UNIVERSITY OF SOUTHAMPTON

FACULTY OF MEDICINE, HEALTH AND LIFE SCIENCES

School of Nursing and Midwifery

Searching for Effective Health Care: A Hermeneutic Study of Traditional Herbalism in Contemporary British Health Care

by

Christine Vanessa Little

Thesis for the degree of Doctor of Philosophy

May 2007

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

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SEARCHING FOR EFFECTIVE HEALTH CARE: A HERMENEUTIC STUDY OF TRADITIONAL HERBALISM IN CONTEMPORARY BRITISH HEALTH CARE

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Prevalence studies confirm the increasing popularity of complementary therapies in the United Kingdom and other westernised societies but, despite this, the fundamental reasons behind this continuing trend remain inconclusive and sometimes contradictory. In response, this study focuses on people who consult with registered medical herbalists and, in particular, it explores their reasons for doing so.

Set in the south of England, the study applies an interpretive research methodology to expose the views of 19 adults, who were interviewed in relation to their experiences of medical herbalism. The study reveals how participants discriminated between acute health care, which was adequately provided in the conventional setting, and everyday health care, which they found in medical herbalism. Participants valued medical herbalism for its perceived effectiveness; where effectiveness was defined according to participants' personal criteria, where it was judged according to their personal experiences of improved health and well-being and where confidence in its healing potential was reinforced by knowledge of its enduring history. In medical herbalism, participants also experienced a patient-practitioner relationship that was founded on corresponding ideas about the nature and purpose of health care. Being conducive to the development of mutual understanding, the nature of this relationship therefore emerged as a central factor in the provision of effective health care, especially in relation to the individualisation of health care treatment.

The study suggests a complementary relationship between herbal and conventional health care but signals a desire for a medical pluralism that has the potential to accommodate participants' health care needs in totality. It offers an alternative patient perspective on health care: one that emphasises the importance of consensus and self-determination but that also recognises the necessity for health care to have relevance and meaning, from the patient's unique perspective.

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With thanks to Andree le-May and Tony Frew for their support and guidance in completing the study and also to personnel within Bournemouth University and the University of Southampton, who helped in securing time and financial contributions that were essential to the study's completion.

Thanks also to the support provided by a number of friends, particularly Stephen, Oliver and Max, who all helped in their own, very special ways. Of most importance, tremendous gratitude to the study participants, whose enthusiastic participation made the study possible. Without them, the study would have neither substance nor purpose.

Definitions

Alternative health care	See Complementary and Alternative Medicine (CAM)
Alternative medicine	See Complementary and Alternative Medicine (CAM)
Alternative therapy	See Complementary and Alternative Medicine (CAM)
Complementary and Alternative Medicine (CAM)	Health care therapies and practices that are not generally encompassed within the dominant health care system of a society
Complementary therapies	See Complementary and Alternative Medicine (CAM)
Conventional medicine	Health care that is endorsed and provided for by the dominant health care system of a society
Conventional health care	See Conventional Medicine
Herb	Plant material having therapeutic value
Herbalism	See medical herbalism
Mainstream medicine	See Conventional medicine
Medical herbalism	The therapeutic use of herbs in the treatment of illness
Non-conventional medicine	See Complementary and Alternative Medicine (CAM)
Non-western herbalism	Herbal health care that is based on beliefs and practices other than those inherent to western herbalism. These predominantly encompass Chinese, Tibetan and Ayurvedic traditions
Orthodox medicine	See Conventional medicine
Over-the-counter (OTC)	Therapeutic preparations obtained through retail outlets for the purposes of self-medication
Western herbalism	The herbal health care tradition indigenous to the United Kingdom and other Westernised societies
Western medicine	The modern (biomedical) health care system that is dominant within the United Kingdom and other Westernised societies
Western health care	See Western medicine

1 INTRODUCTION

In this study I explore the use of traditional, western medical herbalism in the context of contemporary, conventional health care in the United Kingdom. Set in a defined geographical area of southern England, I focus on a small number of adults who consult with registered medical herbalists and, in particular, I clarify their reasons for doing so. Utilising a hermeneutic, phenomenological methodology, the study is essentially of a reflexive nature, whereby I acknowledge the influence of subjective and inter-subjective elements on the research process. I concur with the view that the researcher's behaviour affects research participants' responses (Finlay 2002) and that interviews augment, rather than merely reflect, participants' experiences (Beer 1997). Consequently, I acknowledge my contribution to data generation, the impact of which I evaluate through reflexive practices, which enhance the overall integrity of the research.

1.1 Rationale for Undertaking the Study

I planned this study in response to the well-documented rise in the popularity of medical herbalism, and other complementary therapies, in westernised populations. I was motivated particularly by my own long-standing interest in medical herbalism and also following my observation that lay and professional perspectives on complementary therapy use can be inconsistent. In particular, it was the array of (often competing) perspectives in the literature about the nature, purpose, effectiveness and safety of non-conventional therapies that brought me to question the extent to which these views actually reflected the consumer perspective. This uncertainty was further reinforced during my own academic activities (Little and Parsons 2001, Little et al 2001) and by hearing patients' concerns about their limited opportunity to influence matters in relation to their own health care. I concluded from these reflections that the complementary therapy-related literature might not present a fair representation of the consumer perspective and this, coupled with my own long-standing interest in medical herbalism, provided the impetus to explore the phenomenon of herbal health care, from their perspectives. I summarise the influence of these experiences on the study process in a decision trail (Appendix 1: Section 1).

It is also my view that an unambiguous understanding of the consumer perspective is imperative if the provision of health care is to remain responsive to their needs. At a time when the regulation of medical herbalism is under review (Department of Health 2005, Department of Health 2004), this clarity of understanding becomes equally crucial in the context of complementary, as well as conventional, health care. In this study, I illustrate, clarify and privilege the consumer perspective as a means to enhancing that understanding.

In planning the study, I also respond to the current research agenda for complementary and alternative medicine in the United Kingdom, which is driven primarily by the Department of Health in association with the Prince of Wales's Foundation for Integrated Health (FIH). In the discussion document *Integrated Healthcare: A Way Forward for the Next Five Years?* the Foundation for Integrated Health encouraged integration between conventional and complementary health care and promoted the active involvement of patients in their own health care (Coates and Jobst 1998). The Foundation also published a national research strategy (Foundation for Integrated Medicine 2000), which coincided with the report on complementary and alternative medicine published by the House of Lords Select Committee on Science and Technology (2000). Subsequently, the Foundation recommended priorities for future research, endorsing the need for studies on safety, efficacy, cost effectiveness, professional regulation and standards of training but also emphasising the importance of exploring the consumer perspective on complementary health care issues (Coates and Jobst 1998). Furthermore, the Foundation also identified five major disciplines for initial research and regulation: herbalism, acupuncture, homeopathy, chiropractic and osteopathy and urged the use of alternative research methodologies where these are appropriate to study purpose (Coates and Jobst 1998). I would argue that this prioritisation is consistent with the suggestion that herbalism is one of the most popular complementary therapies in both the United States (Eisenberg et al 1998, Eisenberg et al 1993) and the United Kingdom (Ernst and White 2000, Thomas et al 1993) and that it lends credibility to the view that herbalism is an increasingly popular health care choice outside mainstream medicine (Capriotti 1999, Ernst 1999).

The study addresses the Foundation's research agenda in several ways and I draw on their recommendations in rationalising the timeliness of the current study, which:

- Focuses on one of the complementary therapies identified as a major health care discipline in the United Kingdom
- Addresses an identified gap in the current evidence-base for complementary and alternative medicine
- Explores the consumer perspective
- Applies a research design that is highly appropriate to the study aims.

My overall aim in designing the study is to enhance understanding about the increasing popularity and use of medical herbalism, in the context of contemporary health care in the United Kingdom. I achieve this by addressing the following objectives which, consistent with hermeneutic phenomenology, were broadly framed at the outset of the study:

- To contribute to the complementary therapy knowledge-base, consistent with the current research agenda
- To present a consumer perspective on complementary therapy use
- To provide insight into people's experiences of using medical herbalism and to explore their reasons for doing so
- To clarify contradictions in the literature by eliciting meaning implicit to participants' accounts of their health care experiences
- To interpret the significance of the study's findings to contemporary health care in the United Kingdom by expanding on propositions raised from the research data.

1.2 The Context of the Study

The evolution of health care in westernised society reflects a transition from early traditional systems that relied largely on natural resources and local knowledge, towards the biomedical model of scientific and technological health care that is evident today. As an example of traditional health care, the therapeutic use of plants as medicine spans history and crosses the boundaries of most civilisations; amongst Europeans, medical herbalism constitutes the main approach to traditional health care practice (Gruber and DerMarderosian 1996). In many societies, traditional herbalism represents mainstream health care provision but, in westernised societies, this has become largely replaced by biomedical health care and modern pharmacology. In recent years, however, medical herbalism has enjoyed renewed interest as part of a general demand by the public for the provision of a range of non-conventional therapies, collectively referred to as complementary and alternative medicine.

1.2.1 The Scope and Meaning of Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) is an umbrella term that encompasses more than 100 different forms of health care treatment (BMA 1993). A common definition of the term is elusive, ranging from those that focus on fundamental health care values to those that are concerned with how and where health care is delivered. American and European societies commonly describe health care as complementary or alternative according to whether or not it is routinely delivered within mainstream health care services. In theory, this definition allows for flexibility between different societies based on their respective determinants of what constitutes 'mainstream'. In practice, it is argued that health care is acknowledged as mainstream only when it can be legitimised according to western biomedical principles (Saks 1997, Verhoef and Page 1996, Eisenberg et al 1993). Another difficulty in assigning clear distinctions between complementary, alternative and conventional health care relates to the absence of core principles to which all complementary and alternative therapies subscribe (Scottish Office Department of Health 1996, BMA 1993). In response to these concerns, a working group was established to debate and clarify the terminology in an attempt to agree a suitable, working definition (Panel on Definition and Description 1997). The Panel acknowledged the likelihood of conflicting interpretations in a field as large, diverse and dynamic as complementary and alternative medicine and they emphasised the temporary nature of such definitions, given that the usage of complementary and alternative medicine will inevitably change over time. Despite these difficulties, they proposed the following definition:

> "Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed."
>
> (Panel on Definition and Description 1997, p50)

There is further disagreement about how the terms 'complementary' and 'alternative' should be distinguished. In the United States and Canada, the two terms tend to be used interchangeably whilst, in the Netherlands, all non-conventional therapies are viewed as complementary, largely on the basis that most are practised within or alongside orthodox medicine (Schepers and Hermans 1998). In the United Kingdom, The British Medical Association suggests a distinction between the two terms, depending on whether they are used as an adjunct to mainstream health care (complementary) or whether they are used in preference to mainstream health care (alternative) (BMA 1993). Others demand a more rigorous distinction, arguing that it is inappropriate to consider complementary and alternative practices together (Cassileth 1999). According to Cassileth, complementary therapies are "typically pleasant, non-toxic and beneficial" in comparison to alternative therapies, which she views as being "physiologically active, potentially harmful and in conflict with mainstream care" (Cassileth 1999, p35). She believes that, at best, alternative therapies are wasteful of patients' time and a waste of resources. Drawing distinctions between complementary and alternative therapies according to their comparative safety and efficacy is difficult, however, due to non-conventional health care being generally under-researched in this respect (Berman et al 2000, Ernst 1997). Saks (1997) also urges caution in making distinctions between therapies according to whether they are perceived as either complementary or alternative. Firstly, he argues that a single, broad term that embraces all non-conventional therapies obviates the requirement to make judgements about which therapies complement conventional medicine and which do not, according only to the perspective of western practitioners. He also contests the view that some therapies can be viewed as complementary to conventional medicine, since none receive comparable research funding and none are equally represented in the undergraduate curriculum. Aptly summed up by the Panel on Definition and Description (1997) the differences between alternative and complementary are largely circumstantial[1].

The relative lack of consensus in defining complementary and alternative medicine is also evident in discussions about the meaning of medical herbalism. According to the World Health Organisation a medical herbal preparation is:

> "A plant-derived material or preparation with therapeutic or other human health benefits, which contains either raw or processed ingredients from one or more plants."
>
> (World Health Organisation 1993, p4)

This definition, however, fails to capture the essence of traditional herbalism, which is described in terms of treating underlying illness causation by supporting the body's own healing ability (Hoffmann 1990). The current regulatory working group for medical herbalism in the United Kingdom also reflects this philosophy in describing herbalism as patient-centred, where the therapy is "...directed at the causes (of illness)..." and the prescription is determined by "... an understanding of the significance of the signs and symptoms in that individual ..." (Herbal Medicine Regulatory Working Group 2003, p30). The working group also emphasises the individualised nature of the herbal prescription, which is frequently supported by additional health care advice. Medical herbalism aims to "... support and revive the innate healing process and power of mind, body and spirit" (Herbal Medicine Regulatory Working Group 2003, p31) and it therefore differs fundamentally from the use of plant materials in the modern pharmacology of biomedicine. Traditional medical herbalism has also been distinguished from modern phytomedicine, with the former being firmly based in empiricism and thriving on intuition and individualised plant mixtures and the latter entailing a rational approach to the application and research of medical plant products (Ernst 1999).

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[1] In this thesis the term 'complementary therapy' is favoured, partly in recognition of the tenuous nature of the distinctions proposed in the literature and partly to avoid the biasing nature of the term 'medicine.'

1.3 Organisation of the Thesis

The thesis comprises a further five chapters:

- Chapter 2 outlines the current prevalence of complementary therapy use in westernised society and evaluates the literature that explores people's reasons for this health care trend. This chapter substantiates the rationale for the current study
- Chapter 3 provides an account of the study design, which is rationalised in the context of the study purpose
- Chapter 4 presents the study findings
- Chapter 5 provides a substantive discussion that interprets the study data in relation to the literature
- Chapter 6 summarises and concludes the study and proposes implications for future practice and ongoing research.

The main chapters of the thesis are supported by additional appendices that elaborate on selected elements of the study, as appropriate.

2 LITERATURE REVIEW

Consistent with the principles of qualitative and phenomenological study, the primary literature review occurred in response to the study findings and is therefore integrated into the main discussion. The preliminary literature review presented here therefore provided a useful means to engage with the subject matter prior to commencing the study, without unduly influencing the direction of subsequent enquiry. The review serves two main purposes:

1. It summarises the conclusions derived from prevalence studies, as a means to situate the study in the broader context.

2. It evaluates studies that specifically explore the reasons for people's use of complementary therapies in order to establish the strength of current evidence. This body of literature substantiates the rationale for the current study by ascertaining the study's appropriateness and uniqueness at the present time.

2.1 Search Strategy

With the exception of efficacy and effectiveness studies, information about the use of medical herbalism tends to be subsumed within the body of literature that addresses complementary therapy use in general, the majority of which emanates from the United States of America, Canada and various parts of Europe. This observation is evidenced by Ong and Banks (2003), whose literature review identified herbalism-specific studies only in relation to prevalence statistics and health outcome measures but not in relation to motivational data. Similarly, the literature search for the current study failed to reveal a single study that specifically explored the reasons for people's use of herbalism. To maximise capture of relevant material the search strategies for locating prevalence and motivational studies therefore aimed for high recall at the expense of low precision by seeking studies on complementary therapies as well as herbalism and by including non-British studies (Appendix 2). Since the function of the prevalence studies was to provide a broad, contextual perspective, these were identified in accordance with the search strategy alone. The motivational studies, having a more substantive function, were filtered against pre-determined inclusion criteria to ensure their relevance to study purpose (Appendices 3, 4 and 5).

To maintain consistency, studies were appraised in accordance with published critical appraisal frameworks appropriate to their methodology (Milton Keynes Primary Care Trust 2002) or, in the case of survey studies, were evaluated against criteria derived from the literature (Appendix 6). Data extraction forms were designed specifically for this study and provided a means for recording both the study data and the outcomes from quality appraisal (Appendices 7 and 8).

2.2 Prevalence and Patterns of Use of Complementary Therapies in Westernised Society

The popularity of complementary therapies within the westernised population is well documented, the literature reflecting common trends across most of the western continents (Ernst and White 2000, Eisenberg et al 1998, MacLennan et al 1996, Vickers 1994, Eisenberg et al 1993). Of particular importance is the observation that the use of complementary therapies is noted to have significantly increased in westernised society in recent years (Coates and Jobst 1998) although a more recent systematic review of the literature identified that reliable prevalence statistics were evident in only three studies (Harris and Rees 2000). These studies revealed that complementary therapies were used by up to half of the population in southern Australia (MacLennan et al 1996) and by approximately 34% of the American population (Eisenberg et al 1993). The American study was replicated in 1997 to reveal that the overall rate of use of complementary therapies had risen from 34% to 42% with an increase in practitioner consultations from 36% to 46% (Eisenberg et al 1998). The same two studies reported the rate of use of herbal therapies to have increased by 380% during the same period. In 2005, Tindle et al (2005) reported that the overall use of complementary therapies in the United States (at around 35%) had remained stable since Eisenberg et al's 1997 study and that herbalism had remained the most popular complementary therapy (19%) followed by relaxation therapies (14%) and chiropractic (7%). The greatest increase in use was also seen in herbalism (from 12% to 19%), with self-medication amongst herbal users increasing from 85% to 95%.

Although there are few reliable studies specifically relating to patterns of use within the United Kingdom and Europe (Ernst and White 2000, Coates and Jobst 1998) these do suggest a similar trend. Vickers (1994), for example, reports on four prevalence studies undertaken in the United Kingdom during the mid to late 1980's. In 1986 a Gallup poll reported that 14% of the population had consulted with a complementary therapist while a regional prevalence study in Cardiff, also carried out in 1986, reported complementary therapy use to be in the region of 2.6%. One year later, in 1987, an RSGB Omnibus study reported national prevalence to be as high as 34% and in 1989 a MORI poll reported a similar prevalence of 28%. More recently, a national study that focused on a limited number of complementary therapies estimated public use to be approximately 8.5% during the preceding 12 months and 16.9% for lifetime use (Thomas et al 1993). In addition to people who visited complementary therapists, Thomas et al also found that a further 25% of respondents reported over-the-counter use of homeopathic or herbal remedies. In common with the replicated American studies (Eisenberg et al 1998, Eisenberg et al 1993), these statistics were seen to have increased from 8.5% in 1993 to 10.6% in 1998 (Thomas et al 2001). The most recent findings that report on a national scale are drawn from a market research telephone survey conducted by the British Broadcasting Corporation (BBC) during the summer of 1999 (Ernst and White 2000) and from an Omnibus survey a few years later (Thomas and Coleman 2004). The study reported by Ernst and White (2000) indicated that approximately 20% of their 1204 respondents had used complementary therapies within the previous year, 6% of whom reported that other member(s) of their household had also used complementary therapies in the same period. Regional differences were reported as 23% prevalence in the north of England compared with 26% in the midlands and 30% in the south. Notably, 78% of respondents in this study reported that their use of complementary therapies had increased during the previous five years. A cautious extrapolation of national annual expenditure on complementary therapies was estimated to be £1.6 billion. According to the study reported by Thomas and Coleman (2004), national prevalence was around 10%, 6.4% of whom had used one of the five major therapies previously identified (see: Section 1:1, Rationale for Undertaking the Study). Other regional statistics suggest a prevalence of complementary therapy use in around 7.8% of the population across the counties of Berkshire, Buckinghamshire, Northamptonshire and Oxfordshire (Ong et al 2002) and in 48% of the population in a defined area of Scotland (Featherstone et al 2000). Although an increasing interest in complementary therapy use is clearly indicated in these studies, a particular difficulty in drawing meaningful conclusions from these statistics relates to the specification of different time spans in accounting for people's actual use of complementary therapies. With time spans ranging between one month (Featherstone 2000) and lifetime use (Thomas et al 2001), this inconsistency makes it difficult to establish prevalence with any certainty. As Thomas and Coleman (2004) point out, these differences are more likely to be due to variations in research methodology rather than overall poor reliability of the results.

Many prevalence studies also report on patterns of use, especially in terms of user characteristics. Women are generally found to be more frequent users of complementary therapies than men, estimated to be in the region of 60-65% (Ong et al 2002, Ernst and White 2000) although these proportions are not too dissimilar from the ratio of female attendees at general practitioner surgeries or outpatient departments (Peterson et al 1998). People in the age bracket of 35-44 years are also thought more likely to use complementary therapies (Ong et al 2002) although another recent study found a much more even age distribution with the exception of slightly fewer users under the age of 34 years (Sharples 2003). In addition to the regional differences already reported, complementary therapy use is also considered to be higher in people residing in the south of England (30%) compared to those living in the midlands (26%) or the north of England (22.5%) (Ernst and White 2000) and amongst professional or clerical workers in comparison to those in semi-skilled, skilled or manual employment (Ong et al 2002, Ernst and White 2000). Although it has been reported that complementary therapies are used for the treatment of multi-system conditions and for the maintenance of well-being (Ong and Banks 2003) it is widely believed that people are mostly motivated by the failure of conventional medicine in the treatment of chronic conditions (White 1998).

The underlying reasons for the increasing popularity of non-conventional therapies are unclear although user characteristics reported in prevalence studies are often interpreted as predictors of use. Other authors propose, very broadly, that people resort to complementary therapies either because of a general dissatisfaction with conventional medicine (Capriotti 1999, Rao et al 1998, Boisset and Fitzcharles 1994, Murray and Wrubel 1992) or because they have a natural attraction towards non-conventional treatments (Capriotti 1999, Astin 1998, Verhoef and Page 1996, Furnham and Beard

1995, Aldridge 1990). Capriotti (1999) suggests that this increasing interest may also be a reflection of expanding cultural diversity in the West. It is notable, however, that this body of literature presents inconsistent and contradictory evidence in relation to complementary therapy use. In particular, the assumption that most people are motivated to use complementary therapies as a result of ineffective conventional treatment for chronic illness (White 1998) is countered by the suggestion that complementary therapies can provide first-line and/or preventative health care (Eisenberg 1998, MacLennan et al 1996), suggesting that the reasons for people's use of complementary therapies may be more complex than first appears.

2.3 The Reasons for People's use of Medical Herbalism in Westernised Society

The 13 motivational articles reviewed were published between 1996-2003 and they reported either on complementary therapy use in general (mixed populations) or on complementary therapy use in specified diagnostic groups (population-specific). Since the emphasis in these two groups is fundamentally different, the two sub-groups are evaluated independently of one another.

2.3.1 Mixed Population Studies

The seven mixed-population studies included five cross-sectional surveys, one qualitative study and one literature review and were undertaken in the United Kingdom (four studies), Canada (two studies) and Germany (one study). Every study in this sub-group reported multiple reasons for people's use of complementary therapies and these, in common with the prevalence studies, reflected both dissatisfaction with conventional medicine and attraction to complementary health care, described in the literature as 'push' and 'pull' factors, respectively. In these studies, push factors included ineffectiveness or side-effects of conventional medicine and problems with the patient-doctor relationship. Pull factors included the desire to participate in, or maintain control of, their health care and a preference for holistic or natural treatments.

The only factor identified across all seven studies, and identified as the most important in three, was the push factor 'ineffectiveness of conventional medicine.' Mitzdorff et al (1999) surveyed 200 patients in two German complementary therapy hospitals. Despite the two hospitals being fundamentally different – one providing western complementary therapies and the other providing traditional Chinese medicine - sample characteristics of the two groups were remarkably similar with the exception of age, where younger patients (30 years or under) prevailed in the western therapies group compared to those in the Chinese therapies group (51-70 years). For these reasons, data were considered for the group as a whole. Mitzdorff et al found that 68% of their respondents identified ineffectiveness of conventional medicine as a major reason for turning to complementary therapies. This was also reflected indirectly by 80% of the sample, who stated that they hoped to be able to achieve a favourable outcome with complementary therapy. The incidence of previously ineffective treatment might be expected to be quite high, however, in a study such as this, that included only hospital in-patients. The questionnaire, which comprised only closed questions, was supplemented by an assessment of respondents' personality traits, which were compared to earlier studies of healthy people and to studies of people with cancer. Unsurprisingly, this showed the incidence of anxiety and depression to be higher in complementary therapy patients than in healthy people but to be lower than in people with cancer. There was a tendency, rather questionably, to equate these traits to motivational factors and, although comprehensively reported in many respects, discussion around motivational aspects was disappointingly sparse.

Of the two remaining studies that reported ineffectiveness as the most important push factor, Sirois and Gick (2002) found this to be cited by 42% of complementary therapy users (n = 196) in their Canadian survey across a number of mainstream and complementary health practices. They found little difference between new and established users. A British study, which was reported only briefly, reported the same motivating factor in 62% of 499 outpatients who attended complementary therapy clinics at the Royal London Homeopathic Hospital (Sharples et al 2003). As with Mitzdorff et al's study, Sirois and Gick's survey is potentially limited by the inclusion of only one open question and by the requirement for impromptu completion of questionnaires, which necessarily precluded individuals with insufficient time or understanding about the study implications. They also showed a similar tendency to relate user characteristics to predictors of use. Interestingly, the authors chose to report only on three out of six motivational statements; the two most frequently endorsed and the one least frequently endorsed.

Arguing against the study of complementary therapy users as a homogeneous group, two further studies included sub-group analyses in relation to the use of different types of complementary therapy. In the United Kingdom, Vincent and Furnham (1996) revealed that concerns about ineffectiveness of conventional medicine were more likely to be voiced by people attending homeopaths, in comparison to those attending osteopaths or acupuncturists, and also that these concerns were raised only in relation to their current condition. Survey questions had been derived predominantly from previous research and included 20 motivational statements, each to be ranked on a scale of 1-5 (1 = not at all important, 5 = extremely important). Although some questions had been influenced by preliminary interviews, the report included little detail about this process, making it difficult to ascertain how these contributed to questionnaire design. Similarly, there was insufficient detail included to ascertain the extent of data analysis. In the second of the two Canadian surveys, ineffectiveness of conventional medicine was the only push factor to be identified (Kelner and Wellman 1997). In this study, 22% of the total sample (n = 300) stated that they had been driven away from mainstream medicine as a result of their desperation to find an effective therapy. Sub-group analysis showed that this was particularly the case for people visiting naturopaths (33%) and acupuncturists (33%) but less so for those seeing Reiki practitioners (10%) or chiropractors (9%). Interview content was not disclosed but technique was semi-structured, with data being analysed from a predominantly quantitative perspective. Although very clearly discussed, much of the data were explained in the context of the Anderson and Newman socio-behavioural model with a lesser proportion devoted to motivational aspects.

Importantly, all but one of the surveys (Sharples et al 2003) relied exclusively or predominantly on closed questions, limiting the extent to which respondents were able to elaborate on their responses, a limitation addressed by the single qualitative study in this group (Paterson and Britten 1999). Part of a wider study, they interviewed 20 patients of complementary therapy practitioners in the south-west of England, who had been purposively selected from 12 community-based complementary therapy practitioners, to provide a maximum variation sample. The purpose of the study was to allow people to describe their experiences of illness and treatment and this was achieved through semi-structured interviews, which included open questions. Data collection and analysis involved the constant comparative method, analysis being undertaken within a temporal framework that tracked participants' experiences over time. Their study revealed that some participants had experienced, or had doubt about, the effectiveness of conventional medicine and, in common with the respondents in Vincent and Furnham's (1996) survey, this tended to be in relation to the treatment of their current condition. Others had felt rejected by conventional medicine or had been discouraged by the risk of side-effects from conventional treatment. The authors highlighted how some patients make their own judgements about risk, pointing out that health care professionals often make value judgements about treatments on the patient's behalf. What their study suggests is that, in making their own judgements about risk and side-effects, patients might be indicating a desire for greater autonomy in health care decision-making.

Other push factors identified in the mixed-population studies included the occurrence of side-effects from conventional medicines and issues concerning the patient-doctor relationship. According to the survey undertaken by Sharples et al (2003), 26 % of patients reported being attracted to complementary therapies as a consequence of experiencing adverse effects following conventional treatment, whilst a further 47% expressed concern about this possibility. Vincent and Furnham (1996) also identified that the risk of side-effects was a particular concern to people visiting homeopaths, who tended to express a general feeling of despair, and to those visiting acupuncturists, who expressed scepticism about conventional medicine as a whole. Similarly, interviewees in Paterson and Britten's (1999) study identified unacceptable side-effects of conventional medicine as one of the main reasons for seeking alternative treatments particularly in respect of the use of steroids.

Concerns in relation to the patient-doctor relationship emerged in the studies undertaken by Mitzdorff et al (1999) and Sirois and Gick (2002) although the extent of these concerns differed sharply between the two studies. While 53% of Mitzdorff et al's respondents were unhappy with the patient-doctor relationship, this was reported by only 7% of those surveyed by Sirois and Gick. In addition, a considerable 67% of Mitzdorff et al's respondents also reported dissatisfaction about their doctor's attitude to complementary therapies. Both issues were also mentioned by Vincent and Furnham (1996) but, unfortunately, they failed to provide further details of these particular findings.

In respect of pull factors, the reason cited most frequently by Sirois and Gick's sample was being able to take a more active role in one's personal health care (52%), a view shared by 59% of Kelner and Wellman's (1997) respondents, who reported being involved in pro-active and preventative health care activities and who recognised their personal responsibility for health care decisions. In this study, only 20% of people visiting complementary therapists viewed their family physician as being responsible for this, in comparison to 70% of those visiting family physicians (general practitioners). Of those who consulted with Reiki practitioners, 58% identified personal responsibility as a major reason for using complementary therapies. A desire for personal control was also identified by Paterson and Britten (1999) although, in their study, this appeared to emerge only after complementary health care had commenced, suggesting that this might not have been a primary reason for their use of complementary therapies. However, their suggestion that concerns about efficacy and side-effects might indirectly reflect a more deep-seated desire for autonomy and control in health care cannot be discounted.

Only two of the pull factors cited for using complementary therapies related specifically to the nature of the therapy itself. Both Kelner and Wellman (1997) and Vincent and Furham (1996) identified the concept of holistic therapy as an important motivating factor whilst the respondents in Vincent and Furnham's study also identified the natural origin of complementary therapies as an additional attraction. Of the 28% of Kelner and Wellman's sample who revealed an attraction to holistic health care, this was found to be reported mostly amongst those receiving Reiki (38%), naturopathy (30%) and acupuncture (23%) but less so amongst those visiting chiropractors (12%).

Building on the findings of these primary studies, the Prince of Wales's Foundation for Integrated Health developed a brief for a pilot survey of grey and unpublished studies on the use of complementary therapies amongst the general public. Undertaken by Ong and Banks (2003), the study addressed a number of questions about the use of complementary therapies, one of which specifically explored the underlying reasons for this trend. The authors, who identified the prevalence surveys undertaken by Thomas et al (2001) and Ernst and White (2000) as being representative of the usual approaches to this research question, suggest that the user perspective can be more uniquely reflected by drawing together the findings of these smaller studies. Despite this, the review drew similar conclusions to those already discussed, identifying similar push and pull factors to those suggested in the main body of literature. Issues of personal control and consumer choice were also revealed as important in influencing people's health care choices.

The mixed population studies are valuable in that they expand on the findings of the general literature but methodological limitations impose some restrictions on the extent to which questions about people's motives can be explored. In particular:

- Frequent and often exclusive use of closed questions limits the opportunity for free expression: (Sirois and Gick 2002, Mitzdorff et al 1999, Vincent and Furnham 1996)
- Impromptu completion of questionnaires allows only for superficial responses and precludes the inclusion of individuals who have insufficient time or understanding of the study implications: (Sirois and Gick 2002, Vincent and Furnham 1996)
- The tendency to equate predictors of use with reasons for use is questionable: (Sirois and Gick 2002, Mitzdorff et al 1998, Kelner and Wellman 1997)
- Self-selected research samples make it difficult to verify the appropriateness of the sample: (Sirois and Gick 2002)
- Limited reporting of respondents' personal views impedes evaluation of their perspectives: (Sirois and Gick 2002, Kelner and Wellman 1997)
- Differences between sample size, sample characteristics, study location and methodological approach make it difficult to synthesise cumulative evidence.

2.3.2 Population-specific Studies

The six population-specific papers comprised four qualitative and two mixed methodology studies that had been undertaken in Canada (five studies) and the United Kingdom (one study). Five of the study samples were defined according to diagnosis: cancer (two studies) specific chronic illness other than cancer (two studies) and menopause (one study). The final study focused specifically on the older population.

The population-specific studies concurred with the findings of those in the mixed-population group in that participants cited multiple reasons for using complementary therapies, which included both push and pull factors. There were also a few differences:

- Every population-specific study cited personal control as an important motivating factor, although this was identified in only one of the mixed-population studies
- Only two of the population-specific studies cited ineffectiveness, a factor found to be common to every mixed-population study
- The population-specific studies revealed two additional factors: the avoidance of toxins and the promotion of self-healing.

The concept of personal control, common to all studies and of the greatest significance in three, is described particularly well by Truant and Bottorff (1999). Their excellently conducted grounded theory focused on 16 Canadian women who were selected purposively to represent the entire trajectory of breast cancer, from early diagnosis to palliative care. All women had received both conventional and complementary treatments at some stage of their illness and the study explored the decision-making process in relation to their use of complementary therapies. At the point of initial diagnosis the women wanted to do something for themselves that might increase the chance of success of conventional treatment, reflecting the views of Paterson and Britten's (1999) participants, who expressed some doubt about efficacy of mainstream medicine. This stage of illness was associated with a need to initiate control and the women's choice of complementary therapy was often arbitrary. As they subsequently sought to maintain control they established a complementary therapy regimen that fitted their personal beliefs about cancer, their personal beliefs about the effects of mainstream treatments on their bodies and their personal beliefs about the promotion of well-being. On completion of conventional treatment, the women believed that disease control had been achieved through a combination of both conventional and complementary therapies. In common with some other studies (Sirois and Gick 2002, Paterson and Britten 1999, Kelner and Wellman 1997, Vincent and Furnham 1996), the women in this study indicated a strong desire to participate in their health care, to contribute to the process of decision-making and to maintain a sense of control. Lending support to the view that personal control might also be reflected indirectly, Truant and Bottorff's participants even described their dissatisfaction with the patient-doctor relationship as a reflection of their overwhelming desire to regain control.

Two further studies also identified personal control as the single most important factor (Thorne et al 2002, Seidl and Stewart 1998). Thorne et al's (2002) secondary qualitative analysis included people with HIV/AIDS, multiple sclerosis and type II diabetes mellitus, the data for which were extracted from an earlier study that was concerned with self-care decision-making. The methodology for the original study was, unfortunately, not provided although the depth and clarity of discussion implied that this had been rigorous. Although Thorne et al did identify some sub-group differences, participants in all groups shared a general desire to discard the dependence imposed within a biomedical health care culture, in favour of one that was conducive to the patient taking control and responsibility for their own health. Similar to the women in Truant and Botorff's (1999) study, participants tended to combine mainstream and complementary health care and they were selective about which treatments were acceptable and which were not. Contrary to a view of complementary therapy users as being ideologically opposed to biomedicine, participants in these studies demonstrated a healthy scepticism towards the concept of a medical singularism, demonstrating complex reasoning processes that reflect neither irrational nor unrealistic expectations. Participants in these studies also emphasised the right to make their own decisions, a view that was mirrored in Seidl and Stewart's (1998) qualitative study on menopausal women. In this study, data were collected from 13 Canadian women via semi-structured interview (nine participants), telephone interview (two participants) and focus group (three participants) although methodology was not well described and was especially uninformative in respect of depth of data analysis. The women in Seidl and Stewart's study also emphasised the right to make decisions about their own body, relying on their own interpretations about what constitutes appropriate treatment. In particular, they considered that the reported benefits of hormone replacement therapy did not outweigh the potential risks and side-effects. Their reluctance to take 'artificial' hormones was the basis of their preference for natural therapies, a preference that was substantiated by their use of herbal, nutritional or homeopathic treatments. Interestingly, they further related a fear of side-effects to their dissatisfaction with the patient-doctor relationship, describing how they often felt pressurised by their doctors into making treatment decisions and feeling resentment at being told what to do. These concerns, in turn, influenced their preference for natural therapies, which they had personally experienced as being free from unpleasant side-effects.

Although not identified as the main reason for using complementary therapies, the need to regain and/or maintain personal control was also reported as a central finding in the second of the two cancer-related studies (Montbriand 1998). This three-year ethnography, which included one-to-one interviews, a longitudinal case study and a focus group, revealed several reasons for participants' use of complementary therapies: the avoidance of side-effects from conventional medicine, ineffectiveness of conventional medicine and poor patient-doctor relationship. They reported how these factors triggered a turning point in their lives that was characterised by taking personal control of their health care. In contrast to the measured approach taken by Truant and Botorff's (1999) sample, however, the desire for control in Montbriand's participants emerged from a sense of anger as a consequence of their dissatisfaction with conventional medicine. This dissatisfaction resulted from previous experiences of arrogance and disinterest from their doctors in relation to their use of complementary therapies. It is notable, however, that every participant in Montbriand's study had been diagnosed with either advanced or recurrent cancer and none had been offered hope for successful treatment by their conventional practitioners. Their anger may well have been influenced by these circumstances, a possibility also reflected in their stories, which evoke a sense of disillusionment, tragedy and desperation. The study also differed from the others in that it was primarily concerned with the phenomenon of abandoning conventional medicine and, by focussing specifically on this perspective, is likely to have provoked reports of negative experiences.

The two mixed methodology studies both combined survey and interview techniques, one in relation to complementary therapy use amongst older people (Andrews 2002) and the other focussing on people with irritable bowel disease (Hilsden et al 1998) but neither study provided sufficient methodological detail to draw convincing conclusions. Hilsden et al (1998) surveyed 134 people and interviewed a sub-set of 14 but they provided little methodological detail and no information at all in respect of qualitative methodology. In addition to the significance of personal control raised in all studies, the survey component of Hilsden et al's (1998) study also identified side-effects (40%) and ineffectiveness (35%) of conventional medicine as important push factors. Andrews (2002) surveyed 144 people (36% response rate), aged 60 years or over, recruited from 20 different complementary therapists in the south of England. The survey was supplemented by qualitative interviews with a sub-set of 20 people. Respondents identified the main inadequacies of orthodox medicine to be associated with long waiting lists, rushed appointments and a lack of care and they were keen to avoid toxic side-effects from conventional medicines. The perception that complementary therapy integrated both physical and emotional well-being and provided opportunities for people to talk with therapists were also identified as important elements of health care that were not available to them within mainstream medicine. They were also attracted by ideas of holism and individualised treatment. Andrews also suggests that their interest may be a reflection of long-standing use of traditional health care practices. Although the majority of respondents had been using complementary therapies for 2 years or less (61%), others had used them for more than 10 years (23%) and some in excess of 20 years (10%) with a few reporting their use of complementary therapies to pre-date the National Health Service. According to Andrews (2002), older people's experiences of using complementary therapies provided feelings of increased control over their health care and it was this that underpinned their interest in complementary therapies. Contrary to the perception of older people as passive health care recipients, older users of complementary therapies appeared to have well developed knowledge about complementary therapies and were keen to make their own decisions about how, when and which therapies they would use. But for the prohibitive costs involved, many claimed that their use of complementary therapies would be even greater.

The pull factor 'self-healing' was raised only by participants in Thorne et al's (2002) study but was discussed with great clarity. Secondary only to the desire to maintain personal control, participants acknowledged the importance of enhancing the body's innate ability to deal both with illness and with the side-effects of treatment. They also described the importance of learning to 'body-listen' - paying attention to subjective experiences of physiological responses. Body-listening provided a means of gaining exclusive information that could be integrated with other forms of evidence (including that provided by conventional practitioners) as a basis for making informed decisions. Making informed choice was seen as a component of taking personal responsibility for one's own health and included the process of framing their own health care outcome measures, which included both biological markers and messages from body-listening. In common with Truant and Botorff's (1999) breast cancer patients, this highly informative study revealed how people actively explore, experiment with and evaluate complementary therapies, selecting or rejecting treatment on the basis of their own, personal evidence.

Several of the population-specific studies, whilst citing multiple motivating factors, related these to a common aim – achieving a sense of personal control. As such, they were more successful in portraying a coherent interpretation of people's reasons for using complementary therapies. However, in relating complementary therapy use to such narrowly defined diagnostic groups, there is a risk that the universal reporting of personal control as a major motivating factor has as much to do with their particular health circumstances as it does with the attributes of complementary health care. This is especially true where concomitant circumstances may have previously induced a sense of loss of control, for example:

- Following the diagnosis and treatment of cancer
- As a consequence of long-standing chronic disease
- When menopause coincides with other life changing events
- When there is a loss of independence associated with the ageing process.

Despite this, it is noteworthy that the concept of regaining personal control emerges throughout a range of different health, and health care, experiences and the possibility that this reflects an inherent deficiency in conventional health care cannot be discounted.

All studies included in the review are summarised in Table 2.1.

REFERENCE	SAMPLE	METHODOLOGY	MAIN FINDINGS (in respect of motivational factors)	COMMENTS
Andrews 2002	n = 144 (survey) 20 (I/V) Aged 65 years plus United Kingdom	Survey plus qualitative interview Self-completed questionnaire Open questions	Push: long waiting lists, lack of attention, ineffectiveness, no opportunity to talk. Pull: individualistic, holistic, natural, avoidance of toxins, opportunity to talk, desire for personal control.	Lacking in methodological detail - "derived" from GT Much focus on demographics Limited to older population.
Hilsden et al 1998.	n = 134 (survey) 14 (I/V) Patients with IBD Canada.	Survey plus qualitative interview Postal questionnaire Closed questions	Push: side effects, ineffectiveness of conventional medicine, incompatibility with personal beliefs and lifestyle, lack of 'human' touch. Pull: Quality of life as important as symptom reduction.	Original sample selected from general IBD database Very sparse methodological detail – qualitative analysis and detail to be "published elsewhere"
Kelner & Wellman 1997.	n = 300 Randomised sample, recruited from complementary and conventional practices Canada	Interview-based survey Semi-structured I/V Mixed questions Sub group analysis for different therapies	Push: ineffectiveness of conventional medicine. Pull: holism, personal control and responsibility.	Explained within socio-behavioural model Qualitative health histories not evident, limited reporting Predictors equated to reasons
Mitzdorf et al. 1999.	n – 200 Alternate admissions of in-patients in CT hospitals Germany	Survey Self-completed questionnaire Closed questions	Push: Dr./patient relationship, side effects and ineffectiveness of conventional medicine. Pull: positive previous experiences of CT.	Hospitals of TCM and Western CTs but samples very similar Specific to German health system Predictors equated to reasons

Table 2.1
Summary of Included Studies

REFERENCE	SAMPLE	METHODOLOGY	MAIN FINDINGS (in respect of motivational factors)	COMMENTS
Montbriand 1998	n = 8 Snowball sampling, people with cancer Canada	Ethnography I/V, case study plus focus group Content analysis, analytic induction.	Push: ineffectiveness and side effects of OM, poor Dr./patient relationship. Pull: personal control (triggered by anger with OM).	Main focus on abandonment of O All had had prior negative experiences of OM All had been receiving palliative care
Ong & Banks 2003	Not specified	Review of grey and unpublished studies	Push: incongruent health views, dr.-patient relationship, ineffectiveness and side effects of OM Pull: congruent health views, practitioner-patient relationship, effectiveness,participation	Review of grey literature Broadly consistent with primary studies
Paterson and Britten 1999	n =20 Purposively selected patients of CT practitioners UK	Qualitative Semi-structured I/Vs Open questions Constant comparative analysis	Push: ineffectiveness, side effects of conventional medicine, desire to make own judgements. Pull: positive experience of CT, personal control .	Specific to new users of CTs Difficult to discriminate between actual and perceived motivation Limited reporting
Sharples et al 2003	N = 492 Outpatients attending during 3 week period U.K.	Survey Closed and open questions Self-completion	Push: ineffectiveness and side effects of OM. Pull: personal preference	Aspects of reporting are brief
Siedl & Stewart 1998.	n = 13 Self-selected menopausal women Canada	Qualitative Personal and telephone I/Vs plus focus group Semi structured I/Vs, same key questions	Push: fear of side effects, avoidance of HRT. Pull: personal control, natural therapies	Inadequate reporting.

Table 2.1
Summary of Included Studies

REFERENCE	SAMPLE	METHODOLOGY	MAIN FINDINGS (in respect of motivational factors)	COMMENTS
Sirois & Gick 2002	n =196 Self-selected from conventional and complementary clinics Canada	Survey Self-completed postal questionnaire Closed questions Sub group analysis for new and established CT users	Push: ineffectiveness of conventional medicine, Dr/patient relationship, desire for active participation.	No sub group differences Impromptu completion of questionnaires Predictors equated to reasons. Limited reporting
Thorne et al 2002	n = 18 Sampled from earlier study People with HIV/AIDS, MS or DM Canada	Qualitative Secondary analysis Constant comparative analysis	Push: desire for personal control, desire to make own decisions, self-healing Pull: desire for personal control	Original study focus was self-care decision making
Truant & Bottorff 1999	n = 16 Purposive sample, maximum variation (cancer trajectory), women with breast cancer Canada	Grounded theory Personal I/Vs, one initial trigger question "Consistent with GT"	Push: uncertainty about effectiveness of conventional medicine, Dr/patient relationship. Key finding was desire for personal control.	Excellent methodology Specifically cancer-related
Vincent & Furnham 1996	n = 268 Convenience sample, patients of 3 different CT therapists UK	Survey Self-completed questionnaire Closed questions Sub group analysis specific CTs	Push: ineffectiveness and side effects of conventional medicine. Pull: active participation, holism, natural therapies.	Impromptu completion of questionnaire Limited reporting

Table 2.1
Summary of Included Studies

2.4 Conclusions and Implications for Current Study

The motivational studies reviewed expand on the conclusions drawn from prevalence studies but, in general, they concur with the view that complementary therapy use might be associated with any of the following factors:

- Ineffectiveness of conventional medicine
- Side-effects of conventional medicine
- A desire to avoid ingestion of toxins
- Dissatisfaction with the doctor/patient relationship
- The desire to participate in, and to maintain control of, their health care
- A preference for holistic health care
- A preference for natural health care
- The desire to enhance the body's ability to self-heal.

As such, the findings from these studies remain inconclusive and, of particular importance to the current study, none make explicit reference to the use of herbal therapy. The tendency to dichotomise people's reasons for using complementary therapies (either push or pull reasons) also encourages a relatively simplistic view that overlooks the possibility that these factors might be related in a more complex way than is immediately evident. The possibility that complementary therapy use reflects a broader desire for more autonomous health care participation or that it might demonstrate a rejection of biomedical exclusivity in the provision of health care, suggests that issues surrounding the use of complementary therapies have not yet been adequately explored.

The studies are complementary in terms of the strengths and limitations inherent to their respective methodologies but methodological limitations do need to be taken into account in drawing conclusions from the review. Whilst the survey studies both confirm and expand on earlier prevalence studies, methods for sampling, questionnaire design and data collection all limit the extent to which consumer perspectives can be adequately explored. In contrast, the qualitative studies are detailed and insightful but are applicable only to very specific populations.

In terms of methodological deficiency, only three studies demonstrate high quality research design (Sirois and Gick 2002, Truant and Botorff 1999, Montbriand 1998) with one other of an apparent high quality, although this is not made explicit by the authors (Thorne et al 2002). Inadequate methodological reporting makes it difficult to assess the remaining studies especially with regard to:

- Sampling strategy: (Andrews 2002, Paterson and Britten 1999, Hilsden et al 1998)
- Data collection technique: (Paterson and Britten 1999, Vincent and Furnham 1996)
- Data analysis: (Andrews 2002, Paterson and Britten 1999, Seidl and Stewart 1998, Hilsden et al 1998, Kelner and Wellman 1997, Vincent and Furnham 1996).

Despite these limitations, the process of literature review highlighted three aspects that were subsequently significant in influencing the design of the current study:

1. The lack of reference to medical herbalism is an important omission in the literature, given the relatively high profile of herbalism in modern British health care. The utilisation of current evidence in making judgements about the future of herbalism could therefore be misleading, to the potential detriment of consumers. Studies, such as this one, are therefore of particular importance at the current time.
2. Inconsistencies in the literature may be compounded by the tendency to discuss complementary therapies collectively. Contradictory data might therefore say more about inappropriate study design than it does about people's reasons for complementary therapy use. This possibility has important implications for the design of the current study, to enable the uniqueness of herbal therapy to emerge.
3. Methodological evaluation of the current literature reinforces the necessity for appropriate study design. The limitations highlighted have therefore been instrumental in tailoring the current study design to maximise its relevance to the study purpose.

3 THE RESEARCH DESIGN

This study pertains to a small number of people who consult with registered medical herbalists that practice within a defined area of southern England. The study is very specifically designed to enable exploration and clarification of participants' perspectives, in order to enhance understanding about the interaction between ill health experience, health-related actions and the use of health services (Popay et al 1998). I achieve this by applying a qualitative methodology that is underpinned by Gadamerian hermeneutic phenomenology, the principles of which enable rigorous interpretation whilst preserving meaning implicit to linguistic expression. The ultimate goal of phenomenological study is to enable insight into another's perspective and is therefore consistent with my personal aspirations for the study.

3.1 Philosophical Framework

The study design reflects my personal philosophy (Appendix 1: Section 2.1), which embraces the following beliefs:

- The patient has a right to self-determination in matters relating to their health care
- The patient experience provides a unique form of expert knowledge. It is different to professional knowledge but is of equal importance and value
- With some exceptions, effective health care is health care that meets the self-perceived needs of the recipient (Popay et al 1998)
- Health care preferences are influenced by personal experience of health, illness and health care
- Inadequate clarification of meaning can result in misunderstanding, with subsequent imposition of another's perspective.

Consistent with these values, my approach to research design aspires to privilege the consumer perspective and to represent this perspective as faithfully as possible. These values are implicit to all aspects of the research design but have been especially influential in determining the research question, which evolved as a consequence of my own health care experiences that emanate from personal, professional and academic perspectives (Appendix 1: Section 1). To achieve the study aims, I draw on the principles of the interpretivist research paradigm and, in particular, on the philosophy of hermeneutic phenomenology. The purpose of research underpinned by phenomenology is to seek out meaning that people assign to everyday experiences, in contrast to most other research approaches, which tend to be more concerned with how these experiences are conceptualised (van Manen 1990). I therefore apply this approach as a means to privilege the consumer perspective and to expose meaning embedded within the research text[2]. In recognising the implications of research methodology for data management and interpretation, I present an overview of the philosophical underpinnings of research informed by hermeneutic phenomenology.

3.1.1 The Philosophy of Hermeneutic Phenomenology

The historical evolution of phenomenology is described in terms of three major phases:

- The preparatory phase (mid nineteenth to early twentieth century), which favoured a descriptive psychology
- The German phase (mid to late twentieth century), which saw the development of Husserlian transcendental and Heideggerian existential/hermeneutic phenomenologies
- The French phase, which was essentially a continuation of the existential bias and was perpetuated by the philosophers, Sartre and Merleau-Ponty.

(Cohen et al 2000, Cohen 1987, Spiegelberg 1984).

This study is informed by Gadamerian hermeneutic phenomenology, which evolved from the German school. The origin of the German school is generally accredited to Edmund Husserl (1859-1938) who argued that experience is the fundamental basis of knowledge but that the constituents of lived experience were taken for granted and

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[2] In the context of this study, the concept of research 'text' includes discourse and action as well as the written word (Kvale 1996, Ricoeur 1971). In addition to interview transcripts, which provided a record of the spoken word, contextual data and conversational notes (recorded as fieldnotes) also contributed to the process of interpretation and, as such, I also regarded these as research 'text'.

could not be readily brought to mind. Husserl conceptualised people as subjects living in a world of objects and he perceived consciousness as always being directed towards objects (intentionality). He proposed that human understanding could be examined and described through the act of bracketing (phenomenological reduction), which allowed the investigator's assumptions to be temporarily suspended as a means to eliminate all preconceived notions (Schutz 1970).

This emphasis on objectivity led to his approach being perceived as the culmination of the Cartesian tradition (Koch 1995, Walters 1995) and became the subject of criticism by his contemporary, Martin Heidegger. As a student of Husserl, Martin Heidegger (1889-1976) rejected the notion of Cartesian duality and he rejected Husserl's concept of intentionality, arguing that people could not be understood in isolation from their world (Heidegger 1962). In contrast to the Husserlian view of human perception as a product of objective consciousness, Heidegger perceived the origin of knowledge to be embedded in everyday activities. He also viewed people and their worlds as co-constituted – inseparably united, each being constructed by the other. He considered that interpretation and understanding always occurred in a circular process, understanding being both enabled and limited by one's pre-understandings, which could not be eliminated from the interpretive process (Heidegger 1962). The existential phenomenology espoused by Heidegger was continued by Hans-Georg Gadamer (1900-2002), who concurred with the view that understanding is dependent on linguistic and cultural tradition and that interpretation occurs in the context of background knowledge (Leonard 1989). He also endorsed the concepts of pre-understanding and the hermeneutic circle (see below).

Contemporary hermeneutics is concerned with recreating meaning as a means to enable more complete understanding (Geanellos 1998) but also recognises the potential for multiplicity of interpretation, where understanding is viewed as little more than an approximation (Gadamer 1976). It is Gadamer's view that textual interpretation leads only to understanding of itself, not to understanding of the author's original meaning, renewed understanding resulting from the dialogue that occurs between text and interpreter (Hekman 1986). Consequently, interpretive acts do not result in certainty, consensus or objectivity, nor do they represent accuracy (Geanellos 1998).

Being naturally inclined toward notions about the impact of cultural background on interpretation and being naturally doubtful about the possibilities of phenomenological reduction, my own orientation is consistent with the philosophical principles set out by Gadamer. I therefore recognise the concepts of pre-understanding, fusion of horizons and hermeneutic circle as crucial to informing the study methodology especially with regard to the processes of data collection, data analysis and data interpretation. I describe each of these essential elements below.

3.1.1.1 Pre-understanding and the Fusion of Horizons

The term ‘pre-understanding’ is synonymous with the characteristic commonly described as preconception, prejudice or bias. According to Taylor (1993) pre-understanding is a universal feature of humanity that makes assumption-free description an impossibility. This view is supported by Lather (1986) who suggests that knowledge, even scientifically derived, cannot be free from social construction.

Gadamer contests the Husserlian notion of bracketing, arguing that people can never be free from their pre-understandings but, by adopting an authentic hermeneutic attitude, these prejudices (pre-understandings) can be identified for what they are, which is to “strip them of their extreme character” (Gadamer 1979, p152). Furthermore, pre-understanding is derived from shared background practices (described by Gadamer as ‘tradition’) that enable common meaning to emerge, making it an essential element of interpretation, rather than a hindrance to it (Gadamer 1976).

Background tradition is acquired by internalising the culture in which we live, and it determines the frame of reference within which we are able to interpret and understand (Thompson 1990). Gadamer describes this frame of reference as a ‘horizon’ that encompasses everything that we find intelligible (Thompson 1990). Meaning is created when the horizons of interpreter and text become fused (Gadamer 1987) but understanding can be hindered by a number of interpretive barriers:

- A reliance on traditional (dominant) authority
- Inadequate knowledge of the phenomenon under investigation
- Unchallenged pre-understanding
- Unconscious pre-understanding
- Premature closure of interpretation
- Socio-political constraints that privilege some ideas over others.

(Geanellos 1998)

For Gadamer, interpretation is inescapably dependent on pre-understanding but a fusion of horizons allows understanding to evolve. A fusion of horizons is achieved by moving dialectically back and forth between the interpreter's background knowledge (the whole) and focused elements of the text (the parts) - a process described as the hermeneutic circle.

3.1.1.2 The Hermeneutic Circle

The hermeneutic circle is a metaphor that characterises the most fundamental basis of understanding - the relationship between the parts and the whole of a text. The origin of this metaphor is uncertain although, as far back as 1567, Flacius is quoted as saying:

> "The individual parts of a whole everywhere draw their comprehensibility from their relationship to that whole and to the other parts"
>
> (Dilthey 1990, p108)

A critical feature of the hermeneutic circle is the spiralling between the whole and parts of a text, since understanding of one presupposes understanding of the other (Geanellos 1998). Specifically, the parts of a text derive meaning from a preliminary understanding of the whole. The whole, in turn, can be modified by attending to the parts in greater detail. This reciprocal process reaches closure once meaning is acquired that is free of contradiction (Kvale 1996). Although interpretive possibilities are limited by one's tradition and pre-understanding, a fusion of horizons increases the possibility for new understanding. Thus, understanding occurs within a hermeneutic circle where an authentic hermeneutic attitude enables renewed insight to emerge. The Gadamerian concepts of pre-understanding, fusion of horizons and hermeneutic circle enable meaning embedded within research texts to be explored beyond the immediate and the obvious. As such, they carry important implications for the study design – implications that I fully embrace in the application of the hermeneutic, phenomenological method. Consistent with phenomenological philosophy, however, I do not apply method unquestioningly but select methodological techniques that allow for the experiential dimension of health and health care to be communicated and understood more clearly.

3.2 Methodological Framework

To achieve the study aims I integrate two methodological frameworks that, together, provide guidance for the conduct of interview-based study that is driven by phenomenological purpose. Specifically, I draw on the writings of Kvale (1996, Table 3.1) in relation to the interview elements of the study and to those of van Manen (1990, Figure 3.1) in relation to phenomenological elements of the study. For ease of reading, I describe the main methodological stages in the traditional, sequential style (Rationale, Design, Data Collection, Data Analysis, Reliability and Validity, Dissemination) but I would emphasise the dynamic and interdependent nature of these activities in the actual process of the research project. For clarity, I also indicate the associated stages of Kvale's framework in brackets.

STAGE OF STUDY	**DESCRIPTION**
Thematising	Purpose and topic area of proposed study is clarified
Designing	Research design takes into account all 7 stages of an interview study, to include method for obtaining intended knowledge and moral implications
Interviewing	Interviews are based on interview guide and have a reflective approach. Consider interpersonal nature of interview situation
Transcribing	Transcription from oral to written text, in preparation for analysis
Analysing	Method of analysis is appropriate to purpose, topic and nature of interview material
Verifying	Ascertain generalisability, reliability and validity of study findings
Reporting	Dissemination results in readable product that addresses scientific criteria and ethical aspects

Table 3.1
Seven Stages of Interview Investigation (Kvale 1996)

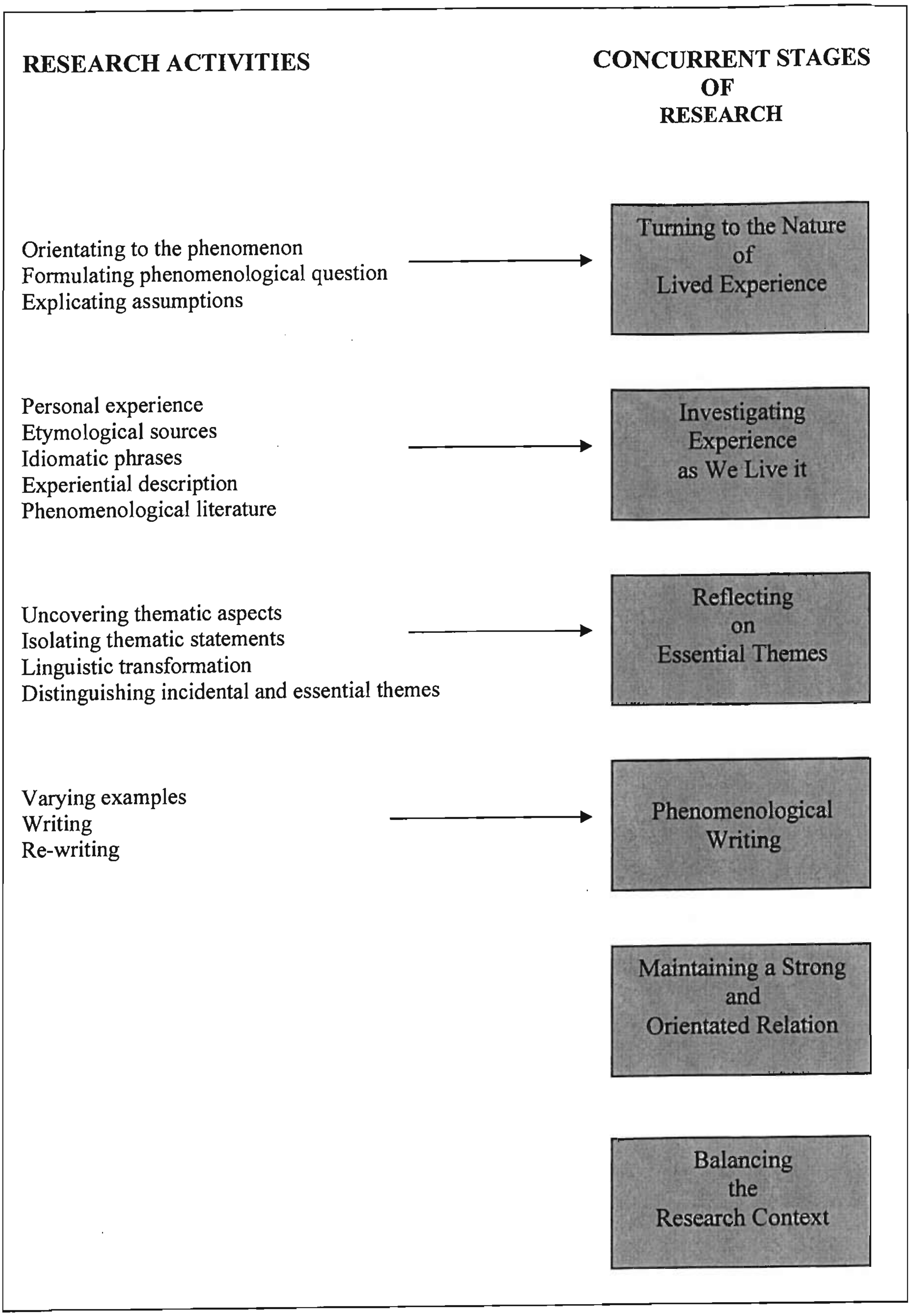

Figure 3.1
A Structure for Human Science Research
(Adapted from: van Manen 1996)

3.2.1 Rationale and Study Objectives

(Stage 1: Thematizing)

The study was triggered following my observations of contradictory evidence about the use of herbalism in the United Kingdom and other westernised societies (Appendix 1: Section 1). The main purpose of the study, therefore, is to address the contradictions and inconsistencies reflected in the current literature and I achieve this by exploring consumers' perspectives on their use of medical herbalism in the context of modern health care. I have designed the study with this aim in mind and, by intensively focussing on participants' motives for using herbalism, I help to clarify this uncertain aspect of the complementary health care phenomenon in the United Kingdom. In designing the study I also respond to the current research agenda for complementary therapies in the United Kingdom in the following respects:

- The study focuses on one of the complementary therapies identified as a major health care discipline in the United Kingdom
- It addresses an identified gap in the current evidence-base for complementary and alternative medicine
- It explores the consumer perspective
- The research design is highly appropriate to the study aims.

The particular objectives of the study are to:

- Contribute to the complementary therapy knowledge-base, consistent with the current research agenda
- Present a consumer perspective on complementary therapy use
- Provide insight into people's experiences of using medical herbalism and to explore their reasons for doing so
- Clarify contradictions in the literature by eliciting meaning implicit to participants' accounts of their health care experiences
- Interpret the significance of the study's findings to contemporary health care in the United Kingdom by expanding on propositions raised from the research data.

3.2.2 Research Design
(Stage 2: Designing)

I utilise a qualitative, interview-based design that is underpinned by hermeneutic phenomenology. My approach is generally pragmatic in that I challenge the purist argument for a clear alignment between research philosophy, epistemology and methodology, whilst endorsing the view that the most appropriate methodological techniques are those that best answer the research question (Booth et al 1997, Stew 1996, Atkinson 1995, Patton 1990). This open attitude toward methodology is an important feature of phenomenological research that ensures methodological rigour without being prescriptive, allowing method to be tailored to meet the research aim. According to Boyd (1993), this flexibility serves to prevent ideas about method being reduced to dogma whilst Bickman and Rogers (1998) argue that it is a fundamental requirement in qualitative research, to ensure that methodological decisions remain responsive to emerging ideas. Flexibility is therefore core to my research approach, in which I incorporate principles and techniques that have significance for qualitative, interview-based and phenomenological enquiry (Appendix 1: Section 2.2).

In the design stage of a phenomenological study, van Manen (1990) emphasises the need to draw on personal experience as a source of data, an activity consistent with the idea of researcher reflexivity. Although there are several (sometimes competing) accounts as to the practice of reflexivity in the research process, I subscribe to practices that are consistent with phenomenological study:

1. I began by drawing on personal experience as evidence (van Manen 1990, Moustakas 1994).

   I achieved this by audio-recording an account of my own experiences of medical herbalism, prior to meeting with the study participants. By referring to this recording during data analysis, my personal account helped in the process of searching for rival statements (see: Section 3.2.4.2, Thematic analysis) and therefore contributed directly to the analytic process. As a further analytic technique, I also drew on this account to identify personal preconceptions, which tended to fall into three main categories:

a) Preconceptions in relation to the reasons for people's attraction to herbalism.

   I believed that, as a long-standing traditional therapy in the United Kingdom, medical herbalism would naturally have a special attraction for indigenous people. In relation to this, I assumed that participants' interest in herbalism would have been transmitted from other family members and that they would perceive medical herbalism as an obvious choice for health care. Also due to the long-standing nature of its history, I expected that herbalism would not really be considered as a non-conventional (complementary) therapy, this term being reserved for therapies of a new or non-native origin. I also anticipated that users would be likely to combine herbalism with conventional health care.

b) Preconceptions in relation to user characteristics.

   Due to the expense involved in the process of herbal consultation and treatment it was my expectation that users, on the whole, would be situated in a relatively financially secure position. I also anticipated that users of herbal medicine would be more likely to be older people, attempting to preserve family tradition.

c) Preconceptions in relation to my experiences as a nurse.

   Based on my direct experiences with patients in the conventional health care setting, the study was partly motivated by my belief that patients sometimes received inadequate consideration of their personal health care beliefs and wishes. I essentially believed that patients who felt intimidated in the health care situation were more likely to be treated as passive recipients of health care and were therefore less likely to be encouraged to engage in decision-making processes with health care practitioners. By contrast, it was my belief that patients who had greater self-confidence or who did not feel intimidated by the medical consultation would engage more readily in deliberations about their health care.

Being conscious of the risk that unchallenged preconceptions can block out the participant's voice and therefore limit the possibilities for renewed understanding, I incorporated my preconceptions into the analytic process by considering their influence on the research data. This reflexive activity enhanced the rigour of the study by enabling me to recognise preconceptions for what they are and by highlighting issues and emphases in the data that otherwise might have escaped my attention.

2. I engaged in dialectic between personal preconceptions and the research data (Finlay 2002).

   This ongoing dialectic was directly facilitated by the process of hermeneutic analysis and, more specifically, by my engagement in the hermeneutic circle. However, I remained conscious of the need for reflexivity to remain purposeful, a principle that I upheld by striving to strike a balance between enhancing my own self-awareness and over-privileging my position to the detriment of the participants' voices (Finlay 2002, Finlay 1998). I maintained this purposefulness by raising questions about the ways in which my preconceptions related to the data.

3.2.2.1 Methodological Framework

I am guided predominantly in the interview and phenomenological elements of the study by the frameworks proposed by Kvale (1996) and van Manen (1990), respectively.

Kvale describes how methodological decisions during each of the seven stages of an interview study should be made reflectively according to the researcher's knowledge of the research topic, their knowledge of methodological options, and by taking into account the potential consequences of these for the study as a whole. I select Kvale's framework for interview study (Table 3.1, p45) for the following reasons:

- It informs the essential elements of qualitative interview
- It encourages flexibility in selection of methodological techniques
- It embraces the concept of method as a responsive, rather than a rule-following, exercise
- It allows for the specifics of phenomenological study to be addressed.

Van Manen's 15-step framework (Figure 3.1, p46) reflects six concurrent stages of research that are both phenomenologically and hermeneutically sensitive. I concur with Boyd's (1993) view that van Manen's phenomenological framework aligns more closely to Spiegelberg's (1984) ideal phenomenological criteria than do other approaches, especially those that utilise highly structured processes of data analysis (Colaizzi 1978, Van Kaam 1959) or that emphasise techniques for phenomenological reduction (Parse 1990), which are thought to be less representative of these ideal criteria. It is my view that these two frameworks complement one another in the design of this particular study and I illustrate their inter-relationship in Table 3.2.

INTERVIEW STRUCTURE **Kvale (1996)**	**PHENOMENOLOGICAL STRUCTURE** **van Manen (1990)**
1. Thematizing	Orienting to the phenomenon Formulating the research question
2. Designing	Inclusion of additional sources of knowledge, where relevant: personal, etymological, idiomatic. literature
3. Interviewing	Experiential descriptions
4. Transcribing	Linguistic transformation
5. Analyzing	Uncovering thematic aspects Isolating thematic statements Distinguishing incidental and essential themes
6. Verifying	Maintaining a strong and oriented relation Balancing the research context
7. Reporting	Varying examples Writing and re-writing

Table 3.2
Relationship between Interview-based and Phenomenological Study
(Adapted from: Kvale 1996 and van Manen 1990)

3.2.2.2 Ethical Aspects of Research Design

As a data collection technique, the interview process directly affects the interviewee, whilst analysis of interview data produces knowledge that can influence understanding about the human condition. In this respect, interview enquiry is fundamentally a moral enterprise that carries ethical implications for each of the seven stages of research design (Kvale 1996).

My ethical stance reflects utilitarian, deontological and contextual-virtue perspectives, where the contextual-virtue position is less concerned with the application of rules than with the researcher's personal integrity and the research participants' own ethical values (Kvale 1996). This approach encompasses the four major ethical principles of non-maleficence, beneficence, autonomy and justice (Beauchamp and Childress 1994) and allows for issues specific to qualitative (Spradley 1980), interview based (Kvale 1996) and phenomenological study (Cohen et al 2000) to be addressed. My ethical behaviour throughout the course of study has been consistent with my Professional Code of Conduct (Nursing and Midwifery Council 2002) and I strived to preserve the rights of participants at all times, their wishes taking precedence over the advancement of knowledge. In particular, I highlight the following five ethical issues, which I considered to be of prime importance in planning the study processes:

1. Protection of Participants. In using an interview-based data collection method I was conscious of the need for sensitivity regarding the extent to which questions could be pursued (Kvale 1996). (see: Section 3.2.3.2, The Interview Process).

2. Access to Participants. To decrease the risk of coercion, I recruited participants via the herbalist with whom they were consulting. Potential recruits subsequently contacted me directly but only after they had decided to volunteer their participation in the study (see: Section 3.2.3.1, Sampling Strategy).

3. Informed and Voluntary Consent. The meaning of 'informed' consent, and establishing how this can be ascertained, is problematic in all types of research (Behi and Nolan 1995) but is of special significance in qualitative research. The tentative and exploratory nature of qualitative research makes the provision of adequate information at the outset of a study particularly problematic (Holloway and Wheeler 1996, Kvale 1996), as this does not allow for the researcher to follow up unanticipated leads. In recognition of this, I opted for a process of ongoing informed consent (Ford and Reutter 1990), consent being established at the outset of the study and again prior to each interview (Kvale 1996).

   I provided every participant with written information about the study and each was offered additional verbal clarification, prior to their consenting to participate. I took care to ensure that the information process provided:

   - Comprehensible detail about the study's purpose
   - Information about potential benefits and risks to participants

- Sufficient time for participants to discuss and consider their possible participation, without coercion
- Assurance that consent would be ongoing and that withdrawal from the study would be possible at any time
- Information about the nature of the interview process and their likely time commitments
- Reassurance regarding anonymity and confidentiality
- Contact numbers for additional information prior to, and during, the study
- Assurance that participants' medical care would not be affected by their participation/non-participation.

4. Confidentiality and Anonymity. I preserved participants' anonymity and privacy by the following means:

   - Application of coding system(s) to audio recordings, transcriptions and publications
   - Omission of quotations that might jeopardise anonymity
   - Secure storage of audio recordings, transcripts and electronic material
   - Non-disclosure of passwords and coding systems to others
   - Safe storage and/or destruction of data on completion of the study (subject to University protocol).

5. Consequences of Research. I identified three aspects of the study design that posed possible risk of harm to the research participants but, consistent with the principles of beneficence and non-maleficence, I believed that, in each case, these were outweighed by the sum of potential benefits and potential for knowledge gain:

   - Effects of personal disclosure. The rapport built between interviewer and interviewee, along with the intimacy of the interview situation, can lead to later-regretted disclosure of issues of a personal and/or sensitive nature. Conversely, by providing a focus for attentive listening, the interview is often experienced very positively by the interviewee (Kvale 1996). By taking a sensitive approach to the interview situation I was able to maximise the likelihood of the interview being perceived positively whilst minimising any risk of distress.

- Effects of interview focus. The building of trust and rapport can encourage a therapeutic focus to interview, where the participant seeks or receives feedback on their behaviour. I minimised the risk of harm, as a consequence of unintentional therapeutic engagement, by carefully maintaining the research focus during the interview process (Appendix 1: Section 4.3).
- Effects of research application. Studies of consumer experiences can be used for purposes of predicting and manipulating consumer behaviour (Kvale 1996), a possibility that cannot be confidently predicted by the researcher. Despite this, my intention in undertaking the study was emancipatory, the study being designed to contribute positively to human welfare.

In addition to the main ethical implications I also took account of the following:

- The risk of counter-transference between researcher and participant, which can lead to a loss of critical perspective (see: Section 3.2.3.2, The Interview Process; Appendix 1: Section 4.4)
- The impact of outside influences on the production of independent research (see: Section 3.2.5, Reliability and Validity)
- The responsibility on researchers to produce useful and verifiable knowledge (see: Section 3.2.6, Dissemination)
- The requirement for the process and product of the study to be sufficiently transparent to allow judgement about the effects of personal prejudice on the study outcomes.

The study was granted ethical approval by South West Multi-Regional Ethics Committee in July 2002 (Appendix 9).

3.2.3 Data Collection

(Stage 3: Interviewing)

I obtained data from interviews that I had undertaken with adults who were receiving health care from registered medical herbalists. I ensured that the sampling strategy was consistent with the principles of qualitative research by recruiting participants who had significant experience of the phenomenon (Morse 1991), to allow for issues central to the study to be revealed (Patton 1990). I defined 'significant experience' of the phenomenon in terms of a person's current receipt of treatment from a medical herbalist (Appendix 1: Section 3.1).

I selected the research sample purposively to ensure that participants met the study inclusion criteria. In accordance with qualitative principles, I aimed for depth rather than breadth of information and I recruited participants who I believed would be sufficiently able to participate in phenomenological interviews, which are characteristically flexible and therefore potentially unpredictable. Although desirable, I did not consider demographic variation to be analytically crucial for this particular study and I therefore excluded this criterion from the sampling design (Sandelowski 1995a). The incorporation of this criterion might also have resulted in limited sampling opportunities due to the relatively small pool of potential recruits. However, I do present demographic data, to allow readers to consider the potential for transferability of the study findings. As with other methodological aspects of the study, I retained a degree of flexibility in the sampling strategy to allow exploration of emergent information and to enable responsiveness to real world conditions (Coyne 1997).

3.2.3.1 Sampling Strategy

My strategy for recruitment commenced by consulting practitioner lists published by the two main registering bodies for medical herbalists (National Institute of Medical Herbalists, International Register of Consultant Herbalists and Homeopaths), which allowed me to identify practising herbalists within the study catchment area. In addition, I also referred to local Yellow Pages directories to identify practitioners not yet included on registration lists. I identified fourteen eligible herbalists and I sent written information about the nature of the proposed study to each. Seven herbalists subsequently agreed to participate and I sought their co-operation in forwarding information packages to clients who met the study's inclusion criteria. Interested clients were subsequently invited to contact me directly (Appendix 1: Section 3.2).

The information package included details about the nature and purpose of the study and also included details about my professional background. Specifically, this revealed my nursing and educational qualifications and it outlined my current professional role as well as the academic underpinnings of the research project's purpose. During my first meeting with each participant, I reiterated the nature and purpose of the study and further explained my professional background. I briefly described to participants my previous nursing career and explained that, more recently, I had continued in the nursing profession as a university lecturer involved in the education of both student and qualified nurses. I outlined both the nature of my current academic role and that of my current status as a PhD student. In particular, I highlighted my input to the research curriculum for nurses and other health care professionals and emphasised to participants that I was undertaking the current study in the capacity of researcher, rather than educationalist or nurse. Although I commented to participants on my professional interest in the popularity of herbal medicine, I chose not to disclose my personal experience of using medical herbalism as I believed that this might encourage participants to seek out my own opinions and experiences during the interview process – a risk that I considered might unduly influence the direction of interview. Every participant was invited to ask further questions in relation to my professional background and role but further queries were minimal, mostly relating to participants' interest in the relationship between my university employment and 'doing the research.' They seemed satisfied that my position as a PhD student was embraced within my university employment.

Although patients often view nurses kindly, in divulging my background there was a risk that participants would perceive me in the light of a 'conventional' health care practitioner. Potentially, this perspective could have discouraged participants from divulging their health care experiences, either to avoid causing me offence or in fear of jeopardizing their future health care. They might also have perceived me as cynical toward complementary therapies in view of media impressions to this effect, a situation that might equally have influenced their willingness to disclose information. Similarly, having knowledge about my academic background could have discouraged participants' full engagement in the interview process due to their lack of familiarity with academic purpose and a potential uncertainty as to the intention of its future use. Conversely, there was also a risk that participants would see me as an authority figure, attributing unrealistic expectations about the sphere of my influence in health care matters. The enthusiasm subsequently demonstrated by participants during the interview process suggested that these concerns had been unfounded.

Sampling Criteria

My aim in constructing the sampling criteria was threefold: to identify rich sources of experience, who would be suitable for interview study and who were not unduly vulnerable due to age or mental acuity. I provided the seven herbalists with the following criteria for selecting potential recruits:

Inclusion Criteria

- Consultation with a registered medical herbalist within the previous 12 months
- Aged 18 years or over
- Herbal treatment for a physical complaint
- Ability to communicate verbally and fluently in the English language
- Willingness to participate in the study.

Exclusion Criteria

- Current history of depression, mental illness or learning disability
- Communication difficulty that would impede the interview process
- Frailty or history of recent events that might increase a person's vulnerability.

Sample size in qualitative research is deemed adequate when data saturation occurs (Morse 1998) and is usually between 4-40 participants (Holloway and Wheeler 1996). In phenomenological research, sampling tends to be highly efficient, reducing the overall requirement for sample size (Morse 1991). Taking into account the purposes of the study, the number of practising herbalists in the area, the likelihood of undertaking multiple interviews with participants and resource constraints, I anticipated an ideal sample size of 15-20. Assuming an arbitrary 50% response rate throughout, I therefore invited each herbalist to recruit up to six clients, a strategy that resulted in a final sample size of 19 participants (Table 4.1, p80). I planned to continue sampling in this manner, in the event that the initial sample should fail to yield sufficient or relevant information.

3.2.3.2 The Interview Process

I interviewed all but one participant on two separate occasions, neither of which exceeded one hour in duration, the recommended maximum for interview participation (Field and Morse 1985). A series of shorter interviews is considered to be less tiring than one longer one for both participant and researcher and is considered to be more effective (Field and Morse 1985) and more likely to be successful in achieving data saturation. The multiple interview approach is also conducive to what van Manen (1990) calls the collaborative hermeneutic conversation, which establishes both parties as co-investigators by allowing them to reflect together on the significance of themes generated from earlier texts. I reminded participants that they would be free to terminate an interview at any time although I found the majority to be eager to pursue discussions beyond closure of the designated interview period. I took this opportunity to document these informal conversations in the form of field notes, which I subsequently used as a source of additional data.

In conducting the interviews I embraced principles common to all qualitative interviewing (Burns and Grove 1993, Morse 1991) as well as those specific to phenomenological research, since the specific purpose of the hermeneutic phenomenological (conversational) interview is to gather experiential narrative material and to develop a conversational relation about the meaning of the experience (van Manen 1990). This approach, which reflects a qualitative mode of understanding (Table 3.3) that is implicit to the qualitative research interview, enabled me to seek out assumptions that underpinned participants' meaning. The process is regarded as a professional conversational technique that enables knowledge to be constructed as a result of interaction between interviewer and interviewee (Kvale 1996) and this I achieved by adopting an "engaged, profound approach to listening" (Sorrell and Redmond 1995, p1120) and by producing both narrative and contextual data.

CHARACTERISTICS OF INTERVIEW	DESCRIPTION
1. Lifeworld focus	The topic of qualitative interviews is the everyday lived world of the interviewee and his or her relation to it
2. Accounting for meaning	The interview seeks to interpret the <u>meaning</u> of central themes in the interviewee's lifeworld
3. Qualitative perspective	Qualitative knowledge, expressed in normal language, is sought without quantification
4. Descriptive style	The interview attempts to obtain open nuanced descriptions
5. Specific focus	Specific experiences rather than generalisations are elicited
6. Deliberate naivety	The interviewer exhibits an openness to new and unexpected phenomena, rather than having ready-made categories and schemes of interpretation
7. Focused approach	The interview is neither structured nor non-directive but is focused on particular themes
8. Acknowledging ambiguity	Ambiguous statements reflect contradictions in the interviewee's lifeworld
9. Accommodating change	The interview process may produce new insights and awareness and the interviewee may come to change his or her descriptions and meanings about a theme
10. Dependence on sensitivity	Different statements may be produced by different interviewers dependent on their sensitivity to, and knowledge of, the interview topic
11. Interpersonal situation	Knowledge is produced as a consequence of interpersonal interaction during the interview process
12. Positive Experience	A well carried out interview can be a rare and enriching experience for the interviewee

Table 3.3
Qualitative Mode of Understanding
(Adapted from: Kvale 1996 pp 30-31)

An essential objective of the hermeneutic interview is to maintain a focused orientation towards the phenomenon of interest (van Manen 1990, Gadamer 1975). For this I constructed an interview guide that enabled me to maintain sufficient focus, without drawing on predetermined questions (Table 3.4).

ASPECT OF INTERVIEW	**TECHNIQUE**
Initial warm-up	Clarification of interview purpose Establishment of initial rapport
Initiation of interview	Posing the opening question: "Please can you tell me something about your first ever visit to see a herbalist?"
Maintaining focus	Encouraging description, rather than analysis: asking 'how?' rather than 'why?' questions
Maintaining purpose	Maintaining a focus on participant's experience Allowing silence for reflective thought Refraining from use of 'probing' questions
Maintaining rapport	Confirming importance of participant's contribution Attentive listening
Interview closure	Providing assurance that information has been useful Establishing whether participant has any more to say Confirming that no more information is required at present
De-briefing	Expressing thanks to participant Reiterating closure Reminding about contact numbers for further information/support Verifying willingness to contribute to further interview(s), if needed

Table 3.4
Interview Guide

The interview guide allowed me to remain responsive to individual participants (Sorrell and Redmond 1995) but also minimised the risk of my being overly directive (Appendix 1: Section 4.1). I conducted the interviews in participants' own homes at a mutually agreed time and I audio recorded these to allow my concentration on the dynamics of the interview process. I incorporated measures into the interview process that were designed to enhance the reliability and validity of interview data (see: Section 3.2.5.6, Reliability and Validity of the Interview Process).

3.2.4 DATA ANALYSIS

(Stages 4 and 5: Transcribing and Analysing)

The concept of data analysis as a linear process is incongruent with phenomenological investigation although the notion that it begins at the point of data collection (Cohen et al 2000) and ends with the production of a final narrative text, is generally accepted. In analysing the data I identified, and reflected on, structural aspects of meaning embedded in lived experience and I captured these in the form of themes. My analysis also acknowledged phenomenological boundaries that recognise the 'end product' of data analysis as both tentative and historically bound (Cohen et al 2000). I concur with van Manen's (1990) description of themes as a reflection of insightful invention, discovery or disclosure, established through a free act of 'seeing' meaning, rather than by mechanical coding that depends on application of pre-determined rules (van Manen 1990).

3.2.4.1 Data Transcription

Since the process of transcribing interview data carries significant implications for validity of qualitative research, I discuss this aspect of data analysis within Section 3.2.5.6: Reliability and Validity of the Interview Process.

3.2.4.2 Thematic Analysis

My approach to thematic analysis was guided by methodological techniques described by van Manen (1990) and Cohen et al (2000) and was underpinned by Kvale's (1996) seven canons of hermeneutic analysis, which he derived from Radnitzky's (1970, cited Kvale 1996) analysis of the hermeneutic circle:

1. Continuous interpretation of the parts and the whole of the text
2. Closure of interpretation
3. Testing of partial interpretation
4. Textual autonomy
5. Researcher knowledge
6. Pre-suppositions
7. Creativity.

The seven canons have, more recently, been adapted by Kvale (1996) to take into account the implications for interpretation of interview texts. Since I considered this process to be sufficiently robust to guide and authenticate hermeneutic data analysis (Appendix 1: Section 5.2), I adopted Kvale's adaptation as a framework for analysis in the current study. My application of Kvale's framework is described below.

1. Continuous interpretation of the parts and the whole.

   This stage characterises the basis of hermeneutic analysis and was achieved through several methodological techniques, which I describe below and illustrate in Figures 3.2 and 3.3. I initially analysed participants' transcripts independently of one another (intra-textual analysis) and I subsequently re-analysed these collectively (inter-textual analysis). In the following text I italicise key stages of the analytic process, to highlight their relationship to the corresponding diagrammatic representation.

   Intra-textual Analysis (Figure 3.2):

   - My *initial reading* of each transcript produced a *global summary* that captured the fundamental meaning of the text as a whole (van Manen 1990). This activity represents my immediate impressions of each participant's interview text

   - Following the construction of a global summary, I returned to the transcript to undertake more *focused reading(s)* to identify *preliminary themes* that reflected essential characteristics of the data (Cohen et al 2000)

   - Prior to further analysis, I compared the preliminary themes and global summary for 'fit,' this process of mutual verification reflecting my engagement in the hermeneutic circle (Appendix 10). Where inconsistencies were identified, I resolved these by returning to the text for verification and making modifications to the global summary or preliminary themes, as appropriate.

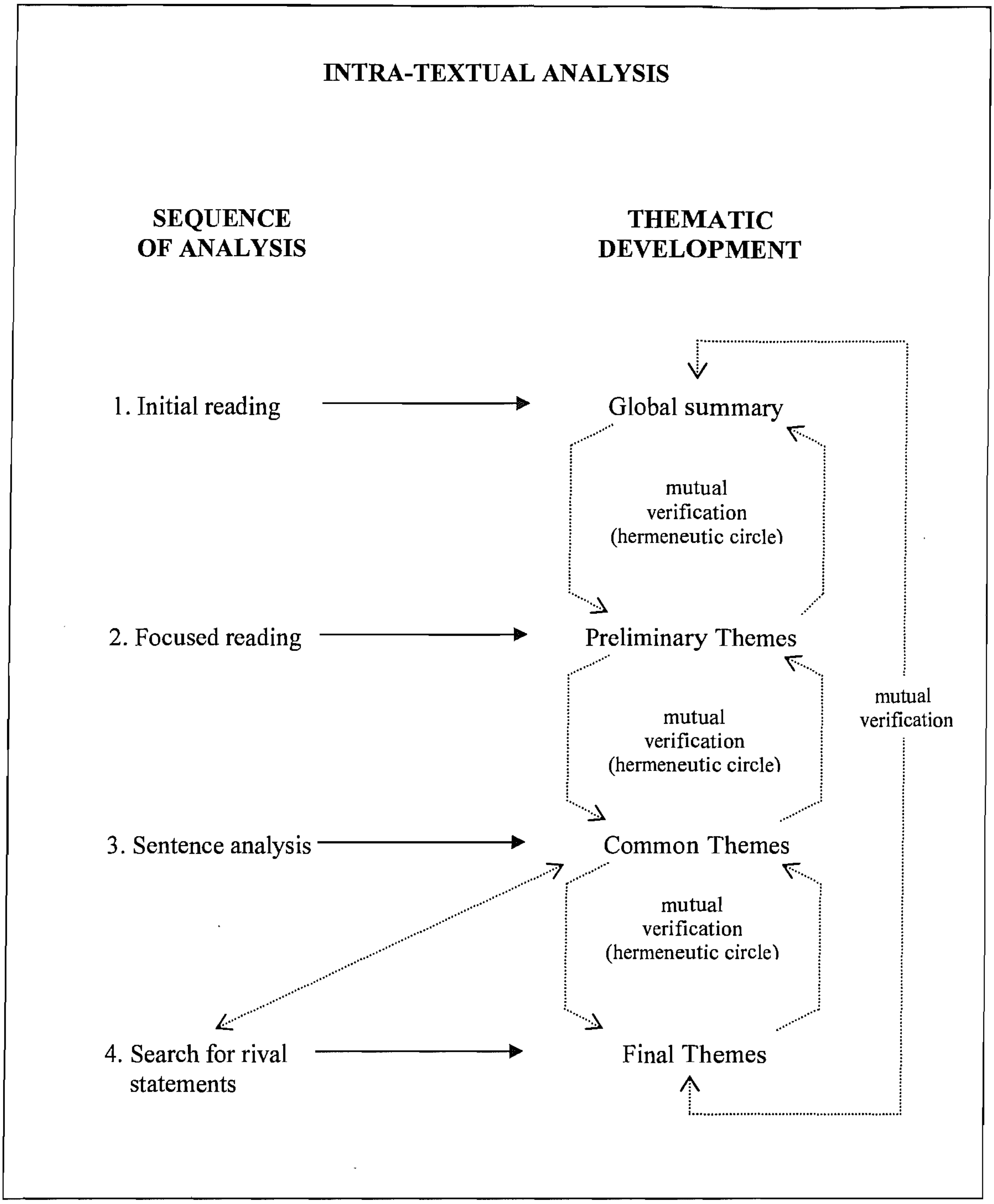

Figure 3.2
Intra-textual Analysis

- Once I was satisfied that there was corroboration between the global summary and preliminary themes, I undertook a detailed *sentence analysis* that produced statements about concrete experience (preserving original terminology where possible), which I subsequently clustered into *common themes.* As before, I engaged in the hermeneutic circle by comparing common themes with preliminary themes for 'fit'. Inconsistencies were resolved by returning to the text for verification and I modified preceding analyses (preliminary themes, global summary) in the light of new meaning (Appendix 1: Section 5.1)

- I concluded intra-textual analysis by carefully examining the transcript for *rival statements* (Appendix 11). This process was twofold: firstly, I searched the transcript itself for statements that either contradicted or failed to support the common themes. Secondly, I compared common themes to my own preconceptions and, where I observed similarities, I returned to the transcript to verify that the participant's responses had not been coerced. Intra-textual analysis culminated in the production of *final themes*, verified for 'fit' against the global summary, and subsequently labelled to reflect essential content.

Inter-textual Analysis (Figure3.3):

- On completion of intra-textual analyses, I re-examined the *global summaries* as a whole to explore for *commonalities* and, in the spirit of the hermeneutic circle, these commonalities were verified against the global summaries. Since this process revealed a common motive for every participant's use of medical herbalism, I called this the *motivational theme*

- I then compared the *final themes* as a whole and I clustered these into common groups that reflected the underlying *structures of the motivational theme* (i.e. those elements of medical herbalism that motivated participants' use). Following a process of mutual verification, I named these *structural themes.*

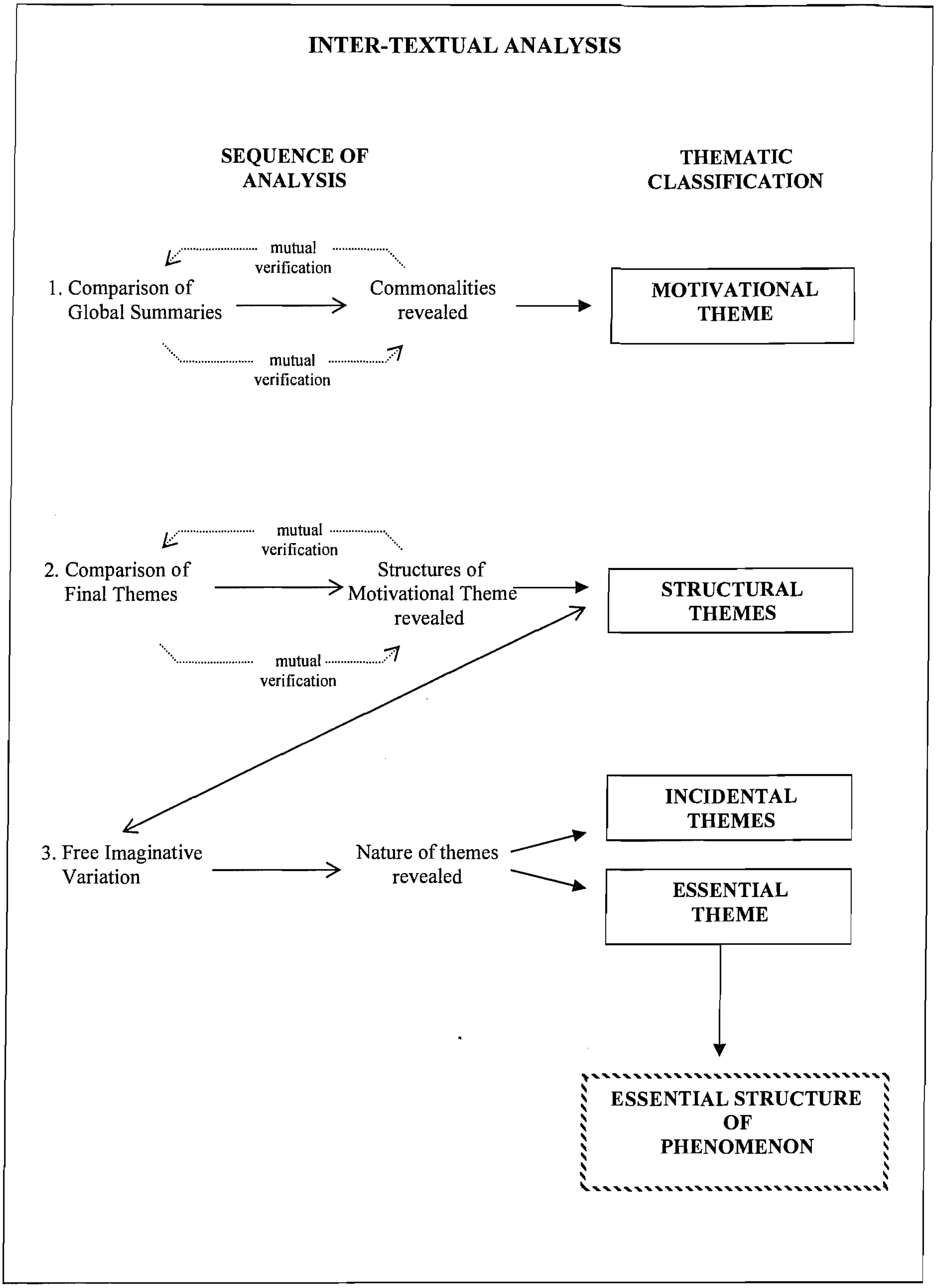

Figure 3.3
Inter-textual Analysis

- Finally, I applied the process of *free imaginative variation* to the *structural themes* as a means to identify their *incidental* or *essential* relationship to the phenomenon (Appendix 12) - according to van Manen (1990) the most difficult and controversial element of human science research. I achieved this by posing the following question to each of the structural themes in turn:

> Is this theme specific (or even unique) to medical herbalism or is it also common to conventional health care?

Through this process, I was able to discriminate between structures that were specific to the phenomenon (*essential themes*) and those that were not (*incidental themes*). In doing so, free imaginative variation allowed me to identify the *essential structure of the phenomenon* (the aspect that made herbal health care fundamentally different from conventional health care, according to study participants).

2. Closure of interpretation.

Closure occurred at the point of data saturation, which I determined by the absence of contradictory statements, as well as the emergence of thematic patterns into a coherent unity. Together, these measures signalled a logical conclusion to interpretation (Kvale 1996). As Bollnow describes:

> "... when the conversation finally does sink into silence, it is no empty silence, but a fulfilled silence."
> (Bollnow 1982, p46)

3. Testing of partial interpretation.

During analysis, I tested statements against each other and also against the global perspective (see Canon one).

4. Textual autonomy.

I respected textual autonomy by interpreting each interview text within its own frame of reference (multiple transcripts from the same interviewee were regarded as a single text)

5. Researcher knowledge.

I had personal knowledge of the phenomenon under study, sufficient to enable sensitivity toward nuances of meaning embedded within participants' experiences.

6. Pre-suppositions.

I acknowledge that the product of an interview is co-constructed by both the interviewee and interviewer. To account for my own pre-suppositions, I authenticated emerging themes by actively searching the text for rival statements and by ensuring that participants' responses had not been encouraged by leading questions.

7. Creativity.

Phenomenological description does not end with meanings given immediately within the text but extends through acts of interpretation that ultimately enrich understanding. My interpretation of the data occured in several layers: analysis of individual texts, comparison between texts and interpretation against additional sources of data (personal, contextual and published, for example). Although my focus was primarily on individuals as unique beings, my understanding evolved by interpreting the phenomenon through shared human experience. I therefore illustrate the phenomenon from individuals' perspectives but also as a coherent whole that reflects shared meaning.

3.2.4.3 Maintaining the Research Focus

According to van Manen (1990) human science texts that are oriented, strong, rich and deep help to maintain an appropriate focus to the study. I achieved these in the following ways:

- By relating theoretical knowledge to concrete experience found in experiential narrative I maintained a focused orientation
- By consulting with forms of knowledge that had the potential to inform the study, I maintained a strong focus to the study
- By exploring lived experience beyond that which was immediately given in the texts I produced rich data
- By maintaining an open attitude that allowed the fundamental ambiguity of lived experience to be heard I acquired depth to the study.

3.2.5 RELIABILITY AND VALIDITY
(Stage 6: Verifying)

The concept of validity in qualitative research is concerned with the extent to which the chosen methodology investigates the phenomenon of interest and the extent to which defensible knowledge claims can be established. Research validation is equally concerned with the process of knowledge production as with the end product of enquiry. In addition to a critical evaluation of research methods, this concept of validation also addresses the quality of investigative craftsmanship and the researcher's ethical integrity (Kvale 1995). From an interpretivist perspective, interpretation is considered contingent and tentative, validation being concerned with the extent to which the investigator's biases have influenced the study (Cohen et al 2000). It is also argued that validity criteria can differ according to the validity threats inherent to a particular study design (Whittemore et al 2001) and, for this reason, rigid adherence to method is not considered to be an assurance of validity (Sandelowski 1993).

I refer to Lincoln and Guba's (1985) criteria for qualitative research (credibility, transferability, dependability and confirmability) as the broad framework for addressing reliability and validity of the study and, to a lesser extent, to Sandelowski (1995b, 1993, 1986) and Cohen et al (2000) in respect of specific aspects of the study. I also acknowledge Kvale's (1996) notion that validity issues are implicit to every stage of an interview study (Table 3.5).

INTERVIEW STAGE	IMPLICATIONS FOR ESTABLISHING VALIDITY
1. Thematizing	Theoretical validity Logic of derivation from theory to research question
2. Designing	Congruity between research design and intended knowledge production Potential for beneficence Minimal risk of harm
3. Interviewing	Quality of interview process Validation of interview data
4. Transcribing	Choice of linguistic style
5. Analyzing	Transparency of logic applied to interpretation
6. Validating	Application of validation techniques, appropriate to methodology
7. Reporting	Valid reporting of main findings Validation by readers of report

Table 3.5
Validity Implications for each Stage of an Interview Study
(Kvale 1996 p 237)

3.2.5.1 Credibility

An assumption implicit to my research design is the existence of multiple constructed realities and a belief that a study's truth-value is dependent on a conscientious reconstruction of those realities. I demonstrate credibility of the study findings through the following techniques:

- The production of 'thick' description. I present sufficiently context-rich interpretations, to increase plausibility and to enable recognition and verification of emergent themes

- Prolonged engagement with interviewees. I engaged in multiple interviews with the participants, to enhance the quality of interview data by establishing rapport and trust. Prolonged engagement with interviewees also enabled my orientation to each situation, and allowed me the opportunity to explore inconsistencies in the research data
- A search for rival statements during the process of data analysis. To verify the authenticity of thematic analysis, I actively examined the research texts for statements that contradicted, or failed to support, the emerging themes or that failed to support the researcher's existing assumptions
- Participant validation. The return of interview data to participants for validation has been recommended (Hoffart 1991) although the value and practicalities of this activity have been debated. Whilst data that have been subjected to analysis and coding can present difficulties for participant validation, the value of validating a verbatim ('clean') transcript has also been questioned (Koch and Harrington 1998). Taking these arguments into account, I invited participants to validate a summary of my interpretation of their interview to ensure accuracy of my interpretation. This provided an opportunity to correct erroneous interpretations and to incorporate additional information prior to subsequent interview(s) being undertaken.

(Miles and Huberman 1994, Lincoln and Guba 1985)

3.2.5.2 Transferability

Careful data interpretation can enable an element of transferability to be achieved in qualitative studies. Maxwell (1992), for example, describes theoretical validity as abstract explanation that allows analysis to be extended beyond the immediate study. Case-to-case transfer, however, needs to be assessed according to the specific alternative context and is therefore difficult to predict. I therefore address the potential for transferability by providing sufficient data to enable judgement by others:

- I describe the characteristics of the research sample and study processes, sufficient to enable adequate comparison with other groups or settings

- I provide rich, raw data, to enable others to judge potential transferability to alternative settings
- I suggest the scope and limitation of transfer possibilities.

(Miles and Huberman 1994, Lincoln and Guba 1985)

3.2.5.3 Dependability

Overall dependability of the study is reflected in the extent to which credibility criteria are met and the extent to which the process and product of the study can be examined for internal coherence and accuracy. I employed the following techniques to establish dependability:

- Consistency of interview focus. I carefully constructed the research question to enable participants to maintain a focus appropriate to study purpose
- Consistency of interview approach. I ensured that the processes of data collection and data analysis were congruent with the research question and I nurtured an interview technique that encouraged reflective, rather than analytic, discussion
- Consistency in interview completion. Interviews were continued until I was satisfied that data saturation had been achieved
- I have documented the processes of data collection and data analysis, sufficient to allow corroboration between data and interpretation to be established.

(Miles and Huberman 1994, Lincoln and Guba 1985)

3.2.5.4 Confirmability

The concept of confirmability is concerned with how well the study's data can be confirmed as a reliable representation of the phenomenon, from the originator's perspective. The ultimate aim of this criterion is to achieve "relative neutrality" and "reasonable freedom" from researcher biases to ensure that conclusions can be attributed to participants with some degree of confidence (Miles and Huberman 1994, p278). I demonstrate confirmability of the study by reporting methodological data in a transparent and comprehensive manner and I summarise the techniques employed to address each of Lincoln and Guba's criteria in Table 3.6.

CREDIBILITY	**TRANSFERABILITY**
• Context-rich interview data • Prolonged engagement in the interview process • Incorporation of raw interview data into analysis • Peer debriefing • Examination of texts for rival statements • Participant validation	• Clear description of research sample • Context-rich interview transcripts • Incorporation of raw interview data into analysis • Exploration of potential for case-to-case transfer • Indication of limitations of transfer possibilities
DEPENDABILITY	**CONFIRMABILITY**
Reflected in the extent to which credibility criteria are met, plus: • Consistency: - of interview approach - of interview focus - in timing of interview closure • Documentation of data collection and data analysis processes • Construction of a decision trail	• Transparency in reporting research design

Table 3.6
Techniques for Achieving Reliability and Validity
(Adapted from: Miles and Huberman 1994, Lincoln and Guba 1985)

3.2.5.5 The Audit Trail

The recommendation for audit trail as a means of confirmability in qualitative research, has persisted since the early work of Lincoln and Guba (1985). The concept has since been modified and applied by other authors (Miles and Huberman 1994, Rodgers and Cowles 1993) although its essential purpose remains consistent; to provide a systematised record of researcher-generated data that illustrates how information was collected and how conclusions were drawn (Miles and Huberman 1994). The audit trail also promotes coherence of the written report by enabling the degree of corroboration between data, analysis and conclusions to be ascertained. Acknowledged as a means to "convince the scientific community of their rigour" (Wolf 2003, p1), the audit trail is still considered the measure of choice in determining qualitative research credibility. Despite its widespread endorsement, I raise the following questions in respect of the universal application of audit trail in establishing confirmability in all types of qualitative research.:

1. Where the research report is sufficiently transparent, the audit trail duplicates some aspects of information, especially those that provide a rationale for methodological decision-making.
2. The finer aspects of analytic activity can be difficult to articulate, especially for the experienced researcher, who draws as much on prior knowledge and intuition as they do on methodological rules and principles (Cutcliffe and McKenna 2004). As van Manen (1990) points out, hermeneutic analysis involves 'seeing' meaning, which is a difficult process to document.
3. The requirement to explicate researcher bias through the audit trail is difficult to achieve, in that prejudices are not always readily brought to consciousness. It is also an unusual requirement, in that bias is inescapably present in all research and, especially in qualitative research, is often viewed as a necessary contribution to the enquiry process. As Cutcliffe and McKenna (2004) point out, the detection of bias would indicate only that the study is congruent with qualitative methodology. I would also argue that, working within a framework that espouses all interpretation to be valid, the purpose of using audit trail to establish validity is disputable.
4. It can be difficult to recognise conclusively whether the research findings are grounded in the data in anything other than a purely descriptive study. Interpretive studies, by definition, build on original meaning.
5. The audit trail requirement for raw data, data analysis products and data synthesis products (Wolf 2003), whilst of use in brief research reports, are all readily available in a fully reported study, the benefits of further documentation therefore being questionable.

I therefore reject the traditional audit trail as a measure of the study's confirmability and dependability, a decision that was further reinforced by the writings of Cutcliffe and McKenna (2004). In juxtaposing the practice of audit trail and the key features of the expert (experienced) qualitative researcher, they propose that the two may be incongruous and incompatible, arguing that the audit trail may, indeed, exaggerate the case for method and achieve little in the way of establishing credibility of the research findings. They further argue that the writer and reader (auditer) may subscribe to different chains of reasoning that lead to different conclusions being drawn, a situation that undermines the very purpose of audit. Acknowledging that the rationale for audit trail reflects positivistic concerns, and having sympathy with Kvale's (1995, p36) observation of a "mania for legitimation", Cutcliffe and McKenna (2004) offer a case for testing the credibility of qualitative research by considering its usefulness – its 'fit and grab' as they put it.

Despite these concerns, I do document essential reflections in a decision trail, since these personal reflections underpin my rationale for methodological decision-making and, in part, they actively contributed to the analytic process. As such, they provide additional methodological data. Although I question the extent to which subconscious prejudices can be elevated to conscious awareness, the decision trail does offer my known pre-conceptions for examination in terms of their possible influence on data analysis. In this respect, I present a decision trail in the hope that it helps others to critique, or be guided by, method. I invite readers to judge the rigour of the study on the basis of methodological appropriateness (rather than orthodoxy), and according to demonstrable corroboration between research process and research product. I also appeal to readers to consider the degree of usefulness of the study findings for those to whom the study pertains. My personal reflections, I document in Appendix 1 and I signpost, as appropriate, within the text.

3.2.5.6 Reliability and Validity of the Interview Process

Data collection and data transcription processes carry particular implications for reliability and validity in an interview-based study. Reliability of interview data can be especially hindered by poor acoustic quality, most commonly caused by equipment failure or by environmental hazards (Easton et al 2000). I anticipated these potential hindrances by applying the following precautions:

- I minimised the risk of equipment failure by using quality recording equipment, by checking record and playback ahead of each interview and by maintaining a stock of spare tapes, back-up recorder and batteries
- I minimised the risk of environmental hazard by requesting a quiet and private location for interview. I also suggested a maximum duration for interview and emphasised the importance of the participant's contribution, in an attempt to minimise the risk of interruption (Appendix 1: Section 4.2).

My use of an interview guide also promoted relative consistency in interview technique, whilst allowing responsiveness to individual participants (Table 3.4, p61).

Validity associated with the transcription process can be difficult to achieve (Kvale 1996) due to the complexities involved in this activity (Sandelowski 1994). One way to simplify the process is to determine a transcription protocol (Sandelowski 1994):

- The nature of phenomenological research demands as full as possible a representation of the interview conversation, which I achieved by producing verbatim interview transcripts
- In order to explore meaning embedded in interview text, I supplemented the transcripts by including carefully constructed contextual data
- I constructed a notation system to preserve and emphasise meaning within interview transcripts (Appendix 13)
- I used the transcripts only for analytic purposes in relation to the study. 'Clean' copies of transcripts have been retained as a requirement for research examination but not for other purposes.

(Sandelowski 1994)

Sandelowski (1994) argues that, although transcripts are defined as exact duplications of speech, the process of transcription involves a transformation that is only partially representative of its original form. The process is both realist and constructed in that some elements of the interview are captured whilst others are altered. Threats to validity are therefore most likely to occur during the transcription process. The risk of mis-hearing, mis-interpretation and/or inaccurate transcription are all potential threats to validity of interview data and careful checking for accuracy is essential, prior to performing analytic procedures (Easton et al 2000). To achieve this, I invited participants to verify the accuracy of initial interview interpretations prior to further interview procedures.

3.2.6 DISSEMINATION

(Stage 7: Reporting)

Dissemination of the study findings has implications for each of the stages of the research process (Table 3.7) and I therefore took these into account during the course of study. Through dissemination, I aim to make explicit both the consumer perspective and the study methodology, to enable external evaluation of both study outcome and study process. I plan to disseminate the study findings by means of professional publication, conference presentation and presentation to professional and consumer bodies, and I intend to tailor the reporting style to suit the intended audience and the dissemination format. For textual dissemination, I will utilise guidelines that ensure the effective and responsible incorporation of direct quotations (Figure 3.4). To date, I have disseminated the findings to mixed European audiences in Belgium and Finland, which comprised multi-professional, undergraduate health care students. My purpose in presenting to these particular audiences was to encourage inter-professional debate about patient choice and the impact of this of the patient's health care experience.

Stage of Study Design	**Implications for Dissemination**	**Implications for Study Design**
Thematizing	The anticipated end product of the study is borne in mind at the design stage of study	Clear focussing on research question
Designing	- Methodological procedures recorded - Interview format conducive to reporting - Ethical issues accounted for	- Audit trail - Interview guide, transcription process - Ethical standards
Interviewing	Audio recordings in communicable format	Interview guide, interview technique, recording equipment, fieldnotes
Transcribing	- Transcriptions legible and understandable - Confidentiality maintained	- Transcription process and guidelines - Ethical standards
Analysis	Analysis embedded in final reporting	Techniques for data analysis
Verification	Communication contributes to verification	Trustworthiness
Reporting	Early consideration of final report enables substantiation of study findings	All stages

Table 3.7
Research Design: Implications for Dissemination
(Adapted from Kvale 1996 p257)

Guidelines for Reporting Interview Quotes

- Quotes should relate to general text
- Quotes should be contextualised
- Quotes should be interpreted within the text
- Quotes should not exceed 50% of the text
- Single quote should not exceed half a page
- A single ‘best’ quote should be utilised
- Quotes should be rendered to a readable style
- A system for editing quotes should be provided

Figure 3.4
Guidelines for Amalgamating Quotes into Text
(Adapted from Kvale 1996 pp266-267)

4 THE STUDY FINDINGS

The study data presented here are derived from interviews undertaken with each of the study participants and they illustrate participants' experiences of medical herbalism in the context of contemporary health care in the United Kingdom. The findings are therefore presented predominantly from the perspective of medical herbalism but also include reference to participants' experiences of conventional health care in order to contextualise their perspectives. Data analysis was undertaken both within (intra-textual) and across (inter-textual) individual texts but, consistent with phenomenological purpose, data are presented collectively, to illustrate the phenomenon itself. Interview data are presented verbatim, keeping emphases intact, in an attempt to preserve meaning (Appendix 13). Data analysis was undertaken in accordance with the processes previously described. The results incorporate data provided by every participant (Appendix 1: Section 5.4).

Following a summary of participants' personal characteristics (see: Section 4.1, The Study Sample), the study results are presented sequentially, to reflect the process of hermeneutic enquiry, which is characterised by ever-deepening interpretation and understanding:

- Section 4.2 outlines the main themes emerging from data analysis
- Section 4.3 describes the underlying motive (motivational theme) that was found to be common to every participant's use of medical herbalism
- Sections 4.4 - 4.6 detail the main themes (structural themes) that emerge from, and therefore substantiate, the phenomenon
- Section 4.7 discriminates between incidental and essential themes of the phenomenon
- Following a re-capitulation of the study findings, Section 4.8 concludes with a phenomenological summary of participants' lived experience.

4.1 The Study Sample

Of the 14 registered medical herbalists identified within the geographical boundaries of the study, seven agreed to participate. Of the non-responders, four were no longer practising and one had since retired from practice while two failed to respond to either initial or follow-up communication. Within the discussion, herbalists and participants are identified according to the practice with which they are associated. For example:

- The code 'S2' refers to (the herbalist practising in) site number 2
- The code 'S4' refers to (the herbalist practising in) site number 4, and so on
- 'S2.1' refers to the first participant recruited by herbalist S2; S2.2 and S2.3 to the second and third participants recruited by the same herbalist.

The seven participating herbalists all practised within a 50 mile radius in the south of England and each identified between one and five potential recruits. A variety of presenting conditions was evident within the sample as a whole and, where a herbalist had recruited more than one participant, this variation was also evident within subgroups (Table 4.1).

HERBALIST	**RECRUITS**	**PRESENTING CONDITION**
S2	3	Acne; migraine; dermatitis and dry eyes
S4	2	Debilitation; hormonal and insomnia
S5	5	Blepharitis; asthma; irritable bowel; palpitations and hypercoagulation; cardiac failure and leg ulcers
S7	1	Menopause
S9	2	Irritable bowel; gallstones
S11	2	Cancer; hypertension
S13	4	Stress; cough; cystitis; eczema

Table 4.1
Participants' Presenting Conditions

Every recruit subsequently consented to participate in the study, bringing the initial sample size to 22. This number fell, however, to a final sample size of 19 following the loss of three recruits: two who failed to commence the study and another who was excluded after completing the first interview:

1. Participant S9.2 had been experiencing considerable domestic difficulties at the time of recruitment, which made participation in the study difficult at that time. However, due to the participant's eagerness to contribute to the study, an open invitation to contact the researcher at a later time was issued but, having failed to make further contact, the participant was excluded from the study.

2. Participant S9.3 was excluded due to difficulty in negotiating a mutually convenient meeting. Being located some considerable distance outside the defined study catchment area it became impossible to identify mutually agreeable interview opportunities within the timeframe of the data collection period. Disappointingly, this participant was also excluded from the study.

3. During the first interview with participant S13.1, the participant expressed uncertainty as to her reasons for seeking herbal health care and expressed doubt that she would commence the herbal treatment prescribed. The participant had volunteered to contribute to the study because "it looked interesting" but subsequently withdrew on the basis that she had decided against using herbal treatment, for "no real reason". Having visited the herbalist on only a single occasion, her recruitment to the study had been inappropriate and this reflected an oversight in the construction of inclusion criteria.

The 19 remaining participants resided in one of three neighbouring counties, which included urban, suburban and rural locations. The 13 female and six male participants were aged between 18–84 years and were employed in, or retired from, skilled/unskilled (n = 7) or professional (n = 5) employment, the remainder being either unemployed (n = 4), in higher education (n = 1), housewives (n = 1) or of private financial means (n = 1). Participants had initially consulted with medical herbalists for the treatment of different types of condition and the majority (n = 16) had first seen a medical herbalist within the previous two years. Sample characteristics are summarised in Table 4.2.

GENDER	AGE	SOCIAL STATUS	INITIAL CONSULTATION	TIME SINCE FIRST VISIT	LOCATION
S2.1 Female	18 years	Student	Acne	1 year	North Dorset
S2.2 Male	24 years	Unemployed	Migraine	2 years	North Dorset
S2.3 Male	60 years	Retired	Dermatitis, dry eyes	2 years	West Dorset
S4.1 Female	34 years	Housewife	Debilitation	9 months	West Dorset
S4.2 Female	37 years	Unemployed	PMT, insomnia	1 year	West Dorset
S5.1 Female	64 years	Retired	Blepharitis	1 year	East Dorset
S5.2 Male	74 years	Retired	Asthma	18 months	Hampshire
S5.3 Female	68 years	Retired	Irritable bowel disease	5 years	East Dorset
S5.4 Male	69 years	Retired	Palpitations, anticoagulation	2 years	East Dorset
S5.5 Male	55 years	Unemployed	Cardiac failure, leg ulcers	18 months	East Dorset
S7.1 Female	57 years	Professional	Menopause	2 years	East Dorset
S9.1 Female	48 years	Skilled	Irritable bowel disease	2 years	North Dorset
S9.4 Female	84 years	Retired	Gallstones	1 year	North Dorset
S11.1 Female	69 years	Retired	Cancer	2 years	Wiltshire
S11.2 Female	54 years	Skilled	Hypertension	6 months	Wiltshire
S13.2 Female	68 years	Retired	Stress	9 months	Hampshire
S13.3 Female	60 years	Unemployed	Psychiatric	20 years	West Dorset
S13.4 Female	42 years	Professional	Recurrent cystitis	3 years	East Dorset
S13.5 Male	44 years	Professional	Eczema	18 months	West Dorset

Table 4.2
Sample Characteristics

The majority of participants had first consulted with a medical herbalist for the treatment of a chronic condition but this pattern changed following their initial treatment, every participant subsequently consulting with their herbalist for the treatment of everyday conditions (Table 4.3).

CATEGORY OF CONDITION	**PRIMARY CONSULTATION**	**SUBSEQUENT CONSULTATION**
Chronic, intermittent	10	3
Chronic, persistent	9	1
Acute	2	1
Everyday	0	15

Table 4.3
Conditions Treated at Primary and Subsequent Consultations

In respect of their primary consultation, six participants had already discontinued conventional treatment for that condition, on the basis of its perceived ineffectiveness. Others (n = 13) initially used the herbal treatment whilst continuing with conventional treatment, of whom seven subsequently discontinued conventional treatment, two reduced the frequency and/or dosage of conventional medicine and three maintained the use of both herbal and conventional treatments. The one remaining participant had commenced herbal therapy as a first line treatment. The majority of participants (n = 15) had informed their general practitioner that they were using herbal therapy. Of the four who had not, three considered that it was not their general practitioners' business since they had not been receiving conventional treatment at the time and the fourth participant had been too scared to mention it.

4.2 The Main Themes of the Phenomenon

Human science research is concerned with the underlying meaning of the phenomenon being explored, where meaning is multi-dimensional and multi-layered and where the formulation of thematic understanding reflects a free act of 'seeing' meaning (van Manen 1990). In phenomenological research, themes reflect the structures of experience (van Manen 1990). A theme is a reduction of that experience, a simplification that gives shape to the essence of the experience, allowing it to be more easily understood and to be more easily conveyed to others.

In this study, intra-textual analysis (see: Section 3.2.4.2, Thematic Analysis) produced a 'global summary' that captured a sense of the text as a whole, as well as identifying preliminary analytic themes (Appendix 14). These summaries produced a relatively superficial impression of participants' experiences prior to further analysis and, when compared to one another (inter-textual analysis, see: Section 3.2.4.2, Thematic Analysis), they illustrated broad findings and highlighted any immediate similarities and differences. This process culminated in the description of a common theme – 'searching for effective health care' – which reflected the shared experience that all participants identified as primarily motivating their use of herbal therapy. The theme 'searching for effective health care' is described as the 'motivational theme'.

Subsequent intra-textual analysis involved more focused reading and rigorous interpretation of individual sentences or units of meaning, to produce final themes from each participant's text (Appendices 15 and 16). Ongoing inter-textual analysis subsequently exposed three main 'structural' themes in that they described the structures of the motivational theme. These structural themes are named:

1. Dealing with illness causation
2. Enhancing healing through patient-practitioner collaboration
3. Authenticating health care effectiveness.

The theme 'authenticating health care effectiveness' had not been reported by participants as a primary reason for their use of herbal therapy and, for this reason, was initially considered as an adjunct, rather than a structural theme. As data analysis progressed, however, the relative importance of health care evidence to participants' judgements about the effectiveness and safety of health care emerged as more significant than had first been thought and was thus elevated to the status of 'structural theme' in its own right.

Thus, the motivational theme represents early stage analysis that enabled initial impressions to be drawn about participants' use of herbal therapy whilst the structural themes emerged as a consequence of ongoing data analysis, to provide insight into the meaning of that experience.

4.3 Motivational Theme: Searching for Effective Health Care

Preliminary analysis revealed a range of reasons for participants' use of medical herbalism. Including both push (10), pull (8) and relatively neutral (n = 1) factors, this finding initially appeared to concur with the literature, which suggests that the reasons for people's use of complementary therapies are many and varied. Also broadly in agreement with the literature, was the nature of the push and pull factors identified:

Push Factors

- Ineffectiveness of conventional health care
- Side-effects from conventional health care
- A desire to avoid the ingestion of chemicals
- A dislike of doctors' attitudes.

Pull Factors

- The naturalness or gentleness of herbal medicines
- The underlying philosophy of herbalism.

One other participant had become interested in herbal medicine following the successful homeopathic treatment of a pet cat whilst another had felt that it would be worth a try, following a social introduction to a practising herbalist.

Despite the apparent similarities to the literature, further analysis of the data revealed how these discrete reasons for people's use of herbalism actually concealed a common, underlying motive: regardless of their initial response, every participant had been searching for more effective health care:

1. Firstly, where participants had initially cited a pull factor, they subsequently described how their attraction to herbal therapy had been triggered by one or other dissatisfaction with conventional health care. For example, where participants cited an attraction to herbal medicine due to the natural origin of herbs, it emerged that they had been seeking a natural alternative because they had experienced side-effects as a consequence of the (unnatural) pharmacological option.

2. From this, it emerged that every pull factor concealed a primary push motive.

3. It further emerged that each push motive, regardless of its nature, was described by participants in terms of ineffectiveness: "… and then there's the side-effects. It don't work … 'cos you don't take them!" (S5.4).

4. Consequently, every participant's interest in an alternative health care option occurred as a result of one or other push factor, each of which was viewed as an indication of the relative ineffectiveness of conventional health care. Thus, the search for effective health care emerged as a common motive for this group of people.

The possibility that dissatisfaction with conventional health care lies at the heart of people's attraction to alternative options is, perhaps, also reflected by the finding that only three participants had been specifically attracted to medical herbalism, as distinct to other non-conventional therapies (Appendix 1: Section 5.3). For the majority, their search had been merely for 'an alternative' to conventional health care:

> "Well ... I was with a homeopath ... felt that it wasn't really doing me any good. Then I picked up her (herbalist's) leaflet at a local surgery" (S13.2).

On this basis, the pursuit of a specifically compatible ideology appeared to be of less importance than finding an effective, but non-specific, health care alternative. Thus, every reported motive ultimately emerged in the shape of a quest for effective health care, which participants defined in terms of the following criteria:

- The achievement of symptomatic relief
- The promotion of ongoing repair and recovery at multiple levels of a person's being
- An absence of adverse effects during and following treatment
- No illness recurrence, unless this is an inevitable consequence of the patient's illness
- Minimal disruption to everyday life
- A constructive patient-practitioner relationship.

Thus, in the spirit of hermeneutic enquiry, the meaning of 'effective health care' subsequently emerged as the fundamental issue around which data analysis revolved and is embedded within the following descriptions, which detail the structural, supporting themes of the phenomenon.

4.4 Structural Theme: Dealing with Illness Causation

Typically, participants described herbal health care as a complex process but they viewed this complexity as being essential to its effectiveness. At the heart of this effectiveness was the structural theme 'dealing with illness causation,' which was achieved by accounting for ill health in the broader context of a person's life. This theme comprised two interdependent sub-themes:

- Exposing the contributory factors to illness
- Accounting for uniqueness in the treatment of illness.

4.4.1 Exposing the Contributory Factors of Illness

> "With herbalists ... they find out what is the problem ... where it's come from ... the **origin** of it. And they bring it out, not suppress it" (S2.3).

This participant summed up the general sense that herbal health care achieves its effectiveness by way of identifying, and subsequently treating, the underlying cause(s) of illness. The approach to diagnosis was one of the most frequently cited factors that singled out herbal from conventional health care, participants' arguing that herbal, but not conventional, diagnosis explored beyond the presenting symptoms to seek out their underlying origin:

> "I'm very conscious that normal medicine deals with that particular bit that is going wrong, regardless of the effect that it has on the rest of the body. In their specialism, they deal with that speciality regardless of anything else, more or less. But a symptom ... it's nothing unless you open it up a bit" (S9.4).
>
> "... you have to look at everything that is making that body go ... you have to look at everything that's happening to find out what's making the symptom. You can't just attack something so intricate from the point of view of a single reaction" (S4.2).
>
> "... I would say they are more interested in what is **producing** this symptom rather than just trying to stop the symptom. I do feel this ... rather strongly" (S9.4).

Participants considered herbal diagnosis to be a complex process, which was typically described in terms of 'taking everything into account.' By addressing the various dimensions of a person's life in the context of their health, herbalism provided individualised health care that was conducive to the healing process:

> "She looked at different things ... things that the doctor didn't **ever** look at ... the whole person. I felt as though I had somebody dealing with **me** ... the whole person. Picking up on little snippets of information I was giving her ... looking for the root cause. Trying to get down to a base level to see what was happening" (S11.2).
>
> "She's looking into the sort of person you are, which has probably been very instrumental in giving rise to the problem you've got. And she's thinking how to, sort of, heal you generally ... not just whack the problem. You see, she's

> got to know me quite well. Got to know **me** … got to know my temperament … and what **I** need" (S11.1).

> "Two herbalists I've been to see and they both wanted to know **everything** about me. Emotional, physical, my feelings … they wanted to know everything … before even thinking about some sort of remedy. When they look at the remedies, they ask further questions … you just wouldn't believe ... just to find out more about you. Everything seems to make a difference - even the emotional side of things - when it comes to healing" (S5.5).

The intricate approach to diagnosis was valued because it helped participants to make sense of their situation. In particular, every participant commented that, through the herbal consultation, they began to recognise the significance of seemingly trivial information to the effectiveness of the diagnostic process:

> "Yes, it was different in as much as the herbalist took my body, my personality, my problems as a whole. Didn't leave a stone unturned. You know, things that you wouldn't even think about and wouldn't think that they would have any relevance" (S5.1).

> "You know, it's only when she starts to ask you questions that you think: "Well, no, that's not quite right." But it's actually how everything seems to fit into a pattern. Talking about things that are not all that related … or not **apparently** related … you can suddenly see a pattern and how things fit together" (S7.1).

To emphasise their point, participants compared the intricacy and complexity of herbal diagnosis, which every participant emphasised as a necessary foundation for effective health care, to their experiences in the conventional setting:

> "They have this, such a simplistic view: we're ill, we go to the doctor, we get some pills and that makes us better. It just sort of brings our beings into such a one dimensional space and the depth of **who** we are – which has so much to do with **how** we are – is completely ignored" (S4.1).

> "I mean, in 10 minutes you can't just make a snap decision about something if you don't know them. If they don't know you … don't know your lifestyle … don't know your diet … what factors are affecting your health. Well, they're just treating you like a … well, you're not an individual are you? It's like being in a factory. It's like: "Next!" You know, … come along … give them a pill … send them off. A doctor might overlook something because he hasn't talked about it" (S13.5).

As participants came to recognise that the cause(s) of illness were frequently concealed within apparently trivial or irrelevant detail, they began to see the importance of engaging in social communication ('chat') during the diagnostic process. This was an interesting finding to emerge from the data and one that revealed itself also in relation to other constituents of effective health care:

> "You know, things that you wouldn't even think about and wouldn't think that they would have any relevance. And, of course, she picked all this up you see, just by, well ... **chatting** to me ... although I inwardly was thinking: 'Oh, no, that's not right'" (S5.1).

> "I felt it was totally unhurried ... so that made me relax anyway and just chat ... like I'm chatting to you ... as long as is necessary. We would talk about all sorts of things. Really thorough. Absolutely complete. I think it's pleasant but I also come away with far more **confidence** ... that the medicine I've taken and the sort of chat I've had is going to **work**" (S5.2).

The importance of chat to the process of diagnosis is captured particularly well by one participant who succinctly sums up the relationship between this and effective health care:

> "It's a different process isn't it? It's a different perspective of looking at the problem. A herbalist looks at why something is being created and attacks the problem rather than suppressing the symptoms. I go along and have a chat about my life ... talking about my problems ... giving him a viewpoint as to how I'm feeling ... really important to my treatment. The questions he asks ... the questions that your own doctor would never think of asking. He asks all sorts. Who? What? Obviously elaborates on all these things. What triggers you feeling this and that? How does it affect me? Can I relax at night? He says: "I need to know this if I am to find the right thing for you." **Everything** affects your body. Every little detail is important. **It's important.** And herbalism ... it treats every part of you" (S4.2).

Ultimately, herbal diagnosis was described as an approach to health care that "... sees beyond science" (S4.1) and, in doing so, maintains a connection with the reality of the human condition:

> "I think that the detail that herbalists ... the detail that they take ... You know, that time's lovely because you feel heard and that they really know you but actually it isn't about that. The detail, in that time, is critically important in the diagnosis. I think that they're, from the consultation, they're much more realistic. I think there's a more realistic expectation of how long it might take

> to get better, for example. The course of treatment, the tinkering, I think that they – the herbs – work **appropriately** quickly" (S4.1).

Interpretive Summary

Observable illness symptoms represent only the tip of the diagnostic iceberg and rarely reveal the true origin of a problem, which might relate as much to a person's past as to their present. The diagnosis of illness causation is therefore equally dependent on clues provided by seemingly trivial, everyday experiences, as much as by classic signs and symptoms. Diagnosis is facilitated through the process of social communication ('chatting'). This is seen to be a highly constructive process that is conducive to interaction and it enables the assimilation of new knowledge as a means to enhancing mutual understanding about the patient's illness. Through chat, the patient acquires sufficient confidence to reveal the personal minutiae of their life, exposing subtle clues that provide important insight into the nature of ill health and the origin of disease. It is essential to the provision of individualised health care. In addition to providing diagnostic insight for the herbalist, 'taking everything into account' also enables the patient to recognise how their illness has evolved, enabling them to make sense of the health care situation.

4.4.2 Accounting for Uniqueness in the Treatment of Illness

Treating the root cause of illness was seen to be a goal in herbal health care but not in conventional health care, which was seen to "...just stomp on the symptoms" (S7.1). At the heart of this distinction was the notion of healing: every participant recognising the achievement of healing in herbal medicine in comparison to the achievement of symptomatic relief in conventional health care:

> "Well you see, that's what people get so wrong about herbal medicine. It's a **different** approach. The idea of a remedy is not to fix something ... not to **fix the symptoms**. There is a difference in that, with the herbs, you aren't actually just looking at the symptoms ... masking something or stifling it. It makes sense ... looking at the underlying causes" (S7.1).

> "And it (conventional medicine) nearly always **won't** get rid of the cause of the problem. The idea that you've got a complex illness, in a complex organism

> and you can treat it with one particular agent is, to me, very simplistic. But it's the prevalent viewpoint amongst the western orthodox approach" (S13.5).
>
> "I mean, a drug will **control** ... control **the thing**. But I wasn't getting better" (S5.3).

Participants valued the healing that was achieved by herbal medicines, even though it was seen to provide less immediate effects:

> "It takes a while. It's very subtle but it works. When I take my herbal medicine it treats what's actually wrong with me" (S9.1).
>
> "It's not always quite so immediate (as conventional medicine). It's more long lasting **because** you're tackling the problem" (S4.2).

4.4.2.1 The Healing Properties of Herbal Medicines

According to participants, herbal healing was attributed partly to the unique properties of herbal medicines and partly to individualisation of the herbal formulation. Participants believed that herbs were effective in promoting healing because all living things (herbs and humans included) shared a common origin:

> "It's the little things, like ... they grow in the same conditions as we live. They need air and sun and water ... like every living thing does. And I think when you consume herbs, you take that essence into ... that's how I think it works at different levels of a person. Herbal energy ... it seems to sort of pass into you. It may sound a bit far-fetched but that's how I feel. Yes, that's what it is" (S2.2).
>
> "Well, it's natural. What can I say? It's like, well, there's ... an **aura** or something. You know, the earth and everything ... everybody. With herbs, the body will accept ..." (S2.3).

... and because of this shared origin, herbs and the human body also shared an essential compatibility that enabled healing to occur:

> "The herbal stuff sort of mingles in with everything ... enhancing everything inside. Rather than just going for the spot that's a bit iffy, it seems to be able to relate to everything in your body. It's a connection. It goes with the flow. I can't express it very well" (S13.4).

> "You've got your mind, your emotions, your feeling, your systems ... it's all a big circle. And your herbal medicines, they slot in to that circle" (S4.2).
>
> "My belief is that that's nature's way. You help your body to adapt to a change. The herbs, they help your body. They don't stop ... **the thing**. They work **with** the body. The herbs work **with** you" (S9.1).

By contrast, every participant believed that the occurrence of side-effects from conventional medicines provided evidence of their incompatibility with the human body. Further, they believed that this incompatibility impaired the healing process and that it was often the source of additional problems:

> "I feel that a drug is an artificial thing that the body is inclined to react to unfavourably. The drug and the body are not in harmony ... it has side-effects and prolongs the healing"(S5.1).
>
> "The drugs are **fighting** the body aren't they? Yes. An **intrusion**. And you don't know what they are going to do to you in the long term" (S5.3).
>
> "When I take a drug it seems to affect every part of me. You can't feel **well** on antibiotics. You can't feel **well** on steroids. You can't feel **well** on antidepressants. You take drugs and then you have to take drugs for the side-effects. And so on and so on until you end up with a concoction that makes you feel very ill. Sometimes, you can feel a lot worse on the drugs than when you were off it" (S9.1).
>
> "I feel quite strongly that if you start taking tablets, in the end you'll be taking tablets to cure the side-effects of those tablets. You start to take ... tablets for tablets" (S13.2).

In relation to herbal medicines, participants acknowledged their potential toxicity but they related this to inappropriate prescribing rather than an inherent body-herb incompatibility. Indeed, all participants hailed the absence of side-effects from herbal medicines and this reinforced their views about the importance of body-medicine compatibility:

> "They're respective of the body. They work with it. They kind of interact well so they don't have negative effects"(S4.2).
>
> "I don't think of herbs as poisoning your body. I know there are some poisons amongst them, everyone knows that. But ... if you use them sensibly ..." (S13.2).

> "I accept that herbs in excess could do you harm. Yes, taken indiscriminately, there could be a danger but not if you're careful" (S11.1).
>
> "Well, I don't think you ever really hear of anybody having any really bad side effect from herbs ... unless they're taken in huge amounts or if they are mis-prescribed or anything like that" (S13.5).

The importance of body-herb compatibility was also reflected in the emphasis that participants placed on the primacy of self-healing, which some participants evidenced by reference to the placebo effect. To participants, the healing potential of herbs related directly to their ability to interact with the body, because this allowed the herbs to support and enhance the body's intrinsic healing capability:

> "The body and the herbs are in harmony with one another. Being slower, it's more thorough and the body is given a chance to repair itself" (S5.1).
>
> "I think that herbal medicine is more likely to contribute to the healing of the body ... and to support the body to improve the overall health of the person. Get them functioning and in balance. It's supporting the body and the whole individual ... helping the body to heal itself" (S13.5).
>
> "You know, people dismiss the placebo effect as if it's cheating in some way. I mean: "It got better on its own?" You know, what's more powerful than the placebo? I mean it's actually the body that heals isn't it? All right, I **know** it ... it **is** the body that does the healing" (S7.1).

Of particular interest, was the belief that self-healing was also enabled through the achievement of patient empowerment:

> "And empowerment ... it helps the healing" (S4.1).

A further difference between conventional and herbal medicines that participants believed to influence the healing process, was the level at which each exerted its therapeutic effect. Whilst conventional medicines were seen to work "... at a much more limited level" (S4.1), herbal medicines were thought to be effective at multiple levels and participants saw this as a pre-requisite for healing to occur:

> "It's not just to do with the tailoring of the treatment, it's the herbs themselves ... **they** work at different levels. What I feel that the herbs can do is that they start to help to **repair** ... at a **different level**. It's a deeper level isn't it?" (S4.1).

> "On one level, I can almost feel the benefit three or four days after. It helps me, at one level, so quickly and, at another level, over a period of time. And I don't slide backwards so I don't have to go and take it again" (S4.2).
>
> "It **is** working at a deeper level. Supportive. At **every** level. That's what I'd say. It's a long-term resolution" (S7.1).

Participants' references to such things as dealing with root cause, healing and long-term resolution imply that they associate herbalism with eradication, rather than relief, of illness. The following examples more explicitly demonstrate the importance of avoiding illness recurrence as a measure of health care effectiveness:

> "They treat **me** – not the thing I've got. And by treating **me**, my body deals with it so it doesn't come back. With the doctors, they don't deal with the problem so it comes back again anyway. So, it doesn't work as well" (S5.3).
>
> "Just seems to get rid of it ... good and proper" (S5.4).

This association between herbal medicines and healing was raised repeatedly by all participants and many reported that they had actually experienced a sense of the healing process. Participants found the nature of this experience difficult to describe: "It's just a sense" (S13.5), with most participants referring to vague sensations of wellness or inner cleanliness:

> "I think what happens with herbs is that they heal at a deeper, energetic level. You can **feel a** difference" (S4.1).
>
> "I think its something that gets into your body, your blood stream or whatever, to enhance the body and make it intrinsically good for the body. And because it's good for the body, it makes the body **feel** well. You feel, you know ... that your blood is being done good to, your bones or skin or whatever it is, is being done good to, and therefore you **feel good**. You can relate to it" (S5.2).
>
> "It's as though there's a vibrant energy or something. I can almost **feel** the benefit ... they are more healing" (S4.2).
>
> "I just feel that every dose that I have is making me better. I **feel** it's making me better. I don't say I feel all, you know, excited and full of joy. I don't mean that, I just mean I'm going through a steady but certain process of getting better. To be quite honest, I feel **cleaner within**. I feel **cleaner**" (S5.1).
>
> "I don't know. It makes me feel **clean ... clean inside**. I know that must sound really weird but I don't know how else to put it" (S13.4).

One participant summed up the experience of herbal healing in the following way:

> "They work with your body. You don't feel high or anything. They help you. They don't slow you down. They just take the edge off it. They don't always take it completely out of the way. They're so minor that they don't disturb your everyday workings. You don't feel ill on them, they don't give you side-effects. You don't get to feel sick, or dizzy or constipated or whatever" (S9.1).

To participants, the key to the healing potential of herbs lies in their naturalness, healing being part of their intended purpose:

> "I feel they are out there ... **in nature** ... for us to use ... to put us right when we are wrong. It just seems such an obvious way of treating yourself if something has gone wrong ... I just feel it is a healthy form of treatment" (S11.1).
>
> "I don't know, it's sort of ... **reassuring** ... knowing that it's something that nature has produced rather than something that man has made. You know ... there's nothing to hide. It's just the important bit" (S2.1).

... and this confidence brought about by the naturalness of herbs was reinforced by their observations of the instinctive use of herbs as medicine, in the animal kingdom:

> "I feel it's a very natural thing. The same as a dog will go and eat a special grass if it needs it. Or a horse will. Anything will ... it's back to nature" (S13.2).
>
> "Think about the animals. When they were eating the natural fodder for themselves and they didn't have products put into them, you didn't get BSE. It's interfering with the natural habitat" (S13.3).

Because of this, any attempt to manipulate their natural form was seen to be detrimental to their overall effectiveness:

> "It's about not changing it from its natural state. Maybe some components are beneficial and others aren't but I think that, **as a whole**, they **must** ... all work together" (S2.2).
>
> "And I don't agree with isolating a bit of it either. How do **they** know that all the components of that herb might not work together? Not just the one bit that **they** can see" (S4.2).

… a concern that was also reflected in participants' comments about the composition and production of conventional medicines:

> "I don't really know how drugs are made but, taking out one component, that is like treating the part and not treating the whole thing. That is the whole essence of conventional medicine. We're going to take what we want and reject everything else and then, as we realise that everything is in reaction with everything else, you're damaging the reason for the herb" (S9.4).
>
> "Modern medicine, it's **synthesised.** It's about changing it from its natural state … tampering ... isolating certain compounds ... interfering" (S2.2).
>
> "They don't just put in the potion that you need. They put in **preservative**. For God-knows-what reason, they put in **colours. Now who needs colours?** In my book, nobody does. It's unnecessary. If I saw all those things in a food shop well, I wouldn't buy it! Not if it had all those things in them" (S13.3).
>
> "Well, I know about the bacterial origin of antibiotics but they are **still** manipulated" (S13.5).

Importantly, preserving a herb's wholeness was not viewed simply as desirable but as essential to protecting its intrinsic healing and protective properties:

> "… all the different components of the herb, they interact. And when you take one, you've lost something haven't you? Because you've lost the interaction. And I think, no doubt, that the interaction does make the whole thing gentler" (S9.4).
>
> "Providing the herbs haven't been manipulated in any way … altered in any way … they're how **nature intended.** If you do give herbs as they are in the plant … **the whole thing** … there is going to be some protection within the plant against creating side-effects within the person" (S13.5).

… and participants were worried that the synthesis and manipulation of conventional medicines would extend to the production of herbal medicines, with detrimental effects:

> "And they're trying to do this to herbs now. They're trying to extract **the thing** and trying to use it in that way. But it's only by altering the plant and manipulating the ingredients … **then** do you make them harmful" (S13.5).

A final factor that influenced participants' confidence in herbal medicines was the reassurance that they seemed to acquire as a consequence of their familiarity with the herbal substances:

> "Well, it's just that herbs are natural. I mean ... the herb ... **everyone** knows what a herb is. It's quite normal" (S5.3).
>
> "I think that herbal medicine is natural and I can recall it. Yes. Yes. **This** ... is growing in the allotments! It's growing all around me" (S9.4).

Conversely, their lack of familiarity with conventional medicines triggered a sense of suspicion:

> "Well, the conventional drug is, like, something that's been concocted in the lab. I never quite **know** ... what's been put into it or taken out of it. They produce these pills, which are merely a synthesis of what the herbalist uses. But, of course, once it's separated, most of the goodness has gone" (S5.2).
>
> (With herbal medicines) "I can say what's in it. I know exactly what it's comprised of really. You bring home a prescription from the doctor's and I wouldn't know one thing from the other" (S2.2).
>
> "Modern medicine ... nobody knows what half the things are in the tablet that they get prescribed ... or some of the processes of how they're made. I don't know about that ... ..." (S2.2).

4.4.2.2 Individualising Health Care Treatment

To participants, the intrinsic healing properties of herbs was fundamental to achieving healing but, in addition to their intrinsic healing properties, the effectiveness of herbal medicines was also crucially dependent on individualising the prescription. The modification of health care treatment to the needs of the individual was seen to be essential to 'getting the treatment right' and was identified by every participant as being of the utmost importance to the provision of effective health care. Although several different terms were used to reflect this aspect of health care, treatment modification was predominantly described as 'tailoring' and was thought to be crucial to achieving healing:

> "You talk to her ... she picks up on things ... she varies it slightly. This is the thing that I like about herbalism ... it's so **individual** ... taking into consideration matters of temperament as well as the physical symptoms. My tincture has all sorts – to help both temperamentally and physically. All

> aspects of my being … helping you on all levels really. There's something unique in that … and it's very valuable" (S11.1).

> "When I go to my herbalist, it's **me**. He sits … he listens … I know I'm paying for it but he **listens** … **genuinely** listens. He tells me what he's going to mix up … what measurement. He will tell me that he doesn't want to go overboard on this one but, if we find it's not enough, we'll up this one and take that one down a bit. If we find that it lifts you a bit too much, we'll lower this one and increase on that one. **We** work with it … to get the perfect balance … for **me**. He can then make that mixture … err on the side of caution … he can add to it … you get a fine balance. Together, we cracked it. You don't get that with the drugs from the drug companies" (S9.1).

Participants also described how treatment was tailored, not only at the outset of a course of treatment but also subsequently, in response to the patient's changing needs:

> "For instance, I was on a bottle that I'd had for quite a while and she said: "Do you think that you could do without anything?" I said: "Yes, I feel as though I'm not having so much pain and …", something else, I can't remember what. Anyway, so I discussed it with her … what it was … and she said: "Well now, we'll try … and we'll take out this and we'll put in a little of that." She was explaining what she does. I was fine for the first bottle, it seemed to be going fine but the second bottle, I could go back to her and say: "Do you know what? That pain's coming back." "Oh well, perhaps you need this other a little bit longer." And you know, she knew exactly which herb was the one that I needed putting back in there. **This** … is the difference. She listens … and she mixes up accordingly" (S13.3).

To emphasise the importance of tailoring the prescription, many participants drew comparisons to their experiences of receiving standardised prescriptions in the conventional setting:

> "My doctor gives out a drug that's already measured out. It's not tailor made … for **you**. It's made for all and sundry and I want something that's for me. I don't want to take a drug that … everybody's got different chemicals in them … it reacts differently with different people" (S9.1).

… and some participants described how the failure to consider their individual needs had led to their receiving inappropriate treatment:

> "Well, when I got these tablets home and read the leaflet, it said: "Extreme care for people that have hiatus hernia." So, there! Straight away! Although they had it in my notes, that tablet has been given out" (S5.3).

> "The Tamoxifen … I was told I was on it for five years and I was getting various side-effects. Anyway, I got so fed up with this I phoned up the help line and asked if I really needed to be on it for another two years. And she said: "Well it largely depends on whether you are oestrogen factor positive or negative." And it turns out I was negative. So I came off it but I thought: "Good grief, I could have been on it for two more years and gathered even more symptoms." I thought, you know, that I probably needn't have gone on it and yet I'd been given the stuff automatically and nobody had reviewed whether I should be on it or not" (S11.1).

What participants specifically valued in the context of individualised health care was the recognition of people's differences, as opposed to the assumption that they share similarities. This was of special importance when people presented with apparently similar complaints:

> "You see, you go to a herbalist and everyone could come out with a different medicine but it would be for the same problem. **Personal. Individual.** It's because everybody is so different. I don't see how one thing can work for every single person. It's about what's better for **me** as opposed to everybody else" (S2.2).
>
> "I mean, it's not the case that you go there and: "Right, that herb, that herb and that herb." There might be several herbs for that particular problem and they might take one out and put another one in. You know … one might suit **me** better than somebody else. Tailor made is the key to the whole thing. I think things should be tailor made to the person … because no two people are the same" (S5.3).

But, in the context of conventional health care:

> "With GPs and doctors it's quite uniform really. Twenty people could be prescribed the same thing – for migraines, say – you know, just on that symptom. Just on the pain, nothing else. The same dosage, nothing personal about it … a bit like a dinner queue" (S2.2).
>
> "My doctor gives out a drug that's already measured out. It's made for all and sundry. But your body make-up is totally different to mine. None of us is the same. So how could you give us all exactly the same medicine?" (S9.1).

In addition to tailoring the herbal prescription, individualised health care also included the recommendation of self-help measures that were both achievable and related to their specific needs:

> "For example, he's added nettles now and again for different reasons – producing milk, hay fever, that sort of thing – and he's talked to me about that and about picking some nettles to make tea. He said that it would be a very good way of supporting my immune system against over-reaction to the pollen. So that's something I can do for myself. I can go and pick nettles ... you don't get that from doctors" (S4.2).

> "And I've had helpful hints from (herbalist). I just feel, with (herbalist) that I can just, sort of ... trust her. I feel that what she suggests is just, sort of, very much for **my** good. But, the doctor ... he never says anything helpful" (S11.1).

Ultimately, participants related individualised health care directly to the overall effectiveness of the treatment they received:

> "It **worked**. It worked because she designed something specially for me. Part of the attraction is that you get the personal ... the tailored ... the discussion. That's one of the reasons that I think herbs are so successful" (S2.1).

> "I mean, herbal remedies are **absolutely** tailored ... they're fine-tuned to the individual. Yes ... it's all about getting it right" (S7.1).

In summary:

> "The process with the herbalist is much more balanced. And I think that that works, for me, at a deeper level. It's a much more holistic approach – mind, body, spirit – treating at different levels ... **energetic** levels of well-being. The herbalist – who is very aware of how I am physically and emotionally – thinks more about the way the mental, emotional and physical work together and I am much more confident about the treatment he is giving me. When I leave the herbalist I feel that that's been a **complete thing** that has happened" (S4.1).

Interpretive summary:

The treatment of illness causation is achieved by addressing the interdependent factors that contribute to a person's unique illness profile. It is essentially concerned with the promotion of healing, which encompasses the eradication of illness symptoms but also involves restorative processes that occur at multiple levels of a person's being –

emotional, physical and spiritual. Healing occurs by harnessing the intrinsic healing properties of herbs, with which the body interacts, to maximise self-healing potential. Herbal medicines promote healing by way of their inherent compatibility with the human body, a naturally occurring harmony that is evidenced by the absence of side-effects and by healing that occurs at a rate that is conducive to recovery. Crucially, self-healing is further enhanced by promoting the patient's understanding of the illness situation, which evolves from processes that enable patient empowerment. The treatment of illness causation provides the means by which generic health care becomes transformed into individualised health care and it meets participants' expectations because it is consistent with their understanding of illness causation.

4.5 Structural Theme: Enhancing Healing Through Patient-practitioner Collaboration

Health care based on patient-practitioner collaboration was viewed as open and 'honest medicine' (S4.2). Participants acknowledged the expertise of health care practitioners but, in matters concerning their health, they also emphasised the importance of their own expertise and of their right to self-determination. According to participants, the practitioner's professional expertise was crucial to:

- Teasing out illness-related information that would otherwise elude the patient's awareness:

  > "... things that you wouldn't even think ... would have any relevance ...and, of course, she picked all this up ..." (S5.1)

- Integrating diverse information, to help both the practitioner and patient make sense of the person's illness:

  > "... talking about things ... you can suddenly see a pattern and how things fit together" (S7.1)

- Suggesting health care interventions, appropriate to the patient's unique illness profile:

  > "I feel that what she suggests is ... very much for my good" (S11.1)

- Following through a patient's health care treatment until an expected resolution is achieved:

  "And she will always revisit things … issues that we've dealt with even if they've apparently gone" (S7.1).

Importantly, participants did not consider it the responsibility (or the right) of the practitioner to act on these principles in isolation but to consult with the patient in every respect because "I know my own body" (S13.5). Furthermore, whilst participants recognised the unique contributions of both practitioner and patient, they emphasised that the patient's perspective was paramount:

> "**I'm** in charge of my health care … alongside my herbalist" (S4.1).

Without exception, participants recounted how they experienced a collaborative relationship with their herbalist but not with conventional practitioners:

> "You chat away. It's a partnership. When she looks at the remedies she'll run through them, she might ask some more questions and I can ask her questions. You know … almost thinking out aloud. You do feel as though you're sharing in the choice somehow" (S7.1).
>
> "For all the years before that (before seeing a medical herbalist), I've been barking at the doors of conventional doctors and no one ever listened. Their route is very much: "Well, we'll do this first … we'll do an endoscopy, then a colonoscopy, we do this, we do that." And I told them that they were stressing me out, that they were overlooking what I was telling them. They weren't listening to me. <u>I **know** how my body works and you're not listening</u>. <u>Why don't you listen to me and then suggest a route</u>? They dictate. They give you an ultimatum. There's no sense of personal control in orthodox medicine. There is none" (S9.1).

Indeed, in the conventional setting, participants sometimes described how collaboration was positively discouraged, to result in their feeling like "… just another patient" (S2.1):

> "And I always get the impression: "I don't want to see too much of you. I want you in … dealt with … and out." I was in there on one occasion when he started writing the prescription before I'd even finished telling him what it was all about" (S5.2).

To participants, patient-practitioner collaboration was more than a mere formality. It was an essential component of effective health care that encouraged and facilitated two-way communication and enabled participants' understanding:

> "It's about trust … because I **trust** her. So, I'm much freer with my information. You feel more confident and you are freer with what you would regard as private information … things I wouldn't say to my doctor. I will tell the herbalist private thoughts that I wouldn't tell my doctor … because I feel more in control" (S11.2).
>
> "I think, it's not so much **her** seeing these things … but **you** see them. I think that **you** start making connections, **you** start seeing how things you are doing in one part of your life may affect … you start to **understand** it. Rather than you being told things: "If you do that, such and such will happen." If you start to come up with it yourself … yes, I think that's probably the difference" (S7.1).

Collaboration led to increased patient confidence and it facilitated treatment deliberation:

> "If you build up a relationship, as you do with your herbalist, then you can start to feel confident enough to challenge a bit or say: "No, actually, I don't want to do that, I'm quite happy to do it this way." The herbalist doesn't **expect** to be in a position of power over me. **I'm** in charge of my health care … alongside my herbalist" (S4.1).
>
> "Oh, it's a lot different. It's more equal. Over a while, you get to know each other so she'll end up … she knows what's good for the individual. With the herbalist, you don't feel like a patient" (S2.2).

Furthermore, treatment deliberation involved mutual agreement about the goals and purposes of health care:

> "… and not just (sharing in) the choice – the decisions too. It's as if … as if … well, you plan together. You know: 'This is what I think but what do you want?' … kind of thing" (S7.1).
>
> "I can relate to her – we seem to work together. It's up to me but we get there as a team" (S13.2).
>
> "It's my body. I know where I need to be and he helps me get there. It's about what **we** think, not what **he** thinks" (S9.1).

Through the sharing and integration of knowledge, patients also became enlightened as to the influence of their own actions on their health and this encouraged their participation in health care activities:

> "I suddenly felt very much responsible for how my body works" (S9.4).

By contrast, participants described how a lack of collaboration in conventional health care impaired their ability to participate in, or cope with, their illness:

> "The doctor, by the nature of the consultation, takes that away from the individual as well ...the individual's own involvement in the healing process. It's almost like, it's up to the doctor. You know, he's 'under the doctor', she's 'under the doctor'. It's almost couched in the language isn't it? That's the mentality. You go to the doctor and he, or she, **makes you well**. It's not you who does it. **They** make you well. The idea of the healing is more the responsibility of the doctor and not the person" (S13.5).
>
> "You know, they're not really listening to me. You don't get an explanation. If they could just say it's this or that or it's nothing to do with that. But they don't explain. **They** know why but they don't tell you. They don't give you the full picture. But it helps you if you know. Then you can deal with it no matter what it is" (S13.3).
>
> "Going to the doctor's scares me ... it's in, out and that's it. I **need** to have an explanation. Anything unknown, I can't cope with. If I know that something's wrong, I can adjust to that and get on with it" (S11.2).

The following participant illustrates very well the comparative effects of herbal and conventional health care on their attitude to health care participation:

> (With the herbalist) "For the first time I realised what was wrong. I suddenly started to realise that the body is working in unison ... all the bits and pieces were working all together to produce what is physically me, which I found quite a powerful feeling. Because I suddenly felt very much responsible for how my body works. It's a fact! I felt confident and had confidence in him. But when I see a GP a different thought process comes into play because, the way a GP talks ... more interested in what research has been done and what is being produced ... that's **outside my body**. When I'm talking to the doctor, I'm thinking: "This is work that is being done in the lab." **Outside** my body. That is the feeling that he gives me. He makes me think in a different way. To put it quite naively, I come away feeling: "I am **being made** better." With the conventional medicine, **they** are doing something to **me** ... to make this particular part of my body work properly" (S9.4).

Another participant captures the sense of frustration that results from an inadequately collaborative relationship. What emerges from this story is a sense of unfinished business:

> "So, I went to the doctor and I thought: "Well, actually I feel blooming awful." My digestion was up the spout, my hair was dropping out and I felt dreadful. I felt awful. So I got an appointment ... and he ignored everything I told him. He took my blood and said: "You could be anaemic, come back in three weeks for the results." Well, I remember almost bursting into tears because I thought: "I can't go on like this for three weeks." He was just interested in my head because he could see it. <u>I just knew he hadn't heard anything I said</u>. They have this, such a simplistic view: we're ill, we go to the doctor, we get some pills and that makes us better! It just sort of brings our beings into such a one dimensional space and the depth of **who** we are – which has so much to do with **how** we are – is completely ignored. It's basic things. There is no relationship built up. What the GP does is he treats the symptoms, which I think is a mistake. It disempowers people because it's not teaching people. It disempowers because you walk in, you tell him what's wrong and he tells you what to take. But it's not teaching people that how they are up here (pointing to head) and how they are down here (points to body) and how they are in here (points to heart) is so linked that, if a part of that cycle is not balanced ... there's so much more going on" (S4.1).

This failure to meet patients' health care expectations in the conventional setting was reported frequently and, as the following participants illustrate, suggests a fundamental misunderstanding about their needs:

> "You're in and out that quick that you forget. I always seem to forget to say other things that I meant to. I go in ... the prescription is written out ... and I'm out. You might have gone there about something else. To be honest they miss things and I don't really feel that I receive any sort of benefit from it" (S2.2).

> "I suppose the fact that there was no discussion about anything. It helps me to have a little bit longer conversation ... ... to develop what I'm really thinking. But you come away with a prescription – just one on a conveyor belt ... and you haven't really got what you went for" (S9.4)

> "I was in there on one occasion when he started writing the prescription before I'd even finished telling him what it was all about. How could he know? I might have needed the prescription but what about the rest? My real needs get overlooked because he never found out" (S5.2).

Of most importance to participants was the belief that patient-practitioner collaboration provided a source of patient empowerment and that, significantly, empowerment was fundamental to the process of healing:

> "The herbalist, he listens to you. He talks to you ... on every occasion. He tells you what's going on in your body. Tells you what everything does. He explained what each plant extract ... what its effect was. He has given me more faith in myself, more understanding about my body and more trust in him. It meant that **I** ... **I** ... was in control" (S9.1).
>
> "Trust ... and the therapeutic relationship. And the more that trust develops, the more likely the person is to start doing things for themselves. It takes time to develop, it doesn't happen just in one consultation. It takes time. And once that trust becomes eroded, the healing effect, whether that's through the interaction or through the drug, that placebo effect is eroded. You know, the most important thing when a patient leaves the room is that they feel better already" (S13.5).
>
> "You go to the herbalist and you talk it through. You see, there's a level of **me** taking responsibility. You see, in the consultation, you talk it through but that isn't just to make the patient feel good. It actually clarifies for the patient how this has come about ... it's an incredibly valuable process. It's odd really but it's true. So when that happens, you're clearer about 'the whys' ... which is **very** empowering actually. And empowerment ... it helps the healing" (S4.1).

Taking a different perspective on collaboration, participants were very welcoming of a future integrated health care, especially in respect of enabling patient access to a range of health care options. Although participants demonstrated a preference for herbal health care: "I would always go to (herbalist) in preference to the doctor" (S11.1), they illustrated how they already tended to 'shop' for health care on the basis of need, making distinctions between conventional and herbal health care for the provision of acute/emergency/diagnostic care and everyday care, respectively:

> "They've got the access to where you can go to have tests and things ... the scans, the blood tests, all those things that I can't have through a herbalist. Once they'd discovered what's wrong with me I would go to my herbalist " (S9.1).
>
> "If you break your arm, conventional medicine has an x-ray and herbalism provides things that help tissue growth, fuse bone together more efficiently. Taken in conjunction with having your arm cast, it can work hand in hand" (S2.2).

> "If it was something acute I'd go to my GP for a quick fix ... then I would consult the herbalist on a long-term basis to keep it from coming back" (S5.2).

But ...

> "Ultimately, I'd want the decision to be mine" (S9.4).

At the same time, participants were cautious in their enthusiasm for a system of integrated health care. Whilst they saw great potential for the future of herbalism as part of an integrated service: "In my ideal world, I'd like to see a G.P. practice that does both - patient's choice" (S13.4), they were doubtful that there would be sufficient collaboration between conventional and complementary practitioners to make this initiative genuinely integrative. They argued emphatically for the preservation of the distinct approach that characterises herbal health care, showing concern that these differences would not be preserved and that the future would lead to control and manipulation rather than integration:

> "I definitely see a herbalist as something different. A completely different mind-set ... thinking in different terms ... different ways" (S9.4).
>
> "It would be good for it to be more available but only if they didn't start controlling it ... putting restrictions on it" (S4.2).
>
> "I sort of wonder ... if things got into the NHS ... whether they would be swayed by the medical people telling them what they could do" (S11.1).

In essence:

> "It would be good to see it alongside conventional ... but at what cost to herbalism? It might become standardised. You'd have doctors prescribing it ... they'd like that because it goes along with their way of thinking, the way they've been trained. I sometimes think that herbalism will be made to **fit in** ... with the health system as it now stands. I think that western orthodoxy has got to change. I think that the complementary people have got it right. Okay, technology is great. It saves lives and all that sort of thing. It's just the general thrust of their philosophy of how medicines work and that kind of thing. I mean, **of course**, herbalism only works for some types of things. It doesn't work for everything. But there are other complementary things that do and, as a whole, they can work together you see. That's the idea. It can all become a whole. The Chinese have done it. Why can't we? **Side ... by ... side**" (S13.5).

Their doubts about the possibilities for genuine integration were reinforced by their experiences of a reluctance amongst conventional practitioners to embrace a collaborative attitude, which they saw as a potential hindrance to collaborative health care:

> "I would like to see them trust each other and work together. The herbalist don't seem to say anything bad about the doctor. The doctor does! You know: "Dear, oh dear! Herbalist?" (S5.4).
>
> "I did want my G.P. to work hand in hand with my herbalist but it doesn't work that way. You'll not hear your G.P. say: "Right, I'll work in with your herbal doctor." In fact, once she said that she didn't think it was a wise road to go down. **<u>How can she say that</u>**?" (S9.1).
>
> "My doctor … he doesn't accept … he said: "I don't know about it, I don't understand it." And that's it. End of subject. He was very short" (S2.3).

Some participants attributed this attitude to the values espoused within the conventional, medical educational system:

> "On the whole, doctors seem so utterly blinkered and I can only think it's the training. I think it's the way they're trained. If only they were to have a much more liberal point of view: "Yes, do try that, I think this might suit you better than what I can do." I think I would be more comfortable with that" (S11.1).
>
> "But doctors are generally very negative about the whole of alternative medicine because the whole of their education, it doesn't rely on the same things" (S4.1).

But participants were unanimous in their views that herbalists were generous in their willingness to play a collaborative role:

> "There's honesty. The herbalist will be very open to the fact that this may work but it might not. If not, we'll try something else. And he works very openly with the GP and with anybody else that you're seeing. We'll look at it more deeply, knowing that there are other options … it's not only about science. There's a level of honesty there, **overt honesty**, and the expectations are made very clear … on **both** sides" (S4.1).
>
> "(The herbalist) is not so arrogant, he'll say: 'I think we need to bring your G.P. in on this one'" (S9.1).

Participants' concerns about inadequate collaboration were also reflected in relation to policy development. It was coincidental that the data collection for this study occurred just as the public consultation period for the Department of Health's review of medical herbalism (Department of Health 2004) had come to a close. At that time, an incidental remark made by one participant (during 'chat' outside the interview period) and subsequently confirmed by all other participants, revealed that none had contributed to this important debate because they had been unaware that the debate was taking place and, consequently, of their opportunity to participate. Having potential implications for clients of herbal practitioners, participants responded firstly with astonishment and, subsequently, with anger at learning about this missed opportunity. Given that study participants are directly implicated in this review and were consulting with medical herbalists at the time of consultation period, it is of concern that the opportunity to participate in this important debate failed to reach their attention and it raises important questions about the processes through which lay opinion is canvassed at a strategic level.

Interpretive Summary:

Patient-practitioner collaboration is related to the promotion of healing and is mediated through processes that integrate personal and professional knowledge, to promote a shared understanding about the nature of the patient's illness. Collaborative health care is characterised by health care that privileges the patient's actual health care needs rather than another's perception of those needs and it is enhanced through social dialogue ('chat') that enables the patient and practitioner to disclose and assimilate new information. A collaborative relationship is therefore central to the mutual construction of an illness diagnosis and also to the negotiation and evaluation of any subsequent therapy. Through these processes the patient acquires renewed understanding that enables them to relate the source of illness to the rationale for treatment. By encouraging and facilitating patient understanding, patient participation and patient autonomy, collaboration ultimately enables patient empowerment and, through empowerment, healing processes are both promoted and enhanced.

4.6 Structural Theme: Authenticating Health Care Effectiveness

Participants had a great deal to say about the nature of the evidence on which health care effectiveness is judged, discriminating between different types of evidence and their respective values. To participants, the key determinant of authentic evidence was evidence that reflected ordinary use in everyday circumstances - evidence that they could identify with and therefore recognise as 'believable'. Authentic evidence was concerned with: "Seeing it how it really is" (S2.1). Without exception, participants valued evidence that reflected everyday human experience and that demonstrated consistency over time. By contrast, they were mistrustful of scientific evidence, which was doubted on the basis of its perceived inadequacy and mysteriousness and also because conventional testing methods were deemed to be unrelated to real life situations.

Every participant acknowledged, but rejected, the common perception that science (clinical trials) provides the most trustworthy of health care evidence:

> "It isn't the best. I don't believe that scientific things can give you all the evidence and all the reasons" (S4.2).

Typically, they substantiated this sentiment by emphasising the importance of two sources of evidence that they determined as authentic: personal experience and historical knowledge.

4.6.1 Personal Evidence of Effectiveness

Participants particularly recognised their own, personal experience as valid evidence of effectiveness but this regard was also extended to the experiences of others:

> **"It works! My** personal experience. To me, **that's** evidence" (S2.1).
>
> "On my actual experience ... **my** experience. I have tested all of it" (S9.1).
>
> "... they've been tested ... **by people**" (S13.5).

And the significance of experiential evidence was reflected especially well by those participants who had initially been sceptical about the likely effectiveness of herbalism:

> "I had a preconception that herbalism would be too simplistic, not scientific enough ... and probably not very effective. I thought: "bet that won't work". But it **did** work! And now, I'm completely ... **completely** ... convinced" (S4.1).
>
> "I actually met (herbalist) and I knew he was a herbalist. Well, I wasn't at all impressed. Possibly because I'd been involved with doctors all my life. But then ... I **couldn't** believe it ... how well I was improving" (S5.5).

To reinforce the significance of experiential evidence, many participants subsequently recounted their comparative experiences of herbal and conventional treatment for the same condition, participants particularly emphasising the significance of being able to either discontinue or reduce conventional treatment following the introduction of a herbal substitute.

These examples were typical of participants who had been able to discontinue conventional treatment:

> "How do I know it works? It's partly because the conventional medicine has been so unsuccessful. For example, I've had oxytetracycline, antibiotics and topical things and I also had the contraceptive pill for a while. And **nothing** has made much difference. I hadn't had any results at all from my doctor. He found something ... can' remember what ... which is supposed to be the best but they made it much worse to be honest. With the conventional treatment, they had no effect. They had no effect at all ... except loads of side-effects. But with (herbalist) ... it **worked**. I was surprised she didn't give me anything topical. She gave me something for my digestion and, later, for my hormones as well. She advised me on things ... do this, don't do that. And it's all really helped me in my health problems. Things that the doctors have **never** been able to sort out" (S2.1).
>
> "I've had really bad hay fever for years. Dosed up to the eyeballs with antihistamines, wearing sunglasses ...everything! Well, with the conventional approach, every summer I get a load of antihistamines ... and eye drops ... and nose sprays – they make my nose bleed and it goes down the back of my throat and makes me feel sick. And it's very chemically ... it gives me headaches. But if I don't take the nose spray ... really itchy eyes and I'm reliant on antihistamines ... all the time. It makes me feel weaker ... and weaker ... and weaker. But (herbalist) ... he's started treating me through my digestion ..., my adrenal glands ... stress ... everything. And, for the first time in my life, it's **completely** gone" (S4.2).

… whilst these are typical examples of participants who had been able to reduce the frequency and/or dosage of long-standing conventional medication:

> "I always keep an open mind on these things you know. I don't go hook, line and sinker for any particular thing … even herbal. I'm always ready to have a bit of criticism but I haven't found it so. They all **worked. Amazingly!** The reason I was taking them was the asthma. That was perfectly okay but it also cured these other things as well. It was quite, well … **extraordinary!** I've gone 116 days and I don't feel I need to take steroids. Before, it was every 14 days. Now, as I say, I'm well over a hundred and it seems to me that the time is increasing between each take of steroids. From 14 to 116 days!" (S5.2).
>
> "Well, simply that they work better. They have worked better for me. The conventional medicine I've had repeated … I've had to keep going back for my chest infection. Now, my chest is obviously far, far clearer than it's ever been - for many, many years. You know, I can go along with the children … walk the dog … I didn't want to be bothered walking the dogs. Sluggishness, really, like a heavy sluggishness … your breathing … it got so bad. With herbalism, I've had it back but it's been six months in between visits. I was really lucky to go 3 months with the antibiotics" (S13.3).

Despite their positive experiences of herbal therapy, the majority of participants had experienced difficulty convincing their conventional doctors about the effectiveness of herbal medicines. The following extract captures particularly well, the sentiments of several participants whose conventional doctors had doubted their opinions about the effectiveness of herbal therapy. This particular participant had replaced his anticoagulant therapy with a herbal substitute following the development of unpleasant side-effects and had kept his general practitioner informed about his actions:

> "And after I'd been taking this stuff from (herbalist), I was cutting myself quite regularly and I'd use loads of tissues just to stop it, you know? Just exactly the same as when I took aspirin. So that sorted me out … that **proved** that it worked.
>
> But he (general practitioner) says: 'Well, we can't guarantee that that works'
>
> And I says: 'Well, **I** can'
>
> And he says: 'Well, you can't'
>
> And I says: 'Well, I **can**. I've cut myself since I've been taking it and the blood don't stop running'
>
> And **that** … is the evidence isn't it?" (S5.4).

Many participants attempted to elaborate on the nature of experiential evidence. Although they found this difficult to describe, they offered accounts of both physical and intuitive senses of treatment effectiveness.

In a physical sense:

> "You **know** your own body. You can read your own body if you're aware of it. It's just about how I feel about it" (S9.1).
>
> "I'd see what my body was saying. It's not that I feel: "Yipee, I feel great." It's not that. I just feel that every dose that I have is making me better. I **feel** it's making me better. To be quite honest, I feel cleaner ... within. I feel **cleaner**" (S5.1).
>
> "It's your body talking" (S13.2).

... and in an intuitive sense:

> "And it worked. I know how I ... **feel.** I **know** my own body. I can tell. I just feel it. It's just a sense" (S13.5).
>
> "It's just about how I feel about it. I just have a very strong instinctive feeling and I think that if you're guided by what you feel, then you are guided to what you want" (S9.1).
>
> "Just a gut feeling ... a gut feeling. How I feel inside. Can't expand on that. Just a **gut feeling.** I can't explain it any other way. It's like meeting someone for the first time. It's just a 6th sense isn't it? And it's usually right" (S11.2).

Participants also relied on these senses to detect the unsuitability of a treatment and this, they related especially to their experiences of side-effects from conventional medications:

> "And some drugs, basically, they are **not** good for the body. So you feel ill. I think it's as simple as that" (S5.2).
>
> "The side-effects send me messages that I definitely shouldn't be on the pills ... they're **not** good for me" (S2.1).
>
> "Just a feeling. Just an innate sense ... that something's not **good** for you. I don't think the doctors take that into account. They just think you're a bit silly really. Just because I was **feeling** something wasn't right ... just because I couldn't **show them** ... it wasn't important. I think that it's just a feeling. A 6th sense that you can't put your finger on. You know, animals have it ... a 6th sense ... there's no proof but you just **feel** it. It's so **important**" (S2.1).

> "… if it doesn't feel right, it's damaging yourself" (S9.1).

By contrast, the doubt that every participant had expressed in relation to scientific evidence, was reflected very well by the following 2 participants:

> "I don't mean to knock the proper clinical trials but they're not … well, they're not perfect. I mean, a trial all depends on what you're looking for doesn't it? I mean, you measure what you set out to measure. Yes, I do honestly believe that you just find what you are looking for. That's the whole nature of scientific research isn't it? In a sense. **You** have a hypothesis … and **you** test it. Simple as that" (S7.1).

> "You know, they're only tested on very small numbers. And they're tested in a very rigorous way … on very specific parameters. Okay, you know, they say they're safe. But, you know, how safe are they? Really? You know, the thing is really, what we've got to do really here … we've got to move away from this ridiculous notion that clinical trials somehow prove efficacy of drugs. They should be able to stand up on their own" (S13.5).

4.6.2 Consistency over Time

Participants' personal experiences were corroborated and reinforced by historical evidence that reflected the sustained use of herbs as medicines:

> "There's a **real history** … of them being used for **all sorts** of conditions" (S2.1).

The enduring nature of herbalism satisfied participants' criteria for: adequacy of testing, consistency of evidence and evidence that reflected regular, everyday use. They also applied these criteria to scientific evidence, which they viewed as failing to reflect the full reality of a therapy's potential, especially in relation to the potential for harm.

The evaluation of a therapy over an adequate period of time was seen to be extremely important in judging the effectiveness of a therapy:

> "Now, to say that herbalism doesn't work is **ludicrous**. Because 300 years ago … 200 years ago? … conventional medicine didn't exist. Now, people weren't all ill … they were being treated in various ways and one of which was herbalism. There **were** intelligent people living 2000, 1000, 500 years ago … giving us this wealth of knowledge. If it hadn't worked it would've been chucked out!" (S4.1).

> "Well, no, you haven't got the clinical trials for the herbal things but they have been around for hundreds and hundreds of years. Through time and practice it's been discovered that it does such and such. It has helped people from when time began. It's tried ... it's tested ... **proved**" (S9.1).

Whereas, with the scientific evaluation of conventional medicines:

> "It's not like herbalism, which goes back hundreds and hundreds of years, doesn't it?" (S5.3).

> "I suppose it's trust more than anything. I don't think that their trials are that rigorous and I don't think they're that long tested. Three years is not very long. Then, years later, you find all the problems" (S9.1).

The passage of time was also perceived as a necessary requirement in the evaluation of a therapy's safety. In this respect, participants related the occurrence of unanticipated side-effects from conventional medicines, to an inadequate period of testing prior to their being advocated for human use:

> "I definitely feel that herbs are safer. I feel a real security in taking herbs. It's just that they've been used for so many centuries ... for all sorts of conditions. To survive over so many, many years ... that is so **consistent** and that definitely convinces me" (S2.1).

> "With the doctor's stuff, you might get 10 years down the line and you're told: "Oh, don't take this any more because we think it might cause ...... All these people are, like, **experimenting**, really. You know: "Well, this works, we've tested it for a couple of years, let's give it to people." And then, they carry on doing studies on it ... changing this and that ... to make it cheaper. And how do they **know? Really know?**" (S4.2).

> "I mean, if drugs are tested and then released on to the market ... some of them are so new you still don't know what's going to happen in 20 or 30 or 40 years' time. How do we know what things are going to be like after 20 years of taking something, you know? A lot of these things are not **really proved** ... are they?" (S5.3).

As one participant argued:

> "**Don't** ... tell me it's safe. Not for **at least** 50 years" (S4.1).

Participants' scepticism in relation to scientific evidence was further fuelled by their observations of contradictory evidence, especially when this contradicted their own beliefs and experiences:

> "Also, because you read in the papers **all the time**, about them finding out new things. You know, they advise **this** for years then find out that it was terrible. **All the time** ... they come up with reports that contradict the previous one. They are so contradictory that you can't really believe them" (S2.1).
>
> **"It works! My** personal experience. To me, **that's** evidence. It doesn't matter what the articles say or what the doctors say. And then you start disbelieving what they say about everything else because it doesn't match what you know" (S2.1).
>
> "I think they can say what they like about these drugs. On the media: 'Oh, no, this is perfectly safe, doctors have tested it.' I just don't trust ... I don't believe a word of it any more" (S11.1).

Furthermore, the motivations behind the manufacture and production of conventional medicines was also viewed with some cynicism and this reinforced their mistrust of conventional evidence:

> "It's just the whole, sort of, making money ethos of the present time, you know? The drug companies, they are just out to make their millions. They just dish out this stuff and make their millions" (S11.1).
>
> "The drug companies, they're in it for money but not for making people better" (S5.4).
>
> "Drug manufacturers need to make a lot of money. They don't want to **heal** me, they want to **treat** me. Once I'm healed, I don't need their drugs any more. So they **treat** me, not **heal** me. Just what the drug companies want" (S5.5).

Ultimately, participants believed that the strength of evidence for herbalism lie in the complementary nature of personal and historical evidence. They showed a clear preference for herbs, which had been "... tested ... **by people**" (S13.5), "... for all sorts of reasons" (S2.1) and "proven for centuries" (S7.1). By comparison, they described conventional medicine as being concerned with "... only testing the chemistry of it ... in the lab" (S13.3) where "... you never quite know what scientists are doing" (S5.2) and "... you just find what you are looking for" (S7.1). Whereas herbal medicine provided a transparency of evidence that "... really speaks for itself" (S5.2), conventional medicine was seen to be mysterious and uninformative:

> "Well, they're more matter of fact. Their way of thinking is not about spreading the word. It's all become a mystery hasn't it? All these things have become mysterious. There's not a lot of information out there" (S4.2).

… with, perhaps, a suggestion that participants attributed slightly more confidence to the passage of time as an authentic source of health care evidence:

> "People have been, you know … they started using these plants, found they worked, and gradually over the time their successors have tested them again and refined them and mixed them up with other ones. And now, it's been so long, over the ages, that these really speak for themselves as **proven**. **Proven drugs.** To me, I think it sounds entirely feasible and entirely reasonable. I think, really, the test of time is probably the ultimate test" (S5.2).

> "Well, they've been tested … **by people** … over many thousands of years. Tradition has been passed down for many hundreds or thousands of years. To me, it's common sense really that any herb that wasn't of any use would have been long since classified as something you don't use. And all the ones that have been proved to be useful … I suppose you'd call it trial and error which, in many ways, is surely the best form of testing a drug anyway. Because … what bigger human trial is there anyway than the whole of humanity?" (S13.5).

Interpretive Summary:

Authentic health care evidence is derived from collective human experience in the context of everyday use. It is neither contrived nor controlled. Plausible evidence is evidence that participants can relate to their own beliefs about the nature of health, illness and health care and it predominantly reflects people's personal health care experiences. Evidence is seen to be believable when it accounts for the broader context of a person's life and is consistent with their experiential knowledge, and it is being corroborated by the transmission of traditional knowledge, which is taken as an indication of its sustained, everyday use within human society. Confidence in health care evidence is enhanced by familiarity – being able to relate to a therapy's origin, its history and its methods of production and evaluation. Essentially, authentic health care evidence is evidence that is realistic rather than theoretical and, implicit to this constituent, is the desire for evidence that participants can relate to their own understanding.

4.7 The Relationship Between Themes

In this study, four themes were identified:

1. Searching for Effective Health Care (motivational theme)

2. Dealing with Illness Causation (structural theme)
    a. exposing the contributory factors to illness
    b. accounting for uniqueness in the treatment of illness

3. Enhancing healing through patient-practitioner collaboration (structural theme)

4. Authenticating health care effectiveness (structural theme).

During the course of data analysis it became increasingly evident that issues concerning the patient-practitioner relationship (one of the structural themes) were also found to be implicit to the remaining two structural themes:

1. Dealing with illness causation:
    - diagnosis: "Talking about things ... you can suddenly see a picture and how things fit together" (S7.1)
    - treatment: "And empowerment ... it helps the healing" (S4.1)

2. Authenticating health care effectiveness:

> "... if we find it's not enough, we'll up this one and take that one down a bit. If we find that it lifts you a bit too much, we'll lower this one and increase on that one. **We** work with it" (S9.1).

The structural theme 'enhancing healing through patient-practitioner collaboration' was therefore recognised as being crucial to the achievement of the other structural themes and emerged as a key component of effective health care. The relationship between themes was therefore subsequently revised and is illustrated in Figure 4.1.

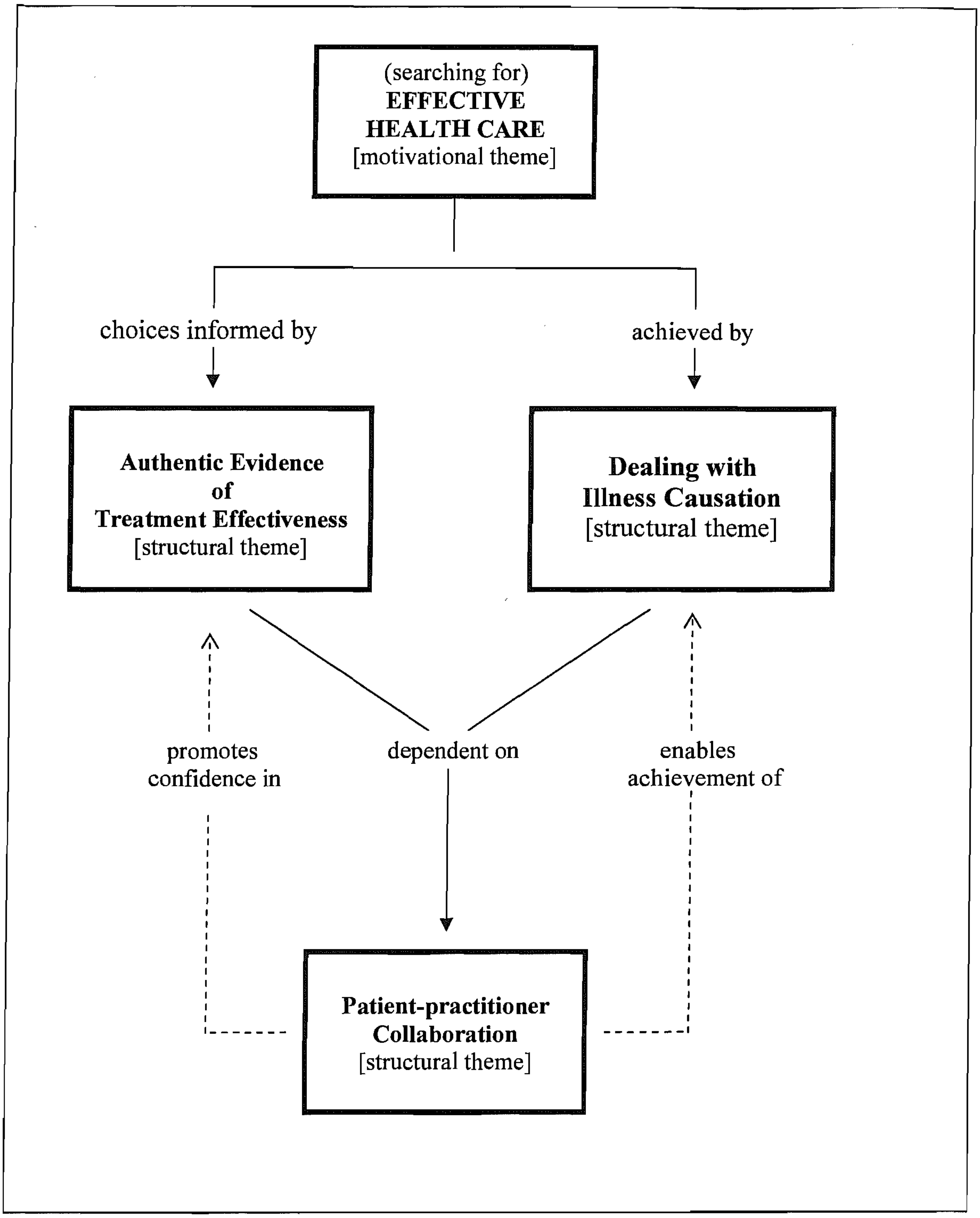

Figure 4.1
The Structures of Effective Health Care:
Relationship Between Themes

4.7.1 The Essential Theme of the Phenomenon: Making Sense of Health Care

In a phenomenological sense, not every theme of a phenomenon is unique to that phenomenon. Such structures are designated as 'incidental' constituents in distinction to those designated as 'essential' (van Manen 1990). The essential constituent (essential theme) of a phenomenon will "... make a phenomenon what it is and without which the phenomenon could not be what it is" (van Manen 1990, p107). According to van Manen, the differentiation between incidental and essential constituents of a phenomenon is probably the most difficult and controversial component of phenomenological study. This process reflects the final layer of hermeneutic analysis.

Following his example:

Ignoring the differences between herbal and conventional health care and focussing on the phenomenon itself (effective health care), the process of free imaginative variation was applied, to determine whether the structural themes were incidental or essential to the phenomenon. If the phenomenon remained intact following the removal of a particular theme, then that theme was identified as incidental. A theme became 'essential' if its removal altered the integrity of the phenomenon. The process was initially unsuccessful:

1. Taking each theme in turn, the removal of any one appeared to render the phenomenon incomplete, suggesting that the themes were sufficiently broad to relate equally to both herbal and conventional health care. In other words, the themes were not robust enough to reveal any obvious difference that could explain the effectiveness of one over the other, indicating that some crucial component of the phenomenon had been overlooked. Being common to both herbal and conventional health care, each structural theme was therefore designated as 'incidental.'

2. This prompted a re-analysis of the key factors implicit to each of the themes, which were subsequently reviewed in relation to the study data. Key factors are reflected in the interpretive summaries for each structural theme and were related to: root cause, social communication, plausibility, understanding,

healing, empowerment, contextualisation and familiarity. Whilst each of these factors is potentially essential to achieving effective health care, their degree of significance might differ between individuals, making their relative importance to the phenomenon uncertain. During the process of re-analysis, the one factor that did emerge as consistent was 'personal significance,' in that effectiveness was achieved only when the contributory factors were recognised as significant by the individual. Thus, personal significance was revealed as the most likely determinant of effective health care and it was at this point that my personal horizon of understanding changed. Furthermore, when the process of free imaginative variation was repeated in relation to each of the key factors, the phenomenon lost its integrity only following the imaginative removal of this characteristic. Personal significance was therefore revealed as the essential structure that determined the relative effectiveness of herbal and conventional health care. It emerged as a constant throughout the data:

- Dealing with illness causation:
    - Being able to make sense of health care diagnosis was essential to an effective health care process
    - Effective health care treatment was dependent on having an understanding of the rationale for treatment. It was further dependent on the promotion of self-healing, also enhanced through a development of understanding
- The ability to relate to health care evidence was implicit to recognising its authenticity
- Central to patient-practitioner collaboration was the facilitation of renewed understanding.

The fundamental difference between herbal and conventional health care was subsequently exposed: participants needed to be able to 'make sense' of things.
It was the participants' ability to *relate* to the structures of effective health care, rather than the structures themselves, that was essential to their effectiveness. The imaginative removal of personal significance rendered the constituents the same for both herbal and

conventional health care. Personal significance is therefore proposed as the essential constituent of effective health care for participants in this study.

4.8 Summary of the Study Findings

The study revealed that medical herbalism appeals to a diverse range of people seeking health care for the treatment of a wide range of health problems. Following an initial suggestion that participants decided to use herbal therapy for all sorts of different reasons, the data subsequently revealed that every participant had been exploring alternative health care options because they had found conventional health care to be inadequately effective, when evaluated against their personal criteria for health care effectiveness. From this finding, the motivational theme ‘searching for effective health care’, emerged. Ongoing data analysis exposed three further themes that essentially reflected participants’ ideas about the constituents of effective health care. These ‘structural themes’ comprised:

1. Dealing with illness causation
2. Enhancing healing through patient-practitioner collaboration.
3. Authenticating health care effectiveness

The constituents of effective health care (structural themes) embraced a common focus – one that reflected participants’ notions about healing – and it was this that constituted the fundamental difference between herbal and conventional health care. Participants attributed healing to the individualisation of health care and to the unique properties of herbal medicines but also to patient-practitioner collaboration, which they perceived as being directly related to the healing process. In addition to its direct healing potential, patient-practitioner collaboration was also seen to be essential to enabling the achievement of the remaining structural themes and was therefore identified as being key to the provision of effective health care. Importantly, participants experienced a collaborative relationship in the context of herbal health care but they reported a reluctance for meaningful collaboration within the conventional setting and this hindered the extent to which their criteria for health care effectiveness could be met.

Crucial to participants' perceptions about health care effectiveness was their ability to recognise the significance of health care. Their ability to interpret health care within a context of personal significance evolved as a consequence of integration between the practitioner's professional expertise and the patient's illness expertise and was implicit to each of the structural themes. Ultimately, it was this personal significance - the ability to make sense of health care - that emerged as the essential determinant of health care effectiveness and, thus, was elevated to the status of 'essential theme.'

The study findings indicate that participants were cautiously optimistic about a future integration between herbal and conventional health care. Whilst herbal health care was found to be effective in meeting their everyday health care needs in ways that eluded conventional medicine, conventional health care was valued in the treatment of acute or serious conditions and in providing corrective treatment prior to the use of herbal (healing) interventions. Participants recognised the respective strengths and limitations of both herbal and conventional health care and were selective in their health care choices, in an attempt to maximise personal benefit. However, their enthusiasm for a future integration between complementary and conventional health care was tempered by a concern that the unique characteristics of medical herbalism, to which they believed it owed its effectiveness, might not be preserved. Overall, the study revealed a pragmatic desire for effective health care that participants found in their own attempts to integrate the best of both herbal and conventional health care.

4.8.1 The Lived Experience of Herbal Health Care: "Herbalism ... it just makes sense" (S2.1)

To reiterate the study findings and to convey a sense of participants' experiences as a whole, the following phenomenological description illustrates participants' perspectives on the phenomenon of herbal (effective) health care. The story comprises selected interview excerpts, creatively amalgamated to capture the essence of the experience of herbal health care and, as such, it reflects a collective perspective. The text is reproduced verbatim, with the exception of minor editorial amendments that serve to maintain grammatical consistency and cohesion.

The Lived Experience of Herbal Health Care

"There's a smile to welcome you. 'How can I help you?' Just putting you at your ease (S11.2). The first 10 minutes is just ... catching up. What I've been up to ... what I've been doing with myself ... not just the primary symptoms that I've gone about but anything else that could be related (S2.2). It's a different process isn't it? It's a different perspective of looking at the problem. A herbalist looks at why something is being created and attacks the problem rather than suppressing the symptoms (S4.2). It's different in as much as the herbalist takes my body, my personality, my problems as a whole. Doesn't leave a stone unturned. You know, things that you wouldn't even think about and wouldn't think that they would have any relevance. And, of course, she picks all this up you see, just by, well ... **chatting** to me ... although I inwardly would be thinking: 'Oh, no, that's not right' (S5.1). And it's only when she starts to ask you questions ... it sort of grows from that. How everything seems to fit into a pattern. Talking about things that are maybe not all that related ... or not **apparently** related ... you can suddenly see a pattern and how things fit together (S7.1).

It's a partnership. When she looks at the remedies she'll run through them, she might ask some more questions and I can ask her questions. You know ... almost thinking out aloud. You do feel as though you're sharing in the choice somehow. I think, it's not so much **her** seeing these things ... but **you** see them. I think that **you** start making connections, **you** start seeing how things you are doing in one part of your life may affect ... you start to **understand** it (S7.1). If you build up a relationship, as you do with your herbalist, then you can start to feel confident enough to challenge a bit or say: 'No, actually, I don't want to do that, I'm quite happy to do it this way.' The herbalist doesn't **expect** to be in a position of power over me. **I'm** in charge of my health care ... alongside my herbalist. You see, there's a level of **me** taking responsibility. You see, in the consultation, you talk it through but that isn't just to make the patient feel good. It actually clarifies for the patient how this has come about ... it's an incredibly valuable process. It's odd really but it's true. So when that happens, you're clearer about 'the whys' ... which is very empowering actually. And empowerment helps the healing (S4.1). It's about trust … because I **trust** her. So, I'm much freer with my information. You feel more confident and you are freer with what you would regard as private information … things I wouldn't say to my doctor. I will tell the herbalist private thoughts that I wouldn't tell my doctor … because I feel more in control (S11.2). I just feel I can relate to her (S13.2).

And then when you walk away … I've been **heard** … somebody's really paid attention to me … to help the whole of my body – physically, emotionally, mentally. I've talked about all sorts of things and I come away thinking about the things she's said. What she says seems to clarify things and you come away clearer about what's going on. It helps me because I haven't got all that muddle in my head. I have been made to feel important. I feel listened to. What I have to say has been **heard**. She explains my medicine so that I know what the medicine is going to do for me. I leave feeling happy … because I've had an intellectual conversation. I haven't been made to feel rushed … or to feel stupid … or mad. I've never felt like I'm in the way. You know, holding her up from something else. I'm treated with respect, with politeness. If I don't understand something she's saying I can ask her to say it again. And, in a way, I get justification for my feelings as well. She reinforces that I'm quite normal and you don't feel so isolated about things. She sort of clarifies why things are happening and I feel then that it's all okay to feel that way. So when I go to the herbalist, that's what I get from her. I'm getting stronger, so I become less dependent on her. I could go on and on … … (S4.2).

The process with the herbalist is much more balanced. And I think that that works, for me, at a deeper level. It's a much more holistic approach – mind, body, spirit – treating at different levels … **energetic** levels of well-being (S4.1). **Everything** affects your body. Every little detail is important. **It's important.** And herbalism … it treats every part of you (S4.2). And the detail that they take … you know, that time's lovely because you feel heard and that they really know you but actually it isn't about that. The detail, in that time, is critically important in the diagnosis. I think that they're, from the consultation, they're much more realistic. I think there's a more realistic expectation of how long it might take to get better, for example. The course of treatment, the tinkering ... ... (S4.1). You see, you go to a herbalist and everyone could come out with a different medicine but it would be for the same problem. **Personal. Individual.** It's because everybody is so different (S2.2). You know ... one might suit **me** better than somebody else. Tailor made is the key to the whole thing. I think things should be tailor made to the person ... because no two people are the same (S5.3).

But it's not just to do with the tailoring of the treatment; it's the herbs themselves ... **they** work at different levels. What I feel that the herbs can do is that they start to help to **repair** ... at a **different level**. It's a deeper level isn't it? (S4.1). It **is** working at a deeper level. Supportive. At **every** level. That's what I'd say. It's a long-term resolution (S7.1). They work with your body. You don't feel high or anything. They help you. They don't slow you down. They just take the edge off it. They don't always take it completely out of the way. They're so minor that they don't disturb your everyday workings. You don't feel ill on them; they don't give you side-effects. You don't get to feel sick, or dizzy or constipated or whatever (S9.1). The body and the herbs are in harmony with one another. Being slower, it's more thorough and the body is given a chance to repair itself (S5.1) ... the herbs work **appropriately** quickly (S4.1). They're how **nature intended** ... the whole thing (S13.5). Herbalism ... the whole thing ... it just makes sense (S2.1).

... I'd suffered eight years before I went on herbal medicine, which was a long time ... and you can see how I was getting so I really didn't want to go out, you know? Yes, after a long period of time like that, and I was **so relieved,** even when the first ... the **glimmer** ... it seemed to be working, **I just couldn't believe it** ... that **at last** I'd found something to help me, you know? Well ... if every day, you have loose, urgent motions, and when I say urgent, you can't get from here to the toilet, which is only a few yards. And then you go through a day when you do manage to get to the toilet all right, and in fact you could perhaps get from here to upstairs ... as far as that. I mean, it's **that** urgent I'm talking about. It's **that** serious. And then ... if you get a day when you do have time, but the motions might still be loose, so that's the first step. Yes,

yes, it was gradual. Now I can give you the actual timings on all that because I used to keep records of how many Imodium I'm taking. Instead of taking one or two a day, or even three a day … eventually I built up so that I was perhaps taking one every other day … and then eventually it got down to about five a month, and it **was** gradual. I mean they work fine now … there's nothing gradual about it now. Initially, you know, it was sort of over twelve months and, you know, the Imodium was gradually reduced. And then I was getting **months** when none are used at all … and then I sort of went **six** months. I **couldn't** believe it … without having to use one at all. And … it's **absolutely marvellous**. Within a year … **I didn't have to bother** to take Imodium everywhere in my handbag. **I didn't have to bother** to take underwear in my handbag all the time when I went out. Some days, you know, I wouldn't want to go out because it was getting that bad. You see, I have so much **confidence** in the herbalism, …what it's done for **me** over the years, which is about five and a half years now I've been taking herbal medicine. I've regained my confidence as regards going out, and it's **that** that's made the difference really. I think that sums it up pretty well … yes. And I mean … how it's **affected** me, and the **benefit** that I've had from it, and I wouldn't **dream** of stopping the herbal medicine now (S5.3).

Herbal medicine … it works! How do I know it works? (S2.1). How I feel is the main thing (S5.5). You **know** your own body. You can read your own body if you're aware of it. It's just about how I feel about it. I just have a very strong instinctive feeling and I think that if you are guided by what you feel, then you are guided to what you want (S9.1). I'd see what my body was saying. It's not that I feel: 'Yipee, I feel great.' It's not that. I just feel that every dose that I have is making me better. I **feel** it's making me better. To be quite honest, I feel cleaner … within. I feel **cleaner** (S5.1). And it's all really helped me in my health problems … things that the doctors have **never** been able to sort out (S2.1). It worked because she designed something specially for me (S2.1).

I definitely feel that herbs are safer. I feel a real security in taking herbs. It's just that they've been used for so many centuries … for all sorts of conditions.

To survive over so many, many years … that is so **consistent** and that definitely convinces me (S2.1). They've been tested … **by people** … tradition has been passed down for many hundreds or thousands of years. To me, it's common sense really that any herb that wasn't of any use would have been long since classified as something you don't use. And all the ones that have been proved to be useful … I suppose you'd call it trial and error which, in many ways, is surely the best form of testing a drug anyway. Because … what bigger human trial is there anyway than the whole of humanity? (S13.5). I think, really, the test of time is probably the ultimate test (S5.2). It's tried … tested … **proved** (S9.1).

5 DISCUSSION

According to the preliminary literature review (see: Section 2.2, Prevalence and Patterns of Use of Complementary Therapies in Westernised Society), complementary therapy use in westernised society:

- Is seen predominantly amongst white, middle-aged women, who are well-educated and who enjoy middle-income status
- Is usually considered for the treatment of chronic disease that is resistant to conventional care
- Is triggered by a variety of motivating factors.

Taking into account the findings of the current study, these commonly promoted ideas about the use of complementary therapies inadequately reflect the underlying reasons for this increasingly popular trend. Whilst the findings, in themselves, are not disputed – indeed, the majority of these suggestions initially appeared to be supported by the current study – they fail to account for the broader context and are, to some extent, misleading. By elaborating on this body of knowledge, the current study provides greater insight into the reasons that underlie people's attraction to non-conventional health care in the context of contemporary health care in the United Kingdom. This is achieved by exploring the literature in relation to the constituents of effective health care whilst maintaining a strong orientation to meaning assigned by study participants, in order to emphasise their perspectives and experiences.

Firstly, the characteristics and broad motivations of study participants are summarised in relation to the main assumptions highlighted in the preliminary literature review. The discussion continues with a more substantive exploration of motivational factors in the context of effective health care.

5.1 Sample Characteristics

In contrast to the 'typical' complementary therapy user portrayed in the literature, participants in this study represented a range of age, income, social and educational backgrounds. In particular, it was in relation to their socio-economic circumstances that participants appeared to differ most greatly from the literature. Despite being drawn from a relatively affluent part of the country, only three of the study sample had engaged in higher education and most spoke about the need to cut back on other expenditures to enable their use of herbal health care. Although details about participants' income and financial situation were not elicited during the course of this study, impressions gleaned during the course of interviewing appeared not to support the general assumption that users of complementary therapies tend to be relatively well-educated and relatively well-off. The study did concur with the literature in that the majority of study participants were female and of Caucasian origin and most were also middle-aged. In relation to age distribution, however, this majority was small (n = 10), with seven participants being aged under 45 years and a further two aged between 74-84, suggesting that herbal therapy appeals to a broader age range of people than is often indicated in the literature. It is also of note that this pattern is similar to that seen in general practice attendance (Peterson et al 1998). The reasons for the exclusively Caucasian origin of the sample cannot be firmly ascertained from the current study although it may reflect residential patterns within the study location, which tends to attract short-stay ethnic minority groups who may be likely to access health care services that are more readily available. It is therefore difficult to attach significance to these demographic findings in relation to the use of complementary therapies.

In relation to the conditions for which complementary therapies are most commonly used, this study suggests that herbalism provides more than a 'last resort' for the treatment of chronic and/or resistant conditions. Whilst it is true that the majority of participants had initially explored alternatives to conventional medicine for the treatment of a chronic condition, the successful treatment of their initial complaint led, without exception, to a more generalised use of herbalism for the treatment of other, everyday conditions. The decision by several participants to reduce or discontinue conventional treatment following the introduction of a herbal option, also suggests that herbal therapy can substitute for, as well as supplement, conventional health care, a possibility also reflected by Sharples et al (2003). Their study revealed that, of 262 patients who had been using a conventional treatment for their condition when they first started using complementary health care, some subsequently discontinued (29%) or reduced (32%) conventional medication. Others (all of whom were in the diagnostic category for cancer) either maintained (33%) or increased (6%) conventional medication, suggesting that complementary therapies can sometimes provide an effective alternative to conventional health care, largely depending on the nature of the condition being treated. Consequently, participants came to regard herbalism as a valuable and effective source of health care for both chronic and acute conditions. They began to 'shop' for health care on the basis of the nature and severity of their condition, utilising conventional medicine for the treatment of serious illness and herbal medicine for everyday health care, with many participants coming to view herbalism as their preferred first-line treatment. On the basis of this study, it is therefore misleading to suggest that herbal therapy is used predominantly for the treatment of chronic and resistant illness, although people might initially be tempted to seek alternative health care for this reason.

5.2 Motivating Factors

The main purpose of the study was to explore and clarify the reasons for people's use of herbal therapy. In common with the findings of previous literature, participants' motives were, indeed, found to be diverse but this diversity concealed an underlying motive that was common to all participants: they were searching for health care that worked. In herbal medicine, participants found a dimension of health care effectiveness that they had been unable to acquire from the conventional option and it was this that was central to every participant's decision to continue their use of herbal therapy.

In part, the search for effective health care concurs with previous literature, which suggests that some people use complementary therapies because they have become dissatisfied with conventional medicine (push factors). Push factors (which include, but are not exclusive to, 'ineffectiveness') correlate broadly with Siapush's (1998) medical outcome hypothesis, which proposes that people seek alternatives because of their dissatisfaction with conventional health care, especially in relation to the treatment of chronic disease and the potential for iatrogenesis. The literature also suggests, however, that others are encouraged by a natural attraction towards non-conventional therapies (pull factors) – this view consistent with Siapush's (1998) medical encounter hypothesis, which posits that doctors have lost the 'human touch' as a consequence of adopting a more materialistic ideology. Although the modern approach to conventional health care does advocate the 'human' element, this study reports on participants' current experiences, which suggest that Siapush's medical encounter hypothesis continues to have relevance at least in some aspects of modern health care. In addition to push and pull factors, other authors postulate that the current popularity of complementary therapies reflects either a preference for medical plurality (Thorne et al 2002, Truant and Botorff 1999), a pattern of long-standing practice that has previously gone unnoticed (Andrews 2002) or that it is representative of an increasingly postmodern attitude (O'Callaghan and Jordan 2003, Siahpush 1999, Siahpush 1998). With the notable exception of long-standing practice, the current study also initially highlighted a whole variety of reasons for participants' use of herbalism but this observation was subsequently found to be misleading. Whilst participants' immediate responses to the question of why they used herbal therapy appeared to support the literature, they subsequently came to disclose how their immediate response actually concealed a more fundamental reason for their interest in alternative health care options. Specifically, participants revealed an underlying dissatisfaction with conventional health care and, importantly, this motive was found to be common to every participant. Furthermore, every participant equated his or her dissatisfaction to a perceived ineffectiveness of conventional health care. This is not to say that participants always saw herbalism as effective and conventional medicine as ineffective but that each was seen to serve a different purpose. In a broad sense, conventional medicine was thought to be effective in the immediate treatment of serious illness but it failed to meet their expectations for effectiveness in a more comprehensive, everyday sense. As such, the notion of effective health care and particularly participants' interpretation of this commonly cited but vaguely defined concept, emerged as the phenomenon of interest in this hermeneutic endeavour.

5.3 The Meaning of Effective Health Care

In common with studies on other types of alternative therapy (Astin 1998, Vincent et al 1995), participants in this study used herbal therapy because of its relative effectiveness in comparison to conventional medicine. At the outset, participants decided to explore alternative health care options because conventional treatment had failed to meet their expectations for treatment effectiveness. Subsequently, their continued use of herbalism was based on their experience of its actual effectiveness. This perceived lack of effectiveness raises questions about the congruence between lay and professional understanding about what actually constitutes treatment effectiveness. Participants, for example, believed that their ideas about treatment effectiveness were fundamentally different from those of conventional health care practitioners. They argued that conventional practitioners generally showed concern for observable signs and symptoms, toward which treatment was aimed, but that this failed to address participants' expectations for health care provision. Participants were remarkably consistent in their views about the criteria for effective health care, judging effectiveness according to criteria that relate to the relief of illness symptoms but also according to criteria that relate to the health care experience, as a whole:

Symptomatic criteria:

- The eradication of illness symptoms
- The achievement of symptom control without the occurrence of side-effects
- The prevention of illness recurrence, except where this was an expected outcome of the illness.

Health care criteria:

- A collaborative patient-practitioner relationship
- The provision of individualised treatment
- The pursuit of mutually agreed heath care goals
- The provision of treatment that can be easily assimilated into participants' everyday lives.

Despite the possibility that lay and professional perspectives on health care effectiveness fundamentally differ, explicit criteria for health care effectiveness were difficult to determine within the professional literature, although one study did directly compare the patient and professional perspective on this (Tang and Easthope 2000). Undertaken in Sydney, Australia, in response to Astin's (1998) and Vincent et al's (1995) earlier studies, Tang and Easthope (2000) observed that, whilst these studies identified ineffectiveness of conventional health care as a primary reason for the use of complementary therapies, they failed to clarify how this was defined by study participants. Using focus groups and case interviews as data collection methods, Tang and Easthope focused on Chinese Australian patients who used both traditional Chinese medicine and conventional western medicine and whose general practitioners were also of Chinese ethnic origin. The authors found that patients and general practitioners had very different ideas about treatment effectiveness, despite sharing a common country and language of origin. Of particular significance was the general practitioners' failure (with one exception) to consider prevention of illness recurrence as an essential dimension of effective treatment. By contrast, patients considered this to be a crucial component, along with effective diagnosis, appropriate intervention and satisfactory outcome – broadly similar to the findings of the current study although lacking in clarification as to participants' understanding about the meaning of these important components of health care.

An interesting observation in Tang and Easthope's (2000) study was that patients and general practitioners also held different notions about the nature of preventative treatment: patients discounting general lifestyle advice as 'preventative', unless it was of relevance to their actual health situation. Although this appears to contradict the views of participants in the current study, who valued self-help advice, it is of particular note that the advice they received from their herbalists tended to evolve from the consultation itself. Consequently, preventative advice was both broad and highly patient-specific due to the inclusive nature of the diagnostic process. Essentially, both this and the Australian study suggest that preventative advice becomes meaningful only against a background of personal significance.

Despite some similarities between the findings of this and the Australian study, Tang and Easthope explore meaning only in relation to the concept of effective health care. Although of undoubted importance, the current study explores beyond this to identify and assign meaning to the constituents that make effective health care a possibility. Crucially, participants believed that effective health care was fundamentally related to the notion of healing. In turn, healing was enabled by the following four components of health care that, together, comprise the constituents of effective health care:

- An inclusive approach to diagnosis
- The provision of individualised, healing therapy
- A patient-practitioner relationship based on collaboration
- Reference to health care evidence that participants recognised as authentic.

These inter-dependent constituents of effective health care shared a common focus – attending to illness causation – and it was this that was seen to be central to the promotion and enhancement of healing. To participants, effective health care was thought to be achievable only by attending to the underlying cause(s) of a person's illness. Being central to effective health care, the identification and treatment of illness causation therefore permeated across much of the participants' discussion, participants speaking about effective diagnosis in terms of "... looking for the root cause" (S11.2) and about effective health care interventions as treating "... what's actually wrong with me" (S9.1). Participants viewed illness causation as a complex process that could not be reduced to a single factor, and they emphasised the importance of a closely collaborative relationship with their health care practitioner, if the real cause(s) of illness were to be exposed.

Of prime importance to dealing with illness causation was the participants' ability to make sense of illness causation, and its subsequent treatment. It was this ability to make sense of health care that differentiated herbal from conventional medicine and it was also crucial to their ability to perceive health care as effective. An important distinction in the context of this study is that the notions of understanding and making sense are concerned, not with establishing comprehension, but with establishing personal significance. It is concerned with the individual's ability to translate their comprehension against a background of personal significance[3]. For participants in this study, the constituents of effective health care made sense in the context of medical

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[3] In this discussion, the terms 'understanding' and 'making sense' are used interchangeably but are differentiated from the term 'comprehension,' in line with this distinction.

herbalism but the same constituents failed to make sense when they were informed by biomedical principles. It is therefore proposed that notions about understanding may be at the heart of participants' disillusionment with conventional health care: where comprehension is mistakenly taken to imply understanding and where the centrality of personal significance to understanding is overlooked.

Whilst the remaining discussion makes no attempt to elaborate on the notion of understanding, itself, it does explore how participants more readily acquire understanding within a context of medical herbalism, in comparison to the conventional health care setting. This is achieved by considering participants' health care experiences in relation to the literature, especially with regard to the constituents that they identify as essential to effective health care. The discussion highlights the essential nature of personal significance to the provision of effective health care and it illustrates the vital role of the patient-practitioner relationship in achieving this. In doing so, the study illustrates the ways in which herbal, but not conventional, health care makes sense to participants and how this impacts on their experience of the health care situation. The discussion therefore serves to reiterate and reinforce familiar concepts but it does so from a new perspective: it emphasises the centrality of clarifying patient understanding in relation to health care practices, where their significance is so often taken for granted.

5.4 "It's All About Getting it Right" (S7.1): Dealing with Illness Causation

Participants' emphasis on dealing with illness causation resonates with classic distinctions between illness and disease. Usually described as a subjective, lay concept (Morris 1998), 'illness' subsumes all the experiential aspects of bodily disorder and is shaped partly by cultural factors that influence a person's perception (Fitzpatrick et al 1984). By comparison, 'disease' is usually described as an objective, professional concept (Morris 1998) that reflects a medical conceptualisation of pathological abnormality that is related to recognisable signs and symptoms.

According to Korr (1988), the positioning of either person (illness) or disease as the central focus of health care is a legacy of the tension between two main medical philosophies. Hygeian philosophy, which is more consistent with participants' perspectives, recognises health, illness and recovery to be inherent to the person themselves, the clinician's role being to support the person's self-healing powers. By contrast, Aesculapian values are generally accredited with providing the foundation for modern medicine and are concerned with the disease itself, viewing medicine as the source and restorer of health. Ultimately, it is the clinicians' adherence to one or other philosophy that subsequently determines the goals and methodology of health care, the nature of the doctor-patient relationship and the criteria for treatment evaluation (Korr 1988). Consequently, where the patient and practitioner subscribe to different health care philosophies, and where the practitioner assumes a position of relative authority, the patient's health care expectations may fail to be met. Morris (1998) argues that these distinctions convey a powerfully divided sense of worth, a viewpoint also implied by Korr (1988), who describes how a patient goes to a doctor with an illness but leaves with a disease. Taking into account Fitzpatrick et al's (1984, p27) belief that illness reflects "... the concerns and perceptions that organize and motivate the patient's consultation" it is unsurprising that an interest in the patient's disease, but not in their illness, may lead to the patient's perception of health care as ineffective.

5.4.1 Taking everything into account

The eradication of illness symptoms is probably core to all health care philosophies but, over and above the provision of symptomatic relief, participants in this study believed that it was equally imperative to identify the 'root cause' of their illness. Without exception, participants attributed the effectiveness of herbal health care to the diagnosis and treatment of underlying illness causation, emphasising the inadequacy of symptomatic treatment as significant in their decision to seek alternative health care. They recalled how their herbalist exposed the root cause of ill health by taking into account all aspects of their personal history. This included a detailed exploration of their physical, emotional, psychological, spiritual and social world, all of which were perceived by participants as being crucial to effective diagnosis, because they believed that "the sort of person you are ... has probably been very instrumental in giving rise to the problems you've got" (S11.1).

By comparison, participants maintained that conventional practitioners showed concern almost exclusively for typical, recognisable signs of illness but rarely considered the impact of their whole being on their health situation. Although the notion of multifactorial illness causation is a central concept in modern medicine, participants argued that they rarely saw evidence of this in their dealings with conventional practitioners, suggesting a latent allegiance to biomedical principles. According to Engebretson (2002), the scientific basis of the biomedical model is seen to mitigate against a view of biomedicine as a culturally constructed system and, in accordance with this view, the biomedical model privileges a 'truth' derived from objective observation. Similarly, Mead and Bower (2000) argue that the biomedical tendency is to assume that a patient's report of illness indicates the existence of a disease process (Mead and Bower 2000). The disease is subsequently diagnosed and treated according to a reduced set of signs and symptoms, all of which are interpreted within a positivist biomedical framework (Mead and Bower 2000). To reiterate Korr's (1988) argument, the patient arrives at the doctor's surgery with an illness but leaves the consultation with a disease.

The limitations inherent to the biomedical model were highlighted almost 20 years ago by Cassell (1986) in his discussion about the changing concept of the ideal physician. He outlined how the era of scientific medicine had encouraged physicians to believe that knowing the disease and its treatment equated to knowing the illness and the treatment of the ill person. In relation to diagnosis, he related the reliance on disembodied knowledge to subsequent (but failed) attempts to formulate computer diagnostics, arguing that medical science was inadequate in dealing with individual variation, which could only be achieved through personal judgement. This perspective resonates with the views of study participants, who highlighted how the conventional approach is concerned with categorising people according to their similarities. In contrast to this view, participants argued that it was their differences that provided crucial clues to effective diagnosis, especially when people presented with similar complaints. To Cassell (1986, p204), proper diagnosis resulted above all from thoroughness; from examining the "... dull, interminable details ..." that are involved in the treatment of the sick. Similarly: "Everything affects your body. Every little detail is important" (S4.2). Building further on this notion, participants also pointed out the inadequacy of relying on signs and symptoms that are voluntarily reported, arguing that details of the most crucial diagnostic significance often go unreported because of their apparent insignificance.

At the time of Cassell's writing, he considered that the concept of the ideal physician was already changing in favour of these perspectives, a change that coincided with Engel's (1977) proposal for a biopsychosocial model for health care. Engel believed that biomedical success in disease management had come at a price – that, by focussing on abstract patterns of organic disease, the biomedical model had become unable to deal with illness as a human experience. His response was to propose a model that recognised the interplay between disease and psychosocial influences. Despite these developments, a historical account of medical diagnosis several years later showed a continued reliance on physical and observable signs and symptoms. In their fascinating summary, Baltodano et al (1993) describe the evolution of medical diagnostics, from the early clinical diagnosis of Hippocrates, which focused on history taking and observation of the ill, through a period of technical development (palpation and measurement) during the Renaissance, towards a description of 'ill organs' in relation to a deceased patient's previous clinical history. They describe the further refinement of both manual (palpation and percussion, for example) and technological (use of the stethoscope and manometer, for example) examination, both of which favoured objective measurement, as a means of enriching the diagnostic process. Although Baltodano and his colleagues argue against the trend for over reliance on diagnostic equipment, it is noteworthy that, throughout history, medical diagnosis has retained a primary concern with "… physical examination and knowledge of pathophysiology" as a means to diagnose a patient's illness (Baltodano et al 1993, p434).

More recently, Morris (1998) recognised the potential in Engel's biopsychosocial model but argued that its influence in contemporary health care was, at best, indirect and, at worst, frequently treated with indifference. He attributes this partly to the 'business as usual' culture, where a lack of time discourages a focus on complex non-biological dimensions of illness. Criticising Engel's model only on the basis of its inadequate attention to the cultural influences on health, Morris situates health in the context of post-modernism. Arguing that illness is no longer perceived as a purely biological state, his biocultural model embraces biomedical developments but also emphasises the social construction of reality and the all-encompassing influence of the cultural context on health and illness. He questions the adequacy of the biomedical model, which he views as a convenient shorthand for the scientific discourse that has become entrenched as the ruling paradigm of conventional western medicine, a view perhaps reflected in one participant's perception of herbal diagnosis as "seeing beyond science" (S4.1).

Consistent with some aspects of these models, participants believed that effective diagnosis and treatment is characterised by two crucial components, neither of which they considered to be achievable by conventional diagnostic means: inclusivity, where "everything seems to make a difference ... when it comes to healing" (S5.5) and individualisation, "... because no two people are the same" (S5.3). These perspectives, which are captured by the view that: "... the depth of who we are ... has so much to do with how we are" (S4.1), correlates remarkably well with Cassell's (1986) notion that the biomedical approach cannot deal with individual variation, with Engel's (1977) claim that it does not deal with the human experience of illness and also with Morris's (1998) biocultural perspective on health and illness. But, in defence of conventional medicine, participants also acknowledge that Morris's 'business as usual' culture is a likely product of modern times and a reflection of the pressures that are imposed on conventional practitioners. They argued, however, that this lack of individual attention also reflects attitude, which they partly attributed to the process of professional socialisation.

In addition to the practitioner's role in diagnosis, participants also emphasised the importance of their own contribution to the diagnostic process. In particular, the inclusion of their beliefs and experiences were thought to be paramount if effective health care was to be achieved. There is also some acknowledgement in the literature about the importance of addressing the patient's beliefs about illness causation. For example, respondents in Tang and Easthope's (2000) study of Chinese Australian people who consulted with both general practitioners and practitioners of traditional Chinese medicine, recognised the value of conventional diagnostic procedures but also valued the breadth of diagnosis achieved by traditional practitioners, which they generally considered to be more accurate. In relation to the effective management of pain, Chapman and Gaurin (1999) found that addressing the patient's perception of illness causation was key, proposing that people's beliefs about the causes of pain are in some way linked to their perceptions about treatment effectiveness. Despite this, Littlewood (1989) argues that the patient's description of their illness becomes narrowed during the consultation process until it concords with the doctor's constellation of recognisable signs and symptoms, thus reinforcing the medical diagnosis. She believes that this situation is likely to persist as long as health care continues to be driven by a biomedical framework that emphasises disease, and she advocates that lay conceptions of illness causation should be taken into account at the nursing assessment stage of patient care. A similar problem has also been observed by Fitzpatrick et al (1984), who point out that patients frequently appreciate the opportunity to tell their illness story in their own terms but that they are constrained from doing so in the medical consultation. Furthermore, they argue that conventional medical history taking fails to elicit the precise circumstances that triggered the initial consultation, leading to an assumption that the 'disease' is the sole reason for the patient's visit. According to the findings of the current study, these relatively dated arguments continue to have relevance in contemporary health care. In common with Tang and Easthope's respondents, participants in the current study dealt with this by 'doctor-shopping,' until a diagnosis that they considered to be accurate was provided – that is, until the diagnosis had personal significance to them.

The tendency to focus on disease rather than illness encourages the imposition of professional understanding, on views about how illness should be treated. A potential consequence of this situation is the creation of conflicting health care goals that ultimately leads the patient to perceive health care as ineffective. Having possible implications for their eventual recovery, the pursuit of a mutually agreed diagnosis is therefore of importance, not only to study participants as individuals, but also to the broader context of health care provision.

5.4.2 Treating Illness at Every Level

To participants, the purpose of inclusive and individualised health care diagnosis is to enable inclusive and individualised health care treatment. Consistent with their views about health care diagnosis, participants differentiated between causative and contributory factors in the effective treatment of illness and, for treatment to be regarded as effective, it therefore needed to relate to the diagnostic profile in its entirety. The herbalist successfully dealt with illness causation by tailoring health care to the individual's needs and by incorporating healing interventions into the health care event. According to participants, it was the herbal medicines and the patient-practitioner relationship, itself, that constituted the healing interventions of herbal health care and it was this – the achievement of healing – to which the treatment of illness causation was fundamentally related.

5.4.2.1 The Promotion and Enhancement of Healing

Participants in the current study were essentially pragmatic people who wanted to be able to get on with their lives. They wanted to get better and they wanted to feel well. They wanted to be free of unpleasant illness symptoms, for which they valued the technological and pharmaceutical developments of conventional medicine, but they also wanted to avoid additional discomfort as a consequence of the treatment. They emphasised a need for something greater than symptomatic relief, a desire they described simply as 'healing'. They measured healing in terms of feeling well, a concept described with some vagueness but reminiscent of Gadamer's (1993) enigmatic description of health as becoming evident only by means of escaping our attention.

A derivative of the Anglo-Saxon 'haelan' meaning 'to be whole' (Quinn 2000), a clear definition of healing in modern health care is elusive. Described by McKie (2003) as an active process that requires the individual to take responsibility for their health, healing is multidimensional and demands the achievement of balance between the different elements of a person's being: "supportive ... at every level. That's what I'd say" (S7.1). To Cassell (1986), healing is a process that restores a person's sense of connectedness while Mitchell and Cormack (1998) define the process in terms of facilitating forces that already exist in the patient and in their social world. Similarly, healing has also been described in terms of expanding an individual's inner potential by learning to open that which has been closed (Dossey et al 2000).

Wholeness is a key concept of healing (Morris 1998). According to Morris, a person's desire to be made whole again is a response to the modern tendency to approach illness in a fragmented way, a situation that occurred under the influence of positivist science in the 19th century. He describes how, at this time, matters concerning mind, soul and spirit became dissociated from matters of health and illness and that this led to the meaning of healing becoming altered. This diminution of meaning is reflected in comparative descriptions of 'cure', where it is generally accepted that a cure provides no guarantee that a person will be rendered healthy (Mitchell and Cormack 1998). In contrast to healing, cure is seen to be a passive process (McKie 2003) concerned with symptomatic relief or with the suppression of disease through surgical, chemical or mechanical intervention (McGlone 1990). It represents an incomplete subset of healing (Barnum 1997) although Keegan and Dossey (1998) believe that each is complemented by the other, their integration resulting in the most effective of health care. Healing and cure are also distinguished in the sense that healing can lead to a sense of wholeness, even in the grip of incurable disease (Morris 1998).

Participants frequently made their own distinctions between healing and cure (equated to symptomatic relief in this sense), repeatedly emphasising the need to treat the root cause of illness if healing was to become a possibility. In support of Barnum's (1997) argument that cure represents a subset of healing, participants acknowledged that symptomatic relief was a necessary component of effective health care but they viewed this as an insufficient measure of treatment effectiveness. This view also concurred with Tang and Easthope's (2000) respondents, who insisted that treating the root cause of illness was significant in their search for effective health care. This point was emphasised in their accounts of how they visited traditional practitioners for the purpose of identifying the underlying cause of their illness, even when they had already achieved symptomatic relief following a course of conventional treatment. With one exception, the general practitioners in Tang and Easthope's study expressed difficulty in understanding what was meant by 'failing to treat the root cause' of disease. The single exception to this finding believed that symptomatic treatment was sufficient for the treatment of acute conditions, but acknowledged that a traditional practitioner would delve beyond this to seek underlying cause. Interestingly, this respondent suggested that he would not attempt to identify or treat root cause in his role as a general practitioner, believing this to be a role for the traditional practitioner, a view that suggests different roles for conventional and non-conventional therapists, and one that concurs with those of study participants, who selectively utilised both herbal and conventional practitioners as a means to achieving comprehensive, healing health care. Although participants recognised that healing could be promoted and supported by external means, they argued that healing essentially emanates from within the human body itself. Fundamentally, they believed that the therapeutic effects of herbal, and other, interventions were exerted through processes that enhance self-healing: "… it's actually the body that heals … all they (herbs) can do … is help it to do that" (S7.1).

5.4.2.2 The Primacy of Self-healing

The phenomenon of self-healing was accepted as the natural expression of an organism until the 17th and 18th centuries, when medical scientists began to seek explanations for 'spontaneous' healing. By the 19th century this was being explained in terms of classical mechanics and, during the 20th century, became understood in terms of immunological defence mechanisms (Lohff 2001). Renaurd (2003) suggests that, throughout this time, knowledge about human self-healing was lost, although Kleinman (1980) believes that, rather than being 'lost', the notion of healing became an embarrassing concept to medicine because its meaning could not be reduced to technological or biological explanation. He argued that the whole concept of healing exposed the archaic roots of medicine and became buried under a façade of modern health care, indicating how little is really known about this most central function of health care. Similarly, Renaurd (2003) maintains that, whilst self-destruction is recognised within the context of psychosomatic illness, the possibilities for self-healing attract less credence, a possible explanation for the paucity of informative literature available today. In contemporary health care, self-healing is acknowledged in the theory of psychosomatic medicine although Renaurd (2003) believes that this field of medicine actually reflects a revival of ancient concepts, which encompassed a view that people propelled themselves into good health by drawing on their own intrinsic life force. This 'back to the future' view is also implied by McKie (2003), who believes that current research in the field of psychoneuroimmunology is re-opening the doors to holistic health care.

A considerable proportion of the literature on self-healing is presented from the perspective of the placebo effect. Generally now regarded a genuine event, the placebo response had often been dismissed as a consequence of the patient's misperception of their illness or recovery (Kaptchuk et al 2002). Even now, sceptics recognise the reality of the placebo effect but dismiss it, at best, as irrelevant or, at worst, as a nuisance (Walach and Jonas 2004). Others afford it only a grudging respect (Kaptchuk et al 2002), being portrayed either as an incidental or artefactual response that confounds 'real' treatment effects, or as an active but poorly understood phenomenon (Noon 1999). The effectiveness of complementary therapies (Kaptchuk et al 2002), and specifically herbal medicine as a component of naturopathic principles (Lohff 2001), has also been denigrated by some as little more than a placebo effect (Kaptchuk et al 2002). Strictly speaking, the view of placebo as something fraudulent does align more closely to its original meaning when, during biblical times, the term 'placebo' described the fraudulent replacement of the real thing, originally in respect of paying others to sing deathbed rites (Walach and Jonas 2004). The enduringly negative perception of the placebo response may well be a legacy of this original meaning although, according to Taylor (2003), this is more likely a consequence of mind-body interaction being largely overshadowed in western medicine by more spectacular physiological advances such as organ transplantation, stem cell research and specialised pharmacology.

To participants, there was no question about whether or not the placebo response exists, emphasising an inextricable link between this and self-healing, where the former was perceived as evidence of the latter. Participants believed that healing is fundamentally dependent on the body's ability to self-heal but that, sometimes, the body is also dependent on external interventions; not that the external interventions 'do the healing' but that they enable the body to achieve its self-healing capacity. This perspective did not deny the therapeutic attributes of external interventions but recognised the facilitative nature of health care. In the absence of self-healing, however, the potential for health care was seen to be limited, those interventions having the greatest harmony with the human body also having the greatest potential to promote healing. Thus, it was the compatibility between herbs and the human body that established the healing capacity of herbal medicines. Similarly, patient-practitioner collaboration, as a health care intervention, enabled self-healing through the promotion of patient understanding. Quite simply, participants accepted that it was the body that provided the source of healing, that sometimes this process required additional assistance, that some interventions provided a greater healing trigger than others and that the placebo response merely provided evidence of this phenomenon.

From a scientific perspective, the placebo effect has been explained in terms of anxiety reduction, classical conditioning theory and neurobiology (Noon 1999) and is often attributed to the release of chemical endorphins and dopamine (Kaptchuk et al 2002).

Moerman and Jonas (2002) offer an alternative explanation, suggesting that the placebo effect is due to the meaning of a therapeutic intervention for a particular patient and context. In this respect, the placebo effect is viewed as the product of psychological processes and can differ from person to person in the context of the same intervention. The generally accepted notion that the placebo effect is a physiological response to a person's belief (Morris 1998) is developed further by Noon (1999), who argues that it is the interaction between the patient's and the practitioner's beliefs that is central to the placebo effect. He cites studies that indicate how the physician's characteristics appear to influence the effectiveness of treatment, regardless of whether the treatment is active or placebo. In other words, he maintains that the physician's personality and manner affects the therapeutic outcome, a perspective that situates the placebo effect in the context of therapeutic alliance, where therapeutic alliance is determined by:

- The patient's perception of the relevance of the intervention
- Agreement between the patient an practitioner in respect of treatment expectations
- The patient's ability to forge a bond with the practitioner.

Current theories about self-healing can also be considered in relation to ancient wisdom. Schmidt (2004), for example, considers self-healing in the context of healing intention, a notion that originates from the Buddhist concept of mindfulness. Healing intention is described by Schmidt as an emotional connection between patient and practitioner, founded on compassion. Referring to original work undertaken by Frank in 1989, Schmidt (2004) describes the non-specific components of healing as being concerned with the patient-practitioner relationship and with meaning that is created within this relationship, through ritual and language. This idea has particular resonance with those of study participants, who identify the patient-practitioner relationship as a crucial component of the healing process. Schmidt identifies four key principles that enable a healing intention to occur, each of which can be related to participants' ideas about effective (herbal) health care:

1. The establishment of a patient-practitioner relationship that is based on a shared belief system and where the practitioner's 'presence' is not concealed behind a professional stance:

   > "An authority figure ... but you get to know each other. It's more equal and, to an extent, you know more where you stand. It's completely different. It's just like walking round a friend's house ... and coming out with medicine" (S2.2)
   >
   > "I just feel I can relate to her" (S13.2).

2. Patient-practitioner bonding, which realises patient expectations but also creates new meaning for the patient, brought about by the practitioner bringing alternative concepts to the health care encounter. Schmidt identifies this as the single most important source of self-healing power, able to motivate the patient to change their mind-set:

   > "And it's clear that her picture of me is bigger than my own, if you like. Talking about things ... you can suddenly see a pattern and how things fit together!" (S7.1).

3. The creation of new meaning (above) is also promoted by a therapeutic rationale that is delivered with enthusiasm and motivation by the practitioner:

   > "A lot more communication. The herbalist will often get books out ... show me what the plants are ... where they grow and all that sort of thing ... and that I like a lot" (S2.2).

4. Active participation by the patient, which generates a sense of responsibility and control, to create meaning for health and illness that makes sense to the patient:

   > "... I suddenly felt very much responsible for how my body works" (S9.4).

In addition to the usual modes of communication, Schmidt (2004) emphasises how healing intention is also conveyed by way of the practitioner's mental state and, in particular, the way in which this is directed towards achieving the goals of health care: "... making me better really interested her" (S2.1). In this respect, he suggests that healing intention may transcend physical space by as yet unknown mechanisms, a possibility he intends to explore in a later study. Corresponding broadly with traditional and contemporary perspectives on the importance of communication on the making of meaning (see: Section 5.7.1, Tradition as the Basis of Understanding), Schmidt's healing intention also correlates closely with participants' perspectives in relation to the essential constituent of effective health care, offering some substance to the notion that effective health care is, at least in part, dependent on the extent to which it has personal significance to the patient.

5.4.2.3 Medical Herbalism and the Promotion of Healing

It is the therapeutic property of herbs that determines the uniqueness of medical herbalism within the collective context of 'complementary therapies'. In part, participants attributed the healing potential of herbal medicines to the practice of tailoring the prescription to suit the individual's needs, both in relation to the combination and dosage of the individual herbal constituents. Whilst participants did acknowledge the potential for conventional medication to be tailored to individual needs, they argued that conventional practitioners were limited in their ability to achieve this. They identified the production of medication in standardised dosages as a particular constraint to individualised prescribing, and they argued that this was compounded by a misguided view of people as uniform beings. In common with Cassell's (1986) viewpoint, participants were adamant that conventional health care could never achieve a similar level of effectiveness because it could not be adapted sufficiently to address individual variation. By comparison, participants highlighted how the herbalist was able to formulate and prepare a prescription that allowed almost infinite variation, to provide truly individualised health care. Furthermore, this attribute was enhanced by the herbalist's knowledge about herbs and their direct involvement in the preparation of the herbal prescription.

More importantly, participants attributed the effectiveness of herbal medicines to their natural compatibility with the human body, which enables their interaction with the body's intrinsic healing processes. As with other studies, the concept of naturalness emerged as a particular attraction to participants but, in the context of this study, naturalness was essentially related to this notion of compatibility. In addition to the effective eradication of illness symptoms, participants believed that this compatibility was further evident in the ease with which herbal medicines could be assimilated into their lives and in the absence of side-effects during their use. Participants spoke about the transference of a healing energy from herbal medicines that was made possible by this inherent compatibility and it was this belief that enabled participants to recognise the potential for a healing liaison to occur – it had personal significance. They were further able to relate to herbal medicines because they were naturally provided for people's use, some participants being particularly encouraged by the instinctive use of herbs as medicine, within the animal kingdom. They liked the idea that herbalists used herbs that had not been reduced, tampered with or manufactured, consistent with the view that synergism is an important source of herbal effectiveness (Berkhardt 2000, Williamson 1999), and they liked the idea that herbs seemed to be effective without producing unwanted effects. They welcomed the relatively slow process of herbal healing, which is rationalised by Berkhardt (2000) as taking time to achieve because herbal healing is concerned with the relationship between the ailing part and the body as a whole. Indeed, Berkhardt (2000) argues that herbal healing does not occur only as a result of its biochemical properties but as a consequence of an essential energetic partnership between the body's healing potential and the plant medicine – a process that takes time. These views broadly reflect the essential tenets of naturopathic healing, the goal of which is to harness the healing forces of nature in order to strengthen or imitate natural self-healing processes (Lohff 2001). In naturopathic terms, the healing forces of nature include medicinal plants, which unfold their healing potential in the human organism (Lohff 2001). In this study, too, it was the notion of self-healing, promoted and enhanced by herbs and by a constructive patient-practitioner relationship, that fundamentally enabled illness causation to be targeted. Participants' views about self-healing, its relationship to the placebo response and its centrality to dealing with illness causation, are also consistent with those of O'Donnell (1995), who claims that the placebo response is the most effective medicine known to science. They also concur with the views of Noon (1999), who purports that the placebo response is a potent element in a complete theory of healing – a theory around which the concept of holistic health revolves.

5.4.2.4 Holistic Health Care

Although participants rarely used the term 'holism', their emphasis on health care that deals with illness causation by providing individualised, inclusive and multi-dimensional health care does suggest an holistic ideology. Generally interpreted as an approach that views the person as a whole rather than as a combination of individual parts (McKie 2003), the concept of holism is not a new one, having been brought into common use in the mid 1920's by Jan Christian Smuts (Pietroni 1997). To Pietroni, holism is concerned with the relationship between the parts and the whole, where the whole is typically described as being either greater than (Pietroni 1997, after Smuts), or different to (Poynton 1987, after Koffka), the sum of its parts. In the context of nursing practice, holism is described both in the synergistic sense (the whole being greater than the sum of its parts) and in the sense that the individual is an "... irreducible, unified whole in mutual process with the environment" (Jackson 2004, p71).

According to Mitchell and Cormack (1998), holistic health care is dependent on three essential components, all of which participants found in herbal health care:

1. A transcendence beyond the body-mind duality that characterises reductionist medicine:

   > "It's supporting the body and the whole individual ..." (S13.5).

2. The recognition of a person's social and cultural contexts and accounting for the impact of these on their health and illness:

   > "... and the depth of who we are ... has so much to do with how we are" (S4.1).

3. A philosophy that recognises, and accounts for, a synergistic relationship between different components of health care:

   > "The herbalist will be very open ... knowing that there are other options ... it's not only about science" (S4.1).

The concept of holism is popularly applied in relation to complementary therapy, the desire for a more holistic health care often cited as a major reason for its use in westernised cultures (Andrews 2002, Kelner and Wellman 1997, Vincent and Furnham 1996). Furthermore, the association between complementary therapies and holism (Pietroni [1997] would say the term had been 'hijacked') is often contrasted with an association between conventional medicine and reductionism: complementary therapy is holistic, conventional medicine is reductionist. However, a dichotomous connotation such as this reflects a reductionist attitude in itself, making the basis of this argument a contentious one. In an holistic sense, an examination of 'the parts' is a reductionist necessity that enables an evaluation of their relationship to the whole. In this respect, genuine holism can be seen to subsume reductionism rather than compete with it. In the spirit of holistic health care, 'the whole' would therefore encompass both complementary and conventional medicine, recognising their respective attributes and utilising these to enhance the overall provision of health care. Study participants who, despite their apparent disillusionment with conventional medicine, recognise the value of both herbal and conventional health care, reflect this genuinely holistic attitude more so than is typically demonstrated in much of the professional literature.

Building further on the notion of the whole and its relationship to the parts, Oschman (2000) describes wholeness in terms of 'coherence,' where coherence relates to how the parts of a whole are in relationship to one another (Quinn 2000), the system becoming more whole as coherence increases (Oschman 2000). Potentially, the concept of coherence has greater relevance than the concept of holism to participants' understanding of effective health care. For example, participants emphasised the importance of the relationship between different levels of their being and the importance of the relationship between herbal and conventional medicine in the provision of total health care. What they emphasise is the relationship between parts (coherence) and the impact of this relationship on the whole. Conversely, their concerns about fragmented health care: "... each person only deals with one thing ... they are not getting together to treat the whole body" (S5.5), imply a lack of coherence rather than a lack of holism. Being greater than the concept of holism and aligning more closely to participants' requirements for an effective health care, it may be that a philosophy based on a concept of coherence would serve the purposes of a future integrated health care if its purpose to

"… bring together body, mind and spirit …" (Prince of Wales's Foundation for Integrated Health 2003, p9) is to be realised.

5.5 "Seeing it how it really is" (S2.1): The Significance of Health Care Evidence to Perceptions of Health Care Effectiveness

The provision of health care that actually works is undeniably an expectation, not just for participants (patients) but also for health care professionals. In a culture that promotes patient-centred care, the provision of health care evidence is also fundamental if the ideal of shared decision-making is to be achieved. Although no participant directly cited the nature of health care evidence as influencing their decision to use alternative health care, every participant subsequently emphasised that their confidence in health care was enhanced when they were able to relate to the evidence on which it was founded. Indeed, the extent to which participants judged the nature of health care evidence was surprising and, since these judgements influenced their perceptions about health care effectiveness, this aspect of health care provision emerged as an additional constituent of effective health care.

The importance of health care evidence to health care professionals is reflected in their endorsement of evidence-based practice. Derived from the concept of evidence-based medicine, and most frequently defined as the "… conscientious, explicit and judicious use of current best evidence about the care of individual patients" (Sackett et al 1996, p71), the evidence-based approach to health care is described both in specific (evidence-based medicine, evidence-based nursing) and general terms (evidence-based practice, evidence-based health care)[4]. Being concerned with the provision of health care that incorporates evidence of clinical effectiveness (Royal College of Nursing 1996) and that integrates "… clinical expertise …external evidence … and patients' values …" (Sackett and Straus 1998, p1336) it would appear that the concept of evidence-based

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[4] The general terms 'evidence-based practice' and 'evidence-based health care' are applied and used interchangeably in this thesis, except where reference to a specific practice is required.

practice embraces participants' demands for health care that "...really helps in my health problems" (S2.1). Despite this, participants were critical about evidence-based medicine, perceiving it to have limited relevance to the reality of their health care needs and experiences.

The concept has also been criticised by health care professionals, some of whom argue that evidence-based practice can be discriminatory (Hassed 2004, Chalmers 1998) or that its principles are not always actualised in practice (Mendel 2004, Feinstein and Horwitz 1997). In response, it is suggested that some critics of evidence-based medicine may be fearful that their professional authority will be threatened by the evidence-based culture (Rosenberg and Donald 1995).

In addition to these general concerns, Feinstein and Horwitz (1997) also question how well the theory of evidence-based health care is applied in practice. With regard to the claim that evidence-based medicine values a variety of clinically relevant research, Feinstein and Horwitz contend that the information collected for evidence-based medicine, and therefore portrayed as acceptable evidence, is confined almost exclusively to the experimental method of enquiry. They argue that the avoidance of non-experimental approaches suggests that the tenacious positioning of the randomised controlled trial and the meta-analysis as the gold standards of evidence persists, despite claims to the contrary. This concurs with Mendel's (2004) view that evidence-based medicine promotes other types of evidence at a policy level but that the reality of this is debatable. Yet, in practice, Feinstein and Horwitz (1997) also maintain that some proponents of the randomised controlled trial often act on other evidence in the course of their practice. To illustrate this point, they cite studies undertaken by avid proponents of evidence-based medicine, which reveal much of their 'evidence-based' practices to be derived from evidence described as 'convincingly non-experimental'. This contradictory practice is also implied by Imrie and Ramie (2000), who argue against claims that evidence-based medicine is not widely based on evidence. Also proponents of evidence-based medicine, they consider that anecdote and subjective experience (so valued by participants) is excluded from evidence-based medicine 'for good reason'. Rather ironically, however, they acknowledge and accept the absence of randomised controlled trials in evaluating whether or not evidence-based medicine actually benefits patients. Instead, they refer to 'outcomes research' as an indication that patients benefit from better outcomes when they receive evidence-based therapies.

French (2002) also believes that there is inconsistency between the theory and the practice of evidence-based health care. In French's view, the proposition that evidence-based practice is a viable concept is based purely on subjective opinion (expert, but subjective nevertheless) and is therefore accepted only on face value. Being founded largely on beliefs about its benefits rather than on scientific evidence of its effectiveness, he argues that the concept of evidence-based health care betrays the very principles that are being extolled. He also suggests that evidence-based practice may be little more than a euphemism for other long-standing traditions such as research-based practice, information management and clinical problem solving or that it is a product of the conceptual overlapping of these traditions. This would situate evidence-based practice merely as a substitute for previously failed systems of quality assurance or, perhaps, as an artefact of information technology, serving to solve issues of poor research uptake by facilitating dissemination of research findings during a period of information explosion.

In a broader, political sense proponents of evidence-based medicine have attributed the approach with the potential to break down the traditional health care hierarchies that have previously been seen to reinforce the political power of medicine (Mendel 2004). With its emphasis on accessibility to health care information, it is claimed that evidence-based medicine places the individual at the centre of health care decision-making, facilitating the creation of an empowered consumer. This assumption, however, fails to take into account the differences in individuals' abilities to access, interpret and/or evaluate published evidence. By favouring the intellectually endowed, evidence-based medicine has the potential to extend existing inequalities in health care and this, according to Fox (1999), could lead to a shift of power to those individuals who possess the greatest capability. The paradox here is that evidence-based medicine is viewed, on the one hand, as classless in that it questions and attempts to overcome traditional hierarchies by promoting equal access to information. On the other hand, it risks the creation of a new class of elites by creating a disparity between social classes based on their respective abilities to utilise available information. The 'open access' approach therefore carries a risk of selective information transfer, a possibility made evident in the current study, where participants' failure to participate in the recent, government-initiated public consultation on herbal medicines resulted from inadequate communication of their opportunity to do so. A further concern in relation to increased accessibility to health care evidence is that it shifts the onus of responsibility onto the individual and this, in an increasingly litigious society, makes an evidence-based health care attractive to health care funding bodies (Mendel 2004), for reasons other than ensuring best practice. This possibility is also raised by others who believe that the emphasis placed on empirical evidence actually favours cost-effectiveness over the needs of patients and that, in reality, this constitutes one of the major reasons for the popularity of an evidence-based medicine based on quantifiable data (Frommer and Rubin 2000, Cheek et al 2000).

Philosophical arguments about the appropriateness of evidence-based practice are compounded by practical issues that are thought to impede the development of an evidence base, especially in relation to complementary therapies. One of these is the reported difficulty in locating published evidence. Although this has previously been recognised in relation to finding health care evidence in general (Ford et al 2002, McColl et al 1998), it is thought to be especially difficult for complementary therapy-related evidence. This is said to be partly due to the limited number of high quality studies available (Richardson 2002) and partly due to technical difficulties associated with literature retrieval (Murphy et al 2003, Richardson 2002). In this latter respect, Murphy et al (2003) explored the relative difficulties in retrieving general and complementary health care literature by comparing the indexing practices in four commonly used databases. Specifically in relation to complementary therapy literature, Murphy et al exposed considerable diversity in the use of controlled vocabulary that hindered literature retrieval and made the process not only difficult but also confusing and ineffective. Another potential hindrance relates to the argument that the evidence requirements for complementary therapies exceed those required for conventional medicine (Hassed 2004, Chalmers 1998). Hassed believes that the processes for evaluating scientific health care are, at best, imperfect and that there are numerous examples of biomedical therapies that continue to be used despite evidence of their ineffectiveness or harmfulness. Similarly, and despite his unwavering endorsement of the concept of evidence-based medicine, Chalmers (1998) also acknowledges this tendency for unfair discrimination. He reminds us that orthodox medical practices have far greater potential for harm than complementary therapies, partly due to their relatively widespread use and partly due to their relatively powerful effects. Chalmers mirrors Hassed's view that critics of complementary therapies are often far more assiduous in their attempts to outlaw unevaluated complementary therapies than they are in outlawing unevaluated orthodox practices. He argues that such double standards lead to grossly unfair discrimination against non-mainstream practices and fail to serve the interests of the public. Professional bias, such as this, is also acknowledged by McQueen (2002), who describes how notions such as 'evidence' and 'effectiveness' have evolved largely from a western epistemology, fostered by logical positivism. He also maintains that the western bias is exacerbated by a dependence on traditionally published literature and welcomes the recent inclusion of non-western perspectives as an acknowledgement of this limitation. In support of these criticisms, it has also been argued that the cliché of evidence-based health care has already become used as a synonym for 'good' or 'scientific' (Jonas 2001) and that the heralding of selected information as 'best available evidence' could lead to a new dogmatism in modern medicine (Feinstein and Horwitz 1997). The limited availability and difficulty in locating 'acceptable' evidence for complementary health care may therefore lead to its being perceived as less good or less scientific, regardless of its actual worth. Thus, the evolution of a new dogmatism could hinder rather than assist the development of an evidence-base for non-conventional therapies.

Returning to the context of the current study, the merits and limitations of evidence-based practice are considered in the context of participants' concerns, which were associated less with the concept itself and more with the nature of the evidence on which it relies. In particular, the data focused around two main areas of concern: the nature of health care evidence and applicability of conventional evidence to the context of complementary health care.

5.5.1 The Nature of Health Care Evidence

Beliefs about evidence relate to notions of proof and rationality:

- In the context of conventional health care, notions of proof and rationality are embedded in the scientific paradigm, where evidence is derived predominantly from research performed within the quantitative tradition (Rycroft-Malone et al 2004)
- In non-conventional health care, notions of proof and rationality tend to be more pragmatic, complementary therapists valuing the contributions of scientific, observational and experiential evidence, as appropriate
- To study participants, authentic evidence was derived from real life situations. Essentially, this included subjective experience, anecdote and historical knowledge.

In turn, notions of proof and rationality reflect, and are driven by, theoretical understandings about the nature of illness and its treatment. In relation to complementary therapies, underpinning theory cannot always be explained according to established theories that inform conventional medicine (Chalmers 1998, Levin et al 1997) and this can lead to the relative isolation of complementary health care (Lewith 2000). In accordance with participants' views, others maintain that paradigm differences between orthodox and complementary health care should be preserved (Mendel 2004) and that the proposal of alternative theoretical understandings can "... open a window of opportunity for successful treatment" (Lewith 2000, p102). According to Mendel, a principle that values the preservation of difference would allow for health care and its underpinning evidence to account for beliefs about illness other than those recognised and adopted by conventional medical practitioners. Chalmers (1998) supports these views, warning against the disregard of alternative theory, purely on the basis that it fails to conform to conventional belief, since orthodox theories about treatment mechanisms can prove to be misleading. He argues that the tendency to dismiss complementary therapies because their mechanism of effectiveness cannot be understood within established theoretical frameworks constitutes a "... misplaced confidence in the validity of theory" as a guide to practice, and that this can result in the inappropriate rejection of some types of care (Chalmers 1998, p212). These arguments apply equally well to notions about health care evidence. In an evidence-based culture that encompasses a "broad range of information" (Feinstein and Horwitz 1997, p530) it might be expected that competing paradigms, such as these, would be comfortably accommodated but the implementation of this ideal has been questioned (Mendel 2004, Feinstein and Horwitz 1997). A similar doubt is expressed by study participants, who question the adequacy of scientific evidence in verifying the safety and effectiveness of the health care, arguing for the inclusion of realistic health care evidence that shows how things really are. In particular, they question:

- The assumed primacy of scientific evidence (specifically, the randomised controlled trial)
- The reluctance to recognise lay opinion as a valid form of health care evidence
- The disregard of historical evidence.

5.5.1.1 The Primacy of Scientific Evidence

Questions about the primacy of scientific evidence in evaluating health care and, in particular, an over-reliance on the randomised controlled trial, are also raised within wider debates about the appropriateness of an evidence hierarchy. Proponents of evidence-based medicine imply that an evidence hierarchy ensures reliable and rigorous evidence (Harlan 2001, Hart 2001) but this view is countered by the claim that an evidence hierarchy promotes a narrow view of what actually constitutes 'good' evidence (Jonas 2001). Jonas acknowledges that laboratory or experimental tests can at times provide the best evidence but he argues that, at other times, best evidence can only be obtained from highly subjective judgement about quality of life. Here, neither questionnaires nor blood tests yield appropriate information, which can only be captured through qualitative research (Jonas 2001, Feinstein 1994). According to Ford et al (2002) the provision of disputable and sometimes contradictory health care evidence often reflects a tendency to focus on issues of popular interest rather than those that reflect patients' values. Furthermore, they report how some of their study respondents believed that the selective availability of evidence actually decreased patient choice by advocating one favoured course of action.

At the heart of many of these criticisms is an opposition to the view that the randomised controlled trial provides the most superior form of evidence, a view also expressed by participants, who believed that the clinical trial:

- Fails to reflect reality:

  > "...they're only tested on very small numbers ... in a very rigorous way ...on very specific parameters" (S13.5)

- Tests interventions for an inadequate period of time:

  > "I don't think they're that long tested ... years later, you find all the problems" (S9.1)

- Produces inconsistent findings and recommendations:

  > "All the time ... they come up with reports that contradict the previous one" (S2.1)

- Privileges the professional perspective:

  > "... a trial all depends on what you're looking for doesn't it? ... you just measure what you set out to measure ... I do honestly believe that you just find what you are looking for" (S7.1).

Participants' criticisms about the supremacy of the clinical trial are also reflected by a number of authors, both generally and specifically in relation to complementary health care. According to Black (1996), the randomised controlled trial cannot meet every informational need and he argues for the inclusion of observational studies as a means to fill in these informational gaps and as an aid to the interpretation of trial results. He summarises the broad limitations of the randomised controlled trial, as follows:

- They can be unnecessary, especially where the effect of an intervention is expected to be dramatic
- They are sometimes inappropriate, especially in detecting rare adverse events, in evaluating the prevention of rare events or when the outcomes of an intervention are expected to occur too far into the future
- They can prove to be impossible if there are personal or ethical objections to the method or where there is anticipated investigator contamination
- They can be inadequate, due to low external validity generated by experimental principles.

Other authors identify more specific limitations of the experimental method. Willett (1998), for example, maintains that it can be difficult to avoid contamination between treatment and control groups or to verify the extent of compliance. Further problems relate to the use of placebo and the uncertainty about its possible effects (Cleophas et al 1997), which can be compounded by the reluctant, and therefore potentially unreliable, distribution of a potentially ineffective (placebo) treatment (Schwartz et al 1997). The ideal of double blinding can also be difficult or impossible to achieve and can even be undesirable, especially where psychological or relationship effects might be an important part of the treatment (Vickers and de Craen 2000, Kleijnen et al 1994). Additionally, Feinstein and Horwitz (1997) identify how the elegant conduct and indisputable results of randomised controlled trials might well relate only to a very restricted population – often people expected to be highly responsive to the intervention - making the concept of generalisation a contentious one. Put quite simply, the study of people in controlled environments is just not a possibility because illness is a complex and synergistic phenomenon (Jonas 2001).

Progressing the evidence debate beyond the boundaries of experimental methodology Rycroft-Malone et al (2004) argue that, if evidence-based, person-centred care is to be achieved, then evidence needs to include practitioner and patient experience and contextual data as well as research evidence. In his discussion about mindfulness in the role of healing, Schmidt (2004) suggests that related research should also be conducted in a mindful way. Without being specific about how this is to be achieved, Schmidt argues that the kind of research culture that seeks a large effect size on the basis of a few specific outcome criteria that are measured over a short period of time will provide only scattered and unlinked results. They will also fail to achieve a deeper understanding of the phenomenon investigated. Similar doubts are reflected by study participants, who expressed a mistrust of scientific evidence based on a belief that scientific testing occurred over an inadequately brief period of time and that its methods inadequately reflect reality. Participants' reluctance to be convinced by scientific evidence is also observed by other authors (Fitzgerald and phillipov 2000, Bastain 2000, Bensoussan 1999) although Eastwood (2000) contends that the tension between evidence-based best practice and consumer preference could be overcome by combining clinical observation and patient demand in an approach that she terms 'clinical legitimacy'. Another proposed solution, which specifically addresses the bias perceived to be inherent to an evidence hierarchy, is the replacement of an evidence hierarchy by an 'evidence house' that provides a full range of information from which interested parties can select according to the question(s) they seek to answer (Jonas 2001). Jonas's evidence house would continue to demand high quality regardless of evidence type, whilst recognising that each type of evidence has a different function, an approach that builds on previous suggestions but fails to address the question of how 'high quality' is to be ascertained without recourse to favoured, hierarchical models that determine how research should be done.

5.5.1.2 Lay Opinion as Health Care Evidence

A risk inherent to the reliance on an evidence hierarchy is that perspectives failing to conform to dominant discourse can become marginalised, potentially to the point of exclusion. Specifically, an evidence hierarchy that privileges orthodox, professional opinion about treatment effectiveness demonstrates bias in favour of that particular group. A similar bias is also implicit to many of the definitions of evidence-based practice, despite claims to a widening of the parameters for the inclusion of evidence. The following definitions illustrate how the evolution of evidence-based medicine continues to implicitly privilege scientific and professional knowledge as the basis for informing health care practice:

> "... evidence-based medicine is the process of systematically finding, appraising and using contemporaneous research findings as the basis for clinical decisions."
>
> (Rosenberg and Donald 1995, p1122):

> "Evidence-based practice is a method of problem solving which involves identifying the clinical problem, searching the literature, evaluating the research evidence and deciding on the intervention."
>
> (White 1997, p175):

> "The thrust of evidence-based medicine is around identifying more clearly those health care interventions that can be shown to be effective on scientific grounds."
>
> (Elkan et al 2000, p1316):

More recently, it has even been explicitly suggested that the evidence for evidence-based practice should be restricted only to research findings, partly to overcome the difficulty in reaching consensus about the meaning of evidence (French 2002) but also in recognition of its unique status in the accumulation of knowledge (Scott-Findlay and Pollock 2004). Whilst acknowledging that experience informs understanding, Scott-Findlay and Pollock (2004) argue that evidence, prior to the process of human interpretation, is a tangible form of information that can only be found in research findings. This perspective, however, fails to take into account the belief that research, as well as knowledge, is socially and historically constructed (Wood et al 1998a, Wood et al 1998b) and that research in its written (tangible) form is subject to transformation by its readers, who necessarily contextualise the findings as a pre-condition to its implementation (Rycroft-Malone and Stetler 2004). Rycroft-Malone and Stetler argue further that beliefs about health care evidence fail to account for the interaction that occurs between research evidence and its contextual, practical and patient variables. As they point out, research evidence provides little more than a working hypothesis that is subsequently integrated with other sources of evidence. As such, evidence is derived from both propositional and non-propositional sources that include research findings, which are always provisional and ever evolving. As Upshur (2001) reminds us, to conflate research evidence with notions of truth can lead to serious misunderstanding.

Whilst attempts to expand the evidence profile are encouraging, the parameters for expansion continue to be selective. In particular, this expansion promotes an equal status for experimental and non-experimental evidence but often fails to acknowledge the potential value of alternative forms of evidence. Indeed, Black (1996) specifies quite clearly that his argument for the inclusion of observational studies in the evidence profile relates exclusively to quantitative but not qualitative, sociological methods. Furthermore, where personal opinion is recognised as a valuable source of evidence, it is ‘expert’ opinion that continues to be favoured. Where the patient’s perspective is taken into account, this tends to be considered as part of an evidence profile from which the professional draws conclusions. Even where an inclusive, step-wise approach to the collation of evidence is advocated (Ernst and Barnes 1998), there is a notable paucity of patient-centred research methodology. Here, only the first step (a series of surveys) canvasses patient opinion but, rather than providing definitive evidence, these serve to identify areas for further research. Beyond this, it is the integration of systematic reviews, clinical trials, reporting schemes and outcome studies that provide a basis for the interpretation of treatment effectiveness, again from the professional perspective.

Yet, as participants point out, it is their unique illness experience that provides them with the greatest insight into the effectiveness of the health care that they receive. Seldom examined at a conscious level, people's uniquely individual experience of illness reflects the broader context of their lives and is described by Morris (1998) as the 'white noise' of illness. Although elusive, the white noise of illness is crucial to understanding the patient's perspective and this, according to study participants, is crucial to achieving effective health care. As such, their subjective experiences provide valuable, if not crucial, evidence about treatment effectiveness.

As this study reveals, patients and practitioners can assign different meanings to the notion of treatment effectiveness but the failure to acknowledge lay opinion in the evaluation of health care encourages health care professionals to make assumptions about the patient's health care experience. This possibility is also acknowledged by Fordyce (1995), who highlights the tendency for health professionals to believe that all patients are the same. Where such assumptions are privileged, outcome measures of importance to patients may remain unaccounted for; where subsequent treatment decisions are based on erroneous assumptions about a patient's wishes, their health care expectations my remain unfulfilled. In the context of these study findings, an illusion of homogeneity precludes the possibilities for personally significant health care. Effective health care is therefore unlikely to be achieved.

The reliance on professional opinion about treatment effectiveness also relegates access to health care partly to the vagaries of professional preference, risking some patients being denied potentially effective treatment. As well as the human cost, the importance of providing treatment that patients perceive as effective has also been discussed in respect of the economic burden, where treatment ineffectiveness is likely to lead to an even greater demand for additional and ongoing health care (Brown 2003). In a culture that promotes patient empowerment it is anomalous that the patient perspective is overlooked in the evaluation of their own health care. It perpetuates a sense of medical paternalism and it trivialises the opinions of patients who, according to this study, have much to say about the health care for which they bear the consequences. Mutual evaluation of health care is also central to the important developments of patient-centred and integrated health care, where it can contribute to a genuinely patient-focused service. Importantly, the failure to explore and account for the patient perspective represents a missed opportunity to expand the horizon of professional understanding.

5.5.1.3 Historical Knowledge as Health Care Evidence

The test of time was also highly valued by study participants as a measure of both health care effectiveness and health care safety. Being more prolific than scientific evidence (Mendel 2004), it is argued that knowledge about long-term traditional use would enhance the evaluation of health care, in a real sense (Bensousson 1999). Indeed, one participant, in discussing the importance of time in evaluating health care effectiveness, raised the question: "… what bigger human trial is there anyway than the whole of humanity?" (S13.5). Despite the surprising absence of literature that actually examines their validity as evaluative measures, there is a general reluctance in conventional medicine to recognise either history or anecdote as credible sources of health care evidence. One exception is seen in Ernst and Barnes's (1998) paper, which proposes six arguments against the use of time as a source of health care evidence:

1. Historical evidence cannot be related to current use because the nature of a herbal remedy (source and production processes) may have changed over time.
2. Historical evidence cannot be translated into modern practice because not all variations of a herbal remedy will have been traditionally used.
3. A remedy might not have been intended to be used by today's routes of administration (for example, homeopathy was never intended to be delivered by injection).
4. Traditional remedies were not originally considered in terms of their potential compatibility with modern medicines.
5. It is unwise to assume similarity between modern illness and conditions that were treated in the past.
6. Today's users may have different characteristics to their ancestors (for example diet or concomitant disease).

Ernst and Barnes (1998) raise important and valid concerns about making potentially erroneous assumptions in the translation of historical evidence. However, their arguments are based largely on the premise that the translation of validity claims cannot be assumed; an argument that correlates broadly with participants' criticisms about the tendency to assume the translation of scientific evidence to the evaluation of herbal therapy. They argue, for example, that conventional evaluation is inadequate because:

- Treatment standardisation alters the nature of the intervention (Ernst and Barnes's argument 1)
- Herbal remedies were not intended to be administered as an isolated constituent of the herb (Ernst and Barnes's argument 3)
- The assumption that common symptoms imply the same illness in different people fails to reflect genuine herbal practice (Ernst and Barnes's argument 5)
- It fails to accounts for individual characteristics, whereas the herbal therapy does (Ernst and Barnes's argument 6).

These comparisons are not offered as counter-arguments to Ernst and Barnes's observations but serve to highlight the need to undertake an equally vigilant critique of the assumptions implicit to conventional theories and principles. In a climate that promotes integrated health care, it is timely that Hassed (2004) and Chalmers (1998) remind us to guard against discriminatory practices, Chalmers emphasising the necessity to challenge people who operate such double standards, if the concept of integrated health care is to be promoted.

5.5.2 Evidence-based Medicine in the Context of Complementary Health Care

Demands for the establishment of an evidence base for complementary health care appear to have been embraced by complementary practitioners although arguments abound as to what actually constitutes sufficient or appropriate evidence. Whilst some argue that complementary health care should be evaluated in exactly the same way as conventional health care, others believe that existing methods need to be modified, substituted or supplemented by other approaches to ensure that evaluation is both rigorous and relevant.

In common with arguments that favour the randomised controlled trial as an evaluative method in conventional health care, arguments that favour its use in the evaluation of complementary health care are based on the belief that this method provides the ultimate standard of evidence (Harlan 2001, Ernst 1995) and that it provides the definitive test of efficacy (Harlan 2001). Other authors believe that existing methods within the evidence hierarchy (but not necessarily the randomised controlled trial) provide an appropriate and sufficient means of evaluation (Ernst et al 2003, Black 1996, Patel 1987). But, despite the acknowledgement that complementary therapists are increasingly cognisant of the need for an evidence base for their practices (van Haselen and Fisher 1999), some object to the imposition of conventional methods of evaluation, arguing that in many situations these are neither appropriate nor effective. In response to these competing views, the National Institutes of Health's working group for quantitative methods were charged with identifying suitable methods for researching complementary therapies. They firstly summarised the main objections to conventional evaluation, as follows:

- Individualised treatment protocols, considered essential to the overall effectiveness of complementary health care, make it difficult to generate data that allows comparison by conventional means
- Treatment effectiveness is understood to manifest itself differently in different people, a situation not amenable to standardised outcome measurement
- Treatment is often targeted at different levels of a person's biopsychosocial system. Again, this precludes the use of standardised research protocols
- Individual responses to treatment can be varied, prolonged and/or may be too subtle to be detected by conventional means
- Measurement of healing modalities, such as chi, is impossible within a framework that fails to recognise their existence
- The belief in unorthodox concepts, such as the existence of complex and multifactorial aetiologies, makes many complementary therapies inconsistent with biomedical thinking.

(Levin et al 1997)

The product of their deliberations was a methodological manifesto that recommended general principles for empirical research, including the evaluation of efficacy. They recommended that a variety of methodologies should be considered but that complementary therapies should endure the same degree of scientific scrutiny as conventional medicine and that therapeutic effectiveness should be demonstrated in relation to accepted outcome measures, implying that 'variety' should be contained within orthodox boundaries.

The most enduring arguments against the reliance on conventional evaluative methods for complementary therapies relate to the requirement for standardisation of treatment (Brewer and Penson 2002) and to the isolation of individual therapies or individual constituents of a therapy (Richardson and Strauss 2002, Wong et al 2001), which can generate false negative results if claims to synergistic effects are correct (Ernst et al 2003). Participants, who unequivocally emphasised the necessity to evaluate herbal therapy in the context of its actual practice, also highlighted these limitations. They, too, saw individualisation and the preservation of wholeness as crucial to both the practice and evaluation of herbal medicine, reiterating the necessity to be able to identify with health care evidence if it is to be perceived as credible.

Vickers (1998) also highlights how conventional evidence can have low clinical relevance to the practice of complementary therapies when testing methods fail to reflect actual practice. This is most usually illustrated in the example of applying research findings that reflect the effectiveness of standardised interventions, in the context of an individually determined therapy. Vickers also identifies how complementary therapies are often tested only on selected disorders, especially those that are considered to be straightforward to test. He cites the prevalence of studies on the use of acupuncture in the treatment of nausea in comparison to the paucity of studies on more commonly treated disorders, such as chronic fatigue, because it can be difficult to research such conditions. It is also claimed that subtle effects can defy quantification by conventional outcome measures, the patient her/himself being the only measure through which effectiveness can be judged (Ernst et al 2003). With regard to the actual concept of evidence-based practice, Adams (2000) goes so far as to suggest that complementary health care is diametrically opposed to the tenets of the conventional evidence-based approach. Based on his study of 25 general practitioners who also practised a complementary therapy (either acupuncture, hypnotherapy or homeopathy), he concluded that the majority (n = 21) saw evidence-based medicine as a restrictive approach that presented a threat to clinical expertise. This was described by one interviewee as making "... a mockery of the individual relationship" (Adams 2000, p250), an important consideration given that participants in the current study identified individualised health care and patient-practitioner partnership as vital components of effective health care.

Ernst et al (2003) argue that many of the objections to conventional evaluation could be overcome with adequate consideration of study design. They maintain that even the measurement of highly sensitive outcomes is possible with the use of validated measures of well-being or quality of life, arguing that even patient preference is quantifiable. Others believe that conventional methods require either modification or substitution if perceived limitations are to be overcome (Rycroft-Malone et al 2004, Schmidt 2004, Oberaum et al 2003, Verhoef et al 2002, Harlan 2001). In an attempt to redress the balance, the European Committee for Homeopathy (2003) proposed the equal positioning of controlled and observational studies to ensure the provision of appropriate evidence. In their report *A Strategy for Research in Homeopathy*, they promoted both efficacy research (randomised controlled trials) that demonstrates how homeopathy can work in ideal circumstances and effectiveness research (observational studies) that demonstrates that it does work in real world circumstances. But, to some, this proposal does not go far enough, arguing that an exclusive reliance on well-established research methods is insufficient. For complementary therapies to be afforded appropriate and credible evaluation, some appeal for the modification of existing methods (Oberaum et al 2003, Harlan 2001) whilst others believe that the addition of alternative methodologies is required (Rycroft-Malone et al 2004, Schmidt 2004, Verhoef et al 2002).

In concurrence with the views of Brewer and Penson (2002) and Vickers (1998), Oberaum et al (2003) also highlight the particular problem of evaluating typically individualised treatment through research methods that demand standardisation of treatment protocols. They emphasise the importance of this point by arguing that individualisation is the most important principle in homeopathy and some other complementary therapies but they believe that this problem can be reconciled providing that the competing paradigms each respect the other's differences. With particular reference to homeopathy, for example, they emphasise the necessity to:

- Employ varying lengths of treatment
- Maintain treatment in the event of symptom exacerbation
- Exclude patients who have received either antibiotics or steroids in the previous three months.

For homeopathy and other individually-determined therapies, they suggest two possible modifications to the conventional randomised controlled trial, one of which recognises and preserves the principle of individualisation, the other more conducive to study replication. Their favoured method is the randomisation of patients to placebo or experimental groups after the same practitioner has determined individual treatment regimes. This would allow for treatment and placebo groups to be compared whilst preserving individualised treatment plans, a method also advocated by Harlan (2001). According to Oberaum et al (2003), this approach would yield the best results but would be difficult to replicate with different practitioners and different populations. Their second solution, although one that would be expected to achieve poorer results, requires treatment prescribing against keynotes. This method would require the recruitment of patients with similar clusters of symptoms that might respond to the same intervention as well as the pre-determinations of treatment by a panel of practitioners. However, this represents an uncommon approach that, Vickers (1998) reminds us, might yield questionable results in the eyes of practitioners. It might also be inadequate in the eyes of study participants, who unanimously attributed the effectiveness of herbal therapy to processes that recognised people's differences and individuality: "... everyone could come out with a different medicine but it would be for the same problem ... because everybody is so different" (S2.2)

Verhoef et al (2002) specifically promotes the addition of qualitative research methods to traditional randomised controlled trials as an aid to understanding complementary therapies. In particular, they outline how qualitative research can reveal how an intervention has been effective in ways other than those expected, because it is case-oriented rather than variable-oriented. They cite several therapeutic examples (acupuncture, qigong, mind-body interventions) where statistically non-significant findings have been shown to obscure other meaningful and desirable outcomes for patients – outcomes also reflected in participants' criteria for effective health care (see: Section 4.3, Motivational Theme: Searching for Effective Health Care). The potential to detect subtle responses through the use of qualitative methods is also emphasised by Sandelowski (1996), highlighting how the reliance on conventional outcome measures can result in important outcomes remaining untested because not all potential benefits of an intervention are known. In addition to the detection of unanticipated benefits, Cohen and Mount (1992) assert that conventional outcome measures are often invalid in palliative care due to their tendency to focus only on physical outcomes, a claim that can also be applied to complementary therapies, since many target multiple aspects of a person's health and well-being. Verhoef et al (2002) also point out that randomised controlled trials measure specific but not contextual effects, which can be an important omission since non-specific effects, such as the patient-physician relationship, can be significant in maximising the therapeutic effect of an intervention. They argue that qualitative methods could lead to deeper insight into this type of phenomenon as well as increasing understanding about the practical burdens of an intervention and, therefore, its feasibility in real life situations.

Different perceptions about what constitutes appropriate evidence for complementary therapies is also evident amongst health care purchasers. Based at the Royal London Homeopathic hospital (a provider of a range of complementary therapies), van Haselen and Fisher (1999) surveyed four different groups of health care purchaser (public health directors and three differently defined general practitioner groups), asking them to rank order 12 aspects of evidence for the assessment of complementary therapy. They found that only two of the 12 aspects – randomised controlled trials and safety – were significantly rated as 'very important.' Although this finding was common to each group, the authors also noted that purchasers having no contractual arrangement with the specialised hospital were more likely to favour randomised controlled trials and were less likely to report patient satisfaction as an important means of assessing evidence (58-68% versus 77%). Although the authors do acknowledge that the differences between groups were subtle and small, the possibility of a relationship between scepticism for alternative forms of health care and scepticism for alternative forms of health care evidence cannot be discounted. The findings are further limited by the requirement to rank-order pre-determined options, which makes it difficult to detect the extent of difference between a respondent's most and least favoured items or even whether their preferred options were actually included within the available choices. Worthy of note, however, is the relatively low rating of patient demand as an indication of treatment effectiveness, which, with the exception of 'uncontrolled outcome measures', was ranked as the least valuable source of evidence. Given the current emphasis on patient-centred care and patient empowerment, the reluctance to acknowledge patient demand for complementary therapy as some indication of its potential effectiveness seems incongruous to say the least.

In the literature, very little attention is given to the patient's perspective on health care evidence. Whilst some authors emphasise the necessity to include a patient perspective on treatment effectiveness, there is minimal consideration given to their perspective on the credibility of evidence, nor to their opinion as a source of definitive evidence. The promotion of an evidence hierarchy that excludes patients' subjective accounts is testament to the assumption that health care evaluation is primarily a concern for health care professionals. Whilst arguments for the judicious use of randomised controlled trials and for the inclusion of non-traditional types of evidence go some way to address participants' concerns about the relevance of health care evidence, the importance of providing personally significant evidence fails to warrant attention. On the basis of this study, however, patients do judge the credibility of health care evidence and it seems that their perceptions about health care effectiveness are influenced accordingly. In this respect, their impressions about the effectiveness of conventional medicine were negatively influenced by the nature of its underpinning evidence and this appeared to contribute to their decision to seek an alternative health care option. Conversely, their attraction to herbal therapy was positively influenced by the nature of its evidence base, which had greater consistency with their personal views of how health care should be evaluated. Of particular importance to all participants was their personal experience of treatment effectiveness as well as the confidence that evolved from their knowledge of long-standing, historical use. Above all, participants emphasised the need for evidence to which they could relate and that recognised patients as individuals whose experiences constitute valid and pertinent evidence of health care effectiveness and safety. In short, they wanted evidence that they viewed as making sense. The constituent: the provision of authentic health care evidence therefore constitutes an important finding of the study.

5.6 "Empowerment helps the healing" (S4.1): The Centrality of Patient-practitioner Partnership to Effective Health Care

According to study participants, healing is at the heart of effective health care. Whilst healing is achieved through practices that embrace an individualised, inclusive and multi-dimensional approach to health care, 'effective' health care also strives to achieve mutual understanding about the nature of health and illness and it recognises the primacy of the patient in decision-making processes. Core to achieving this ideal is effective patient-practitioner collaboration, without which the achievement of consensus in respect of health care diagnosis, treatment and evaluation remains difficult to establish. Patient-practitioner collaboration was therefore identified, not only as a constituent of effective health care in its own right, but also as an essential catalyst for the achievement of the other three. In support of this finding, Ong and Banks (2003), in their review of the grey literature on the use of complementary therapies, also identified the patient-practitioner relationship as one of the most valued aspects of the complementary health care experience.

Further testament to the significance of the patient-practitioner relationship is the relative wealth of related research and other published material available in the professional domain. This body of literature, however, focuses particularly on patient-practitioner communication and on enhancing health care outcomes by improving patient compliance whereas the current study suggests that a collaborative relationship contributes to effective health care in more direct ways; ways that are conducive to the promotion and enhancement of the healing process. In this respect, beliefs about the nature and purpose of the patient-practitioner relationship emerged as a crucial factor in influencing participants' reasons for seeking alternative health care options.

5.6.1 The Nature of the Patient-practitioner Relationship

The health care model to which the practitioner subscribes determines the nature of the patient-practitioner relationship. Almost 30 years ago, the World Health Organisation (1978) declared people's right to participate in their health-care but, despite this, the principle of patient involvement is not readily recognisable in the evolution of health care models since that time.

Until the mid 1980's, the patient-doctor relationship was frequently based on a model of paternalism. Generally well-documented (Coulter 2002, Deber 1994, Emanuel and Emanuel 1992), the paternalistic model assumes that 'doctor knows best.' It favours one-way information exchange, from doctor to patient and views the patient as a passive recipient who acquiesces to professional authority (Charles et al 1999b). The paternalistic model broadly conforms to Parsons's early conceptualisation of the sick role (Emmanuel and Emmanuel 1992), embracing an authoritarian perspective that, at one extreme, might amount to the provision of authoritative information but, at the other, might involve the coercion of a patient's consent to the physician's preferred treatment.

The paternalistic model subsequently became viewed as unacceptable, largely in response to the women's movement and the passage of legislation (Charles et al 1999a) but also in response to consumerist trends (Charles et al 1999a, Elwyn et al 1999) and to trends that promoted patient empowerment (Department of Health 2000). Consequently, paternalistic health care became challenged by patients, health care professionals, ethicists and researchers in favour of a more patient-focused approach (Charles et al 1999b) and this resulted in established medical authority being encouraged to adopt increasingly equitable models. Such approaches were characterised by informed choice, either in the guise of information provision or within a philosophy of shared decision-making.

The informed approach is essentially a consumerist model that, in common with the paternalistic model, is characterised by physician-led communication. It differs from paternalism, however, in that decision-making becomes the sole prerogative of the patient (Charles 1999a). In this approach the purpose of information exchange is to increase the patient's knowledge about the potential risks and effectiveness of treatment, ensuring that decision-making encompasses scientific knowledge as well as patient preference. Whilst the informed approach overcomes the authoritarian bias inherent to paternalism, its particular limitation lies in the assumption that the provision of information actually enables the patient to engage in autonomous decision-making. This assumption is addressed in the more contemporary models, which promote shared decision-making and have been advocated as the ideal for several years (Deber 1994, Emanuel and Emanuel 1992, Brock and Wartman 1990). Essentially, this approach amalgamates the principles of information sharing and decision-making and is characterised by a greater degree of interaction between patient and practitioner. Specific models focus either on the inclusion of the patient in general decision-making processes (Trede and Higgs 2003, Elwyn et al 2000, Charles et al 1999a, Braddock et al 1999) or on the concept of evidence-based patient choice (Ford et al 2003, Towle and Godolphin 1999, Entwistle et al 1998, Hope 1996) but, according to Charles et al (1997), the approach has only ever been loosely defined.

Of the general decision-making models, Charles et al first described (1997) and subsequently revised (1999a) their approach, which advocates shared decision-making in respect of treatment choices. They emphasise the importance of accounting for the patient's unique background and they acknowledge the dynamic nature of the decision-making process, which might include the involvement of third parties, such as the patient's family. Charles et al (1999a) identify three analytic stages that are key to the successful implementation of this approach: information exchange, treatment deliberation and deciding on treatment implementation. In this particular model, information exchange is concerned with the physician's conveyance of technical information to the patient and with the patient's conveyance of self-knowledge to the physician, the aim of which is to ensure that all relevant treatment options are considered and that these are evaluated in the context of the patient's situation. The second stage of the model - treatment deliberation - is based on the assumption that both parties acknowledge that treatment can be selected from a range of potential options. The patient and the physician both declare their personal preferences and make considered judgements about treatment options. The outcome is an agreed treatment plan, whether or not this fully reflects everyone's personal preferences. However, if the physician cannot endorse the patient's preferred treatment, the patient may need to go elsewhere. Similarly, Trede and Higgs's (2003) collaborative, clinical decision-making model recognises patients and professionals as mutually respected partners who account for professional knowledge, health care priorities and health care options in the context of the patient's experience. In addition, Trede and Higgs's model also encourages clinicians to think beyond biophysical problem solving and to relinquish their traditional position of authority. The model also encourages an acknowledgement that generic 'best practice' might be neither appropriate nor 'best', given the patient's personal perspective and priorities.

In the context of the current study, the shared and collaborative decision-making models have the greatest compatibility with participants' views. This is particularly true with regard to accounting for the patient's contextual situation (Trede and Higgs 2003, Charles et al 1999a, Charles et al 1997) and in the tendency to acknowledge the primacy of the patient's health beliefs (Trede and Higgs 2003). But the models depart from participants' ideals in that they continue to emphasise the doctor's role in identifying possible treatment options and this risks the preclusion of the patient's favoured alternatives, especially where the patient may lack the confidence to volunteer an opinion. In this sense, treatment options may not acquire the personal significance that so crucially underpins participants' impressions about healthcare effectiveness. Similarly, the necessity for physician endorsement of the treatment plan suggests that shared decision-making is only effective to the extent that agreement is reached within the practitioner's own, professional frame of reference. In otherwise commendable models, these approaches are also limited by their tendency to focus primarily on shared decision-making in respect of treatment selection but not in respect of diagnostic and evaluative processes - to study participants both constituting important areas for their personal contribution.

A less well-documented model that is also encompassed within the shared decision-making approach is the evidence-based patient choice model. First described by Hope (1996), this model is driven by the ethical principle of providing information for the purposes of enhancing choice and it appears to have evolved in parallel with improved patient access to medical information. The model also embraces a broader than usual definition of evidence, encompassing information of importance to patients as well scientific evidence (Ford et al 2003). According to Ford et al, however, relatively little is actually known about patients' preferences for evidence-based information during the medical consultation and, they argue, there is a lack of consensus about the key components of this approach. To address this, they interviewed professionals (doctors and academics) and lay people to establish what would be required for the successful implementation of such a model. Their research identified six essential components, in the following order of relative importance:

1. The provision of research evidence/medical information
2. An effective doctor-patient relationship

3. Acknowledgement of the patient's perspective
4. Clarification of the decision-making process
5. The provision of adequate time
6. Establishment of the nature of the patient's problem.

Ford et al (2003) present their findings as a reflection of respondents' agreed views but closer examination of the study data reveals differences between lay and professional perspectives that are not explicitly acknowledged by the authors. Based on this observation, the evidence-based patient choice model emerged as the least compatible with participants' views, despite initial impressions to the contrary. In relation to each of the six essential components of the model:

1. The provision of research evidence/medical information.

All respondents agreed on the necessity for good quality health care evidence but, while the study authors tended to emphasise medical respondents' preferences for scientific evidence and evidence-based guidelines, the data revealed that laypersons and academics highlighted the importance of patient experience. It is also interesting that professionals believed that treatment options should be offered according to strength of evidence, suggesting a firm allegiance to traditional evidence hierarchies, and that patients should be educated and directed by the doctor towards relevant information sources – unusual principles for a model based on patient choice.

2. An effective doctor-patient relationship.

The authors acknowledged the importance of attentive listening during the consultation but they failed to recognise how laypersons and doctors interpreted this differently. To the layperson, attentive listening was concerned with "… listening and asking questions when they do not understand", suggesting a desire for patient information and clarification. By contrast, the medical view of attentive listening was "… to have a sensible patient who listens and retains information", suggesting an expectation of patient compliance (Ford et al 2003, p595).

3. Acknowledgment of the patient perspective.

Although an expected component of a health care model based on patient choice, closer examination of the study data again revealed unacknowledged differences between lay/academic and medical perspectives. To lay persons and academics, this principle related to the need to respect patient choice in selecting treatment options. To medics, the emphasis was on allowing patients to opt out of the decision-making process.

4. Clarification of the decision-making process.

Whilst doctors generally emphasised their role in advising patients about the best course of action, laypersons emphasised their right to reject the doctor's opinion.

importance of allowing adequate consultation time, with opportunity for further consultation. An additional point raised by one layperson related to the need for patients to prepare prior to the consultation, an interesting suggestion that has implications for provision of pre-consultation information.

6. Establishing the nature of the problem.

In stark contrast to the current study, this aspect was identified as the least significant to a patient choice model of health care. A response emanating predominantly from medical respondents, the authors suggest that this might reflect the view that diagnosis is an 'obvious' component of the consultation and a primary purpose of the doctor's role - arguably, an assumption also inconsistent with the tenets of a patient-centred approach.

Consistent with Ford et al's (2003) model, participants in the current study also emphasised the need for knowledge and information. They also concurred with Ford et al's lay respondents, who called into question the superiority of scientific evidence in the evaluation of health care. Although Ford et al do advocate a broader definition of evidence than is traditionally assumed, the parameters of this new definition are not made explicit, making it difficult to establish how inclusive their definition might be. Their findings also imbue a sense that traditional notions of evidence and traditional notions of the doctor-patient relationship persist in contemporary health care, a finding that might be partly explained by their recruitment strategy, which attracted only 18% (8 of 45) of lay respondents, the remainder being health care professionals (11 general practitioners, 10 hospital consultants and 5 nurse practitioners) and academics (11 in total, 4 of whom were also general practitioners). In a study concerned with establishing the key requirements of a patient choice model, the study sample therefore seemed to be strangely imbalanced in favour of the professional perspective.

Another important issue implicit within this model, is the assumption that evidence-based medicine and patient-centred medicine share a natural compatibility, although these approaches represent two fundamentally different concepts, an anomaly also recognised by Bensing (2000). According to Bensing, evidence-based medicine is a cognitive rational enterprise that neglects the uniqueness of patients in the decision-making process whereas patient-centred medicine has an ideological base that is better developed than its evidence base. Ironically, this potential incompatibility is also implied, but not explored, in Ford et al's study, which acknowledges that study participants struggled to relate one concept to the other and had difficulty in seeing how the model could work in practice. Bensing (2000) also observes that, despite the prolific availability of literature related to both evidence-based and patient-centred medicine, very few authors attempt to combine the two. Quite possibly, this relative paucity of literature reflects a naturally limited congruence between two competing ideologies.

5.6.1.1 Patient-centred Medicine

Despite some differences, most contemporary models of health care endorse the concept of patient-centred medicine (later referred to as patient-centred care but used synonymously in this discussion). Not a new concept, but seemingly lacking in consensus as to its precise meaning (Mead and Bower 2000), Bensing (2000) believes that the goal of patient-centred care is to combine the ethical idea of the ideal doctor with theories that facilitate patient disclosure and that enhance decision-making. Early descriptions portrayed patient-centred medicine as an approach that understood the patient as a unique human being (Balint 1969), that encouraged the doctor to draw on the patient's knowledge and expertise of their illness (Byrne and Long 1976) or that encouraged them to see the illness through the patient's eyes (McWhinney 1989). More recently, and consistent with participants' perspectives, patient-centred health care has been defined by its focus on illness rather than disease (Smith and Hoppe 1991), by the provision of care that is closely congruent with patient preferences (Coulter 2002, Laine and Davidoff 1996) and by care that involves patients in decision-making (Winefield et al 1996, Grol et al 1990). Patient-centred health care is also central to Stewart et al's (1995) patient-centred clinical method, which:

- Explores both disease and illness experiences
- Attempts to understand the whole person
- Identifies shared management aims
- Focuses on prevention and health promotion
- Attempts to enhance the doctor-patient relationship
- Maintains a realistic focus, in terms of available resources.

Taking into account the various definitions of patient-centred care, Mead and Bower (2000) propose several key distinctions between patient-centred medicine and biomedicine, suggesting that patient-centred medicine promotes:

- The adoption of a biopsychosocial perspective that accounts for the patient's full range of problems and is receptive to the patient's hidden agenda
- A willingness to expand on the biopsychosocial perspective, to incorporate understanding about the patient's experience of illness
- Patient involvement
- The development of a therapeutic alliance
- Acceptance of doctor subjectivity in therapeutic techniques.

An assumption implicit in patient-centred models of health care is that the patient-practitioner relationship is based largely on a model of patient empowerment. In the context of health care, empowerment is concerned with encouraging people to participate as equal partners in decision-making processes (Opie 1998) and is dependent on health care practitioners valuing the patient's input, respecting the patient's ability to make decisions and showing a willingness to relinquish control of the health care situation (Chapman 1994). Patient-centred care reflects these values, which also have consistency with participants' ideas about 'being in charge' of their health care but, despite this, participants' experiences suggest that the rhetoric of patient empowerment is not always matched in practice. This possibility is also reported in the literature, which suggests that health care practitioners can be disempowering in very subtle ways. The patient might be allocated a subordinate role, for example, that corresponds to the practitioner's agenda, or that rests on an assumption that the patient shares the practitioner's views about illness management (Opie 1998). Rather than encouraging a truly collaborative venture, this tactic is seen to reinforce the practitioner's own power base (Arksey and Sloper 1999; Cahill 1998). Other subtly disempowering practices include the tendency to devalue the patient's knowledge and experience of illness in favour of more objective data (Fisher 1991), the expression of doubt about the legitimacy of undiagnosed illness (Howell 1994) and even the chastisement of patients who make their own self-management decisions (Paterson and Sloane 1994). According to Paterson (2001), these practices may occur as a consequence of professional socialisation to the 'practitioner as expert' model of health care, which encourages practitioners to view patient participation as an invasion of their professional territory. As one participant commented: "I know the caring type people are still going in at one end but by the time they get out at the other, they are much more business-like. It becomes a 'them and us'" (S4.1).

Contradictory behaviour, where the practitioner fails to act out espoused practice, is also evident in a small number of studies. One example is provided by Paterson (2001), who undertook a grounded theory study of 22 Canadian adults with type 1 diabetes mellitus who had been nominated, many by their physicians, as expert self-care managers. One aspect of the study focused on the actuality of empowerment in situations where participatory practice was advocated but the study revealed that participants had met few practitioners whose behaviours were truly empowering, despite their proclamations to the contrary. Participants reported how they had been encouraged by health professionals to participate in decision-making but that their contributions were then immediately discounted, betraying expectations of patient compliance with physicians' decisions. In common with previous suggestions, and also consistent with participants' experiences, Paterson's participants reported that practitioners' claims to a collaborative disposition were contradicted by subtle, if not covert, behaviours. One example of this was the tendency to discount patients' experiential knowledge, especially when this contradicted textbook information. Other examples included: the use of medical jargon, which impaired patients' understanding, the tendency for practitioners to adopt a stance of professional distancing and an implied expectation of patient compliance that sometimes led patients to lie about their self-management practices. In addition to these behaviours, patient empowerment was further impeded by the imposition of inconvenient and rushed appointment times and by the requirement to see a variety of different practitioners, neither of which was conducive to interaction between patient and practitioner. Indeed, the current study revealed multiple examples of practitioner-centred practice in the conventional setting and, importantly, these significantly influenced participants' dissatisfaction with conventional health care.

The reality of patient empowerment has also been investigated in relation to nursing practice. Using a case study approach, Rycroft-Mallone et al (2001) studied the extent to which patient education about their medication was patient-led. The study was undertaken in three different types of clinical setting: two hospital wards, two community mental health caseloads and four general practices. Data were derived from several sources including the observation of nurse-patient interactions, client and nurse interviews, documentary analysis, carer focus groups and field notes. In the majority of cases, Rycroft-Mallone et al found that patient education conveyed relatively simple information, was nurse-led and provided little opportunity for patient choice. An exception was found in one of the community mental health settings, where education included more broad-ranging information and was more likely to be patient-led. The authors concluded this to be atypical of the study results overall.

Taking a rather different approach, Skelton et al (2002) explored the actuality of empowering behaviour by observing the nature of discourse between patients and physicians during general practice consultations. Their study was concerned with the deployment of first person pronouns ('I', 'me', 'we' and 'us') during the consultation process, which they observed in 373 consultations involving 40 general practitioners who each undertook a mean of 9.33 consultations. Data were analysed by means of a concordancing program. The study revealed that physicians frequently used the pronoun 'we', which appeared to represent an offer of partnership but which the researchers observed to be used in an ambiguous way, often being applied in an exclusive sense ('we doctors') rather than an inclusive one ('you and I'). They also observed that patients did not include doctors when they applied the term 'we' and they interpreted this as an indication that patients did not perceive doctors as partners, but as co-ordinators of care. Interestingly, participants in the current study did use the pronoun 'we' in an inclusive sense but only in relation to their dealings with herbal practitioners: "We work with it ... to get the perfect balance ... for me" (S9.1). The authors concluded that these patterns of communication might well reveal unequal power relationships, although the brevity of their report makes it difficult to evaluate the likelihood of this. Investigation of this nature, however, may have potential for future study.

The failure to enact empowering practices in the health care context cannot always be related to an individual practitioner's reluctance to engage in a partnership model. In addition to the imposition of prescribed consultations (Paterson 2001), the implementation of empowering practices can also be constrained by other resource restrictions (Paterson 2001, Meerabeau 1998, Lupton 1991), which reflect a generally inadequate infrastructure (Hagenow 2003, Paterson 2001). The current reality of health care provision, according to Hagenow (2003), is that its business function takes precedence over its health care function and that the 'noise' of the business function dilutes the possibilities for patient-centred care. She also believes that the cultural shift towards increased bureaucracy and managerial control acts as a barrier to successful implementation of patient-centred care. These obstructions are further compounded by the constraint imposed on the patient's freedom to consult with a health care practitioner of their choice because the patient is not the purchaser of health care resources (Rycroft-Mallone et al 2001).

Because collaborative and participatory relationships reflect a mode of social interaction, Ashworth et al (1992) argue that patient empowerment is further impeded when the patient and practitioner do not share a common stock of knowledge. That is, when their respective knowledge, assumptions and pre-suppositions are derived from different cultural situations. They believe that challenges to established ideas are considered only when they fall within the parameters of accepted cultural boundaries, a view consistent with Gadamer's (1996) notion about the role of tradition in the process of understanding (see: Section 5.7.1, Tradition as the Basis of Understanding). As current study participants demonstrate, when patients and practitioners operate within different cultural boundaries they can come to view each other as unresponsive or prejudiced towards alternative perspectives: "And I told them that they were stressing me out, that they were overlooking what I was telling them. They weren't listening to me" (S9.1). Also in support of the current study findings, Ashworth et al (1992) suggest that proper patient participation in health care is dependent on understanding the significance attached by them, to the health care situation. They argue further that, although effective participation does not require continual consensus, it is essential that each other's contribution be viewed as equal and worthy of consideration. Accordingly, a condition of equal and worthy contribution promotes confidence, without which the patient is prevented from fully participating in the health care situation: "… you can start to feel confident enough to challenge a bit …the herbalist doesn't expect to be in a position of power over me" (S.4.1).

The literature considered so far focuses on collaboration at the individual level, between patient and practitioner. However, the observation in this study that the public consultation opportunity about the future regulation of medical herbalism, actually failed to reach the awareness of any study participant, demonstrates the equal importance of ensuring effective collaboration at a more strategic level. It is encouraging, however, that current approaches to medical practice advocate partnership with patients in making decisions about their health care (Dean 2004). Although some questions have been raised about the likelihood of long-established health care systems (the National Health Service) being prepared to break deep-rooted dependency cultures (Sang 2004) partnership, in the current sense, is intended to improve and facilitate patient choice and enable their greater involvement in health care processes. It is also encouraging that the status of 'expert patient' is now recognised, although the notion of expertise in the current context appears to be primarily concerned with educating the patient in the management of their illness (Dean 2004). Whilst this goes some way towards recognising the patient's contribution to health care, the emphasis on information provision (from practitioner to patient) falls short of the mutual knowledge exchange and recognition of the patient's intrinsic illness expertise, that emerges in this study as a crucial component of patient-practitioner partnership.

5.6.2 The Meaning of Collaboration in Health Care

It is apparent from this and other studies that the failure to enact espoused (empowering) practice might be directly related to the practitioner's attitude but it can also be compounded by the impact of inadequate health care resourcing. It might also be a consequence of misunderstanding about the meaning and purpose of collaboration in the health care setting. Ambiguity about the meaning of collaboration is also reflected in the literature, which draws on a bewildering array of terminology to describe the concept. This is especially true when terms such as collaboration, consumerism, participation, empowerment, partnership and user-involvement are, at times, used interchangeably but, at others, clearly differentiated. Yet, clarity of meaning and consensus about purpose are essential if implementation of patient-centred care is to be effective.

In the literature, patient-practitioner interaction is most commonly described in one of four different ways: collaboration, participation, involvement or partnership. Although frequently applied interchangeably and indiscriminately, these terms are also described in a hierarchical manner that distinguishes between different degrees of interaction:

1. Patient involvement. At the level of least interaction, patient involvement is concerned with the patient accepting relatively simple, delegated tasks that do not depend on knowledge exchange. Patient involvement does not incorporate the patient's perspective nor does it extend their involvement to the decision-making process (Cahill 1996, Nethercott 1993, Mittler and McConachie 1983)

2. Collaboration. Collaboration involves a greater degree of interaction and is described as a co-operative endeavour that seeks agreement for subsequent decision-making by the professional (Cahill 1996, Henneman et al 1995). Collaborative interaction provides the source of agreement for participants entering into a participatory or partnership relationship

3. Participation. Patient involvement and patient collaboration are both viewed as precursors to patient participation, which requires a narrowing of the knowledge gap and is dependent on the practitioner surrendering a degree of control over the health care situation (Cahill 1996). Participation actively involves the patient in defined aspects of health care, such as taking part in the planning of self-care (Ehrenberg et al 1996), becoming involved in making treatment decisions (Deber et al 1996) or the performance of clinical skills (Saunders 1995)

4. Partnership. The pinnacle of the hierarchy is partnership, which is described as having a contractual basis that involves the patient in the overall process of health care. Partnership reflects an intellectual relationship that involves the patient in decision-making. It is ultimately dependent on closure, rather than narrowing, of the knowledge gap and is recognised as being difficult to achieve in practice (Cahill 1996).

An alternative interpretation on patient-practitioner collaboration is offered by Trede and Higgs (2003), who position the patient's health beliefs at the starting point of the collaborative process, in order that their voice can be heard and acted upon - a view that differs from those of Cahill (1996) and Henneman et al (1995). In relation to patient participation, Allen (2000) describes how individual practitioners often interpret this differently and she illustrates this by providing two examples derived from her studies of nursing practice. She undertook ethnographic studies in each of two hospital wards, both of which claimed that nursing practice was based on a philosophy of patient participation. In the first (urology) ward, nursing staff were consistent in the ways in which they involved patients in their health care. This entailed the patient undertaking allocated tasks such as emptying urine drainage bags and maintaining documentation (fluid balance and pain levels, for instance) as well as their involvement in technical tasks, such as caring for their urethral catheter or measuring their blood glucose levels. In contrast, nursing staff on the second (vascular) ward adopted a flexible approach that designated ward routine to be of secondary importance to the accommodation of patient choice. In this ward, staff engaged in 'meaningful' dialogue with patients, which enabled patients to assert control, for example over their medication regime. In the first example, which aligns most closely with the hierarchical definition of patient involvement, participation appears to be driven by workload considerations where the patient-practitioner relationship continues to be rooted in the traditionally asymmetrical roles assumed by patient and practitioner. The second example, which shows a greater allegiance with the hierarchical definition of patient participation, clearly demonstrates greater negotiation between patient and practitioner, encouraging the patient to determine the basis for effective participation.

Although broadly consistent with its hierarchical definition, Charles et al (1999b) argue that patient-practitioner partnership can take different forms. They believe that all three of the traditional health care models (paternalistic, informed and shared decision-making) can represent variations on the partnership theme, providing the chosen model reflects a negotiated choice. In principle, this argument concurs with the views of study participants, who recognise that different health care approaches have relevance in different health care situations. However, it is questionable whether a practitioner who favours a paternalistic role would choose to engage in the negotiation process at all prior to adopting a paternalistic stance. Charles et al also maintain that partnership is not always a requirement for effective health care - that the treatment of everyday illnesses can be satisfactorily achieved with routinely prescribed remedies whilst shared decision-making is preserved for the treatment of serious or life-threatening illness. Some might argue that a truly partnership-oriented model would leave such decisions to the patient.

Terminological inconsistencies aside, it is clear that current health care trends all advocate some degree of patient participation. Despite these good intentions, however, it may be that the meaning of participation is inadequately explored, leaving both the patient and practitioner with different expectations about the nature of their relationship. Of the few studies that explore the patient perspective on participation, most seek to answer the question of whether or not patients actually want participatory involvement, only one study being identified that explored the meaning of participation to patients themselves. In contrast to Charles et al's (1999b) suggestion that patients prefer to be involved with decision-making for more serious conditions, three of these studies draw inconsistent conclusions about the influence of illness severity on the patient's desire for participation (Mansell et al 2000, Beaver et al 1996, Ende et al 1989). In Ende et al's (1989) study three clinical vignettes were presented to 312 primary care clinic attendees, the vignettes focussing on upper respiratory tract infection, hypertension or myocardial infarction. The authors concluded that the majority of respondents did not wish to share decision-making with their doctor and, of those that did, 75% preferred to participate in decision-making for minor, rather than major, interventions. Similarly, Beaver et al (1996) found that women with benign breast disease were more keen to be involved in decision-making than those with breast cancer, the latter group wanting either no responsibility (52%) or shared responsibility (28%), with only a minority (20%) expressing a desire for active participation. However, it might be significant that the patients in Beaver et al's study who had been diagnosed with breast cancer had been questioned at an early stage of diagnosis and their reluctance to participate might have been influenced as much by prognostic uncertainty as by disease severity itself. By contrast, Mansell et al's (2000) study conclusions were more supportive of Charles et al's perspective. Also using clinical vignettes, this time in relation to myocardial infarction, cancer and diabetes mellitus, Mansell et al's respondents reported a greater desire for shared decision-making in respect of major, rather than minor, illnesses. The authors also observed that respondents were more likely to express a desire for participation where they had had personal experience of the condition represented in the vignette. What this observation suggests is that perceived and actual preferences for participation might differ, an important consideration in interpreting anticipated behaviours.

McKinstry (2000) also explored the relationship between a patient's desire to participate in health care and the nature of the illness being treated, but this time in relation to the treatment of either physical or non-physical physical illness. McKinstry recruited 410 patients who were attending a general practitioner surgery in Scotland, each of whom were shown five pairs of video vignettes. The five scenarios depicted a bleeding mole, a sprained calf, unresponsive rheumatoid arthritis, depression and smoking advice, and each pair of recordings demonstrated a shared and a directed approach to decision-making in relation to the same scenario. McKinstry reported that patients indicated a preference for shared decision-making in relation to the scenarios for depression and smoking advice but not in those depicting physical conditions, for which they preferred a directed approach.

Other distinctions highlighted in the literature relate to patients' educational levels, with patients of a higher educational attainment expressing a greater desire for participation

(McKinstry 2000, Cooper-Patrick et al 1999) and to patients' age, with younger patients being considered either more likely (McKinstry 2000, Ende et al 1989) or less likely (Cooper-Patrick et al 1999) to want involvement in the decision-making process. According to Debèr et al (1996), patients are more likely to want to be involved in treatment decisions than they are in problem solving (diagnosis). However, this relatively simplistic distinction fails to acknowledge the difference between determining and agreeing a diagnosis - according to this study, an important distinction if health care is to be perceived by as effective by the patient.

One potentially compounding factor in drawing conclusions from these studies is the tendency to rely on clinical vignettes. Although potentially informative, the use of clinical vignettes limits the extent to which people's real responses can be ascertained, rendering the study results somewhat speculative. This is illustrated in a study undertaken by Doherty and Doherty (2005), who asked 20 in-patients to indicate their preferred decision-making style in a questionnaire, prior to interviewing them about their behaviours in actual situations. The questionnaire, which identified active, collaborative or passive decision-making styles, revealed a preference for active participation in four patients, only one of whom demonstrated this style in practice. Conversely, of eight patients who identified their style as passive, three subsequently demonstrated frustration at not being listened to by health care professionals and recounted experiences that demonstrated active involvement in health care situations. The possibility that actual behaviour differs from anticipated behaviour is also illustrated in Mansell et al's (2000) study, where respondents who had experienced the illness depicted in the vignette responded differently from those who had not. The extrapolation of behavioural tendencies from contrived scenarios can therefore be misleading and needs to be interpreted with caution, especially in applying the findings to the practice of patient-centred care.

The single study that explored the meaning of participation to patients revealed a number of similarities to the findings of the current study. This qualitative study, which focused on 10 people with heart disease, found that patients related health care participation to the acquisition of confidence, understanding and control (Eldh et al 2004), the findings corresponding quite closely to the characteristics that participants in the current study attribute to medical herbalism. Eldh's participants identified the acquisition of confidence as the most essential purpose of participation, an outcome enabled by:

- Recognising one's own limitations and abilities
- Trusting and responding to bodily communications
- Establishing personally relevant and realistic health care goals.

Participation was also dependent on the patient acquiring confidence in health care practitioners. In particular, this was dependent on health care practitioners interacting with one another and demonstrating respect for one another's expertise and knowledge. Similarly: "There's honesty ... he (herbalist) works very openly with the GP and with anybody else that you're seeing" (S4.1).

The second essential purpose of participation – the acquisition of understanding - was related to the need to comprehend the nature of their illness and to understand the purpose and possible consequences of treatment. Without this understanding, information could not be integrated into their own lives or effect changes in behaviour. Similarly: "for the first time I realised what was wrong ... I suddenly felt very much responsible for how my body works" (S9.4).

Eldh's participants acquired personal control by initiating care planning and follow-up and by establishing for themselves that health care practitioners each had an understanding of the others' contributions. Personal control was dependent on continuity of health care, on co-operation between practitioners and on maintaining respect for the patient's perspective on their health care needs. They identified a lack of personal understanding and a lack of personal control as the greatest barriers to participation. Similarly, participants in the current study valued the sense of control they experienced in the herbal health care setting: "the herbalist doesn't expect to be in a position of power over me. I'm in charge of my health care ... alongside my herbalist" (S4.1).

The current study is highly supportive of Eldh et al's findings, the outcomes of confidence, understanding and personal control all being identified by participants in the current study as constituents of effective health care. What the current study adds to this is the possibility that patient understanding, in the sense of personal significance, is the essential structure that enables confidence and personal control to evolve. Whilst offering important insight into the patient perspective, Eldh et al's analysis just fails to push the level of exploration beyond the boundaries of description. As such, their study leaves issues of 'significance' open to interpretation, which is likely to be based on pre-suppositions about the purposes of health care participation. Whilst Eldh et al's participants may, or may not, share the underlying sentiments of participants in the current study, the correlation between these would be of interest to explore further if the patient perspective on effective health care is to become better understood.

The profusion of collaboration-related terminology appearing in the literature was also reflected in the current study, participants speaking about partnership, personal control, patient empowerment and shared decision-making. Although not making explicit distinctions between the meanings of these terms, participants did describe varying levels of participation, albeit within a context of self-determination. To participants, an effective patient-practitioner relationship enabled the patient and the practitioner to work together towards mutually agreed goals but allowed the patient to retain overall personal control within the health care situation. Personal control was dependent on the development of a shared understanding about the nature of illness, which itself relied on an integration of patient and practitioner expertise. This, in turn, provided a basis for negotiation in respect of treatment selection, goal-setting and treatment evaluation. On the basis of these findings, the term 'partnership' therefore best captures participants' perspectives on the nature of the patient-practitioner relationship and is subsequently adopted in this thesis to describe their preferred relationship style. The terms 'collaboration' and 'participation' are interpreted in the more literal sense to depict communicative and interactive acts, respectively.

5.6.3 The Purpose of Health Care Partnership

The literature identifies several purposes of patient-practitioner partnership but, in common with interpretations about its meaning, the purpose of partnership also lends itself to potential misunderstanding. According to the literature, partnership in health care:

- Provides reassurance and increases patient confidence (Burnard 2003, Fenwick et al 2001)
- Encourages patient responsibility and increases their personal control (Trede and Higgs 2003, Fenwick et al 2001, Grol et al 1990)
- Improves communication (Jardim 2004, Fenwick et al 2001)
- Promotes patient-practitioner bonding (Burnard 2003)
- Increases patient compliance (Jardim 2004, Mead and Bower 2000)
- Increases patient satisfaction (Mead and Bower 2002)
- Leads to improved health care outcomes (Trede and Higgs 2003, Charles 1997, Stewart 1995, Kaplan et al 1989).

In relation to the purposes identified above, the improvement of health care outcomes is, perhaps, the most salient and it concurs with participants' criteria for effective health care. The pursuit of this common goal is marred, however, when the patient and the practitioner apply different interpretations to the meaning of health care improvement. In particular, health care effectiveness is often determined by the practitioner, who measures patient improvement against pre-specified, global markers of treatment effectiveness. To participants, this approach assumes patient uniformity, it fails to take into account the personal significance of health care to the patient and, consequently, it inadequately reflects their perspective on health care effectiveness. By establishing consensus about health care goals and outcomes, patient-practitioner partnership transforms health care into a therapeutic enterprise that is captured in the concept of therapeutic relationship (therapeutic alliance).

Frequently accredited to Peplau who, over 50 years ago, discussed the concept of interpersonal relationship as a source of therapeutic benefit (O'Brien 2001), the contemporary literature mostly considers the therapeutic relationship in the context of mental health care. Despite this, the literature continues to have relevance to other health care situations. Although a full discussion about therapeutic relationship is beyond the scope of this thesis it can be summarily described as a harmonious relationship between patient and practitioner (Spink 1987) that is dependent on patient-practitioner rapport, established through collaboration, communication, mutual understanding and respect (Ackerman and Hilsenroth 2003, Cole and McLean 2003). Essentially, it is concerned with an interactive relationship that evolves from a position of trust, where the practitioner provides information and advice but where the patient's values are respected and where the expression of emotions is encouraged (Moyle 2003, Morse et al 1994). A therapeutic relationship involves negotiated and individualised involvement with patients (O'Brien 1999) but the importance of maintaining professional boundaries is also emphasised, without which a therapeutic relationship can become dysfunctional (Stuart 2001). A therapeutic relationship can relieve distress and improve morale (Moyle 2003) and has been related to improved patient outcomes (Cloitre et al 2004, Paley and Lawton 2001, Connors et al 1997) although, according to Leach (2005), studies that evaluate its effectiveness in health care situations other than mental health, are lacking.

In this study, participants commonly related the therapeutic relationship to their ability to remain 'in charge' of their health care, a notion that has some semblance to the concept of empowerment, although the term was rarely used by participants themselves. Widely described, debated and sometimes criticised (Paterson 2001, Weissberg 2000) patient empowerment is concerned with enabling people to participate as equal partners in health care decision-making (Opie 1998). It is concerned with the patient taking greater responsibility for their health care (Arksey and Sloper 1999, Grol et al 1990) and it requires the practitioner to respect and value the patient's input and to be prepared to relinquish their control over the health care situation (Chapman 1994). Partnership facilitates the patient in evaluating the trade-off between treatment benefit and treatment risk, an important principle since it is the patient that bears the consequences of the health care they receive. Empowerment is therefore inextricably linked to partnership, because the professional adopts empowering practices that enable the patient's relative autonomy in the decision-making process.

Many of the views expressed in the literature are consistent with participants' perspectives, which identify trust, rapport, communication and understanding as important aspects of patient-practitioner partnership. But, while the literature suggests that patient outcomes are enhanced by improving their compliance with treatment regimens (Crellin 1999) or by encouraging them to take responsibility for their health (Larsson et al 1992), participants suggest, more fundamentally, that partnership improves health care outcomes by directly enhancing the healing process. According to this study, the effectiveness of health care relates, not exclusively to the health care treatment, but also to the quality of the patient-practitioner relationship itself, to the partnership that evolves within a therapeutic relationship. Participants believed that healing was achieved partly by dealing with illness causation and partly through the intrinsic healing properties of herbal medicines. They also believed that healing was influenced by the degree to which health care correlated with their personal beliefs and values, the convergence of patient and practitioner values and health care goals being enabled through a process of partnership. The healing process was therefore believed to be directly enhanced by patient empowerment, a possibility also considered by a small number of authors, who associate healing with notions of energy transference (Schmidt 2004, Wright and Sayre-Adams 1999, Noon 1999). In particular, participants' notions about healing are consistent with Schmidt's (2004) description of healing intention, in which healing is related to the nature and quality of interaction between patient and practitioner and the personal understanding that evolves from this relationship. As such, partnership was seen to be crucial to the achievement of effective health care by mobilising and enhancing the patient's intrinsic healing ability.

The therapeutic benefit of patient-practitioner partnership has also been considered specifically in relation to complementary therapies, one suggestion being that the effects of a complementary therapy might be as much to do with the encounter as with the therapy itself (Brewer and penson 2002). In considering this possibility Ernst et al (2003) suggest that training practitioners in empathetic practices might therefore be preferable to training them is specific therapeutic modalities. This argument – that healing results more from the relationship than the therapy - is not supported by participants in the current study, who believe that different interventions act in a complementary manner to maximise self-healing possibilities. One of these interventions is the herbal remedy, which enhances healing by way of its compatibility and interaction with the body's intrinsic healing processes. Another is the facilitation of personal empowerment, which they believe also enhances healing through a similar 'internal physician' pathway. Perhaps it is the relationship between the two – therapy and partnership – that lies at the heart of effective health care, as the following participant illustrates so well:

> "... He will tell me that he doesn't want to go overboard on this one but, if we find it's not enough, we'll up this one and take that one down a bit. If we find that it lifts you a bit too much, we'll lower this one and increase on that one. **We** work with it ... to get the perfect balance ... for **me**. He can then make that mixture ... err on the side of caution ... he can add to it ... you get a fine balance. Together, we cracked it. You don't get that with the drugs from the drug companies" (S9.1).

The mutually enhancing benefits of herbal medicines and personal empowerment were further revealed in participants' discussions about the potential for integration between herbal and conventional health care. Specifically, participants expressed doubt that herbal medicines would achieve the same level of effectiveness if they were prescribed in a context of conventional health care, suggesting that the herbal intervention, alone, did not account for its total effectiveness. Similarly, they believed that a typical herbal consultation would be less effective if it incorporated conventional, rather than herbal, medicines. Again, this belief pre-supposes that partnership did not account for the effectiveness of herbal health care in isolation of other factor(s). Essentially, participants believed that both interventions - the herbal medicine and partnership - contributed equally, but differently, to the overall effectiveness of herbal health care.

Whether or not partnership achieves improved health care outcomes directly through the promotion of healing is uncertain, but what is certain is that the transmission of knowledge and the promotion of mutual understanding were seen to be at the root of its therapeutic value:

> "... you talk it through but that isn't just to make the patient feel good. It clarifies for the patient how this has come about ...which is very empowering ... and empowerment helps the healing" (S4.1).

5.6.3.1 Understanding as a Pre-requisite to Healing

The notion of consumerism in health care has led to certain rights being granted to patients, including the right to the provision of information (Mead and Bower 2000).

Information exchange is well recognised as a key component of shared decision-making and in the promotion of patient-centred and empowerment-based models of health care (Bensing 2000, Charles et al 1999a), where it is assumed that the provision of information enables patients to accept greater health care responsibility (Grol et al 1990). In addition to the provision of information, the promotion of an egalitarian doctor-patient relationship also calls for greater medical recognition of lay knowledge (Mead and Bower 2000). In this respect, modern health care consultations are expected to draw on both patient knowledge and physician-evaluated scientific evidence (Towle and Godolphin 1999) as well as the physician's personal and professional 'craft' knowledge (Trede and Higgs 2003). Over and above information exchange, however, study participants emphasised the importance of the learning that evolved from the herbal consultation, describing how this occurred against a background of mutual information-sharing ("thinking aloud" [S7.1]) that enabled their understanding and facilitated their participation in health care. The distinction between 'being informed' and 'achieving understanding' was a recurring theme in the study data. In the conventional health care setting participants described how, despite the wide promotion of two-way information exchange, their knowledge and experience continued to receive only limited consideration. Nordgren and Fridlund (2001) observed similar concerns in their Swedish study, which illustrated the importance of patient understanding to the actualisation of patient empowerment. In this study, patients described how professional knowledge was expressed as power, being selectively disseminated, in such a way that their right to self-determination (recently determined as a legal right in Swedish law) was difficult to achieve.

Similar disempowering tendencies in the communication process are also implicit to a few other studies. Ford et al (2003), for instance, acknowledge that patient preference needs to be taken into account in the development of a patient-choice model for health care but, in their reporting of the study findings, they seem to favour the perspectives of the professional, rather than lay, respondents. Specifically, they emphasise the sharing of scientific, evidence-based information as a pre-requisite for shared decision-making, despite this being the preferred option of professionals. In this scenario, the physician conveys complex medical information to the patient to 'educate' them about their condition, a well-meaning intention but one that that possibly belies a subtle coercion in favour of the professional perspective. More blatantly, Towle and Godolphin (1999, p768) propose patient competences for a model of shared decision-making, which suggest that patients should be able to articulate their problems "in an objective and systematic manner" and that they should be able to access and evaluate published information. However, the requirement for patients to evaluate published information demands that they have the time, technical ability and access to available material, a skill and resource opportunity claimed to elude many a medical practitioner (Mayer and Piterman 1999, McColl et al 1998). It also assumes patient literacy, suggesting that patients lacking in such skills have a lesser right to share in the decision-making process. In her commentary on Towle and Godolphin's proposals, Greenhalgh (1999) suggests that, in defining patient competences, there is also a potential for some patients to become defined as 'not competent' and therefore to be excluded from the process of informed, shared decision-making.

These particular studies relate to the patient's involvement in treatment decision-making but the current study indicates that knowledge exchange is also of crucial importance to the process of diagnosis. However, the expectation that patients will 'provide information' about symptoms to the physician (Charles et al 1999a) is dependent on the patient's ability to recognise what constitutes a relevant symptom, from the physician's perspective. Similarly, the assumption that the physician will elicit a description of the patient's symptoms (Arksey and Sloper 1999) relies on the ability of the physician to prompt disclosure of symptoms that have personal significance to the patient. Where a biomedical stance is favoured, there is a risk that important but apparently irrelevant information is overlooked because it eludes the patient's conscious recollection and because it is not deemed to be of sufficient relevance to the physician. The importance of this is reflected in the current study, where participants expressed real surprise at the extent to which 'irrelevant' information did actually have relevance to the diagnostic process. Time and again, participants reported how they disclosed information of importance to their diagnosis only as a result of their 'chatting' with the herbalist, a communication style that, according to Jardim (2004), provides access to information that is not readily available via traditional means of interviewing or examination. Furthermore, the mutual construction of diagnosis established the reality of the situation for participants – it helped them to make sense of things – and this, in turn, fostered a sense of responsibility that encouraged their participation in health care. The promotion of participation through understanding is consistent with the concept of emancipatory learning, which is essentially concerned with enabling people to make meaningful changes. It is seen to be central to collaborative decision-making, in contrast to the 'acquisition of knowledge' of other approaches, which can be alikened to learning by rote (Trede and Higgs 2003). According to Brookfield (1987, p12):

> "Emancipatory learning is evident in learners becoming aware of the forces that have brought them to their current situations and taking action to change some aspects of these situations."

... and according to study participants:

> "Talking about things ... you can suddenly see a pattern and how things fit together" (S7.1)
>
> "For the first time I realised what was wrong ... I suddenly felt very much responsible for how my body works" (S9.4)

According to the findings of this study, true knowledge exchange serves to enlighten both the patient and the practitioner, leading to renewed and shared understanding about the illness condition (Gadamer's fusion of horizons). The practitioner, through skilled communication, entices disclosure of subtle and concealed information that provides essential diagnostic clues. This, in turn, serves to identify appropriate, and therefore effective, health care treatment. As a consequence of the practitioner's open and transparent decision-making style ('thinking aloud'), the patient also comes to understand the underlying basis of illness, in the context of their unique situation. Patient empowerment is therefore concerned, not merely with knowledge exchange, but with mutual knowledge construction in relation to each of the constituents of effective health care – this is the meaning of patient-practitioner partnership. Being fundamentally concerned with the facilitation of mutual understanding, it is therefore also crucially dependent on effective patient-practitioner communication.

5.6.3.2 Communication in the Health Care Encounter

As long ago as 1984 Fitzpatrick et al claimed that dissatisfaction with medical communication was a major factor in people's move toward complementary therapies.

At that time, patient dissatisfaction was said to be related to mismatched expectations of the health care consultation, to status and language differences and to restrictions imposed by social role distinctions (Fitzpatrick et al 1984). Recent literature suggests that little has changed, with authors identifying issues pertaining to gender (Bensing et al 1993, Roter et al 1991), education (Fiscella et al 2002), socio-economic status (Willems et al 2005) and health care beliefs (Street et al 2003) as continuing to impede effective health care communication. A recent systematic review of the communication literature (Willems et al 2005) concluded that physicians were less informative with patients of a lower educational level or lower socio-economic class, whilst patients of a higher socio-economic class communicated more actively during the consultation. By contrast, participants in the current study did not report direct discrimination on the basis of gender, with the exception of one female participant who commented that her (female) herbalist would probably be more understanding than her (male) physician. However, this comment was volunteered in the light of a particularly 'female' complaint and the participant had reported the same concern in relation to seeing any conventional doctor, regardless of their gender. Also in contrast to the literature, every participant reported similar communication concerns regardless of his or her age, educational or socio-economic status, suggesting that these particular characteristics were of less significance in influencing communication than the literature suggests.

The one characteristic that did seem to influence participant-practitioner communication was the extent to which their beliefs corresponded, an issue also explored by Street et al (2003). They undertook a case-control study involving 20 primary care physicians in the United States, each of whom interacted with 5-8 patients (135 patients in total). Physicians were oriented either towards shared (n = 10) or physician-centred (n = 10) control. In agreement with the current study, the authors found no correlation between the quality of communication/participation and ethnicity, education, income or gender. Nor was communication improved when there was congruence between patients' and physicians' preferred participatory styles or where the physician had expressed a preference for shared control. What the authors did identify was that patients whose behaviours were more participatory tended to attract greater partnership building, although this conclusion was contradicted elsewhere in the report, which claimed that physicians used more partnership statements with male patients (mean 3.67) than with female patients (mean 2.62), despite female patients demonstrating a more participatory style. This particular finding differed from the findings of the current study, which revealed that all participants had experienced communication difficulties during conventional health care consultations, despite their attempts to instigate a negotiative style and despite the patient's or practitioner's respective gender.

The communication aspect of most concern to participants related to their not being taken seriously or not being listened to, every participant providing examples of their being treated with disdain, not being listened to or being discouraged from interaction. Significantly, participants reported these experiences only in their encounters with conventional practitioners. Arksey and Sloper (1999) also observe that patients tend not to be listened to during the medical consultation. This was evidenced by data derived from two separate British studies: a questionnaire study on 308 adults with repetitive strain injury and a mixed methodology study on parents' and siblings' responses to childhood cancer. In both studies, respondents reported frustration and distress at the need to persuade health care practitioners about their experiences and at being disbelieved about their symptoms. In the childhood cancer study, this included the failure to acknowledge the child's account. Conflicting and/or disputed diagnosis has also been identified as leading to feelings of discreditation, depression, loss of self-confidence and low self-esteem (Ewan et al 1991). Of special significance to the current study, this has also been recognised as a cause for people seeking alternative consultations via Accident and Emergency departments or complementary therapists (Arksey and Sloper 1999), this latter point perhaps supported by participants' emphasis on the importance of being able to 'make sense' of illness diagnosis in order that health care is perceived as effective.

Described as the "royal pathway to patient-centred medicine" (Bensing 2000, p23), the implications of effective communication to a patient's health care have been related to the promotion of patient satisfaction (Bensing 1991, Buller and Buller 1987, Smith et al 1981), whilst others believe that it influences patient compliance (Lassen 1991) or that it positively affects health care outcomes (Stewart 1995). According to Bensing (2000) communication is the only means by which practitioners can come to understand a patient's health care problems and needs or their desires for health care participation. It has even been argued that patients have a greater desire for the communication of information than they do for involvement in the decision-making process (Beaver et al 1999, Degner et al 1997, Ende et al 1989). Arksey and Sloper (1999) acknowledge that the patient's contribution to the diagnostic process is essential to effective health care communication and is currently enabled by the relative ease of access to medical information, which has improved their understanding of medical matters. In exploring the significance of this with participants, it emerged that they were concerned, not merely with issues of courtesy, satisfaction or acquiring greater medical knowledge but with the implications of inadequate communication on the outcomes on their health care. This concern essentially reiterates participants' perspectives on the relationship between understanding and healing, the fulfilment of which is dependent on effective patient-practitioner communication. It also reflects their views on the significance of the patient's contribution, especially in respect of the illness experience, to the diagnostic profile. Despite the relative lack of scientific evidence, the possibility that communication (by enabling patient empowerment) contributes directly to the healing process warrants further investigation. Similarly, the influence of communication style on the quality of the diagnostic process might also provide insight into the relative effectiveness of herbal and conventional consultation. In this respect, participants were unanimous in valuing the contribution of social communication, especially in respect of its impact on diagnostic effectiveness.

5.6.3.3 The Significance of Social Communication

Participants recounted how herbalists communicated in a way that enabled them to relate to one another. Their communication style, usually described by participants as 'chatting,' encouraged participants to disclose important health information and was therefore seen to be vitally important, especially to the diagnostic process. Chatting enabled the participant to relax, it facilitated the development of rapport and it promoted confidence in the health care process overall. Through chat, participants revealed background details that would otherwise have remained undisclosed, detail that often seemed trivial and irrelevant at the time but that provided crucial clues to a patient's unique illness history. Chatting also provided opportunities for the patient and practitioner to explore and exchange ideas, which enabled them to reach a shared understanding about the patient's illness. Significantly, chatting enabled participants to make sense of their illness, to understand the origin of their symptoms and to recognise the ways in which their behaviour contributed to the illness experience. Despite this, the significance of social communication to the health care encounter receives relatively little attention in the professional literature.

Willems et al (2005), in their systematic review of studies on health care communication, found reference to social communication in only two out of twelve studies. Furthermore, these two studies tended to focus either on the amount of information provided (Street 1991) or on the relationship between information provision and interactional style (Street 1992) but not on the qualitative aspects of social communication, as did study participants. The author concluded that information provision was influenced by the patient's personal characteristics and their communication style, especially with regard to the amount of questions the patient asked. In this respect, the results concurred largely with previous studies but less so with the views of participants in this study, who recounted how communication in the conventional setting was rarely constructive despite their attempts to make it so.

A relative lack of regard for social communication in health care is also evident in the design of interventions that aim to improve the quality of communication between patient and physician. Harrington et al (2004) reviewed 20 studies that focused on the development of interventions designed to improve patient participation and patient-physician communication. The studies took place in outpatient departments (10 studies), primary care (8 studies), community practice (1 study) and inpatient settings (1 study) and the interventions included written checklists, personal coaching in question-asking and video recordings of modelling techniques. The interventions were designed predominantly to encourage patients to ask questions, raise concerns and seek clarification and the most commonly measured outcome variable was frequency of questioning by the patient. Five studies also asked for patients' and physicians' perceptions of the tool. The review generally found that the interventions were successful in raising the level of patient participation (frequency of questioning) and a few studies described some improvement in patient compliance, patient attendance or disease control but there were few reports of increased patient satisfaction. Notably, the interventions tested incorporated little, if any, encouragement to engage in social communication and the emphasis on seeking clarification, although important, suggests that the patient was viewed as a recipient of information rather than a partner in the health care process. In addition to the communication aids accounted for in this review, other authors also acknowledge the use of interactive videos (Liao et al 1996), audio tapes (O'Connor et al 1994) and decision boards (Levine et al 1992). According to Llewellyn-Thomas (1995), however, aids such as these are helpful to physicians in communicating information to patients in a standardised way but they tend to encourage one-way communication and fail to acknowledge patients' individual needs.

An intervention that correlates more closely with participants' perspectives is the patient-centred interview (Larivaara et al 2001). Larivaara et al acknowledge the importance of the doctor-centred interview especially in acute or emergency situations but they warn that it can be disadvantageous in general health care, to the point that the real reasons for a patient's visit might not be elicited. Larivaara et al describe the patient-centred interview as commencing with a patient-led storytelling process, which is subsequently summarised by the physician for the patient's confirmation. The interviewer encourages the patient to describe their feelings about the illness and they act with honesty about how they can help, as well as admitting their limitations. Diagnosis, treatment planning and motivational strategies aim to elicit the patient's perception about illness causation and about their likely participation in health care. In comparison to the traditional medical consultation, this approach emphasises the importance of the doctor coming to understand the patient's problems, from their perspective. It also continues to emphasise the doctor's role in developing diagnostic hypotheses whilst overlooking the need for the patient to develop their own understanding – in participants' eyes, a pre-requisite for effective health care partnership. Also, the emphasis on encouraging the patient to story-tell their illness experience, whilst of undoubted value, may not be sufficient in exposing information of unrecognised importance, in the way that 'chatting' is able to achieve.

Also focussing on physicians' interviewing skills, Smith et al (1998) conducted a randomised controlled trial, which related patient satisfaction to the attitudes, knowledge and interviewing skills of two groups of primary care residents: the experimental group receiving a one-month intensive training rotation that aimed to develop patient-centred interviewing skills. The study revealed that the experimental group acquired improved knowledge, attitude and interviewing skills but that these did not result in any significant difference to patient satisfaction or well-being. Although the study outcomes failed to elicit patients' reasons for their dissatisfaction, one possibility is that the interview style, whilst encouraging patient communication and eliciting psychosocial data, failed to involve the patient in the decision-making process. In essence, the model was primarily concerned with improving the quality of data gathering, which it appeared to achieve, but it did not promote social communication, negotiation, shared decision-making or patient understanding.

The development of doctor-centred communication aids and patient-centred interviewing both move some way toward the enhancement of patient-practitioner communication. Participants' ideal of partnership, however, requires a more balanced approach that focuses neither exclusively on the patient nor exclusively on the practitioner but promotes genuinely two-way communication that helps the patient to make sense of the health care situation. The potential value of social communication in achieving this is raised by three authors, who highlight the specific significance of chat in relation to mental health care (Burnard 2003), neonatal nursing (Fenwick et al 2001) and general practice (Jardim 2004).

Burnard (2003) equates chat to phatic communication, which is more concerned with the process of bonding between people than with the communication of information (Prusack 2003). According to Burnard (2003), phatic exchange can be devoid of formal meaning and it incorporates conversational turn taking that, he points out, is a peculiarly cultural phenomenon that is not necessarily shared by everyone. Burnard believes that phatic communication is an important means of establishing bonds and enhancing relationships between people and it is a useful means of providing reassurance. He also maintains that, if communication continues at a phatic level, no formal exchange of information occurs. Indeed, despite participants' emphasis on the importance of chat, they also identified how the herbalist subsequently helped them to make sense of their situation. It is also evident that participants' 'chat' amounted to more than informal, conversational turn-taking, since participants saw chatting to be a highly constructive process that enabled effective diagnosis and enabled their understanding of the health care situation. It would seem that participants' 'chat' carries greater significance than is suggested in Burnard's phatic sense.

Some of Burnard's suggestions are also reflected in a study undertaken by Fenwick et al (2001), who found that chat could be effective at opening up two-way dialogue between mothers and nurses in the neonatal situation. The women in Fenwick et al's study reported that chatting – essentially involving adoption of traditional speech patterns and behaviours – facilitated the development of a reciprocal relationship that they described as 'friendship', a common reference also emerging in the current study in relation to participants' relationship with their herbalist. Also consistent with participants' reports, chatting engendered feelings of safety that encouraged disclosure of health-related issues. Consequently, chatting provided a source of access to psychosocial information that subsequently enabled the personalisation of care, a point particularly pertinent to the current study, where participants identified how health care could not be individualised without getting to know the patient. Importantly, Fenwick et al identified that it was the nurses who chatted who were identified as making a difference to the health care experience. They also suggest that the function of chat is of especial importance to women who, they believe, are more likely to adopt a participatory stance. This was not borne out in the current study, however, which revealed chatting to be of equal importance to female and male participants, and was reported to occur in consultations with every herbalist, but not with conventional practitioners, regardless of their gender. Another important observation to emerge from Fenwick et al's study was that social chat could also be used in a dismissive way, to exert the professional's position of authority. Used in this way, chat can discourage interaction by setting boundaries that determine clear patient-professional distinctions.

Jardim (2004), in a single page commentary, summarises how general chitchat nurtures trust, encourages openness and improves communication and personal satisfaction. To Jardim, the cultivation of trust encourages honesty, improves patient compliance with treatment and enables the patient and physician to relate to one another through discussion of common interests. She believes that chat reveals the human side of the physician and therefore renders medical advice more credible, a possibility also implied by participants, who frequently referred to herbalists' advice and information as being "... very much for my good" (S11.1). Also in agreement with study participants, Jardim also briefly acknowledges the role of chat in data gathering, suggesting that informal discussion can be more revealing than medical history-taking and examination.

Participants' stories were generally consistent in their descriptions of the consultation experience: herbalists perceived as "... genuinely interested ... interested in me ... as a person" (S11.2) whilst conventional practitioners "... want you in ... dealt with ... and out" (S5.2). Even when participants acknowledged their physicians as personable and approachable they still considered that their perspectives had not been taken sufficiently into account, leading them to value the consultation less favourably.

In essence, the "dull, interminable details" (Cassell 1986, p204) revealed by "talking about things that are not all that related" (S7.1) made a crucial difference to the provision of personally significant, effective health care. The detail, revealed through a process of chat, enables not only a professionally-validated diagnosis but also facilitates patient understanding, to the extent that they can fully engage in the health care process. Communication opens up the possibilities for patient-practitioner partnership and, through partnership, patient empowerment can be realised. Of most importance to study participants, it is through empowerment that healing is enhanced and through which effective health care becomes a possibility.

5.7 "Herbalism ... it just makes sense" (S2.1): Personal Significance as the Essential Constituent of Effective Health Care

In the context of medical herbalism, health care had personal significance to participants because it satisfied their understanding of how illness had come about. Even though very few participants had initially attributed their attraction to alternative health care to its underpinning philosophy, it is evident from this study that participants' beliefs about health and illness were more closely aligned with the tenets of herbalism than with those of conventional medicine. Participants and herbalists appeared to be attuned in a way that was elusive to the patient-practitioner relationship in the conventional setting, their understanding being facilitated through interactive behaviours that epitomise the principle of patient-practitioner partnership. In other words, the quest for effective health care was more easily fulfilled where the patient and practitioner shared a common belief system and, conversely, participants found it hard to make sense of health care in a context of divergent interpretation.

The significance of shared belief in the context of health care is recognised by Engebretson (2002), who highlights how social institutions such as health care generate, and reflect, the values inherent to the culture within which they are situated. The biomedical paradigm, for example, is often described in terms of being mechanistic and reductionist, emphasising standardisation and objectivity (Engebretson 2002, Baer 2001, Mead and Bower 2000). Its strong association with science and technology is related to western cultural values that measure progress in terms of scientific and technological developments (Engebretson 2002). By contrast, medical herbalism is person-centred and focuses on illness causation and its significance to the individual, its purpose being to "... support and revive the innate healing process and power of mind, body and spirit" (Herbal Medicines Regulatory Working Group 2003, p31). The public's increasing interest in the use of complementary therapies is considered by some to demonstrate a cultural shift away from the biomedical paradigm towards one that is more consistent with post-modern values (O'Callaghan and Jordan 2003, Siahpush 1999, Siahpush 1998) although others believe that this trend reflects little more than an influx of multicultural values (Capriotti 1999). The suggestion in this study is that, whilst participants were able to relate more easily to the philosophy of medical herbalism, they tended to select creatively and thoughtfully from both conventional and non-conventional options, to create a hybrid culture that could meet their needs more comprehensively than either one alone. To participants, herbal medicine addressed their needs for everyday health care. The philosophy inherent to herbal health care had personal significance to them in relation to their understandings about the nature of health and illness and, by attending to illness causation, it met their criteria for effective health care. At other times, they recognised the conventional option as the more appropriate choice. Whilst their attraction to herbal medicine might be interpreted by some as a move toward post-modern values, it might also reflect an attempt to recapture traditional values, which participants have imported into the modern context.

Whilst the importation of cultural systems is not problematic in itself, their importation into a culture based on biomedical assumptions can lead to their fragmented integration into the conventional setting (Engebretson 2002). Typically, these non-conventional healing modalities become interpreted though new cultural lenses and are adapted to 'fit' the adoptive culture, becoming different from their original form in the process. The provision of standardised, disease-specific herbal preparations is one example of such fragmentation as is the adaptation of traditional acupuncture to a method that is consistent with western views of pathology. Without such adaptation, non-conventional practice can remain sufficiently different from their adoptive culture to maintain their ‘alternative’ status, bringing difficulties in acceptance by the dominant culture. On the other hand, adaptation can lead to non-conventional practice becoming eclipsed by the values inherent to the importing cultural paradigm, risking the loss of those very differences that likely formed the basis of their attraction in the first place.

This fragmentation is further evidenced in the drive to evaluate non-conventional therapies according to a biomedical understanding of disease, without taking culturally specific assumptions about healing mechanisms into account. Although the randomised controlled trial can provide an excellent pathway for the advancement of biomedical knowledge, Hyland (2004) points out that erroneous assumptions about healing mechanism will lead to erroneous conclusions being drawn about treatment effectiveness, a possibility also implied by others (Hassed 2004, Chalmers 1998). Where treatment effects occur via unexpected or unknown mechanisms, the inability to detect this through conventional means may well lead to contradictory declarations of effectiveness. The legitimisation of a healing modality through evaluative means that are inconsistent with its cultural context therefore risks the unnecessary exclusion of potentially beneficial therapies.

5.7.1 Tradition as the Basis of Understanding

Operating within a compatible belief system is also seen to be fundamental to the process of understanding. In the absence of mutual understanding, it can be difficult to reach consensus about the meaning of common health care concepts. Where the patient and practitioner subscribe to different ideas about illness causation, treatment effectiveness, the purpose of partnership or about what counts as appropriate health care evidence, for example, health care outcomes may be adversely affected because health care goals are in conflict with one another. Understanding, however, can be acquired and enhanced through a culturally sensitive health care encounter.

The hermeneutic tradition takes the view that understanding is both a process and a mode of being (Gadamer 1996; Ricoeur 1981; Heidegger 1962). In other words, understanding does not come about merely as a consequence of the learning process but is inextricably linked to a person’s intrinsic cultural background, one that is woven deeply into our lives and is described by Taylor (1995) as our ‘home culture.’

Understanding is inseparable from one's history and tradition, it is dialectical and dialogic rather than unidirectional and it is inherited through language and through the sub-conscious process of socialisation (Spence 2001). Thus, when new information or experience is encountered it is always interpreted in the light of the whole of one's previous experience (tradition) and this, in turn, is re-interpreted in the light of this new information – the hermeneutic circle of understanding. Socio-cultural background is therefore of importance to every hermeneutic enterprise (Koch 1999) and, in this study, is proposed to be at the heart of participants' attraction to alternative health care provision.

Gadamer (1996) had much to say about a person's history and background, especially in relation to interpretation and understanding. To Gadamer, understanding is not concerned with achieving greater clarity of thought but with the ability to see things differently. Central to Gadamer's notion of understanding is the concept of tradition, which describes those shared understandings that reside in, and are expressed through, one's history and language. It is language that Gadamer particularly emphasises in the process of interpretation, being the medium through which understanding occurs and being derived essentially from a person's tradition. From a Gadamerian perspective, language enables understanding but it also imposes limits on what we are able to understand. Gadamer also speaks of the historicity of understanding, where meaning itself is defined according to our particular history. In this respect, all questions (including research questions) are interpreted in the light of historically derived pre-conceptions (Nystrom and Dahlberg 2001). Indeed, Gadamer (1996) argues that there can be no presupposition-less understanding, even in terms of scientific interpretation.

Specifically, it is the acquisition of pre-understanding and prejudice that both enables and limits the possibilities for interpretation and understanding – described by Gadamer as a person's horizon of understanding. Gadamer's horizon of understanding is central to hermeneutic analysis, understanding progressing only when different horizons merge - Gadamer's 'fusion of horizons.' A fusion of horizons is not necessarily concerned with both parties reaching the same conclusion but with their acquisition of understanding that is different and ideally richer than before: "... you can suddenly see a pattern and how things fit together" (S7.1). This is the essence of 'making sense' of health care.

Horizons are therefore not static although their expansion can be limited by a person's reluctance to see an alternative view:

> "My doctor ... he doesn't accept ...he said: "I don't know about it, I don't understand it." And that's it. End of subject" (S2.3).

A limited horizon prevents a person from seeing beyond what is already familiar but this can be overcome by confronting one's existing horizons - achieved by acknowledging those pre-understandings and prejudices that determine the boundaries of interpretive possibility.

According to Gadamer, prejudice has special significance in the processes of interpretation and understanding. In contrast to the negative connotation usually associated with the term, Gadamer considers a person's prejudices to be essential to understanding. He distinguishes between true and false prejudices, which can either enable or constrain understanding, respectively, and he argues for the need to remain open to hidden prejudices that "... make us deaf to what speaks ..." (Gadamer 1996, p270). Prejudice, according to Gadamer, cannot be disposed of, nor should it be. From a Gadamerian perspective, understanding (seeing things differently) is dependent on considering situations against our own biases, of which we need to become aware. Only through these means does it become possible for horizons to combine in order for one person to embrace meaning held by another. In a professional capacity, and therefore especially pertinent to the current study, a hermeneutic stance discourages the tendency to over-value what is already familiar. To Gadamer, a person becomes experienced not only through their own experience but also by being open to new experiences. The truly experienced person does not know better than anyone else but is "radically undogmatic" and is "well equipped to have new experiences and to learn from them" (Gadamer 1996, p355).

In health care, an appreciation of Gadamer's concept of prejudice, and how it comes about, is helpful in understanding how practice can become professionally biased. Spence (2001) illustrates this by providing examples of both enabling and constraining prejudices in health care. Of the former, she includes behaviours that are consistent with the principles of respect, justice, advocacy and 'coming to know' the patient –

Gadamer's true prejudices in the sense that they facilitate ongoing understanding. Participants in the current study also cite examples of how true prejudice benefits understanding. Most notably, practices such as accounting for diagnostic minutiae and accounting for the patient's perspective enabled patient empowerment, which ultimately enhanced healing. In the Gadamerian sense, these practices reflect the practitioner's true prejudices because they embrace the patient's perspective to produce renewed understanding – a fusion of horizons. Of constraining prejudices, Spence (2001) cites the tendencies to stereotype cultural groups and to assume the superiority of western medicine, as well as an unwillingness to question existing beliefs and practices – Gadamer's false prejudices in the sense that they hinder ongoing understanding. In this study, participants provide examples of false prejudice in their reporting of practitioners who privilege the professional perspective, who dismiss the potential of non-conventional health care and non-conventional evidence and who fail to acknowledge a person's individuality, all of which fail to expand understanding either for the patient or for the practitioner.

Also of significance to the advancement of understanding is constructive engagement with conflict (Spence 2001, Lampert 1997), a valuable form of communication that exposes one's 'home understanding' as only one of a range of possibilities (Taylor 1995) and therefore increases the possibilities for understanding (Spence 2001, Lampert 1997). Taylor (1995, p129) argues that prejudices do not necessarily "lock us into ethnocentric prisons" but that ethnocentrism can be overcome through engagement with difference. Gadamer is also positive about disagreement, suggesting that a person comes to understand the limits of their own horizon through negative experiences. When faced with conflict, for example, one can either resolutely maintain their position or they can consider the possibilities inherent to the conflicting view, the latter option providing a pathway for widening one's horizon. In encountering difference, he says: "(it) breaks my ego-centredness and gives me something to understand" (Gadamer 1987, p46). Gadamer relates the structure of understanding to the analogy of play, where play connotes a state of flux that resembles a dialectical relationship and the playing out of possibilities. In the spirit of play, genuine dialogue embraces the possibility that the 'other' could be right (Gadamer 1996), a valuable lesson in the context of considering the potential value of alternative health care modalities and one demonstrated by study participants, who embraced scepticism in order to allow their understanding to evolve: “I thought: ‘bet that won’t work.’ But it did work!”

Consistent with Gadamer’s view of the relationship between tradition and understanding, the contemporary literature also describes how our attempts to understand are shaped by the discourse from within which we operate (Rolfe 2001). For this reason, communication between advocates of competing discourses can be difficult. Rolfe describes the failure of one discourse to recognise the language and logic of another as a ‘differend’ (after Lyotard), a dispute across discourses that cannot achieve a logical resolution for want of a commonly agreed set of principles. Again resonant with Gadamer’s beliefs, it is language that resides at the heart of this differend but, as is evident in the current study, a differend does not result from the use of unfamiliar language but from different interpretations of common concepts. According to Rolfe, this easily leads to a concept or belief being judged favourably according to the logic of one discourse but unfavourably according to the logic of the other. As demonstrated in the current study, the effectiveness of a therapy can be judged with remarkable inconsistency within different discourses because the meaning of ‘effectiveness’ differs.

Rolfe (2001) suggests that ‘differends’ are often resolved, not through rational argument but by the dominant discourse asserting itself to determine the other discourse as invalid. Helman (1993) describes a similar tactic in the resolution of divergent lay and medical explanatory models. Here, the power invested in clinicians by virtue of their professional background enables them to mould the patient’s explanatory model to fit the medical model of disease, rather than “allowing the patient’s own perspective to emerge” (Helman 1993, p95). According to Dimou (1995) the assertive approach to resolution of difference is counterproductive, an outcome also reflected in Paterson’s (2001) study, where participants lied about their self-care practices because their doctors didn’t approve. This approach to the resolution of difference is also reflected in participants’ concerns about the future of medical herbalism in the context of a biomedically-driven integrated health care: “It would be good for it to be more available but only if they didn’t start controlling it …” (S4.2). Whilst welcoming the concept of integrated health care, participants pleaded for the preservation of difference, arguing that the pursuit of uniformity would negate the very effectiveness that they have come to value. On the basis of their experiences, they feared that mainstream practitioners would resist change, a view that concurs with Rolfe (2001), who asserts that the main distinction between modernism (to which he assigns conventional medicine) and post-modernism (to which he assigns complementary medicine) is attitude to difference. A more favourable resolution can occur, Rolfe believes, through persuasive rhetoric that illustrates the world through a different lense – perhaps, through studies such as this one. By this means, positive engagement with difference can be encouraged where there is personal reluctance to do so.

Returning to Gadamer's emphasis on the importance of language in understanding, his hermeneutics has been shown to have direct relevance to the practice of medicine (Svenaeus 2003, Svenaeus 2000, Widdershoven 2000, Arnason 2000). Widdershoven (2000) considers the work of Gadamer specifically in relation to the patient-physician relationship, which he claims has recently evolved away from one unidirectional approach (medical paternalism) to another unidirectional approach (patient autonomy). He argues that the patient has now become the active party who takes control over the treatment process and that, as a consequence of this, there is now a call for a role where both play an active role. Although the basis of Widdershoven's rationale is debatable – there appears to be little evidence in this or other studies of patients 'taking control' of the medical situation – his observations have led him to consider Gadamer's philosophy on dialogue as a useful means for informing this aspect of the medical encounter. Taking Gadamer's starting point of tradition, Widdershoven describes how the patient and the physician both arrive at the medical consultation with pre-conceived ideas that derive from their respective cultural contexts - the patient believing that something is wrong and the doctor interpreting the patient's situation against a background of professional knowledge. He describes how the patient's and the doctor's horizons overlap to an extent, each becoming modified in response to the other, to produce different understanding relevant to the patient's condition – theoretically credible but, according to this study, rarely achieved in conventional practice. By contrast, the hermeneutic stance that is implied in participants' descriptions of the herbal consultation, demonstrates how this can be achieved, to the mutual benefit of patients' and practitioners' understanding and to the benefit of the patient's health care outcomes.

From a different perspective, Arnason (2000) believes that Gadamer's emphasis on tradition can be interpreted as a defence of paternalism, a point disputed by Widdershoven (2000), who argues that it is only through the historical interplay of different traditions – another positive view of difference - that the very transition from paternalism to autonomy has taken place. Widdershoven argues further that paternalism can still persist when it fits a given situation but that this also occurs as a consequence of the interplay between the patient's and doctor's horizons, a possibility also observed by others (see: Section 5.6.2, The Meaning of Collaboration in Health Care) and demonstrated in participants' tendencies to 'shop' for health. Arnason (2000) also believes that Gadamer's analogy to play, in relation to the interpretive process, can be regarded as hostile to the notion of autonomy since, if understanding is dependent on a reciprocal exchange of views, then understanding can never be truly autonomous. This view, however, overlooks Gadamer's assertion that understanding cannot be organised or made to happen at will (that is, autonomously) but that it just happens to us. In this sense, understanding occurs in a circular process that involves exposure to new or different horizons – the hermeneutic circle of understanding. The presence of something or someone else – another 'text' – is therefore essential if understanding is to progress. Furthermore, it is only through the relatively autonomous act of engaging in a hermeneutic enterprise that understanding is made possible at all. As Widdershoven (2000) comments, it requires skill and competence to interact in dialogue, a requirement also common to players in a game. To Widdershoven, dialogue is only fruitful when both parties acknowledge the possibility of learning from one another, allowing a new 'truth' to emerge - a view wholly consistent with Gadamerian philosophy, with contemporary views on patient-centred care and with the views of participants in this study.

Svenaeus (2003, 2000) considers that the practice of medicine, itself, is a hermeneutic enterprise. Accordingly, he views health care professionals not as scientists who apply biological knowledge but as interpreters of health and illness who apply science within a dialogical meeting (Svenaeus 2003). In this context, Svenaeus (2000) considers, and rejects, popular interpretations of the hermeneutic 'text' on the basis that this reduces the patient to a textual object. Arguably, Svenaeus's interpretation of text is taken somewhat too literally in the hermeneutic sense but, nevertheless, he turns to Gadamer's conceptualisation of dialogical hermeneutics as an appropriate philosophy for a hermeneutics of medicine. He maintains that Gadamer's hermeneutics is a basic aspect of life, not just a method for reading texts (again, an erroneous interpretation of hermeneutic 'text'). Gadamer's hermeneutics is applied hermeneutics that, in the context of medicine, seeks understanding for the sake of healing.

Svenaeus (2003) later describes a hermeneutics of medicine as a unique and distinct form of interpretation that envelops the explanatory models of the natural sciences. Specifically, it is the meeting between patient and physician, to which science is subsequently applied, that is hermeneutical. Repeating the now familiar form, Svenaeus believes that Gadamer's phenomenological hermeneutics helps in our understanding of the medical consultation as a merging of two horizons – the patient's perspective on illness and the physician's perspective on medicine and disease. Furthermore, he highlights how the asymmetrical relationship in the medical consultation demands empathy on the part of the doctor in order that he or she recognises the patient as an authoritative text although, interestingly, Svenaeus does not question the appropriateness of this asymmetrical relationship. Subsequently, through a merging of patient and physician horizons, both parties are able to consider the other's point of view, culminating in a different understanding about the patient's condition. The key to this is a shared language of dialogue and its intended outcome is a shared understanding about therapeutic decisions. The goal of this dialogical hermeneutic is to achieve a 'good' understanding – where truth refers to having an openness to other views – rather than a 'true' understanding that strives to achieve a universally correct interpretation. Similarly, Svenaeus (2003) suggests that a good medical encounter should achieve a good life, not merely the treatment of disease.

The practical significance of Gadamerian philosophy to health care is borne out in participants' stories, which reveal the presence of key elements of a medical hermeneutic in their experiences of herbal, but not conventional, health care. Drawing on Gadamerian philosophy, the different perspectives inherent to these paradigms – illness versus disease, healing versus symptomatic relief, anecdote and history versus science – reflect different cultural values that can be complementary to one another but, very often, are not. They are not competitive; they are simply different. Dealt with in a hermeneutic way, they can bring about renewed understanding. In a similar sense, the opportunity to maximise the effectiveness of health care (through renewed understanding) presents itself in principles and practices derived from both complementary and conventional philosophies. At this time, perhaps a fusion of complementary and conventional horizons, rather than the imposition of one, is what is required for a successfully integrated health care, where 'success' is determined not only according to professional or scientific evaluation but also according to patients' criteria for effective health care.

The significance of Gadamer's philosophy as a means for furthering health care is summed up very well by Svenaeus (2000, p185) who describes his dialogic hermeneutics as:

> "... a shared project that contains more than the sum of the two perspectives and which is put to work in the service of healing."

Or, to put it another way:

> "Together, we cracked it" (S9.1).

6 CONCLUSIONS AND IMPLICATIONS FOR HEALTH CARE

6.1 Study Conclusions

The study partially confirms the conclusions drawn from earlier research but it also elaborates on these, to offer new insight into the reasons that underpin participants' use of herbal therapy in contemporary British health care. By respecting the principle of asking simple questions of the consumers themselves (Ong and Banks 2003), the study exposes those dimensions of health care that are valued by the consumer but that can be difficult to reveal through more conventional means of investigation. Whilst the study therefore provides insight into the unique attributes of medical herbalism, many of the findings also have potential relevance to other types of complementary health care. As such, the study has the potential to inform broader health care developments, especially those that promote integrated and patient-centred principles, as well as those of specific importance to medical herbalism.

The conclusions set out below represent my personal interpretations, gleaned predominantly from talking with study participants about their health care experiences and from examining their accounts in relation to the literature. Consistent with interpretive principles that recognise the provisional, tentative and fluid nature of knowledge construction, the following 'conclusions' therefore represent reasoned impressions rather than final end-points; they reflect personal interpretations and are intended to encourage a critical reflection on the significance of health care practices to the patient's experience of health care effectiveness.

6.1.1 Notions about Health Care Effectiveness

The observation, in this study, that medical herbalism is used by a broader range of people for the treatment of a greater variety of conditions than has previously been documented, suggests that previous research provides only a partial picture of the reasons that underpin the increasing popularity of medical herbalism amongst the British public. Similarly, the study also reveals consistency in participants' reasons for the use of herbalism: they were searching for health care that met their personal criteria for health care effectiveness. It was not the case, however, that participants viewed conventional health care as ineffective, or even as less effective than herbalism, but that their ideas about health care effectiveness were more likely to parallel those espoused by their herbalist than those advocated in the conventional setting. These ideological differences were reflected in the respective criteria for health care effectiveness, in the meaning assigned to the constituents of effective health care and in relation to understandings about the nature and purpose of the patient-practitioner relationship. Broadly, these differences were consistent with classic comparisons between the concepts of illness and disease, suggesting that debates about the nature of health and illness persist in contemporary society. Despite initial impressions derived from this and other studies, the suggestion that herbal health care is more effective than conventional health care is, therefore, somewhat misleading and it conceals more fundamental issues that influence the patient's experience and perception of health care. Essentially, these issues are embedded in the notion of patient-centredness and reflect participants' views on medical pluralism.

6.1.2 Patient-centred Health Care

In relating the effectiveness of herbalism to the individualisation of health care, participants suggest a philosophy of patient-centredness in the herbal tradition; one that involves time, mutual knowledge exchange, treatment adaptation and a focus on illness rather than disease. The study also reveals that participants' expectations for health care effectiveness are more likely to be met when health care is seen to have personal significance. Personal significance is established through processes that value a patient-centred approach and that recognise and privilege the patient's perspective in deciding health care priorities. Equally important was their ability to retain control of the health care situation; to execute their right to decide the appropriateness of health care. By working with the herbalist toward a mutually determined diagnosis and by sharing in the evaluation of health care effectiveness, participants engaged in a team approach to health care that enabled their understanding, preserved their personal autonomy and ensured that health care remained relevant to their perceived needs. Although the concept of patient-centred care is conducive to achieving this ideal, participants experienced inadequate (or perhaps ineffective) patient-centredness in the conventional setting. They acknowledged the impact of inadequate and limited resources on this situation but the study also revealed that misunderstanding and a failure to establish consensus can be equally problematic in pursuing patient-centred principles. The promotion of information-giving, as a means to achieving patient comprehension, is a welcomed development that moves some way towards patient-centredness but this study differentiates between the concepts of comprehension and understanding, the latter being essential to the achievement of patient-centred care. In the context of medical herbalism, mutual understanding evolved through diagnostic and goal-setting processes that drew on both practitioner and patient expertise, allowing for existing assumptions to give way to true consensus. Through these processes, the possibilities for patient understanding were maximised and the relevance of health care became meaningful. Being mutually agreed, the criteria for treatment effectiveness were more likely to be met. Thus, the need for unambiguous consensus is paramount in the provision of health care that genuinely focuses on the patient's needs and expectations.

6.1.3 Medical Pluralism

In making distinctions between everyday and acute health care (healing and cure, respectively) and in shopping for health care accordingly, participants imply that neither herbal nor conventional health care provides a totally comprehensive health care service. Being more likely to favour the former, it is unsurprising that their criteria for treatment effectiveness centred on the necessity to achieve healing and recovery, rather than cure. Consequently, herbal therapy was perceived as more effective because it more readily met participants' everyday health care requirements. The issue, here, is that biomedical advancement has come at a price; whilst high technology health care carries its own unique merits, it can fail to meet a person's health care needs in totality. In the context of this study, the curative properties of modern medicine were complemented by the healing properties that participants found in herbalism.

Herbal medicine is neither a serious rival to biomedicine nor is it an optional therapy for satisfying the whims of a few non-conventional patients. Its potential to achieve health care outcomes that elude conventional medicine, however, calls into question the adequacy of a biomedical model in contemporary society. Already recognised as potentially beneficial in the treatment of chronic conditions that respond poorly to conventional health care, the current study also illustrates the potential for herbalism as a first line therapy in the treatment of a broad range of conditions amongst a diverse range of people. Despite this, the full potential of medical herbalism may not be realised because its theoretical basis is not wholly consistent with the explanations of biomedicine. Whilst the necessity to establish health care safety and effectiveness is without question, conventional means for doing so may not be sufficient or appropriate in every situation. Critics who question the effectiveness of complementary therapies on the basis of inadequate scientific evidence would do well to engage in an equally critical examination of the evidence for the success of conventional health care in meeting patients' health care needs in totality. In acknowledging the deficits, as well as the successes, of conventional health care, the desirability of alternative health care approaches takes on greater appeal, especially at the current time, with so many questions being asked about the reasons that underlie people's increasing attraction to non-conventional health care. As study participants recognise, biomedical and herbal health care address different health care needs. Since neither is wholly comprehensive, the requirement for a pluralistic health care that embraces principles other than those inherent to the biomedical model seems to be more pertinent than ever.

In conclusion, patient-centred care is, indeed, key to achieving health care that has personal significance to the patient. It is fundamentally dependent on consensus, which evolves from a position of mutual understanding and that ultimately minimises the risk of erroneous assumptions being made about the patient perspective. Through these means, the patient remains self-determining in matters of their own health care. Crucial to the successful implementation of patient-centred and patient-led health care is that most-valued aspect of herbal health care, namely patient-practitioner partnership, through which personally significant health care can be realised. The model argued for here is one that is patient-led rather than patient-centred, that reflects a patient-practitioner, rather than practitioner-patient, relationship and that genuinely welcomes difference in considering the validity of a range of health care approaches. It is a model that values difference and promotes flexibility in establishing the boundaries for contemporary health care provision.

6.2 Specific Contribution of the Study

By focussing specifically on the user experience, and by clarifying meaning embedded in their accounts, the study proposes new interpretations on existing assumptions about the use of herbal (complementary) therapy in British health care. The particular strength of the study is in the use of a research methodology not usually employed in this context and this provides an opportunity to reconsider the meaning and significance of effective health care from the patient perspective.

The study contributes to existing knowledge in a number of ways. Firstly, it clarifies previous uncertainties about the use of complementary therapies, by highlighting how participants were fundamentally motivated by a search for effective health care. In suggesting a common motive such as this, the study alerts us to the limitations, as well as the strengths, of health care provided within the conventional setting and it provides an opportunity to reconsider the capacity for a singular health care system in a modern health care context. In exploring the contexts within which participants utilise herbal health care, the study also reveals the full potential of herbalism as a part of contemporary health care provision. The study illustrates that herbalism can be effective, not only in the treatment of chronic disease as previously suggested, but also in the treatment of everyday illness and in the promotion of healing following conventional treatment for acute or serious illness. Since these situations are not currently well provided for in the conventional setting, the study suggests new opportunities for the integration of herbalism into the health care system. The study also highlights patient-determined priorities for ongoing health care developments, by exploring the specific ways in which herbal health care meets needs that are otherwise difficult to fulfil.

Participants' emphasis on patient-centredness confirms the timeliness of current government initiatives, especially those that promote patient choice and that value patient expertise. However, the study also highlights ways in which these initiatives could be further developed, to ensure an adequately patient-focused health care. For example, the study tells us that patient choice, from participants' perspectives, embraces a principle of tolerating difference, a finding that could usefully inform a future integrated heath care system. In discriminating between understanding and comprehension in securing personally significant health care, the study also tells us that the current encouragement for information provision, whilst welcomed, is not sufficient in a health care climate that values patient-centredness. Crucially, the study indicates a different emphasis for patient-centred-care, one that recognises the significance of misunderstanding to the quality of the patient experience and that pursues consensus through processes that prioritise exploration and clarification of meaning for both patient and health care practitioner.

The study therefore contributes new knowledge in three different ways, according to Phillips and Pugh's (1994, pp61-62) criteria for originality:

1. The study produces empirical work that hasn't been done before.

   The study is potentially unique in its specific focus on the use of traditional herbalism, in contrast to those that focus on other complementary therapies or that fail to discriminate between herbalism and the use of over-the-counter herbal preparations. By combining these elements in a single study, the study differs from previous research that generalises the use of complementary therapies in a broader context.

2. The study applies new interpretations to known material.

   By exposing a common reason for participants' use of medical herbalism and by illustrating their perceptions on the constituents of effective health care, the study reveals new insight into the underlying motives for people's use of complementary therapies. Similarly, the possibility that the nature of health care evidence impacts on people's perceptions of health care effectiveness, also provides renewed insight into people's reasons for making heath care choices.

3. The study adds to knowledge in a way that hasn't previously been undertaken.

   By utilising hermeneutic phenomenological techniques, which do not appear to have been previously employed in this context, the study explores people's experiences of herbal health care using a research methodology that is not only potentially unique, but also highly sensitive to purpose.

6.2.1 Boundaries of Study Contribution

Consistent with the tenets of hermeneutic phenomenological philosophy, which recognise the tenuous and contextual nature of knowledge, the study neither aspires to, nor claims, generalisability of the study findings to the wider population. The potential for transferability of the findings to other, similar contexts, however, is acknowledged and is for others to judge in relation to their specific health care situations. For their benefit, the following observations are offered as a means to highlighting the broad context to which the study pertains.

As with all research methodologies, the particular strengths of the selected research approach impose corresponding boundaries within which the findings can be interpreted. In common with other qualitative methods, for example, the nature of the sampling strategy limits the extent to which the study findings can be generalised to the wider population and the nature of the data collection and data analysis processes impact on the possibilities for replication. More specifically, study transferability also requires careful consideration in relation to the following:

Geographical boundaries:

- The study indicates that medical herbalism appeals to people from a range of social and economic backgrounds. Despite this, it is acknowledged that the study sample was drawn from a relatively affluent geographical location. The popularity, availability and uptake of medical herbalism may not be comparable in other regions
- The finding that medical herbalism is used for routine, as well as last-resort health care, may also be limited to users who enjoy a relatively affluent lifestyle.

Limitations of sampling strategy:

- There is a possibility that the data collection method (one-to-one interview) could be perceived as being uncomfortably intrusive to some potential study recruits. The possibility that this may have resulted in a degree of sampling bias cannot be discounted

- Being partially self-selected, there is uncertainty about the extent to which the study sample is typical of herbalists' clients. The findings cannot therefore be confidently applied to herbalists' clients, in general.

Participant characteristics:

- Participants were united in their expectations for health care that met their personal criteria for effectiveness and that recognised their right to collaboration and autonomy in health care decision-making. On the basis of such a small and partially self-selected sample, however, it cannot be assumed that others share either a desire or an ability for self-determination in the health care situation
- Similarly, participants' experiences of inadequate collaboration in the conventional health care setting might also be a reflection of the personality traits of this particular research sample. For this reason, the collaborative tendencies of conventional practitioners in other health care situations might be perceived differently.

Relevance to other health care:

- Despite suggestions that the study findings have potential relevance to the use of complementary therapies in general, the findings do specifically relate to people who consult with medical herbalists. Transferability of the findings to the use of other therapies or to the use of over-the-counter remedies should therefore be considered with caution.

Despite these limitations, the study raises a number of issues that have potential implications for health care practitioners and to researchers engaged in related study.

6.3 Implications for Health Care Practice and Research

Several observations emerge from the study findings, some of which carry potential implications for health care professionals whilst others suggest opportunities for further research. Primarily, the study sets out to illustrate the attributes of medical herbalism but these, however, are relative: participants reporting that the ways in which herbal health care satisfies their health care needs can be difficult to meet in the conventional health care setting. In particular, the implications for health care practice and research revolve around notions of health care effectiveness in relation to participants' experiences in the context of herbal health care:

- Participants' health care expectations were more readily met in the herbal setting because participants and herbalists shared a common understanding about the meaning of health care effectiveness
- Health care effectiveness was seen to be more achievable in the context of herbal healthcare due to the nature of the herbal consultation and to the nature of the herbal treatment
- Participants believed that the effectiveness of herbalism was enhanced by the collaborative nature of the patient-practitioner relationship.

The implications for future practice and research therefore reflect the essential components of effective health care, as perceived by the study participants:

- Patient-practitioner collaboration, as a means to achieving patient-centred consensus
- Consideration of the patient's perspective on health care evidence
- Facilitation of patient choice in selecting health care options.

6.3.1 Establishing Patient-practitioner Consensus

According to this study, the provision of health care that the patient recognises as relevant and appropriate to their health care needs is dependent on mutual understanding about the nature and treatment of illness. As such, the pursuit of mutual understanding becomes central to the promotion of patient control in the health care setting. Purposeful negotiation and consensus therefore requires exploration and clarification of meaning – from the perspectives of study participants, a requirement achieved in the herbal, but not the conventional, health care situation. Conversely, the failure to clarify meaning can lead to misunderstanding, especially where the meaning of 'commonly understood' concepts (such as health care effectiveness) is taken-for-granted. Research possibilities in relation to achieving consensus in health care include:

1. In relation to the proposition that mutual understanding enables consensus and that this, in turn, enhances the extent to which health care meets the patient's expectations:

    - Ascertaining the degree of correspondence between the patient's and the herbal practitioner's understanding of common health care concepts (especially in relation to the notion of health care effectiveness)
    - Establishing the ways in which the herbal consultation enables mutual understanding
    - Exploring the impact of mutual understanding on the achievement of patient-practitioner consensus in the herbal health care encounter
    - Exploring the relationship between patient-practitioner collaboration and the provision of health care that meets the patient's expectations of health care effectiveness.

2. In relation to the proposition that social communication (chat) benefits a patient's health care outcomes by enhancing the communication process:

    - Exploring the relationship between social communication in the herbal consultation and:
        - diagnostic outcome
        - the achievement of mutual understanding about the patient's condition
        - the achievement of personally significant health care.

3. The suggestion that patient understanding acquired during the herbal consultation positively influences the healing process, indicates a need to explore this relationship more fully.

6.3.2 Accounting for the Patient Perspective on Health Care Evidence

Since the consequences of health care treatment are borne entirely by the patient, a principle of patient-centred health care might be expected to take into account their views about the credibility of the evidence for its effectiveness. Practitioners might, for example, undertake a critical review of the appropriateness of imposing a professionally determined evidence hierarchy in a culture that professes to value and respect patient choice. Practitioners might also consider the limitations inherent to existing evidence hierarchies, especially in relation to privileging the professional perspective and they might reflect on the possibilities for incorporating the patient's perception on health care evidence, into agreements about their treatment. A particular challenge for practitioners relates to how they reconcile the tension between patient preference and the requirement on practitioners to offer scientifically-validated treatment. Patient-practitioner partnership, and the sense of personal control that it fosters, therefore carries implications, not only for practitioners but also for health care policy-makers, who are equally reliant on evidence hierarchies in determining which health care options should be made available. Achievement of these ideals might benefit from research questions that consider:

- How to incorporate the patient perspective into existing evidence hierarchies
- Whether the patient's utilisation of prescribed treatment is influenced by their perception of the quality of its underpinning evidence
- The extent to which patient-determined health care outcomes correlate with those derived from evidence-based recommendations.

The argument that herbalism owes its effectiveness partly to the individualisation of the prescription and partly to the use of intact herbal medicines, would benefit from studies that demonstrate the comparative effectiveness of:

- Individualised versus standardised dosages of the same treatment
- Individualised versus standardised compositions of herbal treatments
- Preparations based on whole herbs versus those based on isolated constituents of a herb.

6.3.3 Facilitating Patient Choice in Health Care Options

For consensus and patient-centredness to be given serious consideration, a critical review of the relative roles of conventional and complementary health care is required. This is of particular importance where the patient and practitioner hold conflicting worldviews, since it is questionable how patient-centredness can ever be championed in a culture that legitimises the dominance of one (professional) perspective over another (patient) perspective. Whilst healthy debate about the relative merits of different health care approaches is long overdue, such debate demands a willingness to preserve, nurture and integrate alternative theories and practices. The current potential to harness opportunities for health care expansion by way of integrating different health care approaches is considerable, but to do so requires a reconsideration of the appropriateness of a single worldview in the legitimisation of all types of health care.

Practitioners and policy-makers are also implicated at a broader level, especially where policy-making is said to incorporate a lay perspective; the exclusion or trivialisation of the patient perspective in policy debate that impinges on their right to choice being seemingly incongruous in this patient-centred culture. In this respect, there is a responsibility on policy-makers to ensure that the processes through which lay members are recruited to evaluation panels and through which consultation opportunities are disseminated to the wider public, are efficient, effective and inclusive.

Specific research issues that arise in relation to facilitating patient preference relate to:

- Exploring the extent and nature of collaboration between complementary and conventional practitioners and the impact of this collaboration on the patient's freedom to select health care options of their choice
- Evaluating existing processes for public consultation, in respect to their effectiveness and inclusivity
- The design of studies that are able to reflect the full potential of herbal health care, in response to the belief that herbal medicines deal more effectively with illness causation. By illustrating people's experiences throughout the diagnostic, treatment and evaluative phases of health care, such studies would enable the

potential for herbal health care to be more fully appreciated and the basis for people's health care choices to be better understood.

In addition to the specific research possibilities outlined above, ongoing research could build usefully on the broad study findings to determine the extent to which the findings can be generalised to other users of medical herbalism, to users of over-the-counter herbal preparations and to users of other complementary therapies. In particular, future studies might verify whether participants' experiences of comparative effectiveness (herbal and conventional) are unique to the locality within which the study was situated or whether this finding translates to other regions of the United Kingdom: essentially, whether the study indicates a general or localised desire for medical plurality in the context of contemporary health care. Such studies might also explore to what extent personal significance is an important determinant of effective health care in other contexts (for example, in the use of other complementary or conventional therapies).

The study also reinforces the necessity for the selection and application of research methodologies that are appropriate to the study purpose. In addition to ensuring the suitability of methodological techniques, the study particularly highlights the importance of interpreting research findings within the boundaries of the chosen methodology, to minimise the risk of misunderstanding as a consequence of unexplored or erroneous assumptions.

6.4 Tolerating Difference: Towards a Pluralistic Health Care

With the current emphasis on patient-centredness and health care integration, consumer focused studies provide an opportunity to:

- Establish dialogue between consumer and health care professional
- Enhance understanding of consumers' health care needs and expectations
- Expose assumptions inherent to established practice
- Highlight the implications of these assumptions to the patient's health care experience.

Of most importance, inclusion of the public in policy debate should ensure that a future integrated health care reflects the principles of both patient-centredness and integration, in its fullest sense. The challenge now, is for health care professionals, both conventional and complementary, to confront established prejudices and to discard the notion that all health care knowledge should measure up to a single epistemology. The current pursuit of patient-centred and integrated health care, as well as the current review of medical herbalism in the United Kingdom, offers a timely opportunity to embrace a critical examination of difference and to demonstrate, as participants do, an ability to tolerate and integrate difference and to welcome this as a potential source of health care expansion. Furthermore, a medical pluralism that welcomes alternative theories about health, illness and health care is not only consistent with participants' perspectives but also with professional demands for non-discriminatory practice (Chalmers 1998). In a culture that promotes patient-centred and integrated ideologies, the relevance of new, old and current ways of understanding deserve to be considered and nurtured to ensure that health care in contemporary British society has the potential to meet the diverse needs of the people that it serves.

In participants' words:

> "There are other options ... it's not only about science. It's (herbalism) a different approach ...a different perspective of looking at the problem. I'd go to my GP for a quick fix ... then I would consult the herbalist ... to keep it from coming back. As a whole, they can work together, you see. That's the idea. **Side ... by ... side.**"
>
> (S4.1, S7.1, S4.2, S5.2, S13.5)

DECISION TRAIL

Main methodological decisions are substantiated in the personal reflections that follow, the presentation of methodological rationale being considered an essential pre-requisite for the assessment of study dependability (Lincoln and Guba 1985) (see: Section 3.2.5.5, Audit Trail). Whilst the assumptions listed below are believed to have been influential in the design of the study and some will have contributed to data generation and data analysis, I also acknowledge that the ability to recognise one's own pre-understandings is limited.

RATIONALE/REFLECTION	**Cross-reference**
1. Research question	
The impetus for undertaking the study arose from personal, professional and academic experiences:	Section 1.1 Study Rationale
Personal experience derives from lifelong family tradition in the use of herbal medicines, of an informal and non-professional nature. Although not used to the exclusion of conventional health care, this long-standing exposure to herbalism has influenced my perception of herbalism in the context of modern health care. In essence, I have viewed herbal medicine as the 'obvious' medicine for self-medication purposes whilst reserving conventional health care for situations that require professional consultation. I have personally consulted with a registered medical herbalist on one occasion and have integrated herbal and conventional health care with some degree of success.	Section 3.1 Philosophical Framework Section 3.2.1 Rationale and Study Objectives
In a professional capacity, my health care career has exposed me to a variety of views (expressed by colleagues and friends) about the nature of complementary therapies and the nature of people who use them, views that often contradicted what I 'knew' from personal experience. Consequently, my orientation toward the phenomenon evolves from the perspective of a nurse, immersed in Western, biomedical principles, but also from the perspective of a consumer, with experience of traditional values and practices. Whilst these multiple perspectives have not generated personal conflict, they have led me to question how well the perceptions of health care professionals (including myself) actually reflect those of the patient, a view compounded by the observation that patients, as well as non-medical friends, often report that health care professionals assume their health care needs and preferences.	

DECISION TRAIL
(Continued)

RATIONALE/REFLECTION	**Cross-reference**
1 (continued) These assumptions also became evident during personal academic endeavours that also led to my questioning the value of processes that overlooked or trivialised the patient perspective. Specifically, I was struck by the extent to which I was reliant on the professional perspective on herbal medicine at the expense of the patient perspective, during the process of undertaking systematic reviews of effectiveness of herbal therapies. Assumptions: • Patient and professional perceptions about complementary therapies may not be consistent and can be conflict with one another • The patient perspective is often inadequately reflected in academic research and in health care decision-making • Patients have a unique perspective on health care that cannot be acquired theoretically (i.e. in the absence of direct experience) and their contribution to health care knowledge is therefore imperative • Integration between herbal and conventional health care is achievable	

DECISION TRAIL
(Continued)

RATIONALE/REFLECTION	Cross-reference
2. Research Design	
2.1 In undertaking a review of potential methodologies for the current study, I discounted quantitative approaches on the basis that the focus of study was broadly exploratory and would not benefit from precisely defined routes of enquiry. I also discounted survey methods, since they would also require a relatively clear line of questioning. Of the qualitative methods, I selected hermeneutic phenomenology as the most suitable for exploring 'why' questions and especially for clarifying meaning. My belief that people have a natural tendency to make assumptions about others' intended meaning and the potential for this to impinge on people's health care experiences was influential in designing the current study, the over-riding purpose of which was to clarify meaning from the patient perspective. The hermeneutic tradition, with its emphasis on revealing meaning, therefore appealed to this purpose. Gadamerian philosophy, in particular, reflects my experiences of how personal understanding evolves (the significance of the hermeneutic circle and fusion of horizons, to the evolution of renewed understanding) and, thus, provided a viable framework for the pursuit of relatively assumption-free enquiry.	Section 3.1 Philosophcal Framework
2.2 Hermeneutic phenomenological philosophy was initially pivotal to research design, due to my desire to explore meaning. Over time, my perspective on research design subsequently altered, to reflect a transition from ideology to one of philosophical pragmatism (i.e. the selection of principles, methods and techniques, from whatever source, that would best answer the research questions). Firstly, my increasing commitment to explicate meaning transferred the emphasis from phenomenology to hermeneutics, interpretive techniques being selected accordingly. Secondly, the interview process (see above) returned my thoughts to the particular strengths of phenomenology (exposing lived experience). Thus, the relative incompleteness of phenomenology (in the absence of hermeneutics) and the incompleteness of hermeneutics (in the absence of phenomenological description) was reinforced. In essence, the hermeneutic circle became evident once again: lived experience gave rise to understanding and understanding, in turn, led to further exploration of lived experience, and so on ad finitum ...	Section 3.2.2 Research Design
Assumptions: • It is a human tendency to make assumptions based on one's own perspective. Intended meaning can therefore be easily misunderstood.	

DECISION TRAIL
(Continued)

RATIONALE/REFLECTION	Cross-reference
3. Sampling Strategy	
3.1 The sampling strategy reflected my attempt to elicit the views of people who would have the most to gain from the study, judged as being those who currently use herbal therapy in the course of their personal health care. Implicit to the decision to exclude over-the-counter users is my assumption (partly based on personal observation) that people who purchase over-the-counter remedies sometimes seek advice from sales personnel, who advise on an appropriate remedy; the choice of herbal remedy may therefore be arbitrary. Although this group of complementary therapy users would be appropriately placed to comment on their reasons for using complementary therapies, their potential to answer the herbal-specific research question was therefore thought to be limited. Consequently, I decided that a person's deliberate decision to consult with a medical herbalist demonstrated a committed interest in herbal health care (an assumption subsequently shown to be wrong).	Section 3.2.3 Data Collection
3.2 In delegating participant selection to herbalists, I acknowledge the risk of selection bias is acknowledged but the importance of ensuring participants' suitability for interview (especially in respect of emotional stability) was thought to take precedence in the selection process.	Section 3.2.3.1 Sampling Strategy
Assumptions: • Consultation with a medical herbalist implies a considered preference for herbal therapy • Herbalists would be a reliable judge of their own clients' suitability to participate in the study • Herbalists would demonstrate professional integrity in recruiting clients most appropriately suited to the study purpose • Self-selection (by open invitation) posed a greater risk of inappropriate recruitment.	

DECISION TRAIL
(Continued)

RATIONALE/REFLECTION	Cross-reference
4. Interview Process	
4.1 I believed that the most effective way to expand my own personal horizon of understanding would be to allow participants to guide the interview in whatever direction was appropriate for them – that this would allow participants to raise issues of personal significance, whether or not these were already evident in my own mind. To this end, each interview commenced only with an opening question – 'please tell me something about your first ever visit to see a herbalist.' Subsequent questions arose directly from participants' contribution, except where it became necessary to re-direct the discussion towards the herbal focus.	Section 3.2.3.2 Interview Process
4.2 On several occasions, interviews were hindered to some extent by extraneous interruptions: • Progress checks by an interested husband • Participant's need to supervise tradesmen • Proximity to noisy building work • Participant's commitment to supervision of neighbour's children. Although the importance of the environment was initially acknowledged in the research design, the emphasis placed on this aspect at the time of negotiating initial interview appointments was inadequate. The experiences noted above led me to revise the interview guide, in order to emphasise the need for privacy during the interview process and also to emphasise the participant's option to cancel an interview if their circumstances changed in this respect. Subsequent interview arrangements met with a greater degree of success.	Section3.2.5.6 Reliability and Validity of Inteview Process
4.3 Due to my own, professional health care background, participants occasionally sought advice or opinion about various health issues but these were successfully fielded by emphasising the need for participants to discuss their health care with the appropriate practitioner (herbalist, GP or other) or by advising on methods by which they could obtain further advice. Thus, the distinction between research and therapeutic interview was maintained.	Section 3.2.2.2 Ethical Aspects

DECISION TRAIL
(Continued)

RATIONALE/REFLECTION	**Cross-reference**
4.4 My tendency to become overly interested in the stories that people had to tell sometimes tempted me to stray from the intended interview purpose. This applied particularly to three participants, each of whom recounted previous health care experiences with absorbing clarity that grasped my attention almost to the loss of focus on the researchproject. The problem of distraction was resolved by: • Purposefully reviewing the interview guide, as a reminder of purpose, immediately prior to each interview • Clarifying the conversation in terms of the herbal implications at appropriate intervals throughout the interview process. These techniques helped me to maintain the research focus although, on occasions, the failure to pursue stories of significance to the participant (because they were no longer directly related to the study) continued to cause me some frustration.	Section 3.2.2.2 Ethical Aspects Section 3.2.3.2 Interview Process

DECISION TRAIL
(Continued)

RATIONALE/REFLECTION	Cross-reference
5. Data Analysis	
5.1 At an early stage of data analysis, I noticed my tendency to substitute participants' terminology with my 'usual' language. The potential for this to alter meaning or emphasis led me to incorporate participants' own key words wherever possible, to preserve original meaning. Key words also provided a means for authenticating the analytic process, especially in verifying final thematic descriptions	Section 3.2.4.2 Thematic Analysis
5.2 In a hermeneutic sense, the technique of Husserlian 'bracketing' (phenomenological reduction) is antithetical to the development of understanding. Consistent with this perspective, I attempted to engage as fully as possible in the hermeneutic circle of understanding by: • explicating pre-understandings wherever possible and accounting for these in the analytic process • searching for alternative themes (rival statements) to those that readily emerged from the data	Section 3.2.4.2 Thematic Analysis
5.3 The realisation that study participants might not have been specifically drawn to herbal therapy at the outset of their herbal treatment was a personal disappointment, since I had assumed that clients of herbalists would share a common passion for this mode of health care. Care was taken, at this stage of data analysis, to search for rival and/or supporting statements to determine the underlying motive for participants' choice of herbal therapy, as opposed to other complementary therapies.	Section 4.3 Motivational Theme
5.4 Taken out of the context of the interview as a whole, quotations only partially support my personal interpretation of the data. Quotations were therefore selected to reflect a range of perspectives in an attempt to provide sufficient data to allow readers to grasp essential contextual meaning. Assumptions: • Meaning is embedded in language	Section 4 Study Findings

APPENDIX 2

SEARCH STRATEGY

PRELIMINARY LITERATURE REVIEW

Sources

The literature sources included the databases for BNI, CINAHL, CISCOM, Cochrane, MedLine, Theses & Dissertations. References of published articles and relevant websites were also checked. The AMED database was not included due to difficulty in access but this omission was accounted for by the inclusion of the CISCOM database, which does incorporate references from all the other complementary therapy related databases.

Time Span

The search strategy included studies published from 1990-2004, a time span that was considered to be sufficient for the purposes of the current study, which was to review current perspectives on use of herbalism.

Language

The search strategy was limited to studies published in the English language. This is acknowledged as a limitation of the search strategy but was considered carefully against the practicalities and potential benefits of translation.

Keywords

herbal therapy (or synonyms) **or** complementary therapies (or synonyms) **and** reasons for use (or synonyms).

To maximise recall, the search strategy incorporated both database thesauri and free text searches and truncated terms to capture derivations and alternative spellings. As the study was concerned with the consumer perspective, editorials and professional opinion papers were excluded.

Type of studies

Primary and secondary studies were included.

MAIN LITERATURE REVIEW

A similar search strategy was applied but keywords (and synonyms) were substituted in relation to each of the sub-sections of the discussion chapter.

APPENDIX 3

STUDY INCLUSION CRITERIA

Ref:	INCLUSION CRITERIA	EXCLUSION CRITERIA	INCLUDE/EXCLUDE (reasons for exclusion)
POPULATION	Adults (18 years or over) Explicitly identified as using complementary therapies	Aged under 18 years Studies where population is not described as using complementary therapies Over-the-counter use	
INTERVENTION	Western herbalism or Complementary therapies, generally, which have the potential to include herbalism	Non-Western herbalism Single complementary therapy (unless herbalism)	
OUTCOME	Distinct focus on reasons for use	General trends	
STUDY	All primary and secondary studies that meet inclusion criteria Publication date 1990 or later Published in English language	Discussion papers, editorials etc.	

APPENDIX 4

SEARCH HISTORY
(1990 to December 2004)

SOURCE	ARTICLES IDENTIFIED	ARTICLES ASSESSED	DUPLICATES	INCLUDED
BNI	72	15	0	4
CINAHL	2075	6	2	2
CISCOM	69	9	4	0
COCHRANE	0	0	0	0
MEDLINE	2390	40	4	5
THESES AND DISSERTATIONS	0	0	0	0
REFERENCE LISTS	2	2	0	1
WEBSITES	1	1	0	1
TOTAL	**4609**	**73**	**10**	**13**

APPENDIX 5

REASONS FOR STUDY EXCLUSION

REASONS FOR EXCLUSION*	**BNI**	**CINAHL**	**CISCOM**	**MEDLINE**	**REFERENCE LISTS**	**TOTAL**
Population: - Not identified as CT user	4	0	3	22	1	30
Intervention: - Herbalism not included	2	0	1	3	0	6
Outcome: - No explicit focus on reasons for use	3	0	0	14	0	17
Study: - Not a study - Not published in English language	2	2	1	7 3	0	12 3
Duplicate reference	0	2	4	4	0	10
TOTAL	11	4	9	53	1	78

*Some papers excluded for more than one reason

APPENDIX 6

GUIDELINES FOR SURVEY APPRAISAL

RESEARCH DESIGN:	Is there a clear statement of aims and a clear description of target population? Is the chosen type of survey appropriate? Consider: Whether survey type reflects study aims. If author has justified choices made.
RESEARCH SAMPLE:	Was sample selected randomly. How? How was sample size calculated. Was sample relevant to target population? Was there risk of sub-group exclusion?
ETHICAL ISSUES	Are ethical principles of research addressed?
DATA COLLECTION:	What was the response rate? Less than 60%? Was response encouraged? Was there follow-up of non-responders? Is there a profile of non-responders? Is there a profile of partial responders (i.e. later drop-outs). Are details of survey instrument provided? Was survey instrument piloted? Consider: How pilot sample was selected. Whether outcomes of pilot are stated. Whether problems were addressed in main study. How were survey questions generated? Consider: Whether these reflect researcher's pre-judgements or whether target population has been involved. Whether reference is provided, if derived from previous study. How were survey questions validated?
RESULTS:	What do results show? Consider: Statistical technique(s). Whether trends are reflected in data.

(Adapted from: Ajetunmobi 2002, Nelson 1999)

APPENDIX 7

DATA EXTRACTION FORM
(Qualitative Studies)

Reference:	
RESEARCH DESIGN: **Criteria Met: /4**	**Data/Comments**
Aim: Explicit Unclear N/S Rationale: Sound Unclear Tenuous N/S	**Aim:** Location: ....
Method: Appropriate to RQ: Yes No Rationale: Sound Unclear Tenuous N/S	**Method:** GT Phen/Herm Eth Focus Gp Other .... Therapies: Herb. Ac. Hom. Chir. Osteo. Ar. Ref. Any N/S Pre-determined: Yes No N/S Others: ....
REFLEXIVITY: /5 **Criteria Met:**	**Data/Comments**
Reflexive re: RQ DC DA Audit N/S Responsive to events: Yes No N/S	

(Criteria adapted from: Milton Keynes Primary Care Trust 2002)

DATA EXTRACTION FORM
(Qualitative Studies, continued)

RESEARCH SAMPLE: **Criteria Met:** /4	**Data/Comments**
Recruitment: Rationale: Sound Unclear Tenuous N/S	**Recruitment strategy:** Purposive Convenience Other …………………
Relevance to study aims: Appropriate Inappropriate	**Sample:** No. ………… F: ……….. M: ………. Age range: ……………… Ethnicity …………………
Recruitment issues discussed: Refusals: Yes No Drop-outs: Yes No	**Recruitment issues:**
ETHICS: /5 **Criteria Met:**	**Data/Comments**
Issues addressed: Confidentiality Anonymity Informed consent Study consequences Ethical approval: Yes No NS	**Ethical issues:**

(Criteria adapted from: Milton Keynes Primary Care Trust 2002)

DATA EXTRACTION FORM
(Qualitative Studies, continued)

DATA COLLECTION: **Criteria Met:** /5	**Data/Comments**
Method described: Yes No Rationale: Sound Unclear Tenuous N/S	**Method:** I/view Focus Gp. Other ....
Techniques described: I/view method: Yes No Data recording: Yes No	**Techniques:** I/v: Type .... Setting: .... Indiv. Group No/person .... Duration .... Data recording: Audio Video Diary Notes N/S
Data saturation: Achieved Not achieved N/S	**Data saturation:**

(Criteria adapted from: Milton Keynes Primary Care Trust 2002)

DATA EXTRACTION FORM
(Qualitative Studies, continued)

DATA ANALYSIS:	**Criteria Met:** /6	**Data/Comments**	
DA process described:	Explicit Adequate Inadequate N/S Rationale: Sound Unclear Tenuous N/S	**DA Framework:**	GT Phen. Herm. CCA Other ....
		DA Technique: pattern	Line-by-line Categorised Thematic Constit.
Themes:	Derived from data: Yes No Unclear Supported by data: Yes No Unclear Contradictory data explored: Yes No Unclear	**Depth and Saturation:**	
Data validated:	Yes No N/S	**Data validation:**	Participant Co-researcher Other ....

(Criteria adapted from: Milton Keynes Primary Care Trust 2002)

DATA EXTRACTION FORM
(Qualitative Studies, continued)

STUDY RESULTS	
In relation to motivational factors:	**Other findings:** **Conclusions:** Relationship to RQ: Credibility: Transferability: Contribution: Overall impression content & quality: Criteria met: /29

(Criteria adapted from: Milton Keynes Primary Care Trust 2002)

APPENDIX 8

DATA EXTRACTION FORM
(Survey Studies)

Reference:	
RESEARCH DESIGN: **Criteria Met:** /5	**Data/Comments**
Aim: Explicit Unclear N/S Rationale: Sound Unclear Tenuous N/S	**Aim:**
Target Population: Explicit Unclear N/S	**Target Population:** Location: .... Therapies: Herb. Ac. Hom. Chir. Ost Ar. Ref. Any N/S Pre-determined: Yes No Other: ....
Method: Appropriate to RQ: Yes No Rationale: Sound Unclear Tenuous N/S	**Method:** C/S Long. N/S National Local N/S

(Criteria Adapted from: Ajetunmobi 2002, Nelson 1999)

DATA EXTRACTION FORM
(Survey Studies, continued)

RESEARCH SAMPLE:		**Criteria Met:** /4		**Data/Comments**	
Recruitment:	Randomised	Non-randomised	N/S	**Recruitment strategy:**	Self-selected Targeted
Determination of sample size:	Statistical	Estimated	N/S	**Sample:**	No. ………… F: ………… M: ………….. Age range …………….. Ethnicity ………………
Relevance to Target Pop:	Appropriate S-G exclusions:	Inappropriate Yes No		**Generalisability:**	
ETHICS: /4		**Criteria Met:**		**Data/Comments**	
Issues addressed:	Confidentiality Ethical approval:	Anonymity Yes No	Informed consent N/S	**Ethical issues:**	

(Criteria Adapted from: Ajetunmobi 2002, Nelson 1999)

DATA EXTRACTION FORM
(Survey Studies, continued)

DATA COLLECTION:	**Criteria et: /12**	**Data/Comments**	
Method:	Described: Adequately Inadequately N/S	**Method:**	postal telephone face-to-face other ……….
			self-completed researcher-completed N/S
Response:	Rate: ……….. Encouraged: Yes No N/S How?		
	Follow-up: Yes No How?	**Response:**	
	Profile of non-responders: Yes No N/S		
	Profile of drop-outs: Yes No N/S		
Tool:	Described: Adequate Inadequate N/S	**Tool:**	Modifications described: Yes No N/A
	Piloted: Yes No N/S		
	Pilot sample: ……………………………. N/S		
	Pilot outcomes stated: Yes No		
Questions:	Derived: Respondents Researcher N/S	**Questions:**	Closed Open Mixed
	Previous research → referenced: Yes No		
	Validated: Yes No N/S How?		
DATA ANALYSIS:	**Criteria Met: /3**	**Data/Comments**	
Data Analysis:	St. technique ……………………………. N/S	**Data analysis:**	Descriptive Correlational Sub-group
	Reflects RQ: Yes No Correlates with text: Yes No		

(Criteria Adapted from: Ajetunmobi 2002, Nelson 1999)

DATA EXTRACTION FORM
(Survey Studies, continued)

STUDY RESULTS	
In relation to motivational factors:	**Other findings:** **Conclusions:** Related to RQ: R&V: Generalisable Contribution: Overall impression, content & quality: Criteria met: /28

(Criteria Adapted from: Ajetunmobi 2002, Nelson 1999)

LETTER OF ETHICAL APPROVAL

NHS

South West Multi-centre Research Ethics Committee

Ms Christine Little
Senior Lecturer
Institute of Health & Community Studies
Bournemouth University
Bournemouth House
19 Christchurch Road
Bournemouth
BH1 3LH

The Lescaze Offices
Shinner's Bridge
Dartington
Devon
TQ9 6JE

Tel: 01803 861947
Fax: 01803 861914
Email: swmrec@sw-devon-ha.swest.nhs.uk

29 July 2002

Dear Ms Little

Re: MREC/02/6/22: The role of herbal therapy in contemporary health care: a phenomenological study of consumers' experiences.

The South West MREC reviewed your application on 13 June 2002 and following amendment has agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you our approval on the understanding that you will follow the conditions of approval set down below. The project must be started within three years of the date on which MREC approval is given. The following documents have been approved:

- Research Protocol (7 pages plus Appendices - February 2002).
- Appendix 1 – Section 1 of LREC Application dated 7 February 2002.
- Appendix 2 – Herbalist Letter and Response Form (1) (2 pages - May 2002 version 2).
- Appendix 3 – Inclusion Criteria (January 2002, Version 1).
- Appendix 4 – Consent Form for Research Participants (July 2002 version 3).
- Appendix 5 – Participant Letter (2 pages - January 2002, Version 1).
- Appendix 6 – Participant Information Sheet (1) (May 2002 version 2).
- Appendix 7 – Participant Information Sheet (2) (July 2002 version 3).
- Appendix 8 - Interview Schedule (2 pages – May 2002 version 2).
- Appendix 9 – GP Letter (GP Letter. January 2002. Version 1).
- Appendix 10 – Herbalist Letter (2) (Herbalist Letter 2. January 2002. Version 1).

LETTER OF ETHICAL APPROVAL
(Continued)

While undertaking the review of your application the MREC noted the research involves the use of existing information collected for other purposes with subsequent patient contact. For this reason you are asked to read carefully the sections concerning LREC involvement and local NHS management set out below as there are specific requirement involved when undertaking such research.

MREC Conditions of Approval

- No research procedures are undertaken until the appropriate local research ethics committees is informed of the research including the name of the local clinician/herbalist involved.
- The local clinician/herbalist must inform his/her NHS organisation of their co-operation in the research project.
- The protocol approved by the MREC is followed and any changes to the protocol are undertaken only after MREC approval.
- You must promptly inform the MREC of:
  (i) any changes that increase the risk to subjects and/or affect significantly the conduct of the research;
  (ii) any new information that may affect adversely the safety or welfare of the subjects or the conduct of the trial.
- You must complete and return to the MREC the annual review form that will be sent to you once a year, and the final report form when your research is completed.

LREC involvement

When undertaking the review of your project the MREC observed that there is patient contact involving data collection as described in the MREC approved protocol.

You are asked to inform the appropriate LREC of the project by sending a copy of this letter and also giving the name and contact details of the local clinician/herbalist involved and what procedures will be undertaken by this person. If (unusually) the LREC has any reason to doubt that the local clinician/herbalist is competent to carry out the tasks required, it will inform the clinician/herbalist and the MREC that gave ethical approval giving full reasons.

You are not required to wait for confirmation from the LREC before starting your research.

LETTER OF ETHICAL APPROVAL
(Continued)

Local NHS Management

The local clinician must inform his/her NHS organisation of their co-operation in the research project and the nature of their involvement. Care should be taken to ensure with the NHS organisation that local indemnity arrangements are adequate.

Legal and Regulatory Requirements

It remains your responsibility to ensure in the subsequent collection, storage or use of data or research sample you are not contravening the legal or regulatory requirements of any part of the UK in which the research material is collected, stored or used. If data is transferred outside the UK you should be aware of the requirements of the Data Protection Act 1998.

ICH GCP Compliance

The MRECs are fully compliant with the International Conference on Harmonisation / Good Clinical Practice (ICH GCP) Guidelines for the Conduct of Trials Involving the Participation of Human Subjects as they relate to the responsibilities, composition, function, operations and records of an Independent Ethics Committee/Independent Review Board. To this end it undertakes to adhere as far as is consistent with its Constitution, to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice, adopted by the Commission of the European Union on 17 January 1997. The Standing Orders and a Statement of Compliance are available on request or on the Internet at http://www.corec.org.uk.

Yours sincerely

pp **Barrie Behenna**
Chairman

APPENDIX 10

HERMENEUTIC ANALYSIS
(Example)

The following extracts (transcript S9.1) illustrate the revision and progression of analysis within the hermeneutic circle.

1. Following initial reading:

   In the global summary, I wrote: "This participant's interest in medical herbalism was triggered by her attraction to the idea of natural health care (i.e. pull factor)."

2. Following focused reading:

   One of the preliminary themes that I identified, I labelled 'Natural Equals Good.' Following subsequent hermeneutic analysis (mutual verification between global summary and preliminary themes) I believed that this preliminary theme was consistent with the global summary and I therefore left it intact.

3. Following sentence analysis:

   As I clustered sentences together, a common theme began to emerge around this participant's experiences of adverse drug reactions in conventional medicine. I labelled this common theme 'Seeking an Alternative to Conventional Medicine'. Further hermeneutic analysis (mutual verification between preliminary and common themes) revealed an inconsistency between this common theme and the earlier preliminary theme (Natural equals Good). By returning to the text to clarify meaning, the common theme was verified and therefore superseded the preliminary theme.

4. Seeking Rival Statements:

   I could identify neither contradictions nor coercions within the text, leading me to authenticate the common theme 'Seeking an Alternative to Conventional Medicine' and to elevate its status to final theme.

5. Revision of global summary:

   I subsequently revised the extract illustrated in stage 1 in the light of this final theme:

   Initial interpretation:

   "This participant's interest in medical herbalism was triggered by her attraction to the idea of natural health care (i.e. pull factor)."

   Final interpretation:

   "This participant's interest in medical herbalism reflected a far more considered approach than had first appeared. Following several experiences of ADRs (some minor e.g. nausea following non-prescribed NSAIDs; some major e.g. feeling 'zombie-like' following prescribed anti-depressants), she began to question whether body/drug incompatibility might be at the heart of her unpleasant side-effects. Because she equated conventional drugs to man-made chemicals, she came to consider the possibility that a natural alternative (i.e. neither man-made nor chemical) might be 'worth a try' although she did not assume the effectiveness of a natural option. Her interest in medical herbalism was therefore based, not on a fundamental belief about the benefits of natural interventions, but on her negative experiences of conventional medicines, which she considered to be 'non-natural.' The initial impression of a 'pull' motivation therefore emerges as a 'push' motivation."

SEEKING RIVAL STATEMENTS
(Example)

Once I had created common themes from the data, I returned to the transcript to seek out contradictory (rival statements) in relation to each identified theme. This process took two forms:

1. In relation to each common theme in turn, I re-read the transcript to verify that all related dialogue was consistent with the essence of that theme's descriptive label. One example of a revised common theme in response to seeking rival statements is as follows:

Original thematic label:	Doubtful Health Care Evidence
Rival Statement:	"It's not that it isn't useful, it's just that I don't get it … not myself."
Revised thematic label:	Personal Relevance of Health Care Evidence

(Extracted from S5.2)

2. a) I checked each common theme against my previously identified pre-conceptions. Where I found that a common theme corresponded with a personal pre-conception, I re-examined the data to establish how that theme had developed. In particular, I observed my own contribution to the dialogue, to satisfy myself that no coercion had taken place. I found no evidence to this effect.

b) I reviewed the data in relation to each of the remaining pre-conceptions. Where I observed related dialogue, I examined this carefully to ensure that I had neither created nor overlooked data in the creation of themes. For example:

I had a pre-conceived assumption that participants would have been specifically drawn to herbalism, as opposed to other complementary therapies, on the basis of its historical relevance to British health care. During my examination of transcripts for rival statements, however, it became clear that all but two of the study participants had been looking for an alternative to conventional health care but that their choice of medical herbalism had been almost arbitrary. This finding surprised me, but I was more surprised to discover that I had overlooked this important aspect of the data until a relatively late stage of analysis (i.e. undertaking the process of seeking rival statements).

APPENDIX 12

FREE IMAGINATIVE VARIATION
(Example)

The process of free imaginative variation serves to distinguish between essential and non-essential (incidental) themes of the phenomenon under study – a key purpose of phenomenological research. The technique requires the imaginative manipulation of each theme in turn, as a means to identify those that distinguish the phenomenon from other, similar phenomena. In relation to this study, the process involved my examining the data to verify whether or not the themes had equal relevance to conventional health care or whether they were unique to medical herbalism and therefore constituted the basis of its relative effectiveness (see example below)

Phenomenon	**Structures (themes) of Phenomenon**	**Thematic Status**
The relative effectiveness of medical herbalism in comparison to conventional health care	Dealing with Illness Causation Patient-practitioner collaboration Authentic Health Care Evidence	Without greater distinction, each of these themes has relevance to both conventional and herbal health care. None could therefore be identified as being unique to medical herbalism and, as such, I categorised these as incidental themes. Following further analytic processes, however, the themes became more clearly distinguishable according to their degree of personal significance, which emerged as the essential, distinguishing factor
	Personal Significance of Health Care	Because participants were able to recognise the significance of herbal, but not conventional, health care, personal significance emerged as the structure that underpinned its relative effectiveness. I therefore labelled Personal Significance of Health Care as an essential theme.

APPENDIX 13

ANNOTATION GUIDE

ANNOTATION GUIDE FOR INTERVIEW TRANSCRIPTION

The following annotations were applied to the interview transcripts to preserve participants' emphases during the analytic process.

A normal conversational pause was indicated by **...**

A 'thoughtful' pause was indicated by **... ...**

A 'difficult' pause (e.g. feeling emotional or uncertain) was indicated by **... ... ...**

Bold type indicated a strong emphasis on the point being made

Underlining indicated irritation

Bold underlining indicated anger

A sigh was indicated by the symbol ~

Incredulity was indicated by enclosing the relevant text within paired exclamation marks, **!! text !!**

Interjection, which often reflected a particularly animated response, was indicated by the symbol < >

Other specific behaviours (e.g. tearfulness, laughter, grimace) were indicated by writing the response within the text, as appropriate

GLOBAL SUMMARY

GLOBAL SUMMARY
INTERVIEW: S9.1

(S9.1) was motivated to try medical herbalism primarily as a consequence of ineffective conventional health care but also following the recommendation of a friend, whose positive experiences of herbal treatment had been encouraging. Specifically, she had been keen to try an alternative treatment following 10 years of unsuccessful treatment for irritable bowel syndrome, which had also made her feel ill as a consequence of side-effects from the treatment.

After a little while her symptoms eased and she felt more comfortable although the condition remained troublesome until the herbal prescription was adjusted, with good effect. She attributed the effectiveness of the herbal treatment to the herbalist's detailed, in-depth assessment undertaken in relation to her health and personal history, which she thought would ensure that the prescription was just right for her. She was particularly encouraged by the lack of side-effects from the herbal tincture, in comparison to her experiences of conventional medicines, and she believed that this was due to the herbs being more gentle on the body because of their natural origin.

(S9.1) was also motivated by a degree of dissatisfaction with the quality of her relationship with her conventional doctors. She believed that the quality of her health care was impaired because her doctor spent too little time with her and she felt strongly that her personal opinions were not taken seriously. By contrast, she valued the time that the herbalist spent in consultation with her and felt that the herbalist seriously took her views into account. As a consequence, she came to trust her herbalist in a way that she had not been able to achieve in her relationships with conventional practitioners and, through this, her self-confidence developed.

Identification of Preliminary Themes

- Ineffectiveness of conventional health care
- Being taken seriously
- Individualisation of treatment
- The naturalness of herbal medicines

THEMATIC ANALYSIS 1:
SENTENCE ANALYSIS

SENTENCE ANALYSIS **INTERVIEW: S9.1 (pp 3-6)**	**INTERPRETIVE STATEMENT**
The following is a brief extract from an interview transcript, to provide an example of data analysis (second layer).	
He starts at the beginning ... with me. **Me, as a person.** How I am, how I look at life, how I react to things.	Looking beyond signs and symptoms
That must tell him an awful lot.	Context important to diagnosis
He goes into my lifestyle, he goes into my dietary side ... every nook and cranny ... and he will assess you **as a person**.	Looking beyond signs and symptoms to see the whole person
And then I suppose ... you know your own body. You can read your own body if you're aware of it.	Judging health subjectively
See, when I take my (herbal) medicines I know when to start gradually leaving it off.	Valuing personal evidence of recovery
Because your body make up is totally different to mine. None of us is the same.	The importance of recognising difference
So how could you give us both exactly the same medicine? You might need a bit more of that and I might not. You might not need quite as much as me.	Differences demand individualised treatment
But, to a doctor, you just need **a dose** of ... whatever.	Individualisation not achieved in conventional medicine

THEMATIC ANALYSIS 1
(Continued)

SENTENCE ANALYSIS INTERVIEW: S9.1 (pp 3-6)	INTERPRETIVE STATEMENT
I would always stop taking something if it didn't feel right … some people would carry on.	Valuing subjective evidence
If it doesn't feel right, it's damaging yourself.	Side-effects indicate harm
The way I see it, a herbalist uses something that has been grown in the ground, it's infused, it's not full of chemicals, it's not contaminated.	Herbal medicines are good because they are not contaminated by chemicals
It's grown over hundreds of years and through time and practice it's been discovered that it does such and such. It has helped people from when time began.	Time and practice provide evidence of benefits
My daughter has had things that are tablets but have natural things in them but that's not the same.	Differentiates between MH and OTC herbal products
I see herbs as being more pure, untouched. Once it goes into tablet form … to do that they've had to tamper with it. To me, natural is when it's taken from its raw state and it's used … nothing is added to it.	Naturalness defined according to being unchanged from its intended state
Because that is how it's intended to be. If it was meant to be any other way … but it's not.	Naturalness is desirable because it respects original intention
Well when I take my herbal medicine it treats what's wrong with me but it doesn't seem to affect anything else.	Herbal medicines deal with illness appropriately and selectively
When I take a drug it seems to affect every part of me. You can't feel **well**, say, on antibiotics. You can't feel **well** on steroids. You can't feel **well** on antidepressants.	Side effects occur with conventional medicines because they are indiscriminate

THEMATIC ANALYSIS 1
(Continued)

SENTENCE ANALYSIS INTERVIEW: S9.1 (pp 3-6)	**INTERPRETIVE STATEMENT**
(on herbal medicines) You don't feel high or anything... They help you.	Herbal medicines are supportive
They don't slow you down. They just take the edge of it. They don't always take it completely out of the way.	Herbal medicines maintain a level of tolerance
They're so minor that they don't disturb your everyday workings.	Herbal medicines are easily assimilated into lifestyle
You don't feel ill on them, they don't give you side effects. You don't get to feel sick, or dizzy or constipated or whatever.	Herbal medicines are free from side-effects
My belief is that that's nature's way. You help your body to adapt to a change. The herbs, they help your body.	Working with the body to adapt to illness
They don't stop the thing. They work **with** your body. The herbs work with you.	HM resolves helps the body to resolve illness
They don't make you unaware of what's going on in your body ... the drugs do.	The importance of maintaining subjective awareness of bodily function

THEMATIC ANALYSIS 2: REVISION OF PRELIMINARY THEMES

REVISION OF PRELIMINARY THEMES
INTERVIEW: S9.1

1. **Sentences organised into common clusters.** For example:

Looking beyond signs and symptoms
Recognising difference
Individualising treatment
Dealing with illness causation

Targeting the illness
Supporting the body
Working with the body
Resolving illness

2. **Preliminary themes revised in the light of sentence clusters.** For example:

'Individualisation of treatment' was revised as: 'Resolving illness by treating beyond the immediate signs and symptoms of disease'

3. **On completion of sentence analysis, themes were revised thus:**

Preliminary themes:

- Ineffectiveness of conventional medicine
- Being taken seriously
- Individualisation of treatment
- Naturalness of herbal medicines

Revised themes:

- Optimising health care through patient-practitioner collaboration
- Resolving illness by treating beyond the immediate signs and symptoms of disease
- Healing through body-herb interaction
- Time, practice and subjective experience as evidence of health care effectiveness

4. **Revised themes verified for authenticity** by searching for non-supporting statements and checking adjacent text for leading questions.

GLOSSARY

Alternative medicine	This term is used where authors imply a distinction between alternative and complementary health care
Biomedicine	See Western medicine
Complementary medicine	This term is used where authors imply a distinction between alternative and complementary health care
Complementary therapy	The term adopted in this thesis to encompass both complementary and alternative medicine. The term encompasses all health care practices that generally sit outside the National Health Service of the United Kingdom
Comprehension	Describes the intellectual capacity to understand the logic of another's reasoning
Consumer perspective	In the context of this study, the consumer perspective refers to the perspectives of research participants, who are also patients/clients of both herbalists and conventional practitioners. The consumer perspective therefore equates to the patient perspective
Conventional medicine	Used interchangeably with 'mainstream medicine' and 'orthodox medicine' to describe health care that is generally available within the National Health Service of the United Kingdom
Health care practitioner	Used generically to describe any person who practices in the delivery of health care regardless of their particular professional standing
Health care professional	Any health care practitioner who practices by virtue of a professional qualification (includes those who practice in a managerial capacity)
Herbalism	See Medical Herbalism. The terms are used interchangeably

Mainstream medicine	See: Conventional medicine
Medical herbalism	Refers to traditional, western herbalism. Where non-western (e.g. Chinese herbalism) or non-traditional (e.g. over-the-counter treatment) practice is implied, this is made explicit within the text
Orthodox medicine	See: Conventional medicine
Patient-practitioner partnership	A relationship of partnership is characterised by negotiation and prioritisation of the patient's wishes. It subsumes, but is distinguished from, patient involvement, patient participation and patient-practitioner collaboration
Understanding	'Understanding,' which subsumes 'comprehension,' is dependent on the recognition of personal significance
Western(ised)	In the context of this study, 'westernised' pertains to principles and practices that are largely influenced by the scientific paradigm. Although predominantly evident in western societies, such principles and practices can be adopted by societies in other global localities. Hence, the preferred term 'westernised'
Western herbalism	The herbal health care tradition that is indigenous to the United Kingdom, Europe and other societies in the western hemisphere. In this study, it is viewed as a distinct approach that differs from Eastern, or other types of indigenous herbalism, and it is also differentiated from treatment with over-the-counter herbal substances
Western medicine	The dominant health care system in westernised society, western medicine expresses the wider belief system of the scientific paradigm and underpins the British National Health Service. The term is used interchangeably with 'biomedicine'

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