic consultations.

Do I have to take part?

Whether or not you take part in the study is entirely your choice. If you do decide to participate please keep this information sheet and sign and return the attached form, or alternatively telephone me on the above number or email me at the email address above. You can also indicate on the form that you require further information before you decide whether to participate. If you do decide to take part you will be free to withdraw from the study at any time and without having to give a reason.

What will happen to me if I take part?

Once I have received the form indicating your interest in participating, I will contact you by telephone or email to arrange a convenient time for me to outline the nature of the research, to explain the process of filling out the diary and to obtain informed consent. We can either meet to do this or this can be done by post, email or by telephone.

After I have received the completed diary from you and have had time to review the contents I will contact you to arrange an interview which I anticipate will take about 1 hour of your time. With your permission the interview will be audio taped but neither the diary nor the interview will be transcribed or subject to detailed analysis as the primary aim of the diary and interview data is to use it to selectively contextualise and confirm verbal reports of the experiences of the consultation described in previous interviews from phase 1 of the research.

You will be free to turn off the tape recorder at any point during the interview, or subsequently to request the deletion of recorded information.

In view of your time commitment to the study we would like to make a contribution of a book token.

What are the possible benefits and disadvantages of taking part?

There are no direct benefits to you of participating in this study, although you might find it useful to have the opportunity to reflect on your practice. The process of reflection might equally raise issues that you find difficult or challenging. I therefore recommend that you are

Study B Practitioner information sheet. 24/10/07 v1 REC RefNo: 07/H0504/184

in contact with either a supervisor or member of your peer support network to help you resolve any such issues, if they should arise.

What if anything goes wrong?

If you have any concerns or complaints about any aspects of how this research has been conducted by the researcher then please contact, Dr Martina Prude, Research Governance Manager, University of Southampton, Room 4009, Legal Services, Building 37, Highfield, Southampton, SO17 1BJ. Telephone: 023 8059 8848/9 or email: mad4@soton.ac.uk

Will my taking part in this study be kept confidential?

If you consent to take part in the research, all recorded data, notes and the diary will be retained in a secure place and remain strictly confidential. Your anonymity will be assured throughout through the use of pseudonyms and the alteration of identifiable details prior to reporting. Additionally before you begin this research you will be advised how to complete the diary whilst maintaining the anonymity and confidentiality of any patients that you may wish to reflect on. Other members of the research team, such as the researcher's supervisors, who are not homeopaths, may need to read excerpts of the diary or listen to excerpts of the audio tape, but all references to your name and location will have been removed at that stage. You will have the opportunity to review preliminary findings to check that your personal confidentiality has been adequately preserved. Please note that the researcher has a responsibility to report any disclosure by participants during the study that clearly indicate malpractice or illegal activity. All data will be stored in accordance with research governance for 15 years but only myself and my supervisors have access to the data. After 15 years the diary, audio data and any field notes will be destroyed.

What will happen to the results of the research study?

The findings from this study will form part of my PhD thesis. They will also be shared at conferences and published in academic journals. A summary of the overall findings of the study will be available on my website or you can request these to be sent to you if you would prefer. You may also request a copy of the published findings, which will be available by Spring 2009, by writing to or emailing Caroline Eyles at the Complementary Medicine Research Unit at the School of Medicine (see address above).

Study B Practitioner information sheet. 24/10/07 v1 REC RefNo: 07/H0504/184

Who is organising and funding the research?

This study is funded by the Department of Health and coordinated as a PhD project by **Caroline Eyles RSHom, M.A.**, a research fellow, at the Complementary Medicine Research Unit at the School of Medicine, University of Southampton. The PhD is supervised by two supervisors, Drs Sarah Brien and Dr Jan Walker, at the University of Southampton. The University of Southampton are the sponsors of the study and indemnity cover for negligent harm has been provided.

Who has reviewed the study?

The study has been subjected to peer review and approved by the Southampton and South West Hampshire Research Ethics Committee B.

Contact for further information?

If you require further information please contact the chief investigator, Caroline Eyles at C.G.Eyles@soton.ac.uk or telephone 023 8024 1072 or visit my website at www.som.soton.ac.uk/staff/cge/

Thank you for making the time to read this Information Sheet. This is a copy for you to keep for your reference.

Appendix 21 Diary: contact details form

Printed on University of Southampton headed paper

REC Ref No: 07/H0504/184

A qualitative study of homeopathic consultations – Phase 2

Please complete this form and return to me in the FREEPOST envelope provided.

I would like to participate in this study which involves completing
a diary over a two week period recording my reflections of difficult
consultations.

I am not sure if I would like to participate in this study which
involves completing a diary over a two week period recording
my reflections of difficult consultations. Please contact me with
further information by:

Telephone No.....

(Please put convenient time to receive calls).....

Email.....

Address.....

SIGNATURE.....

PRINT NAME.....

Study B Form for Practitioner 12/12/07 v2 REC Ref No: 07/H0504/184

Appendix 2 Diary: Consent form

Printed on University of Southampton headed paper

REC Ref No: 07/H0504/184

CONSENT FORM

A QUALITATIVE STUDY OF HOMEOPATHIC CONSULTATION (Phase 2)

Name of Researcher : Caroline Eyles

Please initial box:

1. I confirm that I have read and understand the information sheet dated... ..for the
above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to
withdraw at anytime, without giving any reason or my legal rights being affected.
3. I agree to completing a diary over a two week period recording my reflections of
difficult consultations.
4. I agree to be interviewed after the diary has been analysed by the researcher, and for
the interview to be audio taped.
5. I agree to take part in the above study.

Name of Homeopath Date Signature

Name of Researcher Date Signature

Copy for Homeopath

Copy for researcher

Study B Practitioner consent form. 24/10/07 v1 REC Ref No: 07/H0504/184

Appendix 23 PCT R & D approvals

Maidstone and Tunbridge Wells NHS Trust

South West Kent	PCTHG 234	12 th October 2005
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Mid Wessex Partnership

Mid Hampshire PCT	MWP/MH/030/05	12 th August 2005
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South East Dorset PCT	MWP/SED/030/05	17 th August 2005
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Eastleigh & Test Valley PCT	MWP/ETVS/030/05	1 st July 2005
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New Forest PCT	MWP/ETVS/030/05	1 st July 2005
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United Bristol Healthcare NHS Trust

	OP/2005/2020	22 nd August 2005
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Sussex NHS Research Consortium

Brighton & Hove City PCT	0550/NOCI/2005	14 th July 2005
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Mid Sussex PCT	0550/NOCI/2005	14 th July 2005
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Portsmouth & Isle of Wight NHS R&D Consortium

Portsmouth City PCT	PCPCT/2005/04ST	5 th August 2005
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Isle of Wight PCT	No Reference	23 rd September 2005
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South Wiltshire Consortium

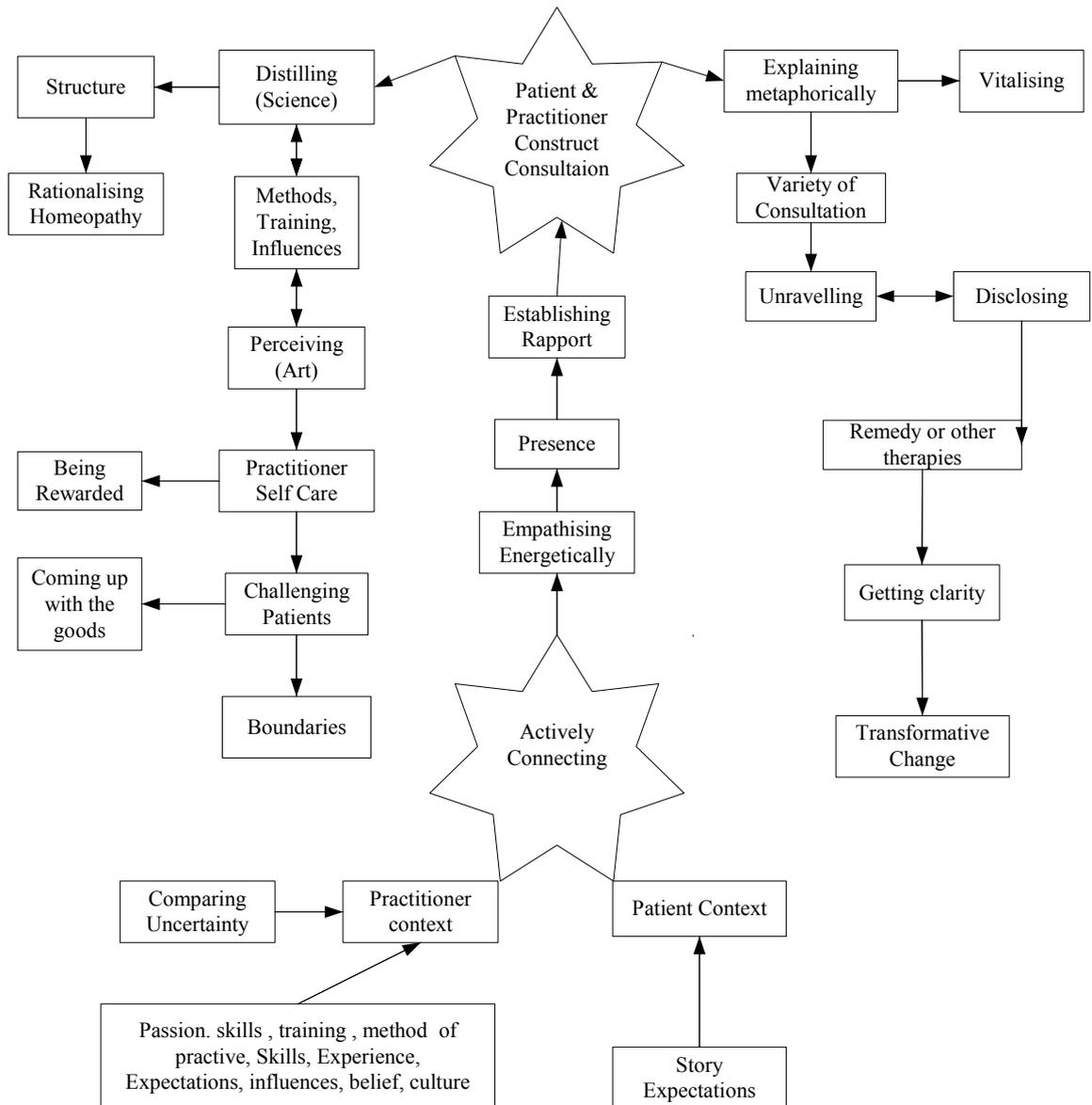
South Wiltshire	PCTRDMC06/05/06	28 th June 2005
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University College London Hospitals NHS Foundations Trust

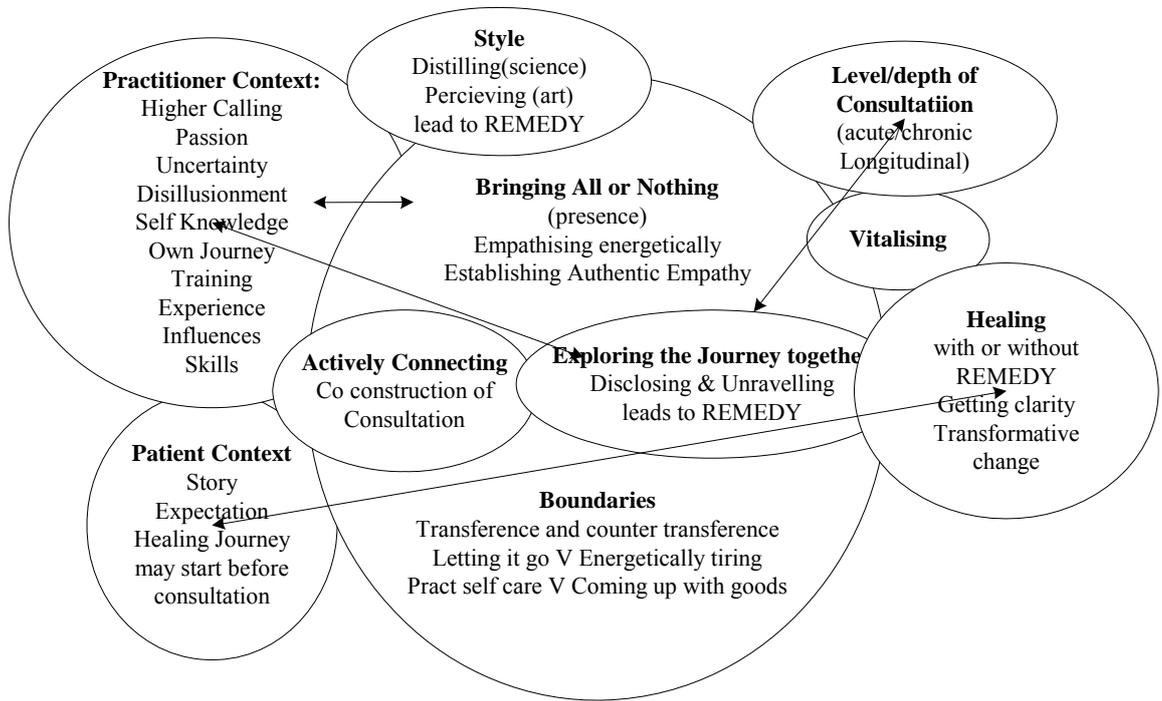
	05/0081	15 th November 2005
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Appendix 24 Diagramming to develop theoretical coding

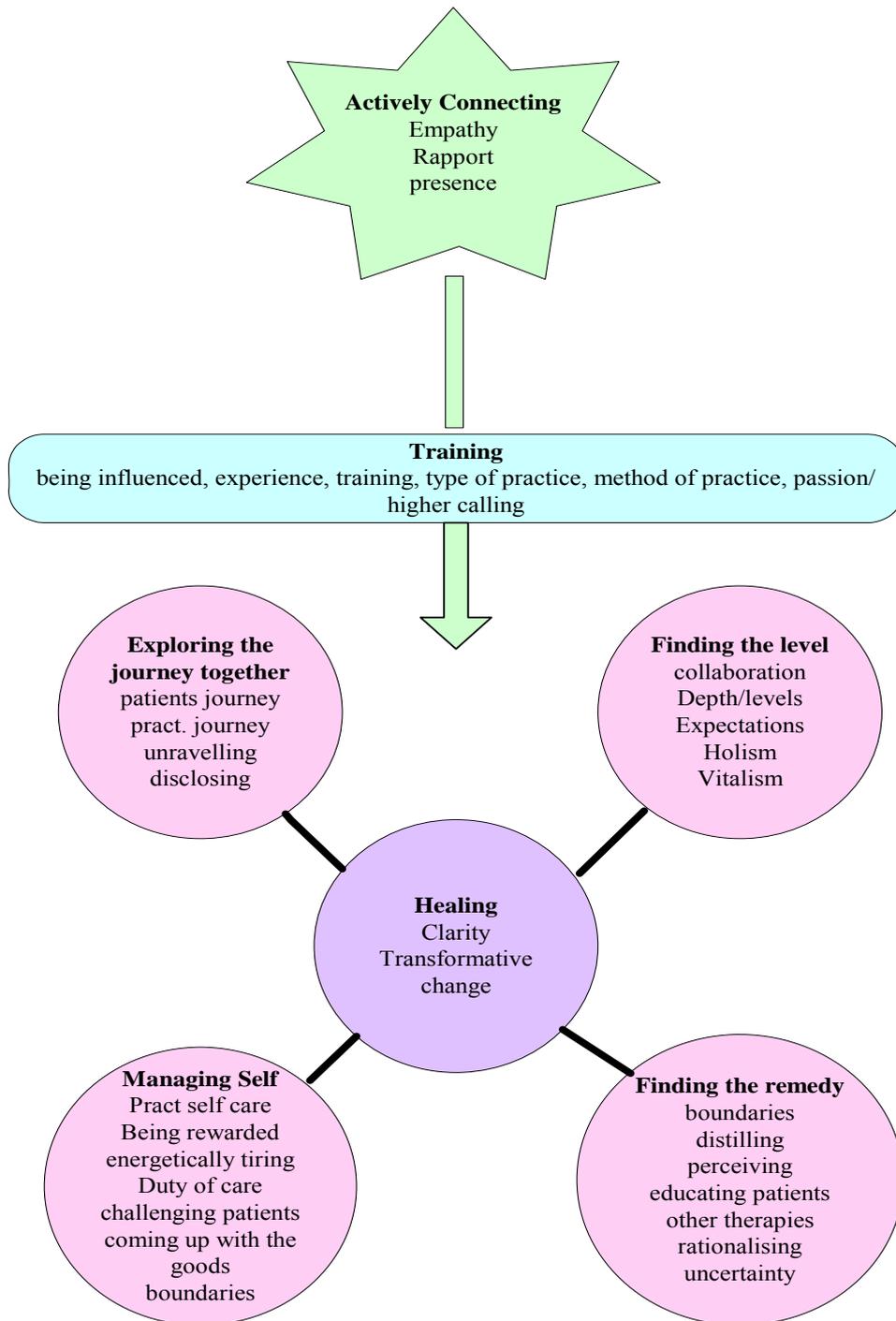
Development of theoretical coding - Part 1



Development of theoretical coding - Part 2



Development of theoretical coding - Part 3



Appendix 25 List of participants

Interview/Observation/Diary Participants Pseudonym	Profession	Type of practice
Int 1 Maggie	Non medical homeopath	Private
Int 2 Rosalind	Non medical homeopath	Private
Int 3 Joanne	Non medical homeopath	Private
Int 4 James	Medical homeopath	Private/NHS
Int 5 Susan	Non medical homeopath	Private/NHS
Int 6 Anne	Medical homeopath	NHS
Int 7 Catherine	Medical homeopath	Private
Int 8 Jonathan	Non medical homeopath	Private/NHS
Int 9 Peter	Medical homeopath	Private/NHS
Int 10 Steffie	Medical homeopath	Private
Int 11 Roger	Medical homeopath	Private
Int 12 Yanisa	Non medical homeopath	Private
Int 13 Sarah	Non medical homeopath	Private
Int 14 Julia	Non medical homeopath	Private/NHS
Int 15 Tricia	Non medical homeopath	Private
Int 16 Sally	Medical homeopath	Private/NHS
Int 17 Richard	Medical homeopath	NHS
Int 18 Christine	Medical homeopath	NHS
Int 19 Wendy	Medical homeopath	Private/NHS
Int 20 Alan	Medical homeopath	Private
Int 21 Judith	Non medical homeopath	Private
Int 22 Diana	Veterinary homeopath	Private
Int 23 Cassie	Non medical homeopath	Private
Int 24 Ruth	Non medical homeopath	Private
Int 25 Helen	Non medical homeopath	Private

Diary 1 Beth	Non medical homeopath	Private
Diary 2 Caroline	Non medical homeopath	Private
Diary 3 Yanisa	Non medical homeopath	Private
Diary 4 Steffie	Medical homeopath	Private
Ob 1 & 2 Caroline	Non medical homeopath	Private
Ob 3 & 4 Robert	Non medical homeopath	Private
Ob 5 Clare	Non medical homeopath	Private
Informal Conversation 1 Jodie	psychotherapist	Private
Informal Conversation 2 Martin	Medical Homeopath	NHS

Glossary of definitions of key terms and concepts

Category	Is a conceptual label given to higher order concepts which are grouped together.
Classical Homeopathy	A form of homeopathic practice derived from the teachings of Samuel Hahnemann (the founder of homeopathy) which uses individualized prescription of single remedies.
Complex intervention	An intervention that consists of multiple components and that may have many potential "active ingredients".
Concept	Is a descriptive or explanatory idea, often developed from open codes.
Constructivist grounded theory	An approach to using grounded theory that assumes that both participants and researchers construct the realities in which they participate.
Context effects	Refers to effects that may occur, such as healing, as a result of the clinical encounter and the practitioner patient relationship.
Grounded theory	Is a methodology for developing theory that is grounded in the data. It is particularly suited for researching the contexts and processes of interactions.
Holism	Homeopaths view holism as representing the person's "totality", physically, emotionally, mentally, socially, environmentally energetically and spiritually.
Homeopathy	Homeopathy is a form of complementary and alternative medicine in which an individualized remedy is deduced during the course of a consultation. Homeopathy is a holistic medicine that aims to assist the natural tendency of the body to heal itself.
Like cures like	The law of similars is a fundamental principle of homeopathy which states that any substance that can cause symptoms in a healthy person and treat those symptoms in a sick person.
Meaning Response	Refers to responses that people experience as a result of the meanings that they attach to their interventions or treatments.
Non specific effects	Refers to benefits that occur through no direct causal relationship with a specific drug or intervention and may be related to factors such as spontaneous remission, the natural course of symptoms and the therapeutic relationship.

Open coding	The first stage of coding in grounded theory which involves assigning labels to portions of text.
Placebo	An inert substance, treatment or intervention.
Placebo effect	Refers to changes or any beneficial effects that occur after administration of a substance or treatment thought to be inert or without therapeutic effect or as if it was real treatment.
Potentisation	A process of sequential dilution of substances to produce different potencies (strengths) of homeopathic remedies.
Qualitative research	An interpretive approach that focuses on the way people interpret and make sense of their experiences and the world which they live in, encompassing many methodologies including grounded theory, ethnography and phenomenology
Reflexivity	Consists of critically examining one's own assumptions and actions by being self conscious and self aware during the research process.
Rituals	Any practice or pattern of behaviour regularly performed in a set manner that may not have any overtly technical effect.
Skill	The ability coming from one's own knowledge, practice or aptitude to do something well.
Specific effects	Refers to any beneficial effect that is derived from the intervention; drug, procedure or remedy.
Strategy	A plan of action intending to accomplish a specific goal.
Succussion	A process of vigorous shaking of each dilution of homeopathic remedy to assist in the production of different potencies (strengths).
Symbolic interactionism	A theoretical perspective which assumes that people construct selves, society and reality through interaction. It focuses on dynamic relationship and addresses processes and roles.
Symbols	Something that is used for or regarded as representing something else.
Theoretical model	Is a visual representation of a reality, through the grouping of related concepts and categories that have explanatory power.
Theoretical sampling	A type of sampling which aims to develop the properties of the developing categories.

Theoretical saturation	Refers to the point at which gathering more data about a theoretical category reveals no new properties or insights.
Vital force	An animating life force within living beings

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