

The body, health, and healing in alternative and integrated medicine: An ethnography of homeopathy in South London



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Abstract

During the recent exponential rise in the use of alternative medicines (AM) in the West and increasing integration into the health service, little research has been done on AM in the context in which it is practised, or over time to look at changing belief systems.

This thesis provides an anthropologically informed analysis of one alternative therapy in depth – homeopathy- explored from the multiple perspectives of biomedical and lay homeopaths, users and students of homeopathy. The ethnography comprised 18 months participant observation in 4 settings in south London: the surgery of a homeopathic GP; a homeopathy adult education class; a vaccination support group; and a low cost homeopathy clinic for victims of crime. The fieldwork is contextualised by a critique of the existing research on users of AM; a review of the history and politics of integration of AM and a review of anthropological conceptions of the body and health.

Analysis of the empirical data reveals different groups of users of homeopathy with differing beliefs around health, healing and the body. 'Pragmatic users' had a normative biomedical view of health. 'Committed users' moved away from the normative biomedical position and were enculturated into a different view of health and the body through interaction with lay homeopaths. Inherent in these practitioners' and users' beliefs and practices were a number of oppositions to science-based medicine. Prolonged fieldwork enabled the changing views of users to be charted as they moved from biomedical to alternative views.

The medical homeopath stayed allied to many biomedical beliefs about the body and health, partly as a result of general practice constraints of time, colleagues and training. Tensions between his biomedical and homeopathic practice lead to paradoxical behaviours that confused his patients. These findings problematise the notion of integration, of trying to incorporate two opposing ideologies into one system. Implications for alternative medicine more widely are discussed.

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I dedicate this thesis to the memory of my mother

Sheila Barry (1926-2001)

She always encouraged me in gaining the education she had been denied, like so many, by her gender and the era in which she lived.

Chapter 1

Prologue and Overview of Thesis

RHUS TOXICODENDRON (Rhus-t.)

Family name: Anacardiaceae

Common names: poison ivy; mercury vine; poison ash; poison vine; pubescent poison oak; trailing sumach



Chapter 1. Prologue and Overview of Thesis

The Re-surgence and Integration of Alternative Medicine

Over recent decades there has been an exponential increase in the formalisation, and availability of alternative therapies in the Western world. Whilst most of the provision of these therapies is through the private market sector, there has also been a marked rise during this period in the provision of alternative therapies through national public healthcare systems. The inclusion of alternative or complementary therapies (as they are more likely to be known in this context) within predominantly science-based medical systems has become known as integrated or integrative (in the USA) medicine. The juxtaposition of such 'natural', 'holistic' therapies to 'artificial', 'reductionist' science based medical therapies, has become a theme of much debate in relation to contemporary health care.

In Britain what has come to be known as the CAM (Complementary and Alternative Medicine)¹ or integration debates have been most vocal from within the medical establishment, albeit at the fringes. Central to the development of this debate has been the Foundation for Integrated Medicine's² campaign to increase CAM in the NHS and the House of Lord's Select Committee on Science and Technology report on Complementary and Alternative Medicine published in 2000. In a medical system currently dominated by the growth of an audit culture and discourses of 'evidence-based medicine', the integration debate has centred on the pivotal issues of the regulation of

¹ Complementary and Alternative Medicine (CAM) has become the latest way of referring to these therapies in the biomedical and political context, I will use this term when citing the work of others who use it. There are numerous debates on terminology in this field. I have chosen to refer to the orthodox, science based, western medical system as biomedicine, taking an anthropological critical stance and seeing biomedicine as a cultural system like any other system of medicine. I prefer the term alternative medicine to complementary or holistic medicine. Complementary is often used in a relational sense to biomedicine and implies that the two systems are compatible, which is not always the case in the field of homeopathy, on which I have focused here. Holistic implies an ideology that is also claimed by certain sections of the biomedical system, notably general practitioners, as is evidenced for example by the British Holistic Medical Association. The term alternative medicine highlights the alternative underlying philosophies that underpin these systems of medicine and that are often ignored in the debates about integration. It has its own problems as it implies a relationship with orthodox medicine. Also alternative medicine is rarely used in this culture as the sole system of medicine but I will use it to keep in mind the importance of alternative paradigms, theories and cosmologies when investigating these systems of medicine.

² The Foundation for Integrated Medicine (FIM) was recently renamed The Prince of Wales Foundation for Integrated Health. I will use FIM in the text as this was its name during the period of my fieldwork.

CAM professions and the production of 'evidence'. Evidence in this context is conceived of as therapeutic efficacy for biomedically diagnosed disorders, within the individual body (or body part), measurable utilising science-based research strategies, most notably the randomised controlled trial. There is little questioning of methodology within these research strategies, usually focused on the debate around constructing suitable placebo control arms.

Much of the work on alternative medicine, especially in the context of the arguments about integration into the NHS and of measuring the evidence base, has made implicit assumptions that alternative medicines (for example homeopathy³) are fixed objects that can be measured as though they were a drug, taken out of one context (for example non-medical homeopathy) and transferred into another (for example into NHS settings) without effecting any changes. This assumption reflects a biomedical orientation towards healthcare technologies (even this terminology suggests that treatments can be seen as separate from the people they treat, the people who provide them, and the settings in which they are provided). The outcome of this worldview is that alternative medicine is often conceived of as a single monumental unchanging category.

This worldview is, in part, a result of the biomedical and science-based culture that shapes western ways of seeing healing and the body. It is also further propped up and constructed through the research methodologies that are chosen by its proponents (usually situated within biomedical institutions) to investigate alternative medicine. The focus is on the Randomised Control Trial as a means to test whether alternative therapies 'work' for specific biomedical diagnosis categories; and on the survey method to measure who uses and who provides alternative therapy, which is then aggregated to epidemiological statistics at the population level.

However, taking a different perspective, therapies like homeopathy can be seen quite differently. If an anthropological and historical perspective is taken, homeopathy is seen not as an un-anchored floating abstract immovable category, but as a context-situated and processual entity that changes, chameleon-like over time and according to the wider

³ Although the technically correct spelling is "homoeopathy" I will align myself with recent trends (see e.g. (White 2000), and refer to it as "homeopathy" in this document, except when I am using proper names in which the original spelling is used.

institutional and local setting in which it is practised and the mind sets of those that practise it and use it.

This alternative worldview is similarly, in part, as a result of the anthropological culture, that allows for multiple situated perspectives, and focuses on cultural and sub-cultural influences. This worldview too is constructed through a different epistemology and supported through different methods of enquiry. Here the importance of setting an issue within a historical and political setting forms the starting point and the primary research tool, participant observation, allows for context situated versions of homeopathy to emerge.

Deconstructing homeopathy

The data on which this thesis is based come largely from 4 settings: a general practice which employs a holistic/homeopathic GP; a homeopathy class; a vaccination support group; and a low cost homeopathy clinic in a victim support centre. These four settings encompassed the use of homeopathy inside and outside the NHS and covered different interactions with homeopathy: one -to-one therapeutic sessions, educational classes, and small group interaction. Viewing homeopathy as a process rather than a category required that I seek fieldwork settings in which interaction could be observed, in addition to the ethnographic interviews that I conducted with providers and users.

Through an analysis of the anthropological and sociological literature, and through my own context -situated fieldwork I hope to deconstruct the uni-dimensional concept of 'homeopathy' talked of in the context of biomedicine and replace it with at least two of many possible 'homeopathies'.

The argument I want to make with the data from my study is that some people who use alternative medicine have a different cosmology of health, and that where alternative medicine is integrated into the biomedical system it is more difficult for the users to attain this new cosmology of health.

To set a background to this argument I want to show how most of the research on users is one off snapshot research and relies on statistics at the population level. Very little qualitative work has been done, with even less ethnographic work and almost no observation of consultations. This leads to over-essentialising of the characteristics of users and little recognition of the processes and trajectories through which these users pass. The qualitative work that has been done, has tended to cover broad groups of users of multiple alternative therapies, thus obscuring some of the important differences between the sub-cultures of different therapeutic worlds. There has been some qualitative research with practitioners of alternative medicine but this has focused on interviews. The absence of observational research on the consultation, results in over reliance in the literature, on what people say they do, as opposed to what they actually do. In the fieldwork for this thesis I have done both and hope that this provides a link in the conception between what people believe, how they come to believe it and what they do in everyday practice.

The role of my personal experience in choosing the topic

How did I come to be interested in studying this issue? I have used acupuncture on and off for nearly twenty years. I first used it during a period of prolonged exhaustion in my early 20's after a serious bout of glandular fever. My GP told me there was nothing he could do for me and someone suggested acupuncture which yielded positive results. When I was diagnosed with a serious illness 10 years later I returned to acupuncture. I also sought nutritional advice, had regular aromatherapy massage and the symptoms disappeared.

Since then I have suffered more minor health problems. More recently during a period of entrenched recurrent yeast infections, not yielding to orthodox treatment, my GP recommended I visit her homeopathically-trained nurse for advice. The GP presented the homeopathy as an additional treatment that could be pursued alongside anti-fungal drug treatment. The nurse however had a different opinion. She advised me to come off the orthodox treatment completely and use only homeopathy, telling me that the homeopathy would not work unless I did so. I found this conflicting advice of the GP

and nurse difficult to resolve. Who should I listen to? Confused by the choice I returned instead to my acupuncturist.

During this time I was working on a research project investigating doctor-patient communication in general practice. The findings of this research showed that the worst problems of doctor-patient communication were most common with patients suffering with chronic health problems (Barry, Stevenson et al. 2001). This group of patients were also the most likely to be using alternative therapies, such as acupuncture, homeopathy and aromatherapy. Why was this? I wondered.

In part they were caught up in the grassroots move to alternative therapy. This was a time during which alternative medicine was gaining an increasingly high profile in the media. The topic of integration was also becoming big in the general practice community. My own experience of 'integrated homeopathy' had left me feeling dissatisfied. The tensions between the GP and the nurse made me uncomfortable, without fully understanding why. I felt more comfortable getting any drugs and tests from my doctor, and alternative therapies from an alternative practitioner outside the health service. The experience of visiting the acupuncturist was very different from visiting the GP and I much preferred these sessions, almost looked forward to them. Why was this? These experiences set me on the path of investigating the differences between alternative medicines inside and outside the NHS.

My own embodied experiences with alternative medicine gave me some insights that did not appear to be reflected in the academic literature on integration and the users of alternative medicine. I realised that I 'knew' various things about alternative medicine through having interacted personally with it. I wanted to turn this knowledge into a more systematised and rigorous research method, but not to lose the idea that embodied knowledge, both of myself and others might be important data in this enterprise. I will talk more about this in my methods chapter below (see chapter 5).

Why Homeopathy?

Much of the literature attempts to represent a spread of different therapies in order to make generalisations about alternative medicine, even whilst stressing the differences between therapies (e.g. McGuire 1988; Sharma 1992). It seemed to me that to focus on one therapy might produce a more nuanced understanding of the issues. I did not want to select the therapy which I had used for 20 years, acupuncture, as I felt this might compromise my analytical distance. However I felt it was important to study a therapy which I was drawn to in some way. As a psychology graduate with counselling training I was very drawn to the emotional and psychotherapeutic aspects of homeopathy. Homeopathy involves a lot of talking. As a verbally articulate person it matched my temperament. Also I had just spent 3 years analysing what goes wrong in the communication in GP consultations: how patients' agendas were often silenced (Barry, Bradley et al. 2000); and the voice of medicine used to drown out the voice of the lifeworld (Barry, Stevenson et al. 2001). Among these 20 GPs there were usually marked inequalities of authority between doctor and patient and little evidence of shared-decision-making (Stevenson, Barry et al. 2000). Reports of homeopathic consultations suggested that here was a therapy that appeared to be structured differently.

Unlike many new age therapies that draw on eastern philosophy, homeopathy is actually rooted in western culture, developed by a 19th century German physician. It also has a special place in British culture, being supported by the Royal Family and the aristocracy for the last 150 years. It has been part of the NHS since its inception, with every patient having the right to be referred for homeopathic treatment at one of the 5 homeopathic hospitals. This represented a paradox during the debates about integration, of an alternative therapy that appeared to be already integrated. Yet as I have already pointed out, my own experience of integrated homeopathy was unsatisfactory, from a patient's perspective.

To provide a counterpoint to the focus on homeopathy I also conducted limited fieldwork and auto-ethnographic research on Tai Chi. This therapy by contrast, is primarily a bodily therapy with few verbal aspects. It is rooted in Taoist philosophy,

comes from China and has not been established in the NHS until the odd few recent attempts to offer Tai Chi classes to elderly patients. I have not written in this thesis about this therapy, but it helped me analytically to see the issues surrounding homeopathy more clearly.

My Experience in the Social Sciences

In addition to my health and healing experiences I think it is also worth explaining my academic trajectory or ‘intellectual archaeology’ as Ronnie Frankenberg conceptualises it (personal communication) drawing no doubt, on Foucault (1976). My prior research in the health field has been from different disciplinary angles. After my psychology degree I worked on a psychological study of stress and breast cancer. In keeping with the epistemology of health psychology this study was focused on individuals and on collecting quantitative data. We were examining the potentially causal relationship between variables: stressful life events, depression and relapse from breast cancer. The project yielded negative results (Graham, Ramirez et al. 2002), and I was left feeling that by reducing patients’ experiences to a numerical score, we had reduced our opportunity to learn very much about them. I was frustrated with the limitations of this type of data in meaningfully explaining people’s reality.

This led me away from psychology into medical sociology. On the afore-mentioned study of GP-patient communication, we used qualitative methods, which yielded richer, more satisfying results (Barry, Stevenson et al. 2001). As a sociologically informed project there was more room here for an exploration of the social factors determining behaviour, although the focus was a little limited, in the main restricted to activities within the clinic. We did not fully explore the context of people’s lifeworlds or attempts to investigate longitudinal processes. The analysis was restricted to the answering of tightly pre-determined questions. Questionnaires were semi-structured and contained a number of prior assumptions. There was little room for the participants to set the agenda of the research and put across their views from their own perspectives. I was more in tune with the sociological model of the world than the psychological but still felt something was missing. Hence my decision to shift disciplines yet again (hopefully for the last time!) and to use an anthropological ethnographic approach for this doctoral work. This would provide rich context-situated qualitative data, a longitudinal focus on

process and research that aimed to capture informants reality from their perspective, not that of the existing academic literature.

I have detailed my academic trajectory to make sense of the way I have written this thesis. Although I have aimed for a traditional anthropological, ethnographic approach, I have also alluded to the literature of psychologists and sociologists. Alternative medicine is a very cross-disciplinary area of interest and it has been useful to review and critique the bodies of literature from the different disciplines of psychology, sociology and anthropology. Having experience of all three I feel I can offer a useful insight into the strengths and weaknesses of these different knowledges. My thesis therefore contains more of a literature review component than many more traditional ethnographies, and often draws on psychology and sociology sources. However when it comes to my fieldwork and analysis I have aimed to be more anthropological. I hope this merging of two slightly different approaches offers a richer perspective, and does not confuse the reader.

Outline of this document

I will start in chapter 2 by reviewing some of the literature on the use and users of alternative therapies. In chapter 3 I discuss insights from the anthropological literature on embodiment in non-western societies, biomedicine, and alternative medicine. I want to emphasise the centrality of cultural conceptions of the body in understanding cosmologies of health and healing and to explore how biomedical and holistic conceptions of the body differ.

In chapter 4 I focus on situating my research within its historical and geographical context. I will start by reviewing the literature on the integration of alternative medicine into the mainstream health system. I want to set the scene by detailing the recent history of this trend. The concepts around the topic of integration, which are the most important for this study, are the issues of power, politics and professionalisation and I will discuss the recent medical sociological literature on these.

In the second half of this chapter, I move on to homeopathy, and a bit further back in time. I provide a brief description of the homeopathic system of medicine and the history of its arrival and growth in this country, in two settings: within the medical system and in the lay community.

In Chapter 5 I outline my epistemological position and the consequences of this in terms of methodology. I sketch out the path taken through my fieldwork and discuss two associated ethical issues. I then discuss the embodied participation of the anthropologist, and the associated changes in my own identity through the fieldwork process.

My data chapters start with Chapter 6 where the focus is on the group of people in my research who had become committed users of homeopathy. I look at the different cosmology of health that they have come to hold, moving away from the normative biomedical position. To illustrate this cosmology I outline 3 case studies of committed users in Chapter 7. In Chapter 8 I use data from three of my fieldwork settings to show the processes of education and negotiation towards this belief system. This transformation is achieved through multiple interactions over time: in consultations; with each other, with female friends and family members; and through publications and lectures organised by sympathetic organisations. In Chapter 9 I focus on the NHS fieldwork setting and look at homeopathy in a general practice. Here I review the beliefs and practices of a holistic biomedically trained GP and investigate what happens when both pragmatic and committed homeopathy users consult him.

Finally in Chapter 10 I will draw out the conclusions and implications of the study and make recommendations for further research.

Chapter 2

Alternative medicine in Western societies - A critique of research on users

SARSAPARILLA (Sars.)

Family name: Liliaceae

Other names: wild liquorice; shot bush; small
spikeard; rabbit root



Chapter 2. Alternative medicine in Western societies - A critique of research on users

In this chapter I review and critique the research on use and users of alternative medicine in the West. I want to demonstrate that much of the existing body of research has produced useful but relatively limited insights as a result of reliance on quantitative methods or on qualitative studies that preclude observation of practices. I hope to make the case for the need for ethnographic research as a means to fill some of the existing gaps in the research on alternative medicine use.

The resurgence in popularity of alternative healing systems since the 1970's has been meteoric in the west. Their rise has not only been as an alternative to biomedicine but also as an integrated part of the biomedical system leading to what has been called "A New Medical Pluralism" (Cant and Sharma 1999). As Ernst suggests 'most experts agree that the interest in and practice of CAM are driven by consumer pressure' (Ernst 2000). Reasons for this rise will be explored in chapter 4. In this chapter I want to look at who these users are and the research on their beliefs.

Surveys of alternative medicine use

Much of the research effort in this area has attempted to pin down how many and what type of people use alternative therapies (Eisenberg, Kessler et al. 1993; Eisenberg, Davis et al. 1998; Astin 2000; Tuffs 2002; Ernst and White 2000; Thomas, Nicholl et al. 2001). This literature is dogged by three key problems. The first is the fast changing position of alternative therapy, with exponential increases in usage over the past couple of decades, making hard usage figures very quickly out of date. The second problem is one of differences in definitions of use (for example 'in the past year', 'in the past month' or 'ever'; visits to a practitioner, versus self-care etc.) and different definitions of alternative medicine. The third problem is the differences in sampling, with many studies conducted in small regional areas and not generalisable to the wider national picture.

Wootton and Sparber have conducted a recent review of the literature on trends and demographic groups in the USA (Wootton and Sparber 2001). They highlight that percentages using alternative medicine vary widely between surveys for the above stated reasons e.g. 8%⁴ if only including those who have consulted provider services in the last year (Druss and Rosenheck 1999) and 42% who have used any form of alternative including self care (Eisenberg, Davis et al. 1998). Wootton and Sparber suggest that the most consistent finding of the studies, is the predominance of women as users and of those from higher-income brackets, mostly of middle-age, with higher education levels. They suggest however, that children and the elderly are also significant users. There is evidence in the USA of a bi-modal distribution related to its high proportion of ethnic minority populations. Higher income groups use disposable income to pay for alternative products and services, in addition to conventional health care, and lower income groups self-medicate and use folk healers as a replacement for conventional care.

Another recent systematic review, by Ernst, of prevalence figures from around the globe, estimated usage at between 9% and 65% (Ernst 2000). Ernst concludes that there are considerable uncertainties about the true prevalence. The only UK survey in his review, conducted by Vickers in 1994, suggested a one year prevalence of 9%, although Ernst believes this was a low estimate (Vickers 1994). Ernst's own more recent survey put the figure for use in the UK in the last year at 20% (Ernst and White 2000). In line with other studies, the figure for women was higher at 24% than for men at 17%. The highest prevalence was among 35-64 year olds (26%) and there was higher use among social classes AB (25%) than DE (16%). The most common therapies used were herbal medicine (34%) aromatherapy (21%) and homeopathy (17%).

Another recent UK study found that 28% of the population had used one of the 8 main therapies and/or self care remedies purchased over the counter (Thomas, Nicholl et al. 2001). 11% had visited a therapist providing any one of the more established 6 therapies in the past year. This accounted for £450 million and 22 million visits, of which 10% were within the NHS. Only 1% in this study claimed to have visited a homeopath in the past 12 months and 6% in their lives, however 9% had used an over the counter

⁴ Percentages have been rounded to the nearest whole figure for readability (and because the limitations

homeopathic remedy in the past year and 15% in their lives. The split between men and women visiting a practitioner was the same proportion as that of Ernst's study; 30% more women than men consulted alternative practitioners. A much higher proportion of women purchased over the counter homeopathic remedies: 60% more women than men, but women, as primary providers of healthcare in the family, were probably buying for men as well as themselves. The gender split with two-thirds of users being female is almost identical to that of general practice patients as described in the General Household Survey 1986. The ethnicity of complementary medicine users is rarely reported, but the suggestion is made by Kelner and Wellman that ethnic minorities are under-represented amongst users (Kelner and Wellman 1997).

Usage for children was considered in a recent survey in an affluent area in the south of England, (Bath). This showed that 14-18% had used alternative therapies at least once for their children and just over a third of these had consulted a practitioner (Simpson and Roman 2000).

I have extrapolated from the most recent UK studies that measured homeopathy use, Ernst (2000) and Thomas (2001), to provide a context for my own work which focuses on homeopathy. Between 3% and 9% of the UK population (a higher percentage for the female population who make up most of my sample, say between 5% and 12%) used homeopathy during 1998/9, a year before my own fieldwork began.

These studies provide useful estimates of the rise in usage of alternative medicine. However they cannot answer questions about why people are using, or the patterns of use of alternative medicine and orthodox medicine. The data tells us that very few people abandon orthodox medicine totally. Most studies show that the majority of users of alternative healthcare continue to use the biomedical system, albeit often reducing their use to reliance on diagnostics and tests, surgery and emergency medicine. For example Kelner & Wellman showed 82% of Toronto users of alternative medicine still consulted their primary care physicians and 88% of them were happy with the care they got from them (Kelner and Wellman 1997). Eisenberg and his colleagues show similar behaviour in the USA (Eisenberg, Kessler, et al. 2001), and Thomas et al (1991) in the

on sampling of the original research probably do not justify the use of such precise figures).

UK. Hence the move has been towards medical pluralism rather than a total shift to a different system of medicine.

Eisenberg's survey showed that a substantial proportion of CAM users do not inform their doctors of their use of alternative medicine in the USA (Eisenberg, Davis et al, 1998). They found that 60% of users had not told their doctors. A recent paper in the UK detailed a case study of a general practice patient who did not inform her doctor of her homeopathy use, which led to considerable confusion and misunderstanding in the consultation (Barry, Bradley et al. 2000).

To answer questions as to why people use alternative medicine and to explore the patterns of their use we need to turn to attitude surveys and qualitative data.

Why do people initially turn to alternative therapies?

After taking into account demographics, the most common finding in the literature for initial use of alternative medicines, is the experience of a chronic (not life threatening) illness that orthodox medicine has been unsuccessful in treating (Cant and Sharma 1999; Furnham and Vincent 2000). It has often been seen as 'a last hope' for patients like these.

The point has often been made in the literature that most people 'shop for health' and are not loyal to particular forms of medicine, being happy to operate a pragmatic form of medical pluralism (Sharma 1992; Vincent and Furnham 1997).

In addition to the illness experience there have also been found to be other associated beliefs and experiences that lead people to use alternative therapies. These include dissatisfaction with conventional healthcare, wanting to avoid the side effects associated with orthodox drugs; and desire for control (Vincent and Furnham 1997; Astin 2000).

Conversely it is interesting to look at those who are less likely to use alternative medicines. A recent study in America surveyed a middle-aged, highly educated university recruited sample (Jain and Astin 2001). Jain and Astin found that the 51%

who had not used alternatives in the last year were more likely to be male, healthier, have physicians who did not support CAM and to hold beliefs that CAM treatments are ineffective or inferior. Income was not found to be an explanatory factor. To illuminate these findings we need to explore the reasoning of users of alternatives in more detail.

Attitude surveys on beliefs held by alternative medicines users

Psychologist Adrian Furnham has conducted a number of studies of users of alternative medicine, most commonly users of homeopathy. In a chapter summarising his programme of work, Furnham concluded that homeopathic patients are different from those who exclusively using GPs in orthodox medicine in four main ways. They are more sceptical and dissatisfied with orthodox medical practice; they are more interested in health issues; they have a different medical career with associated psychological disturbance; and they espouse consistently, but at a fairly rudimentary level, some of the basic tenets of homeopathy (Furnham 1998). This body of work suggests that users of homeopathy may be different therefore from the average patient of general practice.

However most of Furnham's studies have been quantitative, asking people who visit alternative therapists to rate attitude statements. This type of study can lead to misleading results, and give limited information in constructing a picture of the use of therapies. Indeed, Furnham's recent critique of his own work unearths assumptions embedded in his earlier work (Furnham and Smith 1988; Vincent and Furnham 1997). For example he reports having made the mistaken assumption that the people completing his questionnaires would "not only have heard about [alternative therapies such as homeopathy] but have a reasonable understanding of how they operate and what they are supposed to cure" (Furnham 1999: 475). However his later open ended questionnaire study revealed these assumptions to be incorrect. Only a small proportion of his random adult sample (less than 5%) could explain how homeopathy worked, even though 30% claimed to have had homeopathic treatment (Furnham 1999: 475). Most of the sample thought homeopathy was a herbal, natural treatment. (Neither of these facts is untrue of homeopathy, but Furnham senses that the people in his surveys knew so little about homeopathy -not even knowing of the central tenet that 'like is used to cure like'- that their attitudinal ratings of the therapy could be considered meaningless).

Furnham notes in his most recent paper that nearly all the previous research in this area has used structured interviews and questionnaires, the dangers of which are that they “tended to indicate that parents [sic] had coherent and consistent beliefs about alternative medicine in general.” (Furnham 2002: 44).

The methodologies Furnham has used more recently to supplement his attitude surveys: a 4-question open-ended questionnaire, and a focus group study have added more information (Furnham 1999; Furnham 2002). Unfortunately, Furnham’s account of the results of his focus group project combines the responses of users and non-users, rendering the study less useful than it might have been. He does not attempt to differentiate in any systematic way between their beliefs. In the discussion he hints at interesting differences, explaining that “the attitudes of non users mainly followed those of prevailing culture in our society”. Unfortunately he does not go on to detail the attitudes of the users. He does hint at an interesting gender difference, which is not fully explored in the paper, that the women were interested in gaining more information about complementary medicine, whereas the men put more emphasis on the need for on it to be subjected to scientific testing. However, this work still does not provide an understanding of the users of alternative therapy contextualised within their own settings and lives.

Another recent paper, suggests that Furnham's research has been coloured by a biomedical view of homeopathy. He reports that the general population “remain surprisingly ignorant about homeopathy” and are “rather unclear about the major principle by which it works, as well as the medical conditions for which it is best suited” (Furnham 1999: 475-477). This suggests a partial view of homeopathy. Medical homeopaths may claim that homeopathy is suited to certain categories of biomedical diagnosis (See e.g. Downey 1997). Lay homeopaths would be more likely to adhere to the originating principles of homeopathy, as a complete medical system which treats the total symptom picture of the individual rather than any particular biomedical disease. This makes his question about biomedical categories an inappropriate one for the non-medicalised version of the therapy. There is no reference in any of his work to the possibility that the homeopathy being offered within and outside the NHS might be two very different types of therapy, a position that I argue in this thesis.

One of Furnham's comments: "it is interesting that they did not see it as appropriate for purely psychological problems" (Furnham 1999:476) also reflects a possible biomedical stance. This comment suggests Furnham may be close in his own beliefs about homeopathy, to a view that has been voiced by some biomedical doctors, that the effects of homeopathy are akin to placebo and 'all in the mind' (see e.g. Wanjek 2002). However it may just reflect his own interest as a psychologist in the treatment of psychological disorders.

Furnham's focus on the mechanism of action also suggests a viewpoint influenced by science-based medical thinking. His exact question in the study was "Can you describe how you think homeopathy works?". Amongst lay homeopaths certainly, homeopathy, as we will come to see in the next chapter, is not a rational system of medicine where the mode of action is focused on (by its founder or its non-medical practitioners). It is an empirical system of medicine where it is the results that count, and not the black-box of therapeutic action. In any case, if the study had incorporated a similar question for a well-known biomedical treatment, say for example: "Can you describe how you think insulin works?" Furnham might have found similar levels of ignorance.

These points indicate that Furnham is focusing on studying the biomedical level of understanding of the patient. The main references he cites are those of biomedical doctors: Edzard Ernst and Peter Fisher. His model of the patient bears all the hallmarks of the *expert* communicating, in one direction, information to the *empty vessel* of the patient (Kirmayer 1988). The patient's non-compliance (not taking medicines, doctors orders etc.) is seen as a deficit of knowledge, or ignorance (Donovan, Blake & Fleming 1989; Donovan & Blake 1992).

Both Furnham's implicit stance and his own stated conclusions illustrate the problems of research based on prior assumptions about people's beliefs and practices. In people-centred research, such as that undertaken in an ethnographic frame of reference the concept of 'ignorance' would not be used in this way. It would be replaced by the concept of different bodies of knowledge. What such a type of research might find (as will be argued in this thesis) is that the mode of action of homeopathy is very unimportant to even the most knowledgeable of users and practitioners. Indeed the most common answer to Furnham's study's question "What does the word homeopathy mean

to you?” was ‘a natural or herbal medicine’. This appears to fit with how people talk about homeopathy in daily life, and is congruent from that point of view, with it being a common lay perspective, (Blaxter 1983) or particular explanatory model (Kleinman 1980), rather than being seen more negatively as ‘ignorance’ of particular kinds of formal knowledge of homeopathy.

The primary reliance of psychologists such as Furnham and others (see also Searle 2000) on quantitative measures of the individual’s beliefs and behaviours, has a number of additional implications for their findings.

Firstly they consider users of homeopathy as one undifferentiated category. Searle and Murphy’s recent study recruited first time visitors to a homeopath and then made generalisations for this group to all homeopathic patients in general (Searle and Murphy 2000). This does not allow for different sub groups of user, or of changes in beliefs over time with increasing exposure to a different system of medicine.

Secondly such researchers tend to see the individual as a self-contained unit from within which behaviour can be explained. Others, such as anthropologists, would tend to see behaviour as only explainable in interaction with others in specific contexts. Neither Furnham nor Searle and Murphy, for example, made attempts to measure the beliefs of homeopaths or to describe the different contexts in which users were situated and healthcare was administered.

Thirdly, this type of research falls into the trap of measuring behaviour (in this instance adherence) through self-report. One of the underlying justificatory principles of ethnography is that people do not always behave in the ways they report at interview. This is partly because much behaviour is implicit (Polanyi 1958) or contradictory and inconsistent. The rational account required in research interviews may lead to ‘post rationalisation’ of behaviour. In two previous projects I have discovered that often the most potent explanatory power of people’s behaviour lies in the difference between what they *say* they do, and what they *actually* do (Barry 1995; Barry 2002). The best way to unearth this difference is to supplement interview data with direct, and preferably long term observation.

Fourthly the practice of correlating variables cannot tell us anything about the direction of causation or the process through which people come to hold particular beliefs or behave in particular ways. So to remedy some of these problems it is important to turn to the insights gained from more qualitative approaches.

Qualitative approaches to understanding alternative medicine users

Ursula Sharma was one of the first to undertake qualitative research with users of alternative medicine in the late 1980's (Sharma 1992). Her research offers rich interview data on how people got into alternatives, and their concurrent use of orthodox medical services. Her work is much cited as offering considerable insight on these issues. Indeed, there have been very few attempts to reproduce or update her work using qualitative methodology. In this ambitious 1992 book Sharma covers many issues, investigating the perspectives of both patients and practitioners. However for the purposes of this review I will focus on her work with patients.

Sharma categorised her participants into three groups: Earnest seekers, stable users, and eclectic users, with a possible further category of transient one-off trialists, who would not have been picked up by her sampling methods. Earnest seekers were those desperately casting about for a remedy for a particular illness. Stable users had had a favourable initial experience of non-orthodox medicine and a fairly regular relationship with a particular practitioner, in whom they had great confidence, or regular use of a system in which they had faith. Eclectic users had decided, after an initial experience of non-orthodox medicine, that it was a good thing and tended to 'shop around' for what they felt was the best form of treatment (Sharma 1992). Sharma was one of the first to disaggregate the users of alternative therapies and suggest there may be differences between sub groups of such users.

She discovered a key theme in people's use of alternative therapies was that of increased control and responsibility, through a particular kind of relationship, offering a powerful communication of this point from one of her participants:

When I saw her I thought she is of my intelligence, she treats me as an equal.... I have always wanted the kind of honesty she offers. (Sharma 1992:51).

A recent review confirms that patients are attracted to CAM therapists because they are more empathic, collaborative and personal (Kelner 2000).

Sharma properly reminds us that relationships between therapist and patient cannot be taken out of context. She proposes that this relationship is formed both by ideological concerns, about what the relationship ought *ideally* to be like, and shaped by the institutional context within which the practitioner is *actually* obliged to work (Sharma 1994: 83). Sharma explains how, in a holistic ideology of treating each patient as an individual, the patient comes to hold more power. The therapist needs more information from the user than in the average biomedical encounter in order to be able to conduct an individualised treatment. As such, the patient is constructed as more of an expert. She opposes this view to the general practice ideology of the clinical autonomy of the doctor, which invests expertise with the GP alone.

In terms of institutional context, the complementary therapist does not act as a gatekeeper to further services, and so again the equation of responsibility is shifted in favour of the patient. Braathen also makes a related point about the absence of a social control role in private therapy. She reminds us that “as the complementary practitioner usually operates quite independently of the state’s interest in the bodies and health of its citizens, there is always the potential for a very radical difference. Most complementary practice does not (at present) participate in the panoptical surveillance of citizens envisaged by Foucault.” (Braathen 1996).

The holistic ideology of alternative medicine, also encourages patients to take responsibility for their own health and Sharma suggests this may mean a more directive role for the therapist, at least in the short term, even if the long-term goal is empowerment of the patient. She concludes that this is a difficult question to answer “without a careful investigation of what complementary therapists actually do ... and this is something which is not particularly well documented as yet” (Sharma 1994: 90).

Sharma found that the main route to finding a practitioner was through other people, mainly friends, and that in some cases, family expertise was important. She also found that most users had used more than one type of alternative medicine and could see themselves doing so in the future. However she indicated that homeopathy users appeared to be more stable converts to their particular chosen therapy.

Sharma claims that the users she interviewed were very pragmatic about their use of alternative and orthodox systems. They were happy to use both, in a kind of pragmatic eclecticism, out of desperation, because nothing that biomedicine had to offer had worked for them. Their use of alternatives did not imply a rejection of orthodox medicine and it was no problem for them to use both systems without any apparent conflict.

Possibly lay convictions about causes of health and illness are relatively unstructured, and patients are prepared to try anything that seems to work, or has worked for people they know. Another possibility is that people do hold stable beliefs about health and illness but that these ideas are compatible with both orthodox and non-orthodox systems of treatment. (Sharma 1992: 124)

Whilst Sharma's work has made a key contribution in opening up the alternative medicine research field to qualitative approaches, and in focusing on the views of users, a number of features of her work may limit its generalisability. It was actually a relatively modest study, and it was conducted over 25 years ago and thus may not represent all types of user or current patterns of use. It would appear to be important for contemporary qualitative studies to be conducted to examine whether her hypotheses still hold.

One of the main features of her sample, which needs to be taken into account, is the fact that it mostly consisted of married women between 40 and 60 living in the English Midlands. When she concluded that these women were not responding in culture-bound ways, that may have been a factor of their age and situation. Only 4 of the people Sharma interviewed had a long-standing and consistent interest in 'alternative' lifestyles or politics, suggesting a fairly conservative set of respondents. As will become clear later in the thesis, the predominantly younger women in my own sample exhibited

vastly different attitudes and could not be said to be pragmatic and eclectic in the same laissez-faire way that Sharma describes. Also, quite a number of the participants in my study did exhibit interest in alternative ways of life, being for example involved in Buddhist groups, meditation circles, yoga and green politics. Sharma's study does not focus on broader cultural movements, of which alternative medicine has been seen to be a part, such as the new social movements, the new age movement and the new religious movements⁵. Her middle-aged married women in the Midlands were probably not part of such cultural movements, and thus this is an understandable position. However as other (sub) groups of users may take a different view it is important to study them and explore this aspect.

Talking about her sample of users Sharma proposes "that patients are best seen as essentially pragmatic and rational actors, making choices in the light of the costs and benefits which are held to accrue from the use of particular medical or ritual options" (Sharma 1992: 30). Sharma may have overstated the rational aspect of the choices of her participants, through reliance on interview data, in which people are likely to reconstruct the past to fit a tidy, rational narrative. As mentioned above, some aspects of people's beliefs and practices are only known by them tacitly. In an interview they are asked to construct an account that is, in part, a "fiction produced for an audience" (Hollway and Jefferson 1997).

Sharma represented a spread of different alternative therapies in her study: homeopathy, acupuncture, naturopathy, herbalism, chiropractic, and osteopathy. This provides some useful generalisations about alternative medicine users, but makes it difficult to determine any differences in cosmologies of healing that were specific to specific therapies. She does allude to the fact that homeopathy generally seemed to be the system of non-orthodox medicine that was most likely to attract the stable convert, thus suggesting that such differences between users of different therapies might exist

⁵ Alternative medicine is very implicated in the New Age movement, (English-Lueck 1990; Burrows 1993; Riches 2000). Although the converse does not necessarily hold, in that alternative medical beliefs and practices can exist separately from new age beliefs and ideas. The alternative health movement can also be seen as a kind of new religion, (Wilson 1973; Barker 1989; Heelas 1996).

The spiritual component in alternative medicine has received much attention (Berliner and Salmon 1980; Finkler 1980; Glik 2000; Fulder 2001). Alternative medicine has also been conceptualised as a good exemplar of a new social movement (Melucci 1989; Schneirov and Geczik 1996; Schneirov and Geczik 1998; Schneirov and Geczik 2002).

(Sharma 1992:49). However since Sharma's research there has been very little research on what attracts people to particular therapies, as a recent article concludes (Sirois and Glick 2002).

It is interesting that when talking about the therapists that Sharma interviewed, she discusses their enthusiasms and ideologies of healing, but does not seem to find the same in her users. This could have been a feature of the era in which the research was conducted. She does however hint that "Patients may start out using non-orthodox treatment holding health beliefs which are no different from non users, but their very exposure to the ideas of their therapists may effect such a change over time" (p87). She raises the question:

Is the encounter between practitioner and patient used as an opportunity to socialise the patient into new ways of interpreting what happens to his/her body, or do practitioners treat their special knowledge as a source of dominance, a resource they are not prepared to share?! (Sharma 1992: 124).

It was this question among others, that my study was designed to address.

In a more recent book Sharma was able to combine the findings of this earlier study with more recent fieldwork conducted by Sarah Cant (20 interviews with homeopathy users from her unpublished doctoral research which was in progress at the time). This well structured and intelligently argued book "A New Medical Pluralism" raised a number of interesting lines of enquiry into alternative medicines⁶ (Cant and Sharma 1999).

Whilst the authors did cover the users' perspective in this book it was one among a number of topics. The main aim of the book was to give a sociological account of the resurgence of alternative medicine. Through investigating the perspectives of 4 key players: users, therapists, doctors and the state, to see whether the type of pluralism they contribute to, is different to that found in the modern and pre-modern world⁷.

⁶ Cant and Sharma prefer the plural nomenclature 'medicines' to stress the wide variety between the estimated 160 types of alternative therapy on offer in contemporary Britain (Cant and Sharma 1999).

⁷ Focusing on a temporal comparison, between the rise of alternatives in the West and different kinds of pluralism in the historical past (e.g. the more traditional co-existence of traditional and state supported medicine in non western geographical regions), precludes a focus on the contemporary phenomenon of modern versions of alternative medicines being used in other parts of the world. See for example my

Cant and Sharma's book offers the advantage of a more complete overview. However, they are primarily interested in the role of users and therapists as contributors to the political picture of change at the state and national level in alternative medicine use and legitimation.

This book offers a number of insights into the users of alternative medicines. For example, the fact that people were more likely to be dissatisfied with specific biomedical treatments, and seldom with the total system of biomedicine (although wider concerns about science were expressed and a growing disillusionment with the concept of the expert). A second insight was the difference between users being happy to discuss their use of biomedical treatments with their lay homeopaths, but not their use of homeopathic treatments with their GPs. A further insight was the tendency of users to see their homeopathic practitioners as friends and confidantes with the attendant occasional problem of developing over-dependence on the homeopath. They illustrate the strategies homeopaths use to reduce this problem, e.g. having separate phone lines for patients that could be answered only at set times of the day.

Cant and Sharma critique other research on users, firstly for relying on retrospective construction of decision-making which then has to fit the person's illness narrative. Secondly they problematise focusing overly on the first decision to consult alternative therapists, at the expense of a more processual view of the chain of events. In this respect they make two key suggestions for further research. The first is the importance of conducting therapy specific research:

Therapy specific analysis is essential, as is work that follows patients through their experiences of alternative medicine and acknowledges their attempts to use the consultation as a means of making sense of their own illness and identity (Cant and Sharma 1999:47).

The second is the need to take a processual view. Their research hinted at a number of longitudinal processes that need further attention. The fact that much research focuses

colleague Glyn Adams' work on the rise of new age therapies in contemporary Japan (unpublished doctoral work in progress), or Elizabeth Hsu's work on the rise in popularity of modern forms of acupuncture in Africa (Hsu 2002).

on reasons for initially using alternative therapies as though they represented once and for all decisions, ignores the fact that patients are changed through their experience with different forms of medicine. This in turn may lead them to make different decisions at different stages of their dealings with alternative medicine. This is a process that may continue to change over a lifetime.

Patients may undergo trajectories of experience that enable them in time to use various services selectively....What is certain is that the patterns of use are not static but change over time as consumers become more acquainted with the skills of the alternative medical practitioners and consequently we must understand the use of this sector as processual (Cant and Sharma 1999:35&37).

Cant's informants revealed in their interviews with her, that they had become much more aware of their bodies through engaging with alternative practitioners and practices. However she was unable to distinguish whether their motivations to use alternative therapy stemmed from changes to attitudes held about the body, or whether these changes were in themselves a consequence of using the therapy.

We may need to comprehend the rise of the plural use of medical services as a process and introduce the idea of a trajectory into our analysis, recognising that experiences will vary from user to user (Cant and Sharma 1999:47).

There is some evidence from one study in the NHS that changes towards more holistic health beliefs were a *result* of using alternative therapies and not a precursor (Luff and Thomas 2000). My study was designed to incorporate both of Cant and Sharma's suggested methodological approaches. Some of these issues of process have also been explored by other anthropologists.

Ethnographic studies of alternative medicine users

There are many useful anthropological analyses of contemporary medical pluralism and current use of non-biomedical medicines in other parts of the world. See for example the work of (Hsu 2000, 2002; Scheid 2001, 2002; Whiteford 1999) and appendix A for my own review (Barry 2002). However there has not been a great deal of ethnographic work by anthropologists on alternative medicine use in the west. However, Baer, McGuire,

O'Connor, English-Lueck and Johannessen have all have produced useful texts from this standpoint (McGuire 1988; English-Lueck 1990; Johannessen, Olesen et al. 1995; O'Connor 1995; Baer 2001).

Meredith McGuire's work is one of the more systematic studies. She researched alternative medicine in the USA using ethnographic methods (McGuire 1988). The power of the technique is shown through the insights in her book and later papers (McGuire 1990, 1995). Her focus is wider than that for example, of the psychologists I have cited. She aims to look wider than the question 'why are people using it?' to ask 'what does it say about society and of what larger social phenomenon is it a part?'

McGuire concludes from her study that these therapies represent a different definition of medical reality, with an alternative aetiology of illness and different theories of health and healing power. She also exhorts us to deconstruct our biomedically constructed notions of efficacy, to broaden this concept of 'what works' out from bodily changes into wider changes in people's belief systems, their meaning systems and their moral order.

McGuire found that there were differences between the groups she studied as well as broad similarities. One similarity was the concept of healing power as being accessible to anyone. Among her informants healing is not seen as coming from experts but as an endogenous transformation in the person. This is accomplished by the healer and participant working together to understand the illness and its causes, and to negotiate an interpretation of illness that gives meaning. Efficacy of healing for these groups, as was mentioned above, involves restoring a sense of order and meaning. Her respondents spoke for example of:

...experiences of renewal, new directions, renewed close ties with loved ones, fresh visions or hopes for the future, purification and insight...and perceiving how their lives and suffering were linked with something larger, interpreted variously as God, cosmic energy etc. (McGuire 1988: 243).

none of which usually would be perceived of as falling within the realm of biomedical efficacy.

An example of the differences between users of different therapies was the response towards doctors. The Christian healing groups were much more respectful of the authoritative approach of medicine, and saw doctors as being guided by God. The other groups respected doctors' advice but were much more critical. They appeared to be moving towards a position of taking over the authority of doctors, seeing themselves as becoming "contractors of their own health care" (McGuire 1988: 198).

McGuire's ethnographic approach enabled her to see the importance of the extensive use of ritual and symbolism in healing practices. She demonstrates how the healing rituals were mostly individual-oriented emphasising individual choice and transformation, unlike much comparative ritual in anthropological literature about non-western healing practices, reflecting differences in the organisation of western society. However the type of individualism produced and maintained by the rituals was very different to the industrial capitalist notion of the individual, being much more a self that experiences a powerful connectedness with others as well as the natural environment (or indeed the whole cosmos) (McGuire 1988: 254).

In a later paper McGuire stresses the importance in the healing process of changed experiences and notions of the body (McGuire 1995). For example in the eastern and metaphysical religious modes of healing, the immanent healing power is seen as tapped by individuals from within themselves. So healing is based on increased self-awareness, enhancing natural healing, and removing internal blockages to natural energy. This implies a different role for the body in such a system of medicine, as secondary to the self (as does the downplaying of the body in healing). All her alternative groups described healing as transformation, a gradual process of development towards a desired self, with the body merely as part of the context of this transformation of self.

Through this analysis McGuire shows the importance of focusing on the uses of symbols and rituals through which people transform themselves, to investigate how everyday body practices produce change for example at the emotional level. She gives the example of daily food preparation rituals as providing spiritual, emotional and body nourishment.

This focus on the body provides a tool to investigate the degree of medicalisation of different alternative therapies. As McGuire points out, many therapies may inadvertently reproduce elements of the non-holistic notion that a sick body can be treated independently of the sick person's self and lifeworld.

Whilst McGuire's work offers useful insights, it has limitations in terms of its applicability to all alternative therapies because it focuses on more spiritual and esoteric practices such as occult healing, metaphysical groups, religious spiritual healing and meditation. Also because she did ethnography with such a wide spectrum of therapies and settings. Her work is stronger on breadth than depth of insight into a particular therapeutic modality. A possible successor to this sort of study is ethnographic work that focuses on one therapy in more detail such as I have tried to do with my work. Also McGuire's study was conducted in the USA so it is also important for some UK based ethnographic work on alternative medicine.

Lack of qualitative research on integrated alternative medicine

The majority of research on users of alternative medicine has been conducted with patients visiting private non-biomedical practitioners. There is a growing body of literature on the integration of alternative medicine into biomedicine, however most of this has been through analysing the historical development of this trend and the changing positions of therapy organisations vis-à-vis the biomedical system and the state. This work will be reviewed in Chapter 4. However there is a gap in the literature. Most research on the use of alternative medicine in the biomedical system in the UK is quantitative, comprising surveys or case studies of individual general practice projects (see e.g. Luff and Thomas 1999; Christie and Ward 1996; Treuherz 1999). The few qualitative studies have focused on practitioners (see e.g. Adams 2001; Anderson 1999; Dew 2000; Shuval 1999; May and Sirur 1998. This work is also reviewed in chapter 4). There are very few in-depth qualitative studies that incorporate research with the users of such services. Charlotte Paterson's recent thesis on acupuncture in primary care is one (Paterson 2002). I will refer to her findings in the next chapter. As yet there are no ethnographic studies of biomedical alternative medicine that I know of. This is a gap that I hope to address with my current study.

Studies of homeopathic consultations

One of the main critiques of much of the research into alternative medicine is the failure to investigate practice through observation. Just as there is little work on alternative consultations in biomedical settings, there is little observation work focusing on consultations in alternative medicine outside the biomedical system. Some of the anthropological work of this nature will be reviewed in the next chapter (See e.g. Johannessen 1996).

A body of work relevant to this study of interaction is the use of conversation analysis and discourse analysis to study interaction in medical settings (see e.g. Mishler 1984; Silverman 1987; Drew and Heritage 1993; Atkinson 1995).

Very little of this strand of work has looked at consultations in alternative medicine. Two exceptions are two current projects in progress. The first is being conducted in Finland and has yet to be reported (Johanna Ruusuvuori, personal communication). The second is a project using this methodology to look at homeopathic consultations with lay practitioners: the Department of Health funded PAPAYA project on communication in healthcare (Watt, Entwistle et al. 2002). Whilst this work in progress has not been fully analysed and published, an early paper on methodology proposes the importance of conversation analysis as a method for studying interactions between alternative therapists and their patients.

For the study of communication in homeopathy, consideration of a patient's commitment to the healing process, in conjunction with the supporting role of the practitioner, would seem to be particularly relevant, because of the degree to which the discipline regards the stimulation of the patient's own healing abilities as central to the therapeutic process. (Chatwin and Collins 2002:24).

Chatwin and Collins' interim analysis supports Sharma's earlier finding that the homeopathic consultation represents a more equal balance of power between homeopath and patient than is normally found in medical consultations (Sharma 1994). In an example of a consultation used in Chatwin's paper, the homeopath shows a greater

willingness to incorporate the patient's lay medical reasoning process than is usual of doctors in general practice consultations. The authors suggest that this interaction “helps reinforce the patient’s perception of herself not simply as a reporter of symptoms, but as someone who can take an active role in solving the ‘puzzle’ of her condition” (Chatwin and Collins 2002:25). Another example of a more equal balance of power is that during the process of choosing a remedy, the homeopath invites confirmation from the patient and involves her in the deductive process. Chatwin and Collins interpret the feel of this consultation as a discussion between two people, not the more usual biomedical question and answer format, and they feel that this is also an important distinction.

Non verbal aspects of the consultation are also analysed. The use of overlapping speech is used to show how the two participants are both closely in tune and anticipating what the other will say. The phenomenon of shared laughter shows that unlike in allopathic consultations where patients’ attempts at humour are attenuated, in the homeopathic consultations homeopaths are more comfortable with humour and this free expression of mutual laughter is another factor leading to more equality in the interaction (Chatwin and Collins 2002).

In making suggestions for future research, Chatwin and Collins suggest that:

Methodologies such as Conversation Analysis could be used, in conjunction with other, more subjective approaches, to map relatively esoteric or nebulous processes, such as the mechanisms involved in the generation of empathy, or the patient’s assimilation of homeopathic knowledge. (Chatwin and Collins 2002:26).

Although this paper was published after I conducted my analysis, the two particular issues that are mentioned, happen to be two areas that I have focused on in my analysis of homeopathic interactions (see chapter 8).

The way forward for research

The preceding critique and review of existing work on the use and users of alternative medicine reveals a number of possible ways forward for research, including the following.

1. Therapy specific research that investigates why people are attracted to a specific therapy and how their relationship with that therapy develops.
2. Focus on individual case study data to investigate possible individual differences.
3. The need for open-ended, people-centred research, to avoid implicit assumptions of the researcher and to allow lay definitions emerge.
4. Attention to longitudinal aspects, to explore whether changed views about the body and illness come as a precursor to, or result of, engagement with alternative practices.
5. Researching practices as well as meanings, and looking at these practices as interactions between different players in specific contexts rather than as individual sets of cognitive ‘health beliefs’, (including research on interactional aspects of consultations).
6. The need for more research of alternative medicine as practised by biomedical healthcare workers as well as non-biomedical practitioners.

The methodological approach that is most suited to filling these gaps is ethnography with its trademark technique of participant-observation and its focus on situated interaction in context and processual aspects over time. I will discuss the benefits of ethnography from a methodological perspective more in chapter 5. In the next chapter I raise the issue of utilising theoretical concepts from anthropology in tandem with such an ethnographic approach.

Chapter 3

Anthropological conceptions of the body

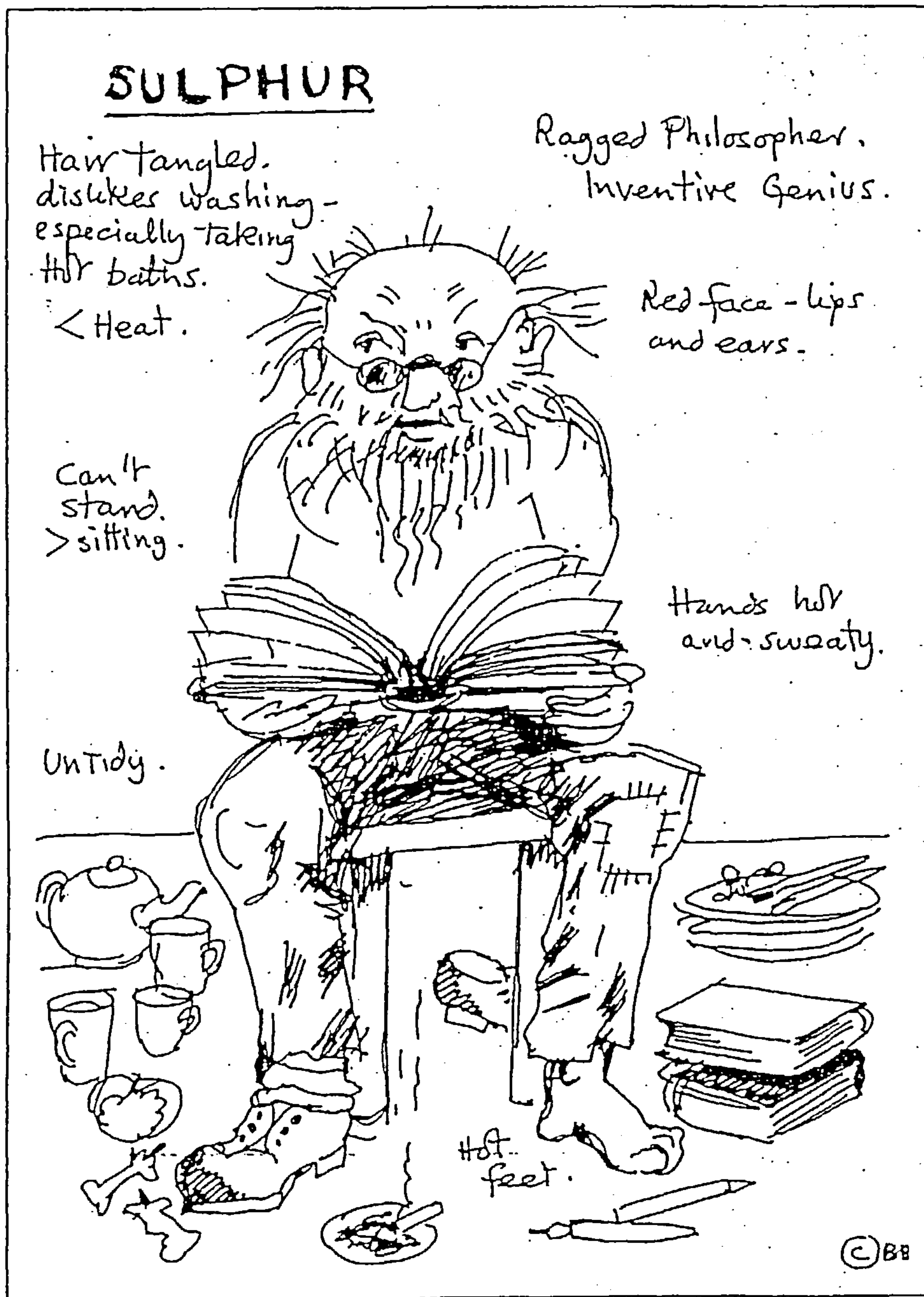


Illustration by Berenice Benjelloun

Chapter 3. Anthropological conceptions of the body and health

In the last chapter I made a case for an ethnographic approach to researching alternative medicines. In this chapter I want to argue that whilst the methodological techniques of ethnography can provide useful insights in themselves, that using such an approach divorced from theoretical frameworks can weaken their application. Whilst there have been recent calls for more application of the ethnographic method to healthcare research, for example Savage (2000), some of the ethnographic research in healthcare has been criticised for divorcing ethnographic method from anthropological theory. Lambert and McKevitt believe this has led to much qualitative research in healthcare that is "thin", "trite", and "banal" (Lambert and McKevitt 2002). They explain that these weak projects arise from the misguided separation of method from theory. They advocate the greater involvement of anthropological conceptual frameworks, substantive knowledge, and methodological insights. In agreement with this pronouncement, it has been my aim to utilise the ethnographic method but also to apply anthropological theoretical concepts to my data in order to produce "thicker description" (Geertz 1973) and more illuminating analysis.

In particular I want to refer to the anthropological conceptual literature on the body and embodiment to make sense of my data. First I will look at how experiences of the body and bodily practices differ between different cultural groups in non-western settings, and at how these are reflected in experiences of illness and models of healing. I will then outline western dualistic notions of the body and detail how these have contributed to biomedical conceptions of illness and healing. Finally I will show how engagement with alternative healing modalities within western settings leads to different experiences of the body.

The body as a cultural artefact

The rich vein of literature on the body and embodiment is particularly useful in the arena of health research as it illustrates that the body is a highly culturally circumscribed

entity. The anthropology of the body shows how the body comes to be experienced differently in different societies and reflects the different cultural cosmologies in place.

Mauss, in his work on techniques of the body, was one of the first to draw attention to the idea that all our natural bodily expression is culturally determined, even simple everyday actions such as washing and walking (Mauss 1934). Mary Douglas, a central figure in the embodiment literature in anthropology used his ideas and, borrowing from Levi-Strauss (1969) coined the phrase “The body is good to think with” (Douglas 1966). She made powerful analogies between bodies and their boundaries, and nation states and their boundaries. This analysis revealed that in threatened societies, there is a common tendency to pay increased attention to the maintenance of purity in the body boundaries of the individual members (Douglas 1966).

Through her concepts of “group and grid” she showed how societies with different make-up exhibit different bodily behaviours such as trance or witchcraft possessions. She demonstrated how our physical experience of the body is always modified by social categories and the body can thus be used as a map with which to read culture (Douglas 1970). This process whereby the individual is incorporated into the group and the group is incorporated into the individual is contained within the notion of embodiment.

Working with Douglas’s ideas, Scheper-Hughes and Lock (1987) expanded on the notion that the body is both a physical and a symbolic object, naturally and culturally produced in a specific historical moment. They developed Douglas’s distinction between the physical and social body into a useful tripartite framework for thinking about the body as a cultural object. They differentiate between three possible units of analysis: the lived body, the social body and the body politic. The lived body refers to the phenomenology of everyday lived experience. The social body is where nature, society and cultural processes are played out. The body politic refers to the ways in which the state and institutions shape the body through mechanisms of regulation and surveillance⁸. For the purposes of this chapter I aim to focus at the level of the phenomenological lived body.

⁸ The sociological work on the body tends to focus at this level of the body politic (Turner 1992), investigating for example the effects of post modernity on the body (Fox 2002; Haraway 1993; Novas & Rose 2000), whereas anthropological work has been conducted on all three levels.

Another key theorist of embodiment is Thomas Csordas. Drawing on the work of Merleau-Ponty on perception (Merleau-Ponty 1962) and Bourdieu's concept of Habitus (Bourdieu, 1984) he developed the concept of the lived body as the primary locus of perception (Csordas 1990). He explains that from a perspective of embodiment, which does away with the Cartesian dualities of mind and body, perception is not a cognitive mental process but a bodily and somatic mode of being in the world. For Csordas the body is the starting point for the analysis of human participation in the cultural world. He exhorts the anthropological community to stop looking at the body in terms of its semiotics and start looking at it through the phenomenology of the lived body, proposing that the body be seen as:

The existential ground of culture- not as an object that is 'good to think with', but as a subject that is 'necessary to be'. (Csordas 1993: 135).

Using the concept of "somatic modes of attention", Csordas demonstrates how the way in which we pay attention to our bodily experience and that of others, is culturally determined (Csordas 1993). In the area of healing he gives the examples of therapists from different traditions paying attention to different aspects of the body. For the Siddha practitioner, a pulse diagnosis technique that aims to synchronise the pulse characteristics of patient and therapist, is used to reduce the divide between the physician and patient. This leads to a different sort of relationship (Daniel 1984). How we experience our bodies also changes how we act in the world. Another example he gives is the way in which psychotherapists of different traditions produce different dreams in their patients. Freudian dreams are very different to Jungian ones (Csordas 1993).

Csordas draws our attention in this paper to the post-modern juxtaposition between different cultural definitions of the body embedded in the one practice. For example, he cites the work of a Catholic charismatic healer who had been trained as a psychotherapist and who used both schools of thought in interpreting his clients' symptoms. This idea of post-modern multiplicity of practices is relevant to my own data. My informants included two alternative healers (homeopaths) who were previously trained as biomedical practitioners (a nurse and midwife respectively) and

who have also trained in other alternative traditions (Reiki and flower essences). Another informant is a biomedical practitioner who has also been trained in a number of alternative traditions such as homeopathy and herbalism.

A number of authors have pointed out that in starting to look at other cultures' ways of experiencing the body, the existing terminology can be restrictive. 'Body' has come to be so synonymous with the individual biological body in western culture, as a result of dualistic thinking that splits the mind and body into two separate entities. To counteract this problem, other ways of talking about the body have been proposed by several anthropologists (Ots 1994; Monks and Frankenberg 1995; Scheper-Hughes and Lock 1987). I personally like Scheper-Hughes and Lock's term 'mindful body'. This reunites mind and body (Scheper-Hughes and Lock 1987), but does not indicate whether the concept of body also incorporates wider aspects of reality as is the case for many peoples in the world.

There are also implications for methodology in researching these different conceptions of the body. Csordas explains that a focus on embodiment requires more creative methodologies to deal with processes such as intuition, somatic perception, bodily imagination and sensation. He himself attempts more subtle and interpersonal methods in his studies of a charismatic catholic Pentecostal community (Csordas 1994; Csordas 1997). Using his own bodily experiences he has shown how the presence of collective bodies produces co-ordinated action and sensory stimulation. For example, in chanting, drumming, dance or drama, this can be seen to have a therapeutic effect. It is important too, not to forget the embodied experience of therapist as well as patient. Shaw's work with psychotherapists showed how they experienced a wide range of somatic phenomena during the therapeutic encounter (Shaw, in press)

The use of the body of the anthropologist becomes key in researching embodiment. Carol Laderman demonstrates how her own embodiment came to change through living in Malay culture (Laderman 1994). She reports how in addition to taking on new body movements and postures, and conforming to a diet based on symbolic notions of foods, she also came to change her habits of mind, absorbing Malay symbolism in her visualisations and dreams. Recording bodily experience of the anthropologist's self, can

be important in order to research embodiment of the other. I will return to this issue in chapter 5.

The phenomenology of the non-western body in illness and healing

Geertz has argued that the Western conception of the person “as a bounded, unique ... integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgement, and action ... is a rather peculiar idea within the context of the world’s cultures” (Geertz 1984). Helman reminds us that our taken for granted Western notions of the body and the self as synonymous, are not true of other cultures. There the sense of self usually extends beyond the individual body (Helman 1995). Helman cites, as an example, research from rural north India where only half a woman’s body is thought of as her own self, the other half is seen to ‘belong’ to her husband and his family. This manifests in symptoms appearing in this half of the body caused by family tensions (Jadhav 1986).

The Japanese self, in contrast, has traditionally been seen as inseparable from the family⁹. Japan has been described as a society of ‘social relativism’ in which the person is not seen to act autonomously but always in the context of a social relationship (Smith 1983). This social conception of self is played out in cultural responses towards death. The biomedical concept of brain death is not acceptable in this society. Before an individual can be pronounced dead a number of family based rituals (which can go on for several weeks after physical death) need to have taken place. This different construction of self has negative implications for the practice of organ donation (Nudeshima 1991).

In Fiji the individual body is experienced as a manifestation of its community, rather than of the self (Becker 1995). So for example a woman’s pregnancy is seen as a community experience, not a personal one, and the consequences of concealing a pregnancy are seen to have damaging effects on the health of the community.

⁹ Contemporary Japan is moving more towards individualism (See Lock 1992), as is evidenced to some extent by the big growth in the use of alternative therapies there, with more people having used CAM in the last year than orthodox medicine (Yamashita, Tsukayama et al. 2002).

In contrast, Scheper-Hughes and Lock cite communities where the same body may contain numerous selves, such as the Bororo who only understand the individual as reflected in relationship with others. Hence their conception of the person consists of many selves - the self as perceived by parents, the self as perceived by enemies, etc. Similarly, the Cuna Indians have eight selves, each associated with a body part (Scheper-Hughes and Lock 1987: 15).

These differences in the definition of body and self have implications for the experiences of illness and healing. As Scheper-Hughes and Lock have explained:

Sickness is not just an isolated event, nor an unfortunate brush with nature. It is a form of communication- the language of the organs- through which nature, society and culture speak simultaneously” (Scheper-Hughes and Lock 1987:31).

Research from other parts of the world has shown how culturally specific illness is, with people experiencing a different relationship to their bodies, interpreting symptoms in different ways, and experiencing disease differently. The notion of culture-bound syndromes is an attempt to come to theoretical terms with this idea of the embodiment of the culture in the individual (Simons and Hughes 1985). Illnesses such as anorexia in Western cultures or soul loss in Latin America demonstrate the way in which individual bodies absorb the cultural categories of illness. There is also the related concept of cultural somatisation, with different cultures selecting a particular organ as the focus for symptomatology. For example the heart is a focus of illness in the Punjab, India and conceptualised as “Sinking Heart” (Krause 1989) and also in Iran, conceptualised as “heart distress” (Good 1977) while the bowels are seen as a focal organ in English conceptions of illness (Payer 1989).

Our insistence in the West that illness is an exclusive property of the body it afflicts, is an exception. Many societies do not separate self and society to the extent of modern Europe so there is not the same conception of being ill 'in yourself'. Causative factors in illness in these kinds of societies are more likely to be attributed to social factors, such as sorcery. Therapy, too is usually a collective ritual, where the individuality of the patient is almost incidental.

In much traditional medical practice, an understanding of the social and psychological origins of illness is made use of in diagnosis and therapy: (Evans-Pritchard 1976; Manning and Fabrega 1973; Lewis 1975). (An observation that is also true of some modern medicine, e.g. psychiatry - Lock 1992).

Western conceptions of the body - dualism and the biomedical body

Reviewing alternative conceptions of the body reveals that the biomedical body is just another (albeit powerful and pervasive) construction of the body, a cultural and historical construction that is not universally shared. With much research on the body conducted by those steeped in Western cosmologies of personhood and the body, there is a real danger of committing what Scheper-Hughes and Lock refer to as "the biological fallacy" (Scheper-Hughes and Lock 1987). This is defined as "falling prey to assumptions that mind is separate from body, spirit from matter, and real (i.e. visible) from unreal" (p.6-7).

This fallacy springs from the dualistic tendency in Western thought, to split mind from body, that started with Hippocrates. When he exhorted Greek physicians to only take account of palpable signs of illness, he started a trend in Western medicine to focus on visible symptoms of illness situated within the biological entity of the body. Aspects of the mind, or wider definitions of the social body thus came to be ignored. Since the enlightenment, the influence of some interpretations of Descartes have continued this tendency to mind/body separation. The introduction of dissection and anatomy, and more modern developments in biomedical science reveal a very dualistic view of an ever more fragmented body. Sampson shows how the newer technologies such as scanning equipment even remove the real body from the diagnostic process, transforming it instead into digitally constructed maps and graphs. The Human Genome project extends the process of dissection and fragmentation of the body to its constituent chemical limit (Sampson 1999).

Given the relative monopoly biomedicine has had in the health care of Western individuals, over the past half century, it can be difficult to see biomedicine as just one of many global medical systems with an associated set of beliefs, rituals and practices. As Rhodes notes, we need a jolt to see the contingent nature of biomedicine, to reclaim the culturally constructed from the apparently 'natural' (Rhodes 1990). He suggests three ways to achieve this:

- through historical analysis (See e.g. Foucault 1973);
- through examining the use of metaphor in medicine (see e.g. Martin 1990);
- and through demonstrating the actual lifeworld of clinicians (See e.g. Hahn 1985).

I would add to this list a further 3 ways:

- an examination of the ritual aspects of practice (See e.g. Katz 1981);
- cross-cultural analysis (See e.g. Payer 1989); and
- investigations into biomedical training (See e.g. Becker, Geer et al. 1961; Good 1994; Sinclair 1999).

From such work, a picture of the defining elements of biomedicine emerges. Some of the key features are: separation between mind and body, body and emotions, and medicine and emotions; depersonalisation and distancing from everyday events; biological reductionism; and the dominance of the natural science model of explanation, incorporating the concepts of a detached observer and calculative reasoning (Gordon 1988). Kirmayer would add the positioning of the physician as active knower and patient as passive (Kirmayer 1988).

Manning and Fabrega have summarised the major differences between biomedicine and most non-western ethnomedical systems. In biomedicine, illness is located in either body or mind. Social relations are seen as separate from health and sickness. In many ethnomedical systems however, the body is seen as a unitary integrated aspect of self and social relations. Here illness can not be located in mind or body alone, and social factors can be implicated in both the cause and the healing of illness (Manning and Fabrega 1973).

In terms of wider cosmologies of the body, non-western notions of the body are conceived of as a microcosm of the universe. In biomedical healing and Western notions of the body, the body is symbolised as a machine with attendant reliance on control, discipline, alienation and fragmentation (Crawford 1984; Martin 1987; Martin 1990). This metaphor of the machine, and practices such as organ transplantation, and mechanical implants, contribute to patients' experiences of their bodies as entities with removable or replaceable mechanical parts (Helman 1992). Another powerful set of symbols in biomedical healing and Western notions of the body, is of healing as warfare, with magic bullets used to blast foreign invading bodies such as germs and bacteria (Martin 1994).

In addition to biomedical practice and science-based thinking influencing embodiment, western values of capitalism and individualism also contribute to defining people's experiences of the body. The body has come to be seen as a project to be worked on (Mellor and Shilling 1997). Crawford shows how the dual capitalist values of productivity and consumption have produced the paradoxical oppositions of health as both 'control': fitness training, alcohol reduction, limited diets; and 'release': pampering, beautification, and self-indulgence (Crawford 1984). Capitalism has also influenced the healing system with doctors acting as agents of social control and functioning as a means to get people 'well enough to work'.

Whilst generalisations about the biomedical body serve analytical and theoretical usefulness, it is important not to portray biomedicine as a single clear entity. As Margaret Lock explains: "The very idea of a bounded model medical system, reasonably autonomous and clearly distinct from other social institutions is a cultural construct" (Lock and Gordon 1988). The pluralism in biomedicine is as great as that between biomedicine and alternative medicine, as Atkinson has shown, for example, in his study of the different specialties of medicine (Atkinson 1995).

In any case, no clear delineation can be made between different systems of medicine as alternative practices have been incorporated into biomedicine (Gevitz 1988) and vice versa. For example Kleinman has shown how biomedical practice in Taiwan has been influenced by the practices of traditional Chinese medicine (Kleinman 1980). Conversely Boon's Canadian study has shown how some naturopaths operate from

biomedical scientific principles of objectivity, reductionism, and practical concrete concepts. Other naturopaths in her study, who were working from within a more holistic framework, operated on principles of subjectivity, intuition, spirituality, abstract concepts, and treatment at the emotional level (Boon 1998).

The ethnographies of medical training can be a useful starting point in examining how the biomedical cosmology is continually constructed and reinforced in the medical system. Following in a tradition started by Becker and colleagues in the 1950s (Becker, Geer et al. 1961), Simon Sinclair's more recent ethnography of training in a London medical school, reveals the processes of medical training as the locus in which aspects of biomedicine are recreated and reinforced (Sinclair 1999). He suggests that certain methods of teaching promote a specific view of medicine. The process of cadaver dissection, promotes emotional detachment and objectification of the body. Presenting data in lectures about the working of the body as an accumulation of discoveries of scientists, without attribution, promotes a view of the practices of medicine as indisputable and uncontentious. The question and answer method of teaching, promotes hierarchy and a view of the diagnostic procedure as one of set formulae and lines of logical reasoning. The process of clerking and 'taking' the history, promotes the formalisation of the patient's narrative into medical categories and the stripping of social and emotional context. The consistent denigration of the social sciences and psychiatry, also contributes to the downplaying of patients' psychological and emotional states.

Earlier work in an American context by Byron Good reveals similar processes and provides a more elaborate theoretical account of how these processes come to construct the body (Good 1994). He shows the hierarchical aspect of medicine does not just come from organisational factors but from the whole way in which the body is learned about. He sees medical training as a set of formative processes through which medicine constructs its objects. Unlike Sinclair, he sees the anatomy laboratory, not as a site that simply dehumanises students, but one that contributes to a deconstruction and then reconstruction of how the human body is experienced: as a different type of object. He shows how students learn to see the body as a hierarchy, moving from the gross structure, through the more detailed anatomy of muscle and blood vessels into a yet more micro level of cellular and molecular structure. He notes that this view of the body

is reinforced almost universally in lectures about the body and disease. No lecture can be given without slides and these usually move down the hierarchy reinforcing this view. Moving from the epidemiology, through clinical slides of patient, pathological specimen, then cell structure, to the electron micrograph, and finally the diagram of molecular structure and genetic expression. Each level reveals the more basic structure of the next order and reproduces this enduring idea of hierarchical orders, each encompassing the other. Students learn to relate surface signs to underlying mechanisms (Good 1994).

Good also shows how the patient is constituted through the “speech acts” (Austin 1962) which quite literally shape and reshape the body: in this case, the writing and speaking about the clinical case. The students learn the format for both the write-up of the case and the presentation of it to colleagues. This then formulates the way in which they interact with real patients, who in some senses become secondary to the paper patient. As one of his informants put it “You begin to approach the patient now with a write up in mind...you’re thinking in terms of those categories”. The story as written and presented, is a story of the disease process, located spatially in tissue lesions and disordered physiology, and temporally in abstract medicalised time (Frankenberg 1988). The person, the subject of suffering, is represented as the site of the disease rather than as a narrative agent (Good 1994:80). This results in a rational form of practice in which the lifeworld is excluded (Mishler 1984; Barry, Stevenson et al. 2001).

It is at this time of training that the pure version of biomedicine is probably at its most apparent. Once trained doctors move into the world of practice they may move away from the ‘ideal type’ and into specialties characterised by other models. For example, general practice sees itself as drawing on more holistic models of health and illness (Balint 1957; Engel 1977; Adams 2001).

The daily practices through which the biomedical system acts upon and constructs the sick body have been analysed in accounts of the experience of 'The Clinic' and what it means to be a patient. The way in which patients are de-humanised in hospital for example, by means of removing their clothes and context, and treating them as objects. Both Foucault (1980) and Illich (1976) have talked of the clinic as a producer of illness. Oliver Sacks’ account of his hospitalisation after a climbing accident, draws our

attention to the relational aspects of biomedicine. For example, the tendency towards constructing the patient as an inferior partner in the healing partnership. Sacks explains that being condemned to lie in bed was experienced as a “miserable and inhuman posture”. He notes the loss of status and power engendered by this posture, which removed the moral posture of uprightness that symbolises standing up for oneself (Sacks 1984:98). Another hospitalised academic, Arthur Frank analyses his experiences with cancer. He claims that there was much reluctance on the part of medical staff to see him as a unique human person rather than as an object. The doctors were loath to maintain eye contact, the anaesthetist was reluctant to shake his hand when Frank offered it, and he overheard himself referred to by nursing staff as "the seminoma in 53" (Frank 1999: 53).

There is also a gender component to the influence of biomedicine. Women’s relationships with the biomedical system are influenced by their experiences of reproductive medicine. Martin notes that the ways in which women talk about menstruation and childbirth involve a fragmentation of the self. Their talk implies a separation between the self and associated physical sensations, such as birth contractions (Martin 1987).

Martin goes on to analyse the symbolic scientific metaphors associated with women’s bodies. She finds a strong capitalist symbolism embedded in notions of the woman's body. It is talked about as being involved in production with a separation made between the labourer and the manager, and the labourer and product (Martin 1987). She also records how women’s bodily experience is denigrated by models implying failed production, waste, decay, and breakdown, for example during processes such as the menopause (p.197). I have written elsewhere at greater length about women’s differential experiences of biomedicine and alternative medicine (Barry 2001, see appendix B).

I have taken some time to outline the core components of the biomedical system as a system of beliefs and practices, as my own data incorporates aspects of both the alternative and the biomedical systems. I will argue in this thesis that many of the beliefs of patients in my study are biomedical in origin reflecting the normative health system in the UK into which they have been enculturated, even when they go on to use

alternative therapies. One of my ethnographic sites, a general practice, is situated within the biomedical system, even though the doctor on whom I focus has many alternative views. My alternative sites and informants also reveal influences from biomedicine. For example the two homeopaths I studied were trained within the biomedical system in their previous careers, as a nurse and a midwife respectively. In tandem with the espousal of more alternative views they also used elements from scientific discourse in their educational support group on vaccinations.

The body in alternative medicine in the West

As outlined above, there has been little work on alternative therapists at work using an ethnographic or observational approach. Where work of this nature has been conducted, it has produced very illuminating findings on embodied and interactional aspects of the consultation. Cant and Sharma's (1996) edited collection "Complementary and Alternative Medicines: Knowledge in Practice" contains reports on a number of such studies. These studies can begin to intimate how people's embodiment might change, from an original biomedical dualistic conception of the body-self, through interacting with alternative systems of medicine. This is a project that I hope I have built on through my own work.

I mentioned above, Csordas's observation of the post-modern tendency towards combinations of practices, as an influence on embodiment. So for example, alternative medical practices may have originated in other less individualistic societies, but when imported into a western setting come to incorporate aspects of the individualistic notion of personhood and the body. Whilst alternative medicine may abandon the dualistic split between body and soul, it does so within a very individualised framework, very much in keeping with the culture of individualism. Johannessen's ethnographic work on reflexologists', biopaths' and kinesiologists' consultations revealed the insight that the process of diagnosis and treatment was highly individualised to each specific patient (Johannessen 1996). As she points out "one can hardly find two persons with identical constellations of physical, mental and social conditions and dispositions" (p122). The totality of symptoms displayed, determined by the therapist or discussed by the patient, is different in every case. The meaning assigned to this gestalt is co-constructed between

individual therapists, each with their individual styles and versions of practice. This results in an entirely unique explanation of the meaning of this person's current state. There is not usually one summarised precise diagnosis but:

The whole conversation constitutes a complex and individualised diagnosis. Patient and healer select among the many potentials revealed and each chooses that which suits himself and his experience best. A pattern of significance and meaning is created. (Johannessen 1996:122).

She stresses the importance of the joint enterprise between patient and practitioner, posing the suggestion that: "The treatment works best if the patient is co-realizing, co-knowing, co-deciding, and co-creating in the process of diagnosis and treatment" (op cit p.127).

Johannessen concludes that these individualised explanations may be a kind of therapy in themselves. Meanings can be of therapeutic significance in regard to both the illness experience of the patient and the pathological disease. She draws attention to the fact that these explanations draw on cultural models. The whole notion of individualised treatment can be seen to be closely connected to Western cultural values of individualism, and thus to hold a great potential healing power by offering explanations that are consonant with cultural beliefs.

Learning to see the body differently

Busby's ethnographic work with a chi gung class showed that people had felt a sense of alienation in their dealings with western medical practice and its reductionism. They experienced a sense of coming home to a practice that was more congruent with their experience of their bodies (Busby 1999). Their chi gung practice not only reflected their own bodily experience more accurately, it concurrently invited a reshaping of their ways of thinking about the body. For example, introducing the idea of an intelligent nature within the body, and the importance of flow and release as healing movements, in contrast to more mechanistic biomedical versions of the body, discussed above. Interestingly the chi gung classes she studied were group rather than individual activities so moving away from this more individualised notion of the body.

Paterson's recent work on acupuncture found similar changes in how people saw their bodies (Paterson 2002). Her qualitative work had a longitudinal component so she was able to see changes in how the patients were relating to their bodies. Her participants reported new or expanded ways of understanding the body and self as a whole being:

The acupuncturist likes to get to know you and find out what makes you tick and how all these things are connected. Listening to what she says, it's all sort of connected up, all your body bits, which is very interesting (Paterson 2002).

They started to talk of being understood and treated as whole and of the body healing itself. This was often expressed in terms of a new relationship between self and body, expressed as learning to: 'do what my body says', 'not to abuse my body', 'listen to my body' or 'learning to live with my body'. The therapists talk and bodily practice could be seen as a large influence on these changes:

'Your body has a wisdom of its own' as Harry [her acupuncturist] put it.

By contrast, Robert Shaw's research shows how a group of patients receiving osteopathy for the treatment of pain appeared to cling to biomedical notions of the body. Shaw reminds us that "the typical osteopathic set-up mirrors that of a doctor-patient consultation" (Shaw 1997: 16). This is the case to a greater extent perhaps than in other therapies, with the exception of chiropractic that is similar in this respect. Shaw showed how patients did not appear to share osteopathic therapists' discourse about pain. The respondents used many medicalised notions in their discourse, such as the metaphor of the body as a machine. They also appeared to conceptualise the pain as a physical problem located within the physical body. Shaw concludes that these patients "carry with them the dualistic paradigm of mind-body disunity" (op cit p. 17).

These differences between clients of different therapies remind us of the importance of therapy specific research projects.

The homeopathic body

As my study focuses on homeopathy it is useful to review work on the relationship between homeopathy and embodiment. Stefan Eggs' work on homeopathy in Calcutta has shown how local cultural constructions of the body have impacted on the practice of homeopathy. Digestive problems are very common among the largely Bengali clientele. Local constructions of the importance of eliminating toxic waste through the bowels as a means to health, have impacted on the homeopathic idea of the body. The homeopaths with whom Eggs conducted participant observation were likely to focus on questions of diet and digestion to a far larger extent than recommended in the classical Hahnemann version of homeopathy (Eggs 2002). Eggs also found that the length of consultation could be quite different. In one clinic patients had on average 2 minutes consultation time with the homeopath. This sounds like a quite different version of homeopathy to that practised in more western settings¹⁰. In longer consultations in European homeopathic consultations (e.g. Germany - Frank 2001) importance is placed on gaining an in-depth knowledge of the person. This fits a western cultural view of the individualised person as separate from social context.

However, whilst homeopathy as practised in the West may draw on local cultural conceptions of the body, it does construct the body differently to biomedicine. Sharma's thoughtful work on homeopathy and the body in the UK, contrasts homeopathic notions with allopathic ones. She concludes that the homeopathic version of the body is less bounded in time and space than that of the allopathic body. The body in orthodox medical textbooks is often pictorially represented in 2 dimensional space, as an inner penetrable and knowable space, in the traditional medical anatomical illustration. She noted that homeopathic texts have no depictions of the body. Instead the body is represented verbally, as a series of tendencies, characteristics and symptoms. Space does exist in the homeopathic representation of the body, but it is a 4 dimensional representation that includes time and is not amenable to illustration. Ideas such as Hahnemann's concepts of 'disease suppression' and of 'aggravation of old symptoms' and Hering's concept of 'direction of cure' mean that symptoms move through spaces of the body at different times, often over a long time period. Symptoms then can only be

interpreted in terms of time sequences, and cannot be interpreted outside the time frame of the patient's trajectory (Sharma 1995). This introduces a more temporal aspect to homeopathic notions of personhood.

Sharma suggests that this is the reason why the physical examination of the patient has low priority, with the major attention given to verbal report of the patient's conscious experience of symptoms (Sharma 1995). This aspect of the homeopathic vision of the body appears to apply as equally to homeopathy in Calcutta, as in South London. Stefan Eggs' work has shown the use of physical examinations is almost non-existent, with the homeopath staying behind the desk and concentrating on listening and writing notes (Eggs 2002). It is interesting to note that in the more biomedicalised version of homeopathy, practised by medical physicians, the reliance on visual signs, examinations, and tests is much greater. The homeopathic physicians in Frank's study report extensive use of physical examinations and diagnostic tests (Frank, in press). Where biomedical physicians are practising homeopathy there is a tendency to stick to the biomedical conception of the body that has been ingrained by a long training.

Sharma suggests that this different homeopathic conception of the body, affects aspects of the practitioner-patient relationship in quite fundamental ways. In biomedicine, the process of diagnosis leads to a splitting off of the patient's subjectivity from their objective symptoms. This precludes any engagement with the patient's experience of their biography and environment, or of the meanings which illness holds for them. Homeopaths cannot do this, as homeopathy does not contain the notion of disease. The patient's experiences and symptoms cannot be aggregated to an objective category. This constructs the patient in a role as expert in their own constellation of symptoms. In this endeavour they are even encouraged to become *more* expert. The homeopaths ask them to learn to notice their symptomatology, with even more attention to detail, such as the times of onset, differential types of pain, and so on. This leads to a relationship between two experts, that is quite different from the subject-object relationship between the biomedical doctor and patient. The patient is the expert in the constellation of their own symptoms and the homeopath is the expert on remedy pictures. However as Sharma notes, the tendencies towards medical pluralism and syncretism between different

¹⁰ Hausman has reviewed the processes of 'Indianization' of homeopathy during the last century

healing systems means that these two different notions of the body can get conflated (Sharma 1995).

Summary and concluding remarks

I have spent some time outlining non-western conceptions of the body and associated cosmologies of health and healing in comparison with biomedical ideas about the body and illness. Whilst I have presented these as groups of ideas that exist in different societies or at different periods of history, in a post-modern world the reality is more complex. As a result of contacts and exchanges of ideas between societies, different cosmologies co-exist within societies. Each gets to be infused with ideas from the others, in a process of syncretism (Stoner 1986). To be more accurate, this is not just a post-modern phenomenon resulting from trends of globalisation, it is a process that has been going on throughout history. In an ambitious overview of holistic health from 700 BC to the present, English-Lueck shows how from the earliest contacts between societies, health ideas and practices were traded, alongside the trade and exchange of goods (English-Lueck 1990). Medical pluralism and syncretism of medical practice have been facts of life since time immemorial (for a review of medical pluralism and its relevance to studies of alternative medicine see Barry (2002) - appendix A).

Looking at health beliefs and practices from an anthropological theoretical stance, implies seeing them as a reflection of cultural factors that become embodied within the individual patients and practitioners and played out in interaction. They are not seen as purely cognitive structures within individual's heads, as is often the way within the discipline of health psychology or as lay beliefs, somehow extracted from context, as is often the case within medical sociology. This approach then requires the observation of these practices and interactions and not just reliance on interviewing participants. It also demands paying attentions to both what individual and groups of bodies do, and how symbolic bodies are constructed through talk and practice.

I have used these ideas about syncretism and changing cosmologies to investigate the processes through which holistic health beliefs come to replace (in part) normative

(Hausman 2002).

biomedical beliefs among groups of users of homeopathy. I have also used them to ask questions about the cosmology of a medical homeopath who practises both biomedical and holistic healthcare within a biomedical system. Alternative health beliefs and different experiences of the body appear to be produced by different forms of healthcare. However it is important to see that prevailing cultural ideas about the body are still very influential in alternative practices. Western ideas of individualism and the ideal body infuse both biomedical and alternative healing practices in the West. For example, alternative healing practices are still largely conducted one-to-one. The site of the healing is located at the level of the afflicted patient, not within the family or the larger community group, as is the case in societies with different conceptions of the body, as a more social entity.

These ideas about health and the body can be used to deconstruct prevailing political discourses. For example in the policy and research worlds of the integrated medicine movement, which aims to promote the provision of alternative medicines within the biomedical system. If we conceptualise biomedicine as just one cosmology of health and the body, we can question the political actions arising from this biomedical understanding. For example, the repeated insistence from the integration movement, on the need for randomised controlled trials as evidence of efficacy, can be deconstructed as a consequence of biomedical ways thinking. In biomedicine illness is located within a purely biological body and healing is envisaged as the effects of chemical substances on this biological body systems.

In this summary of anthropological work on the body I hope I have demonstrated a number of key issues of relevance to my data. Firstly that bodily practices such as those associated with health and illness, can be seen as culturally informed. Secondly, that definitions of the body differ within different societies and we need to be wary, when examining the practices of non-biomedical medicine, of being trapped within a mechanistic and reductionist biomedical conception of the body. We need to remember to look beyond the physical skin of the person. Broader conceptualisations of the body will incorporate other social actors, and aspects of the environment in which the bodies are situated. Thirdly, that if culture is played out through the body, then there is a need to incorporate methodological ways of researching and being attuned to embodied experience. We need also to remember that “culture” is not a fixed entity but a set of

processes (Kuper 1999; Barth 2002), and as such we need to be attuned to the constant change in cultural conceptions.

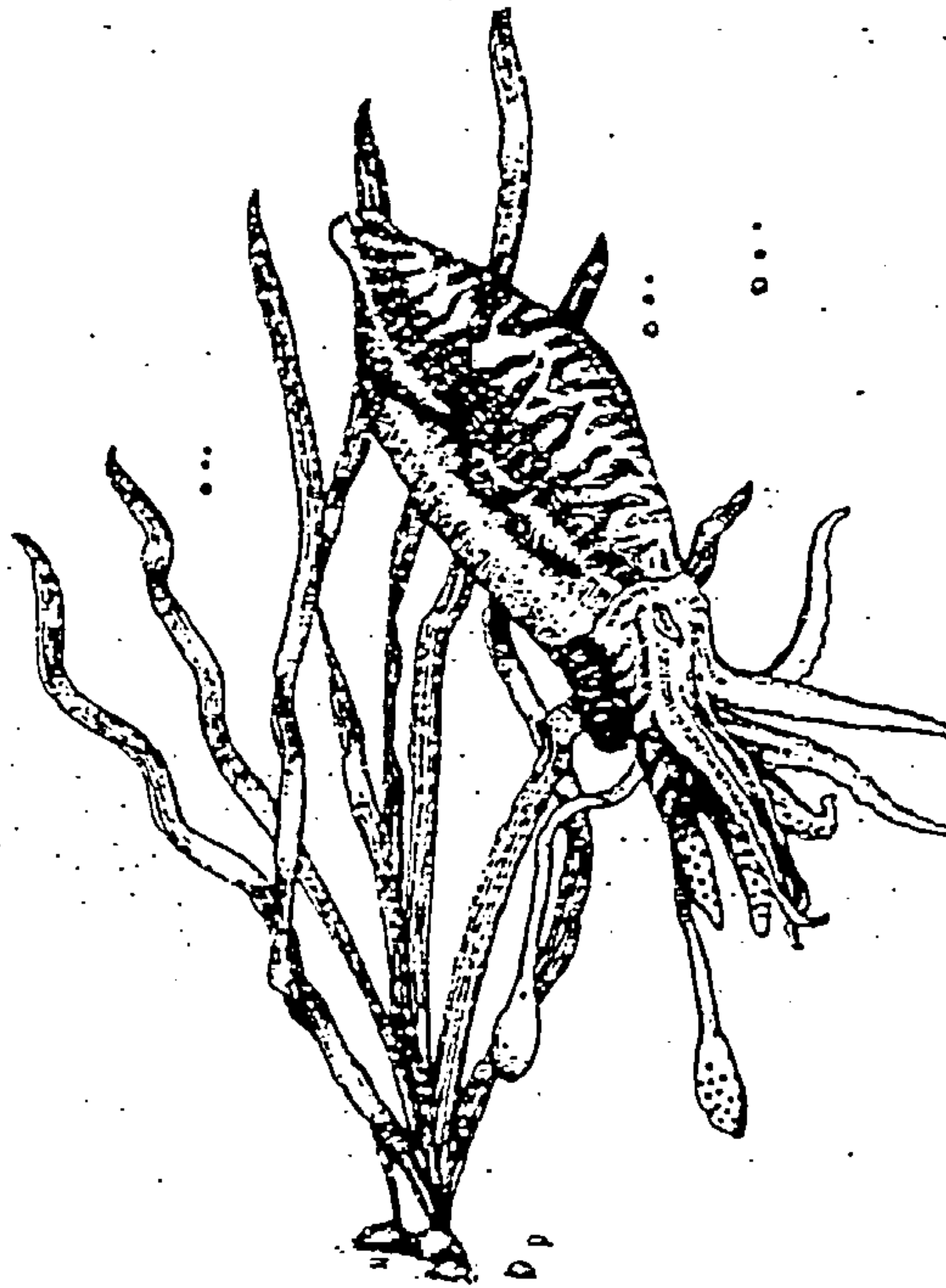
In the next chapter I want to provide historical and political context for understanding the developments in integrated medicine and review the limited research that has been conducted on integrated practice, I will return to methodological issues of embodiment in chapter 5.

Chapter 4

Integration of alternative medicine: History, power, politics and professionalisation.

SEPIA (Sep.)

Family name: Dibranchiata
Other names: squid, cuttlefish



Chapter 4. Integration of alternative medicine and homeopathy in particular: History, power, politics and professionalisation.

In the previous two chapters I focused the analysis at the level of the users and providers of alternative medicine and their cosmologies of health and the body. From the perspective of Scheper-Hughes and Lock's (1987) model I was looking respectively at the level of the social body and the lived body. In this chapter I will move the unit of analysis up a level, into the arena of the body politic, to investigate the relationship of alternative medicine to the state-authorised system of orthodox medicine. I start by outlining some of the issues of power, politics, professionalisation and integration. I will then focus on homeopathy more closely and present an historical analysis of its relationship to state medicine.

Issues of power, politics and professionalisation

The concept of 'integrated medicine' involves the bringing together of orthodox biomedicine and alternative medical therapies under the roof of the state sponsored healthcare system. A discussion document launched in Britain in 1997 by Prince Charles' organisation: The Foundation for Integrated Medicine, entitled "Integrated Healthcare", has been very influential in putting this issue onto the political agenda. However there are other historical reasons for the growth of this movement at this time.

Mike Saks has been the primary figure in providing a commentary on the issues surrounding the relationship between the professions of orthodox and unorthodox medicine, in the context of this current debate about integration (see for example: Saks, 1992, 1995, 1999). He provides a historical overview, to show the shifting relationships over the past 150 years.

One hundred and fifty years ago the strength of the two bodies of orthodox and alternative practitioners was similar (Porter 1997). To some degree the rising popularity of alternative therapies at this time, such as homeopathy and hydrotherapy, helped spur

the orthodox medical system on to greater professionalisation and legislation. The medical registration act of 1858 could be seen as a response to threats to competition from these so-called “quack” groups. This move towards the increasing dominance of medicine continued in the last century with the National Health Insurance act of 1911 and the National Health Service Act of 1946.

Whilst alternative therapists over this period could still practice under Common Law they increasingly lost their legitimacy (Saks 1992). The elite of the medical profession engaged in self-protectionism by using disciplinary measures against any medical doctors who got involved in alternative therapies. The collective voice of the medical profession was joined in a pointed attack on non-orthodox forms of medicine. Evidence of this could be seen as recently as 1986 when the British Medical Association report on alternative medicine denounced it as witchcraft and superstition (British Medical Association 1986; Saks 1994).

However the rise in consumer interest in alternative therapies, from the middle of the twentieth century, has proved to be a major factor in interrupting this stream of increasing denigration and limitation of alternative medicine by the orthodoxy. One effect of the grassroots interest has been a dramatic rise in the number of alternative therapists to around 45,000 in 1997 (Mills and Peacock 1997). These therapists have grouped together in therapy-related groups and associations to start a move towards greater professionalisation. This has been instigated in part by a growing interest of the government, marked for example by the creation of ministerial responsibility for alternative medicine; but also under the threat of legislation by the newly formed European Union (Saks 1994).

In response to this pressure, the medical orthodoxy made a U-turn. In the latest British Medical Association’s (1993) report, they embraced the idea of collaboration with non-medically qualified alternative practitioners. This has led to a growing number of the medical and allied professions providing alternative therapies themselves, what Adams calls ‘direct integrative practice’ (Adams and Tovey 2000). Saks sees this U-turn as a heavily defensive, politically motivated strategy, aimed at reducing the potential threat to biomedicine’s position from alternative therapies, through an incorporationist and assimilationist policy: “To contain alternative medicine in a manner least threatening to

its power, income and status” (Saks 1996). As Saks writes more recently “The blueprint for integration looks rather more like the absorption of non-medical practitioners into biomedical orthodoxy, on a less than level playing field” (Saks 1999:306).

A concurrent trend has been the move of many of the alternative therapy member organisations towards professionalisation. This has involved the grouping together of disparate groups into umbrella organisations (for example 5 different acupuncture groups banding together to form the self-regulating Council of Acupuncture (Saks 1999) and the development of standardised training for the purposes of registration, accreditation and seeking of statutory regulation. These groups are demonstrating a greater willingness to absorb elements of biomedical education and practice into their repertoire, for example including anatomy and physiology into their training. As will be discussed below, in the case of homeopathy, these moves are often defensive on the part of the alternative therapy groups who do not wish to be marginalised and lose power.

However, as Cant and Sharma demonstrate, this influence has been one sided and there do not appear to be reciprocal influences on biomedical training. Although complementary therapy has made an inroad into medical education (Greenfield, Wearn et al. 2000; Berman 2001) it has been as techniques, not in the form of bringing new philosophical insights or approaches from alternative modes of doing medicine (Cant and Sharma 1999).

‘Complementary therapies’ in general practice

Along with the change of heart towards alternative medicine, the second of the aforementioned British Medical Association reports shifted its terminology to ‘complementary medicine’ (BMA, 1993). This could be seen as another strategy to reduce the threat of alternative medicine, by showing it as a partial medicine that can be restricted to those cases where orthodox medicine does not have treatment options. So what is happening on the ground with complementary medicine in general practice?

Access to ‘complementary therapies’

Whenever the issue of access to complementary therapies through the health service, and more specifically via general practice, comes up in the literature, one report is cited. This was a postal questionnaire to a random selection of GPs in England in 1995 (Thomas, Nicholl et al. 2001). This report concluded that 40% of general practices provide access to some form of complementary therapy for their NHS patients. 25% through referral - mainly to the homeopathic hospitals or acupuncture clinics in hospitals; 21% via provision by a member of the primary healthcare team - most commonly a GP; and 6% through the employment of an independent complementary therapist - most commonly an osteopath.

This report has been used to show the widespread nature of provision of complementary therapy in the NHS. However, extracting the figure of 40% without dissecting it, offers a potentially misleading picture. The 40% figure may not represent as rosy a picture as it might imply¹¹. Only half of these practices offer CAM¹² therapies on the premises. 17% of this provision was paid for by the patient so was not free at the point of delivery, and the numbers of patients actually receiving CAM therapies through this route is estimated by the authors to be small. Where they are offered, this may involve only one member of a large practice, and may be infrequent. The study suggested referrals for example, were made on average once a month and GPs administering acupuncture may only be using it occasionally.

Adams and Tovey have cautioned that in talking about integration of alternative therapies into primary care “we are not talking about a complete process, nor, indeed, about one in which the continuing adoption of ‘alternative’ practices is a predetermined outcome of this process” (Adams and Tovey 2000: 167).

¹¹ The study was conducted at the time of the fundholding scheme of organisation in primary care, before the introduction of primary care groups. Those general practices who were fundholders were free to make individual choices about the use of their budgets. Thus the provision of CAM was easier than it is under the contemporary primary care group system where budgets are decided at group or trust level. This mitigates against individual practices ‘doing their own thing’. So the figure may have gone down since the study (Luff and Thomas 2000).

¹² In the ongoing developments of terminology in this area, the latest favoured descriptor (particularly in biomedical circles) is CAM (complementary and alternative medicine). I will use this descriptor when I am discussing author’s work that utilises this term. I could be deconstructed as a political attempt to

What form does this ‘complementary therapy’ take?

The type of therapy being offered is not problematised in the paper on access in 1995 (Thomas, Nicholl et al. 2001). However, their figures show a very low level of involvement of independent therapists, and when they are employed they are likely to be osteopaths. It has been argued that osteopaths, along with chiropractors, no longer represent an ‘alternative therapy’ having been regulated and professionalised and embraced into the medical fold (Anderson 1997). The most commonly cited therapies offered by the primary healthcare teams were acupuncture and homeopathy, and they were most likely to be offered by the GPs. This suggests medicalised forms of these therapies are being offered. GPs are most likely to have trained on courses specifically designed for medics, which offer a hybrid between alternative and conventional practice. Dew’s study of GPs offering acupuncture in New Zealand found them to offering such a hybrid (Dew 2000). Paterson reminds us that knowledge of complementary medicine is generally low amongst doctors; that many doctors have negative attitudes to some or all complementary therapies; and that the sizeable numbers of doctors who use such therapies do so infrequently and often without appropriate training (Lewith, Hyland et al. 2001; Paterson 2002).

Cant and Sharma have stressed the difference between integration of practice and of knowledge. They suggest that the current biomedical integration consists of the former abstracted from the latter. They suggest parallels with Nichter’s concept of ‘Masala medicine’ in which traditional healers in developing countries have taken aspects of biomedicine into them (for example ayurvedic practitioners in South India) without any full concept of integration being implemented, purely as a response to perceived demand from patients (Nichter 1980).

On a recent course I taught on for homeopathic doctors, they differentiated quite clearly between ‘clinical prescribing’ of homeopathy for biomedically-defined diagnoses and symptoms, and ‘classical prescribing’ which adhered more closely to the principles of

reduce the power of alternative medicines by supplanting them with complementary therapies (i.e. those controlled by biomedicine).

Hahnemann, and required long consultation times. Few of the practitioners on the course (mainly GPs) reported the luxury of sufficient time to conduct 'classical prescribing' in their NHS GP practice work. They could only manage this in private appointments, or when they worked in homeopathic hospital clinics (even there, there was talk of reducing consultation times to reduce waiting lists). It is likely that even with more time these practitioners were still unable to break free completely from their biomedical frameworks and ways of thinking.

May and Sirur's study of homeopathic GPs found that the respondents in their study who were working in the NHS, all concentrated their attention on orthodox medical practice. They only used homeopathy as a complementary technique, for problems that were intractable in the face of allopathy (May and Sirur 1998). This does not sound like constitutional prescribing, more like the 'clinical prescribing' alluded to by the course members above. May and Sirur found that, although these GPs were using homeopathy, they were generally still subject to the extraordinarily powerful secular belief system of their scientific medical framework. This, coupled with a deep ambivalence among this group about lay homeopathy practitioners, implies a very different model of practice. After all from the perspective of the lay homeopaths, the philosophy of homeopathy and general practice are seen as incompatible (Cant and Calnan 1991: 54).

This issue alerts us to the problems associated with the limitations of one name covering what may be a range of totally different practices. For example, the term 'acupuncture' may cover the use of acupuncture within a traditional Chinese medical framework being offered by a practitioner with many years training. Or it may refer to the biomedicalised use of acupuncture for pain control, by access to pre-defined meridian points, being offered by a primary care practitioner who may have been on a few weekends training. Saks suggests that the majority of medical acupuncturists want to restrict acupuncture to a limited range of applications within orthodox neurophysiological thinking (Saks 1992). An example of this is a polemical article, by consultant doctor Campbell revealingly titled: "A doctor's view of acupuncture: traditional Chinese theories are unnecessary" (Campbell 1998).

Adams' work with GPs who are involved in direct integrative practice, shows how their use of alternative therapies is severely restricted by time, colleague, and other

bureaucratic constraints (Adams 2000; Adams 2001). One doctor clearly explains the impact this has on his model of practice:

The yin and yang and the circulation of Chi ... are concepts that I don't need to worry about - they seem a bit woolly to me. If you're going to switch into a Chinese model it's a totally different concept to Western medicine ... in real life you cannot sit here and see the patients for ten-minute intervals doing Western medicine and then switch for 2 minutes into Chinese medicine (Adams and Tovey 2000: 176).

These doctors report finding the balance between patient priorities and practice priorities, a source of tension when integrating. The current organisation of general practice favours practice priorities over individual patients. Consequently they use strategies such as highlighting quick treatments; identifying simple biomedical conditions to target; and identifying suitable problem or 'heartsink' patients with whom to try alternative therapeutic techniques. He found that when asked to explain their relationship to alternative medicine, they did not see themselves as users of alternative medicine, but rather as using alternative techniques as a means to enhance the holism they perceive to pre-exist within the concept of general practice (Adams 2001). This holism was defined as generalism: the range of problems treatable rather than quality. There was no associated talk of spirituality or philosophical underpinnings in their explanations of holism. Adams sees this as a rhetorical device, serving their professional interests by differentiating themselves from the specialism of the alternative therapists, and thus quashing threats to medical dominance from lay practitioners.

Anderson researched an integrative practice and found that the panel of different types of therapists communicated by limiting themselves to the language of biomedicine. The author asks, "Will alternative medicine survive integration, if it is stripped down to no more than alternative therapeutic modalities?" (Anderson 1999).

In addition to different models of alternative therapy provision affecting the final medical product, there are other differences. Scheid has shown how traditional Chinese medicine in China is subject to globalising and modernising effects and reminds us that no one system of medicine can be essentialised into one practice, with all the effects of time and context producing a myriad of practices (Scheid 2001). Hsu's work, comparing

the very different acupuncture practices in China and in Africa is also testimony to this fact (Hsu 2000; Hsu 2002).

How is integration seen from within medicine?

In spite of all these issues 'integration' is often un-problematised in medical discourse. A recent issue of the British Medical Journal, representing a conference arranged jointly by the Royal College of Physicians and the US National Center for Complementary and Alternative Medicine, defined integrated medicine:

Integrated medicine (or integrative medicine as it is referred to in the United States) is practising medicine in a way that selectively incorporates elements of complementary and alternative medicine into comprehensive treatment plans alongside solidly orthodox methods of diagnosis and treatment (Rees and Weil 2001).

There is very little discussion within the medical arena of what the implications of this might be, on the nature of the complementary therapies being thus 'selectively incorporated'.

In the same issue of the BMJ, David Reilly, of the Glasgow Homeopathic hospital, a pivotal biomedical figure in the integration issue, reveals a colonising attitude to complementary medicine. Through the rhetorical device of drawing on scientific discourses such as placebo and psychoneuroimmunology he shows how the intention is to bring complementary medicine under the umbrella of science-based practice:

In recent decades orthodox medicine's successful focus on specific disease interventions has meant relative neglect of self healing and holism, and from this shadow complementary medicine has emerged, with its counterpointing biases. The gap between them is, however, narrowing with the emerging view, backed by the study of placebo and psychoneuroimmunology, that to ignore whole person factors is unscientific and less successful (Reilly 2001).

Anthropologist Robert Anderson shows the tactics of one contemporary European physician-scientist, Per Fugelli, as embodying these professional tensions (Anderson 2002). Anderson draws attention to 'the Fugelli tactic'. Fugelli is highly critical of alternative medicine. Yet he encourages doctors to learn as much as possible about what

makes alternative practitioners more effective (in the eyes of patients who are disillusioned with doctors in biomedicine). He suggests that the only thing worth emulating is social skills. This tactic is purely to compete more effectively in maintaining their biomedical monopoly as health care providers.

David Peters, a very high profile GP within the integration debate, set up the UK's flagship integrated General Practice in Marylebone. His writings and his spoken contributions to the conferences I attended (at which he was invariably a delegate) never problematised the issue of integrating medicines from a different philosophical base to biomedicine. His main pre-occupation appeared to be a worry that complementary medicine is becoming a threat to the power of the medical profession. He was very instrumental (with Patrick Pietroni) in setting up the British Holistic Medical Association in 1983, and is very vocal today in that group. His oft repeated phrase (I heard him say in 3 different conferences during 2000-1) suggest he does not want complementary medicine to be the only answer for holistic medicine, "It's the signpost not the destination".

The Marylebone centre offers a very doctor-centred model of integrated care. The GP is always gatekeeper in this practice, regulating who gets to see what complementary practitioner and for what. This is not always the case. Charlotte Paterson has written about a more egalitarian power sharing in her integrated practice (Paterson 2000). In one Complementary Medical Centre that I visited, the lead complementary therapist acts as gatekeeper. Luff and Thomas conducted an in-depth case study analysis of 10 general practices each representing different models of integration. The authors concluded:

The most likely scenario for a stable and harmonious service would seem to be where the key service initiator/s have a clear and consistent vision of the service rationale, the initiator/s have a high degree of control over the funding source, and they employ people who share the same perspective (Luff and Thomas 1999: 11).

Francis Treuherz, once a homeopath working at the Marylebone centre wrote recently of the tensions he experienced during this period. For example, in his recruitment interview he claimed he was asked in 3 different ways what his attitude to conflict was. He hints the GPs did not really understand the project of homeopathy. He claimed the

doctors didn't like the word 'cure' preferring 'management' and 'containment' "Their sights were lower... they did not grasp what we were about". Treuherz experienced the whole place as being "firmly in the hands of the medical profession" and described the place as "a less than benevolent dictatorship. I fear that the ideology prevalent here will provide a basis for the integrated medicine approach." (Treuherz 2000:42-3).

Peters reveals his view of the role of complementary medicine in academic writings. For example in a book chapter about integration, his title "Sharing responsibility for patient care: doctors and complementary practitioners" hints at fears that alternative practitioners might leach patients away from the control of biomedicine. In this chapter he outlines his view of the usefulness of complementary therapies for those areas which biomedicine is "less good at stress, depression and undifferentiated disease" (Peters 1994). His perceived benefits of integration are very institutionally focused: "To relieve overload and provide economies in the management of patients with non life-threatening, undifferentiated illness where high tech and high toxic medicine is not necessary, making those more available where they are really needed". There is not much of a focus on benefits for patients.

It is worth looking at the voice of one of the lone few dissenting voices, speaking from within biomedicine, David St.George, a consultant epidemiologist based at the Royal Free Hospital in London. At a seminar series on researching alternative medicine his talk bore the title: "How can conventional medicine be integrated into a holistic healthcare system?" (St George, 2001).

St.George talked of the 'biomedical myopia' of focusing on alternative therapies as a tool to extend biomedicine's power through colonisation. He pointed out that no one in this debate is asking what is needed from orthodox medicine to make *it* eligible for integration. And that the so-called integration is very one-sided. Biomedical science is proposed as the arbiter of which therapies are eligible for integration (primarily through the tool of the Randomised Control Trial and other biomedically defined notions of evidence). St.George asks the question "Would patients lose everything they are currently gaining from alternative therapy?" He himself cites the BMJ's issue on integration and accuses the lead doctors, Rees and Weill, of medical paternalism asking, "Where are patients' views?" He also cites the Marylebone centre as a bad model for

integration and the Taunton House model (Paterson 2000) where doctors and alternative therapists work as true equals, interviewing the patient together, as a far better model for a more balanced version of integration.

His conclusion is the need for greater humility from the medical profession, with more associated openness about the limits of orthodox treatments; the need to treat alternative practitioners as equals and the move towards accepting new notions of science. Notably St. George is the only doctor who uses the term alternative as opposed to complementary medicine. However I would imagine that few people within the orthodoxy are paying much attention to St George, while doctors such as David Peters are extremely visible, particularly at any public biomedical debate on integration.

Peters too acted as one of the informants to the House of Lords when they prepared their select committee report on complementary medicines. In this report, the separation out of medical acupuncture from Traditional Chinese Medicine, as more suitable for integration into the biomedical system shows the same tendencies towards dissecting, medicalising and syncretising alternative systems to fit biomedical philosophies and practices (House of Lords Select Committee on Science and Technology (2000)).

Assessing efficacy of alternative therapies: the 'gold standard' of the RCT

The repeated focus of the biomedical players on the RCT as the sole method for researching alternative therapies, has become part of the power play in colonising and controlling alternative medicine's power within the healthcare system. A great deal of emphasis is placed on using the RCT as 'the gold standard' to research all complementary medicines. For example this is a very prominent and oft repeated message of the high profile biomedical doctor Edzard Ernst, Professor of Complementary Medicine at Exeter University (see for example Ernst (2000)).

Whilst some of the early RCTs conducted on homeopathy achieved positive results for the therapy biomedical academic doctors have questioned the quality of these pieces of research. For example, Ernst stresses the need not just for RCT methodology to be used,

but for quality control to be exerted, through the use of systematic review and meta-analysis methods of interpreting the results of RCTs.

The York centre for NHS reviews recently conducted just such a review of 200 RCTs on homeopathy. They concluded that much of the evidence was inadequate or poorly designed research and that such evidence as was considered acceptable did not justify acceptance for homeopathy in the NHS (Hunter 2002). This trend points to a possible weapon through which complementary medicine, far from being integrated, becomes marginalised and eventually expelled from an NHS which is bound up in a culture of evidence-based medicine (Ernst 2000; Black and Donald 2001; Wilson and Mills 2002).

Ernst himself produces a prolific number of papers in which the scientific nature of complementary medicines is questioned. For example in a paper entitled "The heresy of homeopathy" he provides critiques of homeopathy from over the last 200 years. The contemporary criticisms he reports are that homeopathy has not proved its clinical efficacy/effectiveness; that "science has moved on and there is no room for homeopathy" and "that homeopathy has all the qualities of a sect and a cult ... [and] fits the definition of quackery." He concurs that "most of what is being expressed makes sense" (Ernst 1998: 30-1). Federspil also draws on a framework of science to question the bases of complementary medicines (Federspil and Vettor 2000). The title of his paper asks, "Can scientific medicine incorporate alternative medicine?" In this paper he claims that alternative modalities do not represent authentic scientific disciplines, as they violate the principle of falsifiability.

The homeopathic medical doctors fall into a strange middle ground. They are very informed by a biomedical view of the world, and have to maintain their position vis-à-vis their medical colleagues and so buy into the concept of scientific measurement of homeopathy through clinical trials (Fisher 1995; Kliejnen 2000). However they are also more sophisticated about the limitations of the RCT method to measure aspects such as classical homeopathy and individualised prescribing (van Haselen 1998).

Perusing the journal of the medical Faculty of Homeopathy "Homeopathy" (formerly "The British Homeopathic Journal") is an interesting exercise, particularly if comparing it with "The Homeopath" the house journal of the lay homeopaths' Society of

Homeopaths. The medical homeopaths' organ appears intensely medical and scientific. There are graphs and flow charts: scientific abstracts for articles laid out with 'objectives/methods/results/conclusions'; symptoms measured in terms of frequency, duration and intensity, and calls for inter-rater reliability in prescribing validity (see an example page in figure 1). By contrast "The Homeopath" is more like popular magazines with lots of photos of plants (used to make remedies), cartoons, and discursive and anecdotal text see examples in figures 2, 3 and 4). In the pages of "The Homeopath" and its international equivalent "Homeopathic Links", one can find interviews with charismatic individuals who talk about prescribing rationale, not in terms of validity and reliability, but in terms of intuition and dreams, and who use group meditations rather than RCTs to assess the efficacy of remedies (See, e.g. Dam 2000).

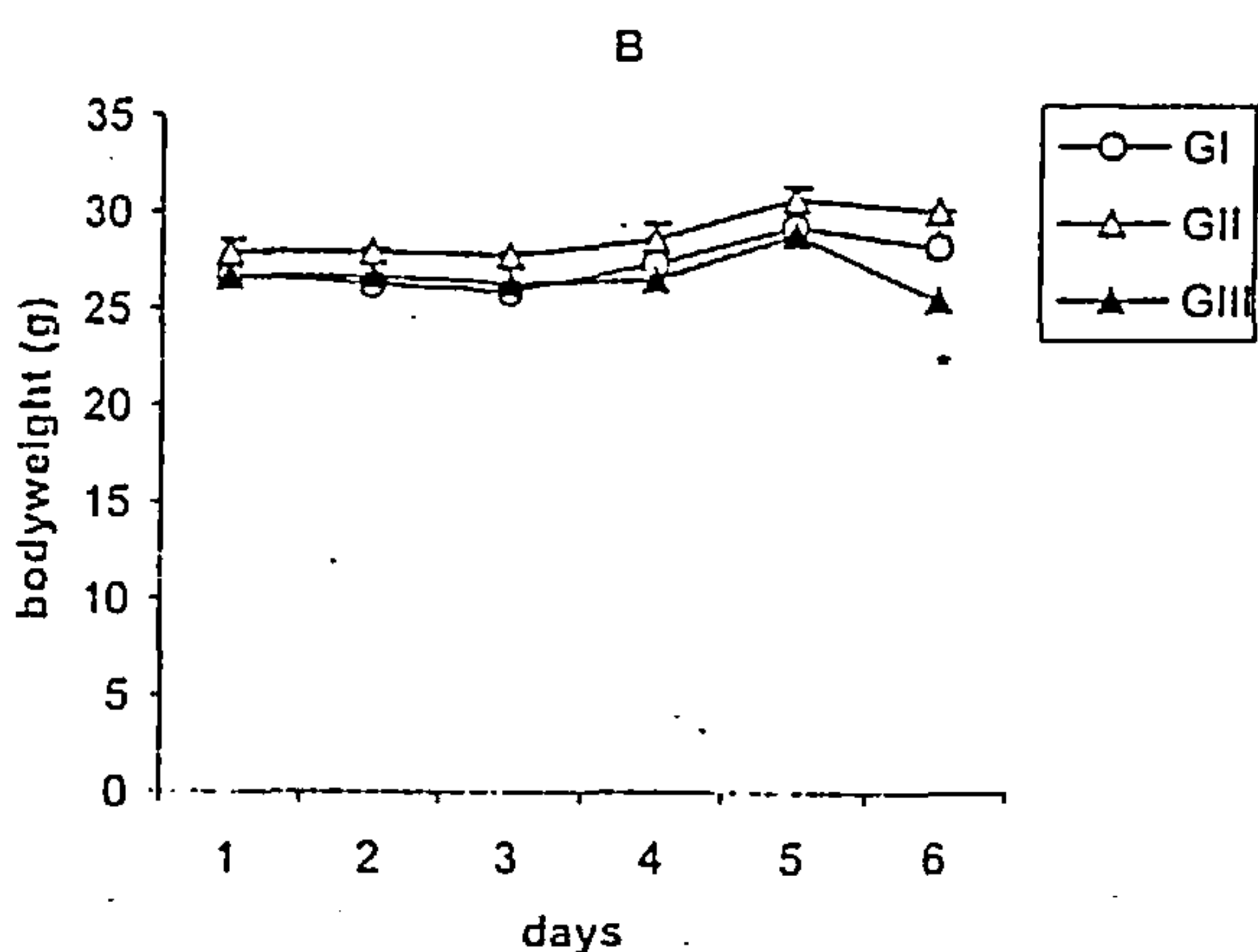
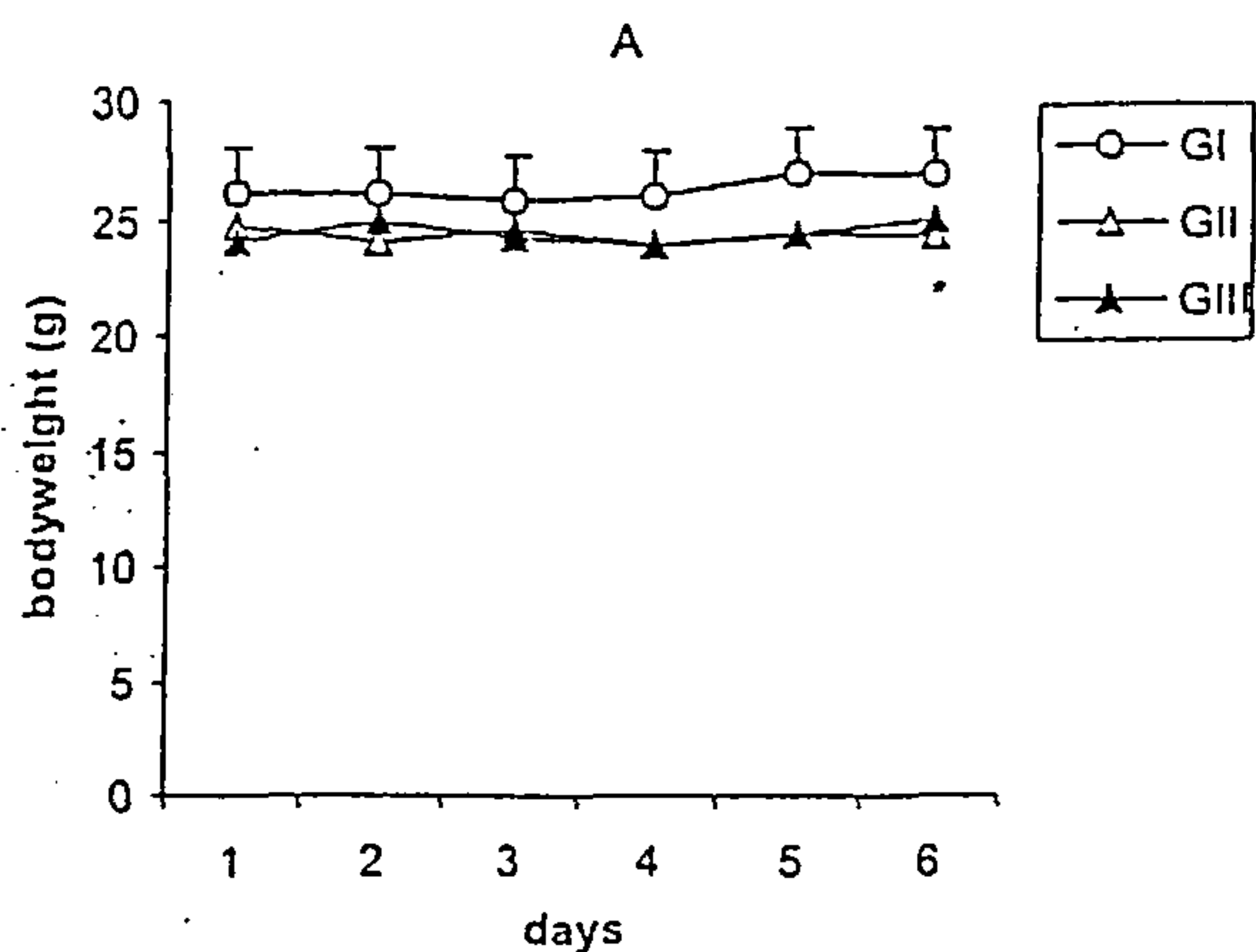


Figure 4 Bodyweight evolution (g) after i.p. inoculation of 10^6 Ehrlich tumour cells. G1—animals treated with PBS (control); G2—animals treated with dexamethasone (4.0 mg/kg) diluted into dexamethasone 7cH (A) or 15cH (B); G3—animals treated with dexamethasone (4.0 mg/kg) diluted into PBS. All treatments were made daily, s.c. Two-way ANOVA, $*P \leq 0.04$.

presence of 7cH or 15cH potencies in G2 should not interfere with the effects of dexamethasone, since from the chemical view point they consisted of PBS only, or at least of minimal concentrations of dexamethasone.

Other experimental manipulations developed in our laboratory show quite different and independent behaviours of the 7cH and 15cH homeopathic preparations of dexamethasone used alone. In those studies, poten-

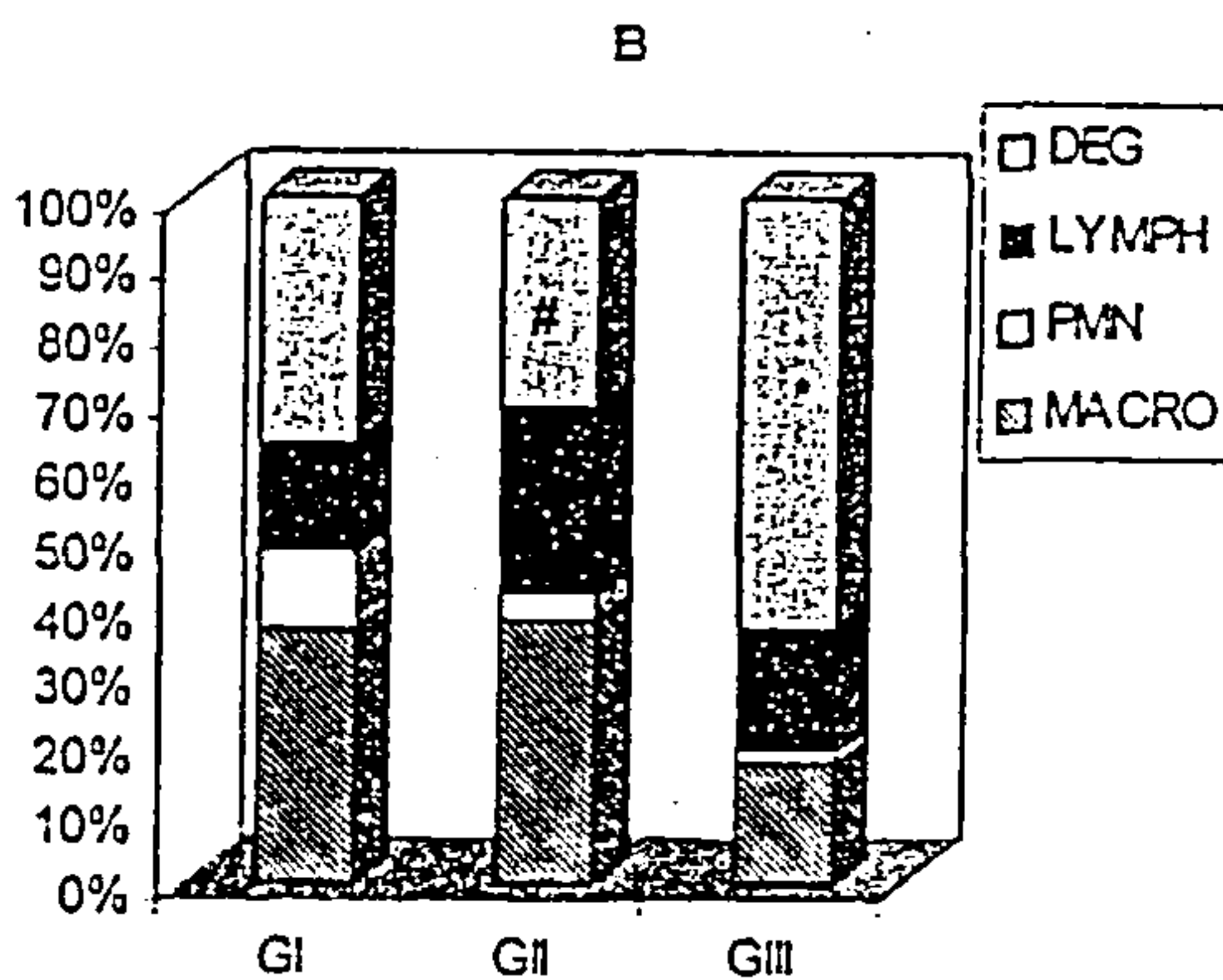
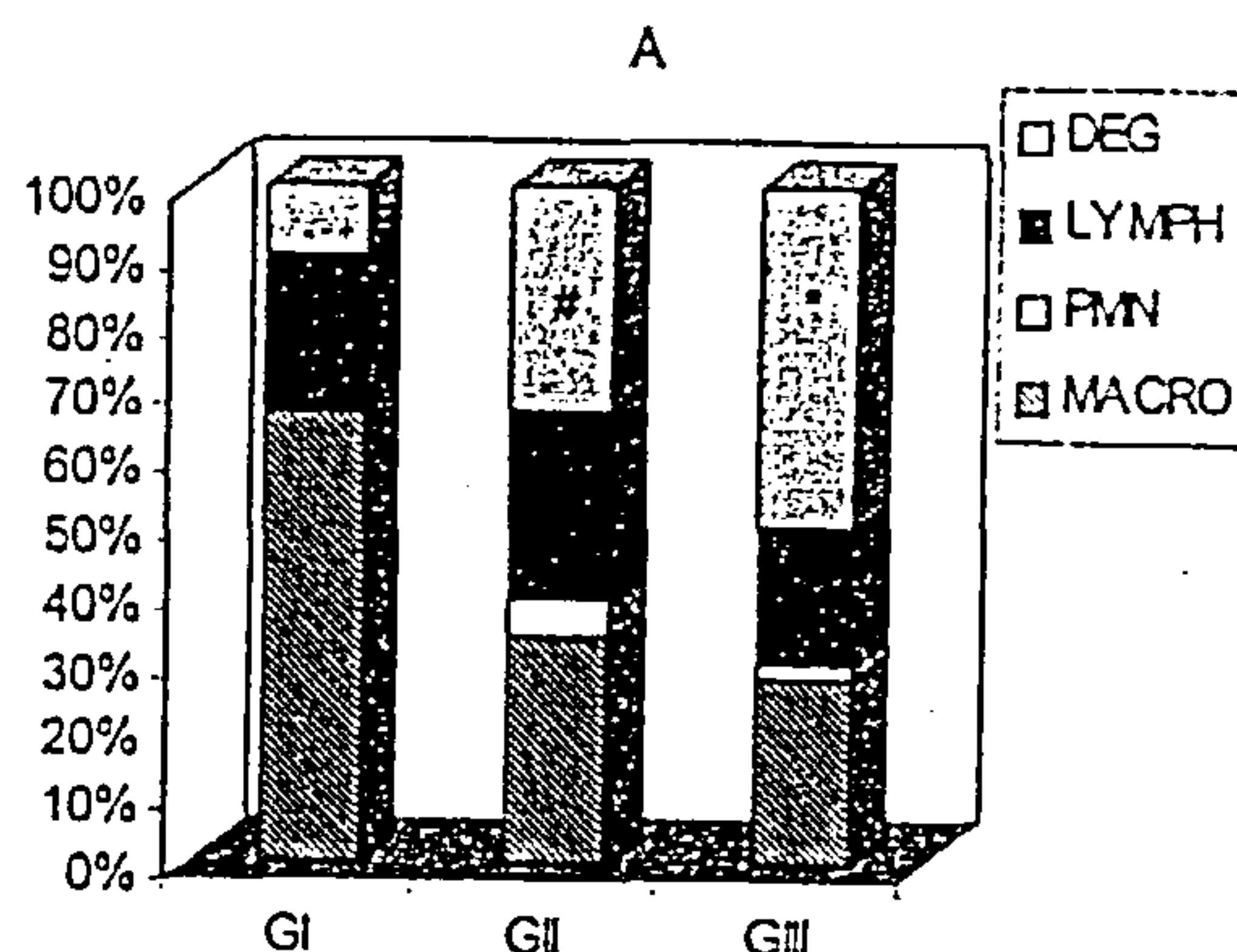


Figure 5 Differential counting, expressed in percentage, of leukocytes present in the peritoneal washing 6 day after i.p. inoculation of 10^6 Ehrlich tumour cells. Cells were counted by smears stained by hematoxylin—eosin. G1—animals treated with PBS (control); G2—animals treated with dexamethasone (4.0 mg/kg) diluted into dexamethasone 7cH (A) or 15cH (B); G3—animals treated with dexamethasone (4.0 mg/kg) diluted into PBS. DEG=degenerated cells; LYMPH=lymphocytes; MACRO=macrophages; PMN=polymerphuclear cells. All treatments were made daily, s.c. χ^2 test, $*P=0.0001$ in relation to G1, $*P \leq 0.0012$ in relation to G3.

tised dexamethasone produced an increase of lymphocyte migration into the tumour site (unpublished).

The experimental design we used is quite important for the comprehension of the great diversity of biological effects that can be obtained from the ultra-dilutions. The use of both forms of dexamethasone (potentised and pharmacological) mixed into a single preparation has not been previously described in the literature, although numerous papers have demon-

Table 2 Differential counting, (mean \pm s.d.) of leukocytes present in the peritoneal washing 6 days after i.p. inoculation of 10^6 Ehrlich tumour cells

Groups	7cH				15cH			
	PMN	MACRO	LYMPH	DEGEN	PMN	MACRO	LYMPH	DEGEN
PBS only (G1)	3.33 \pm 1.63	17.83 \pm 4.21	10.83 \pm 5.49	4.83 \pm 3.06	5.80 \pm 6.90	18.40 \pm 10.73	8.00 \pm 4.00	18.20 \pm 18.80
Dexamethasone and potentised dexamethasone (G2)	4.83 \pm 8.25	23.66 \pm 12.22	25.16 \pm 5.84	29.83 \pm 11.78	4.00 \pm 5.61	33.00 \pm 15.89	24.60 \pm 16.24	28.40 \pm 12.74
Pharmacological dexamethasone only (G3)	1.71 \pm 0.75	26.28 \pm 7.08	20.28 \pm 8.48	50.28 \pm 5.28*	1.28 \pm 0.75	12.14 \pm 5.84	12.71 \pm 6.37	44.85 \pm 20.21*

Cells were counted by smears stained by hematoxylin-eosin. G2 treated with PBS (control); G2 treated with dexamethasone (4.0 mg/kg) diluted into dexamethasone 7cH (A) or 15cH (B); G3 treated with dexamethasone (4.0 mg/kg) diluted into PBS. PMN = polymerphuclear cells; MACRO = macrophages; LYMPH = lymphocytes; DEGEN = degenerated cells. All treatments were made via s.c. *ANOVA, $P \leq 0.05$ in relation to the other groups.

Figure 1 Example Page from "Homeopathy" journal of the medical homeopaths

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Q. So a lot of your roots are from the healing place, the healing wise woman place, that is what has driven you?

I don't know how I am perceived. I have gone through my life doing what I want when I want to do it and not thought twice about it. There is some misconception about what I do. I have heard myself described as someone who does dream provings. I have never done dream provings. I dream about a remedy and then I do a regular proving. I have a reason for staying with that method - you get an awful lot more information. If you did a weekend or a meditation proving there is a lot you miss as the progression of a proving emerges over time.

For example with *Granite*, at first you get weak, then introspective, then you get physical symptoms for a few days, but you still haven't reached what makes *Granite*. After a few weeks you get the symptoms of being dispossessed, needing to protect against invasion.

A remedy works in a proving in a reverse order to what occurs in normal life. At first in real life the psyche feels invaded and dispossessed and then later loses energy and the physical symptoms emerge. You want to find out how someone operates in their normal environment as well as, for example, within a group. I mean if we did a proving here at the Women's Conference we're all in a different state than we normally are, a bit of a high! When I get back to real life that shows me more.

Q. Going back to your history, how do you see your own journey with homeopathy?

My own journey within homeopathy was spelled out for me loud and clear at the end of doing the proving on *Granite*. I was in Devon to do a rebirthing training for a couple of weeks. I was in Dartmoor - which is granite. I dreamt every night I was going back through English and Irish history - it was like two dreams happening at the same time. The same space but one from the English and one from the Irish perspective of the same history. I had the sense of being on the English side.

The dreams settled at the time of Cromwell invading Ireland. The Irish

essence of what *Granite* is all about. I was focused on one British soldier I felt an identity with. In Ireland Cromwell had moved Irish people out of the midlands, the good land, on to the rocky land. A lot of people would have lived in the granite areas such as Connemara where it would have been impossible to live off the land. In the dream I experienced the shifting of people from the midlands and felt I was on that side too. Fourteen days of dreams. Loaded with guilt.

The last night the character who always comes into my dreams turned up and said "Nuala, the reason you stud-



ied homeopathy is because you had to find *Granite* and liberate an old guilt for what happened in Ireland".

What was more interesting than that, was six months later my younger sister met a genealogist and discovered that the first Eaton to settle in Co. Mayo (my mother's maiden name is Eaton which is an English name) was a soldier who came with Cromwell's army. That threw me into questions about genetic emotions, but then that would be *Granite* too - dispossessed, suspicious and so on.

When I've decided I'm not doing any more provings, something will turn up. Each proving leads to another, dreams have led to the next. I feel that something in me is pushing me in a direction - it could be the curse of someone or another! I've always had notions since a child I was not going to die until I knew everything - I didn't know what I meant, I still don't! It's like an internal compulsion, I've got to go for

If you call it a journey, the journey through the provings is my own journey, whatever value they have been outside of that as well. And it pisses me off sometimes! I mean when I did *Fir* proving, nothing to do with Belarus' or Chernobyl, and then all the fires of Belarus' in First World War started to come to me, but it's fine! I don't do anything without a reason, it's something from a deeper place.

I believe in life, in the positive. My work with Chernobyl is not to do with charity, I'm not into charity, we're having a shared experience. I'm doing it because it could happen here, is happening here, is happening in Ireland. We're all living with greater levels of radiation. I believe we can, and we have to, integrate it. I also am patient. I will wait for the right moment, I'll wait, I'll wait for the unfolding of the next part of the journey.

Q. Do you see yourself as part of that tradition of women healers?

I don't.

That is what it feels like and it also feels interesting as others do see themselves as part of a Goddess or Pagan tradition, but it feels as though you are just doing what you have to do.

I'm doing a talk on *Amber* at the conference and this is where the Goddess stuff came in and I nearly died with embarrassment when Norse Gods, especially Freya came into it so strongly! I believe in the future more than the past and need to move in that direction, so I don't have a lot of time for bringing back old cultures.

Again I have no disrespect for it, this is my preference. I have to find the way to do it now rather than learning from something dead or obsolete - out of context. In a symbolic way I can see how mythology fits with our life, although sometimes I am confused - I wonder are the mythological stories an image of the future rather than the time they came from!

I'm a God awful sceptic, especially where groups do things, as I'm afraid of group hysteria! I'm an independent person and I don't define myself in any way, including gender. It's difficult to say this but sometimes I see things being puffed out and people using the lan-

Figure 2. Example Page from "The Homeopath" journal of the lay homeopaths

(Reproduced by permission of The Society of Homeopaths)



The Homeopath No. 57 1995

**Figure 3. Example Page from "The Homeopath" journal of the lay homeopaths
(Reproduced by permission of The Society of Homeopaths)**



Laurocerasus

Figure 4. Example Page from "The Homeopath" journal of the lay homeopaths
(Reproduced by permission of The Society of Homeopaths)

The history of homeopathy

Having set the scene as to the historical and political issues surrounding integration and the relationship of orthodox and alternative medicines, I will now focus more specifically on the case of homeopathy.

Homeopathy was established in the early 1800s by a German physician Samuel Hahnemann who was disillusioned with the brutality of the heroic medicine of the day. He developed an alternative system of medicine based on the universal principle of treating like with like, which he called the law of similars. His first observation of the law of similars was through taking Quinine (Chinchona bark) and discovering it caused a fever similar to malarial symptoms¹³. He called it ‘homoeopathy’ from the Greek meaning ‘the cure is like the disease’, and named conventional medicine ‘allopathy’ meaning ‘the cure is unrelated to the disease’. Hahnemann discovered the action of homeopathic remedies through ‘proving’ (testing) them on healthy people.

Hahnemann was very critical of the “half homeopaths” who attempted to amalgamate the homeopathic and allopathic approach. For example in aphorism 52 of his *Organon of Medicine* he writes:

There are only two principal therapies [the homeopathic method and the allopathic]. They are directly opposed to each other, and only someone *who does not know either* could be fool enough to suppose that they could ever approach each other or unite, could make himself so ridiculous as to treat homoeopathically one moment and allopathically the next to please his patients. This is a criminal betrayal of divine homoeopathy! (*Emphasis in original*). (Hahnemann 1810: 49)

This emotive and fiery critique led to infighting in the world of homeopathy that hasn’t settled down today. The result was a division of his supporters into two camps, those who followed his ideas to the letter the ‘pure’ or classical homeopaths and those who wanted to mix homeopathy with medical knowledge or the ‘physiological school’ (Wood 2000). The classical school was strengthened by the input of the American homeopath James Tyler Kent.

Hahnemann was led to dilute his medicines to an infinitesimal dose when he discovered they could have adverse effects, aggravating symptoms in their stronger form. Experience led him to believe that the higher dilutions were actually more powerful in a medicinal sense. He discovered the importance of succussion or shaking as a means of potentiating diluted remedies. He suggested that the gradual process of dilution and succussion dynamised the remedy, and exerted a vital, dynamic quality similar to that of the vital processes in the body.

He developed a theory of miasms to explain chronic illness and developed the idea of remedies used in a constitutional way to treat the whole person as a means of treating these chronic problems.

Hahnemann held very extreme views about the medical profession of the day and was openly hostile to their methods, characterising them as “[Playing] with the life of the patient irresponsibly and murderously, with its massive doses of dangerously violent drugs of unknown action chosen upon mere conjecture” (Hahnemann 1810: 25). (This is not as unreasonable as it sounds as the heroic medical treatments of the day were quite violent and included bloodletting, purgation, emesis and poisoning with chemical agents). One of his many criticisms of allopathy was its refusal to consider the spiritual dimension. Kent, Hahnemann’s follower backed up this view in saying “You cannot divorce medicine and theology” (Treuherz 1983).

Homeopathy was first brought to England in 1828 by a Dr Quin, who went on to found the London Homoeopathic Hospital in 1849. It quickly gained in popularity. By 1853, 178 doctors in Britain and Ireland had pledged their allegiance to it. There was a wide spectrum of public confidence, clerical sympathy and aristocratic patronage. The response of the mainstream medical profession was through tactics of ostracism, exclusion, and defamation (Nicholls 1992). Nicholls points out that there were three lines of attack against homeopathy that appeared under the following guises:

1. Preservation of the integrity of medical science;
2. Defence of honour in the face of charlatans;

¹³ The homeopathic remedy produced from Chinchona bark is called *China Officinalis* and is still

3. Concern for public welfare

All three could be seen as strategies through which deeper professional interests were addressed in order to bring about the collective social advancement of medical practitioners (Nicholls 1992).

Public confidence in medical practitioners was low and in this time of private medicine, livelihoods were threatened. The 1858 medical act contained a provision that would forbid doctors to pursue any therapeutic system but their own.

In 1854 there was a terrible outbreak of cholera in the immediate neighbourhood of the London homeopathic hospital. The whole institution devoted itself to treatment through homeopathy. The percentage of those treated who died was 16%, whereas for the neighbouring Middlesex hospital the fatality rate was 53%. The Board of Health reviewing strategies for treating the epidemic produced a report to parliament. In this report the statistics produced by the homeopathic hospital were suppressed. A complaint was made about this omission and the committee reviewing it concluded that the inclusion of the homeopathic hospital's statistics would have given: "an unjustifiable sanction to an empirical practice, alike opposed to the maintenance of truth and the progress of science" (Morell and Cazalet 1999). Homeopathy had many friends in high places with its aristocratic and royal patronage and Lord Grosvenor campaigned and got the returns printed by the House of Lords in 1855.

Coulter's account of the progress of homeopathy in America (it arrived there in 1825) showed that there too, the medical profession was very hostile towards homeopathy and refused to make a full investigation into homeopathic medicines or to investigate the underlying therapeutic doctrine (Coulter 1982). In its first two decades, many prominent American doctors accepted it and in 1844 the American Institute of Homeopathy became the country's first national medical association. In reaction the American Medical Association was formed in 1846. Homeopathic doctors were not allowed as members and contact of orthodox doctors with members of the homeopathic profession

was prohibited by their code of ethics (Coulter 1984). Strong biomedical professional interests were not to be threatened without a reaction either side of the Atlantic.

Homeopathy's continued survival in the UK in the first half of the 20th century, in spite of the powerful forces ranged against it (to a greater extent than in America), was very much explained by the influence of the rich and powerful. Nicholls suggests that the niche homeopathy was given in the new NHS in 1947 was made possible by its royal patronage (Nicholls 1988). The Faculty of Homeopathy Act in 1950 gave official recognition to the London Faculty of Homeopathy and empowered it to issue diplomas of competence. The strength of the effect of powerful influence continues today with the influence of the Prince of Wales¹⁴ in the integration debate. The much-published current head of research at the London Homeopathic hospital, Peter Fisher has recently been appointed as the Queen's homeopath.

Tensions between homeopathy and orthodox medicine

Right from the outset there has always been an element of difference, opposition and tension between the principles of homeopathy and that of orthodox medical practice. Coulter's account of homeopathy is somewhat evangelical, and he states the inherent divergence of homeopathy from allopathy very polemically, but putting his presentation to one side, his view of the incompatibilities between the two approaches is spelled out quite convincingly:

- Allopathy relies on common symptoms and ignores idiosyncratic symptoms, while homeopathy investigates the whole dynamic pattern of symptoms.
- Allopaths prescribe on principle of 'contraries' using medicines, that are meant to oppose or neutralise some pathological process in the body, in opposition to the homeopathic principle of 'the law of similars'.
- Homeopathy interprets symptoms as signs of the healing efforts of the body, as beneficial phenomena. Allopathy sees them as harmful signs of deterioration in

¹⁴ Through his organisation The Prince of Wales Foundation for Integrated Health, until recently The Foundation for Integrated Medicine - a change that no doubt has symbolic resonance, and perhaps an implied recognition of the processes of medicalisation at work in FIM.

health or external manifestations of internal disease and uses medicine to suppress and eliminate.

- Homeopathy rejects polypharmacy because it regards illness as a unitary disturbance of the body's vitality (Coulter 1984:70).

Coulter suggests that the conflicts about homeopathy rest on the perennial antagonism between the 2 enduring schools of Empirical and Rationalist views of the therapeutic method¹⁵. The former stresses the importance of experience and observation, the latter stresses logic and pathological theory (Coulter 1982). Coulter concludes that the difference of opinion between the two schools represents a paradigm dispute (Kuhn 1970) and that homeopathy will not in time merge with allopathy since the 2 doctrines are opposed on all points (Coulter 1984).

Coulter does not mention the problems that allopathy has with the logic of the minimum dose. In 1925 Bier, an influential Berlin surgeon investigated the medical view of homeopathy and noted that the tendency of sceptical opponents of homeopathy was to base their entire critique on the impossibility of infinitesimal doses, while ignoring other aspects of the therapy. Dean suggests that "explanations of homeopathy's comprehensive rejection by official medicine should be sought elsewhere" (Dean 2001:271).

A recent article in the New Scientist talks of homeopathy as:

Being asked to believe two impossible things before breakfast: 1) The extreme dilution of the key ingredient; and, 2) The reversal of the dose-response relationship: the more dilute the remedy the stronger the effect (Seymour 2001).

This article concludes homeopathy to be: "witchcraft but it's bloody effective witchcraft". The minimum dose aspect is often a stumbling block for scientists and

¹⁵ The Empirical thinkers stressed the importance of observation of the patient, and his/her symptomatology and rejected the need to understand the inner workings of the body. They followed Paracelsus and the Greek empirical school. The Rationalists, in contrast, only recognised symptoms that could be connected with an assumed pathological process. They followed Galen and Boerhaave, who believed the physician can acquire an a priori knowledge of the organism. (Coulter 1982). Prior to homeopathy Dean claims that the empiricists knew how to observe but not to cure, hence their reliance on diet and the healing power of nature (Dean 2001).

medics alike. Interestingly recent research in chemical science points to a possible new discovery that might be able to explain the minimum dose in traditional scientific terms (Samal and Geckeler 2001).

The well-known scientist Richard Dawkins articulates this problem of scientific logic in the forward to the late journalist John Diamond's anti-alternative medicine polemic "Snake Oil and Other Preoccupations".

Now we come to an awkward fact about homeopathy... It is a fundamental tenet of homeopathic theory that the active ingredient - arnica, bee venom, or whatever it is - must be successively diluted some large number of times, until- all calculations agree- there is not a single molecule of that ingredient remaining. Indeed, homeopaths make the daringly paradoxical claim that the *more* dilute the solution the *more* potent its action.

There is a conceivable loophole, much slithered through by homeopaths ever since this embarrassing difficulty was brought to their attention. The mode of action of their remedies, they say, is not chemical but physical...They believe that, by some physical mechanism unknown to physicists, a kind of trace or memory of the active molecules is imprinted on the water molecules used to dilute them. It is the physically imprinted template on the water that cures the patient, not the chemical nature of the original ingredient. (Diamond 2001: 18).

Ursula Sharma shows how members of the lay organisation, The Society of Homeopaths, legitimate their knowledge by linking it to other scientific and non-scientific bodies of knowledge (Sharma 1996). She suggests that the very nature of homeopathy creates problems in situating its knowledge in relation to the dominant medical and physical scientific discourses. She believes that what she calls the unexplained riddle of how the healing works, causes a clash with other scientific explanations, as does the unsuitability of homeopathy to be measured by the Randomised Control Trial. This scientific tool is designed to produce generalisable knowledge about the standardised effects of a particular intervention which can be regarded as true of all populations at all times. Sharma points out that this is the antithesis of the local knowledge of a specific body with all its individual peculiarities, which lies at the heart of homeopathy.

In the place of these anchors of scientific knowledge, as a means to gain legitimacy, she noted the homeopaths linked their work to notions of quantum science, to the science of the periodic table of elements, and to psychoanalytical knowledge such as that of Jungian theory. She suggests this strategy of situating knowledge in so many directions leads to extreme eclecticism and may undermine their attempts to legitimise themselves through the process of professionalisation. I would agree that the claims to quantum theory as a possible explanation of mode of action could be seen as a legitimising strategy. I believe, however that the other links may not come under this heading of political positioning. The work done on minerals and the periodic table by Jan Scholten in particular, seems to represent a creative attempt to actively link the two forms of knowledge, to promote improvements in the techniques of homeopathic prescribing and knowledge of remedies (Scholten 1996). Or this is certainly how it was portrayed by two homeopaths teaching on the homeopathy education class I studied.

The history of lay homeopathy

Going back to the inception of homeopathy in the UK in the 1850s, Rankin shows how there were two different movements in homeopathy right from the start, both based in different political and class views of the nature of social life (Rankin 1988). The British Homoeopathic Society came out of the reactionary Whig mentality and was made up entirely of doctors. It was a hierarchical and elitist organisation and modelled on the Royal Colleges of Surgeons and Physicians. It tempered Hahnemann's ideas by integrating them with medical ideas and tried to make homeopathy more scientific, ignoring the spiritual and idealist elements of Hahnemann's thinking. Members of this group emphasised the similarity between cases, not the uniqueness of individual patients and also sought remedies for specific diseases. They sought to record internal changes produced by homeopathy through medical examination. This was contrary to Hahnemann's doctrines and could be seen as a strategy to maintain professional medical control over the practice of homeopathy:

If a knowledge of the internal functions of the body and the diagnosis of illness were necessary before treatment could be carried out, then the layman was hardly likely to be successful in medical practice... This interpretation stressed the importance of the internal, the hidden

of those bodily processes and of those indications of disease which were not readily available to the layman (Rankin 1988: p. 51).

In the approach of The British Homoeopathic Society the involvement of patients in their own health was minimised, as disease was seen to be caused by an invading 'miasma', so diet and building up constitution were seen as irrelevancies. Thus the role of the patient was reduced to that of the traditional passive biomedical patient. As Cooter points out this medicalisation of alternative therapy was only to be expected:

The positivist territorialisation of the heterodoxies was almost inevitable, in fact, given that the majority of the advocates (with the exception of medical botanists) had been trained in orthodox medicine and were initially attracted to the heterodoxies more for social and therapeutic reasons than for explicitly metaphysical ones. (Cooter 1988: 73).

John Epps started the rival organisation, The English Homoeopathy Association, shortly after as a breakaway from the first group. He was grounded in a far more radical political stance. He was anti slavery; against the Corn Laws; and, did not agree with the elitist and exclusionary strategy of Dr Quin and his British Homoeopathic Society. He preferred a model of organisation that would encourage lay members. Epps view of homeopathy involved much more of a role for patients: in choosing their practitioners; in adhering to preventive measures such as diet, avoiding alcohol, taking exercise and fresh air. This model of homeopathy was closer to Hahnemann's intended doctrine of disregarding diseases and paying attention to the unique picture of the individual's symptoms, including those that might seem trivial to medical practitioners. This view was eminently suited to lay practice, as symptoms were available to the professional and layman alike. Healing was seen as God-given and attained only by helping the body to heal itself. Attention was paid to the spiritual aspects of homeopathy and it was seen as a means of attaining maximum potential and happiness.

It is fascinating to see how these two traditions have continued fairly unchanged over the last 160 years even if the names of the organisations have changed (to the British Homoeopathic Association and The Society of Homeopaths respectively). As will become clear, my own research with the followers of these two traditions shows similarly diverse views on the nature of health and healing among the practitioners and patients who visit them. Similarly it is interesting to note that anti-vaccinationism,

recently associated with the lay movement, was a movement associated with homeopathy even during its early years in the UK. Barrow (1988) reproduces an illustration representing “The Evil Fruits of Vaccination” from 1885.

Recent research on the lay homeopaths

Cant and Sharma’s 1995 study focused on the aforementioned lay homeopathy association: The Society of Homeopaths (Cant and Sharma 1995). Their case study showed up the tensions felt within the society between being a social movement with a moral need to preserve its ideals, and an occupation that needs to professionalise. Through interviewing key members of the association and the heads of the homeopathic training colleges, attending conferences and analysing the society’s journals and newsletters, the researchers discovered that the druidic and esoteric roots of the society had a pervading influence on the ideology of the members.

When homeopathic practice had almost died out after world war two, two charismatic teachers Thomas Maughan and John da Monte started to teach homeopathy to a small number of people. When they died within two years of each other their pupils banded together to pass on their teachings and started the society.

Maughan’s views on homeopathy were tinged by his other interests: in eastern philosophies, psychotherapy and druidism. The historian Peter Morrell noted that he borrowed concepts such as the subtle body, chakras, and karma from Indian traditions, and of the astral body, the etheric realm and the spirits from spiritualism, anthroposophy and theosophy (Morrell 1996). Maughan and Da Monte, yoked many spiritual traditions and therapies together as a means to improve the life of individuals. Morrell suggests that Maughan’s hidden agenda was to use homeopathy as a way to push people along the spiritual path quicker than on the alternative route of pain, and suffering, believing that homeopathy was capable of a ‘deep spiritual awakening’ in people.

In terms of practice, Maughan conducted deep constitutional therapy for months or years but did not ally himself to the more Kentian classical version of homeopathy of 'one high potency remedy and wait'. He used polypharmacy, giving more than one remedy at once and he used remedies for drainage.

Key informants in my study, lay homeopaths Nancy, Jenny and Eve, are all members of The Society of Homeopaths. It is interesting to note that these traditions of thinking of the founding fathers appear to have passed into current lay homeopathy practice. Nancy used the Hindu concept of chakras in teaching the homeopathy evening class, and emphasised the potential spiritual role for homeopathy. Jenny referred to the etheric body and also practised polypharmacy and used remedies for drainage (for example of lungs) in many of the consultations I observed. These elements did not appear in the consultations I observed with the homeopathically trained GP.

Focusing more on sociological notions of professionalisation, Cant and Sharma do not draw attention to the way in which homeopathy amongst this group became a syncretic medical practice. Current practice of the Society's homeopaths draws on the roots of homeopathy's German classical tradition and combines these with esoteric ideas rooted in English traditional culture (as represented by druidic ideas). This becomes an important aspect in my own data as it becomes apparent that not all practitioners using homeopathy subscribe to these more esoteric values. The ways in which sub-cultures within homeopathy come to appropriate different cosmologies through practice and interaction, is of interest.

Cant and Sharma showed how these esoteric beliefs had been maintained and were still central to the ideology of the homeopaths belonging to the Society. They quote an article in 'The Homeopath' which states "The majority of lay homeopaths in this country have some form of religious or esoteric commitment- it is hard to find lay homeopaths who do not subscribe to new age ideals of some kind" (MacEoin 1993). However they found that these ideas acted as a form of tension in opposition to the wishes of the society to gain professionalisation for its members. These wishes being manifested in a desire to be accepted by the institutions of medicine and the government, in a bid to become more widely used, less marginal and fringe and more accepted. MacEoin's quote states this worry in his article.

What worries me is the possibility that this leaning towards metaphysics instead of rational, empirically based medical practice may retard the process of broad political and scientific acceptance of homeopathy for decades, if not indefinitely.... and there are real grounds for supposing homeopathy might as a result become ghettoised and restricted (MacEoin 1993/4?).

Cant and Sharma found much evidence of the force of this tension among the members of the society. Their data reflected differences of opinion amongst various members on the need to tone down these esoteric aspects of their tradition, in order to achieve recognition and acceptance. The Society of Homeopath's has attempted to distance themselves from the more controversial teachings and align themselves with the orthodox scientific paradigm. "More biology less druids!" However there are heads of colleges of homeopathy who resist this approach and continue to stick to their more radical agendas.

This type of work is very useful for alerting us to the importance of the political and historical context in which practitioners daily work is set. I found evidence for these tensions between the two different groups of homeopaths, and their situation with relation to mainstream medicine in my own data, as will be detailed in chapters 6 to 9. My dataset provides the next link in the chain looking as it does at how these higher level organisational political tensions are played out in everyday practice, not just in the written discourses of these groups.

The social processes of movement towards regulation and professionalisation among the lay homeopathy association, (Cant and Sharma 1995) can be seen within the interactions of the members of that organisation that I studied¹⁶.

I asked two of the homeopaths, at the time of much press debate on the public's failure to take up the MMR vaccination for their children, why homeopaths didn't speak out in the press, giving their view of the harmfulness of vaccinations to the immune system? They told me that this message had been forbidden by their parent organisation, the

¹⁶ As will be demonstrated in chapters 6 to 9.

Society of Homeopaths. In Cant and Sharma's analysis, this instruction had been made in order to reduce possible friction with the biomedical system and the government, during a period in which the Society moves towards hopeful government recognition of homeopathy as a profession through parliament. It was interesting to see this played out in the communications between these homeopaths and their clients. They still told them that vaccination was harmful to their children's developing immune systems, but stressed the need for each parent to make up their own mind about vaccinating or not. Had the research been done a couple of years prior, the more radical nature of the homeopath's stance against vaccination might have been more openly communicated. So when I asked the homeopaths why letters to the press defending the homeopathic position of the harmfulness of vaccines had not been sent, I was told that this view must be suppressed for political reasons.

Integrated homeopathy

Little critical work has been done on the practice of homeopathy by biomedical doctors, although there have been a number of audit style case studies of individual practices, see for example Christie and Ward 1996; Dempster 1998; Hills and Welford 1998; Treuherz 1999; Halpern 2001).

May and Sirur's study, discussed above, highlighted the effects of context-related limitations in general practice. The participants in this study, whilst attracted by the rhetoric, of connecting the organic and psychological components of patients experience, found it "difficult to deploy homeopathy in their everyday conventional practice." (May and Sirur 1998: 174). They conclude that whilst these GPs, who were using some homeopathy, were generally still subject to the "extraordinarily powerful total organising framework for medical practice [of science]" which "acts as their secular belief system" (p.181) "none would have seen themselves as resisting, rather as modifying its practice" (P187) (May and Sirur 1998). This study also focused on the importance for homeopathic doctors, of their colleagues' reactions. A trajectory was noted by May and Sirur where initial hostility was often replaced by amused tolerance

of personal idiosyncrasy, finally moving to a position of a kind of personal conversion, with these colleagues getting trained in homeopathy themselves. This is interesting, as it suggests that there are processes of influence and attitude change between practitioners. I would suspect that this trajectory only applies to doctors with certain predispositions. May and Sirur also mention reports of sceptical and aggressive doctors who want to know the scientific mechanisms, who prove impossible to convert. Adams more recent interview study with doctors involved in what he calls 'direct integrative practice' found that colleagues were not solely an influence through their hostile reactions but also through direct action: "Partners have the ability through their own allocation of practice time and organisation to influence the amount of complementary treatment integrated by others" (Adams 2000: 185).

An ongoing study by Thompson is based on interviews with homeopathic GPs (Thompson, Weiss et al. 2002). He is finding that many of his participants have made the decision to leave general practice and practise as full time private homeopaths, because they see no other way of offering a more classical version of homeopathy within these constraints.

Often generalisations are made about medically trained homeopaths without alluding to context. All the literature on this topic suggests the impossibility, within the institutional constraints of the NHS, of making full use of homeopathic principles such as the long case review. The 'homeopathy' conducted in general practice is thus a very different animal to that conducted elsewhere. Whiteford's study in Mexico noted that it was the inability to spend time interviewing patients that resulted in homeopathic physicians working outside the government run health service (Whiteford 1999). This is not the case in the UK and there are GPs claiming to offer homeopathy within their NHS practice. This has important implications for the interpretation of clinical trial data on the effectiveness of homeopathy. What kind of homeopathy is it that is being tested in clinical trials? And how does this relate to the kind of homeopathy that is being used in general practice and outside the NHS by medical and non-medical homeopaths? I would support Verhoef's call for qualitative research to monitor the context, process and practice within clinical trials so that conceptual generalisations can be made (Verhoef, Casebeer et al. 2002).

Robert Frank's interview study in Germany revealed a number of possible areas of tension between doctors and patients. He contrasts these tensions with the rhetoric of the ideal of 'a dyad of harmony' between practitioners and patients in alternative therapy. For example, these problems were particular to those homeopathic physicians trying to operate within the public insurance funded system where time is a real limitation. Frank's participant doctors also alluded to the problems of dealing with patients socialised into a biomedical patient role with attendant unrealistic expectations, especially around speed of recovery and alleviation of symptoms. Some doctors reported patients wanting a passive "fix it for me" role, with unrealistic expectations of miracle cures and without expecting to participate in their own healing. There was also mention made of a different type of patient with an ideological affiliation to homeopathy who rejects biomedicine and will not countenance antibiotics (Frank, 2001).

Frank makes the important point that biomedical doctors using homeopathy cannot all be grouped together into one category. In his sample of 20 homeopathic physician's all trained biomedically and then through the same 3 year (part-time) homeopathy training programme, he found three distinct patterns of usage of biomedicine and homeopathy. One group of doctors stayed very close to the biomedical model. They valued biomedical drugs and relied on biomedical diagnoses but selected biomedical or homeopathic treatments, according to the patient, using homeopathic remedies in between 20 and 50% of cases. A second group also used biomedical diagnoses but preferred to avoid biomedical drugs except in emergencies, so mainly prescribed homeopathic remedies. The final group only operated in private practice. These were the doctors who had a more alternative orientation and relied on classical homeopathic diagnosis, often with spiritual leanings. They did use biomedical diagnoses, but purely to rule out dangerous conditions, and tended to have a negative appraisal of biomedicine and drugs (Frank 2002).

Frank did not look at the consultation behaviour of these three groups but we could expect it to be quite different in terms of communication, diagnoses, treatment strategies and aspects of the doctor-patient relationship.

Frank looked at the relationship model of the homeopathic physician-patient dyad in terms of the shared-decision-making model. He found that shared decision-making could only be applied to certain aspects of the consultation, notably the choice between a biomedical and a homeopathic treatment route. Once the homeopathic route had been followed, he surmised that the necessity of the choice of one remedy by the physician returned the model of interaction to a paternalistic model, with no room for debate about actual treatment options. He felt that he could not concur with the assumption that homeopathy is popular because of harmonious interactions. However, he only hypothesises that the issues above may lead to conflict and does not provide any evidence of actual conflict being experienced by patients, because he does not have the data to do this. I have been able to explore this aspect of the relationship between a homeopathic GP and his patients (see chapter 9.)

Frank did not study lay homeopaths, and so the kinds of opportunities for conflict may have been exacerbated by the tensions between biomedicine and homeopathic frames of reference and by the impositions of the biomedical institutional pressures.

Differing models of medical homeopathy

If we can accept that one type of medicine, whether it be homeopathy or biomedicine covers a broad and varied range of practices and philosophies, what is required is contextualised accounts of practices and processes in specific circumstances. This is where the strengths of the anthropological method become apparent. This facet makes rather a mockery of the medical camp's evangelical insistence on the importance of the randomised clinical trial as a means to evaluate alternative therapies (for a useful critique of this position see Long, Mercer et al. 2000). When Frank talks of three types of practitioner, within the medically trained homeopathic camp, we need to ask the authors of the clinical homeopathic trials which model the doctors in their study fitted. Given the rhetoric and discourse around homeopathy and clinical trials it seems likely that it is Frank's first type of doctor that is involved. Such doctors are utilising a biomedical worldview, relying on biomedical diagnoses and abstracting from the equation many of the features that a lay homeopath would see as integral to homeopathy.

When homeopathy is on trial we need to ask what type of homeopathy, who is practising it and how. Frank's doctors suggested that there are patients acting out of biomedical and homeopathic frameworks. The interaction of different patient cosmologies with different practitioner cosmologies makes for a wide variety of different possible permutations. Each will have effects on the interpersonal encounter of the consultation and on subsequent health related behaviours.

Franks' study is a useful addition to the literature. However any study based solely on interviews has weaknesses, as I have alluded to earlier. The paucity of data is compounded if the interviews are only conducted with practitioners (and only one type of practitioner in this study¹⁷) and not patients. Especially as Frank claims that one of the main interview questions was "What kind of expectations do you experience from your patients?" This is data that would be much better collected from patients themselves. Frank himself suggests the need for observational data such as videotaped homeopathic consultations. This study shows how drawing conclusions based on thin datasets can lead to potentially misleading conclusions.

In addition to the situation where medically trained doctors are using homeopathy, there are instances where lay homeopaths work within general practice settings. I outlined the opinion of Francis Treuherz, a lay homeopath working in general practice settings, above. He mentions a number of inter-professional communication problems, such as the insistence of allopaths in asking him to define what biomedical diagnosis categories homeopathy is good for. He also claims his colleagues refused to believe the positive findings of his outcome audit study on homeopathic treatment:

I was not believed... It was made clear to me that it must be because I was so nice and because I spent so much time with them that the patients improved. It could not have been the medicines.... The word 'holistic' was interpreted by the GPs as meaning taking a view of the patient as a whole person, understanding somatic illness, being sympathetic, but not having really learned any more therapeutic responses than reaching for the prescription pad. (Treuherz 1999: 43).

Treuherz, like the doctors in Frank's study, also talked of the issue of patients socialised into seeing treatment from a biomedical perspective. One example he gives is of being dismayed to find a patient taking *Sepia* 10m 3x a day every day, when the homeopathic prescription was a one off dose of three in one day. The local pharmacy had sent out a tub of 125 pills minus the homeopath's instructions. He found he was required to educate patients into seeing the remedies differently to biomedical drugs: " 'Conventionally you finish the pills this is the opposite'... One has to realise that not all patients share our zeal and our ideals, and insist on using both schools of medicine simultaneously' (Treuherz 2000: 46)

Summary and concluding remarks

In this chapter I hope I have demonstrated that that the responses of the biomedical orthodox system to the integration of alternative therapies, can be seen as highly political, and as continuing an opposition between orthodox and alternative medicine that has continued over at least two centuries.

The current situation as regards access to alternative medicine in general practice is one of patchy provision and infrequent numbers of treatments, primarily provided by biomedical healthcare staff, and infused with a rhetoric of scientific and evidence-based discourses. There is evidence to suggest this provision is of highly biomedicalised forms of the therapies in question. This is due in part to institutional restrictions, for example on time, but also to paradigmatic differences in underlying philosophies. There is little public discussion from the biomedical players of the implications of this although implicit in much of the discourse, is a feeling of threat to biomedicine and the need for incorporationist and assimilationist strategies to reduce this threat.

Taking the specific case of homeopathy, it appears that where homeopathy is offered within the NHS it is most likely of the clinical rather than the classical variety, although there are different types of homeopathic practitioner within biomedicine. An analysis of

¹⁷ Frank (2001) explains that in Germany there are homeopathic physicians who he did interview but there are also three other sets of people using homeopathy: GPs, natural practitioners, and lay homeopaths none of whom were included in his sample.

the history of homeopathy in this country reveals that the two different homeopathy movements, the lay and the medical, have roots in a quite different political and class ethos, resulting in two very different versions of homeopathic practice. Embedded in the classical version of homeopathy are various tensions with orthodox medicine, that go right back to homeopathy's founding. There is also a spiritual and esoteric element in lay homeopathy, also going back to its origination, that appears much reduced in medical homeopathy. (Although in the moves of the lay homeopathy organisations towards professionalisation attempts are being made to downplay these differences).

Setting this historical and political context has been aimed to help the reader make sense of the very apparent differences between the lay and medical homeopaths in this study, that will be detailed in the data chapters 6-9. Before I start the analysis of data, I will lay out issues of epistemological and methodological significance in the following chapter.

Chapter 5

Epistemology & Methodology: Interpretive anthropology, ethics, embodiment, and reflexivity

CHAMOMILLA (Cham.)

Family name: Compositae

Common names: corn feverfew; matricaria chamomilla; German chamomile



Chapter 5. Epistemology & Methodology: Interpretive anthropology, ethics, embodiment, and reflexivity

In this chapter I aim to review a number of key methodological issues concerning my research. I start with an epistemological position statement. Next I sketch out the path taken through my fieldwork, in terms of choosing fieldwork sites and gaining access. I will discuss two associated ethical issues around consent and 'giving voice'. I then discuss the embodied participation of the anthropologist, and the associated changes in my own identity through the fieldwork process. I make a plea for the centrality of reflexivity to research where the central tool is the ethnographer herself.

Epistemological position: Interpretivist anthropology

Firstly I want to outline my epistemological views, explain how these are situated with regard to a theoretical position and how they have guided my position within the research.

How is the social world constituted?

As an anti-realist I see the social world as one of multiple realities, according to the perspective of the observer. I believe reality changes across history and across cultures, and these macro changes are achieved through daily, situated micro processes of interactions between people. Reality is co-constructed in interaction (Shotter 1993) and does not reside in unchanging essences. The world is constantly changing and in process, with meanings emerging from these processes and interactions. This interpretive perspective is evidenced by work of Clifford and Marcus (1986), Good (1994), Mishler (1984), and Rabinow (Rabinow and Sullivan 1979). The aim of work within this paradigm is only ever tentative, relative and partial: directed not towards objective knowledge, but partial insights.

Language is one tool whereby these interactions are conducted and language can be seen as performative, words become a form of action, or “speech acts” (Austin 1962). However I would not ascribe to the strong version of social constructionism. This suggests that “there is nothing outside the text” and discourse is everything (see for example Derrida, (1978) and Edwards, Ashmore and Potter, (1995). I see this view as problematic because it gives no space to the embodied and felt aspects of life as lived. The interactions which make up reality are firmly grounded in the context in which they occur. Whilst I can see the logic of this approach, I would have argument with much of the work in discourse analysis, conversation analysis and ethnomethodology, that largely limits itself to studying interaction (usually verbal interaction alone) without contextualising the data.

Much research has ignored the embodied reality of personhood, envisaging people as cognitive “rational men” as Allan Young has argued (Young 1981). It has increasingly come to be realised that this is a misleading view of human life, and that actors need to be re-situated within their bodies. This does not mean solely an anchoring in corporeal bodies but also in lived bodies, social bodies and the body politic (Scheper-Hughes and Lock 1987).

The other important aspect in interactional reality, apart from language and embodiment is the emotions. Desjarlais (1992) reprimands anthropology for ignoring the emotions. The emotions could in some way be seen as the glue that binds language and embodiment together. As Rosaldo explains, emotions are a kind of cognition, however with a greater sense of the engagement the actor’s self-embodied thoughts: “thoughts seeped with the apprehension that ‘I am involved’” (Rosaldo 1984).

In terms of health and health practices, this view would counteract the rational cognitive views of, for example much of health psychology and its models, such as the health belief model, as Good has pointed out (Good 1986). Models such as this construct the actor as, “Universal Economic Man proceeding rationally towards the goal of positive health using a threat benefit analysis. Lay medical culture is the precipitate of rational adaptive behaviours of individuals and it takes the form of more or less accurate beliefs which are held in individual minds”. Good calls this a myth, suggesting that

health decisions are far more constrained by social factors and macro level structures of inequality than subjective belief factors (Good 1994:42).

A focus on interactional reality requires discarding notions of fixed categories or of essentialising reality into fixed unmoving monolithic structures. In the place of fixed categories, the ethnographer should focus on processes as set within specific context (Robinson and Frankenberg 2000). Frankenberg, Robinson and Delahook deconstructed categories such as 'vulnerability' and 'ethnicity' in their research on children in different contexts (Frankenberg, Robinson et al. 2000). These concepts were found not to be fixed essences but rather shifting, flowing, changing processes according to settings and situations. If fixed pre-determined categories form the basic structure of research, one may end up researching an artefact, and reifying a non-existent reality. In my study, supposed pre-defined categories such as health, biomedicine, alternative medicine, homeopathy, diagnosis, and illness all have to be deconstructed and reconstructed as they are seen to take place in process, in real life settings.

It is better to start by defining the problem in the vaguest possible terms (Lett 1997). This entails putting aside both findings from the literature and hypotheses of the researcher and attempting to approach the problem as though one is "an anthropologist from Mars" (to borrow from Oliver Sacks, 1995). Rosaldo suggests that interpretive ethnographic work requires the ability to draw on wide ranging theoretical positions, which requires wide reading and implies familiarity across disciplinary boundaries. It also requires attention via fine tuned self-awareness, to a range of the ethnographer's own life experiences (Rosaldo 1989). Intuitive insight and empathic imagination are two further tools required by the interpretive researcher along with the skill of evocation and interpretation through writing (Clifford and Marcus 1986).

To summarise, my view of the social world is as socially constructed, through interactions including spoken and other acts of embodied, feeling persons, set within context and emerging through processes over time.

Implications for methodology

This view of the world has a number of implications for research and the role of the researcher in the arena of health. Methodologies that abstract individuals from context, or that access cognitive and individual accounts of reality will not do justice to this complex relational worldview.

Ethnography and participant observation provide the best method for accessing a suitably complex view of reality. This type of research is conducted in real life settings and so can pay attention to the all important contextual features of interaction. Real life interactions between members of a community or setting, can be recorded, paying attention to the intersubjective space and the co-construction of reality. Geertz, an interactionist, encourages ethnographers “to apply anthropological techniques to the study of modern thought by looking for natural communities in our midst, people who share involvement in one another's lives” (Geertz 1983:157).

Ethnographic work gets around the problem of much qualitative work, of focusing on meanings and not practices. This point has been raised by David Silverman, a sociologist. He makes the claim for the importance of ethnomethodological analysis and ethnography of people's practices, to supplement interview data on the meanings that people hold (Silverman 1998a; Silverman 1998b). My own work on previous projects has shown how totally new data comes to light when both interviews and observations are analysed together (Barry 1995; Barry 2002). The power of this approach has been borne out in this current work, as will be demonstrated particularly clearly in the case of the data on Dr Deakin that is analysed in chapter 9.

The ethnographer, by working with set communities or sites over a long time frame is able to investigate the processual and emergent aspects of reality. This avoids the trap of essentialising beliefs or practices as fixed in time and unchanging, one of the criticisms that can be levelled at some early ethnographic works -see for example Evans-Pritchard (1976).

The role of the researcher

One of the key aspects of an interactionist ethnography is the dialogical nature of research and the intersubjectivity not just between research participants but between the researcher and her participants. “When anthropologists try to understand human experience they contribute to it, distort its variety and thus make it all the more difficult to grasp” (Dwyer 1977).

The position of the researcher in this type of research enterprise is not peripheral in object-subject dialogue, but central. The researcher becomes one of the participants and constituents of the research and must be reflexive about that position to produce useful ethnography.

“Investigator and subject are of the same essence and as such constitute an intersubjectivity governed by dialogue geared towards attempts at mutual understanding” (Obeyesekere 1990:227).

Although Obeyesekere also reminds us that the ethnographer is ever shifting between the participation in dialogue and the observation in detachment.

So researchers need to be conceptualised as central to this kind of research in several ways. Firstly, we are central by researching phenomena we feel passionate about, and which are rooted in our own life experience. Cohen and others have noted that “many anthropologists are motivated by a personal problematic as well as by mere intellectual curiosity” (Cohen 1992: 223). Powdermaker (1966) was one of the first anthropologists to examine publicly the complex of factors that lead her to do her research. For Rosaldo, what the ethnographer brings to the field in the way of personal experience determines the limits of his or her understanding. He invites us to be suspicious of ethnographies that do not incorporate some personal experience or at the least demonstrate real empathy (Rosaldo 1989: 74). He came to this understanding after the death of his own partner impacted dramatically on his understanding of the grief of the Illongot head-hunters he was studying. This viewpoint alerts us to the importance of using the

ethnographer's emotions as a tool towards greater understanding. More recently Charlotte Davies has expanded the view that the products of research are affected by the personnel involved and the process of doing research. She suggests that the personal history of researchers, their disciplinary background, and the socio-cultural circumstances in which they have worked, have profound effects on what they study, how they study it and how they interpret their data (Davies 1999).

Secondly, as researchers we are central because we work with people who want to work with us. This already narrows the possible view of a particular culture or setting (Obeyesekere 1990).

Thirdly, the researcher is central because she or he comes from a position, whether they claim that position or not and whether they are fully aware of that position or not. Hastrup suggests that fieldwork is situated between autobiography and anthropology. She says there is no way of speaking from nowhere in particular (Hastrup 1995). Rabinow holds that "there is no absolute perspective from which we can eliminate our own consciousness from our object" (Rabinow 1977).

Fourthly, because our lives continue to occur during ethnographic fieldwork and cannot be put on hold while the fieldwork takes place. "We cannot disconnect ourselves from our lives to live our fieldwork, just as our subjects cannot disconnect themselves from the world and their pursuits to engage with or to be abandoned by us." (Amit 2000).

Fifthly, the researcher is central to the research because she or he changes the research environment by being in it. Without the ethnographer there would be no ethnographic reality.

Finally, the researcher is central as an analyst, embedded within an academic context. We interpret beyond their understanding: "we must interpret to elucidate" using theory and our professional peers, to help us make sense of our ethnographic descriptive data, to move us "beyond the surface reality of everyday understandings" (Obeyesekere 1990:244).

Given our centrality as researchers and the dialogical nature of the research process, there is a need for constant reflexivity to unravel our position and our influences on the research; to understand our emotional and intellectual responses; and, to bring to light tacit knowledge gained in the field. If “The specificity and individuality of the observer are ever present [they] must therefore be acknowledged, explored and put to creative use” (Okely 1996: 105). There is a need therefore for continual reflexivity throughout the research process and for the researcher to be fully present in the published accounts of research¹⁸. Total reflexivity requires full and uncompromising self reference (Davies 1999). Marcus and Fisher suggest that in interpretive anthropology, this reflexivity benefits the research products as a vehicle for self reflection and self growth of the ethnographer (Marcus and Fischer 1986).

In this reflexive process, it is important to remember that as ethnographers we are embodied participants and should use our embodied knowledge in our reflexivity. Aaron Turner (2000) has suggested that the reflexive anthropologist is most commonly represented as “a sentient consciousness reflecting on fieldwork with no consideration of physical presence in the field”. He suggests that the reflexive anthropologist has been constructed as an analytical consciousness, not an embodied, sensing, acting, socially situated participant. Turner also notes that the focus on embodiment has been on the bodies of others, and encourages us to be reflexive about our embodied participation, not just our analytical observation. Paying attention to our embodied experience, as well as that of our participants, can help us to bring tacit knowledge to light, which is so often highly deterministic in social situations and can provide a key to understanding (Polanyi 1958).

Once it is acknowledged that the researcher is so central, this aspect can be consciously manipulated to improve the research. If, as a researcher, one is drawn to particular settings and people, this should be exploited. As Hastrup explains, the radical nature of fieldwork, implies a dissolution of the well-established opposites between subject and object, with the ethnographer becoming part of her field. “Her presence is the occasion and the locus of the drama that is the source of anthropological reflection”. By her

¹⁸ Or 'researchers' in the plural, I have written elsewhere about the way in which I introduced reflexivity as a group exercise in my previous research team, and the positive effects this had on the research outputs (Barry, Britten et al. 1999; Barry in press).

presence in the field the ethnographer is actively engaged in the construction of the ethnographic reality or the ethnographic present (Hastrup 1995).

I would not agree with Hammersley and Atkinson who provide a note of caution about over-involvement in ethnography. They imply that you cannot just talk to the people you find sympathetic, and that "you are not picking friends". For them the comfortable feeling of being at home in the field is a danger signal, and the ethnographer must always keep some distance, for it is in this space the analytic work gets done. "Never surrender yourself entirely to the setting or the moment" they warn ominously (Hammersley and Atkinson 1983). Whilst I agree to some extent with their concerns, I would suggest that picking friends is exactly what generations of anthropologists have often done and with very successful results (see for example Rabinow 1977). I think the cautions of Hammersley and Atkinson, suggest a more positivist view where subject and object can be clearly separated. This view is less likely to be held by reflexive and interpretive anthropologists.

I would agree, for example, much more with Wax who claims that to know another world one must associate with the natives of that world and even become one of them at least temporarily. She surmises that it is in areas of mutual trust and sometimes affection that the finest fieldwork can be done (Wax 1971). I am also sympathetic to Rose who exhorts us to: "Do radical ethnography, one that gets you closer to those you study at the risk of going native and never returning. It is hoped at least, that you will not again embrace the received assumptions with which you, inheriting your academic texts, methods, and corporate academic culture, began" (Rose 1990).

It is important to remember time as a factor in the positioning of the subject (where that subject could be seen as ethnographer or research participant). Positionings change constantly. Rosaldo talks of the importance of looking at the positioned and repositioned subject. He reminds us that all interpretations are provisional and are always incomplete (Rosaldo 1989). Hastrup's concept of the mirror of fieldwork is relevant. The ethnographer, she claims, will always see herself while studying others (Hastrup 1987), or as Clifford and Marcus put it interpreters constantly construct themselves through the others they study (Clifford and Marcus 1986).

So where do I stand in my research? Firstly I was drawn to the area of alternative medicine through very personal experiences of orthodox and alternative healthcare. I found my dealings with the former to be traumatic and dehumanising, and with the latter to be uplifting and life-enriching. I am passionate about reforming the communication practices of the medical profession, and bringing lessons from the best of alternative medicine to the health service. I feel strongly about helping to avoid the current tendency of biomedicine to medicalise and colonise alternative medicine, altering it in the process and divesting it of most that is good about it. In this respect I would ally myself with the critical medical anthropology movement, committed to social change (Singer 1995).

As a woman, I have been drawn to research other women. I hope that I have achieved what Scheper-Hughes describes as a woman-centred ethnography (Scheper-Hughes 1992). Breaking all Hammersley and Atkinson's rules I not only became friends with my participants but I actually interviewed people who were already my friends. I was in part influenced by Hollway's work. Her notion is that by researching intimately known friends, the quality of data collected might be set in much richer and more meaningful context (Hollway 1989).

The Ethnographer's Path

Beatty (1999) says that as ethnographers, whom we meet and how, are often passed over in the writing of ethnography. So I will outline my links with my key informants and trace what Sanjek (1990) calls 'The ethnographer's path' making explicit the decisions that resulted in my fieldwork strategy.

At the start of my fieldwork I was keen to recruit general practices and to that end made contact with GPs in 8 practices who used alternative therapies themselves, or employed alternative therapists. My supervisor, Ian Robinson, encouraged me to put my research question to one side and to broaden my focus. He advised me to enter a preliminary exploratory phase and to investigate alternative therapies outside the NHS to learn more about their ethos.

This exploratory phase consisted of the following fieldwork activities. I spent two days observing in a private alternative medicine clinic. I attended monthly meetings of a Positive Living group; a group covering aspects of alternative health, personal development and alternative lifestyles. I visited an alternative and complementary health fair in a town hall. I attended a talk on holistic health given by a cancer doctor on a summer school course on alternative health, and interviewed one of the attendees, a man who was half way through Reiki training. I interviewed friends and their friends who were users of alternative therapies, some formally and some informally. They were using one or more of the following: homeopathy, osteopathy, radionics, acupuncture, Bach flower remedies, cranio-sacral therapy, nutritional advice, and aromatherapy. I visited a spiritual healing centre and interviewed the founder. I attended a Clinical Psychology workshop on alternative therapies in mental health.

To explore the biomedical angle on alternative medicine, I joined the British Holistic Medical Association. I attended their annual meeting and three other key meetings in the integrated medicine world: the Royal Society of Medicine Conference "Healthcare for the Whole Person"; the Complementary Medicine in Healthcare conference at Exeter; and the Foundation for Integrated Medicine's meeting to debate the House of Lord's report on Complementary Medicine. In place of my usual role as conference delegate, I approached these meetings as a participant observer and took notes on all aspects of the meetings, the delegates and the formal and informal interaction. I also attended a half-day board meeting of my local primary care group.

During this exploratory phase my thinking shifted on three key issues:

1. Complementary therapy in general practice versus alternative therapy in the community: I realised that the discourses, beliefs and practices around complementary therapies were very different in General Practice to elsewhere.
2. The role of disease categories: I came to see that it was mostly medical personnel who used biomedical disease categories to decide strategies of complementary medicine use or referral. Patients might start out like this but soon progressed away from seeing health purely in terms of medical categories.
3. The break down of the patient-provider dichotomy. Outside the NHS I found that the distinction between patient and provider of healthcare was much more blurred. Many

therapists had come into alternatives through personal experiences of illness and many patients were acquiring sizeable knowledge and expertise about the therapies.

My next task was to narrow the research back down to a manageable focus. Instead of my original strategy of focusing on patients with biomedical illness categories (MS and arthritis), I decided to focus instead upon one therapy. It was my interview with a good friend, Diane, about her use of homeopathy that inspired me to be more interested in this particular therapy. Diane is not just a homeopathy client but trained in homeopathy for a couple of years. It was this that gave me the idea to start an education course in homeopathy as part of my ethnography.

One of my next key informants was the friend of another good friend whom I had met a few times, an ex cancer patient and homeopathy user, Ruth. It was through her that I got access to interview her homeopath Jenny, who then invited me to attend her vaccination support group. Fetterman (1998) suggests that introduction by a member is the best ticket into a community, and this was achieved by starting with my own friends. Jenny's vaccination group became one of my main fieldwork sites. She subsequently offered me the chance to observe her consultations within a victim support centre. This became another key site, allowing access to working-class, ethnic minority patients to counterbalance my other fieldwork sites, that were situated in a wealthy white outer London suburb. The victim support centre is based in a disadvantaged inner city borough with large ethnic minority communities. It was also easier to gain access as an observer, to consultations that were not private. An added bonus was that I got to observe consultations with men, when most of my sample up until then had been women. It is also good to study the same people in different contexts. This gave me the opportunity to see how Jenny was affected by the different contexts in which she operated.

My belief in the importance of embodied aspects of health and of participant observation led me to use my own embodied self to the full and become both a student and a patient of homeopathy. Over 18 months I consulted 3 different homeopaths. The first homeopath Shelagh was a recommendation from the friend Diane, I had interviewed who is a user of homeopathy and who had studied with her. I did not like Shelagh's authoritarian style, so asked Nancy the Homeopathy Class tutor for a

recommendation. She suggested Paula, whom I visited every six weeks for 9 months, until she went on a sabbatical. The third homeopath was Amy, Diane's homeopath whom I visited for a further 9 months. I kept fieldnotes of my embodied experiences with these therapies and the acupuncture of which I was already a patient.

I have already mentioned Geertz's exhortation to study natural communities in our midst (Geertz 1983:157). I followed this in looking for fieldwork sites. My epistemological standpoint of seeing the world as one that is co-constructed in social interaction, meant that I wanted to avoid an over emphasis on the interview as a method. I preferred to find natural settings in which I could watch, listen and interact with people as they co-constructed their health and healthcare realities through language, emotion and embodied interaction. When Jenny the homeopath, invited me to her vaccination support group, this seemed one ideal arena. The homeopathy class became another key site for watching natural interaction between groups of people. I was particularly drawn into these groups and became friends with women in both groups and felt quite far along the participant end of the participant observer spectrum. I was influenced in this by my own discovery of the power of women's groups in my own life, 5 years before, when I first joined a feminist research group. Later I started my own qualitative research support group, which ended up being attended only by women. I found these all-women arenas to be very comfortable, empowering and non-hierarchical. I was thus, drawn to the groups within this current research in a way that was shared by some of my participants.

I wanted my study to be comparative with the alternative medicine within the health service, so I also conducted observations in a general practice, with a holistic doctor who uses homeopathy. My route to access this site was less personal. I read an article about this homeopathic GP in a national newspaper and contacted him through his entry in the British Homeopathic Association's membership handbook.

Studies of health often focus on the health of people as patients not individuals in their contexts. They often focus on illness rather than health and use biomedical disease categories to define illness. Research often spotlights interactions between people and healthcare workers, such as their doctors or midwives. The result of this, is a kind of medicalisation of health research. There have been debates in recent times about the

medicalisation of both sociology (Williams 2001) and medical anthropology (Browner 1999). In my research, I have come to see health as a social, rather than an individual property, embedded as it is in the context of their families and friends. With the people I study, biomedical disease labels play only a very partial role in viewing health. Healthcare interactions are just as likely to be located in the community as in hospitals and GP surgeries, with formal healthcare workers such as homeopaths but also with friends and family, usually female. In part the discovery of this view has been through researching settings in which people meet to discuss their everyday concerns about health, outside the formal healthcare system. I selected both my homeopathy groups as places where people would be discussing health and alternative health care in a naturalistic setting.

Fieldwork details

During the exploratory phase of the research I interviewed 7 users of alternative therapies; 6 alternative therapists; 6 GPs, 1 nurse and 2 psychologists who worked with alternative therapies. I attended an alternative medicine lecture at a summer school, a complementary medicines fair in a town hall, regular meetings of a new age living group, and a number of academic conferences and meetings on alternative medicine.

During the main ethnographic study, I attended the homeopathy class for one academic year, between 2000 and 2001. I observed 19 two-and-a-half hour formal teaching sessions plus social meetings of the group after teaching sessions. I attended a follow-on, self-directed homeopathy study group and a meditation group started by the participants after the end of the course. Seven of the class filled in an open-ended questionnaire for me and I interviewed 4 of them at home.

I attended the vaccination group during 10 two-hour monthly meetings during 2000 and 2001. I interviewed the two homeopaths and 6 of the women from the vaccination group. I had lunch with the two homeopaths on several occasions.

In the homeopathic GP's practice, the data comprised participant observation in the practice, over 2 months. This included observation of four surgeries (23 consultations,

most tape recorded) and interviews with Dr Deakin, Dr Squires the senior partner, the receptionist, practice manager and 7 of the patients whose consultations I observed. I obtained ethical approval from the NHS Local research ethics committee to observe consultations and interview patients.

In the Victim Support Centre, I spent 7 days in the centre during 2001 and observed 23 consultations of between 30 minutes and an hour (some tape-recorded, some noted). I interviewed 6 of the clients at their homes or a local cafe.

In all these settings I observed interactions, took verbatim notes where possible in the group and expanded brief notes immediately after fieldwork visits into longer fieldnotes. With interviews and consultations I tape-recorded the interaction of the participants who agreed. These tapes were transcribed in part by myself and in part with the assistance of a trained transcriber, Debbie Swift. Consultations were transcribed according to conversation analysis conventions, recording interruptions, overlaps, and pauses (Atkinson and Heritage 1984). In taped consultations I concentrated on noting in writing non-verbal aspects of interaction. Where individuals preferred not to be taped (in a minority of interactions) I took as close to verbatim notes as was possible.

Analysis strategy

I used Nudist NVivo qualitative data analysis software, as an initial attempt to identify themes of interest in the data. I have written elsewhere about the usefulness of such a tool for certain more structured types of project (Barry 1998). I found however, that for ethnographic research, without an initial tightly defined focus, and emerging analytical concepts, it was less useful. I therefore did not conduct a detailed coding of all data. I found that my analysis was always developing and therefore the codes of interest at a later time would not have been coded by an earlier 'coding frame'. Also the process of detailed and rigorous coding became extremely boring given the size of the dataset and therefore the antithesis of creative analytical thought. Using NVivo was however useful to help me familiarise myself with my data, and for analysing themes in the consultations, a more contained dataset.

After that I pursued more organic and creative lines of analysis. I read through the data many times, and wrote about ideas emerging from my reading. I produced cognitive map drawings, of concepts and relationships between these (Barry 1997). I gave some transcripts of interviews back to interested participants. I then conducted further interviews with them about their experience of reading their transcripts, and explored emerging themes with them. I wrote detailed descriptions of each fieldwork site and summarised my data. I mapped the biographies of some of the participants chronologically and wrote case studies on individuals. I then explored issues that were raised during my reading of the literature. This was later in the process, as I tried to keep from being too influenced by the literature, until I had made a thorough exploration of the data from a more naive position. I came to understand why no one had ever been satisfactorily able to teach me about ethnographic data analysis in the past. I believe this is because methodological texts and courses often function on a scientific template for methodology, stressing issues for example of reliability. However, it seems to me that the process of ethnographic analysis is closer in nature to artistic notions of creativity. I feel that researchers would be better developing their creative writing and artistic skills, the better to see patterns, make connections and pursue creative links between disparate pieces of data.

Ethical issues: i. Consent and co-operation

Ethical issues are always ever present in fieldwork but I want to focus on two specific problematic negotiations of consent. The first one came about from a change in status of one of my fieldwork settings, and the blurring of the lines between auto-ethnography and the ethnographic study of others. I started the adult education class with a very specific objective. I felt that if I was to understand homeopathy, I needed education to know more about this system of medicine¹⁹. (I was proved right in this decision as the knowledge of homeopathy enabled me to make a more thorough analysis of practices I observed.) I introduced myself at the first session as a PhD student studying homeopathy and wanting to know more about it. After the second class it occurred to me that I was in an ideal fieldwork setting for observing interactions between people on

the topic of health and homeopathy. I quickly realised that in addition to the opportunity to learn textbook knowledge of homeopathy as a student, it also represented an opportunity to learn more informal and embodied knowledges of homeopathy, as an observer of other students in interaction. I started to keep notes not just about textbook knowledge but about interactions in and after the class. I felt very uncomfortable about the ethics of this. I did not feel able to stand up and announce my change of plan to the whole class. So I attempted to explain my new-found interest in the actual goings on of the group to some of the individual students. I found that this concept was a difficult one to communicate.

The culturally accepted concept of research in the UK is based in the idea of the questionnaire or the interview, and I felt I was on much surer ground negotiating consent for interviews. Participant observation is not part of the cultural understanding of research. I never felt that I had quite managed to gain 'informed consent' from this group. At the final meeting I attempted a more formal negotiation. I asked Nancy the teacher whether I could address the whole group. I explained that I had found them very interesting as a group and might want to write about them in my thesis, if that were acceptable to them. My worries that there might be an angry response were immediately dispersed. The group was very flattered that I might want to write about them. Individuals showed interest in reading what I had to say, and offered themselves for interview. Helen appeared to be upset that she had not been one of the people that I had chosen to interview already. Their own evangelical approach to the topic made it entirely consistent that I might want to study the process. Of course I was reacting here to the response of the vocal members. Gaining consent from a group is always difficult, as there may have been dissident responses that were not voiced. Also at this final meeting the group were reduced to the hard core of homeopathy evangelists. I never felt that I had gained informed consent from those who dropped out after the first term.

In my limited experience, participant observation is full of dilemmas about consent. Do the homeopaths realise that as we become friends and go for lunch I am making mental notes of their topics of conversation? I try to raise their consciousness in this situation

¹⁹ During the course of research with Dr Deakin, the homeopathic GP I realised how different his own training might have been. I attempted to get access to Faculty of Homeopathy meetings/ training sessions as an observer but was unsuccessful.

by overtly taking out my notebook every now and then and saying “that’s interesting, can I make a note of that?”. I have tried to deal with this by showing bits of writing to Jenny, Eve and Ruth three of my key informants and to be responsive to their responses. For the people and situations with whom, and for which, I never felt I had gained full consent I feel ethically obliged to consider this during the writing process.

The second problematic issue of consent was in connection with a patient of the homeopathic GP I studied. My gaining of consent from patients in this setting was the most clear-cut of all my informed consent procedures. It involved an application to the local hospital research ethics committee. I had to produce patient information sheets and consent forms for patients to sign (See Appendix C). I found this strategy worked very well. Quite a number of people who read my information sheet felt perfectly able to refuse me access to observe their consultations. Those that did allow me in, did not appear to be under duress as they all seemed very happy to be interviewed.

There was one exception. A man with a consultation about prostate problems whose consultation covered a lot of sensitive ground, who agreed to meet me on his next visit to the surgery for an interview. He never turned up, so I can only assume that he was either uncomfortable with my research or was not happy to be interviewed on such sensitive topic by a female researcher. At least he was able to vote with his feet and not turn up to the interview. I only hope he was not put out by my observing his consultation.

In the consultation he turned to me at one point to ask for a second medical opinion and I had to reiterate that I was an anthropologist and not medically trained. This may be what made him not want to turn up for the interview. Even though this information had been in my information sheet it shows that even written informed consent can be full of misunderstandings.

I have an ongoing ethical issue around the GP in this practice. In the negotiations for me to come and observe in the practice Dr Deakin, as I have called him, was very keen to write a paper with me at the end of the project. I felt this was a fair exchange, in return for the access to him and his practice for data collection. I had interviewed him by then and felt he would be a good doctor with which to write about such issues as he was so

holistic in his views. Once I had done the fieldwork my view on the ease of writing the paper changed. Once I had actually observed him in practice I found him to be far less holistic than his self-presentation would suggest. In my analysis I have explained this through the limitations of institutional factors and the shaping of him as a practitioner through his biomedical training. I am not so sure that he would see the issue in this way and I have yet to contact him about writing the paper so this issue is as yet unresolved.

This interchange shows again how participants are never really sure about what the end product of research is going to be. Their reading of our analysis might come as a real shock to them. The degree to which our writing as ethnographers, has the capacity to harm those that we research is illustrated by Nancy Scheper- Hughes' experiences on her return to the community she studied in the west of Ireland 25 years earlier (Scheper-Hughes 2001). During a conference paper at Brunel in 2000 she dramatically recounted her experiences of being chased out of the village, after bomb threats. I will stay with the issue of writing about participants in the next section.

Ethical issues: ii. Giving informants a voice or distorting their words to our own purposes?

In the monograph "Anthropology at Home" Strathern points to the problem of the inevitable social distance between the scholar and the people researched. She raises the question of "when does one know one is at home?" (Strathern 1987). She suggests that even when the anthropologist broadly shares the worldview of the participants, he or she does not use their cultural idiom to express it, but instead produces something in all probability quite unrecognisable to them. She concludes there is always a difference between indigenous understandings and the analytical concepts that frame the ethnography itself. "The manner in which anthropologists set aside indigenous framings would seem to make their activities in Essex, then, not so dissimilar from their activities (say), in Melanesia (Strathern 1987:18).

I would agree with Strathern that we can not 'give voice' to our informants while we are selecting their words and framing them in our own terms. There is therefore, an element of exploitation in all fieldwork (Strathern 1987).

Many of my informants were very keen for me to do research as they could see there being some benefit to them. Jenny the homeopath, for instance, seemed to think that someone like myself (who she perceived as having had a foot in the medical camp, through my earlier work in a medical school) might offer a useful role in raising the profile of homeopathy in that medical arena. She herself liked the idea of working in tandem with the orthodox system and told her colleague, Eve, in my presence that she would like to work inside a general practice. I am somewhat extrapolating what she wanted from my research, from her covert communication. She never told me outright. However when I showed her a copy of an early conference paper that relied quite heavily on some data from her setting (Barry 2001- See appendix B) her response was not what I had expected. She was quite shocked by what she had read. She told me she felt it did not make her look very professional.

For this paper, I had selected data to make the point that there were not distinct roles in the vaccination group. Both the homeopaths and the mothers took up the roles of 'advisor and expert' and 'worrier and parent' at different times during the group. To me this data supported a positive thesis about the relationship in alternative medicine being more egalitarian and less hierarchical. Jenny saw me using her words about doubt and worry, and felt she came across as not knowing what she was taking about. I had taken her words and produced a version of Jenny that she would not have produced herself. I had lots of data in which Jenny acted as an informed expert and passed on information in a professional health-care-provider manner. However, this aspect of the data did not interest me as much as when she deviated from this role.

I conclude from this experience that it is unavoidable that we appropriate people's voices. I will bear Jenny's concerns in mind. I have promised to balance any depiction of her, to a medical audience in particular, with data on her 'professional' activities. However I can see now, that whatever I do with Jenny's data will not be what she would do with it. However nor am I ready to give over the task of representation to her. I am interested in placing my own analytical slant on her voice and using the anthropological literature to further interpret it. This means I have to be happy with the fact that I am 'exploiting' not 'giving voice'. Although I hope that some of my 'exploitative writing' will also advance the agendas of the participants.

Embodied participation and auto-ethnography

At first I saw the use of myself as a patient of homeopathy as a separate part of the enterprise. I gave a seminar on auto-ethnography and discussed the degree to which I should integrate this separate part of my fieldwork strategy into the main ethnography. I am very admiring of the canon of autobiographical work in which ethnographers use themselves as their sole participant and write about their experiences with illness (Sacks 1984; DiGiacomo 1987) and disability (Zola 1982; Murphy 1987; Sparkes 1996). However I was also aware of the critiques. Davies (1999) asks: “Can an anthropologist be reflexive without being narcissistic?” Anthony Good thinks not: “If social anthropology is only reflexive, if it is only autobiographical (heaven help us, not even biographical but autobiographical), if it is a form of psycho-therapy for jaded aesthetes, then it is not worth doing” (Good 1996: 34). I would not agree with Good, but in any case my research was not to be solely autobiographical.

Hastrup (1995) has enlightened me that the autobiographical aspect of my research is not a separate enterprise. It is a fundamental part of the ethnography. She talks about the performative paradox of Anthropology: maintaining an objective view gained through intimate experience. She positions fieldwork as being between autobiography and anthropology: “If fieldwork is a personal adventure and belongs between autobiography and anthropology, it implies that the ethnographer is a person with a distinct biography.” (Hastrup 1992: 119). Hastrup explains that reflexivity is part of the ethnography itself, not just part of the analysis. “This means the anthropologist becomes her own informant. Shared experience implies we are part of the plot and it is this position that provides us with a unique key to an understanding of worlds” (Hastrup 1992: 115). Davies (1999) agrees that it is precisely in this interaction between ethnographer as self and ethnographer as other, that social knowledge of general interest and significance is produced.

Instead of seeing my own activities as separate to my ethnographic fieldwork with practitioners and their clients, I came to see these as just ‘other sites’ and other forms of participant observation, albeit where I was situated perhaps just a bit further along the

observer - participant continuum. Hastrup explains that “There is no way of speaking from nowhere in particular” and in which case it is preferable to be explicit about one’s position, perhaps not only preferable but necessary.

Margaret Mead (1977) warns that immersion in a culture is fine as long as you do not drown. So the answer must be to be explicit yet analytical about that participation. To have two levels of awareness the experiential and the meta-analytical. I talk more about my journey to achieve this analytical distance in the next section on reflexivity and identity.

There are implications of this intimate knowledge for the written ethnography. If by her presence in the field the ethnographer is actively engaged in the construction of the ethnographic reality or the ethnographic present, then the ethnographer should be a central player in the written ethnography. Again I have struggled with this and tried not to write about the fieldwork and participants as something out there and then separately to reflect on my own experiences. Instead I have tried to move towards greater integration of myself in the text. Rabinow offers a model for the centrality of the ethnographer, in his text on bio-technical scientists (Rabinow 1996.).

In this chapter I have written largely on the role of myself in the research. As Cohen has expounded ethnography is “an ethnographer focused art” and in it we use ourselves to study others (Cohen 1992). However, he also stresses that the ethnography “shouldn’t be about the anthropologist’s self, rather it must be informed by it” (p.236). Okely stresses the three ways in which we inform our ethnography: through lived interactions, participatory experience and embodied knowledge (Okely 1992). For her, this strong acknowledgement of use of the self becomes a political project with autobiography acting to “dismantle the positivist machine” (p.3) She points to the fact that the personal is not only political, in the words of the feminist slogan, but that the personal can be theoretical (p.9).

The areas in which I could attain the least level of embodied participation was in the vaccination group. Here the gap between me as childless, and the mothers of small children was always un-bridgeable. I was not able to gain embodied insight into their predicaments and life experience. There may have been a way to reduce this knowledge

gap. When I mentioned this to Ruth, she offered for me to come and stay for a fortnight and see first-hand and ethnographically what it was like to be a single mother of a 3 year old. She felt sure I would have a much better insight after this - I declined the offer!

From my embodied participation I can now look back and see how my own participation in similar experiences to those I was studying yielded different responses. It appears that the space between these two is quite important for analytical insight.

In the homeopathy education class, for example, I was caught up in the enthusiasm for a more spiritual view of the world, in which homeopathy could become one route to achieve it. However, my failure to pursue that path with the other students showed that in some way I was different to them.

Helen, one of my fellow students asked me to join two meditation groups. She was starting one straight after the end of the course and then another in a different format a year later. I attended the first session of the first group but found that the ideas of the group were not really those I could buy into. I realise now that my own search for a spiritual path had come to me at two points earlier in my life. 15 years ago I was divorced, and ten years ago I had a serious health diagnosis. My own spiritual views on life were formulated during these periods. I was not searching for a spiritual answer in the same way as I had been then. I had even tried meditation during those periods and had moved beyond that into other spiritual practices that were focused more around my participation with music, nature and dance. The death of my mother during the fieldwork prompted me to re-assess the need for spiritual answers and tempted me to join their group, but I wasn't sufficiently motivated to continue. I stopped attending the group and went back to pursuing my own path.

This led me into the analytical insight that the homeopathy seemed to be attractive to people at a time in their lives when the seeking of a spiritual path had become centre ground. The data proposed the idea that such an openness to the spiritual aspects of homeopathy might be brought on by life difficulties such as the break-up of a marriage. This was the case for Helen who had recently been divorced; or through the intensity of the transition to motherhood, through the experience of childbirth and the associated changes in identity.

Similarly my embodied involvement with homeopathy as a therapy provoked a similar gap between my experience and that of my informants. Yes, I shared some of their embodied experience. I found myself changing in my relationship to bodily symptoms through the socialisation process of the two homeopaths who I consulted over longer periods. When I got a cold shortly after taking a homeopathic remedy, I learned to attribute this to the power of the remedy: to see it as a positive sign. My body was working through old stuff and throwing it out of my body in the form of a cold. All those nasal discharges were positive. I should not try to suppress them. I began to see these colds as friendly encounters not as inconveniences as I would have done before. My body was speaking to me and showing me its healing power was being awakened.

However, I did not accept this with the blind and ongoing faith that many of my informants appeared to display. I was not a convert and periods of believing that the homeopathy was working have been interspersed with great feelings of scepticism and doubt. I might take a remedy and experience some bodily symptom as sign that it was working. After taking Thuja a wart appeared on my hand two days later and as warts are heavily linked with this remedy this seemed like a miraculous sign. However I might just as likely feel that the homeopathy was not working for my current health problem, give it two days, and then resort to my GP and or my acupuncturist (as I did when I got recurrent tooth pain that could not be explained by my dentist). I was not a believer in the same way they were. I was not happy to give up the drugs of western medicine. When I contemplated future travels to remote places, I did not see myself being able to put my faith in the homeopathic green travel box of remedies, or being brave enough not to take anti-malarials or have the cholera vaccinations.

Again I used this insight analytically. I came to see that seeing interpreting bodily changes, in line with the way in which I was being trained to by my homeopaths and the educational training, was not sufficient to 'convert' me to becoming a committed user. It was then that I saw two possible reasons in my data why I was different to them. One was that so many of them had experiences of seeing their children miraculously and speedily cured of a variety of symptoms without needing to take orthodox drugs. This appeared to work very powerfully on them, as will be demonstrated in chapters 6, 7 and 8. The second area in which they were different to me, was their mantra-like belief

system around health, which I detail in chapter 6. I could not say that I did hold those views and so I was not as committed to their view as they were. When the chips were down and I had a painful dental abscess I did not even consider the homeopath as a path to healthcare. I immediately sought antibiotics from my doctor. In my belief system antibiotics were not an evil force (as long as they were only used on serious infections, and my abscess had turned to septicaemia). So the gaps between my own embodied experiences and theirs have helped me to analyse what factors may be important in making them more committed than me.

At the same time, my positive experiences mean I have been also able to maintain a dialogue of understanding of their own embodied experiences. I experienced being truly heard in consultations in the context of my life events. I was given a meaning for my illnesses and given profound and spiritually informed advice about how I was tackling events such as the mourning of my mother or the stress of writing my thesis. This has made me committed enough to continue attending my homeopathic practitioner long after fieldwork, even given my inherent scepticism about the remedies. I feel great relief at finding a healthcare practitioner who really treats me as an equal and as a respected unique human being. Visiting a healthcare practice where I do not feel like a cog in a great machine is an area of homeopathic experience I can value as much as my informants. I may have gone to my GP for antibiotics with the abscess, but I felt devalued and belittled when she questioned me for having sought advice from the dental hospital first, and dared to suggest which antibiotics I needed and in what strength dose, at their recommendation.

Reflexivity and changing identity

I have written in more detail elsewhere about my changing identity/identities during, and after, ethnographic fieldwork "at home" (Barry 2002). In this paper I explore my changing identities as a rite of passage (Van Gennep 1960) using Wengle's notion of symbolic death of identity (Wengle 1988). I detail the process of 'going native' to a certain extent, or certainly of taking on a much more new age and alternative identity than I would claim to have now. I will summarise my themes of that paper here.

After four years prior research in biomedical contexts, in which I frequently felt alien, I came to feel much more at home studying the world of alternative medicine. Although I had been an acupuncture user for some time, my approach to alternative medicine had been a fairly instrumental one. I had not been fully engaged in the lifestyle associated with alternative medicine, its discourses and practices, because I was bit of a sceptic. However, as my fieldwork progressed I became more and more interested in and excited by alternative ideas and practices. Over the course of my year's attendance on the adult education homeopathy class, I shifted from a more detached observer position at the start, to thinking quite seriously about enrolling at homeopathy college and training to be a practitioner.

However, on my exit from the field I became again slightly sceptical and much more removed from the alternative world. Wengle's analysis appeared to fit my experiences. He suggests that fieldwork involves a loss of identity and threat of disintegration of the self. One strategy for dealing with the resultant anxiety, he suggests, is the strategy of adopting a new identity, what he calls secondary identification, more familiarly known as the concept of 'going native'. He suggests that, in the light of the threats to identity, internalising the other's culture reduces anxiety and gives the anthropologist a sense of belonging. The threat to identity is not just experienced in the field, the experience of 'culture shock', but can also be experienced on exiting the field, 'reverse culture shock'. The third stage of the rite of passage, re-integration, involves the building of a new identity, that of the fully-fledged anthropologist.

My strategy of 'becoming New Age' can be interpreted using these ideas. With my own identity shaken by serious life events (the illness and subsequent death of my mother during fieldwork) the new identity on offer provided comfort, and I was quick to 'go native'. As a result, my fieldwork period was not experienced as stressful, but enjoyable. The stress for me came with an experience of reverse culture shock, of discovering my New Age persona to be purely a fieldwork survival strategy, and the attendant anxieties about reclaiming my initial identity.

Having come through this difficult phase post fieldwork, I now find myself to be more critical of Wengle's conception of identity. He has fallen into the trap of essentialising

identity as a relatively stable and fixed property residing within the individual. In this sense he is operating from within a psychological paradigm of explanation. If instead, identity is seen as a property of interaction and as a negotiated process, then it is easier to see that identities are always shifting according to the contexts and the participants. I have shown how my own identity during fieldwork was very context dependent and shifted dramatically according to whether I was in a new age/alternative or a biomedical context (Barry 2002).

In this intersubjective view, my 'going native' could be re-interpreted as a process in which my informants played an active part. Most potential informants wanted to position me from the outset. Was I sympathetic to their world view or was I hostile and aiming to discredit them? I was not consciously aware of my strategy of moving closer to a sympathetic view. In retrospect I can see how I began to frame myself as more and more accepting of new age ideas, in part in order to get better quality information from people. This sounds like a manipulative strategy with associated moral implications. However, it was not a fully conscious strategy nor was it a purely of my own doing. It was a co-constructed interactional pattern that stemmed from my informants wanting to accept me and wanting me to see the world as they did, and wanting me to value them.

My own feelings of wanting to be accepted were not just aimed at improving the quality of the information for my thesis. It was also about wanting to belong in the groups I was studying rather than feel like a marginal outsider. I liked most of the people I was researching but I did not always like their views. If I could come to see their views as less strange, I could come both to like them better and to be more accepted by them. So my enthusiasm and openness to alternative ideas was an identity constructed intersubjectively, over time. Through accepting the influence of the majority of my informants to adopt more new age beliefs, and enthusiasm and openness for alternative ideas, I gained greater access into groups and individuals lives. I became more accepted as a participant in the settings of my ethnographies. I think that as a result the quality of the information I received was far better and represents more of an insider's view. However it could be that, had I struggled to maintain my more sceptical identity, that my interactions with the groups would have revealed less positive and more sceptical elements in these groups.

My own behaviour in interaction in these settings also tells me something about how other members behave and interact within these alternative groups. 'Belonging' and 'believing' seems to be important to many of my informants. Maintaining a sceptical distance is not easy in collective settings. Having felt marginal in many ways in their mainstream lives, in holding alternative views (such as being a minority opposed to childhood vaccination), they relish a setting in which they find they are at last one of a group which thinks like them. This may have the effect of increasing the levels of enthusiasm and belief within the group, as positive group identity may depend on this. None of the attendees at the homeopathy class and the anti-vaccination group expressed scepticism or lack of enthusiasm in these group settings. However, some of the members did admit to these more negative feelings once alone with me.

I also learned first-hand, as I have mentioned above, that the alternative lifestyle can seem particularly appealing during times of life crisis, and psychological upheaval. This was reflected in the life experiences of some of my informants. For example, a number of those at the homeopathy class had suffered recent important life events, such as birth of a first child, divorce, and redundancy, and seemed to be seeking support as will be detailed in the next three chapters.

Embodied influences on identity

Whilst some of my openness was constructed in these verbal interactions with informants, some of my enthusiasm arose from my embodied participation in groups. For example I had an ecstatic experience at a summer school being part of a group involved in communal meditation. Such experiences, of altered bodily awareness and states of consciousness, could be likened to those of anthropologists who have experienced trance states in the field. Desjarlais has attempted to write about his emotional and bodily experiences of a shamanic journey (Desjarlais 1992).

Group meditation changes the energy of both the individuals and the collective space. I experienced the events I participated in as healing. I went in troubled by my life experiences and came out feeling lighter, relaxed and with good feelings flowing through me. I can only describe these good feelings as infectious and perhaps a little

addictive. Csordas (1994) has written about the difficulty of analysing transcendent experiences and I do not have space to attempt that here. However I would say that my embodied being in these environments contributed to my changing identity during fieldwork.

My final destination in this journey is of becoming another identity, that of experienced ethnographer, one that I am still in the process of 'becoming' through the experience of writing-up. The new identity is one in which I have learned experientially the power of using oneself as the main tool of research. But with the attendant capacity to move into the world of theory and ideas and make higher level connections.

Writing in the ethnographic present

I have constructed the fieldwork in the present tense, in deference to Hastrup's notion that the encounters being depicted in ethnographies are encounters fixed in a certain moment abstracted out of time. They have no real past and no real future as the ethnographic reality depends on the presence of the ethnographer. As she puts it, the ethnographic knowledge transcends the empirical and becomes a knowledge that is out of time. "Although the dialogue was then, the anthropological discourse is now" (Hastrup 1992).

Summary and concluding remarks

In this chapter I have discussed a number of key epistemological and methodological issues. I have outlined my position as that of interpretive anthropologist within a multiple socially constructed world. Such a position demands attention to interaction, language and discourse and also to the embodiment and emotional reality of participants. I have stressed the need for context and process, and for investigating both meanings and practices, and the dangers of essentialising reality into unchanging categories.

I have discussed ethical issues of consent and co-operation and of the inevitability of exploiting our research participants.

I have also detailed the many ways in which the researcher is central, and focused on the dialogical nature of the research process. I have made attempts to fully include myself in the research, in three ways. In the fieldwork, I tried to listen to Turner's caution about the dangers of the reflexive anthropologist as a disembodied "sentient consciousness" reflecting on fieldwork with no consideration of physical presence in field" (Turner 2000). As such I interpreted the 'participant' aspect of my participant-observer role to fully incorporate my embodied self, as a student and patient of homeopathy. Taking inspiration from Rabinow (1977; 1996.) I have tried to appear within the text as a presence shaping interests, fieldwork and analysis decisions and as one of the participants in interviews. I have also attempted to deconstruct my impact on the field through a reflexive account of my changing identities, and my impact on the interpretation through recording my history and position with respect to alternative and bio medicines.

I have also justified my decision to make full use of my own embodied participation in the field through becoming a patient and a student of homeopathy. All these aspects of the researcher's role demand constant reflexivity. In addition to my reflexive interpretations embedded into the analysis, in the data chapters of the thesis, I have reflexively outlined my path through the choices of fieldwork sites and participants and have explored my own shifting identities through the fieldwork and beyond. I hope that this exposition of my methodology will provide a good basis from which to interpret the data chapters, 6-9 that follow.

Chapter 6

Homeopathy among committed users: A different cosmology of body, health & healing

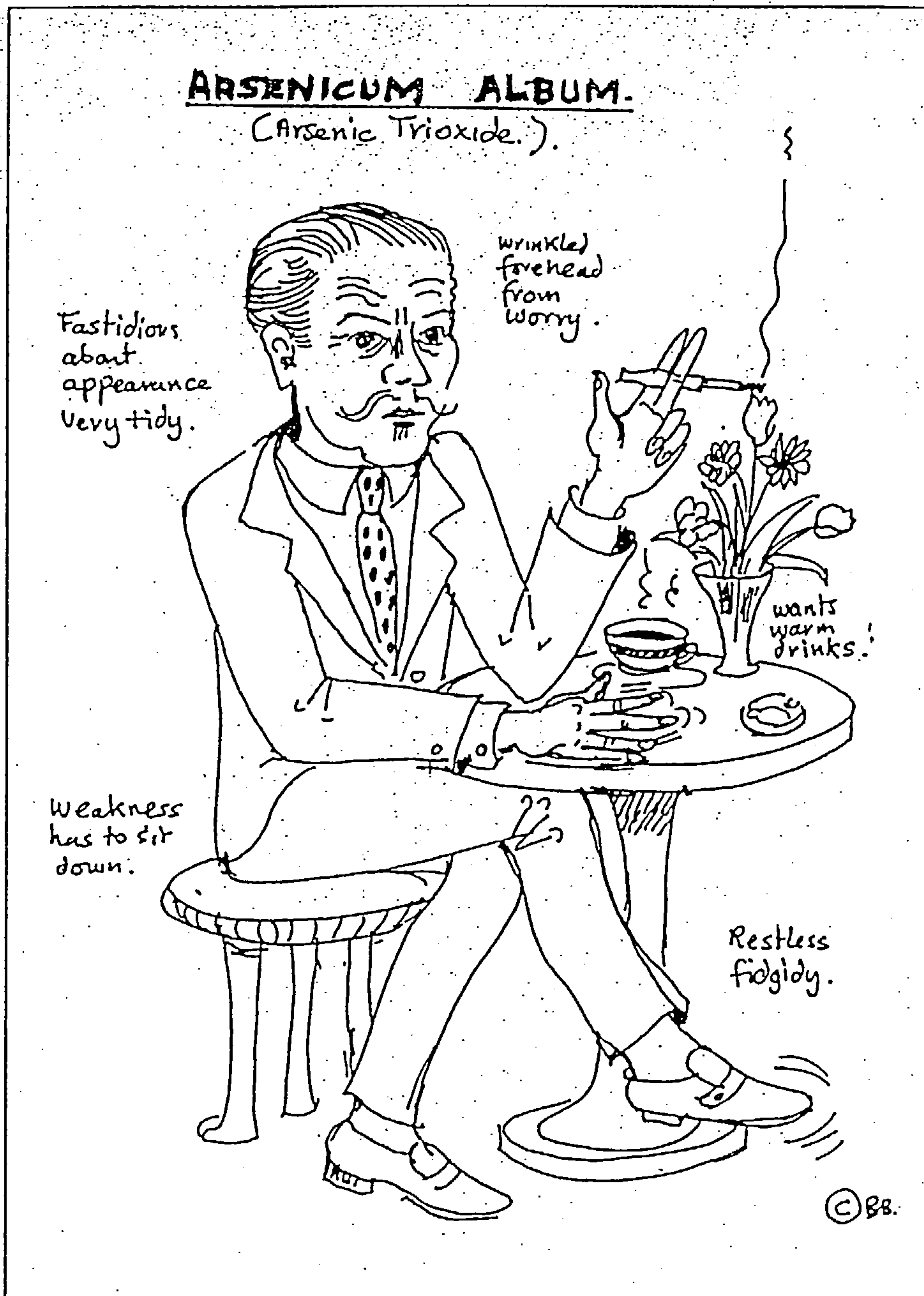


Illustration by Berenice Benjelloun

Chapter 6. Homeopathy among committed users: A different cosmology of body, health & healing

Homeopathy meant different things to the different people with whom I conducted research. For some it is an inferior complement to orthodox medicine, to others it is a comprehensive system of healthcare that is far preferable to orthodox medicine and reduces dealings with the orthodox system to a minimum. Compare the views of these two groups:

Homeopathy as a complement

(Homeopathy) hasn't been proven, it's not been accepted, but eventually the two medicines will work together, homeopathy as a complement to medicine. The choice [being] which of these two medicines is suitable for this particular complaint...If you've got cancer, don't kid yourself (Joanne, patient of homeopathic GP).

[Homeopathy is] another option when it comes to treating minor ailments and especially stress related illnesses and symptoms. I do not however feel it would be a realistic option if faced with a serious illness such as cancer or heart disease. (Belinda, GP attending homeopathy class).

Homeopathy as an alternative

[Homeopathy is] a safe and pleasant way to aid the body to restore its own good health without the use of blanket drugs with long term or short term side effects. I would like to think that in the case of a major disease affecting one of us we could use remedies to help us deal psychologically with the problem as well as physically. I very rarely visit the doctor at all. (Jean, homeopathy user attending homeopathy class).

We use homeopathy mostly as an alternative to orthodox (allopathic) medicine. It offers us a comprehensive philosophy of health, and reassurance, and confidence in a safe holistic system of medicine without the fear of toxification or side effects from the orthodox system (Angie, homeopathy user attending homeopathy class).

The women in these two different camps show how differently homeopathy is perceived. In tandem with these differing beliefs comes a marked difference in the whole cosmology of health and healthcare. Those who see homeopathy as a

complement could be said to have a cosmology of health that is normative for English turn of the 21st century culture. This view of health is biomedical, science-based and individualistic, with health seen as a property of individuals and disease located at the cellular or body organ level (this prototype biomedical view of health was outlined in chapter 3).

Those who see homeopathy as an alternative, come to hold beliefs over time about health and illness that are very different to the prevailing biomedical norm. In their view, health is not a property of individuals but of interconnected systems that encompass people in relationship with each other and with the environment. Illness is seen as a positive part of health and as occurring across a mind-body-spirit unity. Associated with this view is a different definition of the body, spreading out beyond the patient's skin and encompassing the significant relationships in which they are embedded.

The 27 users of homeopathy that I interviewed in my study fell into one or the other of these two distinct groups. The first of these I have called pragmatic users and the second committed users.

The committed users of homeopathy numbered 17. All of them had taken active steps to seek out homeopathic treatment and in some cases, to study it - to learn more about it. In Sharma's categorisation, this group could be seen as 'stable users', although some also reported looking around for alternative remedies for specific problems in the vein of Sharma's 'eclectic users' (Sharma 1992). For example Tamara, a regular user of homeopathy, took her children to a cranio-sacral osteopath for additional treatment when cases of TB were discovered in a nearby school.

All but 4 of this group were consulting a private homeopath regularly. Clara, a single parent on a low income, was unable to afford private treatment and so 'made do' with consulting a homeopathic GP. However she expressed her understanding that she was not getting the same treatment as she would, were she able to afford private consultations. Jane also consulted the homeopathic GP but was sufficiently well off to pay him privately for additional telephone help and advice outside surgery consultations. Natalie and Ros were not yet users of homeopathy. Their main concern

was with avoiding vaccination for their children. They were attendees of the Vaccination Support Group run by homeopaths and they were considering consulting a homeopath for their children's health as part of this strategy.

The ten pragmatic users were people who had accessed homeopathy without seeking it out, almost by accident as it were. Either through their GP (who happened to have training in homeopathy) or through a victim support centre they visited after becoming the victims of violent crime (which happened to employ 2 homeopaths and offered very low cost homeopathic treatment). At the stage when I interviewed them, they were open to using homeopathy as an alternative or additional option to orthodox medication. This group were probably closest to Sharma's 'eclectic users' but not in every respect (Sharma 1992). They had not actively shopped around for therapies, more bumped into them by accident. However their views of health and illness did not seem to have changed through their contact with homeopathy, and they seemed unlikely to give up their orthodox medicines.

These pragmatic users saw homeopathy as just another possible treatment and stayed within western concepts of diagnosis and illness. None of them had actively sought out homeopathy or consulted a private homeopath. They showed little interest in finding out more about the homeopathic remedies they had been prescribed or offered. They tended to have views on the appropriateness of homeopathy for certain illnesses and unsuitability for others, for which they saw biomedical medications as far more suitable. All of them were taking biomedical drugs in addition to their homeopathic treatments and showed no signs of coming off them. The pragmatic users tended to share biomedical views of the world. They stayed seeing illness within biomedical disease categories, as located firmly within the skin of the individual. They tapped into biomedical discourses such as the lack of scientific 'evidence' for alternative therapies. Whilst some of them bought into common, recent Western discourses of 'stress' as a cause of disease (Young 1980; Pollack 1988) they did not implicate the emotions as a big etiologic factor.

The committed homeopathic users shared a homeopathic view of health, illness and treatment that was quite different from the biomedical view. Their use of and attitude towards orthodox medical services was also quite different from the pragmatic patients.

Just as the pragmatic users tended to share the views of health of biomedical healers, the committed users shared the views of health of their homeopathic healers. However in the case of the committed users, the whole notion of healer and user or patient was much less clear. Three of the committed users were also practising homeopaths and so shared a dual role as patient and healer. Two had recently embarked on professional training in homeopathy and four had done introductory adult education courses in homeopathy. With the remaining eight, the boundary between healthcare provider and patient is also not clearly defined. In addition to consulting homeopaths, they were also involved in home prescribing of remedies for themselves and more particularly their children. This lack of clear differentiation between therapist and patient is reflected in the philosophy underpinning much alternative medicine. For example Wright & Sayre-Adams explain that:

Everything is connected. It is impossible to see the patient as a total separate entity from the therapist. That which affects one, at some level affects the other.... Holism is not biopsychosocialspiritual care. Holism asks us to reach beyond our limited definitions of what people are - we are caught up in the healing process together (Wright and Sayre-Adams 2001).

It is interesting that this philosophy permeates into the everyday practice of the therapists. The interchangeability of roles is also evidenced in the therapeutic interactions, as I will go on to show in chapter 8.

In this chapter I will focus on the committed homeopathy users and their views of health and illness. In order to illustrate the remarkably consistent viewpoint of health and healing of this group, I will talk about the commonality between their views under a number of conceptual headings.

It is important to note, that categorising these women as homeopathy users might be misleading if it were to imply that homeopathy was the only alternative therapy they were involved in. Most of them have a network of different alternative therapies they use. However there is insufficient space to explore this aspect here, and I think it is more useful to focus on their primary allegiance to homeopathy.

I want to look at the trajectories of experience that lead them to consult a homeopath; at the relationship they have with that homeopath; at their changing views of health and illness; and at their intersection with orthodox medical care. Then I want to investigate their consulting of GPs, their use of orthodox drugs and their stance on vaccination for their children. In the next chapter I will examine how they come to hold these views by studying them in interaction with professional homeopaths in three settings: homeopathic consultations, homeopathic education and a homeopathic self help support group.

Committed homeopathy users beliefs about health and healing

There must be another way, especially when the conventional way is particularly unpleasant. There must be a kinder way. (Sally, committed user of homeopathy).

The views of the committed group of homeopathy users can be grouped into 6 main beliefs about health, illness and healing:

1. Health is an ongoing interdependent relationship with the social, physical and spiritual environment.
2. Illness is an active and positive part of health.
3. The healing process starts with health not sickness.
4. The body does the healing naturally.
5. Homeopathy helps, pharmaceuticals hinder.
6. The user has primary responsibility for healthcare.

I will begin by outlining these views in more detail under each of these six headings and will then go on to investigate how these views lead to a changed relationship with orthodox health services.

The users come to espouse these views in a very committed and enthusiastic way and their adherence to this belief system could be seen in terms of a conversion to a new

religion. Szerszynski (2001) has talked of alternative medicine providing a modern-day equivalent of traditional religions (there are spiritual elements within their beliefs which will be discussed below). However in spite of the fervour of their new views they do not leave behind the orthodox healthcare system as the literature has reported (e.g. Thomas, Carr et al. 1991). They all continue to interact with this system at some levels. However this does not mean that they remain unchanged, which has been an implicit assumption of many of the usage surveys. Inherent within the homeopathy cosmology is an opposition to many facets of orthodox medicine (Coulter 1984). This makes these many oppositional tensions within their belief system, worthy of focus. I will discuss the points of tension that revolve around vaccinations, drugs and the nature of the practitioner-patient/user relationship.

Having outlined this generalised homeopathic view of the world, I will present three case studies of homeopathy users, to show how adherence to this new cosmology has affected their health beliefs and practices, within the context of their specific lives and experiences (in the following chapter 7).

Views on health and illness

The views about health and illness as held by this group can be seen as slightly independent from the formal knowledge of homeopathy itself. Allan Young (1981) reminds us of the danger of separating knowledge from praxis. Knowledge can end up reified as something distinct from the process through which it is produced. I have tried therefore to concentrate on knowledge as produced in interaction. When these users talk (to me or to one another) about health and illness, they tend to talk about a system of more informal beliefs. Some of these have a one-to-one relationship with homeopathic ideas of healing. However some are more broadly holistic in nature and would be shared by users of other alternative medicines or perhaps new age beliefs.

I have included some details on the more formal knowledge concepts of homeopathy as they were taught in the homeopathy class in appendix D. However this more formal knowledge was only likely to be shared by the homeopaths themselves and those who have studied homeopathy through a formal educational route. However even those

practitioners and knowledgeable users who have studied these formal concepts, still tend to talk to me and each other about health using the more informal belief system that I am about to outline.

1. Health is an ongoing interdependency with the social, physical and spiritual environment

Interconnectedness with the environment

It is the cultural norm in this country to view health as the property of the individual body. This is encouraged by our individualistic society and by the reductionist focus in biomedicine on disease at the cell and organ level of individual bodies. This is not the case in all cultures, as was outlined in chapter 3, with many people seeing health as a property of the social group, for example the family or the village. The committed homeopathy users come to move away from this belief in health as an individual property to a much more connected view of health as an interdependent relationship between the person and their environment.

I recognise that being healthy is not just eating good food and exercising, it's very much as well your relationships with people, and particularly your family (Olivia, homeopath).

In this interconnected view a person's health is created and maintained within a network of social relationships and when these are unhealthy the person may become ill. Part of the curing may be about changing aspects of relationships in order to become truly healthy. In several of the homeopathic consultations I observed, people were encouraged to reflect on aspects of their relationships with their partners or family members, with a view to making changes in these and thus improving health.

Connection with others is seen as vital to health, but so too is a wider sense of connection to the universe, as a spiritual entity and as part of the physical environment. This group tends to see the earth as sick in terms of levels of pollution, unhealthy

farming methods and the stressful ways in which people work and live. This sickness of the environment is seen to be an important factor in producing individual's health.

There is an underlying romantic notion of the loss of a harmonious relationship with the land in the last century. This break-up of our direct relationship with the land is seen to explain part of the problem with our 21st century health. When I asked Paula, one of the homeopaths I consulted during the research, whether she believed each person could be seen to have a constitutional remedy that was characteristic of them she replied:

I think if we all lived pretty healthy lives on the land, without the kind of 20/21st century stresses and pollution, somebody might be born a certain type [of homeopathic constitution] and continue their life and still show signs and symptoms of that remedy even into their later years. But I think that we are bombarded by so many influences of so many different kinds, [that this does not happen any more].

The homeopaths talk of their task in curing patients, often in terms of clearing out the toxic effects of our unhealthy world from the body.

Although the belief about causation of illness is rooted in the social and wider world, it is interesting to note that the notions of healing are still largely individual. This is in contrast to most societies who hold a belief in social causation of illness, and where many of the healing practices involve the whole social group. Homeopathic healing here, in Europe, is conducted on a one-to-one basis between homeopathy practitioner and user. Many alternative therapies draw heavily on the medicines of traditional societies. Homeopathy, however was devised within western culture, in Germany, by a disaffected medical doctor who continued to use the model of expert practitioner-patient healing encounters.

This tension between the social aetiology and the individual healing modality suggests that users do not have a unitary conception of the body. They are perhaps moving away from the purely biological biomedical notions of the body, towards a more social notion of the body. Their views however, suggest an incorporation of both social and individualistic symbolism. Syncretism in medicine (as in religion) produces this type of mixture of cosmologies. (See, e.g. Durkin 1988) on a reverse example: the syncretic influence of biomedical thinking upon ayurvedic practice in Nepal.)

Interconnectedness of mind body and spirit

As well as interconnectedness with the external environment, these committed homeopathy users see health and healing as holistic, in the sense that mind-body-spirit is treated as one entity and not separated.

The idea of treating the whole person without dividing it in parts is superb (Roberta, Homeopathy class).

A holistic understanding of the person and how health works [means a] framework for health which includes - and doesn't at all differentiate between different levels - the physical level, the emotional level, mental level and indeed the spiritual level (Diane, homeopathy user).

However they do continue to divide the person into parts in their talk referring to the spiritual, physical and emotional aspects of their health. So Diane having explained the holistic connection also says:

I did feel better [after the acupuncture] but the headaches didn't feel at all better but I felt better in myself which is always a good sign. I think on the emotional level it was really helping me but physically I was really crap. I think sometimes those planes can operate independently of each other.

This quote shows Roberta's enthusiasm for this connected form of healing. When she told me the story of her health over the past 20 years, she still talked of her mental, physical and spiritual health as though they were separate entities and yet connected. She found it difficult to articulate her "positive regard" for homeopathy, as she put it, which had been very important in changing her life. This was because she saw the reasons as situated within the spiritual realm for which she could not find words to express some evidently deep feelings:

It's impossible to, to express your words, your feelings, so whoever asked me I never answered because there were no words really to express such a view, you know. And comfort, you know, so deep.

Roberta has suffered many allergy problems with serious asthma and eczema and depression. She has had homeopathic treatment for 7 years and claims that the main effect has been on her spiritual health, although she is still experiencing a lot of physical symptoms. She sees the cause of her illness as being “from a very early age. It was very spiritual, because I always was very kind of unhappy.” She sees the homeopathy as having cured her spiritual 'dis-ease' and has been lead through her homeopathy to develop her spiritual life. She tells me she is “ very involved in a kind of self-discovery”. She has joined the Gurdieff School where she goes every Monday for meditation and discussion, and every Friday for special movements, called the Gurdieff dances. She sees that this development of her spiritual life as a really positive result even if she is not getting the same improvement with her physical symptoms:

Basically always there's this blockage, you know, in my reaction, so it seems that something is blocking the physical healing. So even if mentally and spiritually I respond very well to a remedy, physically there is a, a certain blockage, something that we [she and her homeopath] don't know what it is.

I asked Roberta what role the homeopathy class has played in her life. She explained that both the class and her attendance at the Gurdieff School are all part of this same self-discovery and exploration of the spiritual philosophy of life.

In the adult education class Roberta attended there was quite a focus on the spiritual aspects of homeopathy. Nancy, the teacher, stressed the homeopathic theory about the workings of the vital force in health. She presented this force as a spiritual form of energy, talking about it as 'the breath of life' (a term she borrowed from her current training in cranio-sacral osteopathy: another example of syncretism). Nancy also used the Hindu chakra system (yet another instance of syncretism) as a framework for teaching about certain aspects of homeopathy. She used the chakras to stress the lifelong spiritual-developmental aspects of life and health. In several sessions Nancy lead the group in a chakra-based meditation. Nancy is not necessarily unusual in this, when she was away one week, her replacement Dave described her as “from one of the esoteric colleges of homeopathy”. And, as was outlined in chapter 4, druidism and other esoteric ideas have heavily influenced The Society of Homeopaths (of which Nancy was a member). There is also much talk about spirituality in the formal literature of

homeopathy (see for example Sankaran (1992)). In week ten, Nancy quoted from Hahnemann's "Organon of Medicine", the key text of the founder of homeopathy:

In the state of health the spirit-like vital force (dynamis) animating the material human organism reigns in supreme sovereignty. It maintains the sensations and activities of all the parts of the living organism in a harmony that obliges wonderment. The reasoning spirit who inhabits the organism can thus freely use this healthy living instrument to reach the lofty goal of human existence. (Hahnemann 1810).

Many of the class members were ecstatic about this new spiritually infused view of health. These newly discovered possibilities of homeopathy seemed to be offering more than just a treatment of health problems. They seemed to be offering something that appealed at a deeper level of spiritual need, that aided in the search for meaning. Homeopathy was seen by some as a framework in which to make sense of their lives. This view has been discussed in the homeopathic literature (Zarfaty 2002). These enthusiasts did not appear to want to accept the label New Age - when I tried the term out on some of them they didn't accept it as applying to them. However the experiences of the homeopathy class, in particular, appeared to reflect a lot in common with the beliefs of those engaged in new age communities and spiritualities. The difference may have been perhaps, that this group were a little more grounded in contemporary capitalist society than many of those researched in more alternative communities (in America (McGuire 1988; English-Lueck 1990) and in the new age epicentres in the UK, such as Glastonbury (Riches 2000) or Findhorn (Burrows 1993)).

Angie said it was the nearest she had got to a religion in her life. She felt that as a result she had recently decided she needed to pay attention to the spiritual aspects of her life, joining a yoga and meditation centre. Jean, who is a practising Buddhist, was also drawn to this aspect. Roberta talked about homeopathy and the view of health she was acquiring, in evangelical terms. Helen had been suffering with quite a lot of personal issues since splitting up with her partner just before the course and found this view of health, combined with spirituality, to be life changing. She has now started a meditation group in her home, and a book group focusing on discussing books with a self-help, spiritual and/or philosophical component.

This linking of the spiritual sphere, to ideas about health, is really welcomed by the users who attend the homeopathy class. The idea that the remedies and the chakra framework can aid personal development appears to ring real bells for people. It makes sense to them when Nancy suggests that the remedies can tackle lifelong psychological issues:

We adopt 'diseased postures' in childhood such as 'The only way I can be loved is by achieving'. This posture might be appropriate at the time but is no longer appropriate later. This delusion is a disease. Most remedies have central delusions: 'I must achieve to be loved is Aurum'. Like psychotherapists do, the homeopathic remedies find the central delusion and bring it to your attention so can cure it.

The class responds with enthusiasm to this possibility of deep change and development. Sarah asks, "Will these delusions gradually dissolve?" Stephanie says, "We'd all like to be able to look in the mirror and say we can do it". Agnes replies "If you are recognising you are doing it, you are half way there".

Living in a toxic world

Many of the committed users talk about the harmful effects of the toxic modern world. The three main forms of toxin that are mentioned are pollution, chemical farming and pharmaceutical drugs. All three are seen as poisons that are building up in the body over time. Homeopathy is seen as capable of clearing the effects of this build-up and helping us to live in a world where these influences are present. Olivia, is a homeopath and shiatsu practitioner and also home prescribes for her 4 year old:

I think homeopathy woke me up to the fact that the world today, it can be pretty toxic, you know, with drugs, vaccines, all of that kind of stuff. You know, it's like the homeopathy gives you another tool to deal with that.

Olivia focuses a lot in her practice on treating people with homeopathy to get rid of the effect of vaccines upon them.

Many of the women talk of healthy diet and of organic food in particular as another strand in their strategies for dealing with this toxic world. Samantha made an impassioned plea during the foot and mouth crisis "I want this country to be an organic

nation" (homeopathy user from homeopathy class). Ruth, a single parent on a low income, would love a completely organic diet but cannot afford it. She tries to buy it for her daughter when she can. Even though she herself is in remission from cancer, she sees the importance of getting her 3-year-old off to a healthy start with organic food, as more of a priority.

Our emotions and relationships as catalysts for illness

“Your biography becomes your biology” Myss (1996:34)

Emotions get a lot of attention from the committed homeopathy users as being fundamental to health and the major cause of illness. One of the reasons I was drawn to focus my research on homeopathy was this tendency to psychologise health through a discourse that is saturated with emotional expression and personal development issues. Homeopathy as it is practised by lay homeopaths, draws particularly on the work of the psychologist Jung (Whitmont 1980).

Jenny, one of the homeopaths I studied told me how she sees all disease as having developed from the emotional level:

The whole process of how disease develops is so interesting to me. And I find it is usually some change on the emotional level, on the mental level that precedes physical symptoms. Almost always. Well absolutely always. But, you can't always- people don't always tell you everything.

I usually say to [people] “Well you had your arthritis for ten years. What was going on for you ten years ago? What happened in your life?” You know people aren't used to thinking in that way, they have to think quite hard but then they usually do come up with something. Usually something some stress, some grief, some bereavement, something going on in their lives that was so hard for them to deal with, that the symptoms developed. Arthritis developed or something else developed. Cancer or whatever. [Orthodox] medicine is very good at, you know, zapping symptoms but it doesn't look for the underlying illness.

Jenny applies this notion of illness to herself as well as her clients. “If I get physical symptoms, I know it's because I'm not handling an emotional situation”. On one day I spent with her she told me about a chest infection she had just got over and linked the

causality of it entirely to issues in her family life. In the next chapter I will show how Jenny puts these ideas into practice within individual consultations.

Shelagh, another homeopath described homeopathy as: "The only system of medicine that I know of that works on a mental and emotional level. Abuses in childhood - it can be the only thing that reaches it. The other [systems of medicine] are all limited to the physical."

Homeopathy is based on that principle that every thing that happens- you are your experience. It becomes a part of who you are. Disappointment, unmet needs and all those things, loss, bereavement. But GPs how could they understand that?" (Diane, homeopathy user).

The causes of illness are seen in part to be about individual inherited susceptibilities. These are discussed more below under 'time'. However all the committed homeopathy users are agreed that the reason a particular illness comes out at a particular time, is always related to emotional aspects of life, which in turn means relationships with self and others.

Interviewing Diane a committed homeopathy user for the past 10 years, it became clear that the main reasons for her use of homeopathy and prior to that, her attempts at acupuncture, were not disease related. They all stemmed back to the multiple family bereavements she had suffered several years before. Whilst her initial reason for trying alternative medicine had been for repeated headaches she had come to see these as manifestations of the emotional processes.

I feel as if she's really unravelled something that had got very knotted up in my body. Emotional processes that had got really lodged in my body and just wouldn't let go. All these symptoms dated from a time when two of my brothers died, within two months of each other, although they didn't really come out until about 18 months after. And I think what the homeopathy did- just the frequency on which it operated was able to get at that - relationship between these these really traumatic events and how I'd taken them in physically and held onto them there. You know just the shock and grief and all that sort of stuff. ... On an emotional level it's just helped really, really massively.

When Clara's GP asks in a consultation about her son Ollie "Is he generally in good health?" Clara's answer reveals a definition of health situated within the family rather than in the individual.

He's generally in good health. I think we're having quite a lot of changes at the moment, for the better. Changes in the way we all relate to each other at home, and the way things are going with me working now. Just the general way we spend our time is different, much more positive and [Ollie's] a lot more open, rather than moody and closed and irritable. Perhaps it's just stuff coming out that needs to be cleared, that he's been hanging onto for a long time.

'Stuff' that needs 'to be cleared'. These are terms often used by this group. This 'stuff' is an invisible substance but which is seen to have real effects on the bodily system, and usually comes from emotional sources. It is talked about, as though it was a material substance left in deposits in the body tissues with the homeopathic remedies as the agent to cleanse it out of the body.

This talk shows a conception of the body that is quite different to that of the biomedical body - as bounded by the definitive boundary of the skin, only permeable by invading bacteria and viruses. The body for these homeopathy users extends out beyond their own skin, and into the skins of their loved ones. The 'stuff' is also part of this conception and so the individual body is seen as far more permeable to outside influences with emotional 'stuff' passing between people.

Within Clara's implicit definition of health are incorporated ideas of a healthy family and of healthy interactions within that family. Ollie's alcoholic dad Jon left Clara 4 years ago depressed and struggling to cope on income support with Ollie and Jack respectively 5 and 3 years old. Clara herself is now happier having taken up Buddhism and classes in homeopathy and found a job. She shows in her discussions with Dr Deakin, and with me in an interview later, that interactions with herself and Ollie's father are all part of her view of Ollie's (and perhaps not seen separately) the family unit's health. Ollie is visiting the doctor with infected lymph glands in his armpit after falling over and cutting his hand badly on a dirty riverside. Clara believes there is a direct link with the fact that this accident happened during an emotionally fraught meeting between the family and Ollie's dad Jon and his new girlfriend. She explained to

me that Ollie's "susceptibility" to illness was influenced by the fact that "the night that he hurt himself, we went to meet his dad".

Clara expanded to me in our interview her view of health and susceptibility as learned on her homeopathy course and reflected in her Buddhist beliefs. In this Clara is actually explicit in defining the lack of clear boundaries between the body and the outer world:

Clara: I believe within everybody there's an inner person almost like an inner-childly thing, we have this exterior world, but we have an interior world as well, and what's going on in our interior world will be clearly magnified in our exterior world. That's to do with our clothes that we wear, the colours we're drawn to, the people we're drawn to, erm, you know, even the areas that we live. Even on a wider scale, the countries we're born in, the parents we're born to, all has a reason, and homeopathy for me says that nothing happens for no reason.

Why will you get ten people going out for a meal, two of them get food poisoning and eight of them don't, what is it with those two? I learnt that it's to do with susceptibility, that certain people are susceptible to certain things in different environments, and it's the inner person that's susceptible. So for me the homeopathy fits in, by treating the inner person. The homeopathy treats the spiritual realm, the realm of causes... Not treating the material, the physical, but treating the spiritual person or being. The homeopathic remedy will give that person what they need in order to be more healthy in this world.

CB: You're talking about general philosophies of life, and I just wondered, here we have a situation where your son gets ill. Does that link to what you're saying generally?

Clara: Yeah, yeah it does (laughs). Yeah, it does definitely link. Ollie, well his susceptibility- the night that he hurt himself, which is where it all started - we went to meet his dad.

Clara links health and illness to the emotional interactions between significant others such as family members. This is a belief shared by all the committed homeopathy users. For Clara these links can also be seen as extending to the spiritual realm. Many of the committed homeopathy users talk about this spiritual element to health to some degree. Those, like Clara, who have studied at homeopathy classes, are more likely to be more explicit about this view of health. Several of them share Clara's Buddhist beliefs.

Where emotional states are involved, the curing is experienced in subtle ways, and the reports of the effects of the homeopathy are far reaching into the daily struggle of people's lives. Both Jean and Angie report their experiences with homeopathy as a form of consciousness raising: as a force to help them change themselves at a deep level. With Angie the issues relate to her relationship with her partner and their joint responsibilities for raising their child.

Angie was 9 months pregnant when I interviewed her about her experiences with homeopathy during the pregnancy.

Angie: When I got pregnant this time it really, it wasn't planned, and I didn't feel very happy about it. I went to the homeopath and told her I was really, really irritable and sort of short-tempered and angry. Feelings of resentment were coming out of the last year of having looked after Sandie, I felt like I'd done so much on my own and that Mark hadn't suffered from the sleeplessness that I'd had. I had *Sepia* and went away and was much worse (laughs). I got really irritable with Sandie as well, which I'd never really been, I'd always been really patient all through the eczema and everything. And then when I went back about four weeks later, I'd realised why I was feeling resentful, but I didn't know it when I'd gone the first time. So it had made me sort of realise things. It was actually 'cause I felt that Mark hadn't helped enough over the year, but I didn't know that when I went with feelings of anger.

CB: Yeah, I see. 'Cause you'd just been living through it without thinking about it.

Angie: And then I spoke to Mark. So in that sense it did help. Then she gave me some *Nux Vomica*, and that felt much better. Afterwards I was thinking, "Well what was all that about?" and I just started to feel all right about the pregnancy. I started to feel happy about it and started to look forward to it, and it was like a sort of shove to sort of make me think differently about something.

So, Angie reports the effects of the treatment as being both at the level of her own moods but also at the level of her relationship. She was feeling able to talk to her partner about her feelings of being unsupported through her mothering. When she did, assisted by the homeopathy, she discovered Mark was suffering from depression brought on by the change in family life. He then sought help from a counsellor and started to visit Angie's homeopath. Angie herself felt much better disposed to her own pregnancy so there were a number of real shifts within the family unit. The 'healing' then was operating at the unit of the family body not just the individual body.

Angie sees homeopathy as having a role in her coming to accept her unwanted pregnancy and deal with her feelings of resentment, through discussing these with her partner. When she implicates the homeopathy in this process it is unclear whether she means the remedies or the sessions where she discusses her symptoms with the homeopath. She does not seem to make a distinction between the two. As with so many situations in which homeopathy is used, it seems very unclear to me whether the homeopathic remedies have really played any part in resolving her emotional issues. Has her homeopath provided a counselling role? Or is this just part of the natural process of pregnancy and would have come about without intervention? Angie definitely attributes the changes to her homeopathic treatment.

When the users talk about this type of psychological moment of realisation or of new learning about the self or situation it is implied that it is the remedies that have contributed to that shift. This might sound strange to those situated in a biomedical paradigm, that a pill can bring about this sort of inter-relational awareness. However the fact that the remedies themselves are linked to emotional states makes this a more logical conclusion for users. *Nux Vomica* for example, the remedy Angie was given during this episode, is very strongly associated with the emotional state of anger, as this excerpt from a materia medica entry on the *Nux Vomica* constitution attests:

These are extremely impulsive, quarrelsome, stropky individuals who know what they want and who 'want it now'! ...They hate to be contradicted, are irritable if questioned and then enraged if they are obliged to reply when they do not want to...They tend not to keep their anger in and will always feel better for a good row. If they do suppress their anger they feel awful and often get sick. (Castro 1995)

For Jean, the explanation for the emotional changes she experiences as part of her homeopathic treatment lies in part in experiencing the therapy as a talking cure. Jean has issues around lack of achievement in her life, and she reports the homeopathy as a real force for change in how she sees herself and lives her life. She told me that during the homeopathy education course:

The more Nancy talked about things, the more I came to realise that I didn't really feel healthy as such, you know. I've been practising Buddhism for

sort of nearly twenty years on and off, for the reasons that I was now beginning to look at homeopathy, just to feel better about myself. And the more she talked about things, you know, this *Gelsemium*, the glass coffin, I was thinking, "Oh, that's me, that's me." I mean ostensibly we're going to [our homeopath] to sort out physical problems, and then we sort of get talking, 'cause it's all part of the same thing isn't it.

Whilst she puts some of the effect down to the fact that she and her homeopath 'got talking', there is also a level of attribution of the change to the remedies. In this case *Aurum* and its association with crippling high standards (mentioned above: 'I have to achieve to be loved'). 6 months later Jean told me she had changed in subtle ways as a result of the homeopathy:

I think I don't feel any different, but I feel a lot more able to cope with the fact that I feel the way I do, if you see what I mean. Before I took the *Aurum*, I used to think, "Well... I'm just going nowhere, nothing's going to change," and if it wasn't for my son, you know, I'd be thinking, "Well, what's life all about really." Sounds very dramatic, but I was feeling that I could never achieve, that things had gone so far that I couldn't change anything. But now I just think "I'm me, I'm not everybody else, I'll do what I can and I've still got plenty of life left to do it". But I was thinking before, "Oh God, I'm at the end of my life, you know, and I haven't done anything, haven't achieved anything, I've failed at everything". And I think that bit in *Aurum* about setting high standards for yourself and not achieving them was what was really crippling me. I just felt everybody else was doing things and I wasn't. And I couldn't, if I wanted to I couldn't, but now I think well I can if I want to. And I don't have to feel I've run out of time.

At the start of the homeopathy course Jean told me she would have liked to go on and study to be a homeopath, but she was too old and it was too late to start now (she was 48). However by the end of the year in which she had had this homeopathic treatment, Jean had enrolled on a professional homeopathy training course. Her actions seemed to support her beliefs about her changing self.

In both these cases the women are dealing with the transitions of life. Jean at 49 is at the stage of questioning her achievements and feeling time is running out for her. Angie is dealing with the changes in her relationship and her self brought on by becoming a mother. Both find the homeopathy helpful in this process. In neither case would they be called ill in the orthodox medical system. They are using homeopathy to help them deal with the everyday problems of living and with changing themselves to deal better with

life's problems. "I think the remedies just make you look at accepted behaviour and say, 'I don't accept this any more'" Jean explained.

The emotions are central in this homeopathic worldview. They are seen as possible early warning signs of potential illness, as causative catalysts for physical illness, and as a kind of illness or 'dis-ease' in themselves that is amenable to treatment. Homeopathy is seen to work particularly effectively on an emotional level, more than any other therapy they have encountered. In many cases this is what appeals to them about this form of therapy, and what makes them so loyal to it.

They come to see this centrality of the emotions in the homeopathic treatment process, both through the consultation process, and through the effects of the remedies (I will try to show this process as it occurs in consultations in the next chapter). Diane learnt through consultations that her homeopath was "very interested in what was going on emotionally as well and what events and what significant events there had been, you know in the past". This was news to her: "I didn't know that homeopathy could work so dramatically on an emotional level at the time. It was only after I had started it. And I really went into. I did really deep emotional work with the help of some remedies".

Diane gave me one example of emotional response to homeopathic treatment:

There's this remedy called *Staphysagria*. It's got a lot of fear of violence in it. And a lot of violent feelings in it from the person themselves. It's given a lot to victims of rape and victims of war. Anyway I took this remedy for something completely- something that was happening on a physical level. And I couldn't go to work. I couldn't do my job for like about 5 days. - It just brought up the most terrified feelings around these boys I was working with. It did plunge me into something, which I'd been so avoiding in my therapy but I couldn't avoid it any more and I had to sort of face this terrible-. That actually I walked around carrying this fear with me all the time, which most of the time I was able to defend against and not experience it except at a really low level.-I mean it was affecting my whole life anyway. So that was extraordinary.

Diane comes from a family in which there had been a lot of violence and the deaths of her two brothers, mentioned above, were both violent deaths. She experiences this remedy as helping her deal with this fear of violence she has been carrying all her life, something her psychotherapy has failed to achieve.

This power to deal with emotions is often what is so attractive to people and what gives people like Diane, Angie and Jean an almost evangelical religious fervour about homeopathy.

Time and health

Among these committed homeopathy users, the concept of inherited susceptibilities is very important. Health is seen as having a temporal element. In chapter 3, I presented Sharma's analysis of the homeopathic body. She showed it as being constructed as having a time-dimension as much as a space-dimension, with many time related concepts embedded in homeopathy, such as direction of cure of symptoms (Sharma 1995). Health then is seen to start before you are born and extend throughout your life and beyond. There is no notion of unconnected bouts of illness that come out of the blue, purely brought at random by outside pathogens such as bacteria, as is seen in the biomedical conception of illness. Instead the particular illnesses a person suffers are thought to be connected to the emotional goings on in their lives and to the notion of individual susceptibility. These are weaknesses that run in families, but also the effects of the lives lived by ancestors on the health of the current individual. These susceptibilities are usually located within a particular part of the body or a tendency to certain illnesses. I was told, for example, by several of the users of their susceptibilities being in the chest, on their skin, in their stomach and in a repeated tendency to get flu, respectively.

Diane reports that her area of susceptibility for health problems is her chest: "I've always had a really bad chest and any cold thing will go to my chest and I've had pneumonia and bronchitis and all these sorts of things". When her homeopath gave her certain remedies she told me she would lose her voice for three days or would get a really tight feeling in her chest for 2 days.

There is a powerful notion of what the newborn baby "brings with them". Its susceptibilities are seen as being determined by its ancestors, the health of its parents and its experience in the womb.

I asked Ros what she meant when she used this phrase. She said that the whole of her early life, up to the age of 18, she felt she had been in a dream and experienced the world through tunnelled vision. She had not been able to see things clearly, although she had not had any particular illnesses. She had been diagnosed dyslexic. She seemed very certain that this was a state brought with her into the world.

Sally explains that the inheritance of health goes back centuries into the past: ‘Some of the remedies, the miasms, work with genetic stuff way, way back, from hundreds of years ago, when people had syphilis and psoriasis and tuberculosis and they were sort of part of, in your body’.

Eve the homeopath (an ex midwife) talks about the importance of the state of health of the mother when she conceives, for the future health problems of the child. She often finds that she is prescribing remedies for babies that are the same as those that the mother was taking during pregnancy or whilst in labour.

Just as health is built up over the life cycle, so too healing works by going backwards over the lifecycle and unravelling the past. When these homeopathy users are being treated at the deeper constitutional level of the whole patient (rather than just treating individual acute symptoms), one of the signs of success is a phenomenon referred to as ‘the return of old symptoms’. This is where the user experiences in a milder form, the symptoms of some illness from the past, for a short duration.

I myself experienced this in my own homeopathic treatment. After being treated with *Thuja*, a remedy that is very strong for warts, a wart appeared on my hand within 2 days. As a teenager I had many warts on my hands and my homeopath suggested to me that the remedy was working by clearing back through my previous health problems. Christina in the homeopathy class likens it to the peeling back of the layers of the onion. Roberta replies that she is a good example of this. During 3 years of homeopathic treatment she worked through a repetition of old symptoms of all the health problems she had experienced since childhood: “Asthma then eczema then allergic sneezing for 12 months then conjunctivitis, stomach problems and finally thrush which I had as a

baby”. Although sneezing for 12 months sounds too long for what I know about this phenomenon.

The temporal aspects of the healing are seen to match the temporal aspects of health. So if it takes a lifetime to work through these illnesses that make up our health history, then it can not be expected to clear back through this history over night. There is an expectation that homeopathic treatment of this constitutional type will take certainly months and more likely years, but that at the end of this the person will be much healthier for having cleared out all this stuff from the past.

Olivia, a homeopath, was telling me of a new patient who had rung with a shopping list of problems expecting her to be able to cure them in the first session:

I’ve had to learn that I’m not a perfect homeopath and I’m not gonna clear it in one session. They can have an amazing change from the first session or the first lot of remedies, but it’s like, you know, but how long did that person have that problem. You know, you’re looking at years, and I’ve learnt that okay, we’ll make a difference now and they need to come back, but you’re not gonna bloody- you know, it’s not a magic pill you’re giving them. (Olivia, homeopath).

The discussions of time and health suggest that the remedies are used to alter the natural relationship between time and the body: to speed up recovery, to divest the individual of past influences. This is presented as very benign and natural. Homeopathy is always discussed as nature’s friend. Frankenberg has shown how in contrast, biomedical practice alters the relationship between time and the body in more invasive and unnatural ways. For example the anti-temporality rituals of hospital life and the practice of using inductions and caesareans to alter the natural tendency of mothers to give birth during the night (Frankenberg 1988).

2. Illness is an active and positive part of health

In biomedical views, health is often described as the absence of disease. In the homeopathic view health and illness have a different relationship. Rather than polar opposites, health is seen to encompass illness. Illness is seen as a positive part of health.

Illness is a regulatory mechanism through which the body works through constitutional susceptibilities and weaknesses; through which the immune system is strengthened; and through which emotional and toxic pressures from the environment are cleared out of the system.

This is one reason why the homeopathic line is against vaccinating against childhood illnesses such as measles and mumps. Childhood illnesses are seen as a very necessary process through which the immune system is strengthened. Vaccines are therefore seen as having two negative effects on the system. Firstly the vaccines themselves and the harmful carrier substances in which they are housed, such as thiomercyl, a mercury derivative, are seen as a toxic assault on the immune system²⁰. Secondly the process of preventing illness is seen as harmful in itself in that the growing immune system does not have the opportunity to develop through contact with these illnesses.

Illnesses and individual symptoms are seen as helpful to the person in two ways. They are seen as messengers giving information to the person and as pointers to change something in their lives. They are also seen as positive ways in which the body regulates itself. Two of the key regulatory mechanisms are fevers and discharges of any kind. Both are seen as signs of health, not to be interfered with by suppression through orthodox drugs.

Symptoms as messengers

Angie a student on the adult education course was surprised by this new idea that diseases are to be seen in a positive light and to be learned from:

Angie: To think of health in the way that diseases are good for you, are doing good things, or telling you things about yourself.

CB: It's quite radically different, isn't it.

Angie: Yeah. Very, very different, to always thinking of disease as a bad thing. And you start to learn. I mean I found that I've started to learn, even from

²⁰ See Allen (2002) for an interesting recent discussion of thiomercyl in the vaccine debate, and (Schreibner 1993) for a book against vaccination, recommended by the homeopaths in the vaccination support group.

little minor illnesses, starting to think, “Well why did that happen then,” and instead of just saying, “Oh, it’s ‘cause I’m stressed,” or, “It’s ‘cause I’m run down,” it’s like, “Well what do you mean by that?”

Tamara a member of the vaccination support group shows how she too has shifted her understanding of illness in this direction:

Prior to (Homeopathy) I subscribed to the whole idea that illness was inherently bad. Whereas now I see it as a, a signal that, you know, something is wrong in your regime. And you have to look at it and say, “Well I’m not getting enough sleep, I’m not getting enough fresh air, I’m not getting enough exercise, I’m not taking care of myself, I’m suffering from stress, I’m not eating properly, I’m drinking too much.” If something is going wrong with your system you have to listen to that.

Sally another member of the group shows her conception of the link between symptoms and emotions. Sally has trained in acupressure and so draws on her explanations of causation from homeopathy and Chinese medicine. The symptom of a boil is seen as a sign that her husband needs to deal with emotional issues.

I think my husband’s skin stuff was a lot to do with emotion and mental stuff, the fact that the skin is the biggest organ that manifests stuff. Its releasing things I suppose, isn’t it. When Claire was born he had a huge boil on his back, it was just vast. And knowing you store all your fear and things in your back and it was in the heart centre, so it was kind of across here (pointing to her mid chest). And in acupuncture that’s where you store grief and things, the energies go up the back and down the front, and people push things to the back ‘cause they don’t wanna deal with them. He’d got that ‘cause there was lots going on in here that he wasn’t able to kind of deal with. Now if you don’t learn the lesson of how to deal with all these kind of things, you’re gonna get things... other things round the chest or heart attacks or some-, your body has to deal with things in some way, and all those things are signs telling you to cope, deal with it, come to terms with it or whatever.

Symptoms as regulators

As well as being signs or messengers, symptoms are also perceived of as regulatory. For example a fever is seen as a way in which the body brings about healing. Discharges are a way for the body to expel toxins and the 'stuff' of emotional baggage. On the first week of the homeopathy class Nancy explains this concept:

What are symptoms telling us? They are an expression of something. They aren't disease they are the body's attempts to fight disease. So vomit, diarrhoea, coughing, fevers are all attempts to expel toxins. Eczema is anger on the skin. Your body is talking to you telling you something. If we fight against these symptoms and try to suppress them with drugs we are working against the body. 'Killing the messenger'. It's the equivalent of sticking a plaster over the oil light when it appears on the motor-way. The homeopathic remedies however do the same thing the body was trying to do. Homeopathic remedies can be given alongside conventional drugs like antibiotics but they will be working in opposite directions.

At the start of term 2 Nancy re-iterates: “Symptoms are a sign of health”.

At my first visit to the first homeopath I consulted she asked how much I sweat. When I told her I had a tendency towards producing quite a lot of sweat and how I had to use a stronger than average anti-perspirant, she explained that this was not good. By suppressing the sweating I was stopping up a route by which the body expels toxins. I should reduce my use of anti-perspirants to allow this positive regulation of the body to take place. I will illustrate how other users of homeopathy are educated to see symptoms as regulatory in the next chapter.

Views on Healing and maintaining health

3. The healing process starts with health not sickness

In the view of the committed homeopathy users one does not wait for symptoms of illness to appear before beginning the healing process. One notable surprise for me was that so many of the families I researched were regular visitors to the homeopath in spite of being apparently healthy. My preconception was that most people using alternative medicine would be suffering from chronic disease incurable by science-based medicine, yet most of the people in my sample were healthy. Whilst serious illnesses such as Ruth's cancer or childhood illnesses, most commonly eczema and asthma, might have lead people into homeopathy they continued to consult regularly even once healthy. There are differing rates of consultation some people attend monthly or 6-weekly while

others attend less frequently. Sally talks of taking her children every six months or so to the homeopath as regular MOTs: “My children go regularly, every- I take them for a kind of MOTs certainly every six months, sometimes every kind of term, you know, during the holidays”.

Children are usually initially taken to a homeopath with a physical illness. However parents then continue to take them once physical symptoms have been controlled, as a way to build up their health for the future. Alice (whose case study is detailed in chapter 7) explained “I’m hopefully making my children healthier by treating them this way”. Implicit within this is the temporal view of health, that you do not necessarily do healing at the time of apparent sickness. Instead healing can be done during times of health. Thus one can work on the effects of old illnesses from the past, or other assaults on the immune system such as childhood vaccines, or to prepare the body to be healthier, and resist illness in the future.

Nancy the teacher in the homeopathy class encourages people to heed early possible precursors to illness such as emotional problems and to treat those before illness appears. So whilst this might not be seen as illness it is seen as a precursor to it and thus treatable in order to prevent illness.

4. The body does the healing naturally

The body is transformed in this different view of health and in place of the passive suffering body afflicted by illness comes the intelligent body. This is a body that interacts with illness and makes its own decisions about how to respond and how best to heal itself, if allowed to do so. In this view the body is given far more agency than in the biomedical model where the body is a victim of invading forces. The committed homeopathy users have come to have a great deal of respect for the skill of the body. Jean wrote in a questionnaire for me: "Homeopathy offers me and my family a safe and pleasant way to aid the body to restore its own good health". The body is portrayed as primary agent of healing. When Eve first came to homeopathy she found all the concepts were new to her except one: the idea of the body’s ability to heal itself “that the body knew what it was doing and we should be supporting it rather than going

against it". This is a concept shared by the radical natural childbirth movement that she belonged to as a former midwife.

The debate about expertise in healthcare focuses on the need to shift from an expert model (i.e. health care providers as experts) to a participatory model (i.e. patients and health care providers in partnership together). This is exemplified by the shift from compliance to concordance (Royal Pharmaceutical Society 1997) and moves towards shared-decision-making (Stevenson, Barry et al. 2000). However this model sees the patient as a vocal consumer guided by wishes and ideas about illness. In the alternative model of health, there is a third party in the arena: the body as a self-regulating and equilibrium-seeking responsive system. So the partnership becomes a three-way one between health care providers, patients as thinking consumers of healthcare and the intelligent body (Busby 1999; Jobst, Shostak et al. 1999; Paterson 2002).

Roberta's homeopath uses a piece of equipment (biolumanetics) to decide on the right remedy. In this extreme version of the relationship between user, practitioner and remedy, the body even does the choosing of the remedy. The user holds the remedy in their hand and an adapted camera photographs the user. The better the match between the remedy and the person's symptoms, the clearer the focus of the pictures (see figure 5 for an example of this biolumanetic technique -Wansborough 2000). Roberta explains to me that no talking is involved "Because it's just what your body gives, it's just involuntary information, so you are not able to give false information because your body does it". I was sceptical about this machine but was quite impressed when Roberta showed me pictures that varied enormously in their clarity according to which remedy she was holding

Biolumanetics & Classical Homeopathy

by Charles Wansborough

My object in writing this article is to comment on a technology I adopted from an American scientist, Patrick Richards, who had spent over twenty years studying and evolving a methodology which could be used effectively with subtle energy. I have studied the process in depth over a two-year period to elucidate its effectiveness within the 'classical homeopathic model'.

I must summarize the main aspects of this technology before entering into a discussion of its relevance. A more detailed exposition, written by Patrick Richards himself, may be accessed on the Internet web site <http://www.biolumanetics.net>

Patrick Richards came upon the entire process quite accidentally when he designed a machine to balance air temperatures for efficient heat energy management. The instrument – called a Luminator – not only created a uniform temperature gradient but unexpectedly seemed to improve the health of those individuals working in its environment.

In further investigations, and over a period of eighteen years, he found that the Luminator had created an unusual electromagnetic field whose main effects, he deduced, were not easily explained using present scientific paradigms.

It seemed to alter the magnetic field, and using a standard magnetic compass a change of up to 38 degrees to the west from normal north was indicated. Sensitive light meters also indicated an increase in light emissions in the working area. He concluded that such an extraordinary electromagnetic field seems to isolate individuals from those of a normal environment, creating a type of 'null field'. As he comments on the website, to date neither he, nor any of his colleagues, have been able to explain this phenomena scientifically. It falls into the category of a *scientific anomaly!*

Photographs taken in the altered field produced anomalous images. The pictures changed: some were out of focus, some were clear and some had multiple images. Using the same photographic procedure in a normal environment did not produce similar images. By trial and error, over many years, he was able to draw certain conclusions about these photographic images.



Patient base photograph



Patient holding correct constitutional remedy Calcarea carbonica.

Photographs of people suffering health challenges were vague and distorted. Photographic images of healthy individuals were clear and crisp.

of health, while any incoherent images represented incoherent states of ill health.

He then noticed that by introducing different materials one at a time into the field of the patient, and then taking a photograph, the images captured changed. He was able to draw further conclusions that a correct prescription changed the photographic image to that of a clear picture, which always restored vitality and health to that individual.

Furthermore, by the introduction of various different medical interventions ranging from the subtle effects of homeopathic medicines, acupuncture treatments, the use of Ayurvedic medicine, and even orthodox drugs, the photographic assessment as to the degree of coherence that individuals demonstrated in respect to each modality gave crucial information in restoring coherence and health to that individual.

Patrick coined the term 'bioliminal' (coming from the Greek *bios* = life and *limen* = the limit below which a stimulus is not perceived) to indicate the nature of this phenomenon. The term was specifically tailored to study and legitimize this area of research, and to emphasize the subtle nature of this investigation, since by using the bioliminal field one is able to gain information below the threshold of conscious awareness. This information will enhance or detract from the coherence of the healthy state. When the individual lacks sufficient integration to exist in harmony with his changing environmental conditions, it is possible to introduce subtle energy information into the field of the individual to restore harmony. Using bioliminal photographic imagery it is possible to assess the degree of coherence an individual displays in respect to the various effects of subtle energetic information.

Explanations

Figure 5. Example of the biolumanetic technique

(Reproduced by permission of The Society of Homeopaths)

5. Homeopathy helps, pharmaceuticals hinder

In these users' views of health, science-based pharmaceuticals are seen as toxic and suppressors of natural healing processes. Both the words 'toxic' and 'suppression' come up again and again in interviews and in their interactions with each other. This appears to be quite a harsh position where all drugs are black and all homeopathy is white. There is no balancing discourse with exceptions made for certain drugs for certain conditions. The main contenders that are mentioned as baddies are antibiotics and steroids; these are the two most likely drugs to be prescribed for the common childhood illnesses of infections, asthma and eczema.

Scientific drugs are seen as very active agents having a negative and quite powerful impact on the body. All their effectiveness happens within body boundaries. Homeopathic remedies are not talked of in such powerful and agentic terms. As I described above, the body is the major agent of healing. It is the combined three way efforts of the body, the remedy and the homeopath that produce healing, with the latter seen in a helper role, and both as situated in the natural world. Nancy explains to the homeopathy class how the remedies act as a witness that stimulates the body's own healing, through a kind of mirroring which allows the body to see what it needs to do.

In all healing processes the healthy body is wise. It knows what to do but it requires a sympathetic witness, a remedy or having hands on it for example. Just to see what the body is holding: the fulcrum. Just by witnessing you are mirroring something back and the situation starts to resolve. This is the only true healing. If you self-prescribe you don't get good results (Homeopathy class: third session, spring term).

This is another example of the permeability of body boundaries to external influence from other people. In the earlier example it was the emotional 'stuff' as a cause of illness. Here it can be healing power from another person. Now the location of the healing activity can not be located purely within the body boundaries of the individual, but somewhere in the ether between patient and therapist.

Jenny talks about her changing perception of, and responses to biomedical drugs, when she first used homeopathy for her own children 15 years ago. She uses this insight with her own clients now she is a practising homeopath. It took her a time to move from

being reliant on drugs such as antibiotics towards being able to dispense with them and trust the homeopathy. This might have been even more difficult for her than the average mother as she was a nurse within the NHS system at the time she started using homeopathy for her children:

The doctor would always give me antibiotics, and I'd come home, put them in the fridge, ring the homeopath and get some remedies. In that way more often than not the antibiotics would stay in the fridge, but I would know they were there and I would feel happy that they were there if they needed them. But more and more I didn't need them, and found the children getting healthier and healthier. So when parents ring me up and say 'what shall I do?' I usually say 'If you're worried go to the GP get a diagnosis, get whatever it is they prescribe, you don't have to give it but you can. It's like another opinion and then you can come and see me and we'll discuss what I can do to help. You can try the remedies and if they work that's wonderful. And I'm 90% sure they will and if they don't and you're still worried then you've got what the doctor prescribed. You can use both together if you want, but generally it's not the best idea to use both together. But if there has to be that process, while somebody is changing over in their thinking patterns, from conventional to 'there is another way' then that's OK. Sometimes parents are still putting steroids on their babies' eczema, while I am giving remedies. But eventually they stop, putting the steroid cream on because they realise that it's just suppressing the symptoms and actually what's going on is still producing the eczema. So we've got to treat what is going on. We've got to treat whatever it is inside the child that is making the child have eczema.

From the homeopath's point of view, most of the orthodox drugs are bad for people and they should come off them. However, given the patient's primary responsibility for their own decisions about health, the homeopath has to allow them to come to this conclusion themselves. Ian, another homeopath, even labels these decisions potential conflicts:

The conflict over contraception is that I can't take these decisions for a patient, and the same with vaccination. If they decide they need the contraception and they want to take the risk or they don't perceive a risk in relation to their health: it might take terrible headaches before, over a period, for them to realise that actually if they stopped taking the Pill... HRT is another.

Scientific drugs may be the 'baddies' but vaccinations are the most castigated of all. There seems to be a power in the fact of their being injected straight into the bloodstream and the fact they are mainly applied to babies and small children. There seems to be slightly more sympathy for the Polio vaccine because it is ingested through

the stomach and therefore the body is seen to have some way of filtering harmful effects. This direct injection into the body appears to produce quite violent responses from people and not one person in the committed homeopathy group was not actively involved in the debate about vaccination. In many cases mothers with older children had vaccinated first children but come to question it more and more and stopped vaccinating more recent babies. More recent mothers seem more likely to have encountered information on the harmfulness of vaccines with their first child. Most notably whilst they were pregnant a friend, family member or if they were already attending a homeopath raised the issue for concern. Often providing them with information from The Informed Parent, or What Doctor's Don't Tell You organisations that publish newsletters that are quite anti vaccination. The vaccination support group that I studied arose from a demand from homeopathy patients with these concerns who gave Jenny the idea to start the group as a forum for these concerns to be aired.

Vaccination is not just seen as bad for children. Olivia a homeopathy patient who trained as a homeopath puts her husband's health problems down to his repeated experience with travel vaccines:

My husband went to Africa a lot with his job and he had to have all these vaccines. And it was only when I went to (Homeopathy) college, which just gave me more awareness, that I thought, "Hang on, Simon's had all these vaccines and he's a chesty person anyway. That was his susceptibility, he comes from a tubercular family - his Mum coughs a lot." And I began to see that maybe the vaccines, the toxicity from the vaccines had created- he became asthmatic over the years, and he's allergic to cats and dust, which he never used to be. Then he got psoriasis 2 years later.

6. The user has primary responsibility for healthcare

One of the really appealing factors of homeopathy to the committed users is the different balance of power in their healthcare. They are encouraged to be much more active partners in the healing relationship with homeopaths. They are also invited to take over ultimate responsibility for health issues and to become the primary healthcare provider. They then use a variety of healthcare providers as a resource, such as homeopaths, other alternative therapists, health-food shops and GPs.

Equality and respect in homeopath - user relationships

Creating a more equal relationship starts with the homeopaths. Not all homeopaths are keen to promote an egalitarian relationship and some of the users talked of changing homeopaths because they were not treated as equals. For example reports of homeopaths who would not tell them what they were prescribing or why. The first homeopath I consulted, Shelagh, was notably more authoritarian than the second two I visited. She was not overly friendly She sat behind a big desk, did not tell me what she had prescribed, and got angry with me when I admitted to having only been able to give up coffee for a week (coffee can be an antidote to the effectiveness of homeopathic remedies). I had no desire to return to her and sought out a homeopath who was prepared to be more open and egalitarian with me. The users I interviewed similarly valued this latter type of relationship, and I saw Jenny, Eve and Bryony interacting with their clients in very open, friendly, and egalitarian relationships.

This interesting experience of authoritarian homeopathy throws more light on Sharma's (1994: 83) 'equation of responsibility' where the patient comes to hold more power, because the therapist needs more information. Indeed, Shelagh needed me to provide her with lots of information. In this first case-taking session, I talked for over an hour with few questions and hardly any interruption. When it came to the treatment part of the relationship she very firmly took back the control. This may have been unusual. The homeopathy consultations studied in the Papaya project mentioned in chapter 2 were characterised by a more equal balance of power (Chatwin and Collins 2002:24).

The feeling of equality is not just fostered by interactional factors. Ruth explained to me that there is a feeling that she is very much in control of what is being prescribed, as a homeopathy patient. Firstly because of the consultation format in which she is encouraged to talk about all aspects of her life. This makes her feel as if she (and her body) is very active in creating the choice of remedy. There is also a feeling that she is in control of how she takes the remedies. Jenny usually encourages her patients to take the remedy until they feel better. It is up to them to decide when to stop treatment. Ruth explains that this gives her a feeling of being in control of the treatment. Also Jenny

gives a lot of information about what she is prescribing and why, and Ruth feels like an active partner in the process.

The feeling of equality is also fostered through the encouragement to patients to become more knowledgeable through reading and/or studying about homeopathy itself. Ruth has read up on homeopathy at a previous homeopath's suggestion. Through this she has learned quite a lot about the treatment of first aid and childhood illnesses, knowledge she uses in home prescribing for her daughter Lily's minor ailments. This is discussed more below.

Diane also rates her homeopath as a "really good homeopath" because she gives a lot of information. "She really explains everything about what the treatment is for and why she's giving you the remedy she's giving you and how it - just where it might go". I consulted with Diane's homeopath myself. I too experienced this degree of two-way exchange of information as very agreeable, in comparison with my dealings with the medical profession where I always feel like an inferior partner.

As well as being a more equal relationship and perhaps linked to it, there is the feeling that this is quite a personal relationship. It is important to like your homeopath. Alice talks about her homeopath as though she was a friend. Ruth was let down by a naturopath she started to consult after her cancer diagnosis and she switched to a homeopath instead. She told me:

I think that's the thing with natural therapy. Sometimes it takes a while to find a person that you feel on the same wavelength, that you feel you can really work with, because it's quite an intimate relationship I think.

Seeing one particular practitioner at regular intervals over time allows for a deepening of this relationship. Sam says of her osteopath and homeopath "I've been seeing them a long time so they know me". This both makes the consultation more enjoyable and leads to better prescribing. The choice of remedies is based on the therapists having access to an ever-increasing knowledge of the person. Information that can not possibly be gathered in one consultation but really must amass over time.

Taking more responsibility for decisions about health

All the homeopaths I researched and all the committed users agreed that it was imperative for the user to take more responsibility in matters of health.

To truly benefit you have to be open and willing to take responsibility for your own health and want to do your own curing (Shelagh, homeopath).

We need to be more in control of ourselves and to be able to cure ourselves as opposed to going to somebody else to tell us what to do (Sally, homeopathy user).

Homeopathy encourages one to take responsibility for one's own health and discourages the idea that GPs have all the answers!" (Kate, member of homeopathy class).

I think one of the things about going alternative is the way that you know their practice is also underpinned by a philosophy of you starting to take care of yourself. And that's been really, really helpful. Taking responsibility for your own health and not handing it over to the doctor and saying 'now give me a pill to get rid of this'. 'Cause they don't promise anything. That's the other thing that I kind of appreciate really. That nobody I have gone to see has assured me that it's all going to be fine. Even though it's hard to hear that that it might not be all right. We'd love somebody to say 'don't worry'. I feel much more as if I'm being treated as an adult in that way and not so infantilised really. Also the growing realisation that they were saying: 'You've got to meet us half way, if you really want to get the best out of this then you need to think about giving up smoking and not smoking so much dope or drinking so much or getting a bit more exercise or less stress' or whatever (Diane, homeopathy user).

For Diane this contrasts with her previous relationship with doctors during the three years when she suffered disabling headaches. "I was such a wimp with doctors and I never pushed to have any tests done or blood tests or brain scans and I know other people would have. I was just like the classic really passive patient. It was pathetic".

The route to responsibility involves challenging the authorities of traditional medicine and the mass opinion of one's peers. This can be a daunting prospect. Sally explains how it took her time to pluck up the courage to go with her feelings about not wanting to vaccinate her children and take them down the homeopathic route. This was difficult without support but became easier when she found a group of like-minded people. Sally

explained that she was not brave enough to resist vaccination for her first 3 children, because taking this responsibility alone and unsupported was too scary:

I really felt I had no one to talk to, then. My friends were all very much into conventional stuff and were very happy to give antibiotics at the drop of a hat and it was just too much feeling out on a limb on your own.... I was just too scared to do it on my own. I didn't really have the courage of my convictions. It was easier with the fourth child, 'cause I really knew that homeopathics [sic] worked 'cause I'd used them more. [By then] I did feel I had some contacts to fall back on. To feel that I'm not the only loony in Greyborough who's (laughs) not gonna vaccinate their child. ..I joined an ante-natal yoga group and suddenly I was in a completely different mix of people, who were all much more interested in what I was doing, a slightly more esoteric type thing, and also just are more into alternative remedies, alternative lifestyles and different ways of doing things. And that's been very, very reinforcing to have a different group of friends who are all trying to do the same thing, who aren't vaccinating their children, and who are aware of alternative ways of doing things. It's the opposite of the herd mentality that the medical professionals talk about, that there's safety in numbers. We feel we're growing a little herd of our own.

The confidence from this support helps Sally to stick to her decisions when she comes 'under fire' from the medical profession.

One doctor who I saw got hysterical with me about not having had the HIB meningitis [vaccination] and I just kind of walked away. I said, "Well, you know, I've think I've made an informed choice. I can't regurgitate all my reasons right now. I tend to forget...because I can't draw on them fast enough, but I've done a little research and I've thought a lot about it, it's not just because I'm ignorant or stupid or, or lazy or, or anything like that".

Using the orthodox medical system

The literature on alternative medicine use shows that in spite of the term 'alternative', no one abandons the orthodox system altogether (Cant and Sharma 1999). The relationship is often described as the use of both systems in tandem. What has not been discussed is how the use of the orthodox system changes. Certainly among the committed homeopathy users there is a universal experience of interacting differently with the orthodox system, which has not been documented in the literature to any great degree.

For some there is a tendency to reduce visits to the GP. Jean explains that she rarely ever visits the doctor and she is really happy with that "If you can deal with it yourself without having to phone the doctor it's brilliant". Many, particularly mothers, report still visiting the GP on occasions when their children are ill but with an emphasis on obtaining diagnosis and tests not on obtaining treatment. Shelagh a homeopath, and also a user, verbalises this change concisely: "I only go for diagnosis and chuck the antibiotics in the bin". Many committed users such as Diane, Tamara, Ruth reiterated this phrase "I only go to the GP for diagnosis".

There is not just a diminishment in frequency of visits but reports of a changed perception of the GP and of an instrumental relationship. They report going to get what they need or want from the doctor and embedded in this is the shift in responsibility discussed above. Sally's critique of medicine as "a quick-fix a lot of the time, and I don't really think that, for most of us, that's the way forward." is linked to her responding differently to her GP:

I know other people who will trust the doctor and do what he says. I don't actually feel like that about doctors. ... I suppose distrust isn't terribly it, because I like my doctor, he's a nice chap... But I've always rather felt that I've had to say what I want from him, to get what I want, and it's not antibiotics necessarily, it's to get a decision or a definite answer like "Will you tell me, is this chicken pox?"

Once the diagnosis has been obtained the committed users then take over treatment either themselves or with the help of their homeopath. Jean explains

I very rarely visit the doctor at all... I would take my son [to the doctor] if I suspected a serious condition or needed confirmation of a non serious condition i.e. Severe bangs to the head - check for fracture... Having put my mind at rest, then I'm prepared to take the treatment on board myself. I mean she [GP at a visit to check son's eye after damage] immediately said antibiotics, and Angus, touch wood, has never had antibiotics in his life.

Apart from the diagnosis function, the homeopathy users do keep orthodox medicine in mind for accidents and serious and life-threatening illness. In the vaccination group all mothers agree they would take their child straight to casualty with suspected meningitis (even though they might treat them with homeopathic remedies in the ambulance). Roberta says she will go to the doctor if she has an extreme asthma or eczema attack

and she will "use adrenaline or cortisone to save my life". Although she expresses a desire in the homeopathy class to try the homeopathic version of adrenaline next time she has an attack, she says she would not take too many chances.

Whilst they might keep orthodox medicine in reserve for emergencies, the homeopathy users appear to be consciously rejecting the authoritative knowledge of biomedicine. They are seeking another whole system to rely on as their first stop for healthcare. This is supported in the literature. Furnham and Bragrath's research also found that homeopathy users were more critical and sceptical of biomedicine and more conscious of health in general (Furnham and Bragrath 1993). Users of homeopathy were also more likely to believe they could improve their health. They reported being more self aware and more aware of the environment, holding holistic views, and generally were more knowledgeable about their bodies than patients who only used biomedicine (Furnham and Forey 1994).

Could this be linked to the maternity and childbirth experiences of women and a turning away from Biomedicine? Two thirds of homeopathy users are women. Many of the women in my research started using homeopathy during pregnancy or after the birth of their first child. Dissatisfaction with healthcare may not be the only factor. Certainly many of these women were very open to alternatives and had been brought up in households where traditional forms of medicine were used and alternative views expressed, and so could be seen to be more open.

The change in the relationship with the orthodox medical system produces a number of tensions that will be discussed below. A brief example of the sorts of tensions is revealed by Shelagh, (the authoritarian homeopath I mentioned above) who is a mother. She explained how her non-vaccination of her child and her use of homeopathy produced tensions with her GP:

I used to go to Dr Canter but fell out with her because I wouldn't vaccinate my child. We had a falling out. She gave her antibiotics and I was too scared to say I didn't want them but I didn't give them to her. I gave her a homeopathic remedy. And she got better. So when I went back to her I wondered should I be honest. Should I demonstrate to her to open her mind? 5 years ago I used to broach the idea of homeopathy and got the reaction 'it's a load of rubbish'.

Education and knowledge as a route to responsibility and equality

Knowledge is power (Tamara, homeopathy user and home prescriber).

Gaining knowledge about homeopathy is an expected part of the role of homeopathy user. Ian, a homeopath explains how he encourages his patients to learn more:

My role is to support the patients in whatever decision they take. If they don't want their kids vaccinated, that support has to be very positive. I want them to have a first aid kit, I want them to have books that will show them how to cope with fevers and measles and various things, so that the support is meaningful, not just a verbal... thing.

Learning about homeopathy is encouraged by homeopaths in an attempt to give patients more responsibility and to reduce the hierarchical differentials in knowledge. Homeopaths encourage their patients to buy books, get educated, learn how homeopathy works, use it for first aid and become home prescribers. Nancy explains that only 4% of people on homeopathy college courses actually become professional homeopaths. If so, there are a lot of other people learning about it for their own sakes, as mothers or just for themselves. They are still encouraged to consult a professional homeopath for constitutional treatment and to help them with advice if they are having difficulty finding a first aid remedy.

Angie explains that her attendance on the homeopathy course was prompted by a suggestion from her homeopath.

I thought [studying homeopathy] would help improve my understanding of both the philosophy and practical use of homeopathy. I also thought it important to have first aid knowledge as I do not wish to give my children antibiotics, Calpol or other suppressants. It is also important for those who "opt out" of the orthodox system to understand clearly how to manage illnesses in some way rather than ignoring them.

The fact that a group of 14 people are willing to attend a whole year course, taking a morning out of each week to study a system of health and healthcare, in itself shows an interesting level of commitment that may not be shared by users of other therapies. As

does the commitment among the vaccination group to learning more about vaccination, both through attending this group and other lectures, and reading books and searching actively for information. Tamara, a homeopathy user and home-prescriber, explains her and her husband's view on information in relation to the vaccination debate:

We were both convinced that knowledge is power and that, you know, the only way to feel comfortable with this decision [not to vaccinate] was to acquire as much information as possible about why we didn't want to do it, and what the ramifications of not vaccinating would be. It's not an easy option, it's a hard option, because you have to work a lot harder protecting your child's immune system. We felt well now we've got to look at nutrition and a regime of preventative health. And we wanted to learn about symptoms of the illnesses, treating illnesses homeopathically [so we went to Jenny's support group].

Research by Furnham and his colleagues would support the idea that homeopathy is different from other alternative therapies in this respect. They found that homeopathy users valued involvement in their healing process to a far greater extent than users of osteopathy and acupuncture (Vincent and Furnham 1996). I would support this from my experience. Even though I have consulted acupuncturists off and on for nearly 20 years I have never sought to learn much about the system of acupuncture, being happy just to undergo the therapy and trust in its efficacy through witnessing results. However many of the homeopathy users report being actively encouraged to educate themselves in homeopathy. Homeopathy is perhaps a more accessible body of knowledge than many alternatives. Whilst a little arcane, Hahnemann's *Organon* is surprisingly understandable to the lay reader (Hahnemann 1810), far more so than most biomedical texts and papers. The same can be said of the repertories and materia medica for homeopathy (see, e.g. Kent 1998; Vermeulen 2000). Early on in my acupuncture treatment I did ask for a reference to a textbook to read up on it and found it incomprehensible (Kaptchuk 1983).

In chapter 4 I outlined the historical legacy of homeopathy in England. I suggested that the lay homeopathy faction in particular was based on the principle of accessibility to the lay person and a conscious move away from the hierarchy and protected knowledge of biomedical doctors. It is interesting to see this played out in current day homeopathy, 150 years later.

Tensions with orthodox medicine

In Chapter 4 I also detailed the many points of tension with respect to biomedicine, that had occurred during the historical development of homeopathy. This history has left its legacy and one can see such tensions at many points in the belief system of committed homeopathy users. The front-line of this contemporary tension between the two systems of belief is played out most actively in interactions with GPs:

There aren't many people that are so closed that they won't accept some of what you say [about homeopathy]. I think the only person I know that's quite dogmatic is Phil's brother-in-law who's a GP, oh and my GP. I have to be very careful with him. When I suggested that I wasn't vaccinating Angus he turned on me and got quite... (Jean, homeopathy class member).

The first point of tension relates to the scientific basis of homeopathy. What the converted refer to as 'the magic of the minimum dose'²¹ becomes a real sticking point for those in the biomedical camp. In discussing alternative medicines with doctors, they often responded that homeopathy was the one they really had problems with. Violet, a GP who visits an osteopath for her bad back and who has allowed a patient to set up tai chi lessons in her practice, is evidently open to alternatives yet homeopathy provides a real challenge to her because she cannot explain how it works. She has a mechanism for understanding how tai chi works: 'You're learning control over your muscles and your posture and that makes some sense, I can understand why that should help pain in the muscles'. However when it comes to homeopathy she is stumped:

Homeopathy I can't- my scientific brain doesn't allow me to really believe that it works and yet..... I've got a very good friend who's a GP and he's a homeopathic practitioner. I don't know, I find it difficult to believe. I think I always have to have a sort of mechanism for knowing why something works. But I... (sighs) I can't understand why unmeasurable quantities of something...

Violet, like many others medics and scientists as I outlined in chapter 4 is "Being asked to believe two impossible things before breakfast" (Seymour 2001).

²¹ "The Magic of the Minimum Dose" was the name of a text book on homeopathy given as recommended reading for the homeopathy adult education class.

Those in the committed camp have no problem with the mechanism of homeopathy. Interestingly it is not because they are abandoning western scientific principles and resorting to magical explanations. They too draw on western science to explain the mechanism. However it is the new physics of quantum theory, that they draw on²². Nancy, teaching on the homeopathy course uses Einstein in her explanation of how homeopathy works:

From Einstein we know that all matter is energy and that matter and energy interact and vibrate within a field and are inseparable. This vibration can be changed. This is how homeopathic remedies work. Disease is a problem of the dynamic body not the chemical body. The lower potencies work on the material body and as we move into higher potencies we are moving into the sphere of the dynamic body and the realms of the mental, emotional and spiritual levels.

Homeopaths are not worried whether there is any chemical molecule remaining in the diluted homeopathic preparations, for they talk of energy transfer from the original substance to the homeopathic remedy (in the manner disparagingly referred to in the extract from Richard Dawkins in chapter 4 (Diamond 2001). However in daily life neither homeopaths nor their clients pay very much attention to the mode of action, as was discussed in chapter 2, in the review of Furnham's wrong assumption that people would know the mechanism of homeopathy (Furnham 1999). Homeopathy is distinguished for the lay homeopaths and users by its results not its mode of action.

The second aspect of tension with biomedicine is in the symbolic differences in the view of disease that was outlined in chapter 3. The biomedical notion of disease is that of an enemy to be fought in active combat through the symbolism of warfare, conflict, fighting and ammunition (Martin 1990). In homeopathy disease is seen in much more benign, organic terms, as part of the body's natural healing. In place of bombarding the patient with strong drugs to fight off the attacking enemy organisms, the strategy in homeopathy is about supporting the body through witnessing, providing a mirror to its symptoms to enable it to heal itself. In the former, the body is seen as an inert site of the battle. The power of healing rests with the expertise of the doctor to diagnose the illness and the magic bullet-like drugs to zap the attacking causes of illness. In the latter the

²² In a recent paper by Schlingensiepen in the homeopathy literature, the question is raised of where homeopathy should anchor its knowledge base. Quantum physics is one option ranged against the

expertise and the magic lie within the body as a far more involved and active agent in the healing process.

A third point of tension between the homeopathic and orthodox view is the way in which orthodox drugs are seen as part of the toxic world. From the homeopathic view they are a cause of illness, from the orthodox view, a cure of illness. The orthodox medicines themselves are seen in homeopathy as toxic poisons. This is especially the case for vaccines that are so dramatically injected directly into the bloodstream with no safety barriers, but also in the case of chemotherapy and even in a milder way, everyday drugs such as antibiotics. In addition to their toxic nature, they are seen to act against the body's natural healing processes by suppressing helpful healing symptoms such as discharges and fevers. This is seen as a mechanism that pushes problems deeper into the hierarchy of body organs. A biomedical doctor will see the removal of eczema symptoms through the use of steroid cream as a successful cure. In the homeopathic view, the symptoms on the skin will have been seen to be pushed into a deeper and more damaging level in the body, only to emerge as more dangerous problems such as asthma.

The fourth tension relates to the time-scales of health and the practice of treating healthy people not just those with symptoms. Orthodox medicine is unlikely to respond to someone who comes to them asking for illnesses suffered 20 years ago to be treated when there are no active symptoms. As Diane, a committed user of homeopathy explained when I asked her "How would you feel about the concept of going to your general practice to get alternative therapy?"

I think it's a framework with acupuncture and homeopathy - it is a radical departure from the ordinary western allopathic framework. For your average GP I think it is quite challenging for them to get their heads round that holistic idea, and to understand that something very physical and apparent, on a physical level, might have something to do with an event that happened 4 years ago or 10 years ago or even 20 years ago. I mean what the fuck have they got ready to their hands to help them work with that connection!

Similarly, the idea of going to the doctor for an MOT when we are in full health does not seem to work in the current system of organisation of orthodox healthcare. This

revolves around the active treatment of currently present symptoms over a relatively short time-scale.

The final major tension relates to the role of the patient in the relationship with the healthcare provider. In the homeopathic view there are two key, and related interpersonal aspects that do not fit well with the structures and systems of orthodox healthcare. The egalitarian relationship with the provider and the major responsibility for decisions lying with the user. Orthodox medicine operates on more of an expert model where the passive patient provides only as much information as the active doctor needs to make diagnoses and determine treatment. Homeopathy operates on a model of a far more active patient. In fact the label 'patient' seems inappropriate for the active role taken by homeopathy users. They are more in control of what is discussed in the consultation, and comfortable to set the agenda by bringing up what they deem as important to discuss. They are also active outside the consultation in self-educating to prepare for home treatment and to make decisions about which healthcare providers to consult and when.

These five major points of tension make it difficult to see how a model of integrated homeopathy situated within orthodox medicine, could ever work for those committed to the homeopathic belief system. Where the two systems are offered within the biomedical organisational framework and squeezed into the average GP consultation time these tensions create problems. Eve, a homeopath told me her doubts about the possibilities of integration:

My prejudice about [homeopathic] doctors trained in England [as opposed to the Indian doctor/homeopaths] is that they didn't have that intensity of training, and they only learnt at a superficial level. What they do when they only do ten minutes, is that they just like pick off the therapeutic prescribing but don't actually get into person prescribing.

Maybe however it is not just a question of training, but the impossibility of doing person prescribing within a biomedical framework, with all the inherent tensions discussed above. This suggests that any homeopathy that is being conducted within the NHS, is unlikely to subscribe to the model of beliefs of the committed homeopathy users outlined in this chapter. Either the homeopathic practice is heavily syncretised with

biomedical thinking, as is the case with the homeopathic GP with whom I conducted research (and whose case study forms the basis of chapter 9), or more committed non-biomedical homeopaths are working in more subversive ways within the system. A final possibility is that only those homeopaths who are closer to the biomedical system of beliefs would choose to practice within the health service. Ian, one of the homeopaths I interviewed, who has worked in three different general practices during his career, did not subscribe to the full belief system as outlined above.

Summary and concluding remarks

Within this analysis a number of interesting findings have come to light. Although cosmologies of health and the body are different, the practice of healing by lay homeopaths is more similar to western biomedical models of healing. Homeopathic healing is generally conducted in a private room with chairs and a desk, between individual patient and healer. Even though these users and their lay homeopaths hold a more social model of health, there is appears to be little room for direct involvement in the healing situation of wider family (except for children) or community. Although many of the users reported encouraging their partners and wider family to consult with their homeopath for individual consultations. Only one of the consultations I observed fell into this category, where one patient waited outside while her mother consulted, having given up her own booked session because her mother was ill and needed it more. Although they did not enter the consultation room together. However each patient gives verbal reports of her relationships and the activities of significant others and in this way the homeopath becomes more knowledgeable about the family as a unit and is able to treat individuals as embedded members of their social world.

It appears that the active seeking-out of alternative medicines is a key factor in becoming a committed believer. Accidental exposure to homeopathy does not obviously lead people down the same path. Those committed users that had sought it out, often appeared to be going through transitions in their lives, becoming a mother or adjusting to divorce for example. The homeopathy appeared to fill a gap not only in their healing

but in their spiritual and existential worlds. In this way the use of homeopathy could be seen as akin to a new religion (Heelas 1996).

Attraction to use homeopathy also stemmed, for many of the women, from unpleasant prior experiences with biomedicine, particularly through the “conveyor belt” of pregnancy and childbirth, with the associated medicalisation, depersonalisation, lack of control, and lack of continuity of healthcare providers (Oakley 1981; Davis-Floyd and Sargeant 1997; Machin and Scamell 1997).

While the accepted rhetoric of beliefs about the body was of a more interconnected entity, people still talked about physical, mental and spiritual aspects of health and healing, as though they were separate entities. To some extent this reflects the lack of a language (outside academic language: Scheper-Hughes and Lock 1987; Ots 1994; Monks and Frankenberg 1995) to talk about the combined body-self. To some extent it probably also reflects the inability of those rooted in a western society to abandon biomedical and Cartesian dualist notions of the body entirely, resulting in a syncretic view of the body informed by biomedical and alternative beliefs.

This version of homeopathy, whilst different to biomedicine in many respects, is still firmly culturally informed. The primary focus on emotions as the cause of illness and the need to discuss the individual lifeworlds of patients, and to advance their personal development agenda, reveals a very western cultural view of personhood. Individualistic notions of the person and a discourse of self improvement are deeply embedded in capitalist cultural values (Lasch 1991). Egg's work on homeopathy in India shows that the focus in therapy there, is not on emotions and social talk but on the digestive problems of the users (Eggs 2002) reflecting different cultural values about personhood and the body.

However, while this London version of homeopathy is deeply individualistic in one sense, there is more of a recognition of the effects of the healing on a wider social system, than in much biomedical practice. The apparent patient might be the one in the room consulting the homeopath, but there are reports of the remedies healing relationships and bringing about changes in the lives of significant others. So in this

respect the model of healing and the body is less individualistic than within much science-based medicine, where the focus is on healing the individual body²³.

This group of committed users of homeopathy do continue to use the orthodox system in tandem with their use of lay homeopaths, confirming the findings of surveys of users of alternative medicines in general (e.g. Thomas, Carr et al 1991). However, they come to use orthodox medicine very differently. They go to their GP, but primarily for diagnoses, tests, referrals and reassurances, not for treatment. They also strive to produce a more equal relationship in their dealings with their GPs, and other healthcare providers, acting with more assertiveness about their needs and with more openness about other routes of healing they are pursuing. In this way they are constructing themselves as a different kind of patient, to the average patient who has very little voice, and whose agendas are not expressed (Barry, Bradley et al. 2000; Barry, Stevenson et al. 2001).

In the next chapter I want to use case study material for some of the committed users to illustrate how the system of beliefs outlined above, fits into an individual's life story.

²³ As with all generalisations about biomedicine, exceptions can always be found. For example psychiatry and genito-urinary medicine are two branches of biomedicine that focus to a wider degree on the body in social context.

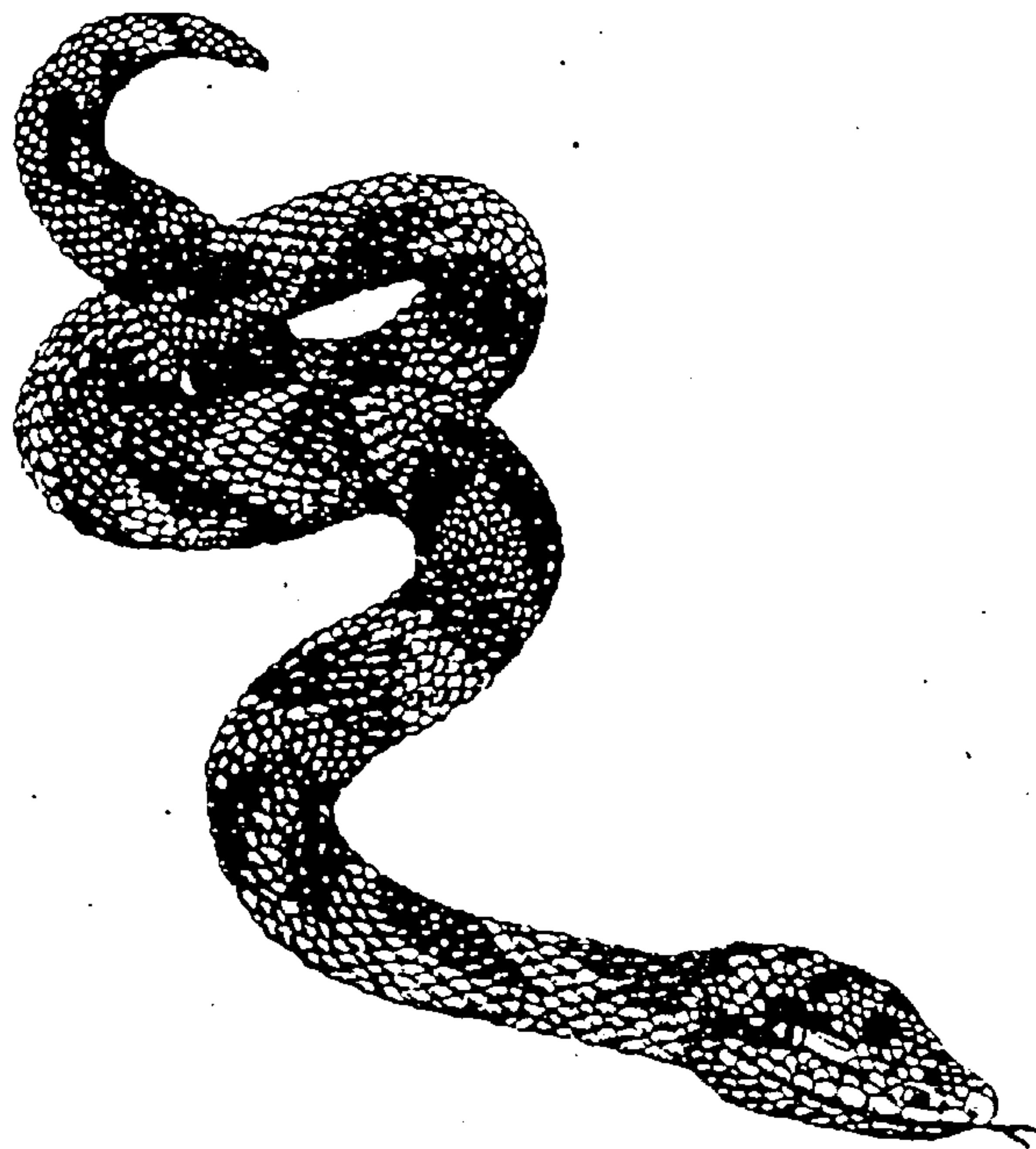
Chapter 7

Case studies: Committed homeopathy users' beliefs and practices

LACHESIS (Lach.)

Family name: Ophidia

Other names: Surukuku snake; Churukuku snake;
bushmaster snake



Chapter 7. Case studies: Committed homeopathy users' beliefs and practices

Trajectories into homeopathy

The literature on usage of alternative therapies, reviewed in chapter 2, suggested that the main reason for first using alternative therapies is having a chronic illness that is not treatable by orthodox medicine. However this was only one factor in the usage among my sample of committed homeopathy users. This may be because they are an unusual sub group of alternative medicine users. Alternatively prior research, relying on survey data, may be insufficiently sensitive to pick up other reasons for use. This latter option is quite likely in closed-response surveys where possible reasons for use are pre-defined by the researchers.

The committed users of homeopathy in my research had five routes into homeopathy, through:

1. their parents' commitment to homeopathy;
2. their own illness experience;
3. their children's illness experience;
4. deciding not to vaccinate their children; and
5. studying homeopathy in an educational setting.

These groups are not mutually exclusive. There may have been one entry point into homeopathy, but the individuals concerned often moved into one of the other groups at a later stage of their life. For example Ruth first started homeopathy when she was diagnosed with cancer. Then 8 years later when Lily was born she decided not to vaccinate her. This decision was made after attending the vaccination support group. Ruth's most recent development is her use of homeopathy for Lily as well as herself.

Jean, who is now 49, was brought up without vaccinations and treated homeopathically by her father. As an adult she has self-prescribed for minor ailments and recently attended the homeopathy education class, in recognition that her father at 80 will not always be around to give her advice. During the course she decided to consult a

homeopath for constitutional treatment, which she has now extended to her husband and son.

A number of the homeopathy students report influences in their family and their upbringing that have predisposed them to be receptive to homeopathy. Jan and Sam were both brought up on homeopathy by their parents and not vaccinated. Angie's grandfather was anti vaccinations. She and her siblings were brought up by a nanny who was very anti medical treatment and used herbs for illness. "She used to go and get Feverfew out of the garden for migraines and things like that, I remember, so maybe it was her influence." Some of the older women have been turned onto homeopathy by the experience of their daughters using homeopathy with their grandchildren.

In her work on new social movements, Searle-Chatterjee found that dispositions in the family were of crucial importance, with parents often radicals or activists, and often with non-conformist religious backgrounds (Searle-Chatterjee 1999). Alternative medicine, whilst rarely conceptualised as such, could be seen as a good example of a social movement, so it is interesting to see the same type of inter-generational influences (Schneirov and Geczik 1998).

As well as through older generations, it is often through same-generation family, and friends that people get into homeopathy. This supports Sharma's finding that most people find therapists through personal recommendation (Sharma 1992: 124). It expands this finding to suggest that friends are not just acting as providers of information about who to visit, but might also be providing the initial motivation to start using a therapy. Sam had not even thought about the issue of vaccinating her child until her best friend's sister raised the issue when she was pregnant. This friend was training to be a homeopath and had two children of her own with eczema. Just after this conversation Sam's osteopath asked what she was going to do about the birth and suggested she visit her husband who is a homeopath. Sam did not vaccinate her children and the recommended homeopath has treated Sam and her whole family ever since. In Roberta's case, she was on steroids and cortisone for 2 years for eczema and asthma and a cousin who was having homeopathy suggested it to her.

Not everyone gets into homeopathy through friends. Tamara reports that she had her baby vaccinated “when I was living in the dark ages” however this resulted in terrible eczema. There was public controversy at the time about MMR. She started to look into it, talked to people and subscribed to “The Informed Parent” and got into homeopathy and aromatherapy.

“It was suggested to me, just out of the blue by a complete stranger, when Iris was in the buggy and had a bad cough. She said, “Why don’t you try a homeopath?” I thought, “Why don’t I try a homeopath?” (laughs). I went to the local health-food shop. The guy who runs it is a just a brilliant source of information, he’s a brilliant contact point. And he pointed me in the direction of this homeopath”.

In order to look more closely at the routes into homeopathy and the path that leads to transformation in worldviews on health, illness and healing I will now present three case studies. I have tried where possible to do this in the words of the three women concerned. I feel their testimonies speak powerfully on the issues raised in the last chapter, set within the context of individual lives.

Committed Homeopathy Users: Three case studies: Alice, Ruth and Angie.

Case study 1. Alice

It’s made me think about life, life as a whole and how we how we conduct our whole lives.

Alice is an expensively-groomed, self-confident woman of 34. She lives with her husband Jay, her 4-year-old son Harry and her 2-year-old daughter Susan, in a spacious Edwardian semi-detached house in a leafy road, in one of the more exclusive of the south London boroughs. Alice gave up work as an accountant when she had children; her husband has a stressful financial job in the city. I first met her in the morning emergency surgery of Dr Deakin, the homeopathic GP. He was running late and she had sufficient confidence to negotiate with the three patients on the list before her so that she could jump the queue, to avoid missing another appointment. Harry was crying,

clutching his ear and grimacing with pain, at the time. It turned out that the second appointment was with her private homeopath in the neighbouring suburb. I have presented the details of the consultation and her interaction with Dr Deakin in chapter 9.

At that particular consultation Alice came home from the GP with antibiotics even though she had been quite assertive in the consultation about not wanting them. The doctor also prescribed some homeopathic remedies. She however only gave Harry the remedies suggested by her homeopath whom she visited later that morning. Harry slept on and off and was “definitely unwell”. By the time her husband came home, however he was running around “as right as rain”. Alice claims she was “absolutely flabbergasted” at his speedy recovery from homeopathy but she told me ‘[it] has happened over and over again over the past 2 years’.

Alice has been visiting a homeopath for 2 years since Sarah had eczema as a baby, after she had tried endless creams from the doctor that were getting stronger and stronger but not helping. “The play group leader said her child had had this desperate eczema and she’d been to this same lady, and it had cleared up within a few months”. Within three weeks of taking Sarah to the homeopath the eczema had cleared up.

Alice and Jay have been convinced by the results on their children more than anything: “We’ve just seen it work so... so miraculously really, in a lot of cases. And I’ve avoided six lots of antibiotics with them. They’ve been as right as rain the next day after I’ve been to the doctor’s and just with a few homeopathic tablets”. Whilst she uses homeopathy, she does not report such miraculous results on herself. She tells me “It’s probably more difficult for adults, because there is more clutter in your system and it’s more difficult to get the right remedy for you”.

Alice’s view of health

Alice had an unfortunate episode of illness when her daughter was only 6 months old and she ended up in hospital on intravenous penicillin for several days. “That was really horrible. My homeopath was saying this was a big factor in the eczema [she later developed], it’s immune system overload that was sort of stuck in her system and she

couldn't get over that." Alice's homeopath has helped her into this new view of the potential for orthodox drugs to create health problems, now or in the future. Alice has also taken on board the concepts of the 'symptom as messenger'; the interconnectedness of life, the environment and health; and the self-healing power of the body:

I've definitely changed from looking at it as, "Right, Sarah has got a rash, I need a cream to put on it." to, "Why has she got that rash?" To treating the initial reason, treating it from the root cause, which is what homeopathy does more than conventional medicine [which] just treats that particular problem, and doesn't really get to the core problem of why that's happened. So I have changed my view in a more sort of holistic approach of treating things.

It's also made me think about life, life as a whole and how we... how we conduct our whole lives. Your body does want to be well. It is an amazing piece of equipment that repairs and consistently repairs and heals itself. The amount of drugs we put into our bodies, the amount of pollution we're exposed to and the amount of stress. It's made me think about what we eat as well, organic products and all the sprays and pesticides and everything that are on all our foods in the supermarkets... I just feel that I don't want to clog their systems up any more.

The role of the homeopath is also apparent in helping Alice to see her husband's hayfever as brought on by emotional causation. She told me that a lot of health problems can be caused by your mental state, and whether you are unhappy:

[Jay] started with hay fever the year that Harry arrived, which the homeopath says is quite common. It's not something he's had before but it's something that can be brought on by major changes in your life, of which your first child is the biggest change in your life.

Alice maintains the importance of keeping healthy. She visits the homeopath even when her family is not ill, but when she feels there may be signs of potential stress or future illness if untreated.

I've been several times where we've not really been ill, but if I've felt like we were all on a bit of a low ebb. Say near the end of term, for instance, and Harry's running out of steam and... I'm feeling a bit 'ugh' in the winter, when the weather was awful and we were all feeling a bit depressed and neither of them were really ill as such, but just a bit moany and just not really on top form, and I would go then.

Relationship with the homeopath

Alice explains why she still consults a private homeopath even though she now has a homeopathic GP: “I feel that she’s known us for a number of years now. She knows all of our characters and our background and, I think that counts for a lot on the homeopathic treatment and getting the right thing. I feel like I’ve got quite a good relationship with her now. She’s really lovely and, you know, I feel really happy to chat to her, I feel like she’s a friend”. Whereas of Dr Deakin the homeopathic GP she admits “I didn’t really warm to him as a person”.

Alice’s role in the healing process

Alice’s role in using homeopathy for her children fills her with a real sense of achievement, increased responsibility and power:

I’m hopefully making my children healthier by treating them this way and, stimulating themselves to get themselves better. Trying to treat these problems with homeopathy: they can stop these sort of problems early on in children, like the eczema and the asthma then it’s a lifetime of better health of that person.

It made me think about learning to manage all of our health and take responsibility for it as well. A lot of people think, and I used to think, ‘there’s something wrong with me, I’ll go to the doctor to make me better.’ So you’re going to somebody and you’re putting that sort of responsibility to make you better into somebody else, rather than actually trying to analyse yourself: ‘Why am I ill? What are we doing to make our health better or worse?’

Like all of the committed users, Alice has read up on homeopathy and has a family homeopathy book. “I would be interested to learn more about it myself actually, if only I had the time”

Alice's views of orthodox medicine

Alice is quite critical of the role of the drug industry: “If they can come up with a drug for a pain in your little finger then they’ll do it. There’s a drug for every single little pin-pointed thing and it’s my perception that it’s not people’s health that these drug companies are interested in any more, it’s just big money”.

She is also critical of doctors: “You just worry that doctors don’t really have your long term health in mind. They’re treating your particular pain in your finger or whatever, but it’s not a general overall well-being is it? As much as homeopathy is treating the whole person”.

Alice, like many other women in the study has put orthodox medicine into second place in her healthcare framework, but has not abandoned her GP totally. This is borne out in the usage statistics reviewed in chapter 2.

I tend to go to the doctors for them to look in the ear and the throat and to see what it actually is. Then I tend to go to the homeopathic lady and say to her, “Right, he’s got a middle-ear infection”, or throat infection or whatever, and then I will tend to treat it with her. So I just use the doctor to tell me what the problem is, and then I go to her to treat it. I don’t know whether that makes any difference to the homeopathic treatment, it probably doesn’t, but I think it makes me feel... that I’ve got all the information as to what exactly the problem is. Then I’ve given as much information as I can to the homeopath to be able to treat it, 'cause obviously Harry can't say where the problem is. They (Homeopaths) don’t look in ears and in your mouth and everything.

Alice reports having had a bad experience with her previous GP whom she consulted when Harry got croup. He gave no treatment just said: “Well all I can suggest to you is buy some cotton wool, put it in your ears, and go to sleep.” Alice was so disgusted by this GP’s response that she registered with another doctor. She chose Dr Deakin because she had heard he was keen on homeopathy. The original doctor had also suggested Harry could be asthmatic, and that they could try him with an inhaler. “I could have had both of these children on (breathes in) steroids from here to eternity. You know, Sarah at one and Harry at three.” She told me exasperated, “and yet three weeks after seeing the homeopath, Harry’s cough stopped completely”.

Attitudes towards orthodox drugs and vaccines

Again Alice is explicit in pinpointing the influence of the homeopath in explaining the harmful effect of vaccinations and orthodox drugs:

Homeopaths they go right back to the beginning don't they and talk about everything they've had from a baby. So all the injections and any antibiotics, and that seems to be a big issue erm in, you know, all these sorts of conditions. We're also a society now who are not good at being ill. We're expected to pop a few pills, a short term fix but probably not beneficial on your health long term really. I'd try every other... possible thing before giving antibiotics.

This new awareness of the potential harmfulness of drugs prompted Alice to look at the product her husband was spraying up his nose for his hay fever. She asked him "Do you know you're spraying hydrochloric acid up your nose every day?" After this she sent him to visit her homeopath. Many of the committed users have 'sent their partners' to the homeopath. Sharma's study showed that it was difficult for women to introduce radical changes to the families healthcare in cases where their husbands were antagonistic (Sharma 1992). On the whole the partners in my study were not reported as being antagonistic except for three women who reported negative male intervention. In all cases this was on the topic of non-vaccination, not the use of alternatives per se.

In reviewing Jay's progress Alice reveals that she is now on a homeopathic time-scale of cure where it might take several years:

This year he still had it, but it's not been as severe. It's built up over three or four years, so hopefully over the next three or four years it will decline as well²⁴.

Whilst Alice has had the children vaccinated she is beginning to question the sense of vaccination and is considering not giving Harry the MMR booster before he goes to school. She is starting to question the medical line on this, and to come over to the

²⁴ I was unable to interview her husband so do not know what his response to homeopathic treatment was, or whether he underwent any changes of health beliefs. This would make an interesting further research project, interviewing the male partners about their use.

homeopathic view that childhood illnesses are providing a vital function in developing the immune system:

I do feel like there's a lack of all round information. The information you get from the doctors is very much 'You must have this, you're putting your children at risk if you don't' almost scare-mongering things really about the diseases. And yes they're not nice and I wouldn't want to see them that ill and I wouldn't want to put them at risk. But then you talk to the homeopathic people about it and their view is very different. Those instances where people go blind with measles or deaf is a very, very small minority and it's probably in the Third World somewhere. My homeopathic lady finds it incredible how we're so frightened of these diseases, because they're childhood diseases. Her view is we're meant to get them when we're children for other reasons later on in life. Having the measles gives you some resistance to cancers later on in life. I mean the rate of cancer is just going through the roof and you just kind of wonder with the whole scope of it, sort of looking at health in your whole lifestyle.

She expresses a nagging sense of being unable to trust the medical system over this issue and preferring her own authority and that of her homeopath. In questioning the need for a booster Alice explains she has heard from a doctor friend, that surgeries do not get their full payments from the Government until the children have had their boosters as well. "Have doctors really got your children's health at the centre of things, or is it money?"

Each case study has to be left in mid air as each user is only at a certain point, in what seems to be an ever shifting relationship with alternative medicine.

Case study 2: Ruth

I am very healthy, but I do have a very serious illness as well. But it's not the same as my health.

Unlike Alice, who got into homeopathy through her children Ruth, now 42, came into homeopathy through her own illness experience, when she was diagnosed with cancer, 12 years ago. Then when Ruth had Lily 4 years ago she chose not to vaccinate her and to treat her homeopathically. Although she came into homeopathy by a different route to Alice, she shares many of the same beliefs and practices about child health. Ruth's

current homeopath is Jenny, who runs the vaccination support group that Ruth attended while her daughter was a baby.

There are several women in my study who came to homeopathy through their own illness experiences. Some of who do not have children (e.g. Diane and Roberta) and some of who now do (e.g. Olivia and Jane). All those already using homeopathy for themselves went on to treat their children homeopathically (although I would have been less likely to pick up those that did not through my fieldwork strategy). Many have not had their children vaccinated and those who have, have considered the issue very seriously before taking the decision.

Until the cancer diagnosis, Ruth worked in business consultancy. After her diagnosis she gave up her job and decided to study part time to train to be a counsellor. Six years ago she met Tim. They bought a house together and had Lily. Ruth and Tim split-up during the course of the research. Ruth now lives with Lily half the week. Ruth is now on a low income as a part-time student. Like many of the committed homeopathy users, Ruth uses a range of alternative therapies. It is worth hearing the story of how she got into each of these.

Using a range of therapies

We've done some good work together.

Ruth had a miscarriage over 20 years ago aged 19. She dates her bad back from 6 months after this time. She went to see osteopaths, chiropractors and physiotherapists in attempts to sort it out. She still suffers with back problems and now visits an osteopath whenever it flares up.

When she had the cancer diagnosis at the age of 30:

They wanted to cut the tumour out and I knew immediately that I didn't want invasive surgery. And although I had the drugs, I was in such a state of shock, that was almost a decision that was taken out of my hands. I just went along with what my consultant suggested. However having said that I'd read the

Bristol Cancer Centre Book. I'd have liked to have gone down there but it was just too expensive.

So I read their book which was all about the different alternative remedies and diets and I got really inspired by that. So I went to see a naturopath who did a little bit of cranial osteopathy and naturopathy. I can't remember how many times I saw him. I think I was seeing him once a week and he put me on a detox diet which I followed religiously. I needed to feel in control of the situation. On one level I felt like I was totally out of control of this thing that had invaded my body and if I'd left it to the hands of the medical profession I wouldn't have been playing a very active role in my treatment at all.

However I felt very let down by my naturopath because he claimed I could contact him in between treatments if I had a problem. About 6 months after my diagnosis I got what turned out to be an ear infection and it was so bad for a week I couldn't actually walk round the flat because it felt like I was on a rocking boat. I immediately thought oh god I've got a brain tumour. I was having such a bad time and I don't think he returned my call for about a week. Eventually he did get back to me saying he'd had his own problems. I thought 'I'm sorry but I'm paying you 40 quid an hour. You claim to offer this service and when I really need your help you're not there'. So I wrote him a stinking letter saying I thought it was really unprofessional and I fired him basically.

After that I was recommended to a homeopath in Churchton. I saw her regularly up until about 18 months ago. I really liked her she was lovely - we did some good work together I thought. And as well as giving me remedies for my emotional state and historical stuff she always chose remedies that fitted in with the tumour picture as well. But I decided I needed someone closer to home when we decided not to vaccinate Lily. I found Jenny through a local health shop in Greentown and she was giving a talk on childhood illnesses and homeopathy. I thought I like this woman so I arranged to see her with Lily and then gradually I decided to go and see her. She runs a vaccination support group for people who've either had their vaccinations or for people who want more information and that's great because we can meet once a month and talk. So I've had homeopathy pretty consistently since I've had the diagnosis.

Shortly after Lily was born she had severe colic and it was a nightmare. The medical profession said 'you will just have to live with this for 3 months this is what babies have'. I suddenly remembered reading an article when I was pregnant about cranial osteopathy on newborns. I found this woman called Allison that I still see. She saw Lily twice and she had the most magic hands.

And when I slipped my disc, traditional medicine didn't work. There was only one [homeopathic] remedy that would in any way touch the pain and I just had that constantly for about 3 weeks and that worked. That and osteopathy. Because again when I went to see the specialist at the hospital he treated it with homeopathy and osteopathy. And I'm now doing yoga as well. What I find is they work well for me in combination.

Jenny is very happy for me to see other alternative practitioners, and the way I work it is that I let each of them know, what's going on with the other one so that they can each put a whole picture together. That's what I do with my osteopath as well. She's often interested in what remedies I'm having from Jenny. So we sort of work in a triangular way, with me being the main person.

I come away from Jenny's feeling fantastic. One session is the equivalent of 2 months therapy. I feel very relaxed. It is friendly, warm and homely [she consults in Jenny's home²⁵]. I feel safe there I suppose. Lily is very happy there too there's lots of space and she can jump around on the sofa and it's light. As opposed to GP's surgeries where they are all full of medical stuff, the walls are bare there are notices about injections and it's very clinical.

Responsibility and control

With the initial diet from the naturopath after the cancer diagnosis Ruth felt she was really helping herself. She discovered the empowering feeling that came through 'feeling in control' at a time when the cancer itself and her dealings with the hospital had made her feel very out of control. In this respect Ruth is voicing an often reported wish of users of alternative medicine (Astin, Shapiro et al. 1999). Several writers have claimed that alternative medicine can be seen as a route to empowerment and it is interesting that Ruth uses this very word (Cummings 1998; Scott 1998; Gaylord 1999). However it should be borne in mind that the type of empowerment talked about here, is more of an attitudinal concept than any wider form of emancipation. Alternative medicines may give people a feeling of more control but they do little to change the disempowered position of women in society. Although it could be argued that taking control of their healthcare, and learning to stand up to the authoritarian body of medicine, could provide a route for women to make more structural changes in the wider society over time.

One of the things that I like about homeopathy is that it's a very empowering form of medicine. I've learnt a lot about homeopathy now and I've got some books and I've got a whole kit at home that I can diagnose minor illnesses at home in the family, coughs and colds and things. But they very much want you to administer the remedies yourself when you need it.

²⁵ I do not have space here to explore the issue of consultation space but it is a neglected area in the literature. Writers such as Shirley Ardener have asked us to see behaviour and space as mutually independent (Ardener, 1993). The use of the home as a space for practice has particular resonance (Bachelard 1994), representing both the individual body (Carsten and Hugh-Jones 1995) and feminine space (Rosaldo and Lamphere 1974).

Or you stop when you think the time is right. So it's very much in my control and I'm actually I'm responsible for my health in a way that I haven't felt with traditional medicine. [Doctors are] secretive or funny about it. Do you know what I mean? Whereas the homeopaths are very willing to share their knowledge with me.

I look forward to going to see Jenny and I look forward to the osteopath. You have a nice chat about things and - its productive and its much more of an equal relationship and I'm involved you know, we're both involved in the process. It's much more collaborative. It's very much a collaboration.

I find that I have to educate the people that are around Lily about it [like her playgroup leader and GP]. It's hard work - it's harder work in a sense. I've now got a big folder of all sorts of stuff on alternative remedies and vaccinations and homeopathy and I'm just trying to learn as I go because then that makes my job a lot easier. And it goes back to what I was saying earlier I need to be informed, I need to do my research because then I feel I am in control.

Emotional causation of illness

The day before I interviewed Ruth, she had mentioned her 20 year history of back trouble to her homeopath:

I still have a trapped nerve in my left leg. Jenny said "its trying to tell us something what do you think it is?" And all of a sudden, this thing that the cranial osteopath had told me, when I saw her after Lily's birth, popped into my head. She had said something really interesting "There's no feeling between your head and your womb". Jenny and I went on to have a long conversation about feeling dead from the neck down. And she said, "Where do you think that comes from?" I had a miscarriage when I was 19, and I said, "I wonder if it comes from there?" So we had a whole talk about the fact that I had never dealt with [the miscarriage] emotionally. It was just swept under the carpet.

Ruth is showing here how her consultations deal with emotional as well as physical issues and that there is a concept of emotional causation of physical problems. Jenny is encouraging her to see these links through the questions she asks: "Where do you think it comes from?" and, "What is it trying to tell us?" I will show how Jenny does this commonly in her practice in the next chapter.

A changing view of health

In Ruth's story I got a sense of a changing view of health over time and a different relationship with orthodox medicine.

When I [first] had my bad back I had a cortisone injection into the muscle. Well I wouldn't dream of doing that now. So I have had things traditionally, that I wouldn't dream of contemplating now.

Allied to this changing view of health is a linked change in how she sees life itself.

I'm glad I had the cancer tumour in a sense, because without that my life wouldn't be how it is today and I like my life very much. I changed my job; I changed lots of things. I changed in my head, which was very important. I faced issues like death and quality of life and what I wanted to be doing with my life. So it gave me an opportunity which I don't think many people have, and I think I was very fortunate to have that opportunity to address all those kind of things.

Ruth is aware that her views have become very different from the popular conceptions of health and illness:

Every time I go to the hospital they write a letter to my GP saying we've seen Ruth etc. And I caught sight of this letter and it said 'this unfortunate 36 year old woman' and I hit the bloody roof, because I just thought that was so judgmental, about what was going on for me. And I felt that really summed up the popular perception of a serious illness. As far as I'm concerned I am very healthy, but I do have a very serious illness as well. But it's not the same as my health. I think that might be quite difficult for some people to get their head round. But that I think is how far I have moved forward in my thinking.

Given the choice between the medical explanations for her illness and the homeopath's, she prefers the latter. It both makes more sense to her and gives her hope and something to work on to change her prognosis:

The medical profession on the one hand is saying "oh you can't do this" and "you mustn't have a baby" and "you must do that". But actually in the same breath they are saying, "we don't know what is wrong with you really. We can't tell you what type of cancer it is. It's very very unusual so we can't

answer any of your questions”. So they are very definite about one thing but not another, and I just feel that those two don’t marry up at all.

So push that to one side. And on the other hand I’ve got the homeopath and the osteopaths looking at the whole picture, both as I present it now and historically, and my family. And saying “OK where’s this cancer come from?” One homeopath talked about it being an emotional blockage in my system, a blockage of anger which has just manifested itself as a tumour. And that felt much more acceptable to me. I thought “Mm that makes sense to me” in a way that was so completely different from what the medical profession were telling me. And I really felt - it gave me hope. It really did give me hope.

Views of the medical profession

Like many women I interviewed, Ruth experienced the medical system during pregnancy and childbirth as really unpleasant.

I was very much in the medical health system when I was pregnant. It’s like a conveyor belt; it’s really frightening. If I was going to have a baby again I’d have one of these private independent midwife services. They are about a thousand pounds, but then it means you are guaranteed that midwife at your birth. You’ll have seen the same woman for every appointment. I just saw so many different people and because I had a few problems with pregnancy, I kept seeing different specialists. It was horrible you can’t build up a relationship with anybody. I think that’s one of the reasons I like alternative remedies, that you build up a relationship with someone and then it’s easier to collaborate because you get to know each other.

When Ruth was in labour she had complications and felt very much out of control. She never got the chance to use her NCT pack and birthplan or her aromatherapy oils.

Instead awful things happened, my trolley was banging into doors, I was surrounded by consultants in suits who all said I had to have a caesarean. Then things went crazy with alarms going and it was like a scene from ER but it was me!

Ruth suffered postnatal depression as a result afterwards. Although she’s an outpatient at the cancer centre, she hates going and has recently negotiated her visits down from 6 months to a year.

They had great trouble with the fact that I wanted to treat myself alternatively to begin with, but they've now got used to me. My feeling is that they find it quite difficult to understand me as a person and as a patient because I don't just go along with what they say. I question everything. I doubt everything. I want lots of answers to things, I go in with questions about all sorts of things and they can't give me any answers and I think they find that very difficult to deal with.

Ruth now reports only visiting her GP for a referral, and using various homeopaths as her first line of treatment:

Sometimes [doctors] are quite useful if you need to get to see someone - if you need a referral. That's when I try to use them. But now that I'm feeling much more knowledgeable about the homeopathy I will try homeopathy first and I will ring Jenny. There's also like a helpline that this guy runs, a homeopath - he can diagnose and suggest remedies over the phone. Cause Jenny isn't always available and sometimes you need to be treating things immediately and then it changes. So that guy was really good when Lily had flu. We were like ringing him up every hour and he was saying now you need to give this, now you need to give that. So I'll now use homeopathy as the first port of call and then if it gets really serious or it doesn't change I'll then go to the doctor, either for confirmation or a second opinion. I don't like going.

I've got to look for a new GP since we moved to Greentown and I'm dreading it cause Lily is not vaccinated and it's like every time I have to go somewhere new I have to explain and it's awful. One of the things we talked about doing in the [vaccination] group is writing a standard letter that can then go on the doctors file, that can then go on the nursery file, so that each time you meet a new person you don't have to keep explaining and feeling like I have to justify why I've made this decision. Ideally, there is a homeopathic GP quite local but his books are full. I'd really love it if I could find a homeopathic GP. Then you're getting the best of both worlds.

Vaccinations

Tim and I had talked about vaccinations before Lily was born when I was pregnant. And we hadn't really made a final decision but we knew that we were both a little bit uncertain and worried about vaccinations.

She had her first DTP vaccination at two months and she got infant eczema almost immediately. I felt so terrible I thought, "I wish she had never had that first one". I feel really bad about it. You know I wished I'd done my research. We didn't do much research we just talked about it. The first set

are at two months and at that point you're still in shock and it's very easy to get caught up in the system.

So then I did lots of research I joined this society called the informed parent which is basically a cuttings service, they send out information about articles that have been in the papers about autism with the MMR. I was still with my other homeopath then and we went to see her and she said this is a very big decision you need to go away and think about it. I realised that if I was going to go this route that I would need to have a homeopath locally, so I managed to find Jenny through a local health shop in Greentown and she was giving a talk on childhood illnesses and homeopathy. So I went along to that one evening and she talked about the immune system and how vaccinating a small baby when the immune system isn't fully developed is very dangerous.

We talk about a different vaccination and a different childhood illness each session. It's great support just to be with other people who have made that decision because it's quite an unusual decision to take. It's very frowned upon by government and medical profession and there's a lot of pressure to join the vaccination programme.

Tied in with this we make sure that Lily's getting all the childhood illnesses. So she's had chickenpox already and she's had German measles. Lily is quite different to a lot of her peers. She's very very lively. She's a real live wire she's very alert. She's very advanced in her speech and homeopaths will say that its because she hasn't been suppressed with vaccinations.

Case Study 3. Angie

(Homeopathy) it's not just medicine, it is a philosophy, it's almost like a religion.

As a mother Angie has a certain amount in common with both Alice and Ruth. Angie's experiences with homeopathy in her second pregnancy have already been discussed in Chapter 6. How she experienced it as helping her and her partner deal with the emotional aspects of becoming parents for the second time.

I met 29 year old Angie at the adult education class. She lives in a run down rented apartment in the exclusive suburb in which she grew up. She comes from a middle-class

family but is on a low income at home with a 2-year-old daughter Sandie, and her partner Mark who is a carpenter.

Getting in to alternative medicine

Angie's alternative family influences have already been mentioned (her anti-vaccination grandfather and alternative nanny). Angie first visited an alternative therapist in Venezuela on a student field-trip. She had a terrible skin rash and consulted an acupuncturist/psychiatrist who had been a homeopath. He told her she was suffering from depression. On her return to England she visited an NHS counsellor who proposed yoga and meditation, which she took up. Since then, she reports having used reflexology for an immune system boost, an osteopath for back problems, and, herbal remedies for colds and menstrual problems.

Angie told me that her first contact with homeopathy was when she was 7 months pregnant through a friend asking if she had thought about vaccinating her baby. The friend asked her own homeopath to send Angie information on vaccinations. Although Angie had always pooh-poohed homeopathy and reported thinking: "Oh, it's rubbish, these micro doses." She heard from several people that it was particularly effective on children and for diseases such as eczema. When Sandie got eczema at 8 weeks, she therefore took her to a homeopath and became a convert when she was cured.

Angie was shocked by the information on vaccines:

It was really horrifying, scary with pieces on how awful vaccination is, and how all these children had been left brain damaged. I thought, "Mm, don't like the sound of that very much". My friend's daughter was vaccinated, and has learning difficulties, and now at 11, has chronic juvenile arthritis. She wasn't a hundred percent convinced that that was Flo's problem, but that those kind of problems do arise from vaccination. Then Sandie was born and it was interesting 'cause the eczema came up about a week before she was booked for the vaccinations, and I thought, "Oh, I'll just take her to the homeopath" and she got in there straight away on the vaccinations (laughs) "Any vaccinations?", "Oh no- they are due next week" "Oh." she said, "I really think you should consider postponing it," and gave me more information. I went away and read that, and I did postpone it. And then I sort of narrowed them down and decided I would give her polio and tetanus,

but none of the others.” And the health visitor was all right, and she was like, “Okay, well I’ll give the polio,” and she gave her the polio, 'cause it was oral I felt a bit better about it, I just thought it wasn’t going straight into her blood stream.

With the tetanus the nurse didn’t know what to do because they give it as a triple vaccine with diphtheria and whooping cough. And she was like, “Oh well I’ll have to look into what dose to give her” and I was thinking, “Hold on a minute.” She was scheduled to have the tetanus a couple of weeks later and I was still ready to do it, 'cause tetanus is just such a horrific illness and I was really scared of it. In between then and the next time I went back, I saw the homeopath again, and she told me about tetanus and how it was contracted and it’s really hard to get it and basically you’ve got to come in direct contact in a deep puncture wound with something that has been in contact with the tetanus virus, which is only carried in the intestines of certain horses. She said to me “It’s just not gonna happen is it?” And I said, “Well it could, you know, and if it does it’s awful,” and she was like, “But there’s a really good homeopathic remedy for it, Ledum, and as soon as she gets a deep puncture wound you give her Ledum, and it’ll be fine.” And then I started to understand that the remedies were actually gonna be able to treat the illnesses. I still, at that point, still had the fear of the illnesses, you know. So I never took her back for the tetanus vaccination.

Through Angie’s early encounters with homeopathic information it is possible to see the role of both friends and homeopaths in disseminating anti-vaccine information. From these sources the women come to see that not vaccinating and treating homoeopathically are two sides of the same coin.

Learning about homeopathy

The homeopath encouraged Angie to learn about homeopathy, so she bought books and tried prescribing for her daughter and friends and then decided to come on the course to learn more. ‘I thought it important to have homeopathic first aid knowledge as I do not wish to give my children antibiotics, Calpol or other suppressants’ she wrote in a questionnaire for me. She told me later in an interview:

Homeopathy has just made complete sense to me. The way it’s fitted in directly with my life. It’s just a natural thing. It’s not just medicine, it is a philosophy, it’s almost like a religion. You know, talking about vital force and things like that.To think of health in the way that diseases are good for you, or telling you things about yourself.

When I last saw Angie she had been accepted to study homeopathy at one of the professional training colleges and was considering training to become a homeopath herself. This route through using homeopathy first as a patient or as a mother; gaining basic knowledge; and then, deciding to go on and train, is a path that quite a few homeopath's in my sample have taken (e.g. Ian, Jenny and Olivia).

Relationship to orthodox medicine

Like Ruth, using homeopathy has given Angie a feeling of power over the orthodox system. Angie's antipathy to the NHS system, in common with many of the women in my study, has in part been formed by her experiences of childbirth. She found her contact with the medical system at this time quite distressing and disempowering.

Even going to see the consultant was disempowering, you know, 'cause they tell you how you're gonna give birth. They don't sympathise with the fact that you feel really strongly that if you are in control, you can control the pain. It's just the whole sort of institution thing; you immediately become this compliant (laughs) sort of person, when it's going against everything that you want. Like you say, "Oh will I have to have an epidural?" What kind of question is that? (angrily). No one's gonna make me have an epidural. But I was actually asking those kind of questions, because I was in that kind of situation, you know. You immediately become powerless, asking questions about your health, which are your business and not theirs.

Angie's antipathy towards the NHS lingers on:

I cannot understand the usefulness or economy of a short term philosophy of healthcare such as that offered by the NHS. Today my daughter was given a prescription for antibiotics for an illness that was not even diagnosed (I took her to the doctor to check for ear/throat infection) and the doctor (a locum) seemed surprised when I told her that I didn't know if she was allergic to them, as at 15 months she has never taken them. Needless to say she will not be taking these either, and we have already had 4 phone consultations with our homeopath (for free) which got her comfortably through 3 nights of high fever and will no doubt cure her.

Summary and concluding remarks

These case studies, told mainly in the words of three homeopathy users, have shown how the homeopathic worldview outlined in chapter 6 manifests itself in the lives of individuals. Ruth's contact with alternative medicine has been over twenty years. Having Lily and going through the vaccination debate recently, have continued to change her views of health and her dealings with medical practitioners. Both Angie and Alice have shifted their ideas towards this homeopathic cosmology of health over a relatively short time span of the last 3 or 4 years. However all three women show remarkably similar views of health.

The process of engaging with homeopathy can be seen as a process of enculturation into a different world view, in which the homeopath plays a vital part. I have come to see it as a process of shifting views, negotiated through dialogue with different therapies and with other people.

This process is a lifelong one, we cannot stop the clock at any point and say that this person once had one view of health and now has another. People are continually engaging in the world, changing and learning and experimenting, so their views are continually changing.

In this piece of research I am often not able to look at the person's views before and after their first contact with alternative therapies as this was long in the past. I can however listen to their tales of transformation in their interviews as has been outlined in this section. In the next chapter I want to use my ethnographic observation to show the real time interactions and negotiations that contribute towards these shifts in cultural understandings about illness and suffering.

Chapter 8

Going alternative creeps up on you:
How the cosmology is produced in interaction

GELSEMIUM SEMPERVIRENS (Gels.)

Family name: Loganiaceae

Other names: yellow jasmine; false jasmine; wild
woodbine; Carolina jasmine



Chapter 8. Going alternative creeps up on you: how the cosmology is produced in interaction

“Going alternative creeps up on you” Diane.

“One thing leads to another when you start off on those paths” Tamara.

What is the process by which these committed homeopathy users come to believe? I saw evidence that this transformation is achieved through multiple interactions over time: in consultations, with each other, with female friends and family members and through publications and lectures organised by sympathetic organisations.

Using ethnographic data from three of my fieldwork settings I want to show the processes of education and negotiation towards this belief system. Interactions in the homeopathy class show how the informal ideology of beliefs is learned alongside the more formal text based homeopathic knowledge through interactions with the homeopath-educator and with each other. Taped and transcribed homeopathic consultations at the victim support centre show the homeopaths' role in presenting the ideology to patients during the course of consultation. Interactions in a vaccination group show similar processes. The data from this setting is used to demonstrate how members co-construct strategies of opposition and resistance to the orthodox medical system, and how they come to position themselves as the central authoritative hub in the network of alternative and orthodox healthcare providers they consult.

I will outline a brief description of each setting and then focus within each setting on how one specific aspect of the homeopathy worldview comes into existence through interaction. I will conclude this chapter by suggesting this can be seen as a process of socialisation and discussing the centrality of the role of the homeopaths in this process.

Adult education class “An introduction to homeopathy”

I will use observations from the homeopathy class to focus on how members of the group come to re-define their views of health, illness and symptoms. "An Introduction

to Homeopathy" is part of the adult education programme in one of the leafier, more prosperous suburbs of South London. The classes take place every Tuesday morning in one of the college campuses, in a draughty classroom with tall Victorian windows. The class sits around an oval table in uncomfortable orange plastic chairs. At the front stands an overhead projector and a plastic skeleton used by the anatomy teacher who shares the room.

Nancy, the teacher, is a homeopath in her 50's who trained for 5 years and has practised as a homeopath for 12 years. She is now also training in cranio-sacral osteopathy and occasionally drops concepts from this other body of knowledge into the sessions. She has been leading this course for a number of years and says she loves teaching and the opportunity to rediscover the magic of homeopathy with each new class. Nancy has a good sense of humour, there is a lot of laughter in the class and it feels as much like entertainment as education.

The group consists of around 17, although at any one class around 12 attend. For the first term all the students are women. Nancy's style of teaching is very participative. She sets the tone in the first week when she gets us all to introduce ourselves and state our interest in homeopathy. She invites questions and input from the group, a suggestion received with enthusiasm by the group. The class involves a lot of discussion and contribution from the members. Many of these contributions are experiential in nature, comprising stories of experiences of taking particular remedies, or of giving them to friends or family with the resultant effects. There are also a lot of questions with students trying to get to grips with the very different philosophy of health that transpires during the course.

The atmosphere in the group is very pleasant. Everyone really enjoys coming and there is a real sense of active learning with lots of excited discussion. After the first couple of weeks Nancy comments on how long it is taking people to have a coffee break in the canteen and how it is cutting down on learning time. After that most people bring in flasks of coffee and snacks and there is a picnic feel during the limited coffee break. The group is very supportive to each other and gives emotional support and advice to those going through problems and life events such as Angie's breech baby, Helen's recent divorce and my mother's stroke.

On the first week of the 13-week autumn term Nancy starts by checking the attendees names against her register. She writes in the numbers allocated at registration, (on payment of the £75 termly fee). She is just launching into an outline of the course, that she has put up on an overhead, when a college official comes in to tell us we will all have to change rooms. He has an officious petty "jobsworth" air about him. Nancy stands her ground and argues with him. She refuses to budge; someone else will have to change rooms. After he leaves, muttering angrily, she says to the class smiling "What do you think? *Staphysagria*?" This is a homeopathic remedy which we later come to learn, is for "Sensitive, touchy people who are very easily offended. They cannot tolerate rudeness in others although they may well be rude themselves" (Castro 1995:154).

In the first 5 minutes, Nancy's remark has revealed homeopathy as a framework in which aspects of people's behaviour and personality can be linked to the characteristics of a remedy. This gives us a hint that we might start to see people and their personalities through this framework of remedy pictures. The implicit assumption is that remedies can in some way be matched to a person's way of behaving, and that person does not need to be demonstrating any evidence of sickness just, in this case, unnecessary anger and irritability. There is also a hint here of the interconnected view of health. That a person's health is as much about how he relates to others emotionally as it is about any bodily symptoms.

Although most of the group has had some contact with homeopathy before and many use it for themselves and their children, not many have visited a homeopath (although several start to do so during the year). The view of health held by the group, as they start, seems to be informed by biomedical norms. When Nancy asks the group "What is health?" Pam kicks off the discussion with "Not being ill". Nancy screws up her face, as though she doesn't like this answer. She's heard it before but it just won't do.

Nancy expounds a view of health that is not a bipolar opposite to illness. She gets the group to re-appraise their conceptions of health and disease. In the first week Nancy asks the group:

What are symptoms telling us? They are an expression of something. They aren't disease they are the body's attempts to fight disease. So vomit, diarrhoea, coughing, fevers are all attempts to expel toxins. Eczema is anger on the skin. Your body is talking to you, telling you something. If we fight against these symptoms and try to suppress them with drugs we are working against the body. 'Killing the messenger'. It's the equivalent of sticking a plaster over the oil light when it appears on the motorway. The homeopathic remedies however, do the same thing the body was trying to do.

In one of the homework exercises there is mention of a patient with pleurisy and bronchitis and possible homeopathic remedies are discussed. I find myself thinking that these are exactly the serious infections that antibiotics were made for. I ask Nancy whether you could also give antibiotics, in addition to homeopathy, in a case like this? She explains that the problem with this would be that the two forms of medicine would be working in opposite directions. So implicitly Nancy is telling us, if you buy into this different view of symptoms you have to buy into a different tool for treating them. The logic is that you can't both believe that symptoms are good and bad. So you can't treat them with two different types of medicines that rest on these two premises.

Belinda the GP is struggling with this notion that the symptoms are not, as she has been taught to see them elsewhere, part of the illness. Belinda's baby recently died. Belinda did not expand on how, but in her introduction to the class she said with feeling "medicine let me down". This experience has opened Belinda to the possibilities of other ways of healing. She visited a reflexologist to help her get pregnant again and now she is here studying homeopathy to see if it is something that she can integrate into her own practice. She may be open to other possibilities but it seems that her medical training makes it more difficult for her to take on these new ideas about health. I talk to her in the coffee break about the homework. One of the example patients is a boy with a sharp puncture wound. We had learned that this was an indicative sign that the homeopathic remedy *Ledum* should be prescribed. Belinda tells me she is finding this new idea of health very different. "All I could think was 'Shouldn't he be having stitches?' but I didn't think I would say anything."

There may be others in the class struggling with these new notions. I certainly find the ideas exciting but also mind boggling. I feel that Nancy's ideas about health are diametrically opposed to the orthodox principles I have grown up with. The idea that

orthodox medicines are not curing at all but 'suppressing' symptoms, which could have quite worrying future consequences, is totally new to me. The idea that homeopathy is 'curing' in an opposite manner, by helping the body to express its symptoms, seems entirely wrong. Surely having lots of symptoms means being ill? However I am also open to new ideas in my learning role, excited by the new logic and trying on the ideas for size to see whether I can buy into them. I puzzle over these issues in my fieldnotes long after the class is over. "The direction of cure is outwards not inwards, so getting a skin rash could be a sign of healing, something coming out onto the surface, from having affected the body at a deeper level. It's not age but vitality that governs strength." I am being asked to reverse a lot of my understanding about health and illness.

Nancy presents Hering's Law of homeopathic healing in the fourth week. Hering was an initial sceptic of homeopathy who had ended up a convert and who had drawn up a set of rules to observe when a cure was taking place. On an overhead Nancy detailed his 3 main precepts: 1) From the deepest parts to the external; 2) In reverse chronological order of appearance; 3) From the upper part to the lower. Or as Nancy summarised on a new overhead for us in capital letters: "INSIDE OUT, BACK TO FRONT, UPSIDE DOWN". This slogan could be seen as a summary of our own learning experiences.

The homework acts as another space in which we can confront these odd new views of health. One week we are given a number of scenarios (e.g. A man with a racking cough gets a profuse nasal discharge after taking the remedy) and asked to judge whether the person was in the process of being cured. I find myself metaphorically scratching my head. Surely a new symptom can not mean the person is being cured yet somehow I have learned enough to mark my homework form that, sure enough, this is a sign of cure.

Apart from Belinda, no one expresses discomfort openly. The talk is of excitement, of new possibilities, of a new way of seeing the world. Belinda is the only one to raise objections in the hearing of the group.

When the class talks about fevers in week 5, Belinda has problems. Nancy explains the purpose of fevers:

Fevers are a healing response. In a fever the body becomes a more efficient machine, the blood is pumped round faster, the white blood cells increase and perspiration is used to expel toxins and cool the body. If there is just a fever with no strong picture of mental symptoms then don't treat it. Just wait for a prescribable picture to develop. If it doesn't, it's because there is not much vitality there so don't squash it by trying to treat the fever.

The class responds very heatedly to this. With many of them mothers with small children this is an area of healthcare which has roused emotions of fear and anxiety in the past and the temperature in the room goes up. Lisa speaks for the group when she says "But if a child's temperature is going up quickly it's very worrying" Sam and others nod with recognition. They would find Nancy's strategy of non-intervention in such a situation quite tough. Nancy however turns their notion of a high fever as a bad sign round:

No, a high fever might be a sign of a very strong vital force. This is why children often get such high fevers because they have a strong healthy vital force. And rapid onset is a symptom in itself in homeopathic terms. This might be a pointer to which remedy is suitable. *Belladonna* and *Aconite* are both remedies for symptoms that come on very quickly.

All of this upturns what we have been used to think about our bodies and illness. I have always seen a high temperature as a bad thing; Nancy is re-framing it as a sign of a healthy system. The group struggles to take on board this notion.

Helen is trying to process this idea in relation to her 3-year-old. "Do you still strip them down and do the tepid bathing thing?" Nancy says "Yes, but what you mustn't do is give them Calpol or something to lower the temperature artificially". Belinda is having trouble with this whole notion of not treating fevers. "A fever can cause fitting so isn't it part of the illness?" she asks, unable to see a fever as part of the healing rather than part of the illness. Nancy tells her that any convulsions are just an underlying problem that has been bought out by the fever. Belinda looks doubtful at this; folds her arms in front of her slightly defiantly and doesn't speak again.

Angie however is drawn to this idea that fevers may be good for you. She recasts this notion of illness as having the potential to perform a positive function, in the light of her own childhood experience. "When I was little and ill, it was a real comfort to be brought

drinks in bed by mummy and daddy, I used to feel relieved when I was ill, my Mum worked and I actually got attention when I was ill.” Nancy validates Angie’s rather than Belinda’s version of events, by laughingly admitting that when she had small children, the only time she got ill was when her mother came to stay, who could then look after both Nancy and her children.

Angie, as we saw in the case study in the last chapter, is one of the group who is drawn into becoming a committed user and who works hard to buy into these new ideas of health and illness. Angie was already predisposed to this notion of fevers as a good sign. Two years previously a friend had given her a book on the danger of vaccinating her child.

The case histories in the book were of children who hadn’t been vaccinated, comparing them to how their peers were at school and they were all so healthy. And a lot of them had had measles or any childhood illness, and it described how the illnesses had progressed and they’d had a high fever, a rash had come out, and they’d recovered within like a week and then they’d have a massive growth, development spurt, and be clearly stronger and more vibrant and healthy, and it was like, well, that was the argument that I needed [not to vaccinate Sandie].

When I interviewed her at the end of the year’s course, she talked of recently treating her now three-year-old’s recent three nights of fever, purely with homeopathic remedies. A new way of treatment that she would not have pursued before the course.

Angie: Her temperature went up to a hundred and five. Thank God we’d done fevers in the course. So I just held back, but I phoned my homeopath who supported me the whole way through it. And I just held back. I did give her Belladonna, when it got that high. ... But I knew that it was good, I knew that it was a sign of strong vital force, so I just sort of saw it as a positive thing. I would never have been able to do that before the course, there’s no way. I would have been straight for the Calpol. And anyone would, I think....And in my head this little voice was saying, “Give her Calpol and you’ll make it much worse,” (laughs) It had been ingrained enough that I knew that giving her Calpol was just suppressing it and I’d got this almost morbid fear of Calpol (laughs).

CB: Where did that come from?

Angie: That came from the course.

CB: The course, yeah. Yeah, I suppose it was mentioned quite often, wasn’t it.

Angie: Yeah. Mm. Yeah. And that this was a really good sign that it was coming out, and she was dealing with it really well, her body was doing it properly... and that was the best thing to do, and that would really strengthen her. [Although] it was frightening to see her temperature keep going up and up and up.

So Angie demonstrates her shift from 'Calpol is good: Fevers are bad', to the reverse view and shows how she has operationalised this new view of health, in her treatment of her own child.

This is not just an abstract ideological shift of belief. The consequences are very real in terms of potential life and death issues. Any mother with a 3-year-old with a temperature of 105 is operating in a very worrying world of possibilities. The importance of support seems important to back up these changed notions of health. Angie mentions support in three forms. The advice from the homeopathy class, the support of the homeopath on the phone during the illness and the support of having homeopathic remedies to give, rather than sit and do nothing but worry.

At the start of the second term Nancy re-iterates: "Symptoms are a sign of health". By now this is taken at face value. No one who has stayed on to the second term has any problem with this concept. It is already seen as self-evident. When the idea was first propounded in term one there was a sense of novelty and excitement. In addition, any students exhibiting resistance have left the group. Belinda the GP dropped out at the end of the first term, not attracted to the idea of learning about the homeopathic theories about chronic illness. In a questionnaire at the end of the first term she wrote for me that she saw "homeopathy is suited for treating minor ailments although I have not tried it at on myself or anyone else". The committed users like Helen were by comparison now "handing it out like Smarties to all my friends and family".

Some other students had biomedical backgrounds. Greta and Agnes had both worked as receptionists in general practices. Neither stayed on for term 2. So there may have been other more silent resistances in the group to these new ideas of health. Greta also wrote very prosaically in her questionnaire of seeing homeopathy as complementary to medicine. She reports she still visits the GP every 4 months to check her blood pressure

and review her hypertension medication. Greta continues to use biomedical terminology throughout the course referring to *Gelsemium* as a particularly suitable remedy for an “occipital headache” for example.

Nancy is putting forward new ideas about health and the individuals in the group decide whether to take them on board or not. The education then, can be seen to be distinctly participative. Both in the overt sense, of jumping in with questions, but also in the more covert sense of whether people choose to jump in with both feet, as it were, and buy into the whole cosmology of health. There is a sense that some people are not willing to buy into this strange set of beliefs, but do not voice their resistance, except through non attendance, giving up at the end of term 1. Janet is a friend of mine who by chance, attended the same course the year after. She stayed for the whole year but told me she had no desire to go on and become a homeopath and “hang around with weird people with weird ideas about organic food and the environment; and, who would not treat cancer if they got it”. She was only comfortable with the idea of treating her children’s minor injuries with homeopathic remedies like *Arnica*. The new view of health and illness was one that she had not bought into and referred to with distaste. There may have been others in the year I studied who felt the same way.

In week seven of the first term, Nancy brings up the subject of vaccination. Quite a long section of the class is spent discussing it. The discussion becomes very heated and people are really engaged. Nancy, (the teacher) Angie, Kate, Sarah and Stephanie are very anti-vaccination. Emma is torn between the different arguments, and is obviously feeling pressure from her partner and her doctor. One of her reasons for attending the course was to help her decide whether to vaccinate the baby with which she is pregnant.

Belinda the GP tries in vain to put the other side of the debate. She is the only one to question the view that vaccinations are inherently bad. It is worth remembering that not only is she a GP but her own baby has died recently. Both of these facts contribute to her appearing again quite defensive and upset in the discussion. Also this is one of the few, if not the only times in the class that there is a resistant counter view voiced, to the hegemony of homeopathy, so I will quote an extended excerpt of the discussion.

Nancy: It's like vaccinations - let's not put the sickness right.

Kate: I have been reading this book on vaccinations [written by a homeopath] which says that if you are susceptible to Polio then you are likely to get it so there's no point in vaccinating.

Nancy: It means you will get something along those lines so maybe ME instead. A lot of people who are vaccinated get the disease anyway. They need that disease. It's Hering's Law. After childhood diseases people blossom and grow, emotionally and mentally throw off something they bought with them, the susceptibility. And if they are not able to (that's partly what childhood diseases are for) instead they get chronic eczema's and asthma's.

Belinda: But what about those things that people die of. That's what vaccinations are for with regard to polio. How do you explain that?

Nancy: What eliminated polio was not vaccinations, but sanitation and so on.

Emma: But what about life threatening killers.

Angie: Yes one percent die.

Nancy: The question is whether they are dying from it or from an underlying condition. In the third world people die of measles commonly but they are really dying of malnutrition and poverty. Things that undermine the health of the whole nation.

Belinda: But the ones that die make it very difficult for parents.

Nancy The trouble is we are keeping everyone alive and weakening the species. All the mental illness and turmoil.

Kate: I refused point blank to have the MMR on my child and I was told I was a bad mother. If I was less bloody minded I would have given in.

Angie: You hear that all the time [angrily]. How dare they say that!

Nancy: But would they have died of something else. Healthy people don't die from measles. And do people who have been vaccinated then commit suicide at 12 or 13 which is becoming increasingly so. Many children are now chronically ill like ADHD and all on Ritalin and no one is asking why?

Steph: Because parents want the drugs. We are pumping poisons into babies who are 1 month old.

Nancy: Yes we are giving mercury and formaldehyde to 1-month-old babies. Mercury is a big nerve poison.

Kate: They are vaccinated 26 times by the time they go to school.

Emma: Once you have started do you think you should go on with them?

Steph: Can I just ask you Belinda why they start so early?

Belinda: If they get the illness at that age then they are more likely to die [spoken in a heated manner with crossed arms and red face].

Nancy: This new meningitis hasn't been properly tested they've just rushed it through.

Belinda: It has in America.

Nancy: Only by the drug company. We are the only country giving it; it's a panic response.

Angie: Anyway meningitis B is the common one not C.

Nancy: It's not an epidemic it's just visible because the media report every case. There's a lot of fear. Fear on both sides if you do and if you don't you are killing children. The most important thing is the soil. It's not just how you eat it's how you live your life.

Emma: It's difficult when your partner doesn't agree and then the doctors if they don't agree they strike you off.

In this discussion Nancy is continually re-framing the problem by alluding to the different model of health and illness that is offered in homeopathy, whereby childhood illnesses are an important part in the child's development of the immune system, and in throwing off inherited susceptibilities. I will return to these arguments which appear in very similar forms in the Vaccination Support Group discussions. There are hints here of resistance from Belinda and worries from Emma, there is support from Stephanie, Kate and Angie who have not vaccinated their children and who both came into homeopathy via this route.

For those in the group who will go on to become homeopaths we can see the start of their socialisation into their future role. Here it is Nancy who is helping instruct the class in how to see health, illness and symptoms differently. One day it may be that Angie, Jean, Kate and John who all go on from this class to enrol at homeopathic college, will be socialising others into this new view as homeopaths themselves. For the other committed users in the class who will stay users and not go to become practitioners, Nancy's role in changing their views of illness will be supported by their

experiences with their own homeopaths. Whilst this education class is one place where I saw people being educated into homeopathic beliefs it was not the only one. For the majority of users the main person from whom they learn to see health differently is their own homeopath.

In the next section I want to show how the beliefs of homeopathy are played out in consultations between homeopaths and their clients.

Homeopathic consultations at a victim support centre

As I outlined in chapter 2, most research on alternative medicine has been through interviews with practitioners or patients. There has been little study of the consultations themselves. Users in other studies have talked of the attraction of alternative consultations as places where they feel valued and given space as unique individuals in an egalitarian relationship (see e.g. Mitchell and Cormack 1998; Kelner 2000). The users in this study said similar things. However there appear to be other processes going on in the consultation of which the two key players are less conscious. As a result these are less likely to appear in interview-based studies, but have become apparent during my observations. The implicit processes that I am most interested in here, are the process of socialisation into seeing health and the body differently, and the process of being shown a different way to relate to orthodox medicine.

This analysis is based on the 23 homeopathic consultations I observed at the low cost clinic in the victim support centre. It is worth drawing attention to the fact that these were slightly unusual consultations, compared to many alternative medicine consultations. The four main differences being:

1. Clients had not sought out homeopathy. They had been offered on attending the centre after being the victims of violent crime, left with physical and emotional scars;
2. The population were largely unemployed, working class with a far greater proportion of ethnic minority patients (mainly afro-caribbean);
3. Consultations were very low cost, at £3 a session; and
4. Appointments were half an hour rather than the usual private consultation hour.

An unintended result of this slightly unusual sample was my discovery that a key factor in becoming a committed user, was the active seeking out of homeopathy. None of the clients that I observed at the victim support centre could be called committed users. They were all much more pragmatic in their use of homeopathy, as a method to manage their current particular crisis. This is not to say that some of these users may not have gone on over time to become more committed, but those six users that I interviewed did not espouse the cosmology of homeopathy that I laid out in chapter 6.

However just because these are not committed users does not mean that the processes by which people come to be committed users were not present. The two homeopaths involved in these consultations spent large parts of the consultations in putting forward aspects of the homeopathic cosmology. I will focus here on two aspects of the cosmology that were manifested in the homeopaths' dialogue in these consultations. The role of emotions in illness causation, and the fact that orthodox medicines are seen as toxic and contrary to the healing process.

The victim support centre

Jenny is an ex-nurse turned homeopath who works in a variety of settings. In her private practice she consults with clients in the therapy consulting rooms at a health food shop on a Saturday and at her home during the week. She offers a lower rate for those on low incomes if they visit her at home. She also works on a voluntary basis in two clinics where she is only paid her travelling expenses. The first is a low cost clinic for mothers with small children. The second is the victim support centre in which she consults with clients between 10.00 and 2.00 every Monday. Jenny also runs first aid homeopathy classes for small groups of mothers and the vaccination support group from which data will be presented below.

I attended the Victim Support centre with Jenny on 7 Mondays between June and October 2001. On 4 of these days Bryony, a second year homeopathy student, training at one of the London colleges of homeopathy, was sitting in with Jenny. With some

sessions she took charge of the consultations and Jenny watched, in some they both worked as a team interviewing the clients together, and in some Bryony just watched. During these days I sat in on 23 consultations. I taped 17 of these with the clients' consent and took notes on non-verbal aspects. Where people preferred not to be taped I took notes and tried to get as close to verbatim as speed would allow. I interviewed 6 of the clients in cafes near the centre or at their homes on a subsequent day.

Jenny and Meg, another homeopath who does the afternoon shift, were invited to practice in the centre by the co-ordinator Sophie 5 years ago. Sophie is a trained counsellor with an interest and partial training in homeopathy. She felt that it could be used to great advantage, in particular for the kinds of emotional reactions of people to violent crime, such as shock, panic attacks, sleep problems and depression. When clients have an assessment of their needs on their first visit to the centre, those who are seen to be suitable contenders (usually exhibiting emotional symptoms) are offered homeopathy. Not all take up the offer; some prefer counselling or more practical help. Claire, one of the workers there, told me that most people who did accept the offer of homeopathy did not know much about it but said they were willing to give it a go. They were often given homeopathic remedies by the non-homeopathic staff, at this initial assessment. In the cases I observed *Arnica* was given for shock, *Aconite* for terror and *Passiflora* to inability to sleep. An appointment was then arranged to consult with Jenny or Meg.

There is nothing of the medical clinic about the centre. Instead it is a rather run down office in a building with other community services and bureaucratic organisations. It has more of the feel of a local government office or an unemployment centre. The furniture is second hand and mainly donated like the battered old sofa which, stuck in the middle of the open plan office, acts as the only waiting area for clients. Jenny consults with the clients in an office with filing cabinets, two desks and a few bookshelves with box-files.

Emotional causation of health and illness

Verbal examinations - locating emotions in the body

Jenny almost never conducts any physical examinations, although she does twice look at feet that are uncovered by clients and offered to her to inspect. She only once actually asks a client for a visual examination, in this case, Serena, to show her her tongue. She never touches the clients, staying on the other side of an office desk from them and only coming round occasionally, to tip a remedy into their hand out of the bottle, in cases where she administers remedies on the spot. In contrast Dr Deakin, the homeopathic GP discussed in chapter 9 conducts physical examinations with most of his patients. This involves touching most of them in the course of, most commonly, taking blood pressure, looking into ears and throats and listening to chests.

I mentioned how the homeopathic body was conceptualised differently to the biomedical body in chapter 3 (Sharma 1995; Frank 2001). For the homeopath the site of 'dis-ease' is the emotional as well as the physical body, not so amenable to inspection. The body can be seen to extend wider still into the relationships between that body and the other significant bodies in its orbit. These other bodies, notably of partners, parents and children, are generally not in the room and so are only open to examination by verbal report. As a result Jenny's relationships with clients' bodies is different. Rather than looking for signs of physical change in the body, her attention to the physical body is more as the location of emotional feelings. When her clients talk about strong emotions: usually fear, panic or misery, she often asks them to indicate for her through gesticulation where they locate these feelings

Reg is full of angry feelings since being mugged by 3 youths late at night out by his dustbins. Jenny asks him "Where do you feel that?" Reg explains that when he starts talking about what has happened

It's down here, you know, you really feel it in your stomach, you know. I mean the, the asthma is across the chest, but I mean the gut feeling you really get in the gut, you know, really down here.

Having located it within the body Jenny asks “Is it a tight feeling or how does it feel?” Reg explains that “It’s like a stitch, like a pain” Jenny asks for confirmation: like a stitching pain?” Stitching pain is part of the terminology of homeopathy. It is always important to distinguish between the many different types of pain in finding the appropriate remedy. In a commonly used repertory of symptoms, pain in the abdomen is alternately characterised as “burning, cramping/griping, cutting, dragging, drawing, lancinating, pressing, sore, stitching or tearing” (Kent 1998). When Reg uses this terminology Jenny is quick to translate his words into her terminology, from “a stitch” and “a pain” to “a stitching pain”, checking back with him if this description seems to fit his experience.

During this sequence Jenny is showing her conception of illness as one in which the emotional feelings are given as much credence and emphasis as the physical sensations of say, asthma.

In another case, Serena, a black single mother, reports feeling fear since being held down while youths opened the safe at the old people’s home where she works. Through Jenny’s questions she locates these feelings as being in her chest. In the next consultation of hers that I observe she starts to cry, talking about the death of her mother:

Jenny: Mm. And when you f- when you feel like- when you feel very weepy, can you feel that anywhere in your body? Do you feel it in your tummy or in your chest?

Serena: In the chest.

Jenny: In your chest, here [pointing to the middle of her own chest].

Serena: Mm.

Jenny: And what do you feel in here?

Serena: I feel pain, there.

Jenny: Mm. And with this pain in your chest, do you feel like a, a weight or a shortness of breath, like it’s hard to...?

Serena: A weight. Like something heavy.

Jenny: Like a weight, mhm. Do you tend to get erm coughs or any er- when you get a cold does it tend to go onto your chest?

Jenny is looking for areas of weakness or susceptibility, a concept that is outlined in chapter 6. She is trying to find out if this experience of emotion as a sensation of pain is also linked to more general problems with health in this body area.

In the third consultation with Serena, the questioning comes back again to locating a feeling. This time it is anger. Serena also locates this emotion in her chest, as a feeling of breathlessness, again by pointing. Jenny tries to locate it more exactly, asking in response to her gesticulating hands and pointing to her own chest “And right in the middle, here?” to which Serena answers in the affirmative.

It is as though Jenny is trying to get the clients to pay more attention to their bodily and emotional responses. How does it feel to be in that body? Where are emotions actually experienced? Her questions indicate a viewpoint that emotion can be located, and that this location is different for different individuals. This understanding seems in no way strange to the clients. They always answer this question with ease and speed and seem to know immediately, on being asked where the emotion is located.

‘Examining’ the wider social body: Emotions and relationships

Jenny’s ideas about health and illness are located in a definition of the body that extends out into social networks. In Chapter 6 I mentioned that Jenny sees all disease as having developed from the emotional level. In order to locate the causes of illness she needs to know what was going on in their lives and with the people close to them.

In the course of several of the consultations, people mention a symptom or condition that they have had for some time. Jenny always asks them why that symptom started and what was going on in their lives at that time? Through this line of questioning she reveals her belief that illness does not come out of the blue but is linked to events in a person's life. These events are likely to be of an emotional nature. In asking these

questions Jenny can be seen to be training her clients to see these cause and effect links with life events.

After Serena's second consultation, Jenny explains to me the link she has perceived between Serena's recent attack with unresolved feelings of grief for her mother's death 5 years ago:

In the first sentence she said she was feeling low, so it had to be a remedy for feeling depressed, and she just wants to be alone. And so then I knew it was probably *Nat Mur*, and so then I was able to ask her where she felt it in her body, and when she said she feels a bad pain in her chest, I was able to say, "Have you ever felt like this before?" and she says, "Yeah, when my mum died." So then I knew it was definitely grief.

Jenny shares this understanding of the effect of Serena's unresolved bereavement on her health during the consultation:

Jenny: Fifty-three. So have your periods finished?

Serena: Mhm.

Jenny: How long ago was that?

Serena: About five years ago.

Jenny: Oh, same? Mm. That could have been the shock of your mum dying when they stopped. 'Cause you were only about forty-eight or something?

So when Serena mentions her mother's death, this falls into the category of an acceptable cause of illness, and Jenny does not have to pursue the line of questioning any further.

In another consultation with Laura, Jenny is trying to locate what emotional factors might have played a part in bringing on her menopause. When Laura mentions her nervous breakdown it is a 'bingo' moment, when Jenny finally gets the kind of answer she is looking for.

Jenny: So what happened did your periods just stop?

Laura: No they were just irregular every 2 months every 3 months.

Jenny: And before they started to get irregular what happened to you. Did anything happen to you a stressful time or [3 second pause] anything difficult?

Laura: No.

Jenny: They started to [get irregular.

Laura: [A nervous breakdown.

Jenny: OK.

Laura: So that's stressful (smiling).

Jenny: So that's something around that time?

Laura: Well it was before [when I was] 35-40 in 1980. It was 1980 to about 84.

Jenny: Do you feel that that may have had an influence on your periods.

Laura: Um.

Jenny: Started to become irregular.

Laura: Well it had a very powerful and strong positive influence on my life

Jenny: And was the breakdown that you had around 15 years ago, after a loss?

Laura: Yeah it was after an engagement stopped.

Jenny: Mmm

Laura: But it had been building up for some time it was really all about loss and separation.

Jenny: Yes and then your sister dying that must have re-awakened those feelings.

Laura's noncommittal response 'Um' suggests she is hesitant and resistant to Jenny's notions of cause and effect. She is reluctant to buy into Jenny's framework, in spite of Jenny's pushing her view quite doggedly. She reveals this resistance by laughing. When Jenny links Laura's increased asthma attacks to her starting Hormone Replacement Therapy (HRT), she shows through humour that she can see that Jenny is manipulating her into seeing things a particular way, and that she is unwilling to buy into this framework.

Jenny: How long have you been asthmatic? All your life?

Laura: Yes mildly but it's got worse

Jenny: Has it?

Laura: Yes and I haven't been smoking all my life

Jenny: How long has it been getting worse for?

Laura: Ten years

Jenny: Since you've been on the HRT

Laura: Yeah (laughing) why?

Laura does not really buy into the homeopathic paradigm during the course of her treatment at the centre; she stays firmly allied to biomedicine. She told me in an interview after her final session

I think I've always been a little, not anti -but I'm glad they call it complementary medicine not alternative, now that was a good change. There definitely is a place for talking therapy which I think is wonderful, I think everybody should have it basically. I'm still not entirely sure about homeopathy. I can understand how it would work if your body was clean to start, but I feel the body is so polluted by all the things that we eat the things that we ingest - air pollution, and those kind of things, it would have to be very strong, from my point of view to actually have an effect. Before Christmas I got bronchial asthma and I went to the doctor and I got steroids and antibiotics and I was very grateful to them, and I believe that medicine is the most wonderful thing really. You wouldn't have a city like London if it wasn't for medicine. You wouldn't have sanitation and healthy people. I think it's a God-given thing..... But at the same time there is another side of life that's not fully explored, and maybe that is where homeopathy can step in. So I think I feel very ambivalent about it... I can't say to you it has solved this problem. I can't honestly say that. It may have been helpful I can't tell.

I have no evidence to suggest that the victim support clients came to see their health as located within anything but a biomedically defined body. I do know that other private clients of Jenny's such as Ruth do come to hold a different view of their bodies. For example, when I was ill during fieldwork Ruth asked me why I thought I had got ill. Her questions revealed that she, like Jenny was trying to locate the cause of illness within

my wider social body. The 'examination' in Jenny's homeopathic consultations becomes the examination of a life as lived.

Bringing the lifeworld into the consultation

In addition to these direct questions about causation, another aspect of the consultation reveals Jenny's belief about the emotional and social causes of illness. This is the degree to which people are actively encouraged to discuss details of their lifeworlds. This is in sharp contrast to most general practice consultations where any mentions of the lifeworld by patients are usually blocked or ignored (Barry, Stevenson et al. 2001). In almost all of these homeopathic consultations, I observed the clients telling Jenny and or Bryony the significant stories of their lives and relationships. They were never blocked or ignored. In just one half hour consultation Laura reveals the distress she had felt after a failed engagement; her nervous breakdown; having to switch off the machine keeping her sister alive after a stroke; and her mourning at the time of menopause for the children she had never had. Other clients tell Jenny about their own life's difficulties.

For Serena it is the death of her mother and father 5 years ago for which she has never properly grieved. For Sue as with Laura, it is relationship problems: her partner is verbally abusive. The different phases of lives bring different issues. Nineteen-year old Mandy's newborn baby died in heart surgery last year. Kevin, 30, is moving house and finding it very stressful. Reg is 73 and can't get over the death of his wife or the loss of his physical powers, and is finding coming to terms with ageing difficult.

The most prominent and obvious of the concerns of the victim support clients are the violent incidents that bought them in. These are firmly situated in the lifeworld and have usually rocked the person to their core, influencing self-confidence, jobs, relationships, mobility and shaking moral and spiritual beliefs. As Laura words it "Well I feel undermined, I feel my whole kind of theory of life has been undermined really".

Woven into these stories are always the same elements: issues surrounding difficult relationships with significant others, partners and families; the setting of current challenges into a temporal relationship with former life events; and the admittance of

strong (often negative) emotions, (although not all the life stories are negative and there are also instances where clients shared their more positive, joyful and life-affirming experiences).

During the consultations I get a very full sense of the clients in the context of their lives and more particularly the current general concerns and issues they have facing them. When I interview general practice patients at home I often feel like an audience to an unfolding narrative told by them about their lives. After observing the relatively impersonal presentation they have made of themselves in the NHS surgery, these narratives are often a surprise to me. When I interview the six victim support centre clients I learn very little that is new about them as people in context. I see them as I saw them in the consultations, and they are continuing a similar genre of dialogue.

The homeopaths facilitate the revelation of these key lifeworld concerns through a number of strategies. First and most importantly they let the client set the agenda. They utilise a lot of listening skills, such as active quiet attention, mirroring back the clients words to encourage them to continue with further detail, and empathic response. When Reg admits to his feelings about being old, Bryony signals her empathic understanding of how he might be feeling:

Reg: I mean because you got mugged, and because you're, you're handicapped, you know, you're disabled, you can't... it seems as if you're put out to grass and nobody wants to know. You're an old age pensioner love, nobody wants to know. You've got to die sometime, so why not go now, this is the attitude.

Bryony: Frustrating, especially for you, because you've had...

Reg: Yeah. I've had such an active life.

Bryony: such an active, exciting...

Reg: Yeah, yeah.

Bryony: life, that to be stuck with this,

Reg: Mm.

Bryony: It, it must be extremely frustrating.

Bryony's empathic response encourages him to open up further and give her more details of the activities he has lost "I mean I used to play football and cricket, and used to do cross-country running. And now, I mean it's as much as I can do walk up the stairs, never mind cross-country running. Them days are past."

Bryony then goes on to prompt him to find out whether he's also been thinking of his wife who died 2 years ago. She asks him "And what about your wife, have you been looking, thinking back at all?" Reg replies "She's there twenty-four/seven."

The positioning of homeopath to client in these encounters resembles the unconditional positive regard of Carl Rogers' client-centred psychotherapeutic model (Rogers 1976). In this model the healing of troubled humans is achieved by encountering a therapist who receives them entirely as they are without judgement and with positive affect. This facilitates them to change and develop. The homeopaths may well have been influenced by this model, which has been very influential in the counselling world (In chapter 6 I discuss how lay homeopathy has been influenced by psychology).

However the system of homeopathy itself encourages this attention to clients lives in the broadest sense. Knowing how the 'Vital Force' is manifesting itself within a person entails knowing how that person is dealing with their life issues and relationships with others. When Laura tells the homeopaths that she doesn't feel like phoning anyone or talking to her friends, this is taken as part of the symptom picture in arriving at the choice of homeopathic *Opium* as a remedy.

To decide if *Sepia* is an appropriate remedy for someone, for example, requires knowledge of such factors as whether the person is feeling unsociable and indifferent to loved ones; feels better after dancing and feels worse ever since an abortion. This requires learning about how the person spends their time and relates to others and what important events have happened in their lives.

It is not just an artefact of the victim status of these particular clients that makes the consultations range over their life issues. When clients consult with Jenny in her private

practice, these issues are also very present. Ruth for example reports to me that she discusses relationship, single-parenting and money problems with Jenny.

Nor does it seem to be the case that the victim support consultations are altered in this respect by being conducted outside a healthcare space. Diane consults a different homeopath, Amy, who is based in what could be interpreted as a more medicalised setting of an alternative health clinic. It has similar arrangement of space to a GP clinic, with a waiting area, receptionist and consulting rooms. Diane has discussed all her significant life events including the violent deaths of her 2 brothers. I visited Diane's homeopath as a client and found that I was encouraged to talk about my lifeworld in a way that I have never found in a medical consultation. As I was with both of the other homeopaths I consulted. In the very first session with each of the three, in which my past history was taken, the conversation ranged over the significant events of my whole life.

Through these two strategies then, of asking clients to locate life events as causes of illness and of encouraging them to talk about themselves and their lifeworlds, the homeopaths are exerting influences on client's views of health that can be resisted or taken up. Serena seems more responsive to the notion that her parents' deaths might be affecting her health than Laura is. Whilst Serena is not a committed user in terms of her beliefs about homeopathy, it may be that she is more open to taking that trajectory. She had not sought homeopathy out but has a daughter who is quite keen on homeopathy. Although Serena has an open mind towards it, she is on a low income and unlikely to visit a homeopath outside this low cost scheme.

Now I want to move on to show how the homeopaths try to show their clients that orthodox medicines are contrary to the healing process. For homeopathy to work requires them to stop their orthodox drugs.

Training clients to view orthodox medicines as toxic and contrary to the healing process

Often in consultations Jenny attempts to get clients to change their views about orthodox medicines. She makes continued efforts to get the older women off HRT, the asthmatics off their inhalers and the hypertensives off their blood pressure pills. There is quite a lot of subtle pressure put on patients.

Jenny introduces a discussion HRT in all the consultations I observed involving women over 50 (Sheila, Peg, Laura and Serena). She and Bryony make clear through their discourse that as homeopaths they see HRT as unnatural. They put a reasonable amount of pressure on women to consider coming off it. In one of the 3 consultations I observed with Laura, Jenny uses at least nine strategies to encourage Laura to consider coming off HRT:

1. Explaining her increased propensity to thrush is HRT related.
2. Using the word 'chemical' hormone to emphasise that this hormone is unnatural.
3. Planting in her mind the idea of discussing coming off with her GP.
4. Asking if she is completely happy on it, implying reasons why she should not be.
5. Suggesting that a 10-year limit is advisable.
5. Proposing that, if she came off, the symptoms of menopause would by now have disappeared.
7. Posing the question for her 'What is the benefit for me at my age?'
8. Telling her she would be free of withdrawal bleeding.
9. Suggesting her increase in asthma symptoms could be HRT linked.

Having suggested these negative reasons, she goes on to explain her perception of the function of going through the menopause naturally without artificial hormones:

You were 40 when you began to go through the menopause. That was a big turning point in your health and in your life so there's a lot going on. What the HRT did was to suppress that changing process. So it's not the HRT that is causing asthma, because it wouldn't do in everybody. If you have 20 people taking HRT you won't have asthma. But asthma is your weak point; your susceptibility is in your lungs. Your lungs are where you hold your

emotion. Your heart area, your chest is where you've been holding that. So if that's a weak point then anything which comes along to upset the balance... like HRT. Just as the menopause started to upset the balance and then the HRT said 'No you're not going to feel that. Not going to go through that process' and then I think you've found that since then, the asthma has got worse, so I think that's the link.

Bryony interjects "HRT doesn't allow you to find your own balance so the body has to struggle to carry on and do what it would normally do".

In the homeopaths' view the menopause is a big turning point in health and life. Change is natural, but if these natural changes are interrupted, the balance is out of kilter, and the body reverts to symptoms that the person has susceptibility towards. Jenny suggests the menopause is linked to emotional processes: those of finding your meaning as a woman at this time of life. Jenny is inviting Laura to join with her alternative view, in which the menopause is important emotionally and an important developmental life-stage. There is some evidence that Laura buys into at least the first of these propositions, responding to Jenny's final pronouncement:

I think when the periods come to an end it is a very important time in a woman's life. I had to mourn for about 3 days. I just sat in the flat and cried, for about 3 days. I had to I remember doing it over a weekend because I thought 'I have to go through it, I can't sit on how I feel'. I'm not quite sure how I did feel because I never really did feel the same way that lots of friends did really wanting children. I didn't have children.

With the HRT however, there seems to be a lot of reluctance to come off it among all the women with which Jenny raises it. They do not see anything problematic about taking HRT. As Ballard suggests, women brought up in the era of the contraceptive hormone pill, see nothing wrong with taking daily doses of hormones (Ballard 2002). They do not buy into Jenny's view of 'orthodox drugs as bad'.

Having laid out the constellation of homeopathy beliefs in Chapter 6 I hope I have demonstrated how these beliefs are manifested by homeopaths in consultations. However for this cosmology of homeopathy to be taken up and for people to commit to it, a one way pressure to change is not enough. Those at the Victim Support centre do not seem to respond much, to the proffered view of a different way of health.

This suggests that the socialisation process is not a one way process but demands the active participation of both parties in the construction of a new way of health. Those at the receiving end have to be receptive to this new view, to be convinced.

Is the simple prescribing of homeopathic remedies outside this cosmology effective? There is little evidence that the victim support centre clients will continue to use homeopathy once they have recovered from their victim status. And if the beliefs about homeopathy working in different directions to orthodox drugs are correct, then the remedies may not be working effectively in this group, who do not come off their orthodox drugs.

In the next section I will investigate Jenny in another context: in the vaccination support group which she runs. In this setting Jenny is preaching to those who are willing to be converted and the effects of her attempts to shape people's views of health are much more successful.

The vaccination support group

Jenny started The Vaccination Support Group 3 years ago. The impetus to start the group came from her clients. At the time she was running sessions for mothers to learn about homeopathic first-aid to use on their children. The people attending had a lot of issues around vaccination, wanting to make decisions but not knowing where to get the information. Jenny recruited her friend from homeopathic college, Eve an ex- midwife, to help her start a vaccination group. The group meets one evening every month for a couple of hours in Jenny's house or the house of one of the group members, Sally. Jenny has a list of topics for discussion and negotiates with the group their preferred topics for a particular session. The women who attend the group are mostly mothers of babies and small children, although quite often homeopath friends of Jenny and Eve's attend, or other alternative therapists, to find out more about the vaccination debate to support their clients. The evenings cover childhood vaccines, the research on their side effects,

and information about homeopathic strategies to boost immune systems and treat symptoms should mothers choose not to vaccinate their children.

The overt rationale given by Jenny and Eve for setting up the group, was the perceived need from mothers with young children to debate these issues with like-minded mothers. The more covert rationale was as another way to recruit new patients and to provide a service for their existing patients and perhaps thus create loyalty. Each time I have been to the group there has been a different group of women, with only a few women attending twice in a row. It is therefore quite a shifting membership, with mothers not able to make every session and coming every few times, or coming on one occasion never to return.

Jenny explains that she is not there to tell people what decision to come to, but to support them in their decision making. "We never make decisions for people. We try not to say you shouldn't vaccinate." Jenny once alluded to me, one-to-one, that The Society of Homeopaths, her parent organisation does not allow her as a member to make this recommendation. This was part of the changes documented by Cant and Sharma -and mentioned in chapter 4- that were designed not to alienate the biomedical system and the government during the moves towards professionalisation (Cant and Sharma 1995).

Not all members of the group choose the non-vaccination route, many of them choose to give some, but not all the vaccinations to their children. Ruth, whose case was detailed in chapter 7 is one of the mothers who has avoided giving her 4 year old daughter any vaccines says:

Its great support just to be with other people who have made that decision because it's quite an unusual decision to take. It's very frowned upon by government and medical profession and there's a lot of pressure to join the vaccination programme. It's a huge responsibility.

The meetings are very relaxed. There is no ceremony. Everyone is in informal clothes; sometimes babies are brought and played with or breast-fed during the session. Tea, cakes and lots of laughter are shared. It is hard to tell whom in the group is an alternative practitioner and who a mother, and some women span both roles like Olivia.

As a homeopath she wants information to support her clients, and as a mother of a 3-year-old, needs information to support her own decisions.

I want to use observations in this setting to focus on the issues of learning to see illness differently, of taking more responsibility for health related issues and of resisting pressures from orthodox medicine.

Learning to see childhood illness differently

One summer meeting of the group is the only one I attend where a father is part of the group. Hester, a homeopathy client of Jenny's has brought her 14-week-old baby and partner James to the group for the first time.

The main topic covered during the course of the evening is the debate about the MMR vaccine (A vaccination against measles, mumps and rubella). What is the rationale for it? What are the pros and cons of giving it versus no vaccination, or versus administering the three components separately? What can be done to counteract the adverse affects of vaccines and how can children's health be managed homeopathically in the absence of vaccination? However this is not a lecture by the homeopaths to the parents. It is far more a group discussion. Everyone contributes to the discussion and the locus of expertise is shared around the group. For example the entire group can offer expertise on their experience of their children's illnesses. Even the homeopathic expertise is not held solely by Eve and Jenny. It transpires that Olivia is a practising homeopath, Penny, Michelle and Eliza have been treating their children homeopathically for some time and Anne was brought up in a school with a homeopathic doctor. (She does not treat her children with homeopathy, partly in response to the resistance from her husband's family, 'half' of whom are doctors.)

Jenny starts the evening by reading out an article in the Sunday Times about research into MMR and autism. At a previous meeting, they had discussed a prior Sunday Times article that had implicated MMR as an influence in the development of autism. In this more recent article it is suggested that it may be thiomercyl (a carrier substance in the vaccine that contains mercury) which may be the danger factor. The mothers all listen

avidly to this and write down the website where you can get more information about which vaccines contain this substance. Horror is expressed about the poisonous content of the vaccine. This leads into a conversation about what does go into vaccinations. Eve, the other homeopath, reminds them that formaldehyde is one of the components: “The stuff used to put dead bodies in or to preserve organs” she says and laughs ironically.

Sally, the experienced older mother, often joins in with advice. She mentions that The Contact Network rang her last week to tell her someone in her area had measles, and to ask if she would like to bring her children round to catch it. James is shocked by this and says with amazement “It’s incredible to me the concept of deliberately giving illness to your child”. Eve points out that in the sixties these illnesses were described as safe and it is only since the 90’s they have become so-called “killer diseases”. Jenny explains that in the homeopathic view, childhood illnesses are good things. “Some people call them a rite of passage. You will often find that after a childhood illness a child will come on in leaps and bounds, literally growing inches in height and developing much faster in all sorts of other aspects”. In this interaction both the homeopaths and other mothers are contributing to the notion of childhood illness as a desired thing. This is an idea that James is trying out for size during the course of the conversation.

James says a number of things in a surprised voice during the evening. “As a complete sceptic I must admit it’s quite interesting - all you are saying does make sense.” So although he is shocked at first, he does not write off the concept. With respect to the critique of the way in which the establishment is manipulating the public on MMR, he says, “You don’t think you have a choice the way they present all these diseases.... It’s very interesting the way they are covering it up. The conspiracy theory appeals to me...I’d never thought about having an option.” James appears to be signalling that, although the ideas are strange to him that he is open enough to consider this new view of health. He hints at the groundwork done in his relationship with Hester who is a committed homeopath user, in shifting his view of health from a particularly biomedical one, influenced in part by his mother’s profession. “My mother’s a nurse and she has never expressed interest. It wasn’t until I met Hester... (Everyone laughs)”. All are familiar with the way in which mothers who move into committed use of homeopathy work quite hard on their male partners to bring them over to this view of health. Some

report success such as Sally. Her husband now visits a homeopath and home- prescribes for the children reportedly buys into the emotional causation of health (he expressed enthusiasm for homeopathy when we met briefly). I mentioned Sally's discussion of the boil on his back at the time of their child's birth, in chapter 6. However other mothers report little success and find themselves as much in battle with their partners over the vaccination issues as with their doctors.

Taking more responsibility for health related issues.

I will use Tamara as an example of someone attempting to negotiate this choice between two worlds of advice. Tamara used to come to the group regularly over a two-year period until last year. She hasn't been of late. She explains how the group served her:

The support thing, the fact that I don't have any friends who don't vaccinate. That's the problem, you do feel isolated. ... So it was nice to meet other parents in the same situation and to talk them through and feel... well just sort of gaining a bit of solidarity really. And having made a decision which puts you in a minority, and it is a decision which is terribly personal and terribly difficult as well, in the sense that it concerns the thing that's perhaps most precious to you in the whole world. You don't want to expose yourself to other people's criticisms, opinions, judgement. You just need to protect yourself, certainly in the early stages about having made that decision, and stick with people that you know are gonna be supportive of it. You don't want to be undermined.

Just recently, there has been a TB scare at a nearby nursery school in Greyborough (a south London borough), and one of Tamara's daughter's friend's has a sister at this nursery. Tamara rang Jenny the homeopath for advice on the dangers of her catching TB via this source, and possible strategies for avoiding it. Jenny suggested she come to the next meeting of the support group. At this meeting in May there are seven women at the group: the two homeopaths, an osteopath Stella, Olivia the homeopath/ mother, and four other mothers including Tamara. Half way through the meeting, the topic of TB comes up and Jenny prompts Tamara "you had some questions on this?" Tamara asks for advice and in response the two homeopaths speak first, giving Tamara advice:

Tam: To what degree should I bother panicking about [homeopathic] prophylaxis. My daughter's school are keeping it very quiet. Should we not be bothered?

Jenny: There is always a risk. If you walk through the local shopping centre there is a risk if someone coughs at the moment you pass, so there's always a risk. If you have a healthy body you are able to fight off most things. If you can maintain good positive health the way you are doing. Breastfeed, give lots of love and attention, exercise, good food. When they get sick treat them with an energy medicine, herbal, homeopathy

Eve: Cranial osteopathy

Jenny: To keep their energy flowing. We are all energy after all. Only our consciousness makes us think we are matter, we are just energy. Give the child a few treatments to ... Our ancestors have passed on their susceptibility

Tam: I am taking it [homeopathic TB]

Jenny: I gave a healthy looking child TB30 recently. She came out in eczema. It was lying dormant. There's an awful lot of TB around. Some people are more susceptible than others.

Eve: The trouble is most bacteria when they dry out die. These don't. In places where people spit into the road they just lie there in the gutter until they are activated and thrown into the air. But on TB wards the nurses and doctors didn't used to get it because they were more healthy.

Jenny: If you're poorly and under the weather.... Wouldn't it be interesting to know for those on antibiotics in Greyborough, their health history compared to those who aren't. Having said all that you are a Mum and so am I. My sister recently invited my 12 year old to stay in Leicester at half term and since then it has been constantly on my mind (laughing nervously). Ninety-nine percent of me believes what I am telling you but I am still a mother and I live next door to Greyborough so it doesn't make sense.

In the next part of the discussion the osteopath Stella, the homeopath / mother Olivia and Sally one of the mothers with older children join in. Olivia asks whether the schoolchildren have all been put on antibiotics. Stella answers that according to the TV they have been. Then there is a discussion between all of them, including Eve and Jenny, about what they would do if it were their children. There is some openly stated disagreement about the best course of action. Eve is laid back, saying she would just use homeopathy, but she does not have children of her own. Jenny says that as a mother she'd be very worried, and she would use the antibiotics. Olivia and Sally the mothers, now support Jenny, the homeopath. The attention then turns back to Tamara. Sally turns to Tamara and says:

Sally: You have to keep healthy as possible. You should take them for cranial therapy.

Stella: My advice to you is to avoid your weakest link. Who is giving you the heebie jeebies about this TB scare? Is it your husband or your mother-in-law? Because it's depleting your energy and you need to avoid that argument.

Sally: It's not helpful

Tam: Ironically it's other mothers

Stella: Well maybe you need to withdraw into your family unit and avoid them for a while that would be a positive response

Sally: It's the herd mentality (lots of yes's, mms around the room) that's what wears you down to have the vaccines. Avoid Mums who just want to discuss how ill their children are every day.

The rest of the session moves away from Tamara's concerns. This extract reveals a number of features. The conversation is unstructured and free-flowing responding to the questions and needs of the women. The women are able to share experiences of their own, and fears and worries with each other as a legitimate form of learning. The women listen well to each other's contributions letting each finish before talking and affirm each other.

This is a space where authority can be questioned. Tamara does not accept the school's stance which is 'keeping very quiet' and not suggesting any action. She takes up her own authority by asking the group for advice. The authoritative knowledge at work here is that of the group not of the medical or educational systems.

Roles are interchangeable with the homeopaths offering advice and support, but also the mothers offering information and advice to each other, and support to Jenny when she reveals her own worries about her daughter's risk of the disease

In an interview with Tamara a couple of weeks later I asked her whether it had been worth going that particular night and what she had got out of the meeting. By hearing of other people's fears she reports growing in her own self-confidence:

Well I think I was feeling a bit vulnerable about the TB thing. [The group] just gave me a little boost. I was quite surprised in some ways that, Jenny owned up to feeling.... Do you remember she said about not wanting to go up to Leicester because it was too [dangerous with the outbreak of TB up there]? I was "What? Come on!" (laughing). I mean it was very honest of her to admit that, but even so I was slightly taken aback. And then somebody else said something to me [about being very worried about the TB risk] and I thought, "Ooh, you know, maybe I'm less spooked than they are by all of this."

Tamara has also taken up Sally's suggestion and consulted a cranio-sacral osteopath to boost her children's immune system during this crisis period. "Funnily enough I'd always been open to the idea. But Sally I think it was, mentioned that her children went regularly, and I was just looking for another thing, because I was worried about this TB thing". In this case the 'authority' to consult a different practitioner to the homeopathy espoused by the course organisers, came from one of the group. Jenny supports mothers in making these sorts of decisions and does not push one form of healthcare at them.

In the popular press and biomedical literature parents choosing not to vaccinate their children are often represented as selfish, irresponsible and/or ignorant²⁶, for example (Sporton and Francis 2001). (For an interesting analysis of this as a strategic discourse to enforce bio-power see Dew, 1999). A recent qualitative project, however suggested that in fact parents are making very complex informed decisions (Evans, Stoddart et al. 2001). The members of this group are certainly putting a lot of energy and commitment into making informed decisions and could not be said to be ignorant.

In the process of making these decisions, far from being irresponsible, the parents appear to be taking on an enhanced responsibility. On this issue the parents have decided not to just accept received wisdom from the medical profession, but to take on the necessary education to make an informed decision. They are using Eve and Jenny and the comments of other mothers as a resource to help with that decision, but they are the ones making that decision. In a sense they are evaluating two systems of

²⁶ A recent paper in the British Medical Journal explains that the anti-vaccination movement is in no way new and has its roots in the mid 1800s (Wolfe and Sharp 2002).

authoritative knowledge against one another and making their own decisions about which knowledge to draw on - often combining strategies from both camps.

Brigitte Jordan has talked about this process of seeking alternative knowledge bases with respect to hospital childbirth (Jordan 1997). She defines authoritative knowledge as: "The interactionally displayed knowledge on the basis of which decisions are made and action is taken". She contrasts the type of knowledge that is embedded into a hierarchy of power, with other forms of knowledge that are present but not dominant, such as the embodied and experiential knowledge of women in childbirth. She shows how these women's knowledge is subjugated to the more powerful knowledge of the medical system. Jordan sees the constitution of authoritative knowledge as an example of situated learning (Lave and Wenger 1991). Authoritative knowledge is not something that is possessed by individuals, rather it is constructed in an ongoing process of social interaction that both builds and reflects power relationships within a community of practice²⁷. This seems to represent very accurately the process in train in the vaccination support group. However in this situation, while the second body of knowledge being appealed to is less hierarchically organised, it is a more formal body of knowledge than that of pure embodied experience. Here the alternative authoritative knowledge is one that is also dependent on textbook material and scientific research. So here we have an example of a body of alternative authoritative knowledge that is head to head with biomedicine.

Resisting pressures from orthodox medicine

How is this alternative form of authoritative knowledge opposed to biomedicine, communicated and negotiated in the group? There seem to be a number of mechanisms. Firstly Jenny and Eve hand out quite a lot of paper resources. At every meeting a large number of pieces of paper are handed out. These include handouts on the vaccines themselves. These are often quite scientific in content. For example a paragraph from the Jenny's handout on the DPT vaccine:

²⁷ For a good example of the use of Jordan's concept see Ketler's analysis of two very differently organised childbirth preparation classes in Italy (Ketler 2000).

The Diphtheria (D) component is purified cell-free toxin, which is treated with formaldehyde to convert it into the innocuous diphtheria toxoid. This substance is not good at stimulating an immune response, so it is then mixed with aluminium phosphate or Bordella pertussis vaccine. The plain vaccine is no longer supplied as it is less immunogenic and causes more systemic reactions.

Some of the information is more clinical, for example details of contra-indications, and adverse reactions, which are phrased in quite technical terms:

Adverse reactions include: Crying screaming and fever, episodes of pallor, cyanosis, limpness. Severe neurological reactions including encephalopathy and convulsions, resulting in permanent brain damage and death.

Then there is information drawn from the homeopaths experience, which is challenging medical knowledge:

As homeopaths we see many children suffering from repeated coughs and colds after DPT vaccine. They retch with the cough but do not show the usual pattern of whooping cough disease, so do not get recognised as having the disease (extract from handout).

The level of the discussion in the group is often quite medical/technical. Jenny and Eve also refer to several alternative outside sources of knowledge and expertise. The Helios homeopathic pharmacy is one such source. They manufacture remedies and can send them out to order. They also provide all the books on Jenny's recommended reading list. Three organisations commonly mentioned in the group, that disseminate alternative information that is often critical of medical practice, are The Informed Parent; What Doctor's Don't Tell You; and the Childhood Diseases Contact Network. Often the handouts include photocopies of articles from the newsletters of these organisations.

Alternative experts' work is also referred to. Eve often mentions the book by Vera Schreibner, an Australian medical researcher. Schreibner's thesis is that vaccines causes cot deaths, and possibly shaken-baby-syndrome (Schreibner 1993). As well as referring to the alternative sources Eve and Jenny quite regularly refer to the "Green book", as they call it. A publication by the Department of Health "Immunisation Against Infectious Disease" that doctors and health visitors use as an information resource.

Another biomedical resource that many of the women have had to evaluate is the local paediatrician, Dr Smythe. His name comes up a lot. Mothers who choose not to vaccinate their children are sent by their GPs for 'a little chat' with Dr Smythe. This attempt by the orthodoxy to convince the mothers of the advisability of vaccinating seems to fail in all cases. Ruth's experience is typical:

I wasn't going to have Lily vaccinated, they referred me to Dr Smythe who is the chief child paediatrician in (Greyborough). And basically his job was to persuade us that we were doing the wrong thing. But we had done a lot of reading by that point. He's a really unpleasant man, of all the health professionals we've come into contact with. He didn't acknowledge Lily, he didn't look at her, he didn't say hello to her, he just completely ignored her. We went together [Tim, Lily and I], and we challenged him about a book he'd written which we'd read and we'd got another book and several other things that posed the alternative view. And he just tried to blind us with science and facts and figures. So we just went away and said we're still happy with the decision we've made and we still don't want Lily vaccinated. Once we'd had a chance to think about it, we thought 'well he mentioned a couple of things that sounded really interesting' so we wrote to him and asked him if he could refer us to the papers that he'd quoted from. And he wrote back saying that basically that he couldn't. And so he completely washed his hands of us.

The homeopaths often mention him. In a February meeting, during a discussion on Polio, Jenny mentions that she and Eve recently went to a talk given by Dr Smythe on vaccines at the teaching hospital. They report to the group that he had intimated that there is no longer any need to give Polio vaccine but that they can't withdraw it, because it is being excreted from babies who have had the vaccine. So everyone is potentially coming into contact with polio through faeces, in swimming pools and so on, and it's a vicious circle. Natalie asks does that excretion last 5 days? Eve picks up the green book and reads from it "up to 6 weeks". Natalie replies angrily "Doctors tell you only 5 days" (even though as a physiotherapist she is a health professional herself).

In this discussion both Dr Smythe and the green book are used to negotiate between the two different authoritative knowledge systems. Women like Natalie listening to all of this, trying to evaluate these different sources of knowledge in order to decide how to act with respect to their own children's health.

Once they have come over to the homeopathic view and decided not to vaccinate, then the work of the group becomes to help each other work out strategies for dealing with their pressurised encounters with medicine. Anne, the young woman whose husband comes from a family of doctors but who herself was brought up homeopathically, advises the group during a discussion of tetanus vaccination: "You can refuse at the hospital. Mine had an open cut and they wanted him to have tetanus but I said no". Eliza adds her support to the idea of resisting medical pressure: "I have been locked in a room in the hospital for 2 hours when I refused to let my child have tetanus, while they tried to talk me into it." Sally explains that she understands the importance of getting support from others "The thing is not to feel all alone on a limb. Now I've had more kids I am more confident. But as a new Mum..." Jenny says "That's why do they do it at 2 months because you are still brain dead." There is laughter of recognition all around the room. There is a feeling of solidarity as they band together in the knowledge of what it is like to be mothers; in their resistance to the biomedical notions of health and healing; and in the knowledge that they share a different and better vision of how to keep their children healthy.

Together these women are negotiating their way to resist the orthodox view of health and instead actively participate in the creation of their own version of health and treatment of illness. If they are to resist the pressures of the medical way of doing things, they have to work out their own way of doing things. During the course of the evening you can see them engaged in this task of defining a different way of healthcare, for example in their discussion of treating fevers homeopathically, This has a lot of similarities with the way the women in the homeopathy class discussed fevers.

Eliza: How do you decide when to start treating? I wait.

Jenny: If you are not concerned don't give anything at all. It's nice to know you can.

Eve: When they are not well.

Olivia When they've got a fever and you are really concerned

Michelle: Me as well.

Sally: I like to see a fever. My eldest just sleeps and when she wakes she's better.

- Penny: Neither of mine have had convulsions.
- Sally: The doctor, if there is any sign of a fever says gives it Calpol - any doctor says that.
- Michelle: Or when you want to get some sleep (laughing).
- Jenny: It can be scary not treating.
- Eliza: My daughter had a fever for 3 days and 3 nights, I gave her fever remedies. My homeopath said none of the remedies was doing anything so just let her have the fever. She was very agitated frightened seeing things on the bed. *Belladonna* should be good for that.
- Olivia: *Belladonna* is very good for fevers
- Penny & Eliza: Yes.
- Jenny: It's finding the right remedy which is difficult.
- Olivia: It's very hard in acute problems with children.
- Eve: If you know what the constitution is.
- Penny: Regardless, yes, yes if they are really sick and wanting you and you are wanting to look up possible remedies in the books.
- Jenny: And you're suffering from lack of sleep.
- Eve: You need to talk it over with someone else.
- Olivia: Yes.
- Penny: Yes, yes.
- Jenny: Even homeopaths need that.

In the course of this interaction, mothers have to take responsibility for deciding when to treat. If they stuck to the orthodox model, the timing would be clear. As Sally points out "The doctor - if there is any sign of a fever- says 'Give it Calpol' - any doctor." It emerges in the views of some of the women, that it is a good idea not to treat at all, (unless there is a risk of convulsions). This suggests that the body might be the best remedy in itself. There is recognition however, of a number of social factors that might stop them sticking to this course of letting the body heal itself. There is recognition that

possible reasons for treating might include the mother being tired through lack of sleep or scared about the child's symptoms.

If treatment is decided on there is the complication of knowing what treatment to give. No longer is it as simple as giving Calpol for everything. Now there is the idea that the treatment needs to be matched to complex pictures of symptoms, which need to be worked out by struggling through the books. There is an added complication of needing to take the constitutional picture of the child (a combination of emotional and general personality tendencies as well as history of susceptibilities and previous illnesses) into account, before deciding on the most suitable remedy.

The simple orthodox equation of every symptom needing a treatment, and there being a one-to-one correspondence between symptoms and treatments, no longer applies. In this new view of health, the idea of a fever becomes a complex multiplicitous one, containing decisions between not treating, or of choosing between multiple possible treatments. Together the women in the group are negotiating this new view of health as a collective exercise. And the homeopaths support this collective view in admitting that they too need to talk to others in making their professional treatment decisions.

Summary and concluding remarks

In this chapter I have illustrated how the homeopathic belief system outlined in chapter 6, comes to exist through interaction. The committed users of homeopathy can be seen learning primarily from their homeopaths, but also from each other, as they become more knowledgeable. Concepts such as symptoms being part of the healing not the illness; the importance of the social and emotional body to health; and the perceived toxicity of orthodox medicines and vaccinations are all shown as being learned through interaction and debate.

The homeopaths play an active central role in educating clients into this new cosmology of health. In addition to their overtly educational activities they also employ a number of more subversive strategies to pressurise clients to change, particularly to reduce their use of orthodox drugs and vaccinations. But the interaction is two-way, in that the users

can, and often do, resist this pressure, maintaining more power than in the traditional general practice patient role²⁸. However, in the homeopathy class and the vaccination support group, the women are mainly predisposed to accept this new view of health, and to reduce their use of orthodox treatments. These are people who have made an effort to seek homeopathy out, signing on for an adult education class, buying books, joining a support group, and in many cases consulting a private homeopath. They are mostly young women in their 20's and 30's with children. They are open to this different form of authoritative knowledge about healthcare (Jordan 1997). For these young mothers, homeopathy seems attractive. Both through the 'push' factors of poor experiences with the medical system during pregnancy and childbirth and the 'pull' factors of a system of healthcare in which they can hold the main responsibility for their children's and their own health, avoiding the side effects of orthodox treatment.

In the victim support centre however, there is much more resistance to taking on this new view of the world. In spite of the efforts of the homeopaths during consultations, which the clients all enjoy and find useful, the shift towards a new way of thinking about health does not seem to be obviously happening. The clients appear to stay rooted within a biomedical conception of health. This group and some of the members of the homeopathy class: the ones with a more firm commitment to the biomedical model of health, such as Belinda the GP and Greta and Agnes who have worked in general practices, do not share the excitement for these new views of health. They are not looking for a new way of healthcare. They are looking for ways to manage their current victim crisis or to deal with the everyday ailments of their children in a more pragmatic way. This group sees homeopathy as one treatment option of many, not as a new way of seeing health and the world.

Included in the groups of users who were not apparently actively seeking another solution, were NHS employees, older people, men, and people from less educated socio-economic groups. It is difficult to make any firm conclusions as it was, to some extent, a result of confounding of variables between different fieldwork sites. However it would seem quite strongly from the data that there is a particular attraction to homeopathy as a

²⁸ Although the universal findings on low adherence to medical advice in primary care suggests that patients still exercise their right to resist when the power imbalance is greater (Donovan and Blake 1992).

belief system among younger, educated women, at times of transition and who have suffered bad experiences at the hands of orthodox practitioners.

In the next chapter I hope to take a different angle by investigating a different kind of homeopathic practitioner. In this case study it is a GP, Dr Deakin, who has trained in a number of alternative medicines including homeopathy and who offers these alongside orthodox medicines in an NHS general practice surgery.

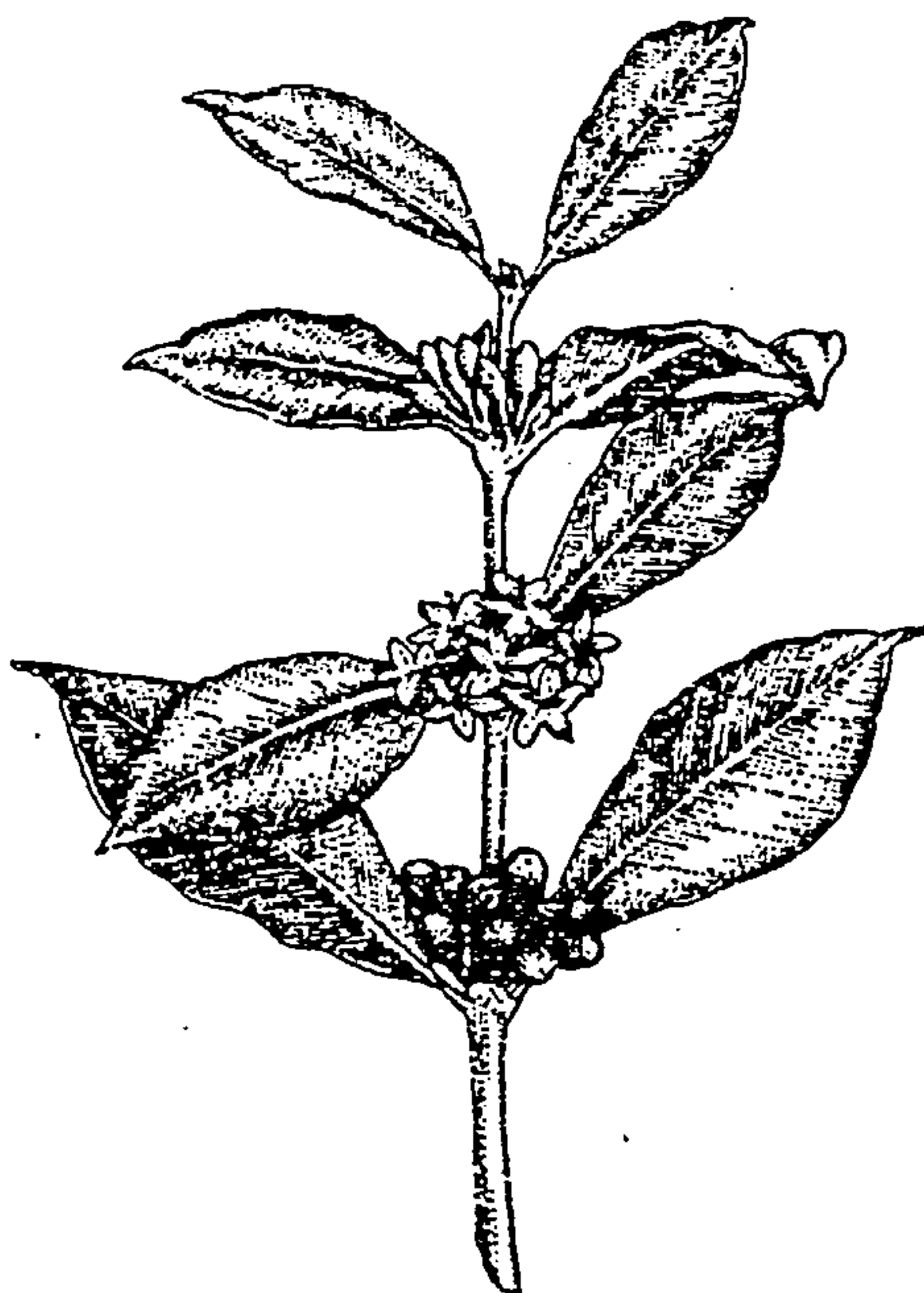
Chapter 9

Homeopathy in a general practice: Pragmatic and committed homeopathy users in interaction with a holistic GP

COFFEA CRUDA (Coff.)

Family name: Rubiaciae

Common names: coffee; coffea arabica; mocha bean



Chapter 9. Homeopathy in a general practice: Pragmatic and committed homeopathy users in interaction with a holistic GP

In this chapter I want to turn to a case study of homeopathy as practised within the NHS. This case study is designed to investigate how the context set within a biomedical framework, and the provision by a biomedically trained practitioner appears to affect the variety of homeopathy practised.

It is worth remembering that the lay homeopaths and biomedical homeopaths are subject to very different forms of training. The homeopathy training offered by The Faculty of Homeopathy to biomedical doctors consists of a post-graduate course of 18 days over 3-4 years. By contrast the lay homeopathy courses are far more intensive. To take one lay college as an example, The College of Practical Homeopathy's part-time course consists of 88 days over 4 years. Also it should be remembered that for a doctor this training consists of one arm of a whole raft of compulsory continuing professional development, and that their interest in homeopathy is just one part of their job. For a lay homeopath this training will probably represent the central, if not the only component of their healthcare training, and homeopathy is likely to be their only job, and their central interest.

In studying a number of different settings outside the NHS, and through my own participation as a patient I had the opportunity to observe 9 non-medical homeopaths at work. By contrast in this NHS setting I only got the opportunity to study one biomedical homeopath, a GP²⁹, whom I have called Dr Jim Deakin³⁰, who had trained in homeopathy and other alternative therapies. Inevitably this makes it difficult to generalise from this one case study to all NHS provision of homeopathy. However, in ethnography such as this, I am aiming for cultural representativeness not statistical representativeness and I would be aiming to make conceptual generalisations about possible issues arising, rather than statistical generalisations.

²⁹ The main provision of homeopathy in general practice is by doctors. There also small numbers of non medically trained homeopaths working within general practices (see e.g. Treuherz 1999). Nurses and podiatrists have also been sitting a specially designed training course in the last 2 years that entitles them to conduct them a limited form of homeopathic prescribing in the NHS from a limited list of remedies.

Dr Deakin may appear in the following pages to be fairly idiosyncratic in terms of his offering a very eclectic selection of alternative therapies. However, it may be the case that many of the GPs who offer alternative therapies are in some way unusual and idiosyncratic. Frank certainly found at least three types of mode of operation of biomedical homeopaths in his study and there was no doubt individual variation within that (Frank 2002). It is to some extent an inherent factor within the nature of general practice work, that there is a great variety of GPs operating styles (Tovey 2000). However, the movements towards evidence-based practice and the increasing formalisation of best-practice clinical guidelines provide a pressure to conform to a greater degree (Raine 1998). Conversely, the movements towards patient-centred medicine (Stewart, Brown et al. 1995; Little, Everitt et al. 2001), shared-decision-making (Charles, Gafni et al. 1997) and a partnership model (Goldberg and Comins 2001) allow for more individual ways of working to be negotiated by GPs and their patients. There are inherent tensions between these two different movements in contemporary healthcare, affecting all doctors, both mainstream GPs and those offering alternative therapies.

Given that many GPs are idiosyncratic and work in different ways, this case study still offers useful insights. Dr Deakin's mode of operation tells us about his particular case but given that this is a context rich study, it can also illuminate the organisational constraints facing GPs who wish to offer alternative therapies within the conventional healthcare system. It also helps us to think about the issues faced by any GP offering plural therapies in working out a way of consulting and of operating vis-à-vis his or her patients. I would invite the reader to view this case study as offering both a case study of a biomedical homeopathic GP and as a study of the more general constraints of offering alternative medicines in general practice and within the NHS.

As will become clear in this chapter, Dr Deakin is operating within a shared-decision-making model with his patients. In this he is subject to the kinds of tensions operating between this mode of operation and the pressures to provide more evidence-based care. These are tensions that face all GPs: A recent study in general practice explains that GPs

³⁰ I referred to the lay homeopaths by Christian name, as they did not have a title that denoted their status

experience these opposing movements as creating problems for practice, regarding regard clinical evidence as a square peg to fit in the round hole of the patient's life (Freeman and Sweeney 2001). However, these tensions must be particularly important for GPs wishing to operate to some extent outside the guidelines and evidence based frameworks by offering alternative therapies for which such an evidence base has yet to be developed (Wilson and Mills 2002).

I will start by outlining Dr Deakin's eclectic mode of operation and then attempt to situate this within the context of constraints offered by working within the bureaucratic framework of the NHS and within this specific practice.

Dr Deakin: A homeopathic, holistic or pluralistic doctor?

Dr Jim Deakin works in a number of different settings both privately and within the NHS. My fieldwork with him was limited to a general practice in which he works one day a week, Golden Hill Surgery. I spent 5 days in the surgery during the summer of 2001. Once I had obtained ethics approval, I interviewed Dr Deakin three times. I interviewed the senior partner Dr Squires, the practice manager and two of the receptionists. I sat in on four of Dr Deakin's half-day surgeries and observed and recorded 23 consultations with patient's informed consent (appendix C). Whilst this does not constitute a full ethnography it does provide some data with which to investigate one biomedical doctors use of homeopathy.

Dr Deakin is difficult to pigeonhole. I started out by thinking of him as a homeopathic GP. I first learned about him from a cutting in the newspaper that discussed his use of homeopathy in general practice. Then, when I was trying to recruit a homeopathic GP to my study I found his contact details in the Faculty of Homeopathy's handbook of homeopathic doctors. These are medical doctors trained in homeopathic medicine, usually through the training courses of the London, Bristol or Glasgow homeopathic hospitals. Dr Deakin works both at the homeopathic hospital where he offers both NHS and private consultations and one day a week in this general practice in south London.

as a healer. I will refer to Dr Deakin in this manner as his title is connected to his healer status.

However, during the course of participant observation with him in the general practice, I discovered that homeopathy is just one of the strings to his alternative bow. He also prescribes a lot of Chinese herbs; gives nutritional advice; draws on the anthroposophical medical principles of Rudolph Steiner; and the principles of traditional Chinese medicine; administers acupuncture with needles; and acupuncture with prisms of coloured light; uses Kurlian photography to diagnose; and refers to full time homeopaths and herbalists. He appears to be drawing on a whole range of philosophies and techniques, although many of these things were reported as taking place during private consultations and away from the NHS practice. In the NHS consultations I observe, Dr Deakin only prescribes homeopathic remedies, herbal preparations and orthodox drugs.

Johannessen has talked about how doctors who come into contact with alternative medicine cannot explain their experiences within the traditional medical paradigm, and tend towards one of two responses:

When clinical phenomena cannot be explained within a physioanatomical realm and monitored by simple counting and measurement, doctors are by and large, conceptually and theoretically lost. Some are willing to accept popular explanations They “go bananas” in the sense that they “go native” (“alternative”) and lose the grounding in science. Others...are not willing to let go of the scientific basis of medicine ... and respond to the whole thing in an aggressive, ridiculing way. (Johannessen 1996:80).

Dr Deakin appears to fall somewhere between the two. He is certainly not aggressively resistant, but biomedical thinking and practice still heavily influence him. He has picked up some elements of the alternative cosmology but there is not one clear ideology but a mixture from different alternative discipline's, different explanatory models. Doctors in general practice are used to operating in a world of a myriad of different explanatory models. Their diverse responsibilities touch in part on a range of types of medicine, from minor surgery to counselling, many with differing underlying ideologies or philosophies.

In one surgery I observe Paul, a head teacher, consulting Dr Deakin about his swollen eyelid. Paul enquires about possible homeopathic and herbal remedies. Dr Deakin starts

by suggesting the possible treatment option of herbal eyedrops. However, he then goes on to explain (at what seems to me to be off at a tangent):

In Chinese medicine, the upper eyelid relates to the liver, some sort of congestion, a toxic congestion of the liver, and the lower eyelid relates more to the kidney system, the genital-urinary system and is more the sort of the bags of exhaustion. Western medicine hasn't quite accepted that view.

When Paul replies laughing (suggesting that he too is surprised by this non-sequitur) "So should I do something about my liver rather than my eye?" Dr Deakin responds

Well ... sounds like it (laughing). But that's oriental medicine, we haven't made a proper oriental diagnosis, so I very much try to keep to the homeopathic treatment approach [therefore I will prescribe] *Euphrasia* eye drops.

This interchange shows that Dr Deakin is pluralistic, not only in his choice of treatment strategies, but in his choice of diagnoses. Dr Deakin is unlike the GP I mentioned in chapter 4, in Adams' research, who said "You cannot sit here and see the patients for ten-minute intervals doing Western medicine and then switch for 2 minutes into Chinese medicine" (Adams and Tovey 2000: 176). Dr Deakin does manage to do a bit of western medicine, Chinese diagnosis and homeopathic prescribing, within his general practice consultations.

When another patient Cally consults about hay fever he suggests a whole host of options. He offers her the choice between simple symptom relief "a short term cure that wont cure in long run" and longer term de-sensitisation. In the former category he proposes either antihistamines or complex Chinese formulas; and in the latter he proffers the options of: a course of desensitising vaccinations at the London homeopathic hospital; advice about avoiding dairy products and eating pollens, taking propylis tincture, herbs, single homeopathic remedies or taking calcium supplements in conjunction with homeopathic or herbal treatment. His final option is to suggest consulting a lay homeopath or herbalist privately.

This multiplicity seems confusing to me and I cannot see any consistency in terms of any particular theoretical model. I even mention to Dr Deakin after observing some

consultations, that I feel his patients might be confused by all the choice of different possible treatments he is offering. “Oh good” he replies, “I don’t mind if they are confused. The main thing is, I want them to know that there is a choice. That there are different options of treatment”. The patients, unlike me, do not seem on the surface, at least, to have trouble with all these competing explanations. They are, on the whole, not looking at the problem from the standpoint of evaluating different philosophies or theories of health. They seem to be more pragmatic. They too are used to the variety of approaches in general practice. Those who stay within the thinking of a more-or-less biomedical frame of reference seem to see these options as either just one more choice of treatment if the biomedical drugs don’t work; or an alternative to drugs without the same risk of side effects.

It may be that Dr Deakin's eclectic philosophy, and his offering of such explanations have some resonance for patients. Their embodied experience may lead them to perceive links between the different symptoms in different parts of their bodies, and yet they do not normally encounter any discourse within general practice that recognises this holistic bodily experience. However, there does appear to be some confusion about the treatments he prescribes. I will return to this issue later in this chapter.

So I decided to think of Dr Deakin as a holistic rather than a homeopathic GP. However, I came to have reservations about this. I could not see much evidence of him working with patients in a holistic way of ‘treating the whole person’. This is a surprise. In my interview with him before observing his practice he was very critical of his colleagues in general practice who are dabbling with alternatives, for not understanding the philosophy.

They [GPs involved in offering alternatives] don’t know how to set up complementary medicine properly. They treat you twice and think the problem has gone away. They enjoy writing it in their practice leaflet. It needs understanding. They need to go on courses. They need to understand the philosophy behind it all. You can’t just do a weekend course. You have to understand what you can treat. Unless you do it in tandem with GPs where they could observe your achievements and the rationale for treatment. They could observe your successes and get feedback of the good news. They

refer heartsink patients³¹ and use it to get rid of them, the most difficult psychological cases or people whose problem is deeply suppressed after years of drugs, so that it is difficult to see the pathology. The wrong patients are referred. Most complementary therapists operate in a holistic way: herbalists, homeopaths. It's so difficult for GPs to understand. You're not treating sore feet or long toenails (smiling). Your digestive problems might be related to your sleeplessness. It's the philosophy of the whole patient not the single disease. They single out the name and put it in a box.

It seems likely that Dr Deakin is in particular, referring to his senior partner in the practice. Dr Squires makes it very clear to me when I interview him that he neither knows much about alternative medicine nor has much respect for it. Dr Squires tells me:

Some people are looking for alternatives and are against immunisations and vaccinations, not keen on antibiotics, which is a good thing. I have no interest in it myself. Organic foods, different ways of living are not to do with mainstream medicine.

This illuminates Dr Deakin's comment. In a roundabout way he is alluding to the problems he has had in trying to implement his alternative philosophy under the types of constraints imposed by working for a 'non-believer'. However, from observing Dr Deakin's own practice it appeared that he was a lot less holistic and a lot less theoretically coherent, than most of the alternative therapists I interviewed and observed.

I was struck by how he seemed much more like a GP than an alternative therapist. His use of alternative therapies, at the Golden Hill surgery, did not seem very different to his use of orthodox drugs. He was usually prescribing for physical symptoms without asking about the wider context of emotions and life events. He was offering homeopathy and herbal treatments without any comprehensive philosophy. In fact his most common strategy was to offer a choice, for example: "Would you like antibiotics, herbal or homeopathy?"

In the main, his patients set the tone as to what kind of consultation it will be. Patients who come to him with more alternative views are more likely to get more alternative

³¹ See Butler (1999) and Steinmetz (2001) for recent discussions of the 'heartsink patient' phenomenon

treatment. Tim who wants a holistic GP to support his alternative cancer treatment; and the three mothers (Jane, Alice and Clara) who know about and use homeopathy as home-prescribers; have the most 'alternative' consultations. However, even here these consultations differ from those of the lay homeopaths I studied in some quite fundamental ways. Dr Deakin has better listening skills than most GPs I have researched, but he is still not as focused on the patients' words compared to the private homeopaths. He pays little attention to the lifeworld, he conducts far more physical and visual examinations, and he prescribes a fair number of orthodox drugs. After one consultation with an elderly woman with shoulder pain, he tells me he has insufficient time to practice acupuncture on her and so administers a steroid injection. This incident hints at the structural limitations on Dr Deakin's alternative practice and I will explore this at greater length below.

Where patients are crystal clear that they have come to him for alternative treatment, this is what he gives them. I only observe two patients who ask for it directly. Tim in his first consultation and Clara in both of her consultations for each of her sons; so 3 out of 23 consultations.

My data collection strategy with Dr Deakin is very limited. I only get to see him in the one context of the Golden Hill general practice surgery. He only practices here one day a week. I would have liked to have observed him at the London Homeopathic Hospital. However, the ethics committee approval took so long for the first round of research that I ran out of time. Dr Deakin was uneasy about me sitting in on his private consultations and was unwilling to let me come out on home visits. Had I done more prolonged research with Dr Deakin, he may have come to allow this. I was only actually in the surgery for 5 Fridays; this does not constitute a proper ethnography. Also my attempts to interview other members of staff were met with resistance. I had to make do with the formal interviews solely with Dr Squires and Dr Deakin and more informal chats with the receptionists and practice manager.

I get some indications that Dr Deakin may be 'more alternative' in his private practice. When Tim and Lesley visit him at the Golden Hill surgery with Tim's recent cancer

in general practice and Frost (2000) for an analysis of the emotional effects of such patients on GPs.

diagnosis, Dr Deakin gives them a fairly long consultation. He has to end it after 18 minutes in the interests of his other patients. It is agreed that they will visit him privately to get more time with him. With his and their permission they take my tape recorder with them (they had found the transcript of our interview so useful they said they would like a taped record of the sessions). In the private sessions Dr Deakin uses a technique called Kurlian photography to diagnose Tim's aura and energy flow. He uses a form of acupuncture that stimulates the acupuncture points with prisms of coloured light. Both of these strike me as very alternative treatments and do not seem to fit Dr Deakin's seeming mild approach to alternative medicines in the GP sessions. This only reinforces the importance of context in medical practice, and suggests potential constraining factors in the general practice that will be discussed below.

Pluralistic treatment strategies

Those who do not come to the surgery asking specifically for alternatives are more likely to be offered a number of choices. The type of treatment they go away with is mainly determined by the patient choosing between a number of presented options. In Table 1 overleaf, I have detailed the alternative and orthodox products Dr Deakin either recommended or prescribed in the 14 more alternative consultations I observed. In all of these consultations more than one kind of treatment was recommended. In eight, at least one of these was an orthodox treatment.

Dr Deakin's offers of choice are in terms of treatment, as the above examples show, and of diagnosis as in the case of Paul's alternative Chinese diagnosis for his swollen eyelid. They are also in terms of explanations of treatment. When he discusses the mistletoe injections he has prescribed for Tim's cancer, with Tim and Lesley, he gives a multi-layered explanation of how mistletoe works. He contrasts an allopathic explanation (although informed by the anthroposophical ideas of Rudolph Steiner: Evans and Rodger 1999) with a homeopathic explanation; an explanation based on the heat of the body (which may come from Chinese medicine); and, a psychological explanation. These explanations are given overleaf in the exact words he uses in the consultation:

Patient Name/No	Prescriptions	Recommended products & courses of action			
		<i>Homeopathy</i>	<i>Herbal</i>	<i>Orthodox</i>	<i>Diet/Other</i>
Clara M09i		<i>Graphites</i> ³² <i>Antimonium</i> <i>Fumulum</i>			No Sugar Hydrochloride foot soak
Clara M09ii	Vitamins. Calendula herbal cream.	<i>Hepar Sulph</i> <i>Silica</i>			Lymph drainage massage
Jane M10	Weleda herbal cough drops. <i>Ferrum phos.</i> Chest x-ray.	<i>Lobelia</i> <i>Antimonium-</i> <i>Tart.</i>	Lobelia tincture. Muling Lung Complex.		
Alice M14	<i>Belladonna.</i> <i>Pulsatilla.</i> Antibiotics	<i>Belladonna</i> <i>Bryonia</i>	Herbal	Paracetamol. Antibiotic rx for weekend	Herbal Teas
Cally P18		Hom	Herbal	Antihistamines	Calcium.
Don P19	Blood Pressure tablets repeat prescription	<i>Kali bich</i>	Herbal		
Bernie P20			Herbal	Antibiotics	
Jill P26	Antibiotics	Homeopath	Herbalist Herbal	Urine Test	Cranberry. Biocarb of Soda.
Vera P30	Kelp Iodine			Thyroid Drugs	Kelp. Iodine.
Joanne P31		Homeopathy	Herbal	Antihistamine	
Paul P32	Eyebright drops <i>Cinnabar</i>	<i>Apis</i>	Euphrasia Eyedrops.		
Tim P33	<i>Thuja</i>	Homeopathy	Miseltoe		Kurlian Photography. Prism Acupuncture.
Marilyn P42			Digestive herbs.		Herbal Tea
Judy P43	Steroid Injection				Acupuncture

Table 1. Dr Deakin's prescriptions and recommendations in 'alternative' consultations.

³² Homeopathic remedies are shown in *italics* here and elsewhere in the document.

1. *Allopathic explanation.*

At one level it's [mistletoe] a parasite that works on tumour cells. On the other side it's a plant that um that has a very strong affinity to light. In the roots of the plant (they go into the bark of the tree) they still have chlorophyll-containing tissue. Plant tissues. And that's very unusual for most plants, so Rudolph Steiner called this plant a plant that has an enormous potential for structure. For cellular structure, or that when the forces of structure have penetrated, not only the leaf system but also the root system of the plant, that it has that sort of effect in an allopathic sense on the human body.

2. *Homeopathic explanation:*

On the other hand being a parasite maybe that's the more homeopathic concept: you treat the same with the same. So you want to treat tumour cells with a plant that is also like a parasite.

3. *Heat explanation:*

It's also the mistletoe lectins that increase temperature in the body, this hypothermia effect. This is something that is really a desired effect in what we call the cold diseases. The cold diseases are degenerative diseases. In childhood you have earache and sore throats and hot joints and the fevers and so on these are all the heat diseases. And as we progress in life we lose that capability to have a strong feverish reaction and to throw out the poisons that we are fighting all at once. In middle age we have chronic problems. Tumour cells don't like heat they become very evasive when it comes to hot organs. It doesn't affect the heart - there are no tumour cells of the heart. The tumour cells do not thrive in an environment where there is oxygen where there is light, where there is heat.

4. *Psychological explanation:*

Certain parts of the body [are linked to] certain emotions and there's something about the digestive tract, the alimentary tract, that is in a way quite psychological. This part is a lot to do with the split between the upper body and the lower body. There's a diaphragm in between and that's why sometimes the energies don't easily meet, and a few knots of- energy blocks. So the mistletoe injection should push the body a little bit more into a febrile reaction.

At the end of offering these alternatives Dr Deakin sums up "So that is really the concept at various levels". This suggests that Dr Deakin does not see these as different competing explanations but as compatible explanations at different levels. This could be compatible with the process in medical education identified by Byron Good (and discussed in chapter 3). Good showed how medical students are taught about the body

and medicine as a number of hierarchical orders: each encompassing the other, with each level revealing the more basic structure of the next order (Good 1994). However, as a non-medic I found this confusing, and as will be demonstrated below so too did some of the patients.

Attention to the lifeworld

In spite of, or perhaps because of, feeling misunderstood and unsupported by Dr Squires, and the time constraints working against him practising holistically, Dr Deakin does not appear to be operating entirely according to the principles of holism. Berliner and Salmon (1980), define the holistic approach to health as comprising

- 1) The perception of health as a value in itself.
- 2) A notion of health as praxis requiring the active participation of person in maintenance of health.
- 3) Unity of mind, body, spirit, illness.
- 4) Interpersonal sensitivity and responsiveness to patients needs.
- 5) Patient responsibility for health and results of their therapy.
- 6) The prominent role of suggestion and belief.
- 7) Less invasive, and dangerous, and more intimate, enjoyable and pleasant.

Dr Deakin's practice does appear to take on board most of these, at least to some extent, and certainly appears more holistic than many GPs. It is really on point 3 that he does not appear to be operating as holistically, as he himself reports himself to be. He does not gather much information about the context of people's lives, and their relationships, outside what is going on in their bodies. He seems quite symptom-oriented and to be working in quite a biomedical way. He relies heavily on physical examinations and tests. He physically examines most of the patients and for many conducts a blood pressure test or sends them off for urine or blood tests or for x-rays. He uses biomedical diagnosis categories such as asthma, although sometimes offers Chinese alternatives, as with Paul's case above.

A recent qualitative project by Linda Finlay explored a similar issue of the relationship of holism to biomedical practice (Finlay 2001). Her research was with occupational therapists whose profession is said to have underpinnings of holistic, humanistic, and

client-centred values. Finlay found firstly that, each therapist interpreted and enacted holism in different ways. She also found that each therapist's practice could be simultaneously reductionistic and holistic, depending on the perceived needs of the situation. The therapists struggled to negotiate the tensions between beliefs and practices with the demands of their work context pushing them to be pragmatic and strategic. This situation potentially mirrors that of Dr Deakin's position as a practitioner with a holistic ideology, straight-jacketed into a biomedical system that makes demands upon him that are incompatible with these beliefs.

Looking closer at Dr Deakin's definition of "the philosophy of the whole patient" from his quote above, the example he uses is of digestive problems being related to sleeplessness. Neither of these problems suggests a patient seen in a wider context of their lives. This suggests his definition of holistic would be looking at the whole body in its entirety and not breaking it down into parts. However, this definition would not go far enough for followers of holistic medicine such as the lay homeopaths. They would also include concepts such as the need to understand constitutions and personalities, likes and dislikes, lifestyle factors and important life events over the whole life course.

One way of explaining Dr Deakin's approach is to look at his conception of the body. In spite of many holistic themes, he is still operating according to many ideas about the body that exist in biomedical training and the biomedical model more generally (as were outlined in chapter 3). It looks from his behaviour that Dr Deakin sees the body as a discrete entity bounded by its skin. In much of his treatment he appears to be operating at the level of the physical, biological body. He is not necessarily incorporating notions of the lived experience of the body, or of the body in relationship with other bodies. This is one way in which Dr Deakin appears to operate very differently to the lay homeopaths. In the next section I will highlight another.

Educating patients

With Jenny the lay homeopath, I get a clear sense of her homeopathic beliefs. There are many incidents in the consultations in which she attempts to get her view across to her clients with a view to changing their views. For example her continued efforts to get the

older women off HRT, the asthmatics off their inhalers and the hypertensives off their blood pressure pills. She puts quite a lot of subtle pressure on patients. As with the example in chapter 8 where Jenny uses 11 different strategies to persuade Laura to come off HRT. There is the sense of a mission: to wean the clients off orthodox drugs and beliefs, and move them into a world of homeopathic beliefs and practices.

I see few signs in his consultations that Dr Deakin is doing this. There is a very minimal presence of expressed homeopathic concepts. One example, where he does use such principles is with Harry, Alice's 4 year old with earache, Harry (Alice was one of the case studies outlined in chapter 7, and this consultation is dissected in more detail below). In consultation with Alice and Harry, Dr Deakin mentions that if the ear were to start to discharge this would be seen a positive development. (In chapter 6 I discussed the homeopathic belief that discharges are a sign of the body healing itself.) Such mentions are few and far between. Unlike Jenny's consultations that are peppered with homeopathic concepts, Dr Deakin appears to treat homeopathy as just another tool in the workbag. He offers his patients a lot of choices but there is no party line. He does not seem to be attempting to educate patients into a new philosophy of health, as the lay homeopaths are. The choices he offers are not 'either/or' but 'both/and'. Where homeopathy is offered, it is most commonly in tandem with other treatments (as I outlined in Table 1). Don is given homeopathy and herbal treatments for his persistent catarrh. Jane and Alice are offered homeopathy and antibiotics for their children. Alice is told to give Calpol alongside her homeopathic remedies.

Other homeopathic issues

In addition to the general ways in which I have already shown that Dr Deakin is different to the non-medical homeopaths there are a number of specific aspects of homeopathic practice in which he differs. He did not seem to have the same reverent respect and almost religious awe for homeopathy. Twice, in connection with homeopathy, he mentions "magic potions" and "cauldrons" in consultations. This was something I never heard the lay homeopaths do, ironically their presentation of homeopathy was in much more solid scientific terms. I mentioned in chapter 4 that the homeopathic GPs in May and Sirur's study stressed the importance to them, of their

colleagues' reactions (May and Sirur 1998). Adams has also discussed the In all probability, Dr Deakin has had these 'magical' allusions made by mainstream biomedical colleagues (perhaps particularly in hospital medicine) to denigrate his unorthodox practices³³.

Dr Deakin's prescribing strategy is also different to the non-medical homeopaths. He does not prescribe constitutionally in any of the consultations I observe. He never prescribes remedies in high potencies such as 1M, which are routinely used by the non-medical homeopaths. He seems to prescribe for biomedical diagnosis categories. Telling Clara for example that "these three remedies are good for athlete's foot", and Alice that "these two are good for ear infections". He is puzzled about why Alice has given Harry *Pulsatilla* for his earache, as he does not see this as a suitable remedy for earache. Alice's rationale, however is that she prescribing not just for the earache, but the total symptom picture. For her this includes the keynote symptom³⁴ of *Pulsatilla* of a crying whinging, clingy-child who does not want to be left alone. Dr Deakin does not appear to be using these types of remedy indications, going much more on biomedical diagnosis and visually observed signs in the body. I have already mentioned how he combines treatments with opposing actions such as homeopathic remedies and paracetamol to bring down a fever. A strategy I never saw the non-medical homeopaths advocate.

In the consultation with Alice and Harry, Dr Deakin does use some homeopathic ideas in the consultation. But he does not adhere to many of the practices I saw the lay homeopaths use in situations like this. He asks very little about Harry's symptom picture. He pronounces that in addition to *Belladonna*, *Bryonia* would be a good remedy for Harry's problem. However, he does not then engage in the kind of discourse that was used, in the lay consultations, to determine which remedy would be more appropriate. In the homeopathy class *Bryonia* and *Belladonna* were taught as two simple first aid remedies, for childhood acute infections such as this one (See appendix D). The

³³ Earlier I mentioned a teaching session I conducted with homeopathic GPs at the Faculty of Homeopathy. When I asked one of these GPs (who I thought I recognised) whether I had seen her at a recent seminar on Buddhism and Ayurvedic medicine, she looked horrified and said "Good God - not me!" in a very touchy fashion. I gleaned from this response that she was used to having to defend herself as "not too weird" among her colleagues (and at the time of this exchange, I think she believed me to be a doctor).

³⁴ A keynote symptom, which was also labelled by Nancy as "strange, rare or peculiar" is an unusual symptom that is very particular to a specific remedy picture. So for example *Ledum* wounds feel cold internally but are made worse by heat and improve on the application of cold compresses (Castro 1995).

keynote difference between the two is that a *Bryonia* illness develops slowly over several days, whilst a *Belladonna* fever comes on very suddenly. Alice has told Dr Deakin that Harry was OK until this morning so this should rule out *Bryonia*. In the event, he finally does recommend *Belladonna* but he does not ask much about Harry's condition in order to determine suitability of remedies. The sorts of questions the lay homeopaths ask in these situations include "Did it come on suddenly? Has he cried a lot? Is his face red and hot to the touch?"

The kind of homeopathy training offered by The Faculty of Homeopathy to biomedical doctors is at the post-graduate level and consists of 18 days over 3-4 years. By contrast the lay homeopathy courses are far more intensive, for example The College of Practical Homeopathy part-time course consists of 88 days over 4 years. Also it should be remembered that for a doctor this training consists of one module of a whole raft of compulsory continuing professional development, and that their interest in homeopathy is just one part of their job. For a lay homeopath this training will probably represent the central, if not the only component of their healthcare training, and homeopathy is likely to be their only job, and their central interest.

Criticising biomedical interventions

However, in contrast to these biomedical facets of his practice, Dr Deakin's opinions are decidedly opposed to many facets of biomedical medicine. This manifests itself in his expression of his views to me. It also surfaces in the consultations, as an openness to criticise practices of orthodox medicine. When Tim consults with his recent diagnosis of oesophageal cancer, Dr Deakin cautions him against accepting the label or the prognosis being offered by his colleagues in hospital medicine:

Cancer is just a kind of a label which doesn't mean anything. In my opinion, it's not that serious. You look generally in good health. There has not been that much change in your vitality recently. You've just been given this diagnosis. You know they shove it down your throat (miming pushing forearm down throat up to elbow) onto your stomach. And it's a kind of a label. I wouldn't get too distressed by that - You may have had this condition for quite a long time and only because someone looked into your stomach with a gastroscopy, they only now found that there's a bit of change in the epithelium.

He also suggests to Tim that his problems might have been caused by an operation to remove his vagus nerve 20 years ago. He explains that the scar tissue may have started problems in that area. He is openly critical of this procedure saying that it would not be an accepted form of therapy today:

Maybe at the time when you had it, it was the best sort of option that was available at the time. But probably one wouldn't do this today, cut such a major nerve like the vagus nerve. (Wife nodding, looking sceptical.) Which is a main regulating nerve for the whole digestive system. Cutting that, you are sooner or later going to run into trouble.

He voices criticism of orthodox medical advice, quite often in the consultations. This struck me as unusual, with doctors more used to maintaining professional allegiance to one another and covering up for each other's mistakes.

Whilst he quite often prescribes antibiotics in the consultations, he does allude to his reluctance to do so in some consultations. Bernie is a minicab driver who is suffering serious problems with urinary urgency and frequency, associated with his prostate problems. He has just finished a 6-week course of antibiotics recommended by the hospital, which cleared up his symptoms. Three weeks later they have returned and Bernie is desperate to go back on antibiotics. Dr Deakin talks to him about the importance of working out what is the underlying cause of the infection through conducting tests. Bernie, while seeing his point of view responds "Yeah, but I know that, see, I need to go to work and so I naturally prefer the antibiotics. Because we've had this [testing] before and they can't find nothing in it." Dr Deakin recognises the patient's wishes and tells him "I can still prescribe you antibiotics and you can start taking them from tonight or tomorrow morning." Bernie expresses deep gratitude to the doctor: "Thanks very much. You're a diamond. Thanks a lot."

So although Dr Deakin has made it clear that he does not think antibiotics are a good strategy here, he agrees to prescribe antibiotics at Bernie's insistence. However, he also tries to get him to take a herbal treatment. He negotiates the choice with Bernie, letting him know it is up to him to make the final decision:

Dr: Here's some more antibiotics. If you want, I can also add something to this prescription, [Bernie: Uh huh] which I think, in my opinion, has the potential benefit of delaying the further intake of antibiotics in the future, [Bernie: Uh huh] and it would be something like the homeopathic and herbal side of things, which, you know, many patients believe works better for them than taking the antibiotics all the time.

Bernie: We could try it, yeah.

Dr: But if you don't like that option, and just want to go for what has worked for you, I'm, I'm also easy about that.

Bernie: Well I say, I don't mind, I'll try anything really for like, you know...

Dr: Yeah? (writes on prescription)

As I mentioned in chapter 5 (in my discussion on difficulties of the consent process) at this point Bernie turns to me saying "So, you don't say much". He asks me for my opinion on what he should take. "So what do you suggest then?" I have to explain that I'm an anthropologist not a doctor. Bernie is seeking a second opinion here, suggesting that either he is unsure about Dr Deakin's advice or hoping for yet another suggested solution. I was unable to find out, as Bernie did not turn up for our arranged interview a week later.

With Jill who has cystitis, Dr Deakin reveals antibiotics to be his first line of treatment, but also voices the non-orthodox belief that they are bad for some people, those with weakened immune systems:

Dr: If antibiotics don't work, there is- in my opinion, often a very good chance if you try alternatives.

Jill: Yeah, okay.

Dr: Some people have a very strong constitution, often antibiotics do work and they can take really loads of them all the time,

Jill: Mm (nodding)

Dr: and they seem to at least help the immediate symptoms, but in the long run they don't make you healthier. ... And if people have a sort of slightly weakened immune system, then they should often look for alternatives. ... And and so there's a need perhaps to see either a nutritionist, or a

homeopath and herbalist to treat chronic cystitis. Some acupuncturists are good at treating that, but certainly herbalist or homeopath do quite well with this situation. They'll give you something in the long run to strengthen your bladder.

This is a more tempered response to antibiotics, than Jenny the homeopath makes. She always presents them as preferably avoided, except in matters of life and death such as meningitis.

Communication and shared-decision-making

It is difficult to make sense of what Dr Deakin's strategy on health is. He does not appear to be offering a consistent package of beliefs. Perhaps I spent insufficient time with him to determine his strategy. Or perhaps there is no overt strategy. Medicine is notable for being a fairly a-theoretical profession, and General Practice, in particular, is a notoriously eclectic sub-specialty.

The overall philosophy of healthcare offered by Dr Deakin seems to be characterised by mixed messages. Intransigent problems need to be treated over the longer term with alternatives, but if you want a short-term solution try this orthodox drug. When I tried to determine what in Dr Deakin's consultation behaviour was different to both mainstream general practice consultations and Jenny's homeopathic consultations, the main factor seemed to be this emphasis on choice. In turn this offering real choice to the patient could be seen to be linked to a radical shift in power. Dr Deakin is not offering a consistent philosophy of healthcare to patients, but a new way of being a patient. His positioning of the patients as in charge of decisions about their bodies and their health, is in marked contrast to the more pressurised evangelical line of both traditional GP, and lay homeopath who both espouse the "I know what is best for you" attitude.

In a previous study of GP consultations, we looked for evidence of shared decision-making between doctors and their patients (Stevenson, Barry et al. 2000). Shared decision-making was defined according to the model of Charles and colleagues (1997) as consisting of the following features:

1. Both the doctor and the patient are involved in the decision-making process.
2. Both parties share information.
3. Both parties take steps to build a consensus about the preferred treatment.
4. Agreement is reached on the treatment to implement.

Whilst the doctors in this study often claimed that this is what they were doing, we found no evidence for it in analysis of a sample of 35 consultations from 20 doctors.

According to Charles et al's (1997) definition, in the consultations I observed, Dr Deakin is operating on a shared decision-making model, unlike the majority of his colleagues in general practice. Perhaps this is part of what Dr Deakin defines as his holistic strategy. His offering of a choice of treatment strategies allows for the differences between his patients. He does not appear to be addressing the individual differences in a truly homeopathic way: looking for constitutional, personality and lifestyle factors. He does not appear to be finely differentiating between the myriad of different shades of symptoms, for example the many different types of pain, modalities in which symptoms get better and worse and so on. What he is doing, however, is treating patients as individuals, by letting them choose their approach to healthcare treatments.

As I did not conduct fieldwork with medical homeopaths in training it is difficult to know how the philosophy of medical homeopathy is transmitted in training. This would be a useful future study, and might illuminate how typical Dr Deakin's views are of his medical homeopath colleagues.

Dr Deakin explains his philosophy as one where he needs to understand the health beliefs of his patients and respond accordingly. In one of the consultations with Tim talking about a monitoring test for tumour markers he says:

Dr D: And nothing is one hundred per cent. There are various options and that's where sometimes a belief system, a religion, your personal outlook, and how you feel about life and disease matters quite a lot.

Tim: Yep yeh yeh, you mean as far as the patients concerned?

Dr D: That's right yeah. That's where reality comes into, the individual (*³⁵) in each case is different.

Joanna's consultation is another in which she is offered choice and they negotiate about the course of action, for her swollen eyelid. Dr Deakin starts off by offering the choice between treatment and a wait and see policy. She opts for treatment and hands the reins back to him to choose the treatment:

Dr: You could simply take some anti-histamines that will reduce the swelling or I could give you an ointment or we could just wait and see whether it will go down by itself.

Joanna: I would like to do something about it. If we can do something about it then I haven't got to take up your time again.

Dr: Yeah OK

Joanna: So whatever you suggest

Dr: The options are you can take a homeopathic medicine if you feel happy with that. That has the least side effects. If you take anti-histamines they work in a similar way but make you a bit drowsy if you have to drive a car or something, but that would be the more chemical option. Or I can give you herbs?

Joanna: I'd like a quick reaction as opposed to a (*inaudible - Dr. saying OK) I'd rather take the, I think it's called the easy way out isn't it?

In the interview afterwards Joanna told me:

Dr Deakin comes over as being a much more caring man, ... but the fact that he leans immediately towards homeopathy... would stop me from seeing him all the time. Because as much as I have a belief in the homeopathic medicine, if you're in pain and/or you're really worried about something that has an obvious root cause, I wouldn't have the confidence to go along that course. I think it would be according to what the complaint would be, how- not how serious, because some of the complaints that you would treat with homeopathic medicine are serious. Like, I have a leaning there must be something in this business with asthma... and eczema. I mention those two things because my granddaughter has them. But if you've got cancer, don't

³⁵ The symbol * within transcribed speech denotes inaudibility by transcriber.

kid yourself. So I think the two medicines should go along in tandem with one another.

Of her granddaughter's complaints Joanna says: "I think that anything is worth a try if it's not going to do her any harm. There's no way it can do her any harm, so let's try it." Her feelings about her husband's cancer are quite different "I would be too frightened... to..... lose confidence in the hospital."

Joanna claims to have used homeopathy at Dr Deakin's recommendation:

I have taken some homeopathy for a chest infection. I went to see Dr Deakin, and in my weak state he said, "Now what do you want, do you want me to give you antibiotics or would you try the homeopathic approach?" So I said, "Well you're the doctor, you tell me." So he said, "Well I think that we could attempt (Homeopathy) because what will happen if you take antibiotics, it will suppress it..... it is left there, but the approach of homeopathic medicine you've got- had this cough and you- it's been (reoccurring), it's been hanging around." He said, "Now the homeopathic approach is that we are treating the root cause as opposed to the immediate fact that you've got a temperature and you've got an infection. But why have you got the infection? I want to know what is the root cause, that this is why, you, you know, you, you've had this come back two or three times." So he said, "So will you try the homeopathic?" So I said, "Yes, all right. Yes, all right. I would." One disadvantage with homeopathic medicine, they give you horse pills. I came home and my husband said, "What happened?" you know, "What did he say?" So I told him, so he said, "So what are you doing?" So I said, "I'm taking the horse pills." Anyway I took the, (laughs) took the horse pills, with... not too much confidence, 'cause I felt rough. ... But I didn't have to go back to the doctor.

Actually it sounds as though it was a herbal remedy the doctor had given her, as homeopathic remedies do not come in horse pill form, rather as tiny sugar pillules or tiny tablets. However, Dr Deakin is quite likely to have talked about homeopathic and herbal remedies in the same breath as he has with Don Chang (whose case is discussed below). As a result some of his patients appear to have difficulty differentiating one from the other. Joanna thinks she has been given a homeopathic remedy, when in fact it is a herbal one. Joanna's understanding of homeopathy is that it is "natural remedies used by the Indians and made from substances like bark" so it sounds as though her understanding of homeopathy is more like herbalism.

Is Dr Deakin's policy of giving people choice related to the injunction he has received from the senior partner to "offer homeopathic treatment only to those that ask for it?" Or does it stem from a deeper philosophy? I did not observe Dr Deakin working in any other setting so it is hard to say.

What do his patients think of him?

What Dr Deakin's patients think of him seems to depend on where his patients are coming from. The more biomedical patients seem to like him. Those with more alternative views are less likely to sing his praises.

By coincidence, Helen, one of the students I studied in the homeopathy class, lives in Dr Deakin's catchment area. She visits Dr Deakin during the course, having sought out a homeopathic GP. She tells me she has a lot of trouble getting an appointment with him, as he is so popular. She has high hopes, as an impoverished single mother of getting the type of homeopathic treatment we are learning about on the course, via the NHS. She heads off to see him very excited about the possibilities of treating her emotional problems, caused by the recent break up of her marriage. Also the course has put the idea in her head that she may be able to cure a leg pain she has suffered with for 8 years. She is desolated after her visit. She tells me she did not get a chance to air any of her own problems and only discussed her daughter's rash. She reports with amazement and disappointment: "He was just like any other GP! He looked at me as if to say what are you doing here, wasting my time". She complains that he appeared to have no time for her and seemed rather grumpy. She vows never to go back to him. Later in the year she starts visiting a private homeopath.

On the other hand, Lesley, Tim the cancer patient's wife thinks Dr Deakin is fantastic, particularly in contrast to the hospital medicine they have encountered during this process of the cancer diagnosis. She says of the hospital visits: "It feels we are prisoners of the system, trapped, being rushed". By contrast she reports warmly on several occasions of Dr Deakin "I'm so pleased we found [him]. We were in anguish before we met him. The first one.. .. to say anything human, you know, humane. To offer a bit of hope. It was wonderful."

Tim is also very positive about Dr Deakin:

He's very good. A wonderful person. He has a good philosophy. Often people do not explain anything; they do not formulate an approach that is intelligent. He gives us hope and knowledge. Often [doctors] are very technical but a human being is not just in need of technical, there is also the wider thing. The philosophy behind it. He can express ideas and an approach which is more fully holistic.

However, Tim is not entirely sure of whether Dr Deakin is the right doctor to fill the role of holistic doctor. Is he holistic enough? Tim is very into, and knowledgeable about, alternative therapy. He has his doubts about exactly how much knowledge of alternative therapies for cancer Dr Deakin has. Tim is an unusually analytical informant, as an academic. He is also one of the most extreme of the patients I observed in his commitment to alternative medicine. He is extremely articulate about the differences between the two philosophies of orthodox and alternative healthcare.

Homeopaths are looking at the whole person. In hospital, they're working within a set of assumptions, very mechanistic. That's what scientific medicine is, it deals with symptoms.

He is also very clear that there is a difference between complementary and alternative medicine. He reports that when he told Dr Squires, the senior partner in the practice that he wanted to "go down the alternative route", he "rapped me on the knuckles and said, 'Not alternative, complementary'". Tim however is very clear to me about the difference "Complementary is added to the conventional treatment. The alternative, is instead of." Tim is totally committed to an alternative route of healthcare. At our second interview, a month after his diagnosis, he reports he is visiting a healer and a nutritionist. He is also using mistletoe injections from Dr Deakin and is about to go on the Bristol Cancer Help Centre's 5-day course. He is also deciding whether to start the Gerson or Plaskett alternative dietary regimes.

Tim and Lesley's assessment of Dr Deakin match my own responses during fieldwork. It was a lovely change to work with a doctor who unusually seemed to respect his patients as equals in the process and who offered them the space to say what they needed to say (Barry, Bradley et al. 2000). He also unusually, consulted them on the

choice of options. However, I felt uneasy with his combination of different types of medicine. There never seemed to be a consistent argument. I felt the consultations were going into many different directions, never really completing any one. This did not seem to bother the pragmatic patients. Regular biomedical general practice consultations have this disjointed, a-theoretical quality, jumping from symptom to symptom and offering multiple treatments and treatments, even to deal with side effects. However, the alternative patients were troubled.

How is Dr Deakin different to other alternative therapists I interviewed?

In addition to his consultation behaviour, Dr Deakin was different to the other 14 alternative therapists that I interviewed, in other ways. They exuded a centredness and an air of being happy with themselves and with their chosen work. They talked in terms of their own lives openly and reflexively, and of the events that had led them to become practitioners. They mentioned alternative concepts in the train of their talk, such as universal energy, the concepts of utopian community, and the interconnectedness of people with the environment. They were enthusiastic about their work and many were training in new areas of alternative expertise, extending their practice into other therapies. Nigel the cranial-osteopath/massage therapist was training to become a Reiki master. Jenny and Bryony the homeopaths were training to use Bush Flower Essences.

Another frequent part of their discourse was around personal development and looking after themselves, and using alternative therapies to keep themselves well. The therapists working at multi-disciplinary clinics and health centres talked about “trading sessions” with their fellow therapists. Jenny, the homeopath with whom I spent most time, and saw in most contexts, seemed very good at keeping boundaries and whilst she worked at several different clinics, and never showed signs of being stressed.

Dr Deakin was always late. Late for every surgery, late for individual patients, late for his interviews with me, late leaving the surgery. He always looked drawn and tired. At the ends of his surgeries (usually around 8pm) he looked exhausted and had taken almost no breaks, often not even stopping to eat lunch.

He did not talk about alternative concepts or about 'looking after himself'. He seemed tired and jaded and talked about giving it all up and moving to work in a private cancer clinic. He was critical of the limitations of working in general practice as a complementary therapist, where his approach was neither understood nor truly supported. Dr Deakin's feelings of stress, and potential burnout in primary care is not unusual, (Frost and King 2000; Mechanic 2001) nor is his voicing of thoughts of leaving the NHS (Huby, Gerry et al. 2002). Potentially, the additional pressures of attempting to integrate alternative medicine into a system into which it does not easily fit, may outweigh the increased job satisfaction of dealing with patients in a way congruent with one's more holistic model of healthcare

Being in his presence as a researcher was slightly stressful. He was always late and hurried and I felt guilty for adding to his time pressures with my research. I did not relax in his company and we never moved to the chatty friendliness I maintained with most of my other informants. He was very wary about sharing details of his personal life with me. In all this, he was like many other GPs whom I have interviewed, who are reluctant to move away from their professional persona to a more relaxed personal exchange.

In the consultations he was certainly warmer and a better listener than most of the 20 GP's from my previous research project. However, he was not as available to the patients as were the homeopaths that I observed and attended as a client. In those lay homeopathic consultations I felt that everything was focused on the client and that they were getting 100% of the attention of the therapist for those 30 minutes or hour. Dr Deakin gave good attention in spurts but there were often competing demands on his attention.

Phone interruptions were one competing demand. In several of the consultations he was interrupted by a telephone call from one of the receptionists and had to deal with issues concerning another patient. For example, several of these interruptions involved a query from the pharmacist about a prescription. In some consultations he was dealing with computer records or signing prescriptions that related to other patients whilst the current consultation was in train.

Then there were the competing demands for attention, of the average GP consultation. Firstly Dr Deakin had to deal with the competing demands of the technology. This meant checking or entering information on the computer and getting the printer to work; and, having to talk over the noisy printing of prescription forms. Greatbatch and colleagues (1995) have shown that desk-top computers have a deleterious and disruptive effect on communication in the consultation. Then there were a number of other factors that took Dr Deakin's attention away from the patient in the room. He had to look for misplaced drugs or equipment in a consulting room that others had used since his last visit a week ago. He sometimes phoned receptionists to check on local hospital procedures for tests; and he had to deal with doctor's daily dual task of examining patients while continuing the verbal exchange of the consultation. There were also the additional demands of offering different types of therapy, all of which appeared to need more explanation than orthodox drugs.

Presumably, as a result of this continual stretched attention in several consultations he did not respond to what seemed like important questions from his patients. In the consultation with Alice and her son Harry with earache, Alice raised her concerns about vaccinating Harry with MMR. Dr Deakin did not seem to engage with this conversation with full attention. He was busy at this point in the proceedings, consulting his homeopathic repertory to find the right remedy for Harry.

Dr D: So the earache is.....(turning pages of homeopathic repertory of symptoms). There weren't any vaccinations given recently were there?

Alice: No.

Dr D: No.

Alice: That's my other big dilemma at the moment

Dr D: Yeah.

Alice: is he's due to have this MMR.

Dr D: Yeah.

Alice: He's had his MMR, he's due to have his

Dr D: Okay.

Alice: MMR booster thing, which...

Dr D: Well delay it at the moment until, you know, (*).

Alice: I just don't want to do it, I don't know what to do, I don't really know...

Dr D: Okay.

Alice: I don't really feel like I have the right- any information to...

Dr D: Okay. I'll give you a choice here of-

Alice: the right information to do that, but... (clears throat)

Dr D: I'll give you a choice here. So simply I would use the *Belladonna* 30 perhaps or 200.

Dr Deakin went on to give further information about the treatment options that he was prescribing: orthodox, homeopathic and herbal. He did not return to the subject of her worries about the MMR, in this consultation at least.

The lay homeopaths Jenny and Bryony rarely looked through the repertory while the patient was in the room. They often sent the patient out at the end to give them a chance to consult the books, discuss and decide on treatment and then called them back to dispense the remedies. There were no interruptions and no computer records. Thus there was less feeling of competing demands, than in Dr Deakin's consultations. More often than not, the other lay homeopaths I studied did not prescribe during the consultation either. They made a decision about treatment in the days following the consultation and mailed the remedy to the client. This was the case for all three of the homeopaths I consulted.

There appears to be sufficient evidence that Dr Deakin is not operating, at the Golden Hill surgery in a similar way to the non-medical homeopaths in the study. In large part this is no doubt influenced by contextual factors and the constraints of operating alternative therapies from within a predominantly biomedical system.

Constraining factors of the medical system

A number of factors appeared to be constraining Dr Deakin against any fuller adherence to an alternative philosophy or practice of healthcare. In chapter 4, I outlined Adams work. This suggests that there are very competing demands between alternative practice and general practice (See, e.g. (Adams and Tovey 2000; Adams 2001) and Shuval et al (2002) found similar constraints in hospitals.)

The lack of holistic thinking among other doctors in the Golden Hill surgery was one such factor. I had expected the senior partner, Dr Squires to be very sympathetic to the holistic approach, as he did employ Dr Deakin as a holistic GP. However, I discovered he not been at all instrumental in the decision to have a holistic doctor in the practice. He had employed Dr Deakin four years ago at the request of the health authority, to take over the patients of a local homeopathic doctor who had died. His view was that Dr Deakin was “Just an extra pair of hands”, except for in the case of the patients who were explicitly seeking homeopathic remedies. At one point in our interview he said quite sharply “He’s only allowed to provide homeopathy for patients who ask for it - Dr Castle's ex-patients”. This may in part make sense of Dr Deakin’s strategy of getting patients active involvement in making the decisions on which type of treatment to use orthodox or alternative.

I asked Dr Squires what effect having alternative medicine in the practice had had on him and his patients. He deviated off into a long detour about computers and efficiency and never came back to the topic. It became apparent in later fieldwork that he did not have any concept of what Dr Deakin was trying to do with his patients. As Dr Deakin hinted above, he was not interested in working in tandem or hearing about successes from holistic treatment.

On the days when I was due to observe, Dr Deakin tried to arrange longer consultations: 15 minutes in place of the usual 10. His argument was that the procedure for gaining informed consent forms and the tape-recording would make the consultations longer than usual. However, he also said to me in an aside “of course it is impossible to do holistic consultations in the time allowed”. My feeling was that he was using this tactic

to get through to Dr Squires that longer consultations were required for his type of medicine, not just for the duration of the research.

Dr Squires reluctantly agreed to the longer consultations when I discussed it with the two of them. However, when I came to arrange the booking of appointments with the receptionists they refused to do it. They said that Dr Squires was not in agreement with longer consultations.” You’ll just have to see him operating as normal- warts and all” was the message that came through to me. He had interpreted it that Dr Deakin had only asked for longer consultations to do better consultations for the sake of the research. It didn’t seem to strike him that Dr Deakin might be making a wider plea for his everyday practice. More likely, he was unwilling to countenance the possibility of Dr Deakin being able to see fewer patients, (as his extra pair of hands) thus landing him with an increased workload.

The split between the different modus operandi of the senior partner and Dr Deakin is reflected in a split in the receptionists. The mainstream receptionists are generally similar to many general practice receptionists. Perhaps not quite as bad as a previous receptionist whom even Dr Squires labelled “a bit of a dragon”. All the same, they were fairly hierarchical with patients and not terribly friendly. My own reception from Lena was not in any way a warm welcome, and she refused to answer any of my questions.

Flo, the part time receptionist who works on Dr Deakin’s day, is quite different in character. She is training in acupuncture and working at the surgery to pay her way through college. She is very warm and friendly towards the patients and very admiring of Dr Deakin’s holistic approach to healthcare. It might be putting it a bit strong to say she idolised him but she was extremely positive about his work. She was also incredibly helpful to me. She saw my research as important, unlike the rest of the staff who treated me and my research as an inconvenient nuisance.

A number of additional factors in the set up at Golden Hill Surgery are not conducive to Dr Deakin providing holistic care to patients. Firstly he is only there one day a week. This impacts on his patients. Apart from the obvious difficulty of wanting him as their principal doctor if he is unavailable 4 days out of five. One example relates to the case of Tim.

Dr Squires saw Tim shortly after his recent cancer diagnosis from the hospital. In this consultation Tim voiced his desire to manage it through alternative therapies. Dr Squires refers him to Jim Deakin. Tim and his wife Lesley have recently attended a Bristol Cancer Help Centre weekend, and had taken up their recommendation to find a holistic doctor to support them. When Tim puts this to Dr Deakin, he replies that this might be difficult on one day a week. Three weeks later there have been real problems in getting hold of the diagnostic test results from the hospital, and Tim is still not entirely sure of his cancer diagnosis. He has been in to ask one of the other doctors at Golden Hill, Dr Simons, to chase the results. Dr Deakin explains that Tim's GP should be providing the pivotal role of communications between the hospital and the patient. However, Dr Squires has 'washed his hands' of Tim by passing him into Dr Deakin's care and Dr Deakin is not there regularly enough. Tim is therefore falling between two stools. He is suffering from the resultant lack of someone on the premises throughout the week to champion his cause.

Dr D: In principle it should be the position or the job of the general practitioner who holds - who is the administrator of all the information, so everything comes back to him. They would basically find ten or fifteen minutes to sit down with you and show you those reports and outline a plan of what the next step is. Explore what your beliefs, your fears, your expectations and the decision on who to see, who to get investigations from and these further arrangements.

Tim: I assume that you're not in a position to do that because you're only there part-time.

Dr D: That's right yeah. And Dr Squires, once he feels someone is into complementary medicine he backs off slightly it's not kind of, his department.

Dr Deakin's patients are not homogeneous, like in any practice. Some are loyal to him and some are happy to see whatever doctor is on duty. Some come to him specifically because he is homeopathically trained and some, especially patients new to the practice, are not aware when they see him that he is different to any of the other doctors. I would imagine there might also be patients of the practice who would prefer the more orthodox approach offered by Dr Squires and would take steps to avoid the days when Dr Deakin

is in³⁶. Of those who are loyal to him and make efforts to come to his surgery there are two groups. Firstly there are those who are fairly orthodox in their health beliefs but are open to using alternative remedies alongside orthodox drugs, like Joanna. Then there is a group of patients, all mothers (of the consultations I saw), who are more knowledgeable about homeopathy and have a different relationship with Dr Deakin. I will say more about this group below.

Where patients are particularly keen to see Dr Deakin and not the other doctors, this requires them trying where possible to work round the restrictions that his one-day a week imposes. If they can they 'save' their appointments up until Fridays. When I mentioned to Jane that Dr Deakin might not be there next Friday (he had asked her to return to check the progress of her daughter's pneumonia) she was quick to say "Oh well there's no point in going then because I don't want antibiotics." Dr Deakin is very popular and his surgeries are very full on a Friday. This popularity combined with the problem that the 10-minute allowance is insufficient for the way in which Dr Deakin works, results in him invariably running very late. On the days that I observed, Dr Squires was always finished by 6 o'clock and Dr Deakin was often still working at around 8, having taken no breaks. He sometimes did not even eat lunch and survived all day on one mug of tea. His patients were all used to waiting to see him, sometimes hours after their appointment. Tim reports a visit where there was not even anywhere to sit in the [small] waiting area as there were so many patients there, waiting to see Dr Deakin. This produced irritation in some patients. Paul the headmaster, with the swollen eyelid, was getting quite annoyed in the waiting room when he was kept waiting for over an hour on his way to work:

It is not always possible for patients, in the case of acute situations, to wait for a Friday. Ollie, Clara's 9 year old (discussed in chapter 6) cut his hand badly, his armpit swelled up and had not gone down after 2 weeks. Clara was too worried to leave it to Friday. She saw Dr Squires for a diagnosis on the Tuesday and then went to see Dr Deakin on the Friday "Because I like to get the homeopathic view." This was not the only case of patients seeing the two doctors for the same problem.

³⁶ As my research with patients was only conducted on the days when Jim was conducting surgery I

A second problem within the Golden Hill practice that mitigates against the provision of holistic care is the tensions produced by Dr Squires not having the same aims as Dr Deakin. Also Dr Deakin has little power and very little say in the running of the practice (as a paid employee rather than a partner in the practice). So when Jane comes in to see Dr Deakin, she is furious to discover that her daughters have been taken off the practice list, because they have not been vaccinated. Dr Deakin is not even aware that this has happened and does not appear to have the power to change the situation. This is a slightly ironic situation as it was Jane who was responsible for Dr Deakin coming to work there 4 years ago. She was one of the patients of the homeopathic doctor over the road that died. It was she who had instigated a campaign to find another homeopathic doctor. This involved a petition and coverage in the local newspapers which Dr Deakin saw and contacted the health authority to offer his services.

A further constraining factor is that by only being there intermittently, the local pharmacy, whilst very sympathetic to alternative products and homeopathy, tends not to have the products in stock that Dr Deakin prescribes. Alice explains that the pharmacy were not able to get hold of the Chinese herbal remedy Dr Deakin prescribed on the Friday for her son's ear infection, until the following Tuesday. She would definitely have given Harry the herbs but as she said it's no good if you have to wait 3-4 days.

Effects on patients: i. Confusion among pragmatic users

The net effect of Dr Deakin's consultation behaviour, no doubt impacted upon by these structural constraints, is that for patients with little knowledge of alternative therapies, the pragmatic users, there is often confusion around the treatment strategies prescribed and or recommended. Joanna's confusion between homeopathy and herbal treatment has already been mentioned.

Don Chang is another such patient. His consultation is quite lengthy at 14 minutes (compared to the British average of 9 minutes (Deveugele, Derese et al. 2002)) He is here to get a repeat prescription for blood pressure tablets. He also has a swollen ankle

would have missed this group.

that he wonders might be a return of gout, and some catarrhal problems in his throat. He tells Dr Deakin that he treated this latter problem successfully with herbs when he lived in China 50 years ago. Dr Deakin asks him "Which would you prefer herbal or homeopathic treatment?" Dr Deakin's question implies that Don has sufficient knowledge of the two medicines to be able to make an informed choice. In fact most patients' knowledge of both is very sketchy and often homeopathy is just perceived as another branch of herbal medicine. Furnham has shown how the general population know little about homeopathy, and commonly confuse homeopathy and herbal medicine (Furnham 1999). Don's reply to Dr Deakin's offer, reveals just such a kind of confounding of homeopathy and herbal ideas: "I'd like homeopathic a kind of brew, almost like a tea. Seemed to clear it last time." As I observe the consultation I find myself thinking, "that does not sound like a homeopathic remedy to me." However, Dr Deakin makes no corrective comment, and pursues a homeopathic diagnosis. He also offers Don a herbal product compounding the confusion.

Dr Deakin questions him about his symptoms to find a suitable homeopathic remedy, asking questions like "What does the phlegm taste like?". He asks a lot of leading questions "Salty, bitter, sweet?" "Any sweating at night?" He does not ask any questions about Don's emotional state. There is no chance for Don to talk about himself and how he is feeling in his own words, as is so characteristic of the private homeopathic consultations. For example, the fact that Don has recently separated from his wife and is living on his own for the first time in 30 years, does not surface in the consultation (I learned this when I visited Don at home).

Dr Deakin says to him:

I'll give you something liquid, as you want to boil it up in a magic cauldron and I'll give you some homeopathic pills for when you travel. One twice a day. If it doesn't work come back. Or if you are travelling I can give you a second choice remedy, a Chinese formula if you want to try that as well or instead. OK it's all on this prescription I recommend you try the homeopathic one first, one twice a day, don't take together with other medicines. After a few days reassess and if no change switch to something else or come and see me again.

When I go to interview Don at home he gets the pills out of a bag. He tells me there was a mix up and he was given someone else's prescription. "It's not the first time. They are not very organised there" he told me. "Dr Deakin is very nice but he's under a lot of pressure and he's not very organised. I was waiting for my appointment for over an hour".

He shows me the pills he finally retrieved from the pharmacy. Blood pressure tablets, arnica cream and a small brown bottle with small homeopathic pillules inside marked "*Kali Bich* 6c. Take one a day. Mr Don Chang". There is no sign of a liquid preparation or of a Chinese herbal product, both of which were promised during the consultation. I did not have access to the written prescription, but tried (next time I was in the surgery) to check exactly what Don had been prescribed on the computer record. However Flo, the receptionist, explained to me that many of Dr Deakin's herbal and homeopathic prescriptions were not encoded on the computer. They had to be added to printed prescriptions by hand and therefore did not appear on the patient record. This of course would have implications too for the patients who consulted with different doctors in the practice. The other doctors, such as Dr Squires would only be aware of the orthodox prescriptions that appeared on the screen. This would help to explain Dr Squire's lack of understanding of Dr Deakin's approach with his patients that Dr Deakin alluded to with frustration earlier. So, without being able to check the prescription, I could not check where the problem had occurred. Had Dr Deakin failed to write these products on the prescription? Or did problem occur at the pharmacy? I assume Dr Deakin was not aware of these sorts of problems and would assume his patients had got and taken the preparations he prescribed.

When Don shows me the pills during our interview, I ask him "What are these?" indicating the homeopathic remedy, *Kali Bich*. He says "I haven't got a clue what they are, or what they are for. I'm not even sure they are for me". In our discussion it becomes clear that Don does not know what homeopathy is and has it confused with herbal medicine. As he had alluded to in the consultation, he was expecting something that looked like dried flowers to brew as a tea, denoting a herbal remedy, not that he is aware of this. Don tells me he made another appointment to go back and find out what the pills were, but Dr Deakin was called away at the second consultation. Don waited there about an hour and "There was no sign of anything happening. I asked the

receptionist and he had been called out so I didn't bother to wait. But that's the NHS I suppose." Don gives up trying to find out what the pills are and ends up not taking them at all. Don had requested homeopathy without knowing the slightest thing about it, and the confusions lead to non-adherence to the medicines.

A similar case of confusion occurs in Cally's consultation. Cally is the 24-year-old girl mentioned above, with hayfever. Dr Deakin offers her several different strategies for both simple symptom relief and longer-term desensitisation. After the discussion of options, Dr Deakin actually prescribes two herbal preparations. Cally is new to the practice, she did not know Dr Deakin was alternative, and just wanted an orthodox prescription. When I interview her 4 days later she has started but given up on the herbal preparations because they did not work immediately. She judged them to have failed even though in the consultation Dr Deakin had talked about building up her immune system. She seems to think this could be achieved in a moment. She is operating on a biomedical model of illness where symptoms can be zapped by biomedical magic bullets in a quick fix. Nothing in her worldview allows for the kind of patience in treating long term chronic problems, such as that built up by the committed homeopathy users.

This version of homeopathy and herbalism in the NHS was not a relaxed and fun experience but the usual rushed stressful visit to the doctor. The patients were not empowered by knowledge. They were utterly confused about what was going on. They had not bought into a holistic model of health. They were judging the remedies as though they were quick fix allopathic remedies that work on particular symptoms. They either work or not. There was no conception of the longer time scales of health. A private homeopathic patient I interviewed said that, "over the last few years" her homeopath has really improved my hay fever. So the expected timescales of treatment are very different.

Effects on patients: ii. Opening the door to alternative approaches

Cally does not persevere with the herbal drugs. She is however, interested enough in Dr Deakin's approach to ask him if he could help her partner. She encourages her partner to make an appointment with him about his allergy-related problems. Something Dr Deakin said (combined with her own predispositions) had resulted in a willingness to engage with alternative approaches. This may make her more amenable to trying alternatives in the future.

There are several other young patients who are seeing Dr Deakin for the first time and are unaware of his alternative approach. One young man with insulin dependent diabetes ignores Dr Deakin's attempts to make the consultation more holistic and sticks to a biomedical agenda in a curt communication style, merely requesting repeat prescriptions. However, there are indications for two young women that he is opening their eyes to new possibilities of alternative approaches to their problems.

Jill, a 25-year-old teacher comes to see Dr Deakin on a Friday afternoon after work. She is suffering from a bad case of cystitis that she has had for over ten days. A previous prescription for antibiotics from Dr Squires has had no impact. "I spent the last week with high fevers, shivers, and very sore kidneys." She tells Dr Deakin the reason she thinks she caught the cystitis was because she had a bladder function test done at the local Hospital. Dr Deakin agrees that this was no doubt the root of the problem and is quite critical of the test having been arranged by his colleagues:

I totally agree, because often what happens - I mean they try to do it under totally sterile conditions. But there could still be some infection. Often after cystitis and bladder investigation, it leaves the patient with a weakness in these organs, and such infections reoccur quite a lot. That's why sometimes unless invasive procedures are absolutely necessary..... if they are just for sort of simple diagnostic reasons, or sometimes they are just carried out because one doesn't know what else to do....

Dr Deakin arranges to have her urine tested with a culture sensitivity test but goes on to say "It doesn't mean, you know, that's the only way of treating you, or getting you better." Jill replies "It's just the best way, isn't it." Dr Deakin tells her "Well it's the sort

of scientific way, let's put it that way." He asks, "Are you taking any sort of sodium bicarbonate, cranberry juice, all these sort of things that probably help? Drink a lot of fluid, were you told that?" He then he goes on to make a long speech introducing Jill to the idea of using alternative therapies:

Dr D: If antibiotics don't work, in my opinion, this is often a very good chance to try alternatives. Some people have a very strong constitution, often antibiotics do work and they can take really loads of them all the time, and they seem to at least help the immediate symptoms, but in the long run they don't make you healthier. And if people have a sort of slightly weakened immune system, then they should often look for alternatives. Anti-infectious products that doesn't make them weaker and, if anything, should make them stronger. So that would be the option for you, but not many GPs advise you on that, as you're probably aware. And so there's a need perhaps to see either a nutritionist, plus a homeopath and herbalist to treat chronic cystitis. Some acupuncturists are good at treating that, but certainly herbalist or homeopath would really, you know, do quite well with this situation. They'll give you something in the long run to strengthen your bladder, your mucous membranes in the body, to not be susceptible. Even if you have cystitis and a bladder infection, then a bladder investigation, you should still not get an infection of this type. That's something maybe to learn from this and to look into.

Jill: Yeah. Yes, get advice (nodding).

After the consultation I asked Jill if I asked if she would consider using alternatives and she said enthusiastically "definitely after this". Jill may make a good candidate for becoming a committed alternative medicine user in the future. Her iatrogenic illness experiences (Illich 1976) with orthodox medical tests have caused her to be infected. Combined with this is the failure of the antibiotics. These two events have made her a bit sceptical of the power of orthodox medicine. In this, she shares something with many of the committed homeopathy users I interviewed. Biomedicine has failed her.

With Jill and Marilyn in a similar consultation, Dr Deakin does not make attempts to prescribe alternatives himself. This might entail the risk that his strategies may not be understood with so little time to educate her into the alternative views of health, illness and healing. Instead he recommends visiting a non-medical therapist. If these young women take up his suggestion their use of alternatives may have more chance of success and less confusion. Non-medical alternative therapists should have more time to educate patients about their therapies, the ways in which they can be expected to work, and the

need for more patience for a longer term solution. This should increase the likelihood of better adherence to the regimes.

In this sense Dr Deakin may be acting as a facilitator for people who have not considered alternative solutions to their problems. In conversation with me Dr Deakin showed a good awareness of the social problems of his more disadvantaged patients. He may have made a conscious decision to recommend consulting a private alternative therapist, to those with sufficient income, such as Jill on a teacher's salary. However, neither Don nor Cally was financially disadvantaged. They were both in work, and Dr Deakin attempted to treat them himself. Thus it appears he does not have a coherent strategy with respect to administering alternative treatment himself, versus recommending outside help. Were I too have conducted a longer period of participant observation with him some of these issues would have become clearer to me.

Effects on patients: iii. Responses of committed homeopathy users

A third group of patients was the committed homeopathy users I presented in chapters 6 and 7 who consulted with Dr Deakin, Clara, Jane and Alice. In some respects these consultations were different in feel. These patients were more assertive about their uses of homeopathy and their needs from the doctor. Their consultations were less hierarchical and patriarchal than many general practice consultations. Still however the doctor seemed to hold a lot more power than the homeopaths in the equivalent private consultations.

Alice and Jane were similar to the mothers at the vaccination group who have come to use homeopathy for children's ailments and then come to question the vaccination strategy. Clara was more like the women in the homeopathy class. She has done an adult education class in homeopathy and like many of those in the class I studied came to homeopathy through her alternative and spiritual beliefs. She is a Buddhist, coincidentally from the same Buddhist group as Jean from the homeopathy class.

Alice, Jane and Clara's consultations differed from the other consultations I observed, although all three did use Dr Deakin rather differently. In their consultations the talk

was mainly of homeopathic remedies, although biomedical drugs were also offered, for example antibiotics.

In both of the consultations I observe with Clara, a week apart, consulting with each of her two sons in turn, she actively requests homeopathic remedies from Dr Deakin. Consulting with 7 year old Jack she asks: “Athlete’s foot. He’s had it about a week and he had some (*)mycin I just wondered if there is anything homeopathic he can have for it?” And a week later consulting with 10 year old Ollie, 3 days after consulting with Dr Squires, Dr Deakin asks why she is here, wondering of Dr Squires asked her to attend. She tells him “Cause I like to get a homeopathic alternative view as well”.

Jane and Alice do not directly ask for alternative treatment. Although they do both explain to Dr Deakin at the start of the consultation that they have treated their children’s ailments homeopathically before attending the surgery. Jane explains she has “been giving her those Weleda cough drops, and before that I gave her *Ferrum Phos*”. He asks Alice whether she has given Harry anything she initially says no then tells him “Well I’ve given him *Belladonna* and *Pulsatilla*, (laughs) homeopathic stuff”. As though she perceives the homeopathic stuff will not count in his book or that she is slightly embarrassed about using non-orthodox drugs.

For both Jane and Alice’s children Dr Deakin prescribes homeopathic remedies. He does also additionally suggest antibiotics to both mothers. Jane as we saw above was very instrumental in getting Dr Deakin appointed. Jane is another wealthy middle class mother in her 30s with confidence, a job in PR and a husband in the city. Her involvement with homeopathy goes back to her great grandfather who was a user. As a consequence her mother is very keen on homeopathy. She got her into it, in her 20s when she was suffering from ME like symptoms. She has had natural births using homeopathy. For Connie’s chest infection (that turned out subsequently to be pneumonia) Dr Deakin mentioned antibiotics as an option in passing, but both seemed agreed on a strategy of tackling it without them:

Dr D: Right. I’d like her to take some Muling lung complex rather than giving her antibiotics. You get it-

Jane: Yes please, I don’t want antibiotics.

Jane told me beaming with pleasure at our interview a week later how they had treated Connie's pneumonia without antibiotics:

He said, "No, you should do the herbs first, because quite often the herbs are more powerful in a acute condition. And then they clear the ground for homeopathy afterwards". So in fact we've done it that way round, so it's been brilliant, so we've treated the pneumonia... using homeopathy and Chinese herbs.

Deconstructing one consultation: Alice and her son Harry

Alice was the first of the three case studies of committed homeopathy users I detailed in chapter 7. Dr Deakin also offers antibiotics for Harry's earache in this consultation which is an interesting one to dissect in more detail. As I explained in chapter 7, Alice says she now only consults doctors for diagnoses.

At the consultation, Dr Deakin prescribes antibiotics, as it is a Friday, in case it flares up over the weekend, in addition to recommending a herbal treatment. Alice is keen to try this in addition to her homeopathic strategy but the remedy is not available in the pharmacy for another 3 days, by which time it is too late. Dr Deakin also recommended a homeopathic remedy, *Bryonia*. In our interview later, Alice does not remember *Bryonia* having been mentioned, it was not written on the prescription. In any case, Alice ignores his prescription and goes straight from the surgery to her private homeopath who prescribes *Belladonna* and another remedy. And as was reported in chapter 7: "by the evening, he was running around as right as rain....therefore avoiding a five or seven day course of antibiotics".

Alice sees Dr Deakin rather dispassionately as a resource to be used. Doctors do not feature very strongly in her worldview after the unfortunate encounter with her previous GP. She reports of Dr Deakin "I don't warm to him as a person" but surmises that she is not looking for this sort of relationship with him. "I've already got this homeopath lady... She's known us for a number of years now, all of our characters, all our

background, I think that counts for a lot on homeopathic treatment. I feel she's got us all summed up."

There is a different balance of power in this consultation (as with those with Jane and Clara). With all three women Dr Deakin asks them whether they have already given their children homeopathic remedies and if so which ones. When he then thinks of a remedy to prescribe, he asks if they have it at home. In these sections of talk in the consultation there is slightly more of a feeling of a meeting between experts than is usual in general practice consultations (Tuckett, Bolton et al. 1985).

So how is this relationship of 'expert' homeopathy user and 'expert' homeopathy doctor played out in this consultation? At some points of the consultation Alice and Dr Deakin appear to be talking the same language: the language of homeopathy. He asks her what she has given him and she tells him *Belladonna* and *Pulsatilla* this morning. He replies that if this was only given this morning this may be an aggravation of symptoms Harry is currently experiencing.

However, the next exchange in the consultation feels like the language of general practice. Dr Deakin offers paracetamol to bring the swelling down and thus reduce the pain and the fever. He also says he will prescribe antibiotics as it is a Friday afternoon and Harry may get worse over the weekend. These are strategies a homeopath would balk at, as we saw in chapters 6 and 8.

The anti-antibiotic stance is not only part of the homeopathic view. It has come to be quite a widespread belief of many mothers. However, I had not heard the anti-Calpol argument until I entered these homeopathic dialogues. In previous general practice research I realised that most mothers saw Calpol as 'mother's little helper'. A helpful remedy in the eyes of both mothers and GPs. GPs often prescribed it for those on a low income.

The mothers who become involved in homeopathy have internalised this homeopathic view of Calpol, not as mother's helper, but as a hindrance to the natural healing process. Jane admits to me rather guiltily she gave Connie Calpol and then immediately reverted to her homeopathic views and stopped after one dose.

So going back to the next section of the consultation with Harry and Alice. We see that Dr Deakin's recommendation of the orthodox strategy of Calpol to bring down the temperature is linked by him to a homeopathic rationale. He says to Alice "maybe that gives us a bit more patience in waiting for the homeopathic remedies to work". But he then says that if they are not seen to be working by this evening she should start the antibiotics.

However, he then voices an un-orthodox strategy on the use of antibiotics. We are all familiar with the repeated advice of doctors to 'finish the course'. The scientific rationale is that a partial course is dangerous as bacteria may re-surge if they are not properly eliminated. Dr Deakin tells Alice "I'm not saying he should have them for seven days, just one or two days to reduce the swelling and then we could deal with the effect afterwards". He then goes straight into a discussion of suitable homeopathic remedies. It seems that his strategy of dealing with the effects, after a short burst of antibiotics, would be a homeopathic one.

Alice is very firm with Dr Deakin that she does not want antibiotics for Harry's ear infection. He rather pressurises her to take a prescription, against her will as it is a Friday and it might flare up over the weekend

Dr D: Okay. And you had some Amoxycillin prescribed some time ago, in February, probably you didn't use it then.

Alice: I didn't.

Dr D: Do you have some left? You threw it out?

Alice: Yes.

Dr: Yeah, okay. ... You'd rather..... I mean I'm convinced these herbs work, and the homeopathy, but-

Alice: Well I'm fi- I'm, I'm happy without the antibiotics, cos I, I have to get to a really bad... stage to get the a- get them on antibiotics. (laughs) So ...

Dr D: Sure, but a weekend coming up, I mean would it be hunting across town on a s- on a Sunday to get some? ... You will take- you will take the, the chance,

Alice: Yeah, I think we'll be all right.

In the event, in spite of her assertive response, Dr Deakin does write antibiotics on the prescription he gives her for homeopathic remedies. Alice's behaviour in this consultation is unusual compared to most general practice consultations. Patients are very unlikely to voice their desires *not* to have a prescription (Barry, Bradley et al. 2000). Dr Deakin is revealing his own shifting commitments to homeopathic and orthodox treatment strategies. Unlike his non-medical homeopath counterparts, he has none of their certainty about avoiding antibiotics. As Harry is "right as rain" by the end of the day it would appear that the problem was not serious enough to warrant antibiotics.

The consultation now moves again into a more recognisably homeopathic discourse. Dr Deakin suggests that the symptom pattern of the ear may change and there may be discharge later on "which would require a different homeopathic remedy". In this he is sharing the homeopathic views voiced by those in the education class, that discharges are seen as a good healing response of the body - another way of eliminating toxins. "Better out than in" was the lay description of this principle by Angie at one of the homeopathy classes. He goes on to question Alice's dosage for the homeopathic remedies. Rightly (in my understanding of homeopathic principles) he confirms her doubts that that she has administered too high a dose (10 M) and recommends in place, a lower dose of 30 or 200.

Dr Deakin then goes into his ideas (detailed above) about selecting between *Belladonna* and *Bryonia* as suitable remedies. At this point it sounds again as though they are speaking the same language. However, Alice then tells him she has phoned her homeopath this morning and got advice over the phone. From the homeopathy users and homeopaths I have interviewed it is standard practice to consult for acute situations over the phone. This procedure is made possible by the nature of the therapy as one that relies so heavily on verbal reports of symptoms and behaviour, as was outlined in chapter 3. Mothers report that they have often dealt with serious acute infections in their children through a combination of looking up remedies in reference books, and consulting their homeopaths on the phone. The general pattern for consulting a

homeopath is to attend about every six weeks and deal with acute problems over the phone in the interim. One of the homeopaths I consulted cited this as one of her reasons for taking a 6-month break from homeopathy. She felt burned out by always being bothered at home, all hours of the night and day by anxious mothers on the phone. Alice herself says of her use of her homeopath: "I can even phone up, you know, I don't even always go now. I phone her up and say, "Oh, you know, Harry's got this," and she'll tell me over the phone".

Dr Deakin does not seem to understand this pattern of consulting. He gets quite angry in the consultation at the idea that a homeopath could not fit in an emergency appointment for a sick child. He is operating on a general practice pattern of consulting, in which emergency appointments are standard and in which consultation is conducted face-to-face and not over the phone (in most cases). Astonished, he asks: "Why can't she offer an appointment for an acute problem?" Alice, untroubled by the concept of phone consulting, reports that she had been given advice over the phone to give Harry *Belladonna*, as though to say that was all that was needed. Dr Deakin passes judgement irritably "I don't like that very much. If it's an acute problem then one shouldn't advise over the phone. An appointment should be made to be seen as soon as possible". Later in the consultation he asks who the homeopath is, and reiterates his concern at her methods. "Why can't she fit you in?" he asks Alice, unable to comprehend such bizarre behaviour. She is totally stumped for words to reply, stammering and stuttering. Eventually she replies "Well er well er.....I mean she was- I do see her quite a lot." Perhaps her awkwardness is reluctance to actually admit to Dr Deakin that she is off to see the homeopath straight after seeing him.

The outcome of the consultation is he prescribes the homeopathic remedy *Belladonna* at a lower dosage, antibiotics and a herbal preparation that he describes as "somewhere in between the homeopathy and the antibiotics".

In place of a classical homeopathic process of selecting a remedy Dr Deakin appears to rely mostly on the physical examination and a biomedical diagnosis of Harry's problem. His insistence on the necessity for the homeopath to consult in person and not on the phone, implicitly backs up his view that diagnosis of this type of problem needs to be done visually. In this case, through examining the ears and looking into the throat. For Dr Deakin the key symptom appears to be the swelling - a visible sign, not the fact it

came on suddenly - a verbal report. This neatly demonstrates Sharma's observation that homeopathy has a more 4-dimensional and temporal nature compared to the spatially located relations of biomedicine (Sharma 1995).

I have deconstructed this consultation in detail as it demonstrates a number of features of Dr Deakin's practice that are mirrored in his other consultations.

Firstly, he operates a policy of integrated medicine in that he uses both orthodox and homeopathic remedies in tandem, often with a herbal preparation thrown in for good measure. He sees no problem with the use of both types of medical system together. His remarks actually suggest he sees them as complementary. In Harry's case the paracetamol will reduce the swelling and fever and the antibiotics will reduce the pain. This will then allow the homeopathic remedies to take over. In the case of Connie with her pneumonia he actually advises against antibiotics and suggests using the herbal preparation to pave the way for the homeopathic remedies. These treatments appear to be treated as having equal standing in his armoury with which to fight disease. He does not see the two systems of medicine as incompatible, as do the lay homeopaths. They suggest that taking the two types of medicine together will counteract the effects of the homeopathy.

Secondly, whilst he is using both types of medicine, he seems to be relying more on the practices of general practice than of homeopathy. He believes in the importance of visually inspecting for signs, and the importance of consulting in person. He talks about remedies that are good for a particular medical diagnosis (he tells Clara that *Graphites* and *Antimonium Tart* are good remedies for athlete's foot. He does not talk in terms of the constitutional properties of remedies and the total detailed symptom picture (incorporating physical emotional and social symptoms) that is required to prescribe in this way. He does not prescribe at a constitutional dosage, giving lower doses suited to a more physical level of diagnosis of the problem.

Thirdly, his approach makes most sense to the patients who are ignorant of the discourse of homeopathy. Patients like Joanna feel they can choose the remedy most suited to their particular problem. In her case a swollen eye demands a quick orthodox solution of antihistamine although she accepts that homeopathy might be appropriate for certain

problems. Although it is notable that her husband has cancer and they have not sought any alternative remedies or approaches for this.

It seems from this that there are two opposing views of homeopathy. The lay homeopaths see homeopathy as a self-contained comprehensive system of health-care, that involves disengagement from orthodox methods to fully work. Again and again clients are encouraged to come off antibiotics, HRT, steroid inhalers, blood pressure prophylaxis and to rely totally on homeopathy. If they are to use general practice it is to gain a label or orthodox diagnosis (Whilst the homeopaths adhere to this system of belief, few of their clients are as committed to it).

Why did Alice go to her GP at all in this situation? She appears to know more about homeopathy than he does (although she may be unaware of this; assuming that as a homeopathic GP he must know more than she does). Why did she not just by-pass him and consult with her homeopath? Her rationale to me was about getting a diagnosis and this visual examination. She herself is not sure that this is necessary on reflection. In part she is using the doctor's eyes in place of Harry's self-report, as he is too young. She says she would not visit the doctor herself with a sore throat just the homeopath, as she would know her symptoms and be able to report them.

I tend to go to the doctors for them to look in the ear and the throat and to see, you know, what, what it actually is, and then I te- and then I tend to go to the homeopathic lady and will say to her, "Right, he's got an ear infection," or, "He's got a throat infection" and then I will tend to treat it... with her actually. So I just use the doctor to tell me what the problem actually is, and then I go to her to treat it... I don't know whether that makes any difference to the homeopathic treatment, it probably doesn't, but I think it makes me feel... that I've... I've got the- I've got all the information as to what exactly the problem is on him, and then I've given as much information as I can to the homeopath to be able to treat it. Cos obviously he can't, he can't say, [2 year old Harry] you know, where- what the problem is...I'm sure that [my homeopath] might say it's not necessary to do that, but, you know, they don't look in ears and in your mouth and everything.

Summary and concluding remarks

As was outlined at the outset of this chapter, this small piece of research with one homeopathic GP obviously has some limitations in terms of generalising to the population of homeopathic GPs as a whole. In one sense it is always a problem when one focuses in detail on a person as they come to be seen as a unique and idiosyncratic individual. Dr Deakin does seem quite idiosyncratic, although again this might be a factor of “alternative” GPs, and many of them might be like him in this respect. This is impossible to tell without further research. Although there are indications from ongoing work that in many ways he is subject to many of the same pressures as reported by other homeopathic GPs, at least in interviews (Thompson, Weiss et al. 2002). However, what my case study has done is to show potential context-situated issues around the provision of homeopathy within general practice that can be explored in further research.

A number of issues have emerged. Firstly that this medical homeopath is very different to other lay homeopaths in his methods of practice. There is very little evidence of him educating patients into a homeopathic model of health in the way I showed the lay homeopaths doing this in chapter 8. In fact quite the reverse, he appears to confuse many of them to the point of non-adherence to their medicines. He himself is not particularly committed to the homeopathic model but extremely eclectic in his use of alternative therapies. He does not seem to use homeopathic modes of deciding on a remedy for an individual. He stays allied to biomedical diagnosis categories, and does not appear to engage in self-care and personal development activities unlike his lay counterparts.

Dr Deakin is also different to many mainstream GPs. He has better than average listening skills and operates with a more equal balance of power and according to a shared-decision-making model. He also seems willing to refer his patients to lay homeopaths and herbalists. However he does not seem to use the same homeopathic modes as the lay homeopaths when deciding on a remedy for an individual. He stays allied to biomedical diagnostic categories. Nor does he appear to engage in the self-care and personal development activities common among his lay counterparts.

He appears to have a different working definition of holism, as being about interconnections between body parts/systems and not extending out into the social world. His dealings with patients suggest his model of the body is still a fairly biomedical one and limited by skin boundaries. He pays little attention to the emotions and social relationships in which his patients are embedded. In his route to diagnosis he appears to place considerable importance on visual signs produced within the biological body.

An interesting aspect of Dr Deakin's thinking is his ability to entertain multiple philosophies of healthcare at the same time. This may be a result of modes of medical training. Dr Deakin is different in this respect to Ian a lay homeopath who has not had a medical training. Ian who works part of the week in a general practice. I asked him about the possibility of a growth in lay homeopaths working within general practices (at the moment the number is very small). Unlike Dr Deakin Ian sees homeopathy as having a different philosophy to general practice:

Homeopathy offers a complementary service while having an alternative philosophy. If it remains that way, if we're allowed to have our alternative philosophy and provide a service that the doctors could do with, then that's fine. If the doctors take over what could be called the holistic philosophy of homeopathy, as the doctors have unfortunately taken over homeopathy in the past in America, when they pretty well wiped it out at the time of the First World War, it will fail. Otherwise it's a great idea [having homeopathy in the NHS]. They have to accept pluralism, medical pluralism

Ian, believes that for homeopathy to retain its power in the NHS, requires it to be operated by a practitioner with an 'alternative philosophy', such as himself. In his view, if doctors cannot accept medical pluralism, homeopathy in the NHS is doomed. The subtext of Ian's concerns is his fears for the medicalisation of homeopathy and the loss of its special philosophy, and its power. He is not alone as a lay homeopath in his views. Nancy, the teacher on the homeopathy course, was very dismissive of doctors who are homeopathically trained, but never prescribed constitutionally. She said such doctors are using homeopathy 'allopathically', and thus do not count as homeopaths.

Dr Deakin, however, cannot be treated as an individual abstracted from context. His views and his practices may be a direct result of working within an NHS organisation,

set within a biomedical framework. These influences are only relevant to lay homeopaths when they work in NHS settings and I did outline the difficulties expressed by one lay homeopath working in the NHS (Treuerherz 2000).

The context-related limitations of conducting alternative medicine within biomedical general practice go a long way to explaining Dr Deakin's patterns of beliefs and behaviours. I have sought to demonstrate how powerfully these limitations operate in the Golden Hill surgery, in particular the limitations on time and the lack of sympathy for, or understanding of alternative ways of treating from colleagues.

However despite these observations about medical homeopathy, my final insight from this case study was that it is not possible to split homeopathic practice neatly into that of lay homeopathy and medical homeopathy. Indeed therapists and patients cross boundaries between both worlds. Ian represents a lay homeopath who works in a biomedical context. Some of the patients who visit 'alternative' doctors have firmly biomedical understandings of their bodies and health. However, some are sophisticated users of homeopathy who are consulting their GPs from a different perspective, as a kind of back up to their primary health care specialist, the lay homeopath.

Chapter 10

Conclusions & Recommendations for Further Research

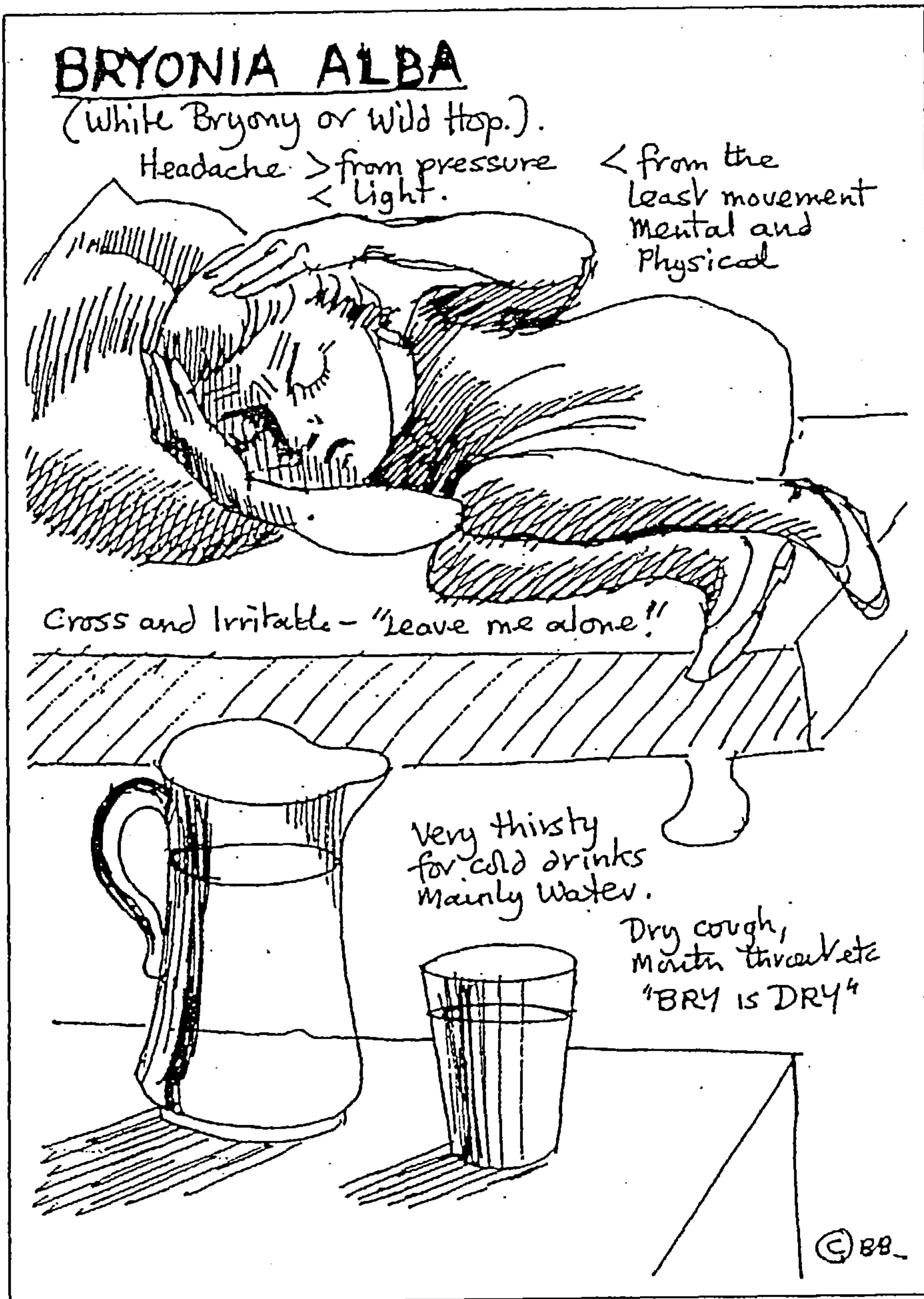


Illustration by Berenice Benjelloun

Chapter 10. Conclusions & Recommendations for Further Research

In the first half of this thesis I detailed a number of key issues that my study was designed to investigate. These issues can be grouped into five main inter-related areas: the beliefs of alternative medicine users; the role of alternative therapists; embodiment and cosmologies of health and healing; tensions between alternative and orthodox medicine and integration of alternative medicine into the biomedical system.

The beliefs of alternative medicine users

I concluded in chapter 2 that much previous research in this area has not differentiated sufficiently either between users of different alternative therapies or between users at different stages of their trajectory of involvement with alternative medicine, as has been pointed out by Cant and Sharma (1999). My research has singled out one therapy, homeopathy, as a case study and looked at the trajectories of a number of users over eighteen months. Within this group of users I identified two distinct groups of users whose belief systems were quite distinctly different. Pragmatic users maintained normative biomedical beliefs whilst the committed users developed quite different views of the body health and healing. The processual and context-situated ethnographic approach that I employed enabled me to chart the changes in views and the shifts in the relationship with health providers. Prior research had suggested that users of alternative therapy continued to use the orthodox system. My own research confirms this. It also illustrates how the use of orthodox services shifts among committed users, with them coming to use doctors for diagnosis rather than treatment, and entering into a relationship that takes on a different quality and accords more with an egalitarian, shared-decision-making model (Charles, Gafni and Whelan 1997). My research would support McGuire's (1988) characterisation that some alternative users see themselves as "contractors of their own healthcare".

Implications for efficacy

I have not focused in this thesis on the issue of efficacy, however conclusions can be posited about the relationship between beliefs about a system of healing and its efficacy. Goldstein (1998) showed that patients with higher expectations of successful outcomes in homeopathic treatment scored higher on physical health status perceived change in primary condition and perceived change in outlook. Goldstein concludes that how a person feels initially about a healing process, whether positive or negative, can affect outcomes. This study along with the work on the placebo effect (DiBlasi 2001) might suggest that the holding of a well developed and enthusiastically supported cosmology of healing, such as that held by the committed users in this study, may lead to better outcomes than for those who hold more pragmatic views. This would require further research to confirm.

The role of alternative therapists

In chapter 2 I also reviewed previous research that has illustrated the existence of a different kind of relationship between users of alternative medicine and their providers to that between doctors and their patients. Confirming previous work my research has supported this different kind of relationship: one that is infused with greater levels of equality, friendship and rapport, and a subsequent feeling of empowerment for users, and reward for alternative therapists (Sharma 1994; Chatwin and Collins 2002:25). The committed users see this more egalitarian relationship as very beneficial, The clients' expertise in their symptoms and life experience is a required facet of the consultation, and they are encouraged to gain more formal knowledge of homeopathy itself, which also reduces any gap of expertise between practitioner and client. These homeopathic patients experience a different balance of power not just in the consultation room, but also in terms of control over the taking of remedies and adherence to the therapeutic regime.

There appears to be a reaction against biomedicine in this process. The women who report most damaging biomedical relationships (particularly with hospital staff) are the

most evangelical about the new type of relationship and their increased control over their healthcare. There may be a gendered aspect to this finding. Women have historically been badly served by the communication patterns within the biomedical system to a greater degree than male patients (Roberts 1985; Todd 1989; Fisher 1993). Women have also been more disempowered and oppressed within society (Deem 1980; Adkins 1995). The committed homeopathy users appear to be using the increased feeling of power about their healthcare to create a new identity for themselves, not only as patients but also as women. As well as replacing religion in people's lives at a time of increasing sacralisation in western society (Woodhead and Heelas 2000), homeopathy appeared for these young women to be offering a route to a construction of a different identity. That of becoming a different kind of patient, a different kind of mother, and a different kind of woman. In this respect I would agree that homeopathy can be seen as a therapy particularly suited to a feminist agenda (Scott 1998) and a way of providing, at least perceived empowerment, if not actual changes in the material position of women in society (Cummings 1998; Gaylord 1999).

My research has pointed out that an important element of this different healthcare relationship, appears to be that the client needs to like the therapist, and have a personal rapport so that they can work together in a collaborative way. This is a particular feature of the private alternative healthcare market where people are free to "shop" for a practitioner with whom they feel they can build this sort of relationship. Several of the committed users reported changing practitioners on these grounds. For example in Ruth's case study, in chapter 7, we learned that she was very let down by her naturopath's failure to return her calls and so she "fired him". I myself found that there was no rapport with Shelagh, the first homeopath I attended. Her authoritarian approach reminded me of biomedical encounters and I felt completely free to shop around for another homeopath.

In chapter 2 I reported on Sharma's supposition that "Patients may start out using non-orthodox treatment holding health beliefs which are no different from non users, but their very exposure to the ideas of their therapists may effect such a change over time" (Sharma 1992: 87). I mentioned Sharma's (1994) observation that there had been insufficient research on what therapists actually do, and outlined her dual possible

hypotheses about the relationship between alternative therapists and their clients. She did not have sufficient data on actual interactions to know whether therapists used their knowledge in an open way to socialise their patients into a new way of health and an understanding of the therapy, or whether they kept this knowledge close to their chests and used it to maintain dominance. My research supports the former rather than the latter hypotheses and finds that it is this very process of sharing knowledge that contributes to a more egalitarian relationship and directly alters people's views of health, the body and illness. This finding illustrates the usefulness of longitudinal research for teasing out such questions of cause and effect.

The lay practitioners I studied were very prepared to share their knowledge and used it to enculturate their clients into new views of health. I did not study the medical homeopath's patients over such a long time period but I did not see evidence of similarly changing ideologies. In his case I do not think he was reserving his knowledge as a source of dominance. He did not have the time to share this knowledge in the average consultation time of general practice. Nor did he seem particularly to feel that he needed to share it, as homeopathy was just one string to his many stringed bow.

This emphasis on both the quality of the relationship and the robust role of clients produces a possible problem for the provision of alternative therapies through standard healthcare providers such as GPs. It can be more difficult if there is no special rapport, as this relationship is less easy to change than that with a private therapist. It is also in effect a dual relationship for the client where the role of alternative healthcare provider and biomedical healthcare provider are combined in the body of the one practitioner. This dual role provides tensions for the GP concerned. He or she may be wanting to work on a more egalitarian basis, as does Dr Deakin, but then be forced to be the conveyor of less egalitarian information from the NHS system to the patient. This was the case when Dr Deakin had to admit to his patient Jane that it was not in his power to get her re-instated on his patient list after she had been struck off by the practice for not vaccinating her children.

In chapter 4 I reviewed Frank's research with biomedical homeopaths in Germany (Frank 2002). In this interview-based study Frank looked at the relationship of the homeopathic physician-patient dyad in terms of the shared-decision-making model.

Frank hypothesised that a shared decision-making model could only be applied to certain aspects of the consultation, notably the choice between a biomedical and a homeopathic treatment route. He concluded that the necessity of the choice of one remedy by the physician returned the model of interaction to a paternalistic model, with no room for debate about actual treatment options. He felt that he could not concur with the assumption that homeopathy is popular because of harmonious interactions. However, Frank only hypothesises that these issues *may* lead to conflict. He does not provide any evidence of *actual* conflict being experienced by patients, because he only has interview data with practitioners. Frank did not study lay homeopaths, and so the kinds of opportunities for conflict may have been exacerbated by the tensions between biomedical and homeopathic frames of reference and by the impositions of biomedical institutional pressures.

I have been able to explore this aspect of the relationship with both a homeopathic GP and lay homeopaths. The decision about the specific remedy lying with the 'expert' homeopath is not seen as evidence of conflict by the patients in my research. This supports the work of others such as Sharma (1992), who suggests that although homeopaths may propose a single remedy there is still much room for patient involvement. Patients in my study reported involvement in terms of: their decisions about whether to consult; whether to accept homeopathic treatment at all; whether or not to come off biomedical drugs; when exactly to take the homeopathic remedy; and when to stop treatment, particularly in accordance with experiencing an improvement in their symptoms. From my data I would therefore have to refute Frank's hypothesis that the "so-called dyad of harmony" is not present at any other stages of the client-practitioner relationship, than at the initial patient report of symptoms.

Embodiment and cosmologies of health and healing

I outlined the issues around embodiment in chapter 3 and using the anthropological literature demonstrated the notion of the body in health and illness as a culturally inscribed entity that can be analysed at the three levels of the lived body, the social body and the body politic (Scheper-Hughes and Lock 1987). I showed how in most non-

western societies, self extends beyond the physical body, but that in western and biomedical notions of the body this is not the case. I showed using the work of Byron Good and others, that biomedicine in itself operates as a powerful influence in shaping notions and experiences of the body in the West (Good 1994; Gordon, 1988). I also reviewed literature that suggested that alternative medicines (Johannessen 1996; Busby 1996) and homeopathy in particular (Sharma 1995; Frank 2001), reflect and construct a different experience of embodiment. I have demonstrated through the use of my own detailed observational data, that just as biomedicine constructs a certain type of body through interactions, so too does homeopathy. I have discovered that the homeopathic body, in addition to being less anchored in the physical body with a more temporal element (Sharma 1995), is also deeply embedded in a network of social relationships, and has a very large emotional component. In addition to seeing how homeopathy constructs a different kind of body and shapes a different experience of embodiment, my data suggests that homeopathy also alters identity for its users, particularly its women users on whom I focused, and particularly at times of life transition. Paying attention to cultural processes in this re-formation of the body I have found support for the notions of Johannessen (1996) and others, that while the model of the body is quite different in alternative medicine, notions of healing are heavily influenced by western discourses of individualism.

Cartesian dualist notions have become all pervasive in the West. These notions have been shaped in large part through interactions with a biomedical health system that splits mind from body, person from context and leaves spiritual issues almost entirely out of the frame of reference. For a certain group of people, the discovery of a medical system, homeopathy, that treats and defines the body quite differently, is a welcome relief. There is a feeling of coming home to a philosophy of the body and health that is more congruent with actual embodied experience and not with culturally accepted notions of the body (Busby 1999). As Johannessen has pointed out, whilst there are many discussions of pluralism in healthcare seeking (e.g. Andersen 1994) there is little recognition of the plurality of ideologies of the body at the level of the social body (Johannessen 2002). In this research I have showed how a group of women shift in how they see and experience their bodies, as they are enculturated into the homeopathic ideology by their lay homeopaths and other homeopathy users. The recognition of the importance of emotions, social relations, and spiritual aspects of the body within

homeopathy is very well received and leads to a commitment to this form of medicine as the primary system of healthcare.

Comparing this approach with the case study in general practice reveals a very different ideology of the body embedded in this particular version of biomedical homeopathy. The body as it is defined by this medical homeopath is still subject to many Cartesian dualisms. The person is still largely stripped from their social context and their emotions are often disregarded. Dr Deakin's version of the body is not quite as reductionist as is the usual biomedical version of the body. He does see links between different body parts and systems. He labels this as holism but it appears to differ from the more usual definitions of holism as a different paradigm of medicine that incorporate a view of the unity of mind-body-spirit-illness (Berliner and Salmon 1980). I did not see evidence of patients changing their perceptions of the body or their embodied experience through interacting with this medical homeopath in the same way as the committed users of lay homeopathy did. The majority of the general practice patients seemed to maintain a western normative, dualist vision of their bodies, unless they already had alternative views that preceded their contact with Dr Deakin.

In the second part of chapter 4 I focused on two different strands of homeopathy. Through a historical analysis I showed how for the last 150 years there have been two distinct homeopathy organisations, resulting in two distinctly different versions of homeopathy, (Rankin 1988; Cooter 1988; Nicholls 1992; Cant and Sharma 1995). Each constructs the body differently. One of them is heavily influenced by biomedical notions of disease categories being located within the physical body, contemporarily represented by The Faculty of Homeopathy. The second of these, the lay homeopathy group, contemporarily represented by The Society of Homeopaths, places a good deal of emphasis on existential aspects of healing, and on treating the total symptom picture of the individual and their constitution. The body is seen to incorporate a spiritual component and to be connected to the universe, not as a separate bounded entity. This second version is much closer to the founding principles of the classical homeopathy of Hahnemann (1810) and his follower Kent (Treuerherz 1983). My data have shown a remarkable consistency of these historical trends in homeopathy, with two very obvious different forms of homeopathy representing these two different groups in lay homeopathy and in biomedical homeopathy. There is evidence of slight shifts over time

as a result of cultural influences. For example the spiritual element in lay homeopathy has remained important from its arrival in the UK to the present day. However, the form of this spirituality has changed from the original influences in the 1850's of Steiner and Swedenborg (Treuhertz, 1983; 1984), through druidic influences in the 1960s to current influences from Hinduism through concepts such as the chakra system.

In my own study I observed a lay homeopath employing the chakra system in teaching homeopathy. I also found more contemporary notions of spirituality as personal development, operating within the consultations and the self-care practices of lay homeopaths. I have found that in gaining commitment from users, it is the lay form of homeopathy that is so attractive. Central to this attraction are the associated existential and spiritual dimensions; the recognition of the individual's constellation of symptoms embedded in a social world; and, the abandoning of biomedical disease categories³⁷.

Tensions between alternative and orthodox medicine

I also demonstrated in chapter 4 that in this lay, more classical form of homeopathy, are a number of inherent tensions or oppositions to science-based biomedicine (Coulter 1984). In outlining the belief system of the committed homeopathy users (in chapters 6 and 7) and in observing their construction in interaction (chapter 8) I have shown how powerfully these inherent tensions are incorporated into lay belief systems, and in healing behaviours. Most committed users in my study refused biomedical treatments including vaccinations through a passionate rationale of the incompatibility of these treatments with homeopathic principles. I also found evidence of these tensions played out in the initial motivations to use homeopathy, with many women reacting against limitations of the biomedical system, particularly through childbearing experiences.

In discussing the case of a biomedical homeopath I discovered the tensions led to paradoxical conflicting behaviours. For example the doctor made claims for the advisability of avoiding antibiotics but prescribed them in any case, alongside homeopathic remedies, or he talked in terms of long-term treatment strategies but then

³⁷ Although the fact that the committed users still consult their GP for biomedical diagnosis, shows that they are not entirely ready to abandon biomedical notions of illness entirely, even if they do not act on these diagnoses.

additionally offered short-term quick-fix alternatives. This practitioner's consultation behaviour was confusing patients, suggesting that attempts to practice a combination of both systems of medicine, has an inherent illogicality for patients.

What these actions suggest is that given the inherent tensions it is impossible to provide this alternative -classical- version of homeopathy within the NHS, particularly if the provider has a dual role as GP. Ian, the lay homeopath I interviewed who works in general practice, claimed to be operating a lay version of homeopathy. However I did not see him practice. Indeed there have been discussions in the literature about how difficult this is to do given the constraints of working in an organisation within the biomedical framework of the NHS (Treuerherz 2000; Adams 2000; Thompson et al 2002).

In any case, even if it were possible to offer this lay version of homeopathy on the NHS, many of the committed users would still choose to consult private homeopaths. This is precisely because they see homeopathy as an alternative to a healthcare system that has failed them, particularly in providing them with an empowering relationship. Alice's case study in chapter 7 provides a good example. She is a committed homeopathy user and uses Dr Deakin as her GP, for diagnosis, but she still chooses to pay to see a lay homeopath for treatment.

Several of the committed homeopathy users in my study enthusiastically mentioned the idea of "getting homeopathy on the NHS" (particularly if they were on a low income) and reported having looked for a homeopathic doctor who could provide it. They were usually unsuccessful; finding they were in the wrong catchment area or that the small number of homeopathically trained doctors had full lists and were not taking on any more patients. However embedded within their wish for homeopathy on the NHS was the same kind of approach they were experiencing in private homeopathy. When Helen visited Dr Deakin she had similarly high hopes. These hopes were dashed when she discovered he was operating more like a GP than a lay homeopath, and she never went back, managing to find the money, even on an unemployed single parent's income, to visit a private homeopath.

Integration of alternative medicine into the biomedical system.

I hope that I have demonstrated through my data that all of the previous key themes affect the integration debate. The beliefs of alternative medicine users; the role of alternative therapists; embodiment and cosmologies of health and healing; and the inherent tensions between alternative and orthodox medicine, all contribute to a more nuanced understanding of the issues involved in offering alternative medicine within a biomedical system. All of the preceding issues are interesting substantive findings in their own right but also each feeds into the final key issue of this thesis. That of integration.

In the two different versions of homeopathy I have studied, notions of the body are constructed very differently. As a result, notions of healing, health and illness are also very different. This problematises the notion of integrating biomedical and homeopathic systems which thus becomes a task of trying to incorporate two very different worldviews into one system. My data on a homeopathic GP shows a very different kind of practice to that offered by lay homeopaths, incorporating many aspects of conventional therapy such as antibiotic prescribing and the use of medical diagnostic categories and tests.

Where alternative medicine is integrated into the biomedical system it is more difficult for the users to attain a new cosmology of health. There are institutional restrictions and the cosmology of the providers may well be heavily influenced by biomedical cosmologies of healing, leading to syncretised or biomedicalised versions of alternative therapies.

Thus my analysis of the homeopathic worldview of committed users and lay homeopaths appears totally incompatible with the precepts of biomedical practice. How then can doctors operate within both belief systems? It would appear that the two ideologies are too fundamentally opposed to be syncretised without unreconcilable contradictions, and an inevitable serious loss to one system of medicine or both. Luhrmann (2001) has illustrated very convincingly the parallel incompatibility of two similarly opposing philosophies in psychiatry: scientific drug-based psychiatry and psychoanalytical psychiatry.

Homeopathy can be seen as just 'pills for ills' by some, or can be constructed as a much wider ideology of beliefs and practices. These beliefs about homeopathy are not static properties of the individual (as expounded for example by the psychological 'health belief model') but come into being through an ongoing process of negotiation through interaction and constant education with healthcare providers and other users. Where the interaction is with those who espouse a committed ideology of homeopathy, and the user has actively sought out homeopathy the individual is likely to develop such an ideology.

Where the provider of homeopathy is based within the biomedical system the development of this ideology is limited, because the ideology of users is so influenced by a particular form of education from their healthcare providers. It is impossible for homeopathic doctors to adhere in full to the committed ideology of homeopathy, because much of this ideology is constructed in direct opposition to biomedical ideas about health and healing. For example the lay (classical) homeopathic stance against drugs and in particular against vaccinations, cannot be countenanced by biomedical practitioners. This is evidenced by the strength of feeling in the debates around vaccination, among even the more holistically inclined biomedical practitioners. Full blown homeopathic treatment is also incompatible with western reductionist diagnoses. And finally the power shift towards the patient being in control of their healthcare is inconsistent with the expert medical model. Although Dr Deakin represents an individual practitioner who has managed to negotiate a different sort of relationship with his patients, he is worn out by the struggle to offer holistic medicine in the NHS and indeed is thinking of giving up³⁸.

This suggests that the debate on integration, certainly with respect to homeopathy, needs to be problematised more so than it has been to date. Firstly it should be clarified that what is being offered within the NHS as homeopathy, may bear little resemblance to what is being offered by private homeopaths. It would seem from my data that the version of homeopathy being practised outside the NHS has more far-reaching effects on the health of individuals. The engagement with homeopathy is promoting changes

³⁸ Not that he is alone among GPs in this respect with morale at an all time low (Huby, Gerry et al. 2002).

not only at the level of the individual, bodily, and physical symptomatology, but also in beliefs, relationships with practitioners, usage of orthodox medical technologies, individual responsibility for health and relationships with self, significant others and similar others in the community.

Much of the impetus for integration is coming from patient pressure to incorporate alternative therapies within the NHS and this pressure is more often reported in middle-class areas where the experience of these patients of private therapies is likely to be of an alternative ideology of health. When they come to find the 'watered down' versions of these ideologies and therapies within the NHS they may be disappointed. Similarly those patients without prior experience, more likely in more disadvantaged groups of the population may only ever have contact with the therapies in their 'watered down' form and may not develop much commitment to them as seems to be the case among the more disadvantaged members in my study.

Another substantive issue is that of what constitutes evidence of effectiveness. The knowledge that there are different types of homeopathy enables us to ask when homeopathy is assessed through RCT methodology: "What type of homeopathy? Who is practising it and how?" Also it has to be asked not only "What type of practitioner?" but also "What type of patient?"

Homeopathy in its classical version as practised by the lay homeopaths in my sample is not amenable to measurement via the Randomised Control Trial (RCT) model. Its adherents believe its effects are subtle and difficult to measure, long acting, and liable to work on not just the physical level, but to lead to profound changes in belief and behaviour. RCTs however are by their nature designed to elicit gross results, over the relatively short term, in particular in relation to body parts or subsystems. Thus this method will not be measuring the full effects of the therapy as considered by the lay homeopaths. This suggests that for lay homeopathy to be seen as successful, it may need to be measured as much by the degree to which individual belief systems are altered over a longer time period, as by focusing on the pragmatic effectiveness of homeopathic pills on particular symptoms in the short term (Long, Mercer et al. 2000).

Committed homeopathy use and pragmatic homeopathy use are based on entirely different perspectives and in using the term 'integration of homeopathy' into the health service (NHS) it should be recognised that it is the most pragmatic form of homeopathy which is most likely to be involved. Thus in relation to issues of assessment and evaluation, and the use of 'evidence' in relation to current debates about health care, it may be that the most profound and important ways that complementary therapies are used to construct and manage health remain unmeasured and un-assessed.

I showed in chapter 4 that the medical discourse on integration assumes alternative medicine to have fixed, unchanging modes of action that are not dependent on context or provider but can be isolated in the same way as drug based therapies, and measured through the scientific medium of the randomised control trial. The frequent use of terms such as 'placebo effect' and 'non-specific effects' in these debates demonstrates some awareness of the therapeutic relationship within the effectiveness of these therapies. However the pressures towards evidence-based medicine lead the protagonists to infer that such effects can be separated and controlled for through RCT methodology. This separation in itself reveals the dualistic notions inherent in the biomedical view that have resulted in integration of practice rather than of knowledge (Cant and Sharma 1999; Nichter 1980). These assumptions of the biomedical discourse on integration (which is the most vocal) are compounded by the lack of research into actual practice and thus attention to context-related factors. What research there has been, mainly interviews with biomedical practitioners who are using alternative therapies in what Adams (2001) calls direct integrative practice, suggests that in addition to these conceptual difficulties, there are also a number of practical constraints on practice. These consist of the pressures of time, colleagues, and bureaucratic factors (May and Sirur 1998; Adams 2000; 2001; Thompson et al 2002).

My study has investigated users' beliefs in depth, and in context and found them to be incompatible with this discourse of homeopathy as parallel to biomedical drug treatments. The effects of the constraints on practice and the tensions in ideologies appears to result in a practice that, whilst in some way preferable to ordinary general practice, for some patients, is inconsistent and confusing and nothing like lay homeopathy. Stripped, in effect of those factors that produce motivation to use and commitment from users.

I think it is important to point out that the medical homeopath I studied was not working in an integrated practice, but as an isolated alternative doctor in a conventional practice. As I mentioned in chapter 4, Luff and Thomas's case study analysis of models of integration concluded "The most likely scenario for a stable and harmonious service would seem to be where the key service initiator/s have a clear and consistent vision of the service rationale, the initiator/s have a high degree of control over the funding source, and they employ people who share the same perspective (Luff and Thomas 1999: 11). This was not the case at the Golden Hill Surgery. It may be that the constraints on Dr Deakin were greater than they would have been in a more integrated practice setting.

Prior research by Frank (2002) had hinted that there might be different types of patient consulting biomedical homeopaths and my own research has found this to be the case. There is very little notion of the importance of patients views in the integration literature, except a recognition of a grassroots demand for alternative medicines, yet my research has shown that patients beliefs about the body and alternative medicine are very influential in the relationship with the provider. An understanding of where the patients stand is necessary in understanding the actions of the provider and in subsequent issues of comprehension, confusion and adherence. The integration literature has tended to assume that many people will want alternative medicine and benefit from it if it is offered on the NHS. My research has found that the active seeking out of alternative medicine is an important factor in producing committed users. Also the context and form of the therapy offered is key and the committed users in my study rejected the biomedical version of homeopathy that was offered in general practice. In reverse, patients with biomedical notions of the body and healing, who were not seeking an alternative system, were not motivated to become committed homeopathy users by lay homeopaths, preferring to maintain a biomedical stance on embodiment and health.

Relevance of these arguments for alternative medicine in general

This case study has been of homeopathy in alternative and integrated formats. There are suggestions in the literature that homeopathy users are more stable in their commitment

to this form of medicine, and more opposed to biomedicine than users of other alternative therapies (Sharma 1992; Furnham 1998). I would hypothesise from my findings that this may be directly related to the high verbal content of homeopathy and the strong educational role of homeopaths. Indeed it may be the case that it is this socialisation into a new knowledge system about health and the body that is most powerfully at work in converting trialists to committed and satisfied users. Perhaps people are searching for an internally consistent and well-articulated alternative framework for health and the processes operating in the lay homeopathy settings that I observed appeared to provide this. Perhaps conversely it is because some other therapies are not as well articulated in therapeutic interactions, that users are not so committed to them. In my own experiences with 3 acupuncturists over two decades I have learned very little about the ideology of health that is promoted through acupuncture, but a year of studying homeopathy and I can articulate a well developed system of beliefs about the body, health, and healing.

The ease in which this ideology is communicated in homeopathy may also be linked to its European roots, making its concepts easier to articulate to a European audience, than a therapy that is rooted in eastern thought, such as acupuncture.

However the supposed differences in homeopathy patients, may only be a research artefact. Patients beliefs about homeopathy have been studied in more depth than any other therapy, in the qualitative and attitudinal work of Adrian Furnham, Ursula Sharma and Sarah Cant. Patients of other therapies have not been researched in such depth. Such studies may reveal a different picture.

In spite of the possible differences between homeopathy and other therapies, I do believe that my research is generalisable beyond the field of homeopathy. Many of the concepts in this study around ideologies of health, views of the body, tensions with orthodox medicine and issues around integration, and the constraints of biomedical settings in attempting to implement alternative therapies, may be very similar for other alternative medicines. Further research is needed to confirm this generaliseability.

Suggestions for future research

The findings of this study suggest a number of potential avenues for further research, with therapists, users, and non-users of both homeopathy and other alternative therapies both in biomedical and alternative settings.

Firstly, the current study contained limited data on use of homeopathy within biomedicine, focusing as it did on one practitioner, for a short period of fieldwork. Further research is needed on those using homeopathy, and other therapies such as acupuncture, aromatherapy and reflexology, in biomedical settings; both administered by those who are biomedically trained and by non-medical alternative therapists. Frank detected three types of biomedical homeopath in his research in Germany (Frank 2002). It would be interesting to contrast Dr Deakin with these other types of biomedical practitioner; for example those who claim to offer a more classical form of homeopathy within an NHS setting. Given the obvious importance of context it would also be useful to conduct research in the different types of integrated practice as identified by (Luff and Thomas 1999).

To understand the philosophy of biomedicalised version of therapies such as homeopathy in more depth, an ethnography on one of the Homeopathic Hospitals' training courses for health professionals, would provide an interesting counterpoint to my own work with the lay homeopathy class and previous ethnographies of conventional training (e.g. Sinclair 1999). Similarly an ethnography of a full lay homeopathy training course would provide more insight into this group to supplement the data from the introductory course that I studied. Ethnographies of training courses for other therapeutic modalities, such as acupuncture would throw light on the ideologies and how they are constructed in interaction in training.

In terms of users of homeopathy and alternative therapies more widely, there are a number of avenues that could be fruitfully explored that have not been the focus of my own research or that of others. Firstly it seems important for more long-term longitudinal studies to examine the longer-term changes in beliefs and use of alternative medicine. In a recent post-fieldwork conversation with Ruth, one of the committed users of homeopathy whose case study I outlined in chapter 7, she told me "I am getting

increasingly disillusioned with homeopathy.” Ruth has been through a number of further major life events since the fieldwork finished and was suffering a bout of depression on which she felt the homeopathy was having no effect. However, she was still visiting her homeopath and had not given up on her entirely, but was trying out a cranio-sacral osteopath. Many of the women I researched had become committed users in the previous year or two, or during the course of my fieldwork. It would be useful to research committed users over a longer period post “conversion”.

Secondly, research with users could be conducted to focus more on their notions of efficacy. A diary study would allow users of alternative medicines to record their perceptions of the effects of treatment on their symptoms and their lives and the lives of those around them, over repeated engagements with the therapies and over a long time scale, to pick up long term effects. This would provide a useful complement to the biomedical randomised control trial studies that tend to be short-term and do not include patient’s notions of efficacy.

Thirdly, this research has focused on these people’s use of homeopathy, even though they were usually using other therapies in addition. Further longitudinal research on the same patients’ concurrent, or sequential, use of different therapies and the belief systems associated with this multiple practice would be very revealing. The question of why particular therapies are consulted at particular times would be illuminating.

As there are less male users of homeopathy, it would be important to research this group in more depth. I only found one committed male user in my ethnographic sites, a student of the homeopathy class who has now gone on to train to become a homeopath. He was unwilling to be interviewed, and said very little in the class, so I was unable to gain any understanding of his motivations or beliefs. It is interesting to note that he was the only participant I approached in any non-biomedical setting who refused to be interviewed. Some of the women claimed their partners fell into the category of male users, but I did not get a chance to interview them. More qualitative research with this group could yield interesting insights, as would research with male lay homeopaths to investigate the extent to which the relationship issues found in my research were gender-related.

As a general observation I have demonstrated in this thesis the usefulness of investigating one therapy in depth. There would be much to be gained from ethnographic work of a similar nature with other therapies.

A final suggestion would be for in-depth research with non-users of alternative therapies. Jain & Astin (2001) have explored barriers to such use and reasons for disuse through quantitative survey work. It would very illuminating to supplement this with qualitative and ethnographic data to more fully understand the life world of this group. This could be supplemented with research with biomedical healthcare practitioners who are firmly against the use of alternative medicine to seek to understand their position with more subtlety (e.g. Wanjek, 2002).

Final concluding remarks

I hope that I have demonstrated fully in the preceding pages, the power of the ethnographic method to uncover a richer, more complex and context-situated view of alternative medicines. My work has focused on homeopathy and I hope I have deconstructed homeopathy from one uncomplicated, monumental, unchanging, category (as it is often portrayed) to at least two of many “homeopathies”. These “homeopathies” have come to be through the influences of history and context, and are continually reconstructed through processes of interaction on a daily basis, between: therapists, doctors, patients, users, family and friends, the media and bureaucratic organisations. There is more than one type of homeopath and there is more than one type of homeopathic patient. The beliefs and practices of practitioners and users vary. Both need to be looked at together to gain an understanding of how these different positions produce different types of therapeutic encounter and different outcomes in terms of effectiveness, and changing beliefs and healthcare practices. The context in which homeopathy is practised is very important, and yet all too often this is what is stripped out of research at the population level in surveys and trials.

I believe that this deconstruction of homeopathy, and recognition of its multiplicity, is equally generalisable to other alternative therapies and in fact to all systems of medicine.

My findings problematise the notion of integration of alternative medicines into the biomedical healthcare system. They raises issues of what version of a therapy is being integrated, how the patients approach it, what constraints are limiting its application and how does it differ in different contexts. One conclusion from my data is that for certain patients, choosing alternative therapies is in itself a reaction against orthodox medicine, and so the offering of alternative medicine by an orthodox system becomes a paradox.

I hope I have demonstrated the importance of cosmologies of the body and health in this arena of alternative healthcare, and stressed the immense difficulties that exist for healthcare practitioners who are trying to operate within two paradigms simultaneously. The difficulties of breaking out of the extremely powerful scientific worldview that is all pervasive in biomedicine and in our society more widely, seems greater for those situated within a biomedical organisation such as the NHS, that reinforces these scientific notion in every daily bureaucratic action and in the communications of its powerful permeating discourses, such as the current one of evidence-based medicine.

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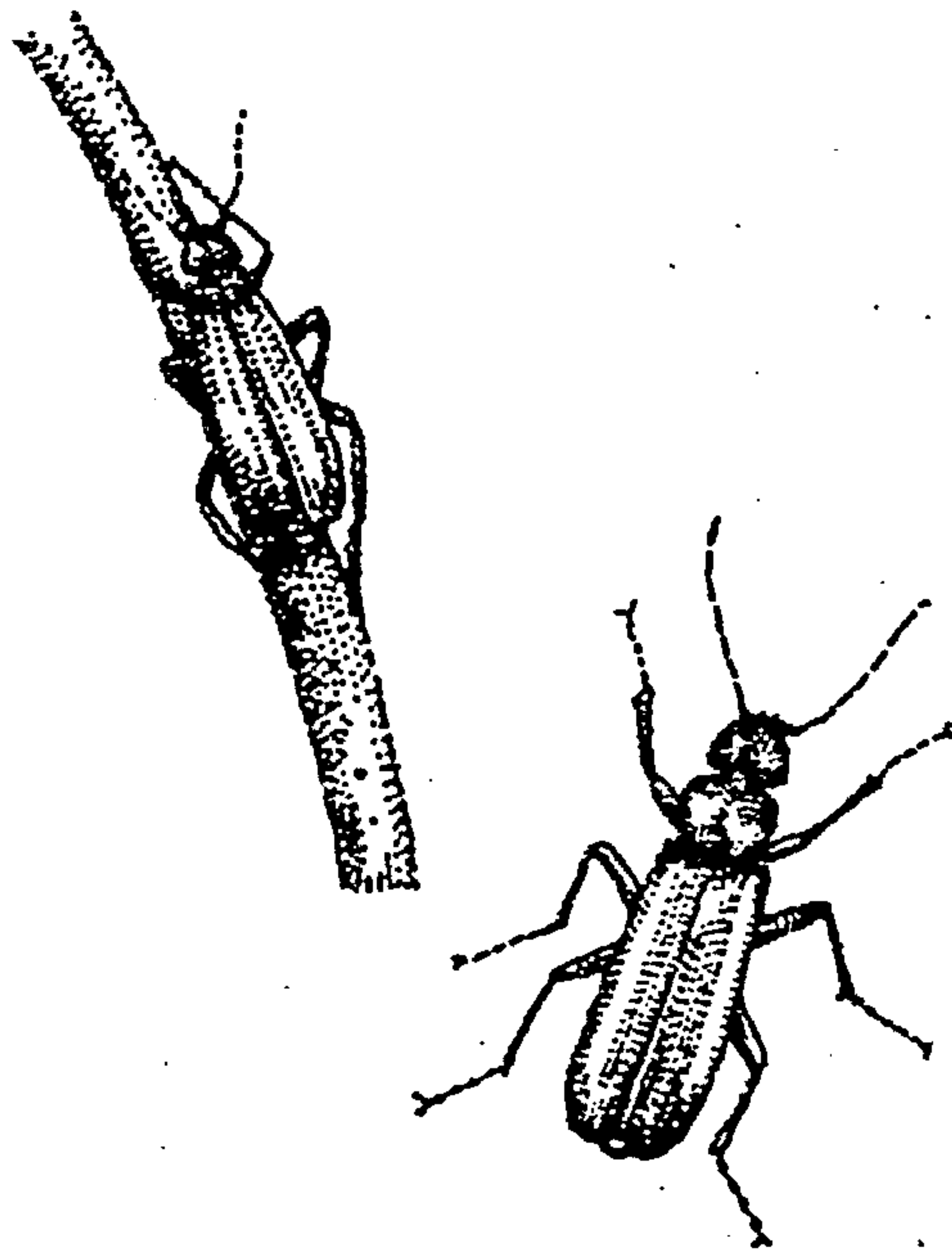
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Appendices

CANTHARIS VESICATORIA (Canth.)

Family name: Coleoptera
Other names: Spanish fly; fabricus; de geer



Appendix A: Medical Pluralism

BRYONIA ALBA (Bry.)

Family name: Cucurbitaceae

Common names: white bryony; wild hops; vitis alba



Pragmatic pluralism or ideological monism? Belief, body and personhood in an ethnography of homeopathy users in South London

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Introduction: The Resurgence of Medical Pluralism in Western Societies

"World is crazier and more of it than we think. Incurably plural." Louis MacNeice

Medical Pluralism is a universal fact of life. Through history and across cultural boundaries there is evidence for people consulting multiple systems of healthcare and healing, either concurrently or sequentially. In western cultures some have a tendency to be surprised by this fact. Sharma proposes that expanding the geographical breadth and the historical depth of analysis might encourage the conclusion that it is medical monism that needs to be accounted for not medical pluralism (Sharma, 2000). In western societies it is a peculiar fact of our own recent history that makes us less aware of the prevalence of medical pluralism.

At the end of the 19th century and beginning of the 20th century medical pluralism was alive and well in Europe and North America and represented a populist anti-elite backlash against scientific and professional medicine. For example Homeopathy, and hydrotherapy were well established medical movements, (particularly strong in the USA, (Coulter, 1984) since their development in the previous century, and osteopathic and chiropractic systems of medicine had been recently developed (1874 and 1895 respectively) and were flourishing. A robust survey conducted in America in the 1920's showed similar rates of alternative medicine use to those of today (Kaptchuk & Eisenberg, 2001).

During the mid 20th century however biomedicine achieved an unprecedented level of medical monism in western societies. This was as a result of various technological developments and societal factors: In particular a substantial drop in premature mortality and reduction of disease (although primarily caused by factors other than biomedicine such as improved sanitation); the rise in antibacterial therapy; a cultural acceptance of the supremacy of science, and technology as a means to progress through industrialisation and capitalism; an associated respect for expert sources of knowledge and authority coupled with the state's assistance in offering biomedicine a monopoly in healthcare through government legislation (Porter, 1997). It was also a result of active

suppression and marginalisation of alternative healing systems by the all powerful medical system. In Britain the British Medical Association's damning 1983 report on alternative medicine acts as evidence that these attempts at marginalisation and suppression were still actively operating until recently, although changes in the subsequent decade showed a shift of the medical establishment away from a policy of suppression towards attempts at colonisation and incorporation (Sharma, 2000; Saks, 1999, 1995).

The apparent power of biomedicine belies the fact that people still continued to use alternative and folk medicines during this period. Several of the participants in my own study report grandparents use of herbs, homeopathy and Steiner influenced medicine as predisposing them to be favourable to alternatives themselves. Conversely use of the biomedical system did not necessarily mean biomedical understanding of illness, as Helman showed in his analysis of folk understandings of minor ailments such as colds and fevers, and the use of biomedical products within alternative philosophies of healing (Helman, 1978).

The hey day of supposed biomedical monism in the West was short, lasting a few decades. Various factors in the 1960's and 1970's lead to it's declining power: the rise in awareness of illness and deaths due to iatrogenic medicine (Illich, 1976); the development of multiple antibacterial resistant strains of bacteria; disastrous publicly visible side-effects of drug therapy such as thalidomide; the failure of medicine to find cures for diseases such as cancer; coupled with a rising populist counter-culture backlash against systems of expert authority exemplified by the feminist movement against patriarchal medicine and the medicalisation of childbirth, and other anti-capitalist groups claiming western society was sick, alienated from nature and the soul, with an a lack of spiritual wholeness (Porter, 1997).

The resurgence of the popularity of alternative healing systems since the 1970's has been meteoric in the west, and their rise has not only been as an alternative to biomedicine but also as an integrated part of the biomedical system leading to what has been called "A New Medical Pluralism" (Cant & Sharma, 1999).

Even if during the last century the idea of medical pluralism seemed a dim memory under the spotlight of the hegemony of biomedicine in Europe and America, in other parts of the world medical pluralism was shown to be alive and well (Stoner, 1986; Amarasingham, 1980; Greenwood, 1981).

Factors contributing to the universality of medical pluralism

So what factors contribute to this almost universal phenomenon of medical pluralism? In part the reasons lie in the inadequacy of any one medical system to provide what humans want from healthcare. If healthcare is seen as providing a number of diverse functions, medical pluralism becomes more self-evident. A framework to understand these different levels of meaning of healthcare is the plurality of conceptual bodies as outlined by Sheper-Hughes and Lock (1987). Different forms of medicine can be seen as ministering to the different bodies: the lived embodied-self, the social body and the body politic. Six possible functions of healthcare seem worthy of mention, and can be related to the three different levels of conceptual body (See Table 1.).

If the function of healthcare is seen to be not only to cure physical symptoms but to heal social problems, and to provide meaning in people's lives, then different systems of medicine are differently placed to achieve these outcomes. For example Allan Young has talked of the greater power of externalising systems³⁹ of medicine at providing the latter two of these wished for functions of healthcare (Young, 1983).

If medicine is used at the level of the body politic, as a tool for the populace to attain power then the existence of alternative more democratic systems of medicine will be preferred over the elite professional oligarchy of state authorised biomedicine. McGuire (1988) found that participants in alternative healing systems in suburban America had come to see themselves as 'contractors of their own healthcare' in direct preference over the biomedical passive patient role.

Table 1. Conceptual Bodies and Functions of Healthcare

The Tri-Partite Body (Sheper-Hughes and Lock, 1987)	Some Functions of Healthcare
Lived embodied-self	1. Physical healing 2. Part of a spiritual/ existential search meaning
Social body	3. Social healing 4. A tool for identity creation and reflection cultural notions of personhood
Body politic	5. A route to democratic power 6. A reflection of prevailing world-views paradigms of understanding

If medicine is seen as a tool for identity creation, perhaps at the level of the social body, then factors in our late modern western culture, of free choice and democracy; loss of power of religious cosmologies; individualism and narcissism with the associated project of the body (Shilling, 1993) will predispose people towards the use of alternative healing systems to reinforce identities and uphold societal conceptions of personhood. Astin's research has shown philosophical value congruence was a big predictive factor in why people use alternative therapies in late 20th century American society. "People seek out therapies that are congruent with their philosophical orientations to health and life".

Astin cites Ray's definition of a sub cultural category of American society he called 'Cultural Creatives' who were more likely to use alternative therapies (Astin, 2000; Ray, 1997). These Cultural Creatives, who according to Ray are at the leading edge of

³⁹ In Young's account externalizing systems of medicine concentrate on aetiologies via narrative accounts of agents, events, motives etc whereas internalizing systems focus on intra-somatic events i.e. physiological and patho- physiological (Young 1983).

cultural change, tend to be upper middle class, educated and women (60%) with a distinct constellation of values: a focus on the inner life; a social conscience and agreement with the tenets of feminism and globalism - with a love of the foreign and exotic and a belief in planetary ecology.

The spiritual component in alternative medicine has received much attention (Berliner & Salmon, 1980; Finkler, 1980; Glik, 2000; Fulder, 2001). Szerszynski has talked of alternative medicine providing a modern-day equivalent of traditional religions religion (Szerszynski, 2001). Astin's recent work confirms that the use of healthcare as a possible route to spiritual understanding is another factor in the use of alternative therapies in western society (Astin, 1998). A significant predictor of alternative medicine use in his survey was having had 'a transformational experience that caused me to see the world differently than before' which points to these therapies being used by people as part of a search for beliefs about life, spirituality and the world more generally.

Whilst these factors all point to an understanding of the 'pull' towards using alternative systems of healing there is also evidence of 'push' factors, many embedded in current cultural beliefs of the society, with the loss of faith in science, disappointments in the doctor-patient relationship and the raised awareness of the toxicity and side effects of many biomedical treatments leading people to prefer more 'natural' based therapies.

In moving towards the use of alternative health systems western patients have not abandoned biomedicine. Most studies of use show that the majority of users of alternative healthcare continue to use the biomedical system albeit often reducing their use to reliance on diagnostics and tests, surgery and emergency medicine. For example Kelner & Wellman showed 82% of Toronto users of alternative medicine still consulted their primary care physicians and 88% of them were happy with the care they get from them (Kelner & Wellman, 1997; Eisenberg, Kessler, et al., 2001 show similar behaviour in the USA). Hence the move has been towards pluralism rather than a different variety of medical monism.

Parallel with all these societal factors, leading to increasingly plural use of healthcare systems has been the move within biomedicine to incorporate aspects of alternative medical systems. In part this has been a political move towards reducing the threat of alternative medicine to biomedical dominance through incorporation. However it has also been fuelled by the interests in alternative techniques among doctors (predominantly GPs), the involvement of the Prince of Wales' pressure group the Foundation for Integrated Medicine⁴⁰ (1997) and the pressure of patients interest in alternatives expressed through voting with their feet.

This has lead to an interesting development in the pluralism debate. No longer is there a clear divide between biomedicine and alternative medicine. Now there is evidence for syncretism between biomedical and alternative practices. For example Dew details biomedical acupuncturists in New Zealand as having appropriated aspects of acupuncture into their biomedical practice (Dew, 2000). In the recent British House of

⁴⁰ Interestingly this organisation has just been renamed The Prince of Wales Foundation for Integrated Health in an attempt to distance it from a medical conception of health. Prince Charles explained "The new name represents more than a simple focus on curing disease and symptoms. It is about encouraging individuals to create better health for themselves" (Integrated Health 2002).

Lords report on Complementary and Alternative Medicine, the separation out of medical acupuncture from Traditional Chinese Medicine, as more suitable for integration into the biomedical system shows the same tendencies towards dissecting, medicalising and syncretising alternative systems to fit biomedical philosophies and practices (House of Lords Select Committee on Science and Technology, 2000).

An interesting sequitur of the development of alternative medicine within western medical systems is that many members of the public are now coming to use alternative medicine directly through the interventions of biomedical doctors who are either offering alternative (possibly biomedicalised) techniques themselves or are referring to alternative therapists outside the health service (Thomas, 2001; Wearn & Greenfield, 1998). The biomedical system has thus paradoxically become an agent of promotion of medical pluralism. Also this introduces a level of pluralism within the one healthcare system. Pluralism may not now consist of consulting a biomedical doctor in the health system and a folk medicine spiritual healer outside. It may be that the biomedical doctor is himself the provider of spiritual healing in his health service practice, as in the case of the British GP and head of the Federation of Spiritual Healers Craig Brown and his GP/healer colleagues (Brown, 1998).

Pluralism therefore can be seen both in the health-seeking behaviour and in the offering of healthcare services by providers.

Pluralism of practice only or also of ideology?

To what degree is the pluralism of both seekers and providers in using offering/different systems of medicine, linked with an associated pluralism of ideologies? Researchers have suggested that patients do not have problems with the competing philosophies of the plural practitioners they consult. In her case study of a Sri Lankan woman affected by a culture bound mental health syndrome 'Pissu' Amarasingham shows how the woman and the family did not seem to need to integrate the different philosophical explanations of illness, during their journey through multiple medical systems. The diagnosis remained open and fluid in an ongoing process of definition and redefinition of her illness. It seemed OK for the family to deal with multiple diagnoses without attempting an over-arching synthesis. Amarasingham implied that this family were not engaged in drawing up an explanatory model⁴¹ which would endure as their single understanding but were happy to draw on a network of possible links at different time points (Amarasingham, 1980).

A study of Indian's in Britain also reveals a similar capacity for multiple ideologies and practices (Bhopal, 1986). There may be a greater ease within cultures such as those of India and Sri Lanka which have a tendency towards pluralism in their wider cosmologies, in juggling multiple ideologies than in more dualistic, monotheistic, Christian based, western societies.

In my own research, among homeopathic practitioners and users I have found evidence that some people whilst using plural medical systems, do appear (at one point in time) to hold one consistent ideology or cosmology of health, illness and healing that informs

⁴¹ Arthur Kleinman, who introduced the notion of explanatory models, has stressed that explanatory models are not fixed entities but often in a state of dynamic interaction created in part by the movement of patients from one system of explanation to another (Kleinman 1977).

their interaction with these different systems. For one group who I have called committed homeopathy users this ideology is a holistic, homeopathic ideology. A second group the pragmatic homeopathy users, appear to be operating from a more biomedical ideology. In both groups the prevailing ideology informs their perceptions and interactions with both homeopathic and biomedical therapies.

However I have also found a contrary case of a biomedical doctor who appears to be working with multiple ideologies. He offers various forms of alternative therapy to his NHS patients including homeopathy, in addition to biomedical interventions. In his consultations he draws on multiple possible treatment options for his patients and also employs diagnoses from different ideological approaches and offers multiple explanations for treatment, often within the same consultation. In comparison with the non-medical homeopaths that I studied he appeared to have a much more pluralistic and less consistent ideology which fused concepts from biomedicine, Chinese medicine, anthroposophy, and homeopathy.

The patients that interacted with the non-medical homeopaths who continually expressed their consistent and well developed cosmology of health in consultations similarly developed unitary philosophies themselves. The patients of the pluralistic GP appeared confused about his multi-level communications and held on to their primarily biomedical conceptions of health and healing.

Research Method

My doctoral research has consisted of a multi-site ethnography comprising 18 months participant observation (2000-2001) in a number of homeopathy related settings in south London. The sites were chosen to represent different arenas of interaction. In the first, a one-year adult education Homeopathy course, users of homeopathy learned about homeopathic treatment and ideology from an experienced homeopath. In the second, a monthly Vaccination Support Group run by homeopaths, users interacted with homeopaths and each other and discussed issues around homeopathic treatment of their children's illnesses in place of vaccination. In the third site, a Victim Support Centre, for victims of violent crime, users consulted with two homeopaths and I observed their consultations. The fourth was an NHS general practice surgery in which one of the doctors was trained in homeopathy, acupuncture and herbalism, and again I observed his consultations (with ethical approval from the NHS local research ethics committee). I also consulted with three different homeopaths myself as a patient during this period in an attempt to understand more embodied issues around homeopathy use. The resulting data comprised observational fieldnotes, 10 open-ended questionnaires, 40 interviews with practitioners and users, and 46 taped and transcribed consultations.

For the purposes of this paper I will outline the ideology of the two different types of homeopathy user in my study the committed and pragmatic users.

Homeopathy means different things to different people. The committed users see homeopathy as a comprehensive alternative system of health that is far preferable to orthodox medicine and reduces dealings with the orthodox system to a minimum. For pragmatic users homeopathy is seen as an inferior complement to orthodox medicine.

Committed Homeopathy Users

Those who see homeopathy as an alternative come to hold beliefs over time about health and illness that are very different to the prevailing biomedical norm. In their view health is not a property of individuals but of interconnected systems which encompass people in relationship with each other and with the environment. Illness is seen as a positive part of health and as occurring across a mind-body-spirit unity. As Jean, a homeopathy user attending the homeopathy evening class sees it:

[Homeopathy is] a safe and pleasant way to aid the body to restore its own good health without the use of blanket drugs with long term or short term side effects. I would like to think that in the case of a major disease affecting one of us we could use remedies to help us deal psychologically with the problem as well as physically. I very rarely visit the doctor at all.

The committed users of homeopathy numbered 17 in my study. All of them had taken active steps to seek out homeopathic treatment and in some cases to study it to learn more about it, or even to become homeopaths themselves. All but 4 of this group were consulting a private homeopath regularly. The committed users shared a homeopathic view of health, illness and treatment that was quite different from the biomedical view, and similar to the views of their non-medical homeopathic practitioners. Their use and attitude towards orthodox medical services was also quite different from the pragmatic patients.

The views of the committed group of homeopathy users can be grouped into 6 main beliefs about health, illness and healing:

1. Health is an ongoing interdependent relationship with the social, physical and spiritual environment. Emotions and relationships are the primary catalysts for illness
2. Illness and symptoms are an active and positive part of health.
3. The healing process starts with health not sickness.
4. It is the body that does the healing, naturally.
5. Homeopathy helps the body, pharmaceuticals suppress symptoms and hinder healing.
6. The user has primary responsibility for healthcare. This results in more egalitarian relationships with healthcare providers, and feelings of empowerment.

The users come to espouse these views in a very committed and enthusiastic way and their adherence to this belief system could be seen in terms of a conversion to a new religion. However in spite of the fervour of their new views they do not leave behind the orthodox healthcare system. They all continue to interact with this system at some levels. However inherent within the homeopathy cosmology is an opposition to many facets of orthodox medicine. So they resist the prescription of orthodox drugs such as antibiotics, and they refuse vaccinations and only use biomedical doctors to gain access to diagnosis, tests and emergency or surgical medicine. They also report being disappointed in the lack of attention within the consultation to wider issues of their

social lifeworlds, such as bereavement, divorce and troubled relationships. I have written elsewhere about how general practice consultations have a tendency to suppress or ignore the voice of the lifeworld and the needs and wishes of patients (Barry et al, 2000; 2001a).

I am currently writing in my thesis about how these users come to develop this new view of health. It is a process over time and is achieved via interaction, mainly with homeopaths, both in and out of the consultation but also with other committed homeopathy users, in social interactions for example in the education and support group environments. Also through the publications of alternative organisations such as *The Informed Parent* and *What Doctors Don't Tell You*. In the homeopathic consultations I studied much of the discourse of the homeopaths voices or acts out the 6 beliefs of health outlined above.

These newly discovered possibilities of homeopathy seemed to be offering more than just a treatment of health problems but something that appealed at a deeper level of spiritual need. At the level of searching for meaning in people's lives, of looking for a framework in which to make sense of their lives.

In line with the literature on pluralism in alternative medicine use these committed users do not abandon the orthodox system altogether. In this literature (see e.g. Cant and Sharma, 1999, Thomas et al, 2001) users are described as using both systems in tandem. What has not been discussed is how the use of the orthodox system changes. Certainly among the committed homeopathy users in my study there is a universal experience of interacting differently with the orthodox system.

For some there is a tendency to reduce visits to the GP particularly for their own illnesses. Many mothers, report still visiting the GP on occasions when their children are ill but with an emphasis on obtaining diagnosis and tests not on obtaining treatment. Sheelagh a homeopath and user sums up the general view "I only go for diagnosis and chuck the antibiotics in the bin". There is not just a diminishment in frequency of visits but reports of a changed perception of the GP and of a more instrumental relationship. They report going to get what they need/want from the doctor and embedded in this is a shift in responsibility where they become the primary decision-maker about healthcare.

Other research confirms that users of homeopathy appear to be consciously rejecting the authoritative knowledge of biomedicine and seeking another whole system to rely on as their first stop for healthcare. Furnham and Bragrath (1993) found that homeopathy users were more critical and sceptical of biomedicine and more conscious of health in general, with a belief in their own ability to improve their health. They were more self aware and more aware of the environment, holding holistic views, and generally were more knowledgeable about their bodies than patients who only used biomedicine (Furnham and Forey, 1994).

In many cases this turning away from Biomedicine appears to be linked to the women's recent disempowering maternity and childbirth experiences. They often reported hating being on the "conveyor belt" of medicine and of having felt let down by medicine during this period. In this respect the medicalisation of childbirth and poor experiences of women reported by Oakley 20 years previously appeared unchanged (Oakley, 1981). Two thirds of homeopathy users are women (Cant and Sharma 1999) and many of the

women in my research started using homeopathy during pregnancy or after the birth of their first child. Scott has talked of the appeal of homeopathy as a feminist form of medicine and I have written about how homeopathy appeals in particular to women and is organised along women's ways of acting and knowing in the world (Scott, 1998; Barry, 2001b).

Entry into motherhood also represents an important life transition in which issues of identity and personhood need to be re-negotiated (Smith 1991; Root & Browner, 2001). There is evidence that a number of the committed homeopathy users in my study were involved in such life transitions, including bereavement and divorce, during which both changes in identity and the search for meaning may make a new philosophy of health particularly attractive.

A case study of a committed user: Angie

Angie is pregnant and has a 2 year old daughter, Sandie, and so has been in the process of adjusting to her new identity as mother. This 29 year old woman was one of the students at the homeopathy adult education class, who has since enrolled at homeopathic college to train as a professional homeopath. She lives in an exclusive south London suburb, but is on a low income at home, with a partner who is a carpenter. She wrote for me in an open-ended self completion questionnaire of her family's use of homeopathy:

We use homeopathy mostly as an alternative to orthodox (allopathic) medicine. It offers us a comprehensive philosophy of health and reassurance and confidence in a safe holistic system of medicine without the fear of toxification or side effects. We now use the family doctor almost exclusively for diagnostic purposes such as blood and urine tests, and to arrange hospital appointments.

Angie got into homeopathy through a friend who had asked her homeopath to send Angie information on vaccinations when she was pregnant first time around. Although Angie had always pooh-poohed homeopathy and thought, "Oh, it's rubbish, these micro doses." She heard from several people that it was particularly effective on children and for diseases such as eczema, so when Sandie got eczema at 8 weeks she took her to a homeopath and became a convert when she was cured after 8 months of homeopathy. The homeopath encouraged her to learn about homeopathy, so she bought books and tried prescribing for her daughter and friends and then decided to come on the course to learn more. "I thought it important to have homeopathic first aid knowledge as I do not wish to give my children antibiotics, Calpol or other suppressants." she wrote in my questionnaire. In an interview she told me:

Homeopathy has just made complete sense to me. The way it's fitted in directly with my life. It's just a natural thing. It's not just medicine, it is a philosophy, it's almost like a religion. You know, talking about vital force and things like that.To think of health in the way that diseases are good for you, or telling you things about yourself.

Angie's passion for homeopathy is equally matched by her uneasiness with dealing with the NHS.

I feel happier not contributing to the coffers of pharmaceutical companies who seem to exploit and even cash in on the suffering of others, especially those with chronic illnesses. I cannot understand the usefulness or economy of a short term philosophy of healthcare such as that offered by the NHS.

In common with many of the women in my study Angie's antipathy to the NHS system has in part been formed by the experiences of childbirth.

Even going to see the consultant was disempowering 'cause they tell you how you're gonna give birth - They don't sympathise with the fact that you feel really strongly that if you are in control, you can control the pain. It's just the whole sort of institution thing, you immediately become this compliant (laughs) sort of person, when it's going against everything that you want. Like you say, "Oh will I have to have an epidural?" What kind of question is that! No one's gonna make me have an epidural. But I was actually asking those kind of questions, because I was in that kind of situation, you know. You immediately become powerless, asking questions about your health, which are your business and not theirs.

In her accounts of recent consultations with her homeopath Angie explained how homeopathy had helped her to deal with emotional issues around becoming a mother for the second time and the changes in her relationship with Mark brought on by parenthood. She had been feeling very sick and angry without knowing the cause but homeopathic treatment had helped her to identify her resentment about having been the primary carer for Sandie, and always the one with interrupted sleepless nights. This understanding enabled Angie to discuss her feelings with her partner Mark which in turn enabled him to admit to feelings of depression since Sandie's birth. Mark is now seeing a counsellor and Angie reports being much happier about her forthcoming baby and the future. Homeopathy in this example has been used to treat Angie's social environment and has become a medicine for the whole family. Angie subscribes to the view that all illness is rooted in emotional and social aspects of life, so this process seems entirely appropriate to her and contributes to her satisfaction with homeopathy.

Homeopathy as a medical system does pay a lot of attention to psychological phenomena and this may make it particularly attractive to people with psychological needs. It has been suggested that homeopathic patients do have a higher number of neurotic psychological traits (Amor and Todd, 1989).

Pragmatic Homeopathy Users

As a contrast 10 of the people in my study were more pragmatic users of homeopathy, who saw homeopathy as a complement to orthodox medicine not an alternative. These people had accessed homeopathy without seeking it out, almost by accident as it were, for example by having it prescribed by their GP, who they were often unaware of had

holistic leanings until he suggested a homeopathic solution. The pragmatic users could be said to have a cosmology of health that is normative for English turn of the 21st century culture. This view of health is biomedical, science-based and individualistic where health is seen as a property of individuals and where disease is located at the cellular or body organ level (Gordon, 1988).

A case study of a pragmatic user: Joanne

Joanne, a patient of the homeopathic GP illustrates this view of homeopathy as a complement to biomedicine, and not to be considered if you are seriously ill:

[Homeopathy] hasn't been proven, it's not been accepted, but eventually the two medicines will work together, homeopathy as a complement to medicine. The choice [being] which of these two medicines is suitable for this particular complaint...If you've got cancer, don't kid yourself.

Joanne who is 58 and a retired publican, has had breast cancer herself. She is married to Charles who is currently having radiotherapy and oncology for his own cancer. They live in an exclusive large detached house in a leafy London suburb. When Joanne had breast cancer a few years ago she did not use alternative medicine nor has she at any other time in her life until recently. Charles has not used alternative medicine for his cancer Joanne says that she would be open to him trying alternatives if she was aware of any "If somebody came along to me now and said, 'If he drank this... it's homeopathic, and it's for [cancer]' I'd encourage him to do it." However Joanne has very little awareness of possible alternative therapies. "I've never even heard, in that particular field, of any doctor who practises that." implying that she would only consider alternative therapy if sanctioned by and provided by biomedical doctors. Joanne was diagnosed with hypertension 'years ago' and given blood pressure pills by the more biomedical GP in her practice.

Joanne has very great respect for the biomedical system. She talks about consultants as advanced technicians and praises them for saving her granddaughter's life from asthma attack and her own from cancer. "My specialist, who to me was my god, I mean I respect him, I respect his position, and I respect the medical profession." "I have faith in the proven medicines of the hospital". She feels very dependent on the scientific expertise of medicine and told me she would be too frightened to lose confidence in the hospital. Joanne's discourse reveals that she takes the authority and expertise of doctors as absolute. She doesn't make decisions about her healthcare without asking them to advise, and implies a preference to give up all responsibility over to the medics. "You take advice that's more knowledgeable than your own".

Joanne is keen to stress the scientific basis of biomedicine and it's advanced nature compared with homeopathy: "They're forever undergoing trials and experiments and research, and it is getting better and better. Hopefully one day they will find that magic, you know, drug or gene that they've gotta get rid of, or whatever it is. I suppose conventional medicine is just thousands of years ahead of homeopathy. Joanne might be surprised to find this is a mis-perception and that homeopathy could be said to be older or at least a similar age to science based medicine.

Joanne's model of illness coincides with the quick-fix approach of biomedicine with treatments for particular bodily symptoms primarily to obtain short term relief. The quick solutions offered by biomedical drugs are important to her. "What we do with drugs, it allows us to get on with our life. And if you've got a busy life... If I had a cough, I'd go immediately to the chemist and say, "Give me something immediately." In the past she was referred to the homeopathic hospital for migraines. But admits that she wasn't strong enough to give it time, so just went back to the strong biomedical drugs in spite of worries about side effects. Her view of illness is accepting of biomedical diagnoses and there is no hint that she sees any role of emotion or social aspects in the causation of illness.

Joanne is a patient at the practice where one of the GPs Dr Deakin offers a number of holistic therapies in addition to biomedical treatments. At Dr Deakin's suggestion Joanne has used herbal treatment to combat recurrent chest infection. She believes the treatment to be homeopathy when in fact it was a herbal complex Dr Deakin prescribed:

I went to see Dr Deakin, and in my weak state he said, "Now what do you want, do you want me to give you antibiotics or would you try the homeopathic approach?" So I said, "Well you're the doctor, you tell me." So he said, "Well I think that we could attempt," he said, "because what will happen if you take antibiotics, it will suppress it..... but it is left there," he said, "but the approach of homeopathic medicine," he said, "you've had this cough and it's been (reoccurring), it's been hanging around. Now the homeopathic approach is that we are treating the root cause as opposed to the immediate fact that you've got a temperature and you've got an infection. But why have you got the infection? I want to know what is the root cause, why, you've had this come back two or three times." So he said, "So will you try the homeopathic?" So I said, "Yes, all right Yes, all right. I would." One disadvantage with homeopathic medicine, they give you horse pills. I took the, (laughs) horse pills, with... not too much confidence, 'cause I felt rough. ... But I didn't have to go back to the doctor.

Her views of homeopathy are as a much more primitive treatment than orthodox medicine. She talks of Indians who have been chewing the bark of trees for years. And suggests that homeopathy is what is used by "Aborigines and Indians, and people parts of the world whom to this day survive without... hospitals and surgeons and doctors". Her knowledge of homeopathy is very slight and she seems to confuse it with herbal medicine. Furnham (1999) found a lot of ignorance of homeopathy among the general public and a common misconception of it as purely a herbal medicine.

She suggests tentatively that it's becoming recognised now, after years and years, however she also refers to it as unproven. She is open to it becoming more acceptable in the future "Eventually the two medicines will work together. Maybe there will be a time when the homeopathy will come up level with accepted medicine, but I believe that it would have to work in conjunction. I do think that they will eventually end up such that they are recognised to the point that the choice is 'which of these two medicines is suitable for this particular complaint. I can't see homeopathic medicine ever overtaking conventional medicine. I mean you don't have operations where homeopathic medicine is concerned. I mean like say you've got appendicitis. Don't even think about it, where would you go? You'd be immediately off to the hospital to get rid of it. As much as I have a belief in homeopathic medicine, if you're in pain and/or you're really worried

about something that has an obvious root cause, I wouldn't have the confidence to go along that course.

So whilst Joanne has used homeopathy at the suggestion of her doctor she will only use it in certain situations. "Dr Deakin comes over as being a much more caring man, but the fact that he leans immediately towards homeopathy would stop me from seeing him all the time." Joanne is thus using orthodox medicine primarily and trying homeopathy occasionally so there is some pluralism of practice there. Ideologically however she is very much in the biomedical model of illness and healing. However as I pointed out earlier the development of a more committed view of homeopathy may be life stage related. Joanne's recent transition to grandparenthood and the problems of her granddaughter's eczema and asthma may make Joanne re-evaluate her views. Whilst she was in the waiting room at Dr Deakin's surgery during my research, she obtained a recommendation from a fellow patient for a non-medical homeopath to deal with her granddaughter's problems.

Two different kinds of pluralism?

If we return to the reasons for pluralism in healthcare that I outlined in the introduction, the group of committed homeopathy users appear to be using homeopathy for several of these. Regaining power was one key reason. After disempowering relationships with biomedicine in childbirth the taking over of responsibility for healthcare and rejection of biomedical technologies was experienced as very empowering. The philosophy of homeopathy seemed to be providing some of the users with an answer in the search for meaning in their lives and of a missing spiritual dimension, so this was another reason. They were also using homeopathy as an active part of a creation of their identities. Their adherence to a homeopathic philosophy represents a kind of ideological monism as their use of the biomedical system was reduced and altered to fit their new philosophy of health.

In the second group however, who appeared to be operating a more pragmatic pluralism of the kind discussed by Amarasingham, there were not the same issues of power. These people were not turning against the authority of biomedicine. far from it they were actually referring to this authority in their use of alternative medicine, which in my study was prompted by their biomedical doctor and not sought out by themselves. They too did not appear to be engaged in a search for meaning. Their use of alternative therapies was a purely pragmatic decision where biomedical drugs had not worked or to avoid their side effects. There was little evidence that their philosophy of health, illness and healing had changed and that their preconceptions were those of the normative biomedical dualistic and mechanistic views of the body. So again there was a kind of philosophical monism but pluralism of practice.

The only member of the study who was operating both pluralism of practice and philosophy was Dr Deakin the holistic biomedical practitioner. His multi-level explanations of diagnoses and treatment drawing on a myriad of different philosophies however seemed very obviously incoherent and produced confusion in his patients. I do not have time to present this data here but it appears to point to a possible need for

consistency and coherence of philosophy of healthcare in users even if this is accompanied by pluralistic practice.

This draws attention to the key role of practitioners in developing patients philosophies of health and healing. In the practice of healing there is also a more implicit and tacit role as educator into a certain philosophy of health. When the GP Dr Deakin conducts visual examinations of parts of his patients' bodies or orders urine tests and refuses to engage with discussion of the patients social context he is reinforcing biomedical conceptions of illness as located in specific body parts, caused by pathogenic invasion and as separated from the social world. All in spite of the alternative treatments he offers to patients. When Jenny the homeopath encourages patients to discuss the life events and social contexts of their lives and to seek for psychological causation's of illness she is subtly educating them into the homeopathic world-view of health.

Conclusion: A host of multiple medical pluralisms

I hope that the data I have presented has raised a number of questions about the nature of medical pluralism. This over-arching concept houses within it a number of different forms of pluralism. Whilst there is good evidence for pluralism in health seeking there appear to be a number of other pluralisms:

- 1. Practice versus philosophy:** Pluralism of practice appears to be possible without pluralism of philosophy. What is the relationship of engagement with multiple medical practices and ideologies of health and healing?
- 2. Use versus provision:** There are the different pluralisms of patient's use and of provider's provision. Some patients may experience pluralism of healthcare through consulting a number of different practitioners, and others through one practitioner who offers multiple therapies such as the doctor in my study.
- 3. Time; within sickness episode and over lifespan:** Plural health-seeking may happen concurrently or sequentially during a single episode of illness but there may be different patterns of pluralism according to different life stages. Whilst in my data there is some apparent consistency of philosophy it has to be remembered that this is snapshot research, only covering a few months in people's lives and these philosophies of health may well become different at other life stages, and with the onset of different life events. For example if Angie gets cancer will she still shun the biomedical system. Will Joanne's role as grandmother lure her in the opposite direction into seeking more alternative care for herself and for her husband's cancer?
- 4. Pluralisms of the body:** Much of the pluralism in healthcare seems to relate to the seeking of healthcare for the different needs of different conceptual definitions of the body, with different medical systems suiting the needs of different levels of the analytic body.

Each of these type of pluralism has the capacity to interact with each of the others resulting in even more categories of pluralism. If the label of medical pluralism is so broad, and covers so many sub concepts is the use of one term confusing? Is there a

need for a more refined taxonomy of pluralism? Certainly ethnographic work offers unique opportunities with its focus on process over time and situated context, and on belief and practice, to investigate the subtleties of these multiple pluralisms, and I hope my work on homeopathy in south London has shed some light on some of these issues.

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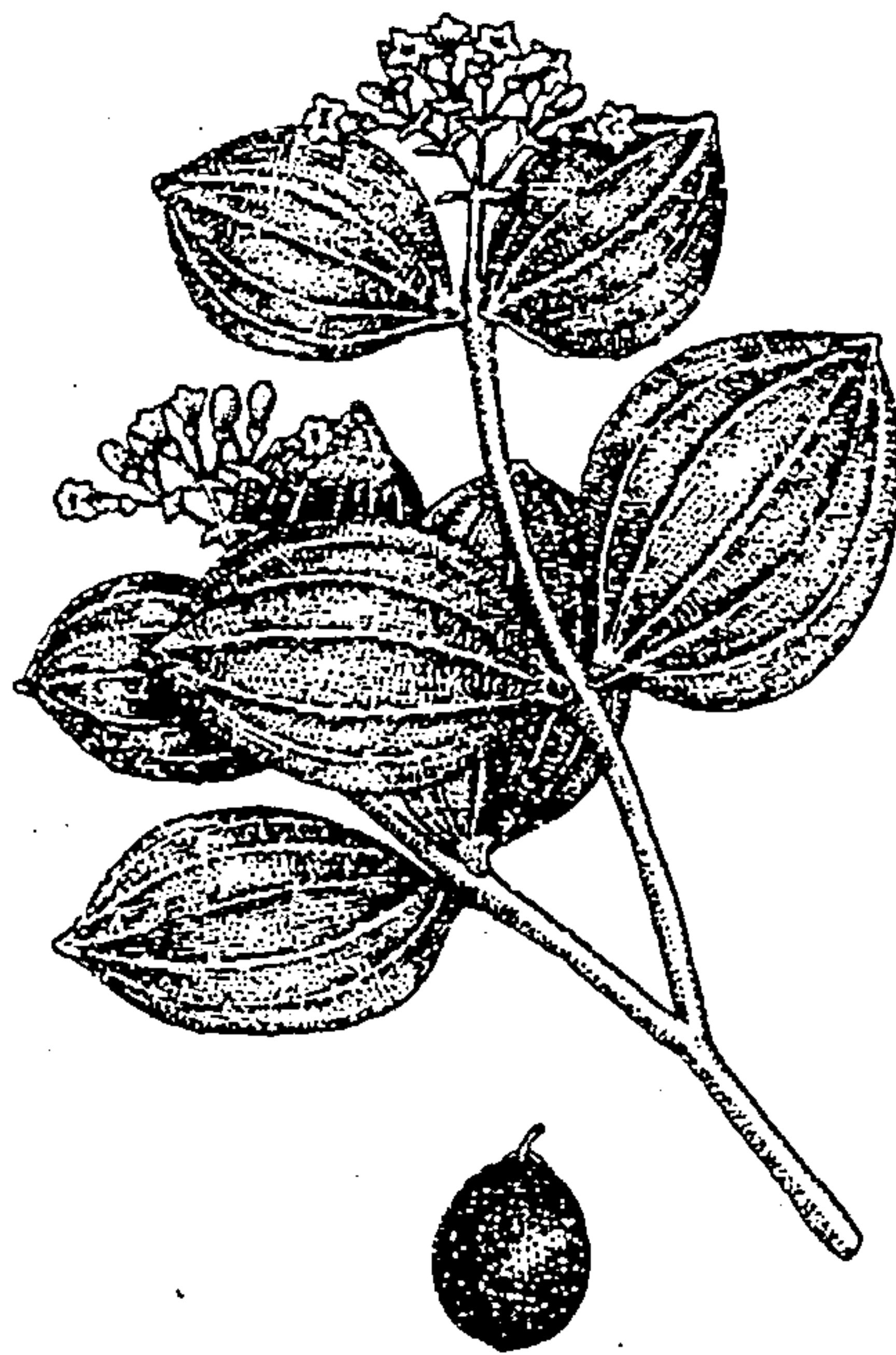
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NUX VOMICA (Nux-v.)

Family name: Loganiaceae

Common names: poison nut; Quaker buttons; semen
strychnos



IT'S A WOMAN'S WORLD: IDEAS AND PRACTICES OF HEALTH AND HEALING IN TWO HOMEOPATHIC GROUPS

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Introduction

This paper is about women's ways of knowing about health, and their learning processes to reach these world views, as a counterpoint to the prevailing biomedical views of health, and ways of learning about health. The data I will present is based on an ethnographic study of two groups of women learning about homeopathy. One group is an adult education homeopathy class and the other a childhood vaccination support group. This is part of my wider doctoral thesis comparing homeopathy inside and outside the NHS.

I didn't set out to study women as much as alternative medicine. However during participant observation with these two groups men did not feature largely. One man was an ongoing member of one group and one man made an appearance at one meeting of the second group. All the rest of my participants in these groups were women. The interactions in these groups were qualitatively very different to that found in the more medical contexts I had worked in as a researcher at a medical school and in the general practices and hospital clinics which had been the locations of my prior research. This prompted me to explore in more detail to these ideas about women's ways of health.

As a counterpoint to women's ways of knowing about health I will use biomedical ways of knowing, rather than the more obvious counterpoint of men's ways of knowing, in part to minimise the dangers of essentialising women and men as bounded static categories. My research is mainly with white middle class women with small children from south London so I am presenting data on a particular group of women, and further research may uncover other women's ways of knowing perhaps related to different life stages, class or cultural backgrounds.

I will start by reviewing the literature in brief on biomedical ways of knowing and learning and in greater detail on women's ways of knowing and learning. I will then present data from these two groups in which women are developing their knowledge around health related issues in real - life group settings.

Biomedical views of health

When reviewing biomedical views of health two issues are important to bear in mind. Firstly the danger of reifying the biomedical as the natural way of healing against which other healing systems are to be compared. And, secondly the danger of essentialising biomedicine into one fixed entity.

On the issue of the fallacy of medicine as the natural system Byron Good convincingly warns against the dangers of the empiricist paradigm in which the biomedical is seen as knowledge and other systems as belief (Good, 1994). Good problematises this notion of belief. In empiricist work belief can be seen to imply counter-factual assertion and denote uncertainty or error. Good illustrates this trap using Evans Pritchard's work on the Azande (Evans-Pritchard, 1976). Evans Pritchard organised his book around what the Azande *believe* (witches) and what they *know* (the naming of diseases). This implies a distinction between those ideas that accord with objective reality - and with the medical practice of deriving diagnoses from symptoms - and those that do not. He uses knowledge to describe the former and belief the latter. Good argues that this differentiation leads to an unhealthy alliance with the official theories of misfortune, backed by powerful social agencies. I agree with Good's suggestion that all medicine joins rational and deeply irrational elements, and hope to be able to avoid this empiricist trap, of seeing biomedicine and alternative medicine as knowledge and belief respectively. Unfortunately the use of the term alternative in itself buys into this empiricist paradigm, but I will continue to use it acknowledging the inherent ideologies denoted by it.

Biomedicine is most usually perceived as a single unitary monolithic entity, whilst it could be shown to be an extremely plural medical system. This plurality within biomedicine is in part a result of the nature of the concepts subsumed by the umbrella term of biomedicine, which are complex and multifarious. Biomedicine simultaneously denotes an ideology, a practice (or series of practices) and a scientific paradigm, all of which are inter-related. Ethnographic accounts reveal some of this diversity {references?}. The practice of biomedicine differs according to medical specialty and individual practitioner within that specialty, and also according to which country or cultural system the practice is located in. There is much variety in the system, much of the practice carried out in the name of biomedicine is far from the central ideology and sometimes completely at odds with it. Even the dichotomy between biomedicine and alternative medicine becomes suspect when reviewing the degree to which there are syncretic mixings of the two systems on both sides. Each system has incorporated elements of the other. My own data provides perfect examples. Jenny and Eve the homeopaths I will come on to discuss are respectively an ex nurse and ex midwife; while Dr Deakin is an NHS GP who offers a variety of alternative solutions to his patients including homeopathy herbalism and acupuncture.

For the purposes of this comparison between biomedical ways of knowing and womens' ways I will tend to present a more unitary view of biomedicine which is perhaps best encapsulated by the training stage of medicine, but will keep in view the idea that this "ideal type" can not be generalised to the whole of biomedicine. Just as women's ways' can not be said to speak for all women.

So how is biomedicine defined in these unitary accounts? Some of the key features are: separation between mind and body, body and emotions, and medicine and emotions; depersonalisation and distancing from everyday events; biological reductionism; and the dominance of the natural science model of explanation with detached observer and calculative reasoning (Lock & Gordon, 1988).

To use a comparative definition Fabrega and Silver (1973) made the following distinctions in comparing biomedicine with the shamanic Zinacantan system in Mexico. In biomedical practice the body was treated as a complex biological machine rather than a holistic integrated aspect of person and social relations. The biomedical healers aimed towards distance, coolness, formal, and abstract concepts as opposed to closeness, shared meaning, warmth, informality and everyday language. Finally the biomedical healing was aimed purely at the body and did not incorporate social relations and supernatural agents unlike the Zinacantan healing.

Two ethnographic accounts of medical training provide a more ethnographic contextualised account of the features of biomedical training, those conducted by Simon Sinclair in a London medical school (Sinclair, 1999) and Byron Good at Harvard medical school (Good, 1994).

Sinclair's ethnography reveals the processes of medical training as ones in which these central aspects of biomedicine are created. He shows how certain methods of teaching promote a specific view of medicine. The process of cadaver dissection promotes emotional detachment and objectification of the body. Presenting data in lectures about the working of the body as an accumulation of discoveries of scientists, without attribution, promotes a view of the practices of medicine as indisputable and uncontested. The question and answer method of teaching promotes hierarchy and a view of the diagnostic procedure as one of set formulae and lines of logical reasoning. The process of clerking and 'taking' the history promotes the formalisation of the patient's narrative into medical categories and the stripping of social and emotional context. The consistent denigration of the social sciences and psychiatry also contributes to the downplaying of patients' psychological and emotional states.

Good's work mirrors these findings in an American context, and elaborates theoretically on some of these points. He shows the hierarchical aspect of medicine does not just come from organisational factors but from the whole way in which the body is learned about. He sees medical training as a set of formative processes through which medicine constructs its objects. Unlike Sinclair he sees anatomy lab not as a site which simply dehumanises students but one that contributes to a deconstruction and then reconstruction of how the human body is experienced: as a different type of object. He shows how students learn to see the body as a hierarchy, moving from the gross structure, through the more details anatomy of muscle and blood vessels into a yet more micro level of cellular and molecular structure. He notes that this view of the body is reinforced almost universally in lectures about the body and disease. No lecture can be given without slides and these usually move down the hierarchy reinforcing this view. Moving from the epidemiology, through clinical slides of patient, pathological specimen, then cell structure, then electron micrograph, then diagram of molecular structure and genetic expression. Each level reveals the more basic structure of the next order and reproduces this enduring idea of hierarchical orders, each encompassing the other. Students learn to relate surface signs to underlying mechanisms.

Good also shows how the patient is constituted through the "Speech acts" (Austin, 1962) which quite literally shape and reshape the body. In this case the writing and speaking about the clinical case. The students learn the format for both the write-up of the case and the presentation of it to colleagues. This then formulates the way in which they interact with real patients, who in some senses become secondary to the paper

patient. As one of his informants put it " You begin to approach the patient now with a write up in mind...you're thinking in terms of those categories".

The story as written and presented is a story of the disease process, located spatially in tissue lesions and disordered physiology and temporally in abstract medicalised time (Frankenberg, 1988) The person, the subject of suffering is represented as the site of the disease rather than as a narrative agent. (Good, 1994:80) Another informant says "You're not there to just talk with people and learn about their lives and nurture them". One result of this approach according to Good is the inattention to the lifeworld, (Mishler, 1984; Barry et al, 2001) the other is routine, rational medical practice.

Good admits that these learned processes of interacting with patients and their bodies are most strong at this stage of medicine and that different processes formulate medical practice for more experienced clinicians and within different specialities. However this view of biomedical ways of knowing will serve as a point of comparison to women's ways of knowing.

Women's bodies / women's health

Women's different bodily experience is seen to produce a different view of health to that of men. Robin Saltonstall researched men's and women's concepts and practices of health in everyday life. This was an interesting study but had one weakness in that none of his sample had given birth to or brought up children, experiences likely to change people's perceptions of health quite dramatically. In spite of this proviso it is interesting to see that when asked for general definitions of health, women frequently alluded to friends and family in their definitions. For example being loved and taking care of family were stated as aspects related to states of good health. The men's definitions focused on them as individuals and did not include other people.

The men in the study talked of health practices as a way of keeping or being in control and minding the body, their talk suggested a 'power over' relationship with the body. They spoke of bodies as though they belonged to them as objects. Women on the other hand spoke of their bodies as though they had a momentum or subjectiveness of their own. The relationship between women's self and body was presented as more collateral and less hierarchical, with women in dialogue with their bodies and listening to messages from the body about what it wanted or needed (Saltonstall, 1993).

In "The Woman in the Body" Emily Martin presents the idea that women are subjected to a dominant cultural view of their bodies, which diminishes their lived experience of them. Women represent their relationships with their bodies as fragmented and lacking a sense of autonomy in the world, of being carried along by forces beyond their control. Martin shows that the scientific metaphors through which women's bodies and their associated processes of menstruation, childbirth and menopause are discussed in industrial society, and in particular in the medical arena, imply failed production, waste, decay and breakdown. However, she suggests that women's lived experiences of their bodies, and the divisions of labour between men and women, lead to women having a different world view to men, one which is less dichotomous and more whole. She discusses how the processes of women's bodies such as menstruation and pregnancy can not be kept separate from the workplace, and how women's more cyclical experiences of

time can not be scheduled to fit with more linear notions of industrial time (Martin, 1987).

Martin cites Hartsock who argues that women's involvement in child rearing, birth, housework, results in them experiencing life as concrete, bodily, natural, real and changing, as opposed to men's experience of daily life as abstract, mind driven, cultural, ideal and static. "The female construction of self of self in relation to others, leads toward opposition to dualisms of any sort, valuation of concrete, everyday life, sense of a variety of connectedness and continuities both with other persons and the natural world. If material life structures consciousness, women's relationally defined existence, bodily experience of boundary challenges, and activity of transforming both physical objects and human beings must be expected to result in a world view to which dichotomies are foreign (Hartsock, 1983:299).

Martin warns us against seeing women's ways of doing things and seeing the world as back to nature. Instead she argues: "When women derive their view of experience from their bodily processes as they occur in society, they are not saying back to nature in any way. They are saying on to another kind of culture, one in which our current rigid separations and oppositions are not present....women are not only often aware of their oppression, but they are able to forge alternative visions of what the world might be like. (Martin, 1987:200).

The role of motherhood in women's views of health and their bodies appears to be key. As Ann Oakley put it "It is the moment of becoming a mother that a woman confronts the full reality of what it means to be a woman in our society. Motherhood entails a great deal of domestic work - servicing the child, keeping its clothes and its body clean, preparing food...It is a crisis in the life of a woman, a point of no return(Oakley, 1981: 1).

Motherhood involves: constant housework, different hours, a different workplace, different workmates, less money, isolation, monotony, fragmentation, 24 hour responsibility, and poor housing for some. Suddenly having no other occupation to call ones own may seriously injure a woman's self concept. To work or not to work isn't just economic it's also about the legitimacy of one's own needs as a person. Meeting people they aren't interested in you if you don't have a job. All of these factors contribute to a change in identity Oakley (1981). Smith's study of identity transition emphasised the growing awareness of complex changing family connections and involvement with others seeing it as a shift to a more relational self (Smith, 1991).

During pregnancy, although women see the process as one of normality and health (Oakley, 1981), they are entered into an unavoidable series of interaction with the medical system, that sees pregnancy as a medical condition. "Processed through labour as if on a conveyor belt, with little or no choice about what happens to her..... she is very likely to feel that her body no longer belongs to her but to the hospital (Kitzinger, 83). The medicalisation of childbirth is a well analysed phenomenon (see eg. Davis-Floyd and Sargent1997).

The contact with the medical system at this time may provide a powerful experience to women. This may well be the most contact they have had with the medical system and suddenly it is extremely concentrated. At the time of Oakley's research in the 1970s the

women in her study made between 7-18 visits to the doctor during pregnancy and the first 4 months after. And during these visits they saw on average 9 different doctors. There was a tendency for the women to become less and less happy the more medical contact they had. The main complaints were about depersonalisation; not being able to ask questions; and seeing too many doctors. As the women put it " You're just a body to them a body with a name" " It's like a butchers shop you are laid out on slabs" " I wanted to say to them that's my womb you've got up there - [on the ultrasound]" (Oakley, 1981:281-2).

Oakley summarises her study of motherhood in this way: " Producing a baby is re-producing, looking differently at ones body, one's identity, one's way of living in the society of which one is a part. And in becoming a mother a woman takes her place among all women, conscious in a new way of the divisions between men and women, more sharply aware both of the ties of human kinship and of the special solidarity of sisterhood." "If any single phrase can sum up the message of becoming a mother it is this: the value of experience"... "Experience brings sympathy: that is the message. Throughout the process of becoming a mother, the people who are valued are those whose expertise is of the personal and practical kind. The contradictions are not between the expert and non expert, but between one kind of expert and another" (Oakley, 1981:307-8).

These themes of on the one hand medicalisation and the rejection of the medical ways and on the other, the moving towards valuing sisterhood, experience and a different conception of expertise, become very relevant within my data. Some of these ideas are encapsulated in the concept of authoritative knowledge which I will outline next.

Authoritative Knowledge

Brigitte Jordan's concept of authoritative knowledge, acknowledges that there are different forms of knowledge at play in situations like hospital childbirth. She contrasts authoritative knowledge: "The interactionally displayed knowledge on the basis of which decisions are made and action is taken", in her example organised into a hierarchy of power, with other forms of knowledge which are present but not dominant such as the embodied and experiential knowledge of women in childbirth whose knowledge is subjugated to the more powerful knowledge of the medical systems (Jordan, 1997).

Jordan (1997) sees the constitution of authoritative knowledge as an example of situated learning (Lave and Wenger's, 1991). Authoritative knowledge is not something that is possessed by individuals, rather it is constructed in an ongoing process of social interaction that both builds and reflects power relationships within a community of practice.

In her analysis of a videotaped high tech birth, Jordan shows how all the participants work to maintain the situation as one in which only the doctor's word on when the woman is ready to push is reinforced as legitimate knowledge. The woman's claim's to knowledge that she is ready to give birth are ignored through a number of interactive processes.

Jordan asks: "How can we move from a situation in which authoritative knowledge is hierarchically distributed to one in which it is horizontally distributed in which all the

participants in the labour and the birth contribute to the store of knowledge on the basis of which the decisions are made"(1997: 72)

Ketler (2000) using Jordan's concept of authoritative knowledge contrasted 2 childbirth preparation classes in Italy and showed how in one a medical hierarchical authoritative knowledge was maintained whereas in another women's experiential knowledge came to take precedence as authoritative knowledge. She links this with organisational processes in the two groups of teaching and learning. In the medical group the women were subjected to a stream of lectures from numerous experts. The second group had more continuity of personnel with women able to build up friendly relationships with the staff and with each other. The learning was decentralised with space for women to interact and to share experiential knowledge in an atmosphere of trust. The women's knowledge gently nudged aside the biomedical knowledge so each became equally legitimate. Women reported the making of friends to provide support after the birth as one of the key benefits of the course.

Women's View of Healthcare

Perhaps one way to move to this more horizontally distributed power is to let women take charge of the organisation of healthcare. Lauver in a recent paper compares women's ways of organising healthcare and spirituality groups (Lauver, 2000). When women define characteristics of acceptable health services, they specify interpersonal interactions that are caring and egalitarian. Mirroring the main sources of healthcare through intimate relationships such as mother/grandmother child.

Women want health practice to involve having their lived experiences listened to, responded to, valued and validated. Women's health practices are characterised by more egalitarian relationships than in traditional health care settings, with practitioners respected for their expertise about health and interventions, and clients respected for their expertise about their bodies and responses (Schaps et al, 1993). When women's experiences with stressful events such as harassment, violence, or abuse are listened to and responded to by groups or communities, women's health is improved.

Lauver(2000) noted that in women-centred healthcare settings women's choices were respected and their control encouraged. And that consistent with feminist principles, practitioners often assist women to change undesirable situations, rather than adapt to them. Thus environments are created for the transformation and empowerment of women.

Feminist writers such as Ehrenreich and English (73) have argued that biomedicine imposes passivity, ignorance and powerlessness on women, and called for collective self help activities to arm women to demand what they need from health and to re-connect the body and social worlds.

Scott (1998) in her paper "Homeopathy as a feminist form of medicine" proposed that homeopathy represents a woman-centred way of doing healthcare. Most homeopaths in this country are women, around 70% (and in other countries like Germany (Frank, 2001)). Scott suggests the ways in which homeopaths work succeeds in creating a feminist form of medicine: through empowering the patient, including social concerns and non trivialising women's' concerns and knowledge. The patient and her body are

given more power because the homeopathic remedies are designed to match the patient, by mirroring back her condition to her, or through supporting the patient's own body in it's own chosen mode of healing. The homeopath is a secondary partner in the healing relationship.

Subjective experience is central to homeopathy's diagnostic procedures. the detailed case taking is very attractive to most women: patients must be set at ease and allowed to set the conversational agenda, and social and emotional factors are a key part of that agenda. The social is a fundamental element of homeopathy. Sankaran (91) argues that each remedy represents a bodily/emotional posture which is the best possible response to some social environmental situation. "Thus the sort of in-depth, respectful attention which feminist critics have wanted from their health care providers is a necessary part of homeopathic practice" (Scott, 1998:205).

Women's Ways of Knowing

In 1982 Carol Gilligan produced evidence that women's ways of thinking about moral issues were more oriented to care and responsibility as opposed to men's' which were more geared to justice and rights. A couple of years later in "Women's Ways of Knowing" Mary Belenky and her colleagues drawing on the work of Gilligan and others (e.g. Chodorow, 1978) researched a wide and varied sample of 135 women to understand their conceptions of truth, authority and knowledge. They came up with five different perspectives from which women view reality. The first two viewpoints were relatively disempowered positions. Women were either passive and had no sense of self and no language with which to explore it (1. silence); or they looked to authorities for knowledge and learn by listening to others, seeing the world in very simplistic black and white/ right and wrong terms (2. Received knowledge).

In the other three groups there was a sense of women's development of their own ways of thinking. These included a position where women moved on from accepting authority (often after crisis of trust in a male authority figure in their lives) to listening to their gut feelings and intuitions, and becoming more aware of themselves through reflection. In this position there was a passionate rejection of scientific values and of logic analysis and abstraction, and a preference to learn through direct sensory experience or direct involvement(3. Subjective knowledge).

The fourth position (4. Procedural Knowledge) involved a move to connected knowing with knowledge coming from empathy and understanding their own and others personal experience. In the final position the women integrated reason and intuition and the expertise of others. They began to evaluate experts' knowledge and used the self as a tool of understanding. Knowledge involved integration of feelings and passions with intellectual life and embraced ambiguity and complexity (5) Constructed Knowledge).

As well as looking at women's viewpoints Belenky et al (1987) investigated preferred models of learning and education. All the women wanted a system in which knowledge flowed in 2 directions where they were treated as containers of knowledge not empty receptacles waiting to be filled up. Their own experiences of life and relationships form part of this existing repository of knowledge, and are valued as contributions in the learning process, via sharing of experiences between people in groups. The kinds of

learning associated with the last two positions were intimate, informal and unstructured. Authority was seen to rest with commonality of experience not hierarchical power or status. Their preferred teaching would involve students and teachers engaging together in the process of thinking, getting to know one another, happy to voice uncertainties, with a breaking down of the separations between the role of learner and teacher. This model is more one of community as opposed to traditional hierarchical and adversarial models of teaching.

Summary

To summarise this literature. Biomedical views of health are structured around separation, abstraction, depersonalisation and biological reductionism. Biomedical education processes are organised hierarchically and promote emotional detachment, logical reasoning and the stripping of social and emotional context.

Women's bodily and childrearing experiences predispose them to see the world in a less dichotomous and more relational and connected way. They prefer to gain knowledge in ways which are less abstract and logical and more grounded and connected to the feelings and experiences of themselves and others. They wish to gain this knowledge through non hierarchical interaction, through sharing of their own experiences with others in informal, intimate and unstructured settings. Health is seen as a property that resides not only within their bodies but in their relationships.

Women's experiences of biomedical healthcare systems, notably through the conveyor belt of prenatal and maternity care does not match women's worldview. Feminists have argued for more woman centred healthcare. Scott has argued that homeopathy matches this model of woman-centred healthcare, and better suits the way women experience the world.

I will use data from two homeopathy related settings in which gaining knowledge about health is the focus of activity to look both at women's views of health and at their processes of learning in women-centred environments.

Methods

Studies of women's health often focus on the health of the women as patients not individuals in their contexts. They often focus on illness rather than health and use biomedical disease categories to define illness. Research often spotlights interactions between women and healthcare workers, such as their doctors or midwives. The result of this is a kind of medicalisation of health research. In fact there have been debates in recent times about the medicalisation of both sociology (Williams, 2001) and medical anthropology (Browner, 1999). In my research, I have come to see women's health as a social, rather than an individual property, embedded as it is in the context of their families and friends. With the women I study, biomedical disease labels play only a very partial role in viewing health, and healthcare interactions are just as likely to be located in the community as in hospitals and GP surgeries, with formal healthcare workers such as homeopaths but also with friends and family, usually female. In part the discovery of this view has been through researching settings outside the formal

healthcare system in which women meet to discuss their everyday concerns about health.

One group is an ongoing Vaccination Support Group run by two homeopaths. The other is a one year introductory adult education class on homeopathy run by a homeopath. I selected both groups as places where women would be discussing health and alternative health care in a naturalistic setting. Both groups are located in south London and frequented by white middle class women, most of whom are mothers or grandmothers, with the odd father attending (during the year of my participant observation one father attended one meeting of the vaccination group and one man joined the second and third terms of the homeopathy class). I attended both groups over the course of a year, between 2000 and 2001 (19 two and a half hour sessions of the homeopathy class, and 10 two hour meetings of the vaccination group). I observed interactions, took verbatim notes where possible in the group and expanded brief notes immediately after the group into longer fieldnotes. I interviewed the two homeopaths and 6 of the women from the vaccination group. Seven of the adult education class filled in an open ended questionnaire for me and I interviewed 4 of them.

The Vaccination Support Group

The Vaccination Support Group was started 3 years ago by Jenny an ex-nurse turned homeopath. The impetus to start the group came from her clients. She started noticing that people were saying they were having issues about vaccination and making decisions and not knowing where to get the information from, so she changed her homeopathic first aid group into a vaccination support group, with the help of her friend Eve an ex-midwife turned homeopath. The group meets one evening every month for a couple of hours in Jenny's house or the house of one of the group members Sally. Jenny has a list of topics for discussion and negotiates with the group their preferred topics for a particular session. The women who attend the group are mostly mothers of babies and small children, although quite often homeopath friends of Jenny and Eve's attend or other alternative therapists, to find out more about the vaccination debate to support their clients. The evenings cover childhood vaccines and the research on their side effects, and information about homeopathic strategies to boost immune systems and treat symptoms if mothers choose not to vaccinate their children.

Jenny explains that she is not there to tell people what decision to come to but to support them in their decision making. "We never make decisions for people. We try not to say you shouldn't vaccinate." (Jenny interview July 00). Not all members of the group choose the non vaccination route, many of them choose to give some but not all the vaccinations to their children. Ruth one of the mothers who has avoided giving her 4 year old daughter any vaccines says:

"It's great support just to be with other people who have made that decision because it's quite an unusual decision to take. It's very frowned upon by government and medical profession and there's a lot of pressure to join the vaccination programme. It's a huge responsibility" (Ruth Interview July 00).

The meetings are very relaxed. There is no ceremony. Everyone is in informal clothes, sometimes babies are brought and played with or breast-fed during the session. Tea,

cakes and lots of laughter are shared. It is hard to tell who in the group is an alternative practitioner and who a mother, and some women span both roles like Olivia. As a homeopath she wants information to support her clients, and as a mother of a 3 year old needs information to support her own decisions.

Tamara came to the group for a couple of years. She explains how the group served her:

"And the support thing, you know, the fact that I don't have any friends who don't vaccinate. That's the problem, you know, you do feel isolated. ... So it was nice to meet other parents in the same situation and to sort of talk them through and feel... well just sort of gaining a bit of solidarity really. And having made a decision which puts you in a minority, and it is a decision which is terribly personal and terribly difficult as well, in the sense that it concerns the thing that's perhaps most precious to you in the whole world. You don't want to expose yourself to other people's criticisms, opinions, judgement, you know, you just need to protect yourself, certainly in the early stages about having made that decision, and stick with people that you know are gonna be supportive of it. You don't want to be undermined." (Interview June 01).

Just recently there has been a TB scare at a nearby nursery school in Greyborough (a south London borough), and one of Tamara's daughter's friend's has a sister at this nursery. Tamara rang Jenny the homeopath for advice and she suggested she come to the next meeting of the support group in May this year. There are seven women at the group the two homeopaths, an osteopath Stella, Olivia the homeopath mother, and four other mothers including Tamara. Half way through the meeting TB comes up and Jenny prompts Tamara "you had some questions on this?" Tamara asks

Tam: To what degree should I bother panicking about [homeopathic] prophylaxis. My daughter's school are keeping it very quiet should we not be bothered?

In response to this the two homeopaths speak first, giving Tamara advice:

Jenny: There is always a risk. If you walk through the local shopping centre there is a risk if someone coughs at the moment you pass, so there's always a risk. If you have a healthy body are able to fight off most things if you can maintain good positive health the way you are doing. Breastfeed give lots of love and attention, exercise, good food. When they get sick treat them with an energy medicine, herbal, homeopathy

Eve: Cranial osteopathy

Jenny: To keep their energy flowing. We are all energy after all. Only our consciousness makes us think we are matter, we are just energy. Give the child a few treatments to ... Our ancestors have passed on their susceptibility

Tam: I am taking it [homeopathic TB]

Jenny: I gave a healthy looking child TB30 recently. She came out in eczema. It was lying dormant. There's an awful lot of TB around. Some people are more susceptible than others.

Eve: The trouble is most bacteria when they dry out die but these don't and in places where people spit into the road they just lie there in the gutter until they are activated and thrown into the air. But on TB wards the nurses and doctors didn't used to get it because they were more healthy

Jenny: If poorly and under the weather.... Wouldn't it be interesting to know for those on antibiotics in Greyborough their health history compared to those who aren't. Having said all that you are a Mum and so am I. My sister recently invited my 12 year old to stay in Leicester at half term and since then it has been constantly on my mind (laughing nervously). 99% of me believes what I am telling you but I am still a mother and I live next door to Greyborough so it doesn't make sense.
(Extract from Session 10 May 01)

In the next part of the discussion the osteopath Stella, The homeopath & mother Olivia and one of the other mothers with older children join in. Olivia asks whether the schoolchildren have all been put on antibiotics. Stella answers her that according to the TV they have been. Then there is a discussion between all of them, including Eve and Jenny, about what they would do if it were their children. There is some openly stated disagreement about the best course of action. Eve is laid back, saying she would just use homeopathy, but she does not have children of her own. Jenny says that as a mother she'd be very worried, and she would use the antibiotics. Olivia and Sally, the mothers now support Jenny, the homeopath. The attention then turns back to Tamara. Sally turns to Tamara and says

Sally: You have to keep healthy as possible. You should take them for cranial therapy.

Stella: My advice to you is to avoid your weakest link. Who is giving you the heebie jeebies about this TB scare? Is it your husband or your mother-in law? Because it's depleting your energy and you need to avoid that argument.

Sally:It's not helpful

Tam: Ironically it's other mothers

Stella: Well maybe you need to withdraw into your family unit and avoid them for a while that would be a positive response

Sally:It's the herd mentality (lots of yes's, mms around the room) that's what wears you down to have the vaccines. Avoid Mums who just want to discuss how ill their children are every day.

(Extract from Session 10 May 01)

The rest of the session moves away from Tamara's concerns. This extract reveals a number of features. The conversation is unstructured and free-flowing responding to the questions and needs of the women. The women are able to share experiences of their own, and fears and worries with each other as a legitimate form of learning. The women listen well to each other's contributions letting each finish before talking and affirm each other.

This is a space where authority can be questioned. Tamara does not accept the school's stance which is 'keeping very quiet' and not suggesting any action, and takes up her own authority by asking the group for advice. The authoritative knowledge at work here is that of the group not of the medical or educational systems.

Roles are interchangeable with the homeopaths offering advice and support but also the mothers offering information and advice to each other, and support to Jenny when she reveals her own worries about her daughter's risk of the disease

In an interview with Tamara a couple of weeks later I asked her whether it had been worth her going that particular night and what she had got out of the meeting. By hearing of other people's fears she grew in her own self confidence:

T: Well I think I was feeling a bit vulnerable about the TB thing. It just gave me a little boost. I was quite surprised in some ways that, Jenny owned up to feeling.... Do you remember she said about not wanting to go up to Leicester because it was too [dangerous with the outbreak of TB up there]. I was, "What? Come on." (laughter). I mean it was very honest of her to admit that, but even so I was slightly taken aback. And then somebody else said something to me [about being very worried about the TB risk] and I thought, "Ooh, you know, maybe I'm less spooked than they are by all of this."

Tamara also took up Sally's suggestion and consulted a sacro-cranial osteopath to boost her children's immune system during this crisis period. "Funnily enough I'd always been open to the idea, But Sally I think it was, mentioned that her children went regularly, and I was just looking for another thing, because I was worried about this TB thing". In this case the 'authority' to consult a different practitioner to the homeopathy espoused by the course organisers came from one of the group. Jenny supports mothers in making these sorts of decisions and does not push one form of healthcare at them.

The Homeopathy Class

"An Introduction to Homeopathy" is part of the adult education programme in one of the leafier, more prosperous suburbs of South London. The classes take place every Tuesday morning in one of the college campuses.

We meet in Room G26, a draughty room with tall Victorian windows that don't quite close. A long oval table and orange plastic chairs seat the group. Nancy, our teacher, a homeopath in her 50's trained for 5 years and has practised as a homeopath for 12 years and is now also training in Cranial Osteopathy. She has been teaching this course for a number of years and says she loves teaching and the opportunity to rediscover the magic of homeopathy with each new class.

The whole group consists of 14 women in the autumn term of 2000. In the spring term 9 of these continue and an additional woman and a man who studied the first term on a different day also join us. The group has a number of different types of constituent. Mainly mothers with small children, who use homeopathic remedies to manage their children's minor illnesses and who mostly have not had their children vaccinated. The

three older members of the group have grown up children and there is one GP who is thinking of training in homeopathy.

At the final session of the third term, by which time the group were well cemented as a community of friends Angie, about to give birth to her second baby interrupted the formal teaching agenda with her fears around childbirth:

Angie: Can I change the subject to what to do about my baby that they think is breech, and I've given it Pulsatilla 200. I need it to turn as I want a home birth (looking and sounding desperately upset and worried and near to tears). I've seen a whole load of midwives and been scanned. Can we do a visualisation of it turning?

Lisa: If we bring it into consciousness we have the power.

Angie: I've had 3 Pulsatilla 200s since I heard. Should I try 1M, or 6X twice a day?

Lisa: 200 or 30s regularly.

Sarah: If you have been on 200s is it OK to take 6s? Or will you end up proving the remedy?

Nancy: You can use Pulsatilla to keep it there, [once it has turned]. Some give high [dose] first and then lower. It won't prove it.

Angie: They are doing an ultrasound to check it. I'm worried about turning the baby into a Pulsatilla [constitutional type]. I've been burning moxa on my toes - from acupuncture, the midwife recommended it.

Nancy: Positive thought. It's so difficult when you turn on the radio and TV the message is it's an evil world.

Sarah: The medical profession do not encourage you to do it for yourself.

Angie: The midwives said you should have a home birth, then changed when they saw the consultant. It moves the control from your own home to control by them - "you will give birth in the stirrups".

Lisa: It's fear.

Nancy: Their fear.

Emma: We are now a suing society -a lot of fear in hospitals.

Sarah: There's a fast increase in caesareans.

Angie: They don't know how to let a woman deliver her own baby.

Nancy: Who will be at the birth with you to give you remedies?

Angie: My friend.

Nancy: Does she know about the remedies?

Angie: No. I'm trying to teach her.

Nancy: Or you could ask your homeopath she might come?

Helen: Do you build up that kind of relationship with your clients? You aren't charging by the hour.

Lisa: Yes we do. No we don't charge by the hour!

Helen: I expect there's a lot you don't charge for phone calls and so on. You spend a lot of time doing work that isn't seen by the sound of it.

Nancy: You won't get rich in money being a homeopath.

(Extract from Session 19 June 01)

Like the other group the advice given comes from both the teacher Nancy and her colleague Lisa but also from the other women in the group, so the role of teacher and pupil is unboundaried. Angie's experience becomes an episode used for learning about dosage, about use of the Pulsatilla remedy and about structural aspects of practising as a homeopath, something several class members aim to train to become.

Angie is free to express her anxiety in the group and to gain support from others who understand her concerns about losing control. There is open questioning of medical authority by Sarah and the homeopaths counter by framing their behaviour as fear of litigation. The group has very similar properties to the vaccination group.

In the interview with Angie at her home the next week I learned that the baby had turned. Angie was very pleased about "now being on for a home birth".

"Having Sandie I was very much in control, considering some of the stories you hear. But just by entering the hospital things immediately became more painful, more confusing... you felt like you had to ask permission for sort of everything. As opposed to being at home where you just do what you want. The thought of when this baby turned breach. ... of having to go to hospital before I'd even started labour, I just knew it was just going to end up as a complete nightmare.

"Even going to see the consultant was disempowering, you know, cos they tell you how you're gonna give birth - or how they're gonna deliver the baby rather. And he was a really nice man, you know, and it's his job, but... they just don't understand. Midwives do understand. But I think doctors, consultants, obstetricians, they probably understand but they don't sympathise with it, cos it's not their field, you know. They don't sympathise with the fact that you feel really strongly about keeping it in control. If you are in control, you can control the pain. Once you lose control, you start to have more pain. So yeah, that was what I was dreading. It's so ingrained in you to...it's just the whole sort of institution thing, you immediately become this compliant (laughs) sort of

person, when it's going against everything that you want. Like you say, "Oh will I have to have an epidural?" What kind of question is that! No one's gonna make me have an epidural. But I was actually asking those kind of questions, because I was in that kind of situation, you know. You immediately become powerless, asking questions about your health, which are your business and not theirs." (Interview June 01)

Angie is clear about the superiority of her own experiential authority in this situation, about the power of the woman herself to deliver her own baby, and the relationship between control and pain. She still needs the emotional support of others to fight mentally against the power of the medical forms of authoritative knowledge "the nightmare" which she knows from experience come so powerfully into play in the hospital where "your power just goes". However this contrasts very clearly with the way Angie is supported in the group.

Conclusion

The data from these two groups shows that they are operating in accordance with previous conceptualisations of women's ways of thinking in general and specifically about health. To a much greater degree than biomedical healthcare systems. These homeopath run groups appear to offer what women want from healthcare and there is support for Scott's notion of homeopathy as a feminist form of medicine.

I do not however want to essentialise women and men's differences and it may be that a healthcare system organised along woman centred lines might also suit some or even all men. I do not have enough data in my research on men. This would need further study.

I also think it is dangerous to essentialise women's thinking as one discrete entity. These two groups have a preponderance of white middle class women with small children. These forms of organisation of healthcare might be particularly suited to women of this type and at this life stage.

There is also a bias in the research to the kind of women who are prepared to attend support groups or education classes. It may be that this type of organisation of healthcare suits only a particular kind of woman, in particular the articulacy and willingness to speak forth of these privileged well educated women may not be matched by those from other backgrounds. Further research would be needed to investigate women at other life stages and from other cultural backgrounds.

The groups might work particularly well at this point in the life cycle. The transitions to motherhood hold a number of specific issues, of learning to look after children's health but also of forging a new maternal identity. This time of great change in identity in women's lives, and the associated lack of social contact that many mothers face at home with small children might predispose them to needing greater levels of community support than at other times in their lives.

However while I shared these women's middle class white status I did not share their status as a mother but still found the groups really inviting and wonderful places in which to debate ideas of health, so my sample of one may point to the idea that these organisational factors may appeal to women at other stages of life. I found the groups

very supportive in my own life transition with the death of my mother that occurred during fieldwork.

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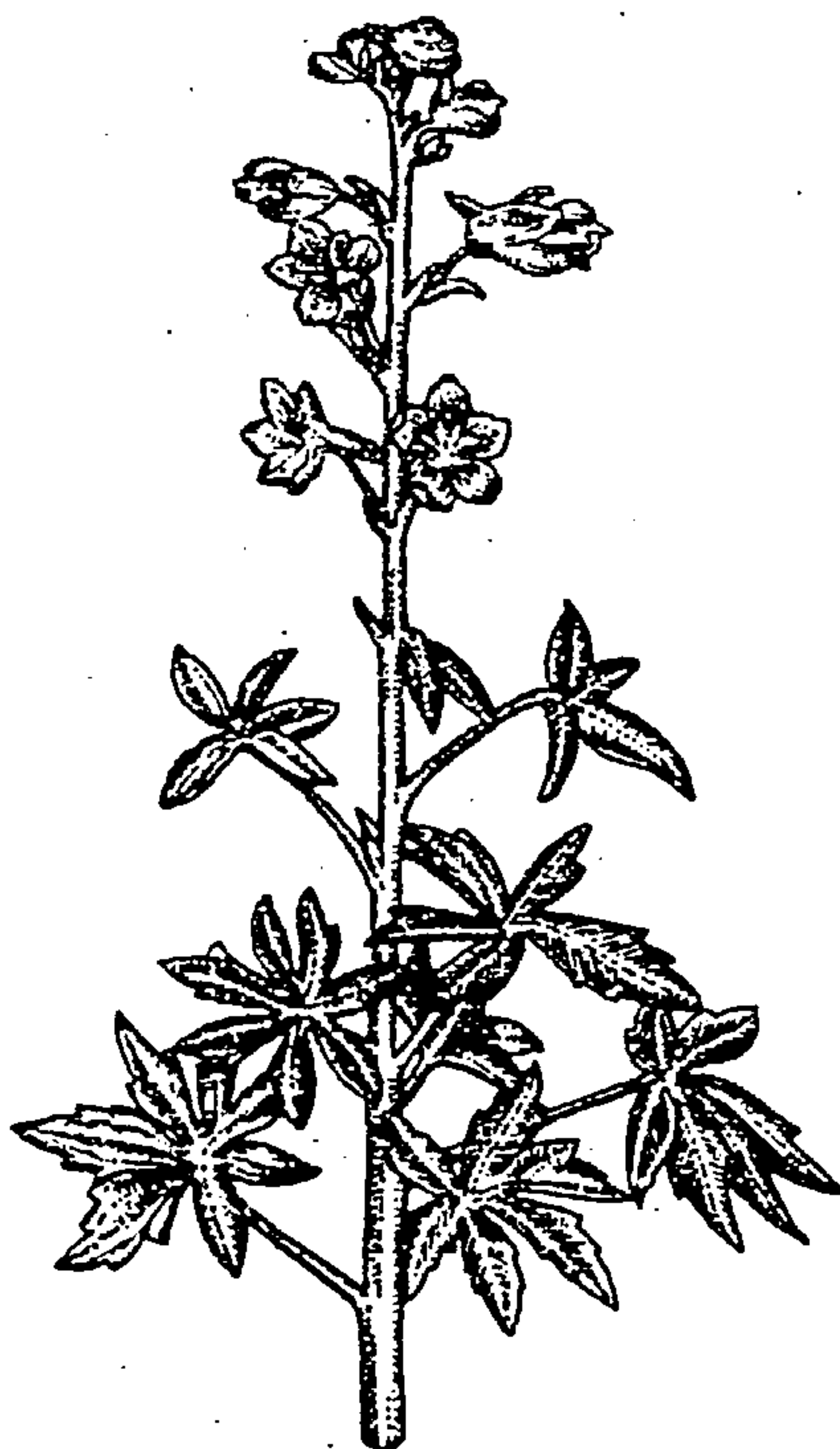
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Appendix C: General Practice ethical approval: Patient information sheets and consent forms.

STAPHYSAGRIA (Stap.)

Family name: Ranunculaceae

Other names: stavesacre; palmated larkspur; Delphinium Staphysagria



PATIENT INFORMATION SHEET

Patients Experience of Complementary Therapies in Primary Care

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and if you wish, discuss it with your the receptionist, your GP/Nurse or Christine Barry the researcher. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Christine Barry is an independent researcher based at Brunel University studying Complementary Medicine for her PhD. She has been funded by the NHS. She is very interested in doctors and patients experiences with therapies like homeopathy. The purpose of the study is to see how complementary medicine can best be integrated into NHS general practice.

Dr/Nurse (name) has agreed to take part in the study. The research will involve Christine sitting in with Dr/Nurse (name) and tape-recording consultations today. Christine would then like to arrange a time to come and interview you at home. This taped interview will be about 45 minutes long and will take the form of a discussion about your experiences with, and views about complementary medicine.

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect the standard of care you receive. If you (or your child) prefer not to take part, either now or later, this will in no way affect your care here at the practice. No one will mind if you do not want to take part.

For those who do take part, the tape recording of the consultations and interviews will be stored in locked filing cabinets at the Centre for the Study of Health at Brunel University. The tapes will be destroyed at the end of the study. Only Christine and Dr/Nurse (name) will have access to them. Any information allowing patients to be identified, such as name and personal details, will be stored separately in a locked cabinet. The Kingston and Richmond health authority's research ethics committee has given us approval to do this research with patients. We will operate within their strict guidelines in the interests of patients.

The results of this study will be written up as a PhD thesis and for publication in medical journals, and a summary report will be produced if you would like a copy. You will not be identifiable in any report or publication.

If you are over 16 and interested in taking part, or if you are accompanying a child under 16 and they are old enough to understand and you are both happy to take part, please complete the attached consent form. (If your child is too young to understand you can decide on their behalf).

If you would like further information on the project please talk to Christine Barry or Dr/Nurse (name) _____ here in the surgery or telephone Christine at Brunel on 01895 274 000 x4851.

Thank you for reading this and for taking part if you decide to. Please keep this information sheet and the second copy of the consent form for your information.

CONSENT FORM

Project title: Patients Experience of Complementary Therapies in Primary Care
Name of researcher: Christine Barry

If you agree to take part, and are over 16 please complete and sign part A of the form. If you prefer not to take part complete and sign part B. Please take the completed form in when you go in to see the doctor.

Part A

I have read the patient information sheet dated _____/version ____. I understand that the information collected on this form, during the consultation and the interview will be treated in the strictest confidence. I understand that if I (or my child) do not wish to participate, I/we are free to refuse or to withdraw at any stage. There is no problem if I wish to say 'no'. A refusal will not in any way affect the treatment I (or my child) receive.

I agree to my consultation with the doctor being tape recorded and observed by Christine and I am happy for Christine to interview me at home.

1. Please write your name and details clearly. NAME :

PHONE NUMBER:

_____ (Day) _____ (evening)

OR ADDRESS IF NO PHONE:

PARENTS/GUARDIANS. I have explained the research to my child who also agrees to take part in the research

CHILD'S NAME: _____

2. Please sign SIGNED: _____ DATE:

Part B

Tick

I would prefer not to take part in this research

SIGNED: _____ DATE:

Signature of Researcher: _____ DATE:

Signature of GP/Nurse

DATE: _____

1 for patient 1 for researcher 1 to be kept with medical records

Appendix D: Formal knowledge concepts of homeopathy -
homeopathy class.

COCCUS CACTI (Cocc-c.)

Family name: Hemiptera
Other name: cochineal



Formal knowledge concepts of homeopathy - homeopathy class.

To demonstrate the key formal knowledge concepts of the course, and give a flavour of the way in which these concepts were taught over the course of the two terms. I will run through the key concepts using Nancy's words as recorded in my fieldnotes.

Theoretical concepts term 1

1. The law of similars

Samuel Hahnemann, a German physician disillusioned with the lack of any philosophy of cure in the existing system of medicine, invented homeopathy in around 1810. He ate Chinchola bark (from which comes the substance we know as quinine) and developed malarial fevers. From this he deduced that if the substance were to produce malarial fevers in a healthy man it could be used to cure a person suffering with malaria. He went on to conduct provings where different substances from the mineral, plant and animal world were given to healthy volunteers and the mental, emotional and physical symptoms that resulted were recorded in the *Materia Medica* and the *Repertory* textbooks. The *Materia Medica* is organised by substance, so one can look up the symptom pictures for each remedy. The *Repertory* is organised by symptoms so one can deduce from the pattern of a patient's symptoms, the appropriate remedy.

Nancy explained that "Magically and mysteriously, substances mimic every state known to mankind." Provings were not limited to herbal substances but included for example trees, salts, metals, and animal products such as squid ink, bee stings and snake venom. In session 11 Nancy mentions some of the newer remedies that have had more recent provings, such as Diamond, Plutonium and Berlin Wall. A proving is conducted by giving a remedy blind to a number of healthy people, often trainee homeopaths and asking them to record their dreams and fears and symptoms while taking it over a long period.

Each remedy operates according to "The doctrine of signatures", or how the remedy behaves. Nancy demonstrates this in discussing Apis a remedy made from the sting of the honey bee. She asks us to describe aspects of a bees behaviour that might link to the remedy. Restless, irritable and drowsy in turn. Apparently bees are sensitive to heat and have an elaborate cooling system in the hive. Consequently people needing Apis have burning, stinging pains that are always better for cold and worse for heat and may be apathetic or irritable and restless.

2. Potentisation

Homeopathic remedies are produced by a sequence of dilutions. The starting point is a mixture of the substance itself which has been steeped in alcohol for some time then strained. This is called the mother tincture. The first dilution marries one part active substance to 99 parts water. This solution is then succussed, or vigorously shaken. Nancy demonstrates holding an imaginary container in her clenched fist and banging hard on the table several times. This process is repeated again and again to paradoxically produce ever higher potencies of remedy. Nancy calls this "The magic of the minimum dose". In the low potency 6c the dilution and succussion process has occurred six times. The most commonly used higher potencies are 200, 1M (diluted 1,000 times) and 10M.

Nancy explains that from Einstein we know that all matter is energy and that matter and energy interact and vibrate within a field and are inseparable. This vibration can be changed. This is how homeopathic remedies work. Disease is a problem of the dynamic body not the chemical body. The lower potencies work on the material body and as we move into higher potencies we are moving into the sphere of the dynamic body and the realms of the mental, emotional and spiritual levels. If the disturbance affects the whole person a higher potency is required. Nancy suggests that if you can get a perfect match to the most similar remedy and you prescribe the right dose the problem goes "Just like that". A remedy only becomes homeopathic when it matches the symptoms.

3. Constitutional prescribing

Constitutional prescribing is where you treat the person's predispositions, susceptibilities and inheritances, rather than just the current symptoms. Information is gathered on illness patterns in the family and the person's own illness history as well as aspects of their personality and preferences, for example do they feel better by the sea, in heat, in fresh air and so on. The aim is to strengthen the vital force to avoid future illness. When treating with a constitutional remedy you are likely to get a return of old symptoms. This means re-experiencing an old illness in a limited and minor form.

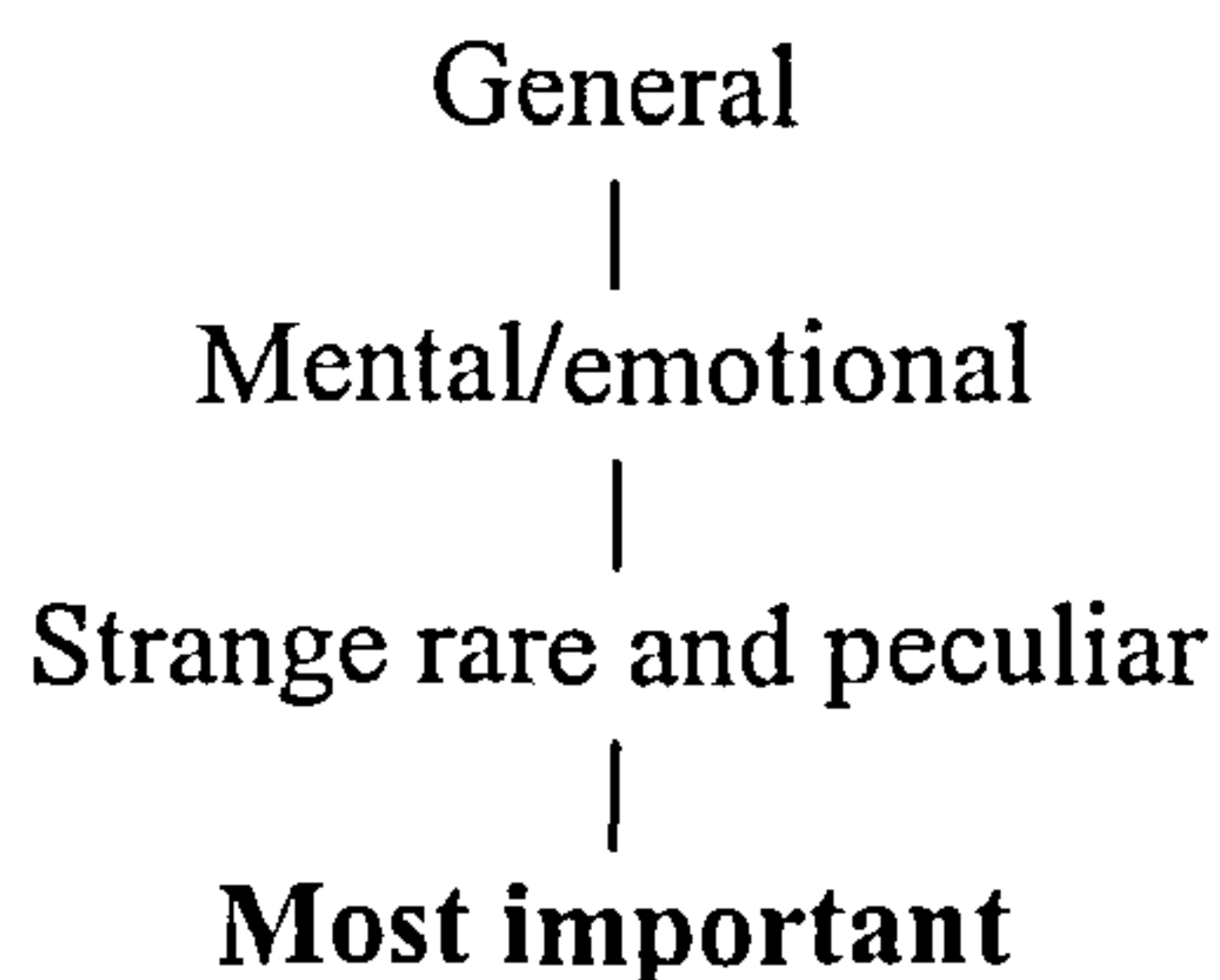
Practice aspects

1. Taking the case from the patient

"A patient saying they have tonsillitis is useless information for a homeopath" Nancy - session 6. In homeopathy there is a hierarchy of symptoms from the least important upwards:

Least important

|
Common
|
Local
|



“*Common* symptoms like tonsillitis and diabetes are not telling you what the characteristic symptoms are for that person. How that person is experiencing that illness?” The assumption being that every person experiences their illness differently from the next. *Local* symptoms are usually confined to one part of the body, not expressing the whole “my” knee hurts. *General* symptoms involve the whole body “I” don’t sleep well. Aspects such as temperature, digestion and sleeping. *Mental/emotional* symptoms include delusions, responses to company, memory and concentration and are changes from the persons normal state. When *strange, rare and peculiar* symptoms are present they can make the choosing of a remedy obvious. A cold blue wound that is better for cold indicates Ledum; burning pains better for heat requires Arsenicum. Other strange symptoms reported by homeopathic patients that have been repertorised include: sensation that limbs are made of glass; delusion of a fishbone in the throat, or a man in the bed; feeling that teeth are too long or that toes have been chopped off. These symptoms cause much hilarity and amazement in the group but Nancy assures us that patients when left to report their symptoms in their own words really do come up with some weird and wonderful experiences, often phrasing it as “Well I know this sounds very odd but....”

Nancy stresses the importance in taking the case to “Never ask leading questions. People will give you what you need if you let them talk”. In fact I don’t like the expression ‘taking the case’ receiving the case is better. The best thing to do is to do nothing and allow it to come to you. Always ask open questions like what do you mean by that? Could you describe your pain?

2. Matching a remedy to the person using the repertory.

The repertory is used to take the person's symptoms and match them up to a remedy. Nancy explains that it is like learning a new language. You have to learn that certain symptoms come under the ‘mind’ section whereas others will be under ‘brain’. She sets us homework to learn how the repertory is set out, to repertorise a possible constitutional remedy for Margaret Thatcher (for example think rigidity) and Tony Blair (desire to please, love of power). At the next session we have a lively and humorous discussion of the possible remedies we have come up with for them. I have come up with Anacardium Orientale for Mrs Thatcher which is indicated for the symptoms: unfeeling, obstinate, misanthropic, and haughty. Angie has come up with Platina whose remedy picture includes snooty, haughty, driving ambition, not being able to abide being contradicted, and thinking they “are it”. As a group we come up with lots of possible remedies and begin to see how difficult it is to know which is the right one. We also realise we have limited information with no chance for the protagonists to present all the detailed symptoms in person.

3. Prescribing issues

One remedy at a time is the general rule and once the body reacts you stop treating and let the body do it for itself. With higher potencies you can just give one dose and only repeat if there is a relapse. Again this advice goes against that of orthodox drugs where if there is a positive response, for example with antibiotics, you need to continue treatment and ‘finish the course’, because it is the drug which is perceived to be doing the healing not the person. Nancy says “Once you get a response you stop the remedies and let the body take over the work – you are just trying to kickstart the body into doing the healing you are not doing it for it”.

4. Hering's Law

In the 19th century Hering set out to discredit homeopathy but got drawn in by it and convinced, and became one of the founding fathers. Hering's Law is used to observe if a cure is taking place. Hering observed that healing occurs: 1) From the deepest part to the external; 2) in reverse chronological order of appearance; and, 3) from the upper part to the lowest.

From Hering's Law we learn that there is a hierarchy of vital organs which is different to that we commonly think of in biomedicine. The most serious illness is that which affects the mind, brain and emotions, followed by the heart liver and kidneys. Nancy explains that a healthy mind and emotions are required for us to fulfil our potential in life. The least serious problems are discharges from the body. If someone with heart disease is treated and their heart improves but they develop arthritis this is seen as evidence of healing as the problem has moved outwards to less serious organs. In reverse if treating a child for eczema and they get asthma this is a deterioration in health. “The vital force pushes things away from the vital organs, that’s it’s function to protect. If you get stressed the best possible response is to get a cold. The day we get a cure for the cold will be bad news for us. The healthiest response to stress is to have a cold and keep it on the surface. The next best is skin.

Nancy illustrates the ‘top to bottom’ rule through one of her cases. “I was treating a girl who'd had lifelong eczema. Her mother said I'll give you 6 months only (in a very domineering tone) I managed to get it down to her thighs but it was very slow and at the end her mother put the creams on and it went back up. The trouble is most people want a quick fix”.

From Hering’s Law we get a sense also that curing may be a time consuming process with the body going back through previous illnesses across the whole lifespan. Nancy says that a return of old symptoms is a good sign and shouldn’t be treated. Tina says it’s like peeling through an onion and Nancy agrees this is a good analogy. Diane, a homeopathy patient who has studied homeopathy on a different course explains how she sees the constitutional curing process:

Diane: there's this homeopathic principal that the treatment is all about unravelling disease basically. So where things have got knotted up or suppressed or whatever or locked into the body then just trying to free that up. There are all sorts of analogies you can use like it's like ... wounds that have healed over but too quickly or whatever. Part of [my homeopath's] job I could feel and see was to dig out old wounds which I in my flight to health had-had- scabbed over really quickly but actually they were doing so much damage, you know the infection sort of underneath. And that all had to be cleaned up and healed and packed bit by bit from the bottom. So it's that sort of thing. But its also in homeopathic treatment you do- you do- the unravelling thing. You do re-experience symptoms and diseases and stuff that you had earlier on. But only in a very very very mild form like - Half the time you wouldn't know that's what's happening. Um For instance I had a couple of really bad skin reactions when I was a teenager and I got some a couple of times when she gave me remedies I had like skin reactions that were similar to those but they only lasted an afternoon. And then they were gone. Yeah.

CB So it goes all the way back really.

Diane Yeah yeah.... And I've always had a really bad chest and any cold thing will go to my chest and I've had pneumonia and bronchitis and all these sorts of things. And she's give me a remedy and I'd lose my voice, for sort of three days or I'd have a really tight feeling in my chest for like 2 days or whatever. But she's a really good homeopath. She really explains everything about what the treatments for and why she's giving you the remedy she's giving you and how it - what - just where it might go. (P0101)

Roberta has experienced this return of old symptoms in her homeopathic treatment over the past 6 years. "I am a good example I had asthma then eczema then allergic sneezing for 12 months then conjunctivitis, stomach problems and thrush (which I had as a baby)" I asked How long did it take to go through all that?

"Over 3 years".

Angie claims it took it took 8 months of visiting a homeopath to get rid of daughters her eczema. Nancy says "that sounds quite usual". So cure is not by any means an instantaneous process.

5. First aid remedies

Over the course of the first term Nancy covers a number of first aid remedies like Arnica for shock, Ledum for puncture wounds, and remedies for fevers, coughs, diarrhoea and so on. However through the teaching we begin to learn that there is not a direct correspondence between remedies and symptoms as there is in orthodox medicine. This happens in two ways. Firstly through learning the symptoms picture of each remedy we begin to realise that each remedy covers an assortment of indications at a number of different levels, physical, emotional and general. Then on handouts for particular symptoms there are multiple remedies given: 11 on the Asthma handout, 11 on the Nausea, vomiting and diarrhoea handout and three remedies appear on both: Arsenicum Album, Ipecacuanha and Nux Vomica.

Take Bryonia for example, a remedy we discussed on week 3. In my fieldnotes I wrote "The whole thing of patterns of keynote symptoms [for each remedy] to look out for is weird. Remedies aren't for particular things you just go by the pattern of keynotes and what the problem is worse and better for, like worse for motion better for pressure". Here are some of the keynote and other symptoms Nancy presented on Bryonia:

"Bryonia has the longest roots of any plant. The person is immovable. Whatever is wrong they won't move because it will make the symptoms worse. So in a headache even moving the eyes is a problem. If it's a cough they may try to stop the lungs by pressing down. Better for pressure. Often right-sided. You will see them lying on the painful side. Touchy people - don't want to be touched. Lie very still, irritable, worse for company. A flu remedy. Profuse discharge at the start but dries up. Very dry in the lungs for example. Very thirsty for cold drinks and glug it down (whereas an Aresnicum will only sip little bits at a time). Pleurisy, pneumonia, bronchitis. Constipation, dry burnt stools. If just have a broken bone - heat, redness, dryness, don't want to move with stitching throbbing pains. Worse at 9pm."

6. Polychrest remedies

In the course textbook Castro (1990) defines a polychrest as a remedy which has produced a wide range of symptoms in the provings and can therefore treat a wide range of problems. In session 9 Nancy introduces Aresnicum as "a huge polychrest which is used a lot and covers many areas". She goes on to tell us about its wide application and she mentions problems as diverse as asthma, stomach ulcers, gastroenterological problems of diarrhoea and vomiting, colds, eczema, boils burns, hives, gangrene and so on. She also explains that as a remedy for highly strung restless and anxious behaviour it is the main remedy for horses. It is suitable for people who show these traits and have a strong desire for company and marked fear of dying "I am going to die if you leave me alone". For this reason it is a good remedy for approaching death to help people to go peacefully.

One remedy can treat all sorts of body parts: Apis will work on symptoms in Eyes, throat, ovaries, skin, kidneys, and bladder.