A Qualitative Exploration of Complementary and Alternative Health Beliefs and Practices in New Brunswick and Nova Scotia

by

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Abstract

In the 1990s, some ground-breaking, large-scale studies concerning the use of complementary and alternative health were conducted in the United States (Eisenberg, Kessler, Foster, Norlock, Calkins, and Delbanco 1993, Eisenberg, Davis, Ettner, Appel, Wilkey, Van Rompay, and Kessler 1998) and, subsequently, in Canada (Ramsay, Walker, and Alexander 1999). Both the Canadian and the American studies presented startling evidence that the use of health alternatives had been greatly underestimated in medical and social scientific literature, and that this use was growing rapidly. In the decades that have followed, there has been a pronounced and increasing interest in the study of complementary and alternative medicine (CAM), from a wide range of disciplines and approaches. This thesis tackles the issue of CAM use from a uniquely crafted lens – it examines the world of complementary and alternative health beliefs and practices from a folklore perspective. Situating the research in the Atlantic Canadian provinces of New Brunswick and Nova Scotia, the thesis is based around interview-based ethnographic fieldwork from the perspective of CAM users, CAM practitioners, and allopathic physicians. It therefore reflects some of the most relevant current CAM-related issues: themes related to region, knowledge and belief, role, and the notion of ideal health care scenarios. It is a thesis about health, but it is also one about agency, power, epistemology and personal experience, and the ways that all of these important factors can help, or hinder an ongoing quest for wellness.

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Chapter 1

Overview: Introduction, Themes and Theory

1.1   Introduction

Health. Independent of historical, geographical, or societal differences, it could be argued that health is one of the greatest universal concerns. A state of health and wellbeing is a goal toward which all individuals continually strive, and one which affects every aspect of life. The stakes surrounding health and illness are always high, and always relevant. Despite this global concern and preoccupation, however, concepts and understandings of health are far from straightforward or unanimous. This is true even in regions of the world with highly functional health care systems – ones that can boast some of the most statistically healthy populations on the planet.

As a case in point, in the 1990s, some ground-breaking, large-scale health studies were conducted in the United States (Eisenberg, Kessler, Foster, Norlock, Calkins, and

Delbanco 1993, Eisenberg, Davis, Ettner, Appel, Wilkey, Van Rompay, and Kessler 1998) and, subsequently, in Canada (Ramsay, Walker, and Alexander 1999). This statistical, survey-based research was aimed at determining the prevalence of the use of complementary and alternative therapies and practices in these countries – in other words, how much individuals were employing health-related modalities or substances that were exterior to the mainstream medical healthcare system. Both the Canadian and the American studies presented startling evidence that the use of such alternatives had been greatly underestimated in medical and social scientific literature, and that this use was growing rapidly.

In the decades that have followed, there has been a pronounced and growing interest in the study of complementary and alternative medicine (CAM), from a wide range of disciplines and approaches. Interest in CAM covers a large spectrum, from practical and technical issues such as safety and efficacy of CAM products and procedures, to much more esoteric concerns, such as the epistemological underpinnings of health-related choices and decision making. It is a subject that is at once incredibly important, and highly complex. While the core of CAM-related research always necessarily revolves around a deeper understanding and improvement of health and well-being, it also often ends up uncovering related issues of power, hegemony, belief, knowledge, and politics. By its very nature, exploring the world of complementary and alternative health care is simultaneously an exploration of official and unofficial culture – where they meet, where they meld, and where they clash.

Steeped in a background of belief and narrative, and with an eye toward the vernacular, this thesis explores the issue of CAM use from a folklore perspective. Situating the research in the Atlantic Canadian provinces of New Brunswick and Nova

Scotia, the thesis uses ethnographic interview-based fieldwork with a wide range of individuals: CAM users, CAM practitioners, and allopathic physicians. By eliciting and studying the CAM-related experiences of those to whom the topic matters and affects most, the goal of this thesis is to identify and discuss the most relevant current CAM-related issues: themes related to region, knowledge and belief, role, and an applied notion of ideal health care scenarios. It is a thesis about health, but it is also one about agency, power, epistemology and personal experience, and the ways that all of these important factors can help or hinder an ongoing quest for wellness.

1.1.1 Chapter Breakdown

What follows is an outline and description of the structure of this thesis.

Chapter 1: "Introduction"

This current introductory chapter is designed to put the thesis into context and perspective. Having broadly introduced the subject matter, and my interests and aims in conducting the research, the rest of this chapter is devoted to providing a comprehensive discussion and selected literature review on the larger, over-arching theories and themes most relevant to the thesis. It should be noted that there are also a number of theoretical/thematic discussions which are integral to the thesis, but do *not* appear in this introductory chapter – instead, they frame the individual chapters for which they are most relevant. In particular, Chapters 4, 5, and 6, which form the main corpus of the thesis, each begin with their own discussion and overview of key theoretical and literary concepts, all of which have particular emphasis on folklore-related background and contributions to the topics.

The broader foci in this introductory chapter include: a discussion of term "vernacular", and what a "vernacular approach" to research entails; a brief but imperative overview of narrative, and "narrative approach" to research, particularly within studies related to health and illness; a broad review of the health-related work that has been done specifically within the field of folklore; and finally, an examination of the term "complementary and alternative medicine" (or CAM) – why I chose to use it, and what it entails.

Chapter 2: "Methodology"

This is a short chapter that outlines and discusses the particulars behind my research methods and processes. Topics include: how and why the research was framed, or limited by geographic region; information concerning the informants or interviewees, including information such as: how interviewees were grouped; occupations or CAM-affiliations; and number of people interviewed; recruitment procedures, including the various methods that were used, and how people responded; the interview process, including information about how and where the interviews were conducted, as well as more technical information about the equipment used; and finally, transcription and coding: technical and methodological details about how interviews were transcribed, and the means by which they were coded and subsequently incorporated into the thesis.

Chapter 3: "Regional Context"

Before tackling the bigger themes that make up the corpus of this thesis, it was important to first situate the work contextually. Due to the fact that my fieldwork

was framed by the geographical location in which it was conducted, the context in this particular case is therefore regional in nature. As such, this chapter has two main goals. The first is to provide an overview of Canada and the Canadian health care system, which helps illuminate the background, strengths, flaws, and inner workings of a system that has direct, but often unspoken or assumed impact on those who are part of it. Secondly, this chapter provides a snapshot of the Atlantic region of Canada, with particular emphasis on the cities of Fredericton, New Brunswick and Halifax, Nova Scotia: the two specific areas where fieldwork was conducted. Included is both a statistical, demographic breakdown of key features, with subsequent discussion concerning CAM and these two Atlantic provinces, and what makes the areas unique.

Chapter 4: "Knowledge and Belief"

At the very core of discussions concerning official and unofficial culture – particularly those related to health – is the complex notion of knowledge and belief. This chapter tackles this issue first by providing an overview of belief studies generally, with emphasis on those from within the field of folklore. This is followed by a thorough introduction to the world of allopathic (or mainstream) medical knowledge, and the scientific imperialism in which it is so strongly steeped. Finally, the chapter moves on to the issues of knowledge and belief from the perspective of complementary and alternative medicine, and how this differs or parallels the allopathic view and approach. There is particular emphasis here on the concepts of "holism" and "energy/intuition", both of which tend to fall outside the approach and explanatory framework of allopathic medicine and scientific imperialism. The broader themes that come out of this chapter involve often differing understandings and value placed on issues such as evidence,

outcomes, and explanatory or epistemologically-based frameworks, and how this affects health choices and care.

Chapter 5: "Role"

This chapter provides a look at the complex interplay of the conception and reality of where and how individuals are placed within the realm of health and well-being. In other words, how do people understand their responsibilities and expectations with respect to their own health or their health-related practices, and how do they understand the responsibilities and expectations of those with whom they interact? The chapter begins with a relatively theoretical discussion of the concept of "role" as I used it in this thesis, and how it was informed by folklore-inspired themes of performance, group, identity, and the esoteric-exoteric factor. It then presents an analysis of how individuals viewed the notion of "role", based on the larger group to which they belong. As such, it was possible to illuminate differing understandings and importance placed on issues such as communication, worldview, and quality of health. As the chapter reveals, exploring the complex web of role ideals and practices can, in turn, have direct impact on the type and level of health care a person receives.

Chapter 6: "In Search of an Ideal"

The goal of this final large, important chapter is, as the title suggests, to provide a means of discussing various conceptions of an "ideal" healthcare scenario, with particular emphasis on the perspective of those who use and value both allopathic and complementary and alternative approaches to health. Considering the very tangible nature of the topic, the chapter begins with an overview of applied folklore, especially

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as it relates to health. It then goes on to outline the most commonly discussed problems that individuals identified within the current health care system – in essence, the factors that limited the care offered and received, thereby preventing any form of "ideal" health care from materializing. Finally, the chapter provides some of the most prevalent and relevant potential solutions to these problems (in particular, different iterations of an integrative approach), as well as how such solutions and outcomes could potentially be realized.

Chapter 7: "Conclusion"

This last chapter summarizes the main points and concepts that were discussed within the thesis. After summarizing each chapter individually, it goes on to describe where my research fits in with the current scholarship, what it was able to accomplish, where it fell short, and the further research that can, and should be conducted in this area. It ends with some personal reflections on the subject and the process.

1.2 Literature Review: Relevant Themes and Theory

To claim to examine a subject through a unique lens, it is, of course, first imperative to describe what makes that lens unique. In this case, my training and background is as a folklorist. My lens is one of folklore theory, scholarship, and approach. Unfortunately, to define folklore as a discipline, or, for that matter, as a subject of study, is not at all easy or straightforward. From the coining of the term "Folk-Lore" by William Thoms in 1846 (Thoms 1999), to present day, there has been a constant flux and evolution in

conceptions about what folklore entails, and the unique purview of folklore scholarship. It would seem, in fact, that there are as many ideas, definitions, and variations as there are folklorists. Even more confusing, it could be argued that there are as many different understandings of folklore as there are folk. As Harlow has pointed out, "A plethora of variant definitions has emerged in various times and spaces... all definitions ever put forth into the world still exist today; and indeed, in a way folklore is all those things that people have said it is" (Harlow 1998, 232-233). This can make it very difficult to shed the overly simplistic yet popular notion that folklore is anything that folklorists study. Indeed, as Elliot Oring aptly summarizes, "the single problem that has plagued folklore studies since their inception has been the reconciliation of subject diversity with conceptual unity" (Oring 1996, 241).

Nonetheless, there is a pervasive notion that folklore is able to provide something different – that it fills a niche in scholarly study that would otherwise be left vacant. For some folklorists, the very nature of folklore is wrapped up in studying what other disciplines ignore. As Dell Hymes wrote four decades ago, "To a great extent, folklore is perceived as the study of things neglected by others, the leavings of other sciences" (Hymes 1975b, 346). Similarly, Barre Toelken has posited that "what we call folklore exists because it says something that otherwise would not get said" (Toelken 1998, 92). The question, however, remains – what is it that makes the lens or the approach of folklorists unique?

I do not mean to attempt to take this history of folklore and the irreconcilably large variations in meaning, and turn out a neat, concise, and authoritative definition of what it entails as a discipline and as a subject of study. I can, however, explain what I, personally, have taken from my folklore training, and the lens through which I

have learned to conduct research. Perhaps unsurprisingly, much of my approach can be directly linked to my mentor, folklorist Diane Goldstein. Far from settling with the notion that folklore is impossibly broad and disparate, she holds a self-proclaimed passion for the field. Much like Hymnes and Toelken, she is of the opinion that folklorists are, in many ways, unique – that we are "keepers of a special secret, a field of study with wisdom, heart, breadth, depth, endless inspiration, and enormous potential for facilitating social change" (Goldstein 2015, 125). Much of this, she would argue, is wrapped up in folklore's long-standing appreciation, commitment, and approach to three very important and interrelated aspects of culture – "local knowledge, narrative and expressive culture" (Goldstein 2015, 138).

It is important to note here that interest in the possibilities inherent in studying narrative and vernacular understandings of the world can no longer be considered to be championed by folklorists alone – in the 40 years since Hymes wrote his piece, there has, as Goldstein asserts, been a "growth in importance of narrative and local knowledge in the contemporary scholarly and worldly scene" – the notion of the vernacular is currently the "cool kid on the block" (Goldstein 2015, 126). There is, however, much to be learned from studying this relatively new scholarly interest, and understanding what folklore has, and can bring to the table – what, in the end, gives it its unique lens.

1.2.1 Local Knowledge: A Discussion of Vernacular

To understand what is meant by the term vernacular, and why it is such an important concept, it is first sensible to go back to its roots. Etymologically, vernacular can be

traced as far back as the ancient Roman Republic, where Marcus Tullius Cicero coined the term in relation to the art of public discourse. As Robert Glenn Howard explains, "though Cicero believed that the primary skills of rhetoric should be learned through a rigorous formal education, he also recognized that some speakers mastered a certain "local" quality in their discourse" (Howard 2005, 324). Cicero termed this quality by using the Latin root verna, translated as "home-born slave" (Howard 2005, 324), or "slave born in his master's estate" (Green 1993, 37). The term was therefore directly associated with being native to a region, and also "has long stood for indigenous dialect perceived as common or uncouth" (Green 1993, 37).

As such, the term "vernacular" became a "handy tool" for linguists and predecessor philologists (Green 1993, 37), but it has been adopted by various other disciplines as well. Howard maintains that "as an analytical category, vernacular appeared as early as 1960 in an American Anthropologist article entitled "Vernacular Culture", in which Margaret Lantis used the term to refer to "the commonplace" (Howard 2005, 328). He goes on to point out that after Lantis' article, vernacular began to circulate in various scholarly circles, and arguably had the most notable impact on the study of architecture (Howard 2005, 324).

Within folklore, the term "vernacular" is often synonymous with "community-based forms of cultural expression" (Goldstein 2004, 71). More than just studying these forms of expression, however, there is a critical importance placed on adopting "vernacular theory" in the analysis. At its core, vernacular theory suggests that, while the intellectual elite hold "theories" it must also be understood and acknowledged that lay or vernacular people do as well. In this sense, to study the vernacular from a folklore perspective means that one also "accepts local voices and native expertise as

the starting point of analysis" (Goldstein 2004, 72). This, truly, is a pivotal aspect of a "vernacular" approach within folklore, particularly when studying voices or narratives that are in some way subjugated or lacking in cultural power. Bonnie O'Connor has drawn an analogy to the concept of vernacular language, which is defined as "contrasted with an officially sanctioned, formal, or idealized spoken form" (O'Connor 1995, 6). When this concept is applied to an issue such as health studies, for instance, to study the vernacular refers "not to what people supposedly do or "ought" to do according to an official set of standards, but what they actually do when they are sick, when they wish to prevent sickness, or when they are responsible for others who are ailing" (O'Connor 1995, 6).

In essence, to study the vernacular from a folklore perspective becomes a matter of listening to and learning from the values, ideas, practices and beliefs of "ordinary" people. It is, as Goldstein has pointed out, a scholarly movement that is rooted in "the activist politics of the 1950s and 1960s, which fought for the rights and knowledge of regular people in the civil rights, labor and antiwar movements"(Goldstein 2015, 139). As Toelken has succinctly stated, "the end of folklore scholarship is, basically, to take the expressions and performances seriously, and to account for them in terms that are honest and fair to those who articulated them" (Toelken 1998, 92)... it is an approach that "insists on the centrality of the vernacular voice in the utterance of all cultural assumptions" (Toelken 1998, 95). Indeed, at its core, a vernacular approach to fully listen to and appreciate local wisdom and knowledge.

A particularly good example of vernacular-based folklore scholarship can be found in a recent special edition of <u>The Journal of American Folklore</u>, which features articles situated around the term "stigmatized vernacular". As Goldstein and Shuman explain

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in their introductory article to this collection, the term "stigmatized vernacular" is meant to explore "double stigmas: those situations where not only are individuals stigmatized, but so are the vernaculars associated with them" (Goldstein and Shuman 2012, 114). As they point out, the very term "vernacular" within folklore studies was originally adopted, at least in part, to "replace other, more stigmatizing terms and phrases, such as *'low culture'*, *'primitive'*, or even *folk* itself" (Goldstein and Shuman 2012, 117). Thus, by suggesting a category called the "stigmatized vernacular", it is suggested that it becomes possible to rethink the relationship between the concepts of both stigma and vernacularity, thereby uncovering issues of "indigineity, cultural/racial mixing, high and low, expert and lay knowledge" can all be brought to the fore(Goldstein and Shuman 2012, 117). Of particular interest with respect to this current thesis are Bock's article exploring stigmatized vernacular and type 2 diabetes (Bock 2012), and Goldstein's piece on the politics of untellability and stigma (Goldstein 2012).

There are, of course, potential pitfalls to a vernacular approach. There is the trap, as Amy Shuman has argued, of romanticizing local culture; painting the "folk" as the "uncritical "other" of the modern", rather than acknowledging local cultures as "contested categories" (Shuman 1993, 362). Also, Goldstein has written at length about the real possibility – especially with vernacular's relatively sudden and widespread cross-disciplinary popularity – of appropriating, manipulating, misunderstanding, or misrepresenting the vernacular voice, rather than celebrating it (Goldstein 2015, 129). This is true not only in scholarly pursuits, but also in public culture. As she points out, "victims/survivors/laypersons/"the affected" – they have become part of a participatory culture that recognizes, at least on the surface, that regular

people not only have knowledge but have greater access to some types of knowing, than do so-called experts"(Goldstein 2015, 129). The problem, however, is when this vernacular voice is used as tool, often as a means of increasing the appearance of public accountability or awareness, thereby "achieving visual credit through manipulation of interest in the vernacular" (Goldstein 2015, 127). In such cases, both public and academic, our job as folklorists, she argues, is to "use our expertise to make sure patients, victims, survivors, and culture-bearers are not run over in the process" (Goldstein 2015, 138).

1.2.2   Narrative Studies

Intrinsically connected to a vernacular approach to ethnography is the study of narrative. As a student of folklore, I have been well disciplined in the significance and prevalence of narrative and narrative approaches to the study of culture. For many years, a narrative focus has been a central tenet of folklore studies, and also a feature that set it apart from most other disciplines. As Diane Goldstein writes,"folklorists came to this party long before our colleagues in other fields arrived... that understanding human beings requires understanding their narratives as they relate to thought, action, individual identity, power, culture and context – were a crucial part of the watershed moments of American folklorists in the 1970s and 1980s"(Goldstein 2015, 139). In the last two decades, however, there has been what Martin Kreiswith coined a "Narrative Turn" in the human sciences (Goldstein 2015, 126) – a "massive and unprecedented eruption of interest in narrative and in theorizing about narrative that began about twenty five years ago, and is still gathering in magnitude and momentum

today" (Kreiswirth 2000, 294). Anthropologists Cheryl Mattingly and Linda Garro explain the phenomenon in slightly different terms. As they assert, "while interest in narrative cannot be described as new, what characterizes the recent surge of attention among a wide range of scholars is the pronounced concern to take stories seriously" (Mattingly and Garro 2000, 4). As a result, there has been a relatively recent influx of research throughout a variety of disciplines that has placed the use and/or analysis of narrative as a central priority.

From a folklore perspective, narrative is understood as falling into different genres, or expressive forms. These include such categories as legend, fabula, life history, and personal experience narrative. By understanding through which generic form a narrative is expressed, there are a number of issues that can be brought to light, such as "authority, distance and direction, identity, stereotype, connections between topic and attitude, areas of tension, taboo, pride, and expectations" (Goldstein 1993, 19). In addition, genre can illuminate ideas of "who can say what, to whom, and under what circumstances" (Goldstein 1993, 19), from (Hymes 1975a) and (Ben-Amos 1969). While distinguishing between these genres is clearly a useful tool (and one that is mostly unique to folklore), most of what is understood as "narrative" from a cross-disciplinary perspective is closest to the genre of "personal experience narrative". These are slightly more difficult to place in a definitive generic category, as they do not follow a rigidly formulaic structure. Although there are various slightly different definitions, Sandra Stahl, who was the first to bring the notion of personal experience narrative into the field of folklore as a genre, gives a concise classification. She asserts that this particular type of narrative "is a prose narrative relating a personal experience; it is usually told in the first person, and its content is nontraditional"

(Stahl 1989, 12). The very title of the genre belies its content – it involves narratives told of individuals' personal experiences, almost exclusively by the person who had the experience.

The concept of narrative is not typically as solidified in other social science and humanities disciplines as it is in folklore. As a result, there is much sharing and melding of narrative traditions and forms of analysis, which is in turn reflective of the idea that within the study of narrative, "it makes little sense to band together in exclusionary disciplinary tribes. . . [as] there is too much to be gained from cross-fertilizations that draw widely upon the social sciences, as well as literature, history, and philosophy" (Mattingly and Garro 2000, 6). There is a widespread notion, however, much like the folklore concept of "personal experience narrative", that the value and the study of narrative is intrinsically linked with the idea of experience. As Byron Good argues, "all narratives, as theorists... have shown, are stories about lived experience... they describe events along with their meaning for persons who live in and through them" (Good 1994, 121). Others have elaborated upon or expressed this connection between narrative and experience slightly differently. "Narrative is the fundamental human way of giving meaning to experience", Mattingly and Good contend in the opening sentence of their introductory chapter (Mattingly and Garro 2000, 1). This connection has been expressed in various other ways as well – for instance, the notion that fundamentally, stories offer a way of making sense of experience (Mattingly and Garro 2000, 10), or that narrative offers a way of "ordering experience, of constructing reality" (Bruner 1986, 11).

Though this narrative turn can be found in any number of different areas of research, there is a particularly large presence in the realm of health-related studies.

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Health-related social science research has put an increasing emphasis on the importance of understanding vernacular-based cultural constructions of health and illness, but researchers have had difficulty accessing these beliefs and forms of decision making. Consequently, many have turned to narrative as a means of gaining insight into these crucial missing pieces of information. As Diane Goldstein notes, "the struggle to access vernacular health belief has prompted, among both medical researchers and social scientists, an exploration of the use of illness narratives as a natural form for articulating the meanings and values associated with health, illness and suffering, within specific individual and cultural contexts" (Goldstein 2004, 83). In this sense, narrative can be understood to give a "voice" to illness experiences – that through the narration of illness experiences, it is possible to illuminate "cultural understandings about illness – including possible causes, appropriate social responses, healing strategies, and characteristics of therapeutic alternatives"(Mattingly and Garro 2000, 26).

Predominantly, especially in medically-oriented research, narrative studies take the form of what are often called "illness narratives" or "pathographies"" (Goldstein 2015, 133). Though they can have a number of applications and research bents, there is a general theme or sentiment that these "written autobiographies of illness experiences "(Goldstein 2015, 133) are an important means of accessing and/or highlighting illness-related knowledge that can fill in gaps of understanding in the biomedical/clinical world. This is reflected not only in the types of studies, but in the very nature of the illnesses being studied – illness which are often stigmatized, poorly understood from a biomedical perspective, or without adequate treatment options. In fact, such narratives are, as Goldstein has pointed out, "commonly used as medical school

textbooks to teach clinical reasoning and moral reflection, and to enhance the human experience of illness"(Goldstein 2015, 133).

As such, illness narratives are, in this sense, not primarily treated as a means of gaining insight into how they represent or express a vernacular, cultural understanding of health and illness. Instead, it becomes more a matter of trying to access what individuals can contribute to a better understanding of an illness. In this sense, a vernacular perspective is sought only in as much as the individual narrator(s) can divulge otherwise hidden knowledge of, or allow access to, issues of symptomology and the disease process. Byron Good, for instance, when summarizing the issues that illness narrative literature has addressed, points to "the kinds of illness knowledge and the values they encode" and "what they reveal about the impact of illness on people's lives" as central themes (Good 1994, 142). Similarly, Arthur Kleinman argues that in seeking how illness obtains meaning, it is then possible to understand "something fundamental about illness, about care, and perhaps about life generally" (Kleinman and Seeman 1988, xiv).

While this understanding and approach to illness narratives can be lauded as well-intentioned, and possibly extremely beneficial from a medical perspective, it is also important to recognize the potential pitfalls inherent in this kind of narrative research. When the focus is taken from the individual to the disease, it becomes very easy to lose sight of the vernacular voice, and the experience/worldview that was being communicated. Goldstein is able to clarify this point effectively: "while folklorists are generally likely to give primacy to the importance of subjective experience articulated in narrative, medical scholars of illness narrativity still question the authority of lay perspectives found there" (Goldstein 2015, 134). In this sense, much like a

vernacular voice generally, it is easy to fall into the trap of manipulating, appropriating, misunderstanding, or reframing narrative in order to achieve a specific goal, or to understand an experience through an epistemologically differing lens. At its core, in fact, it could be argued that the very nature of an institution such as medicine struggles greatly with the stark contrast between scientific method and ideology, compared to the individualizing and unstructured nature of narrative. It is somewhat inevitable, in this sense, that when faced with the reality of using narrative in such a scenario, the "ultimate goal" can become a matter of "narrative management, wrestling narrative away from the teller and rewriting it to fulfill institutional needs and goals"(Goldstein 2015, 136-137).

Another trend in illness narrative studies has been a tendency to focus heavily on what the illness personal experience narratives have to say about *narrative* (and often specifically proving how narrative can access experience), rather than focusing on what the narrator or narrative is actually trying to convey. As a case in point, in the concluding chapter within the collection of essays Narrative and the Cultural Construction of Illness and Healing, Garro and Mattingly highlight this focus. As they reveal, one of their aspirations for this particular collection was that it would "further an understanding of what narratives are, what they help us think about, and when they limit our view" (Garro and Mattingly 2000, 259).

This focus on narrative aspects, and perhaps on the validation of narrative generally, likely ties in with the fact that this "narrative turn" throughout the majority of the social sciences is relatively recent. As a result, there is still potentially a notion that there should be an emphasis on uncovering and demonstrating all of the different cultural aspects that can be understood through narrative. This is unsurprising in

the wake of dissenters who continue to maintain, for instance, that "attention to narrative means neglect of other crucially important features of cultural life and human experience" (Garro and Mattingly 2000, 265), or that the study of personal accounts is too "unscientific" (Murray 1997, 10). For those who are passionate about the beneficial possibilities of incorporating narrative studies into the discourse of their discipline, there would undoubtedly be an ever-present impetus to prove and showcase the value of narrative. These characteristics stand in contrast to folklore, which has had the advantage of working with narrative for a much longer period, and therefore is generally not as concerned with trying to grasp narrative as a concept and/or figuring out how it is best applied as an analytic tool. Also, there is an assumption inherent in the very term "personal experience narrative" which stresses and assumes the value and validity of experiential narrative as a means of cultural access. Folklorists are trained to enter what they study though expressive culture – a distinction that can be understood to, in many ways, set it apart from other disciplines. As Goldstein has noted, "cross-disciplinary uses of narrative are not neutral; to the contrary, they constitute the subject in ways that are sometimes quite divergent from community values that those folklorists would be likely to support" '(Goldstein 2015, 137).

Therefore, while this multi-disciplinary (and particularly, medical) interest in gaining the personal experience and knowledge that can be gleaned from health-related narrative may seem, on the surface, to be similar to a folkloric approach, there are often incredibly important differences. Diane Goldstein sums this up effectively: "Illness narratives in literature... do not make the same distinctions as folklorists would between written and oral narrative; they don't generally recognize connections between narrative and performance context, don't locate narratives in the social relations of

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their productions, don't recognize narrative emergence – and when they *do*, they cast it as an opportunity to correct the story." (Goldstein 2015, 135). Furthermore, particularly when written narratives are solicited and used for specific (often medical) purposes, there is a tendency for these narratives to become "singular, and frozen in time" – a characteristic that can drastically alter the meaning and complexities behind what a folklorist would actually recognize as a fluid, cultural, emergent form of expression (Goldstein 2015, 133-134).

This discussion on narrative was not meant to denounce all forms of health-related narrative scholarship outside the disciplinary confines of folklore. Certainly, there have been countless studies, from any number of different disciplinary backgrounds and approaches, which contribute to the ongoing body of health personal experience narrative study in a way that both values the vernacular voice, and understands narrative as a form of expressive culture, tied in with issues of context and fluidity. It was, however, meant to highlight the relatively recent trajectory of illness narrative research, and the potential for – and, unfortunately, numerous ways – in which narrative can be used in a (consciously or unconsciously) manipulative, appropriative and misrepresentative fashion. In so doing, it was meant also to highlight the ways in which a folklore approach and perspective is meant to counter such narrative abuse, and the ways in which a long-standing appreciation and understanding of narrative allows for a relatively solid, unique lens. Narrative has so much potential – both good and bad – that the way it is used, approached and interpreted is of paramount importance. As Goldsein so eloquently describes, "personal narrative is simultaneously powerful and vulnerable – grassroots, representative, familiar, persuasive – and also exploited, manipulated, simulated, and appropriated, to make bureaucracy appear as

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though it has the ear and the backs of the people" '(Goldstein 2015, 137).

1.2.3 Folklore and Health

In order to begin to examine what scholars have written on the subject of complementary and alternative health beliefs and practices, it is first important to place these studies within a larger context. The most obvious place to begin is in the area of health studies generally. Of course, this is a subject so incredibly broad that it is impossible to come anywhere close to conducting a thorough, cross-disciplinary literature review on the subject. Instead, I will take this opportunity to review what has been written on the subject of health and medicine from within the discipline of folklore.

To clarify, there are a number of different terms associated with this kind of research, which, for the most part, are used interchangeably. Terms such as "medical folklore", "folklore and medicine" "folk medicine", "folklore health research", "health beliefs and practices", and "vernacular health beliefs" are just a few examples that folklorists have used to describe the research that they undertake, and indeed, these terms will appear throughout this thesis in much the same way. Regardless of the exact terminology, these terms cover any health- or medical-related research undertaken from within the discipline of folklore. As I will discuss in the "complementary and alternative" section of this literature review, however, as a subject, the semantics of terms such as "folk medicine" suddenly become much more complicated, with seemingly endless variations and connotations, throughout a wide range of disciplines. I do not wish to confuse the terms used to describe research endeavours with those

used to describe the subject of the research.

Also, in order to understand where folk medical research has come from, and how it has evolved, it is important to first place it within the larger umbrella of folk belief studies. As Bonnie O'Connor explains, "folk medicine has been dealt with, until very recently, primarily as a subset of folk belief (and its attendant practices)" (O'Connor 1995, 53). Belief studies in folklore scholarship began with an antiquarian impulse, fed by a notion of survivalism – that is, it was thought that "surviving items" of folk belief should be collected and preserved. The assumption was that these ideas and thoughts were cultural remnants to which cultures clung, due to factors such as geographic isolation, or a general backwardness or gullibility. As such, these collected beliefs were, for the most part, considered "superstitions", which were no longer applicable in the more "educated" parts of society. Here we find a bias that predominantly equates belief with falsity – a legacy, as O'Connor points out, of "cultural evolutionism and positivism" (O'Connor 1995, 50). The two largest sub-categories of belief in which these items were collected were folk religion and folk medicine. (O'Connor 1995, 49-50).

It becomes clear, then, how early folk medicine research was conducted. As Don Yoder reveals, "the history of the study of folk medicine has followed the same general pattern as other aspects of folk culture, first the literary or philological approach, followed by the sociological and functional approach" (Yoder 1972, 194). Indeed, early European folklorists interested in folk medicine typically collected examples of healing charms. They looked as far back as the early Middle Ages, right up to contemporary or living charms of current practitioners. National collections were compiled, as well as comparative studies of folk medicine, particularly in the late nineteenth and early

twentieth centuries. Similarly, interest in folk medicine in North America resulted in a number of articles in the Journal of American Folklore at the turn of the twentieth century concerning folk medical collectanea, as well as some statewide collections.

Although it appeared further into the twentieth century, and it was not exclusively devoted to folk medical collectanea, a well-known example of this type of collection was Wayland Hand's contribution to The Frank C. Brown Collection of North Carolina Folklore. Hand wrote volumes 6-7, entitled <u>Popular Beliefs and Superstitions from North Carolina</u>. This extensive collection provided American scholars with, as Yoder points out, "the best comparative materials yet available on folk medicine and the related areas of witchcraft and weather lore" (Yoder 1972, 196). Hand's work is interesting not only for the materials collected, but also as an example of some of the prevalent scholarly understandings and beliefs associated with folk medicine at the time. Hand makes the point in the introduction to his volumes, as does Yoder in "Folk Medicine", that this particular subject, much like folklore generally, was outgrowing its previous strict associations and identification with peasant cultures. As Hand reveals, "superstition is not the preserve of the unlettered only, but is a state or a way of looking at things that may befall even the most sophisticated members of society... professional people of all kinds, no less than tradesmen, are prone to many of the same popular conceits and mental errors to which, for want of a formal education, members of the humbler classes have fallen heir" (Hand 1961, xix-xx).

Here we can see the move away from thinking of the folk solely as a peasant culture, (and therefore, folk medical beliefs as exclusively part of that culture). Also made clear, however, are the pejorative connotations that were often associated with such beliefs. Consistent with an antiquarian impetus that abounded in the late nineteenth

and early twentieth centuries, it was believed that such cultural "curiosities" were vestiges that had been rejected or left behind by the "official" culture of civilized beliefs and practices, and therefore become the erroneous products of a less evolved understanding (O'Connor 1995, 36). It was really only in the 1960s that this veil began to lift, and studies began to focus on complex systems and traditions of belief, rather than belief as items (O'Connor 1995, 50-51).

Into the twentieth century, as interest and research into the area of folk medicine began to expand beyond collectanea, one of the trends in North American was to look at various ethnic and regional treatments. Although there are a number of examples, prominent folklorist Américo Paredes provides an interesting case study. In his 1968 piece entitled "Folk Medicine and the Intercultural Jest", Paredes looks at six jests collected at Texas-Mexican border, all dealing with a sick person and a group of people who seek a cure for him. They are parodies of a belief tale that uses a very common formula "pitting the curandero against medical science, with science driven from the field in utter confusion" (Paredes 1989, 65). Paredes finds that, although these jests are parodies of the typical curandero tale, they are not "a relatively simple case of second-generation Americans ridiculing the culture of their ancestors and thereby rejecting it... combined with parody is a good deal of resentment against Anglo-American culture, expressed in a stereotypic view of American physicians and hospital attendants as caring little about Mexican patients of the poorer, less educated class" (Paredes 1989, 76). In this way, Paredes is able to examine folk medical beliefs while simultaneously accessing attitudes and beliefs concerning cultural place within a larger hierarchy. Also important to note here is that context was given to the beliefs in question – something that was lacking from many of the earlier collectanea, and

which gave a much more thorough voice to those that held the beliefs.

Around this same time, Don Yoder began to weigh in on folk medicine, distinguishing it from what he felt were three other spheres: scientific, primitive and popular (Yoder 1972). Much like current concepts of complementary and alternative medicine, Yoder believed folk medicine was directly relational to "scientific" medicine in that it was residual: it encompassed "whatever ideas of combating and preventing disease exist among the people apart from the formal system of scientific medicine" (Yoder 1972, 193). Hearkening back to nineteenth century cultural evolutionary ideals, however, Yoder also maintained that the primitive and folk levels of the population were distinguished from the "educated" classes, in their propensity toward "irrational-medical attitudes and practices" (Yoder 1972, 210). Here again there is the notion of "less civilized" or erroneous understandings of health and illness associated with folk medicine.

It was not truly until the early 1970s that there was an important shift in American folk medical scholarship – what Bonnie O'Connor calls "a quantum leap", which was precipitated by David Hufford's development of the "health belief systems" (O'Connor 1995, 59). This "systems" approach began to "place folk medical traditions in their full, working, cultural and personal contexts" – an extremely important development, that continues to shape the focus and approach of contemporary folklore research(O'Connor 1995, 59). Indeed, it is this more recent work that has most greatly influenced my particular scholarly interest and approach.

In what follows, I will provide examples and synopses of what I consider to be particularly important or relevant examples of research done in the area of folklore and health. The scholars and works I have chosen have certainly been seminal in shaping

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my own folklore knowledge and research interests, but many have also been pivotal within, and in some cases, outside of the discipline as well. Medical folklore scholars often make a concerted effort to construct and disseminate their work in a way that is applicable and accessible to a very broad, multi-disciplinary audience. This not only includes other disciplines from within the social sciences and humanities, but also, appropriately, disciplines within scientific and medically-related fields. As it will become evident, there is also a prominent, related trend within health-related folklore toward applied work – that is, using research for practical, real-world goals. This is a concept that will be discussed in much more detail in Chapter 6: "Ideal", but gets mentioned often here, due its ubiquitous nature in health-related folklore studies.

A particularly prominent folklorist in the area of medical folklore is David Hufford. He can, in fact, be described as a pioneer in both belief and health-based folklore research. As his vast number of medically-oriented publications show, he has spent a great deal of time and effort discussing, defining, and conducting research that focuses on the importance of understanding vernacular medical knowledge and experience, and how this can translate into applied work.

Due to the theoretical, and often seminal ideas that Hufford has contributed, many of his belief and health-related concepts and research will be discussed more thoroughly subsequently. For instance, he developed, among other things, the pivotal notion of "health belief systems" (Hufford 1983a, 1988), introduced an "experience-centred" or "Phenomenological" approach to belief research (Hufford 1982a), and came up with two principles for comparing official and unofficial beliefs: methodological populism and methodological symmetry" (Hufford 1998). These theoretical and methodological ideas all share the common thread of insuring that the beliefs and experiences of

the lay or unofficial voices are seriously considered – a point that he argued was important in belief scholarship generally, and often with direct emphasis on health-related scholarship specifically. He not only championed for the lay voice, but truly drove home the importance of including it in multi-disciplinary research, and gave guidelines for how to accomplish it. All of these theoretical contributions have, as will become evident throughout my thesis, had a direct impact on my own research and approach.

Apart from these more theoretically-based contributions to health research, Hufford has also spent a great deal of effort going back to the basics – that is, actually defining folk medical beliefs and practices – as well as providing excellent examples and case studies of folk health and healers from his own research. Along similar lines, he has also repeatedly emphasized the specially suited skills that folklorists can, and should, bring to this kind of research. Like the rest of Hufford's work, these pieces have been written both for folklore-specific and for multi-disciplinary audiences (Hufford 1983a, 1988, 1992, 1994, 1998, 2002, 1983a, 1984, 1985a,b, 1988, 1992, 1994, 1997a, 1998, O'Connor and Hufford 2001, Hufford 2002). Finally, as will be discussed in more detail in Chapter 6 of this thesis ("In Search of an Ideal"), Hufford has devoted a large amount of his health-related research as a strong advocate for applied work (Hufford 1994, 1997c,b, 1998). He accomplished this both in his publications, but also through undertaking applied projects geared toward improving the medical education process, such as the "Diversity in Medicine Project" (O'Connor 1997, 72).

Another influential folklorist in the area of health belief and practice is Bonnie Blair O'Connor. Similar in nature to Hufford's research, O'Connor's work often incorporates both vernacular and applied leanings. Her 1995 book Healing Traditions: Alternative

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Medicine and the Health Professions explored the interactions between the conventional and non-conventional health care worlds, and was a pivotal springboard for my own research. As was previously mentioned, This book was where O'Connor discussed the term "vernacular", and how it can apply specifically to health-related work. More than that, however, she devotes her attention in this book to two fascinating, and in many ways, contrasting case studies – one involving Hmong cultural views and illness, and the other focusing on the extensive HIV/AIDS alternative health movement. These serve to illuminate the prevalence and importance of vernacular health systems in the lives of those who use them, as well as the necessity of health professionals to acknowledge and understand these systems within their practices. O'Connor is also able to provide an excellent example of how she was able to use her folklore training in a very real, applied sense, to act as a mediator between a Hmong patient (and members of his family and community), and the physicians and nurses providing care.

Akin to Hufford, O'Connor straddles scientific, medical, social scientific, and humanities disciplines in both her career and her writings. Healing Traditions, for instance, incorporated folklore background, theory, and approach, but was specifically designed to be accessible and of interest both to scholars from a wide range of disciplines, as well as health professionals. Indeed, many of her published articles have appeared in medical and scientific-based journals, and a large number have been co-authored by researches from a variety of disciplines (Rubenstein, O'Connor, Nieman, and Gracely 1992, O'Connor 1993, Anderson, O'Connor, MacGregor, and Schwartz 1993, O'Connor 1996, 1997, O'Connor, Calabrese, Cardena, Eisenberg, Fincher, Hufford, Jonas, Kaptchuk, Martin, Scott, et al. 1997, Ososki, Lohr, Reiff, Balick, Kronenberg, Fugh-Berman, and O'Connor 2002, O'Connor 2002, Graham, Ahn,

Davis, O'Connor, Eisenberg, and Phillips 2005, Jenni and O'Connor 2005, McCaffrey, Pugh, and O'Connor 2007).

In keeping with making folklore medical work both applied in nature and available to a multi-disciplinary audience, Diane Goldstein provides a number of excellent examples. In particular, she wrote an important book entitled <u>Once Upon a Virus: AIDS Legends and Vernacular Risk Perception</u>, which explores AIDS legends and how these can act as a window to understanding vernacular risk perceptions (Goldstein 2004). Another case in point is a piece that she wrote with a science and medical-based audience in mind, entitled "'When Ovaries Retire': Contrasting Women's Experiences with Feminist and Medical Models of Menopause". Written for <u>Health</u>, this article focuses on an Internet menopause-centred self-help group, with emphasis on the contributors' thoughts and experiences with the syndrome. As such, Goldstein was able to demonstrate the importance of using such forums to understand "experientially constructed notions of health and illness", thus arguing for "greater medical attention to lay understandings of menopausal syndrome", and, I would argue, to lay understandings of health and wellness generally (Goldstein 2000, 309). Even when writing for a folklore-specific audience or folklore-related journals, Goldstein is conscious of the importance of interdisciplinary discussion. In "Not Just a 'Glorified Anthropologist': Medical Problem Solving Through Verbal and Material Art", for instance, Goldstein highlights the skills and perspectives that a folklorist is uniquely able to bring to the more interdisciplinary realm of medical problem solving. She pinpoints genre, transmission and tradition as particular specialties that a folklorist hones in his or her training, which could provide key or crucial viewpoints and understanding within medical and health-related research (Goldstein 1993). Certainly, I have found that I have kept

these unique strengths in mind when conducting my own research, and that it has helped me position myself within the larger health-related academic arena.

Another important folklorist in the field of health-related studies is Charles Briggs. One particularly influential piece of work was a book he co-authored with his wife, physician Carla Martini-Briggs, entitled Stories in the Time of Cholera: Racial Profiling during a Medical Nightmare. (Briggs and Mantini-Briggs 2003). Focusing on a Cholera epidemic that hit Venezuela in the early 1990s, this fascinating book uses illness narratives to demonstrate themes of disease, blame, social inequality, and institutional and community politics and decisions. They interview many different players – survivors, vernacular healers, doctors, nurses, politicians, and government officials – and they also examine media portrayal of the epidemic. In so doing, Briggs and Martini-Briggs show how the poor, indigenous population, who suffered the most casualties from this epidemic, were also blamed for it. This effected not only perception, but also policy and response to the epidemic, both during, and in its aftermath. This is one of the most comprehensive and important examples both of applied health research and extensive ethnographic fieldwork, and it was both an inspiration and a guide with my own work.

Charles Briggs also wrote a more recent article, dealing specifically with the the direction of Folklore and Health (Briggs 2012). In it, Briggs argues that the field and study of folk medicine has "long been relegated to a subordinate status", or a "relatively marginal space within the discipline", and has been viewed as a speciality that is of interest only to a "small cadre of scholars" (Briggs 2012, 319-320). This is in direct contradiction to disciplines like anthropology and sociology, where, as Briggs points out, "studies of health and disease have mushroomed" (Briggs 2012, 325). As

such, Briggs uses this piece as a means of proposing a framework and methodology for "overcoming entrenched assumptions, and tackling the complex ethnographic and analytic work that would be required to develop a comprehensive folkloristics of health" (Briggs 2012, 319). He lays out four practices and three principles that he believes can aide folklorists in this regard, helping them to embrace the "complexity and heterogeneity" inherent in this sort of research – aspects that he feels have long been a folklorist's area of expertise (Briggs 2012, 338). "Toward a New Folkloristics of Health" is at once current, relevant for folklore scholars both within and outside of health-related research, and important both from an historical and a forward-thinking perspective.

Finally, I wish to discuss a compilation that has made an important contribution in the area of health and folklore research. <u>Healing Logics: Culture and Medicine in Modern Health Belief Systems</u>, edited by Erika Brady, is a collection of essays written primarily by medical folklorists, and medical anthropologists with a close tie to the field of medical folklore (Brady 2001a). Although the articles in this collection span a wide range of topics, many of the essays touched on the issue of complementary and alternative healing practices, making it an especially useful book for my own research. Of particular interest is the excellent first chapter, aptly entitled "Understanding Folk Medicine" (O'Connor and Hufford 2001). In it, O'Connor and Hufford introduce and summarize the contemporary approach to medical folklore, which centres on the notion of health belief systems. They "examin[e] the ways in which these systems draw on bodies of knowledge and belief, support specific means of knowledge production, provide explanatory models for causation and treatment, and supply evaluative strategies to determine efficacy" (Brady 2001b, 9). In short, this

is a very concise, useful reference piece for researchers wishing to learn more about the subject of health research from a folklore perspective. Though the other pieces in this collection are too numerous to mention in detail, they cover many different areas of folklore health-related research, including issues of particular relevance to this thesis: health-related communication (Adler 2001), risk-perception (Goldstein 2001), and ethnographic methodology (Glass-Coffin 2001, Toelken 2001). Finally, it is worth noting the extremely comprehensive and well-organized "Folklore and Medicine" bibliography included at the end of the book (Jones, Brady, Owen, and Hoglund 2001).

Obviously, there has been a wealth of excellent work done by folklorists in the field of health and medicine, and there is much potential for important future research in this area as well. David Hufford, Bonnie Blair O'Connor, Diane Goldstein, Charles Briggs, and others have effectively argued that folklorists actually have something very special to offer in this particular line of study. As O'Connor points out, "the characteristically populist lens of folklorists, and the field's history of examining the dynamics of popular/official interaction, provide the ideal basis for understanding the patient's point of view" (O'Connor 1997, 68). Similarly, Hufford states; "I believe firmly that folklore's ethnographic methods, the field's emphasis on narratives, and its natural populist orientation all allow folklorists to make special contributions to this kind of research and teaching... [and] can add in very important ways to what history, anthropology and other fields offer to medical research and education. If more folklorists would join with us, I am convinced that it would be very much to the advantage of medical education and folklore" (Hufford 1997c, 65-66). Indeed, it is with these comments in mind that I have undertaken my own research, in hopes of

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carrying on the work of applying my folklore skills and background to this fascinating and important area of study.

1.2.4 Complementary and Alternative Health

1.2.4.1 What is CAM?: an issue of semantics

I chose to describe the subject of my research as "complementary and alternative health beliefs and practices", or more concisely, "Complementary and Alternative Medicine", or "CAM". This was not an easy or arbitrary decision to make. The issue of semantics is one that continues to raise problems and discussion, both from the perspective of those who conduct research in this particular area, as well as those who use or interact with this type of healing practice.

There has been a considerable corpus of work devoted to discussing and debating how best to identify this large and sometimes disparate group of healing modalities, and what such a group would even entail. As Jacqueline Wootten points out, "any attempt to classify alternative and complementary medicine reveals a complex underlying puzzle over terminology, historical antecedents, diverse cultural meanings, and entrenched usage" (Wootton 2005, 777). Taking this a step further, Bonnie O'Connor writes, "across the literature, evaluations and descriptions have encompassed – with varying degrees of precisions and accuracy – questions of efficacy, theories of health and illness, modes of achieving therapeutic results, reasons why systems are believed and used, motivations and personality types of healers and clients, longevity and popularity in communities of believers and patrons" (O'Connor 1995, 48).

Indeed, a quick literature search reveals a seemingly endless variation of terms, each

with its own slightly different connotations. Some, such as "unproven"; "nonproven" and "questionable" therapies are, as Wootten describes, "cautious, if not alarmist" in tone (Wootton and Sparber 2001, 196). Others are even more obviously pejorative in nature: "quackery" (medical charlatanism involving deliberate deception); "primitive" (from a presumed earlier mental stage, simplistic, and naïve); "popular errors and misconceptions" (this is pretty self-explanatory – it simply means 'wrong'); "deviant" (connotes aberrance); and "fringe" or "marginal" (near or beyond the limits of accept-ability, also implies inadequacy) being some of the strongest examples. The majority of terms used to describe these health beliefs and practices, however, could be argued to be relatively neutral in nature, at least by comparison. These include examples such as "traditional", "holistic", "popular", "folk", "natural medicine", "ethnomedicine", "concurrent therapies", "integrative", "complementary","alternative", "unorthodox" and "unconventional medicine" (Anyinam 1990, 69),(Low 2001, 106),(O'Connor 1995, 6), (Wootton and Sparber 2001, 196).

Unfortunately, however, it is "difficult to find or forge adequate language in which simply to name and describe, without imposing a connotative judgment" (O'Connor 1995, 3). Indeed, each of these terms carries with it a whole host of meanings and baggage depending on when, where, how, and by whom it is used. Also to be considered is the fact that, despite which term is employed, there is no sharp, distinctive category into which these various different, and sometimes disparate, healing modalities fall. Instead, there are, as Fred Frohock describes, "continuums of various slopes and lengths on which types of complementary and alternative medicine are arrayed" (Frohock 2002, 214).

Furthermore, most, if not all of these terms, share the common distinction of being

residual in nature. In other words, they are created to define these health beliefs and practices not by what they are, but rather by what they are not. These are, in effect, definitions based in an oppositional relationship to the dominant Western biomedical system. Here again, we come across a semantic stumbling block. "Dominant Western biomedicine" is not necessarily the best designation, and certainly not the only one used – it is variously called "conventional", "orthodox", "official", "regular" "allopathic", "modern", "scientific", "mainstream", "biomedicine", "medicine", and (very confusingly) "traditional" – and certainly other examples exist as well (Wootton 2005, 778), (Frohock 2002, 214), (Bates 2002, 13), (Low 2004, 12), (O'Connor 1995, 5). Throughout the thesis, I have chosen predominantly to employ the term "allopathic", as it seemed to carry with it the fewest overt preconceived connotations of legitimacy. No matter which term is used, however, there is an understanding that this dominant medical system has a clear set of sanctioned practices, values, and institutions, which in turn are backed by a significant amount of social, economic and political power.

These semantic conundrums reveal extremely complex, convoluted and highly loaded attitudes and approaches with respect to health beliefs and practices. No matter which terminology is employed, the underlying insinuation is typically that there is an official, standardized medical system, and then there is everything else. Understandably, many have argued that this is a problematic dichotomy – one that lumps together modalities that do not necessarily share cohesion, and places a clear divide between systems that are not necessarily so disparate (Ning 2013). Perhaps even more to the point, this divide between "official" and "unofficial" is often, as the terminology reveals, one that is fraught with derogatory assumptions. For instance, even though positivist assumptions about linear evolutionary processes of human

thought have largely been abandoned in contemporary scholarship, the legacy of these early assumptions has proven to still be influential, and can still hold currency (O'Connor 1995, 16). This is a concept that will be discussed in more detail later on in the thesis, but it is important to at least acknowledge here the problems inherent in a dichotomous definition pitting "official" and "unofficial" health systems against each other.

The question, of course, is one of how to best designate and talk about these different healing systems. If all terminology carries with it loaded connotations and perhaps unwanted or unwarranted assumptions about an official/unofficial divide, how is one even expected to conceptualize and meaningfully discuss the issue? Obviously, this becomes, by necessity, an individual choice. For my purposes, perhaps an obvious initial thought would have been to go with "folk healing" or "folk medicine" as a descriptive term, considering that my background is, after all, as a folklorist, and much of folklore literature uses these designations. Also, the study of unofficial or vernacular health beliefs and practices, is, by its very nature, a folklore concern. In this sense, then, to study unofficial health belief systems is, in many cases, the main focus in medical folklore research.

There are, however, a couple of problems with "folk"-related terms. The first, and perhaps most important, is that the very notion of "folk" and "folklore", especially in areas dealing with belief, still bears the burden of early evolutionist mentality, where the "folk" were considered to be isolated and marginal – those left behind by modern, educated, civilized society. Bonnie O'Connor expresses this sentiment succinctly: "the 'bad' reputation of folk belief in general – assigned to it by its scholars – has been contagious, and the study of folk medicine has suffered accordingly... the same

presumption of randomness and silliness has been applied to folk healing traditions, with the same detrimental effects" (O'Connor 1995, 53). Folk beliefs, health and medical beliefs included, still hold the stigma of being "superstitions" or at the very least, uneducated and erroneous. Although folklorists have obviously fought to rid the discipline of these demeaning connotations, the fact is that they still exist. The associations are alive in scholarly, as well as lay populations.

The second problem is that, regardless of whether or not there are preconceived derogatory assumptions about folk, or folklore, there is often at least a pretty narrow conception of what folk medicine actually entails. Bonnie O'Connor writes, "generally, systems with constituent groups small enough that they can rely largely on oral tradition and apprenticeship for the teaching of tenets and the training of practitioners, and which are sustained largely in specific speech communities or close associative networks, have been those designated "folk""(O'Connor 1995, 6). Such descriptions or understandings of "folk" and "folk medicine"are far too limited for my purposes. My goal was to encompass the full spectrum of health beliefs and practices, and I did not want to feel reined in, or mis-interpreted by using this designation.

The term I actually find most useful is "vernacular healing systems", as discussed previously in the "vernacular" section of this chapter. This much more encompassing term includes the spectrum of what I set out to study, and does so while still maintaining the spirit or essence of folklore scholarship, and it's commitment to valuing and truly examining lay understandings. Of course, it is still a relative, or comparative term – it still denotes a grouping together of all the health beliefs systems that are nonconventional or unofficial. The perspective is, however, at the very least "descriptive, rather than proscriptive" (O'Connor 1995, 6).

So the question remains – if I indeed find O'Connor's term "vernacular health belief (or healing) systems" to be the most useful, why did I instead choose to adopt "complementary and alternative medicine"? The popularity of the term "CAM" can be traced, at least in large part, back to a watershed event in the United States in 1992. It was in this year that the National Institute of Health (NIH) founded the "Office of Alternative Medicine", thereby "conferring a measure of legitimacy to the area" (Wootton and Sparber 2001, 2). As a result, the term "alternative medicine" became current, but was later softened by adding, or in some cases, substituting the term "complementary" – a trend that was already popular in Europe and other English speaking countries (Wootton and Sparber 2001, 2). By adding the term "complementary", there was acknowledgement that, though residual, these types of healing modalities did not necessarily have to be seen as oppositional to mainstream medicine, but rather concurrent. In the late 1990s, NIH reconfigured the "Office of Alternative Medicine" as the "National Center for Complementary and Alternative Medicine" (NCCAM), thereby reflecting and embracing the more popular and widespread change in terminology. It later changed names again, becoming the "National Centre for Complementary and Integrative Health" (NCCIH), demonstrating an even more progressive trend, which will be discussed later in the thesis (National Centre for Complementary and Integrative Health 2015).

As it stands, however, the term "complementary and alternative medicine", or CAM, is one that has become widespread, ubiquitous, and easily recognizable and understood. It is these very qualities – in lay and official populations alike – that cemented my decision to use this term in my own fieldwork and, subsequently, my thesis. In this sense, my preference for using CAM as the main descriptive term

was primarily a methodological decision. For the recruiting phase of my fieldwork, I wanted to be able to convey my research topic and interests in a way that would be most widely understood, and with the largest possible range of modalities. This was especially relevant, in that I was interested in talking to a broad spectrum of people, including allopathic doctors, CAM practitioners, and CAM users. Not only did I wish to make the subject of my research as clear and inclusive as possible; I also wanted to make sure that I was presenting it in a way that would hold the fewest preconceived negative connotations. More than just methodological, however, my use of terminology was also chosen due to the fact that much of the cross-disciplinary literature on the subject uses the same, or similar terminology. In this way, my work became much more consistent with the majority of the published research that came before it.

Choosing to employ specific terminology, however, does not simultaneously cement a specific definition. Variations in meaning and understandings of CAM abound, with nuances that can range from inconsequential to drastic. The matter is complex enough that most CAM-related articles will include at least a cursory discussion or clarification of what the author(s) mean when they use the term, and there have been entire articles and debates devoted to subject, explaining the use and meaning behind semantics, classifications, and concepts (Wootton 2005, Jones 2005, Tataryn 2002, Wieland, Manheimer, and Berman 2011, Cassidy 2002, Frohock 2002, Ning 2013). Even with articles that specifically aim to tackle definition, the topic is not straightforward – typically, the discussion either tends toward the tangible or the epistemological, and will often combine both.

For those articles that lean more toward providing tangible, operational definitions

of CAM, there is a tendency to do so by means of classification systems – a tool used not only for defining, but also for comparative purposes. One of the earliest prominent examples is from 1992, when the National Institute of Health (NIH) organized a series of workshops with the express purpose of developing a standardized categorization system for CAM, resulting in six sections: Mind-Body Interventions; Bioeloctromagnetics Applications; Alternative Systems of Medical Practice; Manual Healing Methods; Herbal Medicine; and Diet and Nutrition (Wootton 2005, 777). While this framework has remained "remarkably intact" and influential, both within NIH and within the academic community, it also has a number of important flaws, and subsequent attempts to refine the system have created even more confusion (Wootton 2005, 777). This is, as Tataryn explains, relatively consistent with many early categorical frameworks, which were "quite varied, and did little to summarize the wealth of CAM modalities coherently", trying instead to reduce CAM modalities into a "manageable set of classes" (Tataryn 2002, 879). In so doing, many would argue that such classification systems missed the most salient features of the modalities they were classifying, leading to unreliable, inconsistent categorization that often did not actually reflect the conceptual underpinnings of the modalities they set out to describe (Tataryn 2002, 879).

Subsequent classifications have tried to get around these inherent flaws, often by creating categorical systems that include all manner of healing techniques, including modalities both within and outside of allopathic medicine. In this way, CAM is not entirely singled-out or dichotomized, but rather considered on a continuous spectrum. Jones, for instance, argued to classify health care practice by mode of therapeutic action, which he determined to include: biochemical; biomechanical; mind-body;

energy; psychological; and nonlocal categories, each with its own sub-divisions (Jones 2005, 937). Similarly, Tataryn devised an all-inclusive framework divided it into four main paradigms: Body; Body-Mind; Body-Energy; and Body-Spirit, again with multiple examples and sub-categories under each(Tataryn 2002, 881). These examples – both the earlier NIH categories, and the more recent, inclusive categories, are truly only a small representation of the attempts to characterize healing modalities, and define CAM in a systematic way. Health institutions, scholars and other interested parties are continually defining and redefining which modalities need to be included and described, and how they should be divided and sub-divided. Though each could be argued to be useful in its own way, there is certainly no coherent agreement or unanimously accepted model.

An epistemological or theoretical understanding of CAM is often directly related to its allopathic counterpart, and will be discussed at much greater length in Chapter 3: "Knowledge and Belief". At it's most basic, such a definition tends to include the following criteria: "CAM is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health sustem of a particular society or culture in a given historical period" (Wieland, Manheimer, and Berman 2011, 4). This is, as was previously discussed, a definition that is entirely residual in nature – CAM is automatically understood in contrast to allopathic medicine. As Wolpe describes, CAM is "defined not by its internal coherence but by its exclusion from other categories of medicine... it is a carve-out category for modalities that do not seem to fit the values of the modern biomedical world view" (Wolpe 2002, 165). While not ideal, this residual understanding and definition of CAM is inescapable,

and therefore impossible to ignore or get around in my own fieldwork and analysis. Of course, much like Bonnie O'Connor succinctly explained, my intention has never been to assume that the official health care system is the "standard against which to measure other systems' adequacy", but rather as a "familiar touchstone having the broadest general utility for illustrative comparisons" (O'Connor 1995, 5). Also, I want to make it clear that I did not enter this subject, or any of my interviews, with the intention of pitting the "allopathic" and "CAM" approaches and systems against each other in any way. Although I chose to work within an established dichotomous relationship, at least semantically, I made sure this was always a topic of discussion, rather than a preconceived truth.

1.2.4.2 Interest in CAM: Scholarly trends, Historical and Current

With a few notable exceptions , it was not until the early 1990s that serious scholarly attention began to be devoted to CAM-related research. Much of this early interest was focused on quantitative, scientific and statistically-based studies – a trend that remains relevant in current-day research as well. As was previously discussed, this sudden concerted effort in studying CAM in the early 1990s can be attributed in no small measure to the development within the National Institute of Health (NIH) of the "Office of Alternative Medicine" in 1992 in the United States (later, the "National Centre for Complementary and Alternative Medicine" (NCCAM), and the the "National Centre for Complementary and Integrative Health"(NCCIH)). Their goal when they developed the department remains consistent with their current mission: "to define, through rigorous scientific investigation, the usefulness and safety of complementary and integrative health interventions and their roles in improving health and health

care" (National Centre for Complementary and Integrative Health 2015).

As Daniel Callahan explains, this move toward formal exploration of CAM actually generated a fair amount of resistance from important parts of the research community, and the National Institutes of Health did not receive the same budgetary increases for their CAM-related research as they did for most other offices within their mandate (Callahan 2002a, viii). None-the-less, there were a number of CAM studies that began cropping up around this time, some of which yielded conclusions that clearly pointed to the value of exploring CAM-related issues more thoroughly. One of the most seminal pieces from this time was "Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use", a Harvard-based study conducted by David Eisenberg and colleagues (Eisenberg, Kessler, Foster, Norlock, Calkins, and Delbanco 1993). This article, which has become one of the most frequently referenced studies in all CAM literature (Wootton and Sparber 2001, 195), provided startling evidence that the use of such alternatives had been greatly underestimated in medical and social scientific literature. It had a number of important, far-reaching effects, most notably that "the much quoted figures on prevalence, use, and out-of-pocket expenditure gave encouragement not only to researchers, practitioners, and patients, but also paved the way for commercial expansion into the area" (Wootton and Sparber 2001, 196).

Indeed, this research provided a springboard for what has become a substantial corpus of quantitative, statistically-based studies outlining general CAM-related trends at a both a national and regional level, as well as studies exploring different patient groups or medical settings. A notable early example is Eisenberg et al.'s follow-up study in 1998, which brought attention to the colossal growth in use of CAM in the United States. It showed a dramatic increase in both the percentage of complementary

and alternative therapy users and the amount spent on these therapies between 1991 and 1997 (Eisenberg, Davis, Ettner, Appel, Wilkey, Van Rompay, and Kessler 1998). Most significantly, the total number of visits to alternative healers during this period rose to 629 million, a figure which was almost twice the total number of visits to conventional primary care physicians during the same years (Barrett, Marchand, Scheder, Plane, Maberry, Appelbaum, Rakel, and Rabago 2003).

From a Canadian perspective, Ramsay et al. published a similar survey-based paper in 1999, which indicated, for instance, that during the 1997 calendar year, Canadians spent approximately $1.8 billion on complementary and alternative health care providers and an additional $2 billion on herbs and vitamins, alternative diet programs and self-help books (Ramsay, Walker, and Alexander 1999, 29). Such studies went a long way toward solidifying the assertions that CAM-use is not only prevalent, but consistently growing in both Canada and the United States. These studies, along with an ever-increasing number of similarly-conducted surveys, painted an important and vivid picture concerning the place of CAM within the general population, and offered a glimpse into significant trends regarding CAM-related use. Mostly, these included issues regarding demographics, health care choices and prevalence, all of which help to piece together an important large-scale health picture.

Another particularly prominent trend in CAM-based studies and literature involves the testing and assessment of various CAM modalities and products. There are a number of journals specifically devoted to this research. The Journal of Alternative and Complementary Medicine, for instance, makes claims at being the "premier peer-reviewed journal of scientific work for healthcare professionals, practitioners, and scientists seeking to evaluate and integrate Complementary and Alternative

Medicine (CAM) into mainstream practice" (Mary Ann Liebert, Inc. Publishers 2012b). Similarly, another CAM-specific journal, Alternative and Complementary Therapies, reveals that it "provides the most authoritative, evidence-based, and practical information for integrating alternative therapies and approaches into private practice or hospital integrative medicine programs" (Mary Ann Liebert, Inc. Publishers 2012a). A third prominant example is the Journal of Complementary and Integrative Medicine, which "focuses on evidence concerning the efficacy and safety of CAM whole systems, practices, interventions and natural health products, including herbal medicines" (De Gruyter 2015). Certainly, these types of studies, geared primarily toward determining CAM efficacy and safety, are not limited to CAM-specific journals. In fact, most of the top medical journals will periodically, and sometimes regularly, include similar research. There was enough interest and demand for such studies, for example, that in 2001, the National Library of Medicine (NLM) and National Center for Complementary and Alternative Medicine (NCCAM) launched a database of 220 000 references: CAM on PubMed (Vastag 2001).

This type of research, almost exclusively based on the medical scientific model, typically uses the "gold standard" of randomized controlled, clinical trials (RCTs) in order to determine what is commonly referred to as the three "e"s of specific CAM modalities or products: efficacy, effectiveness and efficiency (Schaffner 2002, 4) – a fact that will be discussed in much greater detail in Chapter 3: Knowledge and Belief. They serve important functions – as a natural extension of pre-established medically-based studies, they have the potential to bring a number of otherwise unknown forms of healing to the attention of the allopathic medical community, and they also provide what many would consider valuable and reliable results concerning these products

and modalities. In theory, these studies aim to put CAM practices and substances on par with their allopathic counterparts, submitting them to the same rigorous testing, and therefore ultimately providing an assessment of when, how, and if they should be used. As I will discuss in much further detail later on in my thesis, however, it should also be noted that there are a number of arguments against this blanket method of clinical research for CAM-based health.

Although it is not as widely represented as quantitatively-based CAM studies, there has been a fair amount of qualitative research conducted concerning this subject as well. This includes literature from a wide range of disciplines, with particularly strong showings from the humanities and, to a lesser extent, the social sciences and some scientific disciplines as well. As opposed to the quantitative tools of survey and experimentation, qualitative work predominantly makes use of interview and ethnography to access information, focusing particularly on experiential forms of understanding and knowledge. With respect to CAM studies specifically, this often means accessing vernacular approaches and experiences to health. As I discussed previously, in the "Folklore and Health" section of this introductory chapter, the folkloric bent toward studying the vernacular has meant that much of the work done by folklorists in the area of health studies can be understood as CAM-related research. As such, in describing the folklore and health research that has been conducted, I have also, therefore, already largely discussed some of the most pivotal work that folklorists have contributed to the discussion of CAM.

Of course, there is a wealth of excellent and important material outside the discipline of folklore as well. Qualitative CAM-based articles abound from a wide range of different disciplines and perspectives, many of which are highlighted throughout the

thesis. There are books in particular that illustrate this type of research, and were integral to my own work. The first is a collection of essays edited by Daniel Callahan, entitled The Role of Complementary & Alternative Medicine: Accommodating Pluralism (Callahan 2002b). As Callahan states in his introduction, this collection was not conceived of in response to any dearth of literature on the subject of CAM, but rather to explore an element of the professional debate on the topic that greatly intrigued him: "how is sense to be made of the fact that a large and prestigious group of clinicians and biomedical researchers seems so utterly hostile to CAM while a large portion of the public (and the educated public at that) seems so attracted to it?" (Callahan 2002a, vii). In particular, he was interested in questioning some core problems surrounding the issue of CAM and the scientific/medical community, including whether or not there is only one acceptable form of scientific evaluation; examining different methodologies and standards of evaluation; and looking closely at what it even means to claim that a therapy "works" or does not "work" ((Callahan 2002a, viii). In order to explore these issues, he was also intent on selecting a research group of contributors who were "sympathetic to CAM, take it seriously, and yet are quite willing to subject it to criticism" (Callahan 2002a, ix).

What resulted is a fascinating compilation of theoretically-based pieces that address these important questions. The contributors come from a diverse range of disciplinary backgrounds, including medicine, philosophy, research methodology, cultural and folklore studies, and sociology; and the chapters fall into two categories: methodological problems and cultural perspectives. In essence, these pieces are designed to highlight the quantitatively, scientifically-biased approach to CAM studies, and compare and contrast it with more qualitative, experientially-based ways of conducting research

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and obtaining information and results in this area. Certainly, this book was of great use to me in formulating and understanding my own qualitatively-based approach to CAM research, and how this fits into the preexisting standards and examples.

Finally, it is important to mention a book that was written by sociologist Jacqueline Low, entitled Using Alternative Therapies: A Qualitative Analysis (Low 2004). Similar in nature to my own research interests and concerns, Low sought with this book to fill in what she considered to be some essential gaps in CAM literature – namely a focus on qualitatively-derived lay understandings of health and health choices, from a comparatively understudied Canadian perspective. Low covers a range of relevant CAM issues, including how to conceptualize alternative health care and the people who use it; how and why people participate in alternative approaches to health and healing; identifying alternative models of health and healing as "espoused by the people who participated in the research"; and finally, providing a consideration of the potential implications for those who engage in CAM. She concludes by offering a discussion of the implications of these findings with respect to health policy and further sociological research in the area of CAM (Low 2004, 9-10). The similarities between Low's study and my own research interests and undertakings are obvious – as are, therefore, the reasons why this book was an important resource for me. As it will become clear, however, my folklore background, regional focus, scope of informants, and analytical tools and concentrations all result in what is, in many ways, both a divergent and complementary body of work.

As this very brief glimpse into the world of CAM literature reveals, this is a subject that has risen from being relatively under-acknowledged and poorly studied, to one that has, in the few decades, produced a vast, diverse, multidisciplinary array of research.

It is at once an important subject in its own right – one that has direct and powerful implications on both a lay and institutional level – while simultaneously remaining a subject that, in some arenas, continues to struggle for legitimacy. It is my hope that this present thesis can both add to the ever-growing body of ethnographic-based qualitative work, while simultaneously providing a unique voice and perspective.

1.3 In summary

This introductory chapter was a means of highlighting and discussing the overarching themes, concepts, and approaches that are most important to this thesis. The subject of complementary and alternative health beliefs and practices is one that is so broad, complex, and multi-disciplinary that such an overview is at once daunting and, by necessity, highly selective. As such, this kind of literature review and thematic discussion can only scratch the surface of what I would consider some of the most important, fascinating aspects of vernacular health and health-related research which is being (and has been) conducted.

Many of these themes – terminology, narrative, vernacular understandings of health – are pertinent issues to scholars studying the subject of complementary and alternative medicine from any number of different disciplines and approaches. They are necessary and important contextual backdrops by which this particular subject needs to be framed. I strove, however, to pay particular attention not just to these broader issues, but also to explain how the field of folklore specifically fits into the equation. Complementary and alternative health is by no means a new topic, but it is one that is continually relevant, and can offer potentially incredibly important

insights into issues relating to health beliefs, health choices and decision-making, and the continual interplay of official and unofficial culture. Such insights, however, can be dramatically influenced by the lens through which they are interpreted.

In this introduction, then, I have provided examples and discussion not just of the broader themes, but also of the approaches and understandings that folklorists have (and can) bring to the ongoing research. My goals, in this regard, are two-fold. My primary objective is, of course, aimed at framing my particular disciplinary training and approach, and how this has affected or shaped my research, and the resulting thesis. More than that, however, I also wanted to show how and why it is important to offer what can, in many ways, be described as a unique interpretive lens to a such a broad, cross-disciplinary topic of study. This is a technique that I have employed throughout the thesis. Each of the three main chapters that form the core, or body of the work, begin with their own contained discussion of the particular topic at hand. Much like this chapter, each of these discussions offer a broad, multidisciplinary synopsis, as well as a much more specific thematic examination of folkloristic theory and approach, and their impact on the resulting discussion and interpretation.

Chapter 2

Methodology

This chapter aims to present a thorough discussion of the research methods I employed both with respect to the fieldwork I conducted, and the data processing/thesis construction that I undertook over the course of my research. It presents a detailed account not only of the tools and processes I used, but also the reasoning and impetus behind my decision-making processes. While there were certainly pertinent theoretical concepts that guided the fieldwork design and process, I will not include them here, as they will be discussed at various different points throughout the thesis as they are relevant. Broadly, fieldwork methodology and technique was adopted from the such work as <u>People Studying People</u> (Georges and Jones 1980), <u>Fieldwork</u> (Jackson 1987), and <u>The Tape-Recorded Interview</u> (Ives 1995).

2.1 Fieldwork

2.1.1 Limiting the study: Region

When I first set out to distinguish the design and aims of the fieldwork process for this thesis, it became clear that the first, and most pressing decision I had to make was how to limit the study – how to make it a manageable endeavour. I wanted to get as full and broad a picture as possible of the complex, multi-faceted world of the complementary and alternative health modalities. I wanted to uncover what sorts of modalities and items were being used, why people were choosing to use them, who was using them, and where they clashed or melded with the allopathic medical mainstream. I therefore did not want to limit my fieldwork by factors such as modality, illness, or type of informant, or even to make assumptions about what or who should be included in a discussion about complementary and alternative health. Instead, I wanted to cast as wide a net as possible, and start to piece together a puzzle based on the narratives, experiences, beliefs and practices of the people I interviewed.

Consequently, the most viable course of action became to limit the fieldwork regionally – that is, to focus only on interviewing people within a certain city or cities. In this way, the scope of the interview participants and the understandings of CAM could remain broad and inclusive, and there was the added bonus of being able to draw potentially interesting or important conclusions about unique aspects of CAM use within a particular geographic/demographic area. From both a personal and academic standpoint, I was by far the most familiar with the Canadian Atlantic

Provinces [1]. I had grown up in Fredericton, New Brunswick, attended university in both Fredericton and in St. John's, Newfoundland and Labrador, and, as the fieldwork process began, was living in Halifax, Nova Scotia. The appeal of conducting fieldwork in the Atlantic region was therefore two-fold: not only did I already have a familiarity, starting point, and strong personal interest in this part of the world, I was also committed to contributing research into what is inarguably a relatively understudied geographic area within health, and particularly, CAM-related research.

I chose to focus specifically on the provinces of Nova Scotia and New Brunswick, conducting interviews with a cross-section of the population of their two capital cities: Halifax Regional Municipality (HRM), and Fredericton, respectively. These are the only two areas wherein I actively recruited participants. While some of the included interviews were conducted in rural areas outside of the cities themselves, these were done with participants who had health practices within the main cities.

2.1.2 Participants

In order to gather as varied and inclusive a perspective as possible on CAM health beliefs and practices within the designated regional area of study, I sought out interviews with three different but inter-related groups of people: those who use or have used CAM; CAM practitioners; and allopathic physicians. Of course, these three categories are not as clean or mutually exclusive as they appear – most CAM practitioners and many allopathic physicians also consider themselves CAM users, some allopathic doctors also practice CAM therapies, and there were CAM users that I

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[1]A much more thorough and context-rich discussion of region will be provided in Chapter3: Regional Context

interviewed who were planning to become CAM practitioners, or had trained to practice one or several CAM modalities, but were not currently practicing. Nevertheless, I framed my interest in interviews within these designated groups of people, and, I would argue the designations do have merit – a fact that will be discussed in much greater detail in Chapter5, "Role".

In my original study design, my goal was to interview a minimum of ten allopathic physicians, ten CAM practitioners, and fifteen CAM users, for a total of thirty-five participants. In the end, I interviewed sixty-two people in total – a number which includes the interviews I used for the thesis, as well as the ones that ended up being excluded. I excluded interviews for one of two reasons. The first limiting factor was that three interviews ended up being conducted with people from Moncton, NB, and therefore complicated the regional designations or parameters that I had set. Secondly, I simply ran out of time or ability to continue transcribing, and therefore decided to cap the interviews when I reached 50. I almost reached my allopathic physician goal, exactly met my CAM user goal, and far exceeded my CAM practitioner goal. Table 2.1 (see table 2.1 on page 62) shows a break-down of the 50 interviews that were transcribed, coded, and used in the thesis, sorted by type of participant and demographic area in which the interview was conducted.

As was previously mentioned, I did not put any limitations on the types of CAM modalities or substances that people self-identified as using; the specialty of CAM practitioner; or the specialty of allopathic physicians. I interviewed anyone who fit into the broad criteria, and was willing or interested in participating in the project. It is, nonetheless, interesting to see the break-down of what specialities ended up being included. As Table 2.2 (see table 2.2 on page 62) demonstrates, the allopathic

physicians are relatively straightforward to organize in this way, as they all had one particular specialty.

The CAM practitioners, however, were a little trickier, as some practiced multiple specialties, and others had specialties that were not as easily or clearly defined or labeled. With that in mind, I have attempted break the practitioners into specialties with as much accuracy as possible, but the reality is much more nuanced than the table can fully express. See Table 2.3 (2.2 on page 62).

I did not feel a table was necessary or useful with respect to a specific distribution of modalities or therapies employed within the category of CAM users, especially since there is often a large and potentially confusing range and overlap for most individuals. I have, however, compiled a list of the range of different modalities and therapies that were discussed, arranged alphabetically, each with a brief description. These are included in Appendix C.

2.1.3   Recruiting

I relied on a number of recruiting methods for this project. To begin the process, I started by asking a few individuals who I knew personally if they would like to participate, or if they knew people who would like to participate. Some of these initial recruits were people I had known for some time, and met through avenues unrelated to complementary and alternative health beliefs and practices. Others were people I had met through CAM-specific activities or events, mainly by undergoing various CAM treatments myself, or by talking to exhibitors at one of the yearly "Wellness Expos" that I attended in Halifax (Wellness Expo 2015).

A second recruiting method involved directly soliciting participants with whom I had no previous contact or connection. For the most part, this included CAM practitioners that I found advertised in local health and CAM-related publications or directories. Nova Scotia produces a few such documents, but the most helpful for this process was the Nova Scotia Good Health Directory, which offers an extensive list of complementary and alternative medicine and health resources, including Nova Scotia-based companies, therapists, organizations and health practitioners (Nova Scotia Good Health Directory 2015). I also found CAM practitioner information advertised in local brochures, business cards, or posters situated in various local establishments.

Independent of whether I did or did not have any previous contact or connection with these potential participants, my method of solicitation was the same. I would mail a cover letter explaining who I was and what I was asking them to participate in (Figure A.2), as well as a brief synopsis of the research project (Figure A.3), and a copy of the pamphlet that I had designed and printed for recruiting purposes (Figure A.1). Examples of all three of these items can be found in Appendix A: "Recruiting Materials". The letters and information would either be sent electronically (that is, by using e-mail), or physically (in an envelope), depending on the type of contact information I had been able to acquire. Between the pamphlet and the cover letter, everyone who received a request was also given the necessary information to contact me using my phone number, e-mail address, or residential address, depending on their preference. After doing this initial mail-out, I purposely chose to not pursue any follow-up correspondence, unless the recipient contacted me first. I felt this was the least intrusive means of acquiring participants, and it also meant that those who ended up participating were truly interested in contributing to the research, or at the

very least, chose to take the initiative to contact me with no extraneous pressure, or coercion of any sort.

A third form of recruitment involved distributing my pamphlets (Figure A.1) to various locations around Fredericton and the Halifax Regional Municipality. I targeted practitioners' clinics, health stores, community centres, and coffee shops. Similarly, I also posted the pamphlet on two local online message boards – one that served the HRM, called "Halifax Locals", and another that is mainly frequented by people from St. John and Fredericton, NB. Posting the pamphlet electronically did generate some discussion in the particular thread that I had begun, but mainly I was interested in finding participants who wished to do one-on-one interviews. Although leaving pamphlets around town and on-line was obviously not individually directed, and provided less immediate information concerning the project, it was also a means of accessing participants who were truly interested in participating in the research, and chose to contact me on their own accord. Incidentally, this was also how I ended up initially finding participants in Moncton, as a pamphlet had somehow made its way to a homeopathic clinic in that city, completely independent of me.

Finally, I relied heavily on snowball method to find participants. I made a point to ask everyone I interviewed if they could recommend other potential participants for me to contact directly, or whether they could pass my information along to anyone they thought might be interested. I also made it clear on both the pamphlet and the cover letter that I highly encouraged people to pass my information along, whether or not they were personally interested in participating. Through these various means of recruitment, I was able to interview an even larger group of participants than I had initially hoped, and was more than satisfied with the regional and professional

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cross-section that I obtained.

I feel that my recruitment approach was an effective, practical, and ethical means of finding participants, and that it contributed significantly to the rich, informative, fascinating interviews that transpired. I also recognize, however, that there is an inherent bias in interviewing people who are, for the most part, keenly interested in the subject matter to begin with. Certainly, this bias was not entirely uni-directional, especially with respect to some of the allopathic doctors, in comparison to CAM practitioners and users. I would also argue that if this bias did indeed exist, it is not necessarily a hinderance to the quality of research, as the goal was to access a vernacular – and therefore, inherently individual or personal – perspective of health beliefs and practices. As such, pre-established bias toward the topic could simply be argued as having well-formed, articulate opinions and experiences to share and contribute.

2.1.4 The interview process

After contacting me and agreeing to participate in the project, each informant was then asked to partake in one face-to-face interview at the location and time of his or her choosing. In the case of allopathic doctors and CAM practitioners, the interviews predominantly took place in their clinic or office, although I was occasionally asked to come to their place of residence, or a restaurant or coffee shop. For CAM users, we met in various locations, which included coffee shops, universities, the participant's personal residence, or, in one case, my apartment. For those people who could not, or chose not, to meet face-to-face, I also offered the option of phone interviews. This

was, however, a relatively rare occurrence.

I asked participants to allot one to two hours for the interview process, which was meant to include the interview itself, the time taken to explain the project in more detail or answer any questions the participant might have, and also the time taken to sign a consent form (Figures B.1 and B.2), and fill out a demographic information sheet (Figures B.3 and B.4). The forms I used for this purpose can all be found in Appendix B: "Consent Forms and Demographic Information Sheets". Typically, the actual interviews took between thirty minutes and one and a half hours, although some crept into two hours and beyond. I tried to keep the interviews under one and half hours, as I felt that any longer than this was, by and large, the point where fatigue set in for both myself and the interviewee. If, however, the participants were eager to keep going, or had something in particular they still wanted to say, I ultimately let them make the decision on when to stop.

I conducted the interviews in a very loosely structured manner, letting the participants choose what they wanted to discuss, and how the interviews took shape. I always began by asking the participants to tell me their health story, however they wanted to interpret or frame this request. For allopathic physicians and CAM practitioners, I specifically suggested that this story include an explanation of what their practice entails, and how or why they became specialists in their particular areas of expertise. Although I did not have a specific list of questions I wanted to have answered, during the interview process, there were certain themes that I would be conscious to try and bring up or inquire about if they did not come out on their own. These included issues related to: multiple modality use and order of resort; integration of allopathic and CAM health systems; regional concerns or peculiarities; regulation and health

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coverage; patient and practitioner communication and role; and knowledge acquisition and legitimacy. These were all, however, topics that people tended to include without specific provocation.

All the interviews were recorded using a Marantz PMD-660 solid state audio recorder, which recorded to compact flash cards. Although there were microphone inputs, I chose to record using the built-in microphones. I recorded to a 44.1 kHz wav file. I tried with every interview to write any relevant field notes before the interview began, including details concerning recruitment, describing the interview location or setting, or explaining anything I knew about the informant. I also wrote notes throughout the interviews, especially if there were any particularly interesting points, if I thought of questions I'd like to ask, and as a partial back-up if anything happened to the recording. When possible, I also wrote follow-up field notes after the interview, summing up what I considered to be the most important elements, how the interview went, and any other details that I thought might be useful when looking back over the interview or coding.

2.1.5   Transcription and coding

In order to transcribe the interviews, I used a free program called "Express Scribe", which allowed me to import the interviews onto my laptop computer, played them back at whatever speed I chose, and also allowed me to use a foot pedal control. The first eight interviews that I transcribed were done in full transcription. I included the interview verbatim, with both my comments and the participants'. After completing these initial transcriptions, however, I decided that in the interest of time, I would

switch to a system of partial transcription. Using this method, I fully transcribed any sections that I felt were particularly relevant, and only synopsized sections that were potentially less useful. In both cases, I included periodic time checks, in order to be able to quickly access the spot or discussion in the original interview, and to ensure direct quoting for whatever I chose to use in the thesis. Almost all interviews were transcribed or partially transcribed by me, although my husband also volunteered his time, and did four full transcriptions as well. He was careful to use the same transcribing system and method that I had been using, in order to maintain consistency.

Coding was completed manually, using what I identified as the the 22 most frequently occurring, or prominent themes throughout the interviews. These themes had become apparent both as I began the interview process, and as I transcribed. I created separate documents for each theme, and then went through each interview individually, extracting quotes or sections of interview that fell under these broad themes, and placing them in the tables where they belonged. I was then able to distinguish which themes contained the most discussion points, and were therefore of most relevance to the thesis, and how some of the smaller sub-themes fit into the larger, more encompassing themes. I then structured the chapters of the thesis accordingly.

Table 2.1: Distribution of informants by type of informant and region.

Participant	Halifax	Fredericton	Total
Allopathic Doctor	5	4	9
CAM Practitioner	14	12	26
User	9	6	15
Total	28	22	50

Table 2.2: Allopathic physician distribution by specialty

Specialty	Halifax	Fredericton	Total
Family Physician	1	1	2
Gasteroenterology		1	1
Internal Medicine	1	1	2
Geriatrics	1	1	2
Pathology		1	1
Environmental Medicine	1		1
Total	4	5	9

Table 2.3: Practitioner distribution by specialty

Specialty	Halifax	Fredericton	Total
Acupuncture/Acupressure	1	2	3
Chiropractor	1		1
Colonics	1		1
Energy Work	1	1	2
Homeopath	1		1
Massage	1	3	4
NAET		1	1
Naturopathic Doctor	3	2	5
Psychotherapy	1		1
Rolfer	1		1
Yoga Instructor		1	1
Midwife	1		1
Physiotherapist	1		1
Herbalist	1		1
Life Coach		1	1
Breath Practictioner		1	1
Total	14	12	26

Chapter 3

Regional Context

Before delving into the the main themes and issues that came out of the interviews in this thesis, it is first important to put the research into context. As such, this chapter will offer both a brief overview and description of Canada and the Canadian health care system, as well as a more specific portrait of the provinces in which the research was conducted: Nova Scotia and New Brunswick, and their respective capitals of Halifax and Fredericton. This is important not only to gain an understanding of where this region fits in when compared with the rest of Canada and other parts of the world, but it also allows for a discussion and exploration of some of the regional qualities or realities that potentially affect health-related decision-making, particularly as they relate to the CAM-allopathic interface.

3.1 Canadian Health Care System

Canada is a geographically, economically, regionally and culturally diverse country (Romanow 2002, xviii). Claiming the northern part of the continent North America, it

covers almost 10 million square kilometres, and current population estimates are just over 35 million (Statistics Canada 2015a). It is divided into 13 geographical areas, 10 of which are designated as provinces, with the other 3 designated as territories (Figure 3.1). These are, in turn, grouped into five different regions: The North (Nunavut, Northwest Territories and Yukon); the West (British Columbia and Alberta); the Prairies (Saskatchewan and Manitoba); Central Canada (Ontario and Quebec), and the Atlantic Provinces (New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador) (Government of Canada 2014a). Politically, it is a constitutional monarchy, and it functions with three levels of government: a federal parliamentary democracy (headed by a prime minister), provincial/territorial government (headed by premiers), as well as municipal (Government of Canada 2014b). It is a developed country, and one of the wealthiest in the world (International Monetary Fund 2015). It ranks among the highest in international measurements of government transparency (Transparency International 2015), civil liberties (J. Patrick Rhamey Jr. 2015), quality of life (United Nations Development Program 2014), peace (Vision of Humanity 2015), economic freedom (The Heritage Foundation 2015), and education (United Nations Development Program 2013) .

From the perspective of health and health services, Canada boasts a national health insurance program, often referred to as "Medicare". The evolution of this health care system has been both rich and complex, and continues to be evaluated and reevaluated as the needs of Canadians change. The goal of Medicare, however, has remained constant: the "provision of universally accessible medical care to all Canadians, regardless of class, region, educational level, religious background or gender" – a vision that was established in order to abolish the clear relationship between income

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Figure 3.1: Canada

level and use of medical services that dominated the health care system before Medicare was implemented (Clarke 2012, 274).

Though MacKenzie King first suggested a system of universal medical insurance as early as 1919 as part of his liberal party platform (Clarke 2012, 267), it was not until 1947 that Saskatchewan became the first province to "establish universal public hospital insurance". Ten years later, in 1957, the federal government introduced the "Hospital Insurance and Diagnostic Service Act", which provided Canadians with universal access to a range of medical services that were specifically associated with hospitalization and medical testing (Health Canada 2014, 1). Based on recommendations offered by the

1961 Royal Commission on Health Services, the "Medical Care Act" was subsequently enacted in 1966 and implemented by 1972. Designed to be more comprehensive, this act covered the medical services that were not included in the original "Hospital Insurance and Diagnostic Service Act"(Clarke 2012, 268). When a review was taken of Canada's health services once again in 1979, Justice Emmett Hall affirmed that they were "ranked among the best in the world", but also warned that aspects such as double-billing by doctors were creating a two-tiered system that "threatened the universal accessibility of care" (Health Canada 2014, 1). This report, and the national debate that ensued, led to the enactment of the Canada Health Act in 1984 – Canada's "federal health insurance legislation" for publicly funded health care insurance (Health Canada 2014, 1-2). It sets out the primary objective of Canadian health care policy, which is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Health Canada 2014, 2).

The Canada Health Act is based on five principles which, as the Health Canada website reveals, "are symbols of the underlying Canadian values of equity and solidarity" (Health Canada 2010). These principles are as follows:

1. Public Administration (each provincial health care plan must be administered and operated on a not-for-profit basis by a public health authority operated by government)

2. Comprehensiveness (it must cover all services provided by hospitals, physicians or dentists deemed to be medically necessary)

3. Universality (all insured residents of a province or territory must be entitled to the insured health services)

4. Portability (allows individuals to still be insured while out of province, and no minimum period of residence in excess of three months)

5. Accessibility (all insured persons have reasonable access to services, unimpeded by charges or other means) (Health Canada 2014, 4).

There are, as Romanow asserts, many misconceptions about what Medicare is and what it is not, most of which can be argued to stem from the complex and often confusing relationship between the federal and provincial/territorial governments, and their roles within the system (Romanow 2002, 4). As the official Health Canada website maintains, "instead of having a single national plan, we have a national program that is composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage" (Health Canada 2010). In this system, the federal government is responsible mainly for transferring funds to provinces and ensuring that conditions of the act are met (Romanow 2002, 5), as well as overseeing specific areas such as approval and regulation of drugs, and protections and promotion of health (Romanow 2002, 3). The provincial/territorial governments have primary responsibility for the management, organization and delivery of health services for their residents (Health Canada 2010). This includes "setting their own priorities, administering their health care budgets and managing their own resources" (Health Canada 2014, 1). Many provinces have established regional health authorities, which oversee these roles, and "tailor the services to specific regions that plan and deliver publicly funded services locally" (Allin and Rudoler 2015, 21) . This federal-provincial arrangement has lead to an understanding and description of Medicare as a health care system which can be summed up as "delivered locally, but structured on intergovernmental collaboration and mutual understanding of values"

(Romanow 2002, xvi).

Unsurprisingly, the delivery of, and individual's relationship to the Canadian Medicare program is complex, and at times, contradictory. It is continually being reassessed and reimagined. In 2002, for instance, a document entitled <u>Commission on the Future of Health Care in Canada</u> was released by Roy Romanow. As he described, he had been asked to "undertake dialogue with Canadians on the future of the public health care system and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally acceptable, publicly funded health care system" (Romanow 2002, iii). According to his findings, despite a number of areas that people felt needed to be addressed and improved, Canadians overwhelmingly were "deeply attached to the core values at the heart of Medicare", including "equity, fairness and solidarity", which were a "right of citizenship", rather than a privilege of status and wealth. (Romanow 2002, xv-xvi). This has been described as "the Canadian Way" – that Canadians predominantly "embrace Medicare as a public good, a national symbol and a defining aspect of their citizenship"; a "moral enterprise, not a business venture" (Romanow 2002, xvii-xviii).

Nonetheless, despite the fact that Medicare has, and continues to be a much-heralded Canadian value, it is simultaneously the site of "continuing political controversy" (Clarke 2012, 268). The specifics and the future of health care in Canada are always a hot topic in election campaign platforms, and spark debates on topics such as "bringing back a parallell private system", "waiting lists for major tests and surgery", and "doctor shortages and emergency room fiascos" (Clarke 2012, 268).

One of the biggest discrepancies or points of contention has to do with the fact

that for a universally accesible health care system, there is a large component of health services that are private. There is, for example, no nationally defined statutory benefits package – most public coverage decisions are made by provincial and territorial governments, which provide "varying levels of additional benefits", such as outpatient prescription drugs, non-physician mental health care, vision care, dental care, home health care, physiotherapy, aids to independent living, and ambulance services (Allin and Rudoler 2015, 21-22). While some provinces provide public coverage for some of these services, many such services are not covered at all, depending on where an individual lives. For those services that are included under the purview of provincial benefits, they are almost never fully covered, in that they require additional costs such as co-payment and deductibles. Therefore, private insurance plans and employee benefit plans end up covering the majority of these "extra" services, and almost always come with strict conditions on what is covered, and where that coverage is capped (Romanow 2002, 5).

One prominent example is prescription drugs. When used out-of-hospital, pharmaceutical costs are not covered by Medicare. In order to acquire and use prescribed pharmaceuticals, then, patients either need to have adequate private insurance, and/or pay out of pocket. (Clarke 2012, 275). As Romanow explains, this is one of the issues in need of being addressed as Canada and the Medicare system evolve – when it was first established, drugs were a small cost, but now they are "one of the highest costs in the system" (Romanow 2002, xvii). As such, what many would consider to be universally necessary elements of health care now have the very real possibility of "bankrupting families" (Romanow 2002, xvii). Also, it is worth pointing out that those who access the allopathic medical system also need to be able to personally cover

less tangible costs, such as transportation to and from appointments and procedures, taking time off of work, and child care, all of which make universality difficult to claim (Clarke 2012, 277-281).

The solutions to these and other such complex problems within the Canadian health care system are, of course, not easy to determine. This is the reason the system is continually reevaluated, reassessed, and, consequently, also continually evolving. In his 2002 report, for example, Romanow concluded that while Medicare is sustainable in the long term, it needs to change in some crucial areas, such as reorganization of services, improved access to services, and a reduction in disparities (Romanow 2002, 43). Nonethesless, the federal/provincial-territorial structure of the system remains intact, as do the underlying philosophies and principles that were proclaimed when Medicare was first implemented. Though complex and imperfect, it is still a system that aims to provide necessary medical services for everyone in the country, without discrimination. To understand the basics of the system and how it works is also a necessary component when looking at the specific issues related to complementary and alternative health that will form the body of this thesis.

3.2   New Brunswick, Nova Scotia and Atlantic Canada

As was previously described, my method of defining the research parameters for my thesis fieldwork involved conducting interviews in a specific geographic region. To this end, I chose the Atlantic Canadian provinces of New Brunswick and Nova Scotia, with interviews conducted almost exclusively in the capital cities of Fredericton and Halifax, respectively. The resulting findings and discussion must therefore be framed

within the context of these particular parts of the Canada, in order to understand the climate in which the informants live, as well as the characteristics that make this region unique.

Nova Scotia and New Brunswick are both part of the Canadian region called "Atlantic Canada". Atlantic Canada sits on the Eastern coast of of the country, surrounded by the Atlantic ocean. It is comprised of four provinces: the three Maritime provinces of New Brunswick (NB), Nova Scotia (NS), and Prince Edward Island (PEI), as well as the easternmost province of Newfoundland and Labrador (NL) (Figure 3.2). Collectively, these provinces make up a land and freshwater area of 539,064 square kilometres (km^2), the overwhelming bulk of which is NL, at 405,212 km^2. Compared to the rest of Canada, which boasts a total area of $9,984,507km^2$, these four provinces account for only just over 5% of the entire land and fresh water area of the country (Statistics Canada 2005). Similarly, as of the 2011 census, Atlantic Canada was home to 2,327,650 people, thereby comprising approximately 6% of the entire Canadian population, which sat at just over 33,000,000 at that same time (Statistics Canada 2015d).

With respect to both geography and population, then, Atlantic Canada takes up a relatively small corner of the nation to which it belongs. Also, despite the natural resources available within the region (particularly in the form of forestry and fisheries), the region has long been considered among the poorest in Canada. In New Brunswick and Nova Scotia specifically, recent years have shown the economy to be growing more slowly than the national average, with Nova Scotia coming in at one of the slowest growth rates in the entire country (Davis, Geiger, Gray, Hayes, Currie, Bateman, Phillips, Ondaajte, Cooper, and Page 2014, 237,254). Similarly, the 2013 census data

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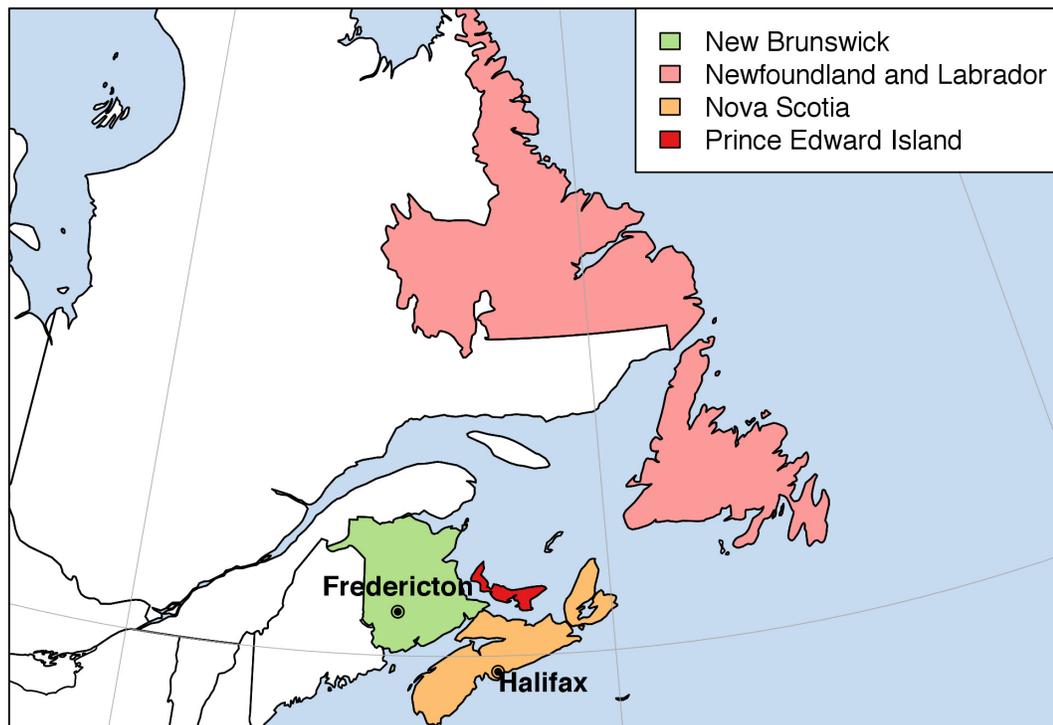
Figure 3.2: Atlantic Provinces

showed the median income of residents of these two provinces to be well below the national average of $76,550, coming in at $70,020 and $67,340 respectively (Statistics Canada 2015c). Also of interest is the fact that, statistically speaking, these two provinces contain some of the oldest population demographics: New Brunswick rated as the highest population of persons 65 and older, and Nova Scotia came in as the highest ratio of persons 65 and older to that of children aged 0-14 (Statistics Canada 2015a).

With respect to health care, it is particularly significant to note that the Atlantic Provinces have been shown to suffer from inequalities within the health care system.

As Romanow has pointed out, there are geographically-related health care disparities that exist in Canada, which "primarily reflect underlying economic, demographic, and cultural realties", such as relative poverty/affluence of regions, the degree of urbanization, population density and ethnic composition (Romanow 2002, 16). He goes on to point out that, as such, particularly serious disparities exist between people who live in Atlantic Canada versus those who live in the rest of the country – a fact which, of course, has direct impact on the study at hand.

It should be noted here that placing New Brunswick and Nova Scotia within the context of the larger Atlantic Canadian region serves a number of important purposes. Perhaps most obvious is simply the fact that Atlantic Canada is a well-recognized and utilized distinction – one that separates it from the rest of the country's regions. This is true both with respect to statistical and demographic information (as evidence above), as well as many of the more thesis-relevant health-related studies (which will be discussed further). I do not mean to attempt to make grand conclusions or assumptions about the Atlantic Canadian experience by using New Brunswick and Nova Scotia as representative examples. I do, however, wish to make it abundantly clear that, despite the fact that each province – and indeed, each city – is unique, they must be understood and considered within the broader regional context of which they are a part.

3.2.1 Fredericton and Halifax

The two specific areas in which interviews were primarily conducted included Fredericton and Halifax, which are the capital cities of New Brunswick and Nova Scotia,

respectively. New Brunswick, which is the gateway province between Atlantic Canada and the rest of the country, initially attracted settlers because of its extensive network of forests, which still covers over 80% of the land (Davis, Geiger, Gray, Hayes, Currie, Bateman, Phillips, Ondaajte, Cooper, and Page 2014, 235). It has three main cities: Saint John and Moncton, which are the two largest NB cities (both hovering around 70,000), and Fredericton, which is the smallest of the three, at slightly over 56,000 people (Government of New Brunswick 2015). Situated along the St.John river, Fredericton developed initially as a garrison town and a centre of administration and education (Davis, Geiger, Gray, Hayes, Currie, Bateman, Phillips, Ondaajte, Cooper, and Page 2014, 240). This is, primarily, how it remains today. Both the government (provincial and federal), and the two universities in Fredericton have a particularly strong presence in the city, acting as its main sources of employment. Consequently, public servants, and university staff and students make up a large portion of the demographic.

Nova Scotia, though it is the second smallest Canadian province, is home to a relatively large city, formally known as the Halifax Regional Municipality. With slightly over 390,000 people, this port city boasts almost 45% of the province's population (Statistics Canada 2015b). Though recent decades have seen the decline of many traditional industries in Nova Scotia, such as fisheries, mining and steelworks, Halifax has managed to buck this trend. It is, in many regards, considered both a global city, and certainly one of most important economic and cultural centres in Eastern Canada (Davis, Geiger, Gray, Hayes, Currie, Bateman, Phillips, Ondaajte, Cooper, and Page 2014, 258). Within Halifax alone, there are four major universities, including world-renowned Dalhousie University, and there is also a large concentration of government

services and private sector companies.

Clearly, despite the fact that Fredericton and Halifax differ greatly in size, they share a number of similarities, particularly with respect to demographics. Also, even though they are both urban centres, and therefore do not fully encompass or represent the more rural areas the provinces, I would argue that they do, by their nature, attract a relatively diverse cross-section of people from around the region.

3.2.2 Atlantic Canada and CAM

Since the directed scholarly interest in CAM in North America, which began in the mid-late 1990s, Canada has produced a number of country-wide surveys and studies on the subject. These have come out of institutions such as the Canadian think tank, the "Fraser Institute"; government bodies such as Health Canada and Statistics Canada; as well as various university programs and disciplines. Health Canada, for instance, published an entire collection of papers entitled Perspectives on Complementary and Alternative Health Care (Health Canada 2001), covering topics such as: defining CAM, policy dimensions, integrative health, ethical issues, and regulation. Statistics Canada developed a National Population Health Survey, which began to be analyzed for CAM use around this same time (Millar 1997, 2001). The Fraser Institute published a comprehensive study of Canadians' use of and public attitudes toward CAM in 1999 (Ramsay, Walker, and Alexander 1999), with a follow-up piece in 2007 (Esmail 2007). University research on the subject is, of course, broad, but there is an impetus toward using nationwide surveys to address CAM-use for specific conditions (Foltz, St Pierre, Rozenberg, Rossignol, Bourgeois, Joseph, Adam, Penrod, Clarke, and Fautrel 2005,

Lunny and Fraser 2010, Fautrel, Adam, St-Pierre, Joseph, Clarke, and Penrod 2002).

Though these publications highlight different aspects of CAM use within the country, many often include a breakdown of statistics based on particular regions, one of which is typically the Atlantic provinces. Throughout the years, and the various slants to the research foci, a clear trend can be seen. When compared with the rest of Canada, the Atlantic provinces report significantly less use of complementary and alternative medicine. In Millar's most recent report, for instance, it was revealed that "only 5% of persons in the Atlantic region used alternative health care providers" – a statistic that was as much as five times greater in other areas of the country (Millar 2001, 156). Similarly, the 2007 report out of the Fraser Institute showed that Atlantic Canada fell at the bottom of the list both for use of CAM in Canada throughout a person's lifetime (63%), as well as use of CAM in Canada in the 12 months preceding the survey (39%). Similarly, for studies which focus on particular health conditions, Atlantic Canada still falls at the bottom of reported CAM usage. One rheumatism-based article, for instance, found those in the Atlantic provinces were the "least likely" to use CAM for their auto respiratory afflictions (Fautrel, Adam, St-Pierre, Joseph, Clarke, and Penrod 2002, 2437), which was the same result as an article detailing CAM use and back-pain (Foltz, St Pierre, Rozenberg, Rossignol, Bourgeois, Joseph, Adam, Penrod, Clarke, and Fautrel 2005, 575).

The above-mentioned articles typically only analyze and mention the Atlantic provinces as a small part of the greater data-set – though they paint an important picture of where Atlantic Canada stands within the national context, there is no in-depth focus on the region beyond what the numbers reveal. When reviewing literature which specifically focuses on the Atlantic provinces and CAM, however, it

becomes clear that that there are relatively few examples. The most prevalent Atlantic Canadian CAM-based studies, much like their Canada-wide counterparts, tend to come out of survey/questionnaire-type research concerning CAM-use for patients with specific medical conditions or concerns. They offer statistical analysis of factors such as the types and rates of CAM usage, and the demographic determinants associated with its use and non-use. These types of studies are primarily linked to the Atlantic provinces by virtue of the fact that they were conducted within the region. The vast majority, in fact, are specifically linked to or conducted within Halifax-based hospitals. Examples include topics such as CAM use by patients with: chronic Hepatitis C Virus (White, Hirsch, Patel, Adams, and Peltekian 2007), gynaecological cancer (McKay, Bentley, and Grimshaw 2005), cardiovascular disease (Wood, Stewart, Merry, Johnstone, and Cox 2003), and patients who bring their children with non-chronic illness to the paediatric emergency room (Losier, Taylor, and Fernandez 2005). In a similar vein, there is also a Halifax-based study which aims to uncover the use and knowledge concerning CAM by the staff (rather than the patients) within a women and children's hospital (Brown, Cooper, Frankton, Steeves-Wall, Gillis-Ring, Barter, McCabe, and Fernandez 2007). Much less frequent are qualitative studies, such as a very specific piece examining cancer care, CAM, and end-of-life within Nova Scotia Black communities (Maddalena, Bernard, Etowa, Murdoch, Smith, and Jarvis 2010).

As such, the majority of these Atlantic Canadian CAM-related pieces are typically geared more toward illuminating broader aspects CAM use in relation to allopathic medicine than they are to explaining CAM use in the particular region that the study was conducted. Conclusions to these pieces almost invariably offer the opinion that the percentage of people who use CAM for particular conditions is great enough that

allopathic physicians need to pay more attention to their patients' use of various practices, and to make it their mandate to open a dialogue with respect to all the treatments a patient is pursuing. While this is certainly salient advice, and adds to the important collection of studies detailing the prevalence of CAM and the importance of communication and education within the allopathic system, these types of studies do not specifically weigh in on reasons why Atlantic Canada seems to show such a statistical difference in CAM usage when compared to the rest of the nation.

Extrapolating from other statistical trends, one could argue that much of these results can be understood as a product of overall demographics in the region. Use of complementary and alternative health care in Canada is repeatedly shown to be higher at "younger ages, among women, among people with higher education and higher income" (de Bruyn 2001, 21). As was mentioned previously, when compared to the rest of the country, the Atlantic Provinces are among the poorest, and contain the highest numbers of elderly individuals. Similarly, education levels are statistically significantly lower in Atlantic Canada when compared to results nationwide. From the 2006 census, for instance, those with no degree, certificate, or diploma came in at 24% in Canada, but averaged 29% in the Atlantic Provinces. On the flip side of this statistic, those who have a Bachelor's degree or higher accounted for 18% of the Canadian population, but only 13.5% of the Atlantic Canadian population (Statistics Canada 2009). The only demographic factor that bore no significance in this respect was the male/female ratio, which was similar in the Atlantic region to that of the rest of Canada (Statistics Canada 2015e).

Certainly, numbers and statistics such as these must be considered as part of the larger puzzle. A much more nuanced picture, however, can be revealed when taking

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into consideration the thoughts and experiences of those who actually live, use, and work with CAM. From my interviews, there were a number of themes that appeared frequently when people spoke about CAM specifically in the Atlantic province or provinces of which they were a part.

3.2.2.1   Pioneers

Of the three groups of people I interviewed for this project, the ones that provided the most insight on the relationship between CAM and regional context were the CAM practitioners. Echoing the statistics on low CAM-usage in the Atlantic region, one of the most frequently occurring observations in this regard was the sentiment that CAM practitioners working in Halifax or Fredericton felt they were, in many respects, forging new and difficult territory. Certainly, there were exceptions to this sentiment, one of the most obvious being massage therapy. As one Halifax-based massage therapist revealed, Nova Scotia is "saturated" with this particular profession, meaning that there is consequently "very stiff competition" for those who choose to practice (Kemp) – an observation that was echoed in Fredericton as well (Bunin). This could be explained, in large part, by the fact that both Fredericton and Halifax have schools which offer degrees in massage therapy, meaning that people do not need to leave the province after graduating. This, however, is not the case for many other disciplines. For those that pursued their training elsewhere, and then chose to settle or open their practice in Halifax or Fredericton, there was an overwhelming sense that they were, in many regards, "pioneers". As three different practitioners, a homeopath, an acupuncturist, and a naturopath, all independently and concisely described:

> *"Homeopathy work is still quite pioneering in Nova Scotia."(Peisinger)*

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"[Acupuncture] is kind of like a pioneer situation here still. People are just beginning to wake up to these possibilities."(Heffelfinger)

"We feel more like pioneers in Fredericton. Especially when we first started, there wasn't a whole lot going on."(Bunin)

Others spoke not only of the paucity of practitioners in their particular fields within the region, but also of the difficulty inherent in setting up practices where residents are not familiar with, or do not understand the services they provide. As one Halifax-based Rolfer revealed, for instance:

"It's really hard to get something going in this town. There are other guys around who were Rolfers or guild workers at one point, but aren't doing it any more, because they didn't earn enough money. I'm the only certified Rolfer east of Montreal."(Panter)

There was also often the strong notion that the Atlantic region was very different in this regard than many other places within Canada. A medical herbalist and a Naturopathic Doctor explained the differences as such:

"When I finished [school in British Columbia], I chose to return to Nova Scotia, because there were no herbal practitioners here, versus one hundred or more in British Columbia. I also felt a need to promote it and spread awareness. There are still only two medical herbal practitioners east of Montreal."(Jarone)

"Oh, yeah. [People will ask] "What do you do? What is that? You're a homeopath?" "No, I'm a naturopathic doctor". In Toronto, it's like "I have a chiropractor and a naturopathic doctor and a massage therapist and dentist" – you have a health team. Everyone there has a team."(Purcell)

Even those who sought to use CAM-based treatments expressed their feelings of being among a small group of similarly-minded people, or of how Nova Scotia and New Brunswick lagged behind the rest of Canada with respect to CAM. Two CAM-users, each with experience in other parts of the country, expressed this sentiment:

"I did just want to talk a little bit about how it's not easy for people in the Maritimes. I'm from Toronto originally, but I've lived here longer than I've lived there. But here I feel almost like a pioneer. If you want to do something differently, the onus is entirely on you."(Monti)

"I spent three weeks last fall in Vancouver, Washington, and Calgary. Vancouver is known to be a really progressive province in terms of health. There's healthy people running around there – it seems to be the norm there. Alberta is the same way. Not to knock what we have here – it's a start... but can we please join the rest of the world?"(Rostek)

This widespread observation that those who use and practice CAM in Fredericton and Halifax are "pioneers", or "forging new grounds" is one that has important implications. The take-away here is that people are not necessarily denigrating or avoiding CAM-related treatments, but rather that there is very little to choose from. Similarly, due to the paucity of practitioners and modalities available, many potential clients do not understand, or are not aware of the different options that exist.

3.2.2.2 "Cultural Nature": Conservatism, Openness and Change

The question, then, becomes a matter of why so many CAM practitioners and users still feel as though they are pioneers – why, in a time and a place where CAM is becoming ever more prevalent, do Atlantic Canadian capital cities such as Fredericton and Halifax supposedly still lag behind the rest of the country? One perspective on this seems to exist in the rather nebulous observation or understanding of these particular regions as more "conservative" than other parts of the country. Though no one I interviewed specifically sought to define this term, it came up a number of times. The reference did not seem to be associated with a political conservatism, or

even a religious conservatism, but rather simply a preference for doing things they

way they have long been done.[1] As one naturopath explained:

> "It is very different in New Brunswick (Fredericton specifically) than other places I have been. The word conservative comes to mind. You could likely be a lot more radical in a larger centre without raising too many eyebrows, but in Fredericton, we made a conscious effort – even in the way the clinic is set up and the naming of the clinic – to keep things very traditional. You know – "Fredericton Naturopathic Clinic", rather than "Shining Stars", or something more ethereal. We tried to appear on the outside to be very much the medical model. We're in an office building rather than a cottage or something like that. So in Toronto, you'd probably attract more people the more you stood apart from the system, but we didn't want to scare people away. Even the way we dress – we try to dress professionally, and maybe we'd like to dress more comfortably – I'd like to have a beard and moustache, but we make those choices."(Bunin)

Similarly, a Halifax-based medical herbalist explained the phenomenon as such:

> "There may be a conservative outlook of health and anything "other" around here. Sort of a very solid cultural rootedness. A lot of them might be skeptical of anything that's not mainstream, and the Maritimes have not been a major flocking place for people who have that knowledge to share."(Jarone)

Another Halifax-based woman linked this sense of conservatism to the fact that

the East Coast of Canada was, historically, settled much earlier than the rest of the

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[1]This is not to suggest that religious or political factors are unimportant here: that they have no impact on health-related decision-making, or that they do not have a relationship to the broader sense of conservatism discussed by those I interviewed. Rather, religious and political affiliation were not specifically pinpointed as the defining elements of this sense of "conservatism". As point of reference, however, both Fredericton and Halifax reported a predominantly Christian population as of the 2011 National Household Survey (70.6% and 71.5% respectively), the greatest number of which in both cases were Catholic (35.3% and 44.2% respectively) (Statistics Canada 2016). Politically, both New Brunswick and Nova Scotia have oscillated over the years between political parties. At the time of the interviews, NB had a Liberal premier, and NS had a Progressive Conservative premier. These both changed in the subsequent election. (The Canada Guide 2016)

country:

> "There's a lot more available out there [than here]. I think the prairies have always been known for change, and the east coast is very reluctant to change, because it's older. People have been here for 400 years... So I think there is some resistance to new things coming in."(Diana)

One allopathic general practitioner even described the Halifax medical system as following this conservative trend:

> "It is so much smaller here; such a small medical community. It is a whole different scale than Toronto. In some ways, the medical community is very conservative here."(Megan)

Even in scholarly literature concerning CAM and Atlantic Canada, this notion of a more "traditional" and "conservative" culture has been mentioned. In a Halifax-based study documenting CAM use among patients with cardiovascular disease, for instance, it was acknowledged that, due to the fact that the study was performed in Atlantic Canada, there may be "cultural issues" that potentially hinder the study's ability to generalize the findings for the rest of Canada and elsewhere. As the authors explained: "Atlantic Canadian residents tend to be relatively traditional in their cultural mores, and therefore the findings are apt to be conservative" (Wood et al. 2003, 812). Significantly, however, this argument was used to highlight the fact that the very high CAM usage that they found in this case was therefore that much more anomalous and noteworthy. As such, this article both reinforces the notion of Atlantic Canada's conservative or traditional approach to culture (and therefore health-related practices), but also highlights what the authors considered an unusually high percentage of CAM users in the region, at least for those specifically dealing with cardiovascular disease.

In an interesting counter-argument to these observations and assumptions about the "conservative" nature of New Brunswick and Nova Scotia, there were also a number of comments throughout my interviews suggesting that many people in this region were actually very "open" to new ideas and change. As one very successful Halifax-based naturopathic doctor revealed:

> " I was really surprised by how open to things people are [in Nova Scotia]."(Hayman)

Similarly, as a Halifax-based acupuncturist, who moved from California, described:

> "I also think they're very open – not everybody, but I find the Nova Scotian people have a very accommodating personality or something. And there's a very stable, earthy quality to the general population. And a sense of loyalty, which is interesting."(Heffelfinger)

It was suggested that this openness was particularly prevalent in Halifax – a feature that some felt did not even extend into surrounding communities:

> "Even within the Halifax Regional Municipality, there are regional differences with respect to openness to different approaches. Sackville and Dartmouth tend to be much more conservative than Halifax. You'll notice that if you look at where the alterative clinics are, there are almost none in Dartmouth. The same thing with Sackville. Whereas in metro – on this floor, there are 4 naturopathic doctors. There are only 5 GPs in the building. So there are very much regional differences."(Jacob)

What, then, accounts for these relatively drastically different conceptions of the "nature" of those in New Brunswick and Nova Scotia? The first important point here is that those who spoke of the "openness" were all Nova Scotia-based, often with particular emphasis on Halifax. As one naturopath speculated:

> " No doubt that Nova Scotia is more progressive and less conservative than New Brunswick."(Bunin)

Also noteworthy is the possibility, as the following woman suggested, that this openness is a relatively new phenomenon – one that is growing quickly, she believes, due to the influx of younger university-aged people coming through the city:

> "I think it's growing really quickly. Halifax is a really young community, especially because of the universities. It's a young population. People go to school here and love it and want to stay and raise families. They have facilitated that."(Diana)

If such speculation is true, then perhaps the "conservative" or "traditional" bent that many have described as existing within this region of the country can help to explain the statistical differences in CAM usage between Atlantic Canada and the rest of the country. Simultaneously, however, it also explains what others have described as a growing openness or interest in CAM – theoretically, as those with less "traditional" views continue to inhabit places like Halifax and Fredericton, the trend will begin to change.

Interestingly, it is possible to link this sort of change not just with the influx of a younger, primarily university-based population, but also with one of Atlantic Canada's defining characteristics – it's size. As was previously mentioned, Nova Scotia and New Brunswick are small, both with respect to geography and population. The Halifax Regional Municipality is by far the largest city at slightly less than 400,000 people, but it still pales in comparison to other urban centres such as Toronto, Montreal, or Vancouver. As such, there is, as many people in my interviews mentioned, a real importance within the world of CAM placed on informal communication networks, or word of mouth. This was expressed both within Fredericton and in Halifax, as evidenced by these two Naturopathic doctors and a Halifax-based CAM-user:

"The other thing here is that it's a small community – everybody knows everybody, and with every patient you have that extra onus to do your best, because one bad experience, and everyone in the city will have heard about it sooner or later. Which is a good thing, I guess, but it's that little bit of added pressure that everybody knows what's going on."(Bunin)

"That's the great thing about Nova Scotia. In Toronto, people don't talk to their neighbours, really. If you're going to your Naturopath, it's hush hush. People don't want you to know that you have anxiety or depression, or need help. But in Nova Scotia, it's like "I've got the best Naturopathic Doctor!", just like "I know where to get the best fish and chips!" Everybody talks. That's how my practice is built."(Hayman)

"One thing about living in the Maritimes is that word of mouth does do something. If someone is really bad or has really taken you for a run, then word will get around, and they won't be practicing for long. Whereas someone like Heidi never advertises or puts out cards, and is as busy as she wants to be based on word of mouth."(Douglas)

With informal communication networks exhibiting such a strong presence in places like Fredericton and Halifax, a clear connection could be drawn between increased interest in CAM, and quick, effective dissemination of information and experiences. In this way, it is possible that change can, and perhaps will start to occur, and that it may happen relatively quickly.

3.2.2.3 Money, Legislation and Regulation

Apart from opinions regarding the cultural nature of New Brunswick and Nova Scotia residents, and how this affects CAM use, the other two most often discussed issues were the inter-related topics of money, and CAM legislation/regulation. As studies have revealed, people are more likely to purchase CAM treatments and/or products if they have greater disposable income (de Bruyn 2001, 21) – a fact that is, in many ways,

common sense. Most basic healthcare needs in Canada are universally provided with little to no up-front cost to the patient; CAM, however, requires additional insurance coverage, out-of-pocket payments, or, often, both. Consequently, it is by no means universally accessible – those who have the means to access CAM modalities typically do so at significant individual expense. This is a topic that garnered much conversation among those I interviewed, and will be highlighted in Chapter 6: "In Search of an Ideal". For the purposes of this chapter, however, the relationship between income and CAM use can be argued to be relatively straightforward: because Nova Scotia and New Brunswick have the lowest incomes in the country, it stands to reason that there would be proportionally fewer people able to access out-of-pocket CAM treatments. As one Halifax-based CAM-user pointed out:

> *"I get really emotional, because we're talking about one of the most unfit provinces in the whole country. And New Brunswick too. I'm sure if people were given the opportunity to take more natural remedies or get educated a little bit – they just haven't found the way because it hasn't been available to them. They're having a hard time making rent, let alone educating themselves about alternatives."(Rostek)*

In truth, however, the link between money and CAM use is much more complicated and nuanced than a simple matter of average income, or individual expenditures. To understand the larger picture, it is important to examine how the healthcare system works at a provincial level, and where CAM fits into the picture in terms of cost and supplemental coverage. A large part of this phenomenon hinges around the complicated issue of legislation and regulation.

In Canada, occupations or professions can fall into one of two categories: regulated and non-regulated. A regulated occupation is one that is governed by a provincial, territorial or sometimes federal authority. In order to be a member of a regulated

profession, a person must pass certain entry requirements, and also meet the qualifications outlined within pre-determined standards of practice. If a professional meets this criteria, he or she can be certified, registered or licensed as a qualified practitioner, depending on the rules of that particular occupation. A non-regulated profession, on the other hand, does not require that you have a licence, certificate or registration before you practise, although some non-regulated occupations do allow you to register with a professional body or association on a voluntary basis (Government of Canada 2015). Most jobs found in Canada fit into the non-regulated variety – in fact, only about 20% of jobs in Canada are regulated. These include professions such as engineers, teachers, lawyers, accountants, doctors, plumbers, and electricians (Government of Canada 2014c).

To complicate matters, "provinces and territories are granted the jurisdiction by the constitution to regulate professions" (Casey and Picherack 2001, 65), therefore requirements for regulated professions often vary from one province or territory to another. Furthermore, it is possible that "legislation can delegate authority for the regulation of a particular profession from the province or territory to an organization comprised of members of a particular profession." In such a situation, this type of organization would then become self-governing (Casey and Picherack 2001, 65). Even if this is the case, however, the self-regulating bodies still differ between provinces and territories. Despite provincial and territorial differences in this regard, it is important to note that there is a "core group" of professions, particularly within the world of allopathic medicine, which are regulated in all of the Canadian jurisdictions. These include occupations such as medical doctors, registered nurses, optometrists, dentists and pharmacists. For most regulated professions however, there is a "significant

divergence among the jurisdictions as to whether a particular professions is formally regulated"(Casey and Picherack 2001, 65).

For those in health-related fields, occupations are primarily self-regulated. In these cases, legislation in Canada has established three primary regulatory structures, each with its own benefits and requirements. The terminology used to designate these different kinds of regulation is, confusingly, not consistent throughout the country, but the definitions are as such:

1. "Exclusive scope of practice", or "licensure": members of a profession are granted by legislation the exclusive right to provide a particular service to the public. This is the most stringent of the three, making it illegal to perform the duties associated with that occupation, regardless of how skilled or proficient an individual may be, unless he or she is a member.

2. "Right to title", or "certification": in this type of regulation, the duties or acts of a profession can be performed by anyone, but only the members are permitted to use a protected title, or promote themselves as being registered. Those who hold the title are required to have passed examinations or other similar means of assessing that they achieved a certain level of knowledge, skill, and/or ability within their field.

3. "Controlled acts system", "restricted activities", or "reserved acts": In this model, only specific tasks or activities are regulated. For example, it could stipulated that the setting of a bone fracture could only be carried out by a member of one or more specified health professions. (Casey and Picherack 2001, 65-66) (Ramsay 2009, 33).

There are, of course, legislative structures that do not fit neatly into these three categories, and there are also cases where a combination of these forms of regulation

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are used (Casey and Picherack 2001, 66). Self-governing professions, however, do tend to use one of the three above-mentioned systems, and as such they are able to provide very valuable services to their members, which in turn benefit those in their care. They act, for instance, as "gate-keepers", establishing and enforcing entrance standards; they provide standards of continued service and performance, often establishing continuing education or competence requirements; and they administer a professional disciplinary process for cases of incompetency or unethical behaviour(Casey and Picherack 2001, 66).

Where, then, do complementary and alternative health professions fit into this complicated system of legislation and regulation? The answer is not at all straightforward, and tends to differ greatly depending on the province or territory in question. There are some CAM professions that have long been regulated – chiropractors, for instance, have been licensed in all provinces since 1992 (Ramsay 2009, 35). Most CAM professions, however, are much more piecemeal than chiropractic – some have been regulated in only certain provinces, and many are not regulated at all. This is, in fact, one of the points that was brought up a number of times in interviews I conducted – Nova Scotia and New Brunswick, it was felt, differed greatly from much of the rest of the country because of the almost non-existence of regulated CAM professions within the area. As one Nova Scotia-based Naturopathic Doctor explained:

> "Full regulation would mean you have a Nova Scotia license. Right now, I am registered in Ontario, but there is nothing in Nova Scotia. You would need to have a regulatory board that sits in Nova Scotia. Right now if you had a complaints about a Nova Scotia Naturopath, you'd need to complain to someone in Ontario. It's like we don't exist here."(Murphy)

At the time I conducted interviews, the same could be said for almost every other single CAM profession in these two provinces. Some were in various stages of trying to obtain legislation that would allow them to begin the process toward various types of regulation, and others did not feel they had any hope in the near future of coming anywhere near regulation. The important questions, then, are two-fold: why is this such a prevalent occurrence in Atlantic Canada, and why is it important?

To address the first question, it is necessary to point out that regulation is not an easy process to begin with, regardless of the profession that is seeking to become regulated. It is often an especially difficult task, however, in the case of CAM-related occupations, for a number of reasons. One large obstacle involves the very large, political question of how the efficacy, safety, and importance of CAM is understood from the viewpoint of those within power, and the difficulties inherent in accommodating epistemological bases which are different than the norm. These are all incredibly important points that affect CAM regulation and possible integration in all parts of the country, and it will be discussed at length in further chapters. From a very practical perspective, however, if a CAM-related profession wishes to regulate, it requires, much like any other profession, an abundance of organization, time, money, and people. As one midwife explained:

> "Nova Scotia is in the process of regulation – a legislation act was passed in November of 2006. It's a very complex process; all the act does is set up a structure so that you have a regulatory body, like a college. Then you have to create the regulation standards – the policies and the bylaws and everything about how your profession is going to work, where you're going to be employed, how you're going to get liability insurance, what you're going to be allowed to do, etc. That's what we're doing now. The expectation is that midwives will be up and running, employed, part of the health care system, integrated into teams with physicians and nurses in hospitals etc, etc by the end of 2008. Interest and demand will spike when

it's regulated – you'll be working in a clinic. Women will know that's an option. There will be educational materials that will be offered. It will be an option, and people will know. [2]*"(Muriel)*

Similarly, a Fredericton-based naturopathic doctor revealed:

"Regulation is not just paying a lawyer and signing a piece of paper – there are many steps involved. It's not an easy process at all. There's a lot of committees that need to be formed with very serious responsibilities, and if the government doesn't believe you can do that, they're not going to go ahead with it. There are lots of different levels. And people who have similar interests all have to have a say."(Bunin)

Also tricky is the fact that there are some CAM-related treatments that other regulated professions have written into their own acts, which makes full regulation of the occupation all the more complicated. Acupuncture is a good example. As one Fredericton-based acupuncture and energy-work practitioner explained:

"It takes a whole lot of time and money to legislate, and [for acupuncture] it confuses the matter when things like physiotherapists have it written into their own act. "(Clavette)

What makes this all particularly difficult in places like New Brunswick and Nova Scotia however, is the dual conundrum of people and money. With a few exceptions, there are too few practitioners, and therefore not enough money or available people to even begin the process of legislation. As one Naturopath succinctly stated:

"In Nova Scotia right now it is not feasible for Naturopathic Doctors to be regulated, because there are too few of us. And we've been told that over

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[2]The midwives did, in fact, attain their regulation in 2009 – an event which affected me directly, as I was, at that time, living in Halifax, and pregnant with my first child. This integration, however, ended up being very rocky, and the program dissolved within the first two years, and then slowly started up again in 2011 (just in time for the birth of my second child). Though I have not been following it closely since that time, it would make a particularly fascinating case study in the challenges and benefits of CAM-allopathic integration.

and over by ministers of finance and everything like that, that because there's so few of us – under 30 – that what you need is a regulatory body that is working full time, and you have to pay them a full salary, and for 30 of us, it's just not financially feasible for us to pay someone full time to do that. In Toronto, they have close to 1000 – maybe 800 Naturopathic Doctors. They can afford to do that. "(Hayman)

Similarly, a Halifax-based acupuncturist revealed:

"I am only new to Nova Scotia, but I hear that some of the people who have been there awhile have been through many rounds with the government to try and get it instated, and it's always been "no", due to lack of money. It's complicated."(Heffelfinger)

Another problem is cohesion. Regulating, by necessity, involves coming together and working as a group. This is a challenge, of course, if there are too few people, but it is especially difficult if there is no network to begin with. Many people I spoke with highlighted the disparate nature of CAM practitioners – most worked as individuals, or within small groups, but very seldom had overarching networks. This was even true of practitioners with very solidly similar background and training, such a Naturopathic Doctors. As one Halifax-based Naturopath lamented:

"I wish the naturopathic community was closer... but for some reason, there is just a lot of disconnect. It makes me sad. It's everywhere."(Purcell)

Even more problematic is if practitioners are not like-minded in their desires to regulate, which can sometimes be the case. This can happen for a number of different reasons, practical, philosophical, and/or underhanded in nature, as explained by three different practitioners, within the fields of Naturopathy, Yoga/Reiki, and Acupuncture:

"I am pro-regulation. I want the same set-up as they have in Ontario. There are some colleagues that don't want it, because right now they are doing more than they would be allowed to, like IV therapies, chelation – things that can go under the radar when they are not regulated."(Murphy)

> *"I don't think regulation equals trust. And there are good doctors and bad doctors. It doesn't matter what the profession is – there are people who are really good at it, and others who are sub-par, and that's within regulated disciplines. There's talk about regulation in yoga, and that's a spiritual path. But there's also a difference between someone who's done a weekend course, and someone who has taught for 20 years. Use your head – buyer beware"(Beck)*

> *"I think that there are people who specifically come here to practice because it's not regulated or legislated. There have been some pretty questionable people. It gets me hot under the collar."(Heffelfinger)*

Clearly, the related issues of small numbers and insufficient funds go a long way toward explaining why provinces such as Nova Scotia and New Brunswick have particularly low numbers of regulated CAM professions. Why, then, is regulation so important, and how can it be used to explain the correlation to lower percentages of CAM clients?

As was mentioned earlier, to become a self-regulating health profession has a number of potential benefits for both practitioners and clients. One of the biggest of these involves safety and ethics – policy analysis of professional regulation has "historically focused on reducing incompetent and unethical services" (Casey and Picherack 2001, 71). For CAM professions in particular, it would seem as though a large part of the safety and ethics-related impetus involves allowing people to distinguish between properly trained individuals, and those who are making false claims. As one Halifax-based CAM-user bluntly stated:

> *"Without regulation, people will be mislead, and spend their money on quack practitioners."(Anne)*

Two Naturopathic Doctors, in both Halifax and Fredericton echoed this concern:

"I work in some small communities, and have come across people who took a 6 month on-line acupuncture course, and are calling themselves small n, small d : "naturopathic doctors". That's dangerous. One, for the person who is calling themselves an "nd", and two for the public. It makes my skin crawl."(Purcell)

" There is no legislation or regulation in New Brunswick right now. That's the prime objective of our association over the short term – in fact, this summer, we are applying for the legislation process to begin. It's very important to us. There haven't been a lot of problems with it up to this point in terms of unregulated practitioners, although there have been some, and there have been a couple of incidents recently of concern with health consequences to people. But it's more about trying to eliminate the confusion, because right now technically anyone can call themselves a naturopath, and legally there is nothing that can be done. We can write them letters and ask them to stop doing it because it is misleading to the public, we can go to the media, but legally there's nothing we can do."(Bunin)

More than just the safety of the clients, however, it was felt that it was also important to protect the reputation of the disciplines and practitioners as well. This was expressed both practitioners and CAM-users:

" Naturopathic doctors are really trying to get away from the term "naturopath", because anybody can use that. Like, if you took a weekend course in acupuncture, or got some degree off the internet. So we really discourage that in our association. We are Naturopathic Doctors, and we want to get to the point where unless you have our qualifications, you can't call yourself that. It's protection of the public, so they know what they're getting themselves into. There are situations where people have got to practitioner who are calling themselves "naturopaths" or "Naturopathic Doctors", and they've been unregulated, and I think in one case it was even fatal – a child was taken off insulin. It was later discovered that this person wasn't actually a Naturopathic Doctor. And another case where someone was calling themselves an Naturopathic Doctor, and had certificates on their wall that were all forged. That's so scary. Right now, when you go to the Yellow Pages in Nova Scotia, and look for Naturopathic Doctors, anyone who has passed the criteria that I've mentioned – we're all in a box under the Nova Scotia Association of Naturopathic Doctors, and if you're outside of that box, you don't know what you're getting."(Hayman)

" Well, the people who've gone through all of that training – I'd be really upset if someone could just hang out a shingle, because it compromises their reputation. "(Monti)

"In Nova Scotia, there is no licensing procedure. I understand that there are 3 provinces that have licensing procedures, but not NS, and not a Canadian one. I believe this is really important. More and more people are using acupuncture as a form of medicine, and the US is much further ahead than Canada. Right now, anyone off the street can practice acupuncture, and that's scary. Scary for the people receiving it – basic stuff that should be tested for like clean needles – and it also gives acupuncture a very bad name not to have stringent guidelines"(Heffelfinger)

There is, however, more to professional regulation than safety and ethics – it serves a "a broader sociological function", related to the "recognition of the profession by the dominant political forces in a society" (Casey and Picherack 2001, 71). In other words, when a CAM modality is regulated, it serves the often critical function of "legitimizing" the profession for any number of important people and agencies, including "consumers, government, third party insurers and other health care professionals" (Casey and Picherack 2001, 71). Certainly, this was a particularly prevalent concern among those I interviewed. Many allopathic doctors, for instance, agreed that they would be much more likely to trust a CAM practitioner or modality that held up to standards of regulation. As these two medical doctors, revealed:

" I think it helps, somewhat, that you know there's some organization to it, and that not just anyone can declare that they're this sort of a professional; to add sort of a professional status to it. "(Moore)

" I know that naturopaths go to school for a long time, so I get the sense that they are certainly well trained to do what they do. My worry – or I guess I would want to be reassured that they would be able to recognize – like, nurse practitioners act as primary care as well, and I think that is safe,

because they are trained to recognize their own scope, and know when it's appropriate to refer to a family physician, and to have that follow up where needed. That would be the kind of reassurance that I would need from a professional body that monitors and certifies the naturopaths."(Breen)

Even a chiropractor stated:

"I don't have a problem with any therapy out there, as long as it's a regulated health profession. That's the difference."(Jane)

Beyond gaining the respect of other healthcare providers, this quest for legitimacy was often directly connected to the issue of money. In the world of CAM, to be recognized as a "legitimate" health provider has potentially important implications both in terms of what private insurance companies will recognize and reimburse, and the types of modalities that can be claimed against income taxes. This was brought up time and again, both from the perspective of CAM clients, and the practitioners who provided CAM services. For example as these four different people (both practitioners and CAM-users) expressed:

"The other big motivator is coming from the patients. A lot of people don't realize, but coming from the standpoint of income tax, if you're not legislated in that province, you can't claim that as a legitimate medical expense. You can try, but if it gets audited, you can't. So for regular clients, that can add up, and is important to them."(Bunin)

"The government needs to recognize [CAM]'s existence. When you have receipts, that needs to be deductible on your taxes. Physiotherapy is, but massage isn't and acupuncture isn't. Blue Cross covers some of them, but if it was recognizable in your tax deductions, that would start making a huge difference."(Grasse)

"The problem now is that we have a 3-tiered healthcare system. There are sick people who get treated by the health care system. There are people

*who have enough money to bump and get better or faster care for their
sickness, and there are people who recognize the value of preventative
complementary and alternative health. I spend 40-60 dollars a month on
supplements that really keep me healthy. I'm sure that if I stopped taking
those I would be miserable and not as healthy. I spend a lot of money on
good food. I would like my supplements to at least be something I can
deduct from my income tax, or if it is a health practitioner that says "this
will make you feel better", then let's have that paid for by a public health
care program, and lets have that information out there."(Joy)*

*"Around here, naturopathy and massage have extended health care cover-
age, but for homeopathy it's very small in terms of health care coverage.
I think if we want to be more accepted in the mainstream, it has to go
the route of becoming standardized – professional standards and all that
entails."(Peisinger)*

Clearly, the issue of regulation, particularly as it relates to CAM professions, is

incredibly complex, complicated, and has factors and implications that extend far

beyond the confines of this current discussion. It does, however, help to illuminate

why the paucity of professionally regulated CAM modalities is so prominent in these

two provinces, and how this affects CAM usage within the region.

3.3 Moving Forward

This brief but important introduction to the Canadian healthcare system and the

regional context within which the interviews were conducted have now set the stage for

an intensive discussion surrounding what participants revealed to be the most pressing

issues concerning complementary and alternative health care. The discussions that

follow are not structured around the region from whence they originated – instead, they

tackle some of the larger, and in most cases, widely applicable issues that surround

the world of CAM, allopathic healthcare, and the places where they intersect.

While the topics are broadly applicable, however, it is still imperative to understand the context from which they came. For instance, while many of the issues discussed are applicable within a number of different nations, it is important to understand the differences that form the backbone of a Canadian context – particularly with respect to the way our health care system functions, and the realties of demographics. Similarly, while New Brunswick and Nova Scotia residents can certainly be considered representative of the larger region and country of which they are a part, there are factors that can drastically colour experiences and realities. At the very least, having a a sense of place, and knowing the particular aspects that set it apart from other areas of the country or the world, can inform and set the tone for the discussions that follow.

Chapter 4

Knowledge and Belief

> " What I know I know, what you know, you only believe – to the extent that it conflicts with my knowledge."(Hufford 1982b, 20; emphasis in original)

When exploring the potential conflicts and common ground between "official" and "unofficial" (or vernacular) approaches to healing, there are seemingly endless aspects to consider. Few, however, are more pivotal or fundamental to an understanding of the complex subject of health and illness than the concepts of knowledge and belief. How do individuals acquire health-related knowledge? What are considered legitimate forms of knowledge? Who has access to knowledge, and who is permitted to use it? How does knowledge and knowledge-acquisition affect who is considered an expert or an authority with respect to health-related issues and decision-making? Where is the line drawn between knowledge and belief, and who draws that line?

This chapter will examine these questions, both from within the allopathic medical model, and the broad world of complementary and alternative health, with a focus on seeking to understand the vernacular. It is possible to attain a much deeper,

more encompassing understanding of issues related to health when knowledge can be explored within the context of worldview – as a variable entity rather than a fixed truth. It is possible to begin to see clues that point to areas where health care flourishes, and where it breaks down; how dynamics of power, responsibility and trust come to play in health care provision and decision-making. It also points to areas where there are gaps in understanding between conventional and non-conventional health care practitioners, and the patients who come seeking help. In particular, it will focus and discuss what was expressed as some of the most fundamentally challenging and polarized contrasts in epistemology and worldview: concepts involving notions of holism, intuition, and energy.

4.1   Knowledge and Belief

Before delving into the subject of knowledge and belief, it is first important to define and discuss what is meant when these terms are used. As anthropologist Luke Eric Lassiter succinctly summarizes, there is a clear distinction within the "natural and social sciences" between "what we 'know' (defined as true and factual), and what we 'believe' (accepted on faith as true and real)" (Lassiter 2014, 190). He goes on to point out that knowledge is typically ranked 'over' belief; the assertion being that knowledge is "based on clear reasoning and experience", and therefore more substantiated than belief, which "may not be based on 'clear evidence' or 'proof'"(Lassiter 2014, 190). This opposition between knowledge and belief draws substantially from the assumptions inherent in empiricism, positivism and reason, which respectively assert that knowledge is based on experience; only useful if it is provable; and that it is logical, factual, and

sound (Lassiter 2014, 190). As Lassiter points out, "following this logic, we might argue that belief (being based on faith, not knowledge), is unempirical, unprovable, and unreasonable" (Lassiter 2014, 190-194). This, I would argue, is consistent with general understanding and use of these terms. As one allopathic physician summarized, for instance:

> " Belief systems to me, by definition, encompass things that can't be proven. What's the rift between science and religion? Nothing. Religion is based on what you believe, science is based on what you can prove. By definition, you can't prove a belief – there wouldn't be religion if you could prove it. "(Workman)

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This dichotomy between knowledge and belief, and the resulting approach to belief-related studies is, as David Hufford points out, long established. Writing about supernatural beliefs in particular, he has argued there has, for "centuries, probably millennia", been a skeptical view that "supernatural beliefs arise from and are supported by various kinds of obvious error" (Hufford 1982b, 19). Moreover, even in research that claims to not be interested in the truth or falsity of statements of belief, "the interpretations that follow often obtain most or all of their explanatory force from the assumption that the beliefs under study are objectively incorrect" (Hufford 1982b, 19). As Bonnie O'Connor has pointed out, "much of the explicative literature (in folklore and in other disciplines) has centred either on falsification of believers' claims, or, later, on their explanation in terms quite different from those used by the believers themselves but purporting to be what they were "really" about (the majority being psychoanalytical or functional analyses)" (O'Connor 1995, 50). Hufford has gone so far as to argue that that "the description of supernatural beliefs as irrational and

non-empirical has been a highly effective instrument of social control" (Hufford 1983b, 27).

As was previously discussed in the literature review, the discipline of folklore was, early on in its existence, a prime example of this way of approaching research. Beliefs (typically those relating to health, magic and/or the supernatural), were collected as decontextualized items, and were often considered erroneous superstitions that circulated among the uneducated peasantry. It was not until the 1960s that this belief-as-item approach began to give way to the much more nuanced understanding of beliefs as part of complex systems and traditions. Pivotal to this newer understanding was a focus on "worldview". Barre Toelken, in particular, has written extensively on the subject of worldview, offering ways of understanding the concept, as well as providing excellent examples of how it can effectively be used within folklore scholarship. As he explains, "'worldview' refers to the manner in which a culture sees and expresses its relation to the world around it" (Toelken 1996, 263). More specifically, it encompasses "those codes, structures and cultural premises", which "society reproduces, through patterning on all levels of expression" (Toelken 1975, 266). He goes on to describe how, "while earlier students of culture were certain that similar conditions would impress any human eye and soul in similar ways... there is now evidence... [that] objective reality (as we like to call it) actually varies widely according to the viewer's means of perceiving it" (Toelken 1996, 263). As such, each person can be understood to have a unique worldview, which "provides us with a secure sense of logic to be used in our daily encounters with the world" (Toelken 1975, 267). Moreover, each worldview must be understood as "internally valid, consistent among its parts, and effective as a means of relating the mind of the individual to those larger occurrences or the world

around" (Toelken 1996, 307).

With concepts such as worldview and the acknowledgement of complex systems of belief, belief scholarship began to follow a drastically different trajectory. What followed was a "description and analysis of folk belief *as it actually exists* on the cultural landscape" (O'Connor 1995, 50-51; emphasis in original). This, in turn, led to the recognition that folk belief actually "coexists with official belief in the worldviews of all kinds of people, from all kinds of cultural backgrounds, and all degrees of formal educational exposure" – an important recognition that continues to inform belief-related scholarship in the discipline (O'Connor 1995, 51).

Instrumental to this ongoing, dynamic approach to belief-related scholarship was David Hufford, who explicitly challenged assumptions that had informed most of the bulk of prior belief studies. As Bonnie O'Connor summarizes, Hufford insisted "that the study of belief be pursued with the same accuracy, thoroughness, and rigor of description as the study of any other aspects of culture" (O'Connor 1995, 51). Hufford developed two principles that he felt were integral in this respect: "methodological populism" and "methodological symmetry"(Hufford 1998). The first, "methodological populism", requires that, "when comparing official and unofficial views, we always begin with a serious consideration that the unofficial position may be correct... one should never assume that experts are right when ordinary people disagree with them" (Hufford 1998, 302). The second principle, "methodological symmetry", requires that "in any comparison of traditions whatsoever... we ask the same kinds of questions to each" (Hufford 1998, 303). Following from these principles, it therefore becomes necessary to acknowledge that *everyone* (whether considered part of "official" or "unofficial" culture) has his or her own unique belief system, aspects of which are

used to "produce and support assertions of truth and claims about the nature of reality"(O'Connor 1995, 9). Similarly, anything that is accepted as proof, or as an authoritative source, or as sufficient grounds for making assertions, must *all* be understood as "culturally defined", and "vary considerably from one worldview or belief system to another"(O'Connor 1995, 9).

It becomes clear, then, that knowledge and belief are not as clearly oppositional as they might initially appear. As Bonnie O'Connor argues,"the definitions of these terms, far from standing in clear opposition to each other, are juxtaposed and interdependent... [they] both involve mental or intellectual acceptance of something as true, actual, or real on the basis of some form of authoritative support for the conclusion" (O'Connor 1995, 7). Furthermore, the difference between belief and knowledge is "positional, and often political, dependant in part upon who may exercise the right to say what shall count as information of one order or another" (O'Connor 1995, 8). It is here we return to the opening quote of this chapter: "What I know, I know, what you know, you believe – to the extent that it conflicts with my knowledge" (Hufford 1982b, 20; emphasis in original). This quote captures a prevalent attitude within Western scholarship – one that is, as O'Connor reveals, "inherently ethnocentric", as it takes the "accepted beliefs of one's own culture or identity group to be universally correct or normative, even sufficient in themselves to falsify competing claims without further investigation"(O'Connor 1995, 8). To move beyond the dilemma inherent in such an ethnocentric approach, Bonnie O'Connor redefined *knowledge* as "any "justified belief" (that is, the grounds for credibility can be logically explicated)", and *belief*, "within any given system or worldview, as constituting "local knowledge" (that is, accepted as actual or factual by members of the system)"(O'Connor 1995, 9). It is

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with this definition in mind that I now move on to a discussion of knowledge and belief specifically within the realm of health and illness.

4.2   Allopathic Knowledge: Scientific Imperialism

In the Western world, allopathic medicine is the dominant health paradigm and practice. Central to both the epistemological and practical foundation of this medical model is science. As Bynum points out, modern medicine is, in fact, so "intertwined with science" that this connection is taken for granted (Bynum 2006, 111). Though pivotal to Western medicine, science is actually a relatively recent disciplinary cornerstone. As Tauber has argued, the development of Western medicine became a product of the "scientific ethos of mid-nineteenth century", where two philosophies of science – positivism and reductionism – emerged, and "decisively shifted the character of medicine toward a new scientific ideal" (Tauber 2002, 179). A positive stance is one that seeks to describe the world in non-personal terms (Tauber 2002, 180). Though notoriously difficult to define, Tauber argues that when it emerged in the nineteenth century, there were key precepts, foremost of which was that it "championed a new form of objectivity, one that radically removed the personal report in favour of one that was universally acceptable" (Tauber 2002, 180). Encompassing a set of rules and evaluative criteria, positivism sought "truth", or "true knowledge". It asserted that the methods of natural science offer the "only viable ways of thinking correctly about human affairs", and that science should "rest on a foundation of neutral and dispassionate observation" (Tauber 2002, 180-181). Reductionism proposed that the body should be treated as a machine, "governed by uniform chemistry and thus

susceptible to mechanical repair" (Tauber 2002, 182).

By the 1940s, the concept of logical positivism, or empiricism, had emerged, bringing with it the notion that proof and certainty in science is possible (Misak 2010, 392). "It held that all of our beliefs and theories must be translatable into first-order predicate logic, with observation statements deductively inferred from them"... which could, in turn, be empirically verified (or falsified) (Misak 2010, 392). As science became linked to medical knowledge, so too changes were made in medical education, diagnosis and therapy (Bynum 2006, 215). There was, at this time, increased emphasis placed on medical specialization, which in turn was intimately related to the consolidation of hospitals as the "cathedrals" of medicine (Lawrence 2006, 269-271). Some of the more important innovations during this time included physiological or functional thinking about disease, particularly when these could be quantified by technology or based on the experimental laboratory sciences (Lawrence 2006, 281). As Hardy concludes, "as a discipline, orthodox medicine emerged from the war with its authority established... in the fifty years that followed, the Western medical tradition, with its emphasis on science and education, and distinctive ways of thinking about the body, became widely influential" (Hardy and Tansey 2006, 405). This, in turn, meant that "the scale of medical enterprise had become increasingly vast, its organization increasingly complex, and its approaches to knowledge and technologies increasingly reductionist" (Hardy and Tansey 2006, 405).

In the 1990s, these approaches to medicine became manifested in a paradigm known as "evidence-based medicine", or EBM. It first emerged from the work of a group of professors of epidemiology, biostatistics and medical informatics at Mc-Master University, Canada (Kerridge 2010, 365). The original developers of EBM

argued compellingly that clinical judgement has the potential to produce poor quality care"(Gupta 2010, 374). As Kerridge notes, "the initial formulation of EBM was very clear: it was that medicine should be based upon the 'conscientious, explicit and judicious use of current best evidence', and that 'best evidence' should be identified using 'epidemiological and biostatistical ways of thinking"(Kerridge 2010, 365). To distinguish or prioritize what is considered 'best evidence', hierarchies were created. Kerridge explains: "The best evidence is specified, to some extent, by the 'evidence hierarchy', an a priori ranking of study designs that are generally based on ideological or consensus judgements about which studies are most likely to provide estimates of 'truth' through reliable and valid data" (Kerridge 2010, 366). Though a large number of such hierarchies have been created and re-created since EBM first made an appearance, they are typically structured on the basis of more "causal" research methods, and "less causal" research methods (Jonas 2002, 124). As such, the grand majority of them place randomized clinical trials (RCTs), and meta-analysis, (or systematic review of such trials), at the top of the list, with evidence such as observational studies, qualitative research and anecdotal evidence at the bottom. (Jonas 2002, Kerridge 2010, Misak 2010). This means that "when disparities are found between observational and experimental research, the observational data is usually considered wrong." (Jonas 2002, 124-125).

This placement of RCTs and RCT meta-analysis as the "gold standard" of evidence based medicine is consistent with the positivist and reductionist scientific philosophies engrained in the biomedical model. The idea of RCTs began in the early part of the twentieth century, as a response to concerns regarding the efficacy of drugs. Traditionally, new drugs were introduced by individual physicians, but it was argued

by academic physicians that "individual reports of efficacy were not a satisfactory mechanism for assessment" – instead, they maintained, a drug's evaluation "should be based on experimental knowledge of its action and clinical investigation by a team of laboratory scientists and experts in therapeutics" (Lawrence 2006, 290). The RCT, then, was a research tool developed in order to bring more objectivity to medical practices. In RCT studies, people are randomly allocated to one of at least two groups, usually designated as the "study" group and the "control" group. Of these, the study group receives a standardized experimental clinical intervention, while the other receives a placebo. In this way, it is possible to rigorously compare the outcomes of both groups, in order to objectively reach conclusions concerning the efficacy of the experimental procedure being studied. The randomization process is meant to "bypass background knowledge and any possible judgement altogether and solve the problem of possible 'unknown confounders'" (Worrall 2010, 358-359). To further limit bias, such trials are often "blinded", meaning that the patients do not know whether they are members of the study or the control group, or "double-blinded", meaning that group allocation is concealed from both the patients and from those conducting the studies (Verhoef et al. 2002, Whitemarsh 2002, Worrall 2010).

The EBM movement has had a profound influence on the modern Western medical system in the last 25 years, influencing "biomedical research priorities, the generation of public health and clinical practice guidelines and the implementation of these guidelines in practice" (Kerridge 2010, 365). Indeed, EBM has demonstrated a "spectacular rise in international acceptance", and a "revolutionary" widespread adoption into clinical practice (Thompson 2010, 267). It was even identified recently by the British Medical Journal as one of the "greatest breakthroughs in medicine" (Wilson 2010,

398). The appeal of EBM within a scientifically-based medical system is immediately understandable. It is, in many ways, "the true application of the scientific method to medicine" (Wilson 2010, 400) – as Angell has argued, "perhaps the most important hallmark of science is its utter reliance on [objectively verifiable] evidence" (Angell 1996, 92). In this way, EBM confers "epistemic and moral authority", promising that "both individual patient care and public health interventions are effective, safe and efficient, that these decisions and standards can be determined (and therefore judged) in a transparent manner and that this form of decision making is reliable, objective and value-free" (Kerridge 2010, 365). From the perspective of those trying to glean and interpret this knowledge, it "provides a means of managing complex and extensive datasets; it provides a means of using data and controlling both uncertainty and disease; it promises access to knowledge about the best and least harmful therapy"(Kerridge 2010, 366). It is also, as Thompson points out, quite simply a "rhetorically powerfully slogan" – "who in their right mind would suggest that medicine should not be based on evidence?" (Thompson 2010, 268).

Certainly, in the interviews I conducted with allopathic physicians, evidence based medicine was a clear priority. As a Fredericton-based gastroenterologist explained, for instance,

> " We have to see facts. There is a world of evidence. The evidence in our education is divided, and then recommendations are based on different levels. "(OK)

Similarly, a Halifax-based geriatrician revealed;

> "I can't strip away the fact that I was educated, even before med school, that you had to have your evidence behind things, because it's really important that you're not going to do something that's going to harm [the

patient], and that you're very confident in what you're saying. That's the
kind of environment I grew up in... Randomized clinical trials with a thou-
sand people that showed this much benefit, had this many risks."(Rowan)

Despite being such an influential, widely accepted paradigm, the EBM movement (and the associated reliance on RCTs as the gold standard in evaluating effects of health interventions), has garnered much interdisciplinary criticism (Bluhm 2010, Bogdan-Lovis and Holmes-Rovner 2010, Jonas 2002, Kerridge 2010, Misak 2010, Richardson 2002, Worrall 2010). The perceived shortcomings of such an approach to medicine are varied, and range from broadly philosophical to precise and practical. All such arguments, however, share a key common factor – they address the problems inherent in strictly preferential knowledge production. Perhaps at the broadest level this circles right back around to the placement of science as the foundation of allopathic medical theory and practice. Science, and therefore the scientifically-based evidence that is used to make decisions, can often become "idealized as possessing a clarity of viewpoint and an unimpeachable rigor of method that inherently surmount cultural values and interest-group bias", and are typically portrayed as "genuinely objective and value-free" (O'Connor 1995, 14). As such, "science and its method are deeply believed by many to have the capacity to provide certifiable knowledge composed only of straightforward distillations of raw and refined facts, and to be the sole means to incontestable and ultimately reliable knowledge."(O'Connor 1995, 14). This argument is often described as "logical positivism" (Hufford 2003).

A closer look, however, reveals that these assumptions about the nature of science and scientific evidence are not nearly as unequivocal as they are often purported to be. As Tonelli argues, "reasoning solely from scientific principles has significant

limitations... Our reasoning can only be as good as our scientific understanding and, despite marked gains, humility in this regard remains in order" (Tonelli 2010, 385). In fact, as Misak details, "the idea that scientific inquiry can be conducted along clear and rational lines has been a site of controversy for generations of scientists and philosophers of science." (Misak 2010, 392). For instance, even elements as basic as how a scientific inquiry is framed, what constitutes a worthy observation, and, how scientific "facts" are interpreted can change over time, and vary between disciplines. Theory choice and "theory reception in modern institutionalized science" can be understood as "ideologically driven", rather than straightforward representations of the truth. (Wolpe 2002, 167). The problem here, I would argue, is not one with science or scientific method generally – the contributions that this method has made to medicine (and indeed to all other aspects of our lives), is irrefutable. The problem is the notion that scientific method, and therefore the results obtained while using scientific principles, are infallible, irrefutable, and always the most pertinent ways to obtain knowledge. This is, in fact, the premise of the sociological approach entitled "Sociology of Knowledge and Science", which views scientific knowledge, "generally presented as 'truth' and taken for granted, as a product of social construction processes" (Keshet 2009, 135). As Hufford summarizes, "logical positivism attempted, unsuccessfully, to equate valid knowledge with science, and the postmodern turn has attempted to demote science to one of many equally valid(or invalid) points of view... both extremes harm rationality in general and science in particular." (Hufford 2003, 210).

The dilemmas implicit in a logical positivist approach to science are the same ones found in critiques of EBM. One of the the biggest issues that scholars have with EBM is how strictly it prioritizes what is considered legitimate evidence. Using

its hierarchy, EBM "makes claims about the nature of good evidence"(Bluhm 2010, 363), and "refers to particular, ideologically and philosophically specific concepts of evidence, medicine and the relationship between them" (Kerridge 2010, 365). As was previously discussed, this prioritized evidence is almost exclusively understood as RCTs and RCT meta analysis. This can prove problematic in a few different ways. Perhaps most obvious is an issue of scope – "RCTs address only one, limited, question, namely whether the intervention has – statistically – an effect"(Verhoef et al. 2002, 279). There are, however, very important effects which can be difficult to determine – "some outcomes of medicine are not adequately measurable or comparable (such as pain), some may not be measurable at all (such as justice or cultural integrity) and some (such as quality of life) may not even be adequately definable" (Kerridge 2010, 367).

Though there are other forms of evidence and knowledge which can be much more useful than RCTs in this respect, such as those with an observational, "narrative, phenomenological and qualitative" base (Kerridge 2010, 370), these fall much lower on the evidence hierarchy and are often excluded from consideration. In its purest form, then, EBM assumes that the "beliefs, thoughts, and meanings of the patient are worthy of neither attention nor study and exert no causal influence on the outcome of therapy that would be of interest to the scientist" (Brody 2002, 77). In a similar vein, because the RCT supposedly controls for "non-drug" factors, all other results are lumped together in the same "wastebasket category", therefore assuming that "every causative factor *except* the "pure" drug or pharmacologic factor is of no interest whatsoever to the medical scientist" (Brody 2002, 77). In other words, the evidence that an RCT is developed to uncover is so narrow in scope that researchers tend to

discard unexplained or unexpected events and results as chance or random error, rather than trying to fully comprehend the different variables involved in the experiment. (Wilson 2010, 400). As Misak summarizes, "EBM, in its quest for objectivity, has narrowed its conception of evidence and imposed limits on inquiry in a way that impedes the search for getting the best answers to our questions... it puts medicine in one of those methodological straightjackets" (Misak 2010, 393).

Another perceived limit to RCT research involves applicability, particularly within a clinical setting. In theory, information that is obtained by RCT is at once specific to the particular clinical trial, and yet is also meant to provide information that is to be considered generally applicable to patients. It has been argued, however, that strictly speaking, the results of an RCT are valid "only for those individuals in the study and not extendable, with preservation of validity, to other populations." (Misak 2010, 394). Similarly, as Jonas suggests, "if we make one type of evidence the "gold standard" and orient our research approaches toward that approach, we not only assume that type of info is the only valid goal for research to pursue, we preferentially serve only a few audiences and their goals to the neglect of others" (Jonas 2002, 134). At the very least, many have pointed out that generalized research findings are often not applicable to individual patients. A properly conducted RCT provides evidence that the intervention works somewhere (i.e. in the trial) – "the decision maker, however, needs to estimate 'will it work for us?"' (Cartwright and Munro 2010, 265). As Tonelli explains, because "knowledge derived from clinical research necessarily represents the aggregate, telling us something about what we can expect from an intervention on average"... "there remains an intrinsic gap between the knowledge derived from clinical research and the knowledge we need to choose the right course for a particular

patient" (Tonelli 2010, 385).

In other words, though the original developers of EBM "argued compellingly that clinical judgement has the potential to produce poor quality care" (Gupta 2010, 374), many would now insist that the information gleaned by RCT data must, in the end, still be interpreted by individual physicians with specific patients in order to useful. In fact, it has been argued that those who adopt an "uncritical generalization of research findings" within medical practice represent one of the major failings of an EBM approach generally (Wilson 2010, 399). As such, it could be argued that EBM can only go so far with respect to caring for real patients – that "ultimately, we may only come to a deeper understanding of the patient experience of care by engaging with each patient in the murky depths of the consultation" (Richardson 2002, 223). This seems, Worrall points out, "to be 'déja vu all over again': it was precisely the attempt to eliminate clinical judgement with its allegedly very poor history in terms of the therapies it endorsed, and to replace it with objective scientific evidence that formed the initial EBM battle cry" (Worrall 2010, 357).

Finally, apart from the problems related to logical positivism and general applicability of EBM-derived results, some of the most scathing critiques that are launched against EBM and RCTs ironically relate to the potential for corruption and bias within the studies themselves. For instance, it has been argued that as EBM became more accepted and influential, so too did the incentives to "inappropriately influence clinical research for financial benefits"(Wilson 2010, 400). Similarly, at the individual researcher level, "as academic productivity is increasingly valued, the incentives for fraudulent behaviours to produce publishable findings also increase" (Wilson 2010, 400). Related to this is a publication bias, whereby journals are "more likely to publish

positive and/or statistically significant results and also more likely to publish particular study types than others" (Kerridge 2010, 368). It is also now widely recognized that commercial interests have distorted and restricted the evidence base of EBM. The pharmaceutical industry, for example, sponsors 60-80 % of all clinical research in the USA, and either sponsors or provides advertising revenue to 80 % of professional organizations and journals (Kerridge 2010, 368). This, in turn, can be understood to result in "loss of research integrity and independence, creation of multiple ties and conflict of interest, loss of transparency in science, and perhaps most importantly, the erosion and distortion of the evidence according to which patients are treated and health policy developed" (Kerridge 2010, 368).

Understanding the evidence-based medicine movement and the use and reliance on randomized clinical trials is imperative when exploring issues related to the Western allopathic medical system. These are, after all, the backbone of both the epistemological and practical workings of allopathic physicians and the institutions of which they are a part. It is also important to understand how, despite the multiple criticisms of these techniques, EBM and the RCTs both continue to "demonstrate an impressive resilience" within the workings of the medical system (Bogdan-Lovis and Holmes-Rovner 2010, 376). This is in large part because many of the critiques that have been launched against EBM have simply been used to tweak the definition – rather than being debunked or rejected, such criticism has been acknowledged, incorporated and therefore "assimilated through corrections to the original formulation of EBM" (Kerridge 2010, 366). One of the ways in which experts propose to make these changes is with respect to the hierarchy itself, allowing for more qualitative or observational methods to also be considered as valuable forms of evidence. Even the National

Institute of Health has called for more "expanded research methods to bridge the gap between efficacy sought in experimental research and data from observational studies to inform treatment practice in a community" (Jonas 2002, 127).

The problem here, however, becomes one of how, exactly, to incorporate these different ways of knowing. Despite acknowledging that RCTs are not the only, or even the best, form of evidence, no "specific method of integrating these [other] kinds of knowledge is offered by proponents of EBM" (Tonelli 2010, 384). EBM has yet to develop a replacement for the hierarchy in which RCTs do not still unequivocally enjoy the place of prominence as the golden standard of best evidence. There are no attempts, even, to "explain the circumstances under which a non-randomized study might be superior to a randomized one"(Bluhm 2010, 363).

Thus, while many acknowledge that it is both desirable and beneficial to integrate different forms of knowledge into the practice of evidence based medicine, how exactly to execute such a feat presents a daunting challenge. The problem circles right back around to the reductionist, positivist philosophy that underlies the scientific principles upon which medicine is based. Hierarchies of evidence, Kerridge explains, "which claim simply to provide a ranking of quality and/or validity, are based upon philosophical assumptions about the status and meaning of knowledge and it may be that ways of knowing are so distinct that they are both incommensurable and irreducible and cannot be incorporated within a single 'theory' of decision making" (Kerridge 2010, 370). As such, Western biomedical professions have what Ning has described as a "knowledge monopoly" – one that is based on a "single bio-scientific framework" (Ning 2013, 150). This is the backdrop against which we can now turn to complementary and alternative medicine, and the ways in which knowledge and evidence are understood,

produced, and used.

4.3 Health Belief and Knowledge: CAM

As was previously discussed, CAM is, by its very nature, a residual category. It encompasses a vast range of modalities, therapies, and epistemological understandings of knowledge, health, and disease. What groups all of these sometimes disparate techniques and philosophies together is their designation as being outside of the medical mainstream. So what creates this divide? As Keshet points out, "it has been suggested that this is part of the incommensurability of the paradigms of CAM and biomedicine and the contradictory metaphysics around which they are built "(Keshet 2010, 338). Within medicine, and perhaps within the scientific community more generally, this distinction is commonly articulated as science versus anti-science; or a scientific approach versus an unscientific approach. What typically logically follows is the notion that there is actually no such thing as "alternative medicine" – there is only "scientifically proven, evidence-based medicine supported by solid data; or unproven medicine, for which scientific evidence is lacking" (Polich et al. 2010, 107). One Halifax-based allopathic doctor I interviewed explained this notion as such:

> " Partly, complementary medicine is that which has not been formally or scientifically tested... it stops being complementary when you clearly do a study that shows it works. Then it becomes mainstream. It may be that we cannot explain how it works, but if you can clearly show that whatever treatment is effective, then it is no longer complementary by definition, because it is a proven form of therapy. You can talk about levels of proof, and put it on a spectrum. Medicine does that – level 1 evidence, level 2 evidence, level 3 evidence. As you go down in the levels of evidence, it goes down to unproven. "(Workman)

Another allopathic physician, based in Fredericton made similar points, with respect to the term "doctor". As he explained,

> "I have to say that I disagree with the term "conventional doctor". I believe that it is basically a misnomer. There is no such thing as a conventional doctor - there is only one thing – a doctor. Doctors by definition are conventional. If they are not conventional, they are not doctors... I think this is very important to differentiate, because being a medical doctor is a very distinct function in a society. One area of this distinction is that this person practices what his or her profession thinks is the way to go – usually established standards, accepted in historical or new guidelines, based on treatments which are going through thorough regulatory processes and approvals. "(OK)

The underlying theme here is about legitimate forms of knowledge, the production of which involves proof, regulations and standards. The understanding inherent in such statements is that anything which falls outside of the allopathic mainstream does so because it does not pass the trials and the testing criteria established by the mandates and protocols in the EBM model. As such, if a form of therapy is truly "proven" to work, then it ceases to be CAM, and becomes a part of the medical mainstream. Any technique, remedy or modality that cannot meet these criteria are typically considered either forms of quackery, or simply to be providing a type of "false positive", or placebo effect. Those forms of therapy which have not yet been tested, or tested without using the properly established standards, are typically not trusted as viable forms of therapy, and therefore remain within the bubble of CAM. This argument is a perfect example of the aforementioned "knowledge monopoly" – it assumes, first of all, that there is a very limited way to determine "true" knowledge, and therefore to prove that a therapy works. It also assumes that all types of healing can – and should – be subjected to the same standards of testing upheld by the

allopathic medical model. In this view, "conventional medical and scientific knowledge are (or should be) authoritative, and conventional medical care can (or should be) sufficient to the health care needs of patients"(O'Connor 2002, 55). Such ideas can also be understood to support a form of expert paternalism, wherein "a patient's autonomous right to refuse conventional treatment and to use legal alternatives is merely the right to be wrong" (Hufford 2002, 17).

From the perspective of those who use and practice CAM, however, what constitutes valid forms of knowledge is not so narrowly defined, and proof or evidence of efficacy is determined by various different means. In this sense, to fall outside the allopathic mainstream does not indicate a failure to provide "proven" therapies. Instead, it indicates an understanding and approach to health and wellness through a different, or expanded epistemological lens. This is not to suggest that there is a universal, or shared understanding of knowledge that can be found in the world of CAM – as Tauber aptly describes, "disease and human suffering cannot be understood solely from one perspective... There are multiple systems of meaning that confer significance and an ordering to such experience" (Tauber 2002, 173). Indeed, to attempt to define or describe the philosophical or epistemological underpinnings of a residual category such as CAM is, it could be argued, a futile exercise. Just as there are many different modalities and approaches within the world of complementary and alternative health, so too are there different understandings of the sources and uses of evidence and knowledge. There are, however, also important similarities with respect to what is valued and accepted as valid ways of knowing and understanding by those who use CAM, many of which run counter to that which is acceptable in a strictly EBM-based model. Rather than using this fact as a means of summarily

dismissing such approaches or understandings as invalid or unsafe, exploring them can offer a broad and potentially enlightening glimpse into the mosaic of health-related knowledge.

4.3.1 Holism

One of the most fundamental and well-recognized differences that is often used to set CAM apart from the allopathic mainstream is what is typically described as a "holistic" approach to health (Ning 2013, Sointu 2013). The epistemic roots of such an approach view an individual as comprised of interrelated, connected aspects, which include the body, the mind, and, for many, also the spirit. In this sense, a person is not reduced to a purely biomedical body – to look only at the physical aspects of a person's well-being or illness is considered to be incomplete. When assessing ailments and suggesting therapies or remedies, the whole spectrum of physical, mental, emotional, and often spiritual aspects of an individual are taken into consideration. They are understood to work together, affect each other, and therefore must be simultaneously addressed. Similarly, even physical symptom sets are addressed in relation to each other, rather than treated or inspected with an insular or specialist approach. In this way, CAM therapies are typically concerned with assessing and treating the whole body, as well as the whole person.

Certainly, throughout the relatively broad spectrum of modalities practiced and used by those I interviewed, this holistic theme was readily apparent. The following three quotes, for instance, were taken from a Medical Herbalist, a Homeopathic Practitioner, and a Naturopathic Doctor, all of whom have very different training,

and different approaches to healing, but clearly place a mutual importance on the concept of holism within their practices:

> " As an herbalist I educate people about synergism and holism, both with the plants themselves and holism as a person. We're not reducing people to their organs or their disease, but rather [looking at] their whole system – their social circumstances, their diets, their health and well-being. Our clinical assessment skills are about looking at someone from a whole perspective... teaching people about how to think of themselves as a whole person, and care for themselves as a whole person. "(Jarone)

> "In homeopathy, it is truly a holistic medicine — it is a system of medicine that completely acknowledges, and is inherently thinking in systems. It sees all symptoms of one person related to each other, be it mental, physical, emotional, and whatever part of the body as well, related as an integrated whole. "(Peisinger)

> " Really, it's a combination of your mental health, your emotional health, your spiritual health, and your environmental health. Mental being: do you think about anything?... Emotions: do you deal with your heart? Do you know when you're mad? Do you know when you're angry? What is the emotion that you're connected with, and what organ system is that connected with? For example, worry is your kidneys; anger is your liver. And if you're really angry over lots of things, we need to look at your liver. Spirituality: you don't have to believe in anything outside of yourself. Often I'll say "do you believe that you can be better?" and people will say "no". Then you've got to start right there. "(Purcell)

This holistic understanding of the interconnected nature of physical, mental, emotional and spiritual health to overall well-being is often described in terms of a mind-body connection. As one trained acupressure and meditation specialist explained,

> " I finished the monastery experience, and was fascinated with this new idea and view of the body. Out of the monastery came with me certain theories that events experienced by the subject also have an effect on the body. So if you have traumatic experiences, they can leave impressions on the body. In my case, I was burned quite badly when I was three and

a half, and started reliving some of this, which is not uncommon in the intensive meditation setting. Mental things started coming up – thoughts that I couldn't exactly put away as easily as other thoughts started to resurface as I was doing these meditations, and I became aware that I was having pains in my body related to the thoughts that I was having. So for me, you start to see the flow both ways. I also noticed that my body was more flexible and calm, and therefore my thinking was not as erratic. So you start to get an impression of how this might work, this connection between your mind and your body. "(Johnson)

Often, the spiritual or mental component of this mind-body connection is understood to be particularly powerful, often being the instigator or root of physical well-being or disease. As one Halifax-based CAM-user simply stated,

" For me all illnesses start with the spirit, then they eventually manifest outward until you're physically ill. "(Graveline)

Similarly, a yoga instructor/Reiki practitioner explained,

" You could argue that what we believe creates our bodies; our physiology. And that's not hard to prove. It's as simple as thinking of a lemon, and starting to salivate. That's the power of mind right there. Or seeing a bill and having a heart attack — interpretation creates a physical change. The problem is that most of us have some level of fear every day. If you have the physiology of fear for 30 or 50 years, that's going to wear on the physical structures. But of you had the opposite: confidence, love, certainty, the body wouldn't wear out. Your whole body would be different. "(Beck)

One CAM-user related the following story in which she specifically came to understand that her body was displaying symptoms as a result of stress and unhappiness:

"Then this little red dot shows up, and it starts to grow, and it's an autoimmune problem, and I started to think "what's going on here? Why am I getting this? Why is this happening to me?", after we found out that it wasn't cancer, and it wasn't serious. And I thought: my body is telling me that there's something wrong here. It's going to show me one way or another that things are going wrong. My immune system — I still

have that patch now. It's still a little bit indented — a little pale purple thing, it looks like almost nothing. But I did end up leaving that job; I found something else, and it was gone — it settled down — it was an inflammation and connective tissue collapse. But again, I think now that was my body saying "you're unhappy. Either you do something about it, or it's going to keep on happening; it will be something else". And I did, and it went away. "(Monti)

It is easy to see how this holistic understanding and approach to health is so easily framed as diametrically opposed to the biomedical paradigm. Steeped in reductionist ideals, and specialized, mechanistic methodology, the allopathic medical system has evolved to function in a manner that does not easily allow for holistically-minded diagnostic or therapeutic interventions. This is not to suggest that there is a general sentiment within the allopathic medical system that holistic principles are unimportant or erroneous. As Ning points out, "upon a closer examination of recent developments among global and local biomedical institutions, a holistic perspective of health and health care is promoted", citing specifically the World Health Organization's definition of health as "a state of complete physical, mental and social well-being and not merely as the absence of [a] disease or infirmity" (Ning 2013, 141).

The reality, however, is one in which, even if biomedical practitioners and institutions share holistic ideals, they work within a system wherein the implementation of such an approach is very difficult to accomplish. Consequently, those who value or seek out holism will often turn to practitioners outside of the biomedical system. As a Halifax-based CAM-user explained,

" The mind and spirit are hugely influential to your physical health, and that context is not really dealt with in an adequate way in conventional medicine. I'm not saying its not dealt with at all, and I think intelligent practitioners will incorporate it and recommend it, but they don't have the tools or the time or resources to engage that. For them, it's all about

the physical self. But the reality is that true healing comes from much much more than physical means, so the time and space that I had with [my homeopath] really allowed me to focus on that intangible, spiritual and mind-side of my health. "(M)

More than just providing a contrasting epistemological base to the allopathic model, a holistic approach also engenders different emphasis on, and sources of, knowledge. As Bonnie O'Connor explains, "medical researchers and lay people who use CAM have different needs, goals, conceptual frameworks and methods for producing and applying knowledge, especially because of different conceptions of the "working" in finding out what works" (O'Connor 2002, 67). Part of this involves the types of evidence that are valued. When compared to the evidence-based model that is so prevalent within the allopathic system, CAM practitioners and users often tend toward placing great emphasis on the very kinds of evidence that are found at the bottom of the hierarchy: observation, experience and narrative. In some cases, this kind of experience and observation is based on longevity – trusting therapies, for instance, based on the length of time they have been around, and the results they have managed to produce. This was expressed slightly differently by the following three people, a Naturopathic Doctor, and two CAM-users:

"At one point in my health journey, I was told I'd have problems having children. And being in naturopathic school, I decided to work on that, and now I have two children. There's a lot of research, which is fine, and double randomized control trials, which work for some things. But when that is being compared to 4000 years of acupuncture, I don't need a double randomized control trial to know that it works."(Purcell)

"Scientific evidence is important, but you also can't ignore what has been documented to work for thousands of years. I think people have to take the years worth of anecdotal evidence and trust it. Chinese and Ayurvedic

medicine working for thousands of years. It makes me sad when things are forgotten, or not taken seriously because there aren't enough studies done."(Anne)

"My sister-in-law goes to acupuncture, and has always felt really good using it. And my brother, who is a vet, is a science-based person, and says it's completely bogus. A waste of money. Really scoffs at her — doesn't support her at all. She says 'the Chinese have been using it for 2000 years, why do you think it's not right? And his point is that you can't scientifically prove it. So what? It works for me."(Grasse)

In other cases, the type of knowledge sought after is more immediate – using anecdotal evidence, for instance, from personal experience or from others who have similar health issues or used similar modalities. The experience valued here is of a more personal or individual nature, and what "works" is, in that sense, subjective. This is precisely why such types of evidence are considered unreliable from the EBM-based perspective – they are "characterised by lack of control and are not conducive to statistical analysis" (Keshet 2010, 335). For those who use CAM, however, anecdotal evidence is often an incredibly valuable form of both individual and collective experiential wisdom, and for practitioners, anecdotal results not only guide their own practices, but are often seen to "constitute a major source of knowledge and to be worthy of publication in professional journals" (Keshet 2010, 335). Certainly many people who I interviewed rated anecdotes and experience high on their list of important forms of evidence. The following six quotes, for instance, were voiced by people a wide range of backgrounds: CAM users, CAM practitioners (a massage therapist and a CAM-psychologist), as well as an allopathic physician, respectively:

" People say "well there's no proof". But science has to be rewritten as far as I'm concerned. Why are we only using strict science to believe anything? Why aren't people's testimonies and thousands of years not worth anything? "(Graveline)

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" I also like feedback — I would rather know what five people think about it than what a study says. "(Anne)

"One of the best resources for PCO[1] that I've found is an online community called Soul Sisters, which is phenomenal. There are 40000 users on this site; it's international. All women with PCO. Because every single woman who has PCO has it differently in some ways. Its amazing to really be able to talk with people. And nothing is not talked about on this site. You talk about everything from the colour of your cervical mucus to your pills, to how your friends deal with PCO – everything. So it's absolutely fantastic... The women on the Soul Sisters board are so educated about PCO. Or because there are so many and there's such a diversity of experiences and opinions that you can get an opinion on anything; everything. And OK – it's not always going to be well-informed; you have to base it on who this is, and what are they saying; what is their experience, but just the depth of different experiences – that couldn't happen anywhere else."(M)

" But there are people like me who see this, and we really see the results. Even if we don't have the research to back it, we see that it works. And we talk to each other, so people are recommended to take these things, and many people are getting better. "(Kemp)

"It's more about exposure and personal experience. If you try it, and it works for you, those studies don't matter. That's what I say to people... If it works for you, do it. "(Julia)

"So even with craniosacral therapy which I have had so much experience of and seeing such profound shifts in people which are very difficult to explain, but the developers of it who have a particular paradigm – you know, I don't personally subscribe to all that as a [sane?] belief. So I don't fully understand the aspects of the system and the approach, but I recognize the effectiveness of it. "(Fox)

To trust and value knowledge gleaned from experience, observation, and anecdotal evidence is often understood, especially within the allopathic system, as non-scientific,

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[1]Polycystic Ovary Syndrome

and therefore unreliable. Indeed, such evidence does not meet the rigorous testing criteria inherent in such gold-standard methods as randomized clinical trials. It is also often of a personal nature, and therefore understood as inherently biased. Significantly, however, such forms of evidence address many of the problems and the criticism that are continuously launched at a system that puts so much weight on RCT-based knowledge acquisition. Steeped in holistic ideals, these "less rigorous" forms of evidence are particularly useful at gauging the effectiveness of interventions in a very broad, multifaceted manner. Whereas RCTs can produce intricate knowledge about how a very specific compound works in a very specific part of the body, observation and ethnography address issues related to overall quality of life, and multi-symptom management. Indeed, many of the potential benefits of a therapy from a CAM perspective can be understood to simply fall outside of what RCTs can measure – a change, for instance, "that is not considered clinically salient could be *'the'* most important change a participant experiences" (Vuckovic 2002, 225, emphasis in original). As such, how CAM practices might facilitate healing is lost within the biomedical focus on efficacy – "it is difficult to measure and understand the subjective and, at times, vague occurrences of healing through procedures such as randomized controlled trials" (Sointu 2013, 2).

Just as allopathic practitioners work within a system that makes a holistic approach difficult, so too CAM practitioners "work with different narratives of health and illness that are difficult to reduce to a positivist epistemology" (Richardson 2002, 223). Whereas clinical trials are based on assumptions about the similarities inherent in human beings, symptoms sets, diseases, and treatments, CAM practitioners typically take the opposite view: "despite the similarity between human beings, individual

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treatment, which is specifically attuned to the uniqueness of each person as a whole, is preferable" (Keshet 2009, 144). In this way, the relevant approach from a CAM perspective is often not to determine efficacy based on biomedically-derived testing methods, but rather "whether it is making a difference to the bodies, beliefs and social and cultural experiences of its clients, and whether patients keep coming back" (Keshet 2009, 146). Similarly, those who use CAM are typically concerned more with how a therapy will work for them, personally, than how it plays out in a clinical trial.

4.3.2   Intuition and Energy

The differences in knowledge acquisition between allopathic and CAM approaches can go deeper than a question of therapeutic evidence. There are ways of knowing that, in many regards, fall outside of the EBM hierarchy all together, and yet can remain an integral part of health-related decision-making. Evidence found within the EBM hierarchy, regardless of how or why it is favoured, shares the often taken-for-granted commonality of being learned. Knowledge is the result of experience, and the narratives that come from experience: those of observation, and of carefully constructed tests and trials. There is, however, a way of knowing that exists at a much more personal, esoteric level. Described variously as intuition, imbedded knowledge, or internal wisdom, this is a concept that is widely understood, but commonly discounted as unsubstantiated, highly unreliable, and potentially dangerous. For many of the people I interviewed, however, this way of knowing is an absolutely essential and powerful tool – one that is universal, but often ignored. This idea is clearly demonstrated, for example, in the following four quotes, expressed by both CAM-practitioners (a Quantum Touch

practitioner, and a Massage Therapist/Reiki practitioner), and CAM-users:

> "There's a lot of intuition in the wisdom and knowledge that we have... Being intuitive is learning to listen to your body, which we tend to discount. That little voice that tells you not to do something, or whatever, and usually it is when you don't listen that you regret it. So allowing that to grow, and to listen to those feelings. I think we all have it, but we tend to tune it out and discount it. "(Culp)

> "Trust – coming from a higher self. People called it God, universe, Buddha, whatever. It's listening to your intuition. And if you get quiet enough – if you think about it, everything is a vibration and frequency."(Mullin)

> "Your body knows. The body knows. And it really sounds so amazing that we have denied that our body has this knowledge, and Western Medicine denies that we have this knowledge. However, with all of this surfacing, these kinds of treatments now, it's almost like we are rediscovering a wisdom that we've always had, but we've lost. It has not been allowed to be part of our culture — it's still very frowned on. The element of denial."(Maggie)

> "I am amazed at how intuitive, how when I listen to my body and what it wants, how clearly it tells me... I have an imbedded knowledge."(Monti)

Much of the language used when describing how to access this knowledge involved being able to condition yourself to listen and trust what your body or intuitive sense is trying to communicate. This was true not only for individuals, but also for many practitioners. Some practitioners revealed, for instance, that they understood part of their job to involve helping and allowing people to access their own intuitive knowledge. As a CAM-based psychotherapist revealed, for instance,

> "I refuse to teach anybody anything that won't actually help them deal with their anxiety and stress. And so much of that is going into the body, being really present with what you're feeling. And that really teaches intuition. People ask me what I think, and I say "why don't you check in with your body"? And I get them to take a few deep breaths, and then ask "what does your body say about that?" And they know — they don't always trust, but really it is about cultivating that intuition."(Julia)

Similarly, a retired Nursing professor/breath specialist described:

> "In the medical model, the expert lies outside of the person, but the expert lies within. It's a universal truth... Part of what I teach people is to learn how to trust themselves, and to listen, and remember to listen and to remember to trust. We are bombarded with information to trust outside of ourselves, and we really don't know how to listen, because we are very busy, and going in many different directions at once. And the expectations are often other people's expectations rather than their own, because we've never been coached or nurtured to discover "who I am". And yet "who I am" is a universal truth."(Cull-Wilby)

More than just helping patients or clients tap in to their internal wisdom, however, practitioners also described using their own, or their clients' imbedded knowledge as an integral part of their therapies. In some cases, this was simply a matter trusting intuition to reinforce or validate therapeutic choice. For instance:

> " And I'm also validated by the experience. I'm not just trusting myself; there are reasons I'm trusting myself, because really, intuition is about directly picking up information. You're just perceiving in a direct way, rather than just from your head, or what you think. It's helped me assert myself and be more confident in what I do."(Julia)

In other cases, however, practitioners described using this powerful form of knowledge in a very tangible way, and allowing or trusting it to take precedence over other forms of knowledge. A Fredericton-based Acupuncturist/Energy Worker, for example, went into great detail about how she simultaneously differentiates and then chooses to use sometimes competing forms of knowledge while in the middle of treatments:

> "What people tell you will help, but it's the body. That's the fun part. That's why, after 21 years, I still have a passion for what I do. Every individual is at a different place every time I see them, and so the treatments will always vary. And it's allowing the treatments to vary. You're working with them... you're releasing their neck, and their feet keep calling you. The next thing, you're having this debate within yourself... and if you

can just drop it all and go work on the feet, then that's easier. They're calling you, for whatever reason... [You need to trust] what the tissues are telling you. Sometimes what the body is telling you is different from your training about how the muscle is supposed to go. So what I try to do is... even though during an acupuncture treatment I am trying to hit points that are really good for heartburn, or whatever, I try to take all of that info from them and all the information from the knowledge from what I've learned, and just push it out of the way, and try to connect with the bigger picture, which I've just learned to trust a lot... So it's just about remembering to trust that. To get out of the way – the body will take me where I need to go."(Clavette)

Similarly, a Fredericton Massage Therapist described an experience when she first truly felt and used this intuitive force in a treatment:

" I was in school in my second year in Montreal... a classmate and I were practicing in the apartment. She had some stuff going on in her stomach, and we were practicing abdominal massages. I felt something inside of my stomach move, and out of the blue, I decided to go to that same spot on her. It would move on me, and every time it would move on me, I'd move on her. She looked at me me kind of funny, and said, "what are you doing?" And I said, "I don't know, I'm kind of just moving where I feel I need to go." She said, "you're going exactly where it's moving". And it really scared me. I didn't know what that was, and what was going on."(Mullin)

This same therapist goes on to describe how she struggled for awhile with validity, and trying to couple scientific knowledge with the more intuitive knowledge. As she discovered, however, trusting the intuitive knowledge proved especially powerful:

" If I was open to it and relaxed, I would know where to go without them telling me. Even though they have an ankle injury, it was necessary for me to work on their hip. You could reason that out with science and mechanics, but it went deeper than that — it was when I did cranio-sacral or Reiki on that spot, they would have a huge emotional release, and their ankle pain would go away. Odd things – or things that people would deem as odd — would happen during the sessions."(Mullin)

In some cases, this notion of imbedded wisdom forms the entire basis behind a healing modality and the ways in which remedies are sought. As a CAM-user explained, for instance:

> "I did Body Talk with someone from away. The idea is that your body knows how to heal, and wants to heal. There are just lines and links that have been severed along the way. So body talk uses muscle testing to ask the body on an unconscious level where it needs to go. So you can ask the body through a chart, like "do you want to go right to the physical", or to the emotional, or through past lives. They heal it through tapping on various acupressure and meridian points. Especially for people who can't figure out what is going on, Body Talk is a wonderful tool." (Quigg)

Understandably, this type of intuitive or internally-based knowledge acquisition runs directly counter to the range of acceptable forms of knowledge within a biomedical – or indeed, a scientifically-based – paradigm. It is a form of knowledge that one cannot learn, teach, or test in a manner that has any correlation to allopathic medicine, and can therefore easily be discredited from such a perspective. For those who use and value the knowledge gleaned from such an internally imbedded wisdom, however, it is considered an extremely important and effective tool, and therefore also an essential component in an ongoing quest for health.

In these respects, the idea of internal knowledge shares striking similarities to yet another epistemological concept that is commonly used to differentiate between the world of allopathic medicine and CAM – the "existence of a 'vital force' or bioenergy" (Ning 2013, 142). As Polich explains, "CAM therapies tend to employ vitalist explanatory constructs such as acupuncture 'chi', yoga 'chakras', chiropractic 'innate intelligence', or homeopathic 'spiritual essence', which denote pervasive benevolent energy resources purported to influence emotional and behavioural as well as organic

disorders" (Polich et al. 2010, 107). Naturally, this concept of energy or vitalism has, as Polich alludes to, a wide variety of understandings and uses, depending on the type of modality or health concern, and even the particular practitioner or person involved in the healing process. In its broadest sense, energy can be understood in terms of the philosophical or epistemological underpinnings of the way the body, mind, and spirit work together, and how they relate to the larger, universal understanding of life and wellbeing. As one Naturopathic Doctor described, for instance:

> "We are energy beings. How can you ignore it? My personal belief is that we have to incorporate the energy into any circle. There's an energetic component to every disease."(Purcell)

More specifically, the concept of energy is understood as a very direct, tangible, and key component within the healing process. This is perhaps most readily apparent and explained within modalities described purely as "energy work", such as Reiki, Therapeutic Touch, and Quantum Touch. Energy practitioners that I interviewed described the energy and the practice of healing with and through energetic means in similar ways. As one Quantum Touch practitioner explained, for instance:

> " When the energy flows well, it helps our body to function. I think part of our ability to function is our ability to heal. When you break a bone, your body heals the bone. The doctor sets it, puts the cast on it, whatever, but your body heals the bone. You cut your hand, the body heals that. Bodies are constantly making new cells and working and repairing, without our help — beyond eating and breathing and sleeping. Sometimes people look askance and say "oh yeah, our bodies can heal themselves" – but they do it all the time. The same way that the vacuum cleaner hose is kinked when you're vacuuming, and nothing's working, nothing's flowing, but the vacuum isn't broken — if you can clear that; straighten that out so the energy can flow again, then things can work. In many ways it's really quite simple. But simple things aren't always easy to get through. But it does seem to be that simple. Any place where the energy is not flowing feels blocked, dead."(Culp)

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Similarly, a Therapeutic Touch/ Reiki practitioner described the similarities and differences between these two energy-based techniques:

> "Therapeutic touch you really don't touch the body — maybe at the beginning, just to make contact, and get the energy flowing. You ask permission, and you do a lot of grounding by holding the ankles and the feet. And that's about the only touching you do. The rest ... you clear the energy first, then you assess, then you sort of centre and feel the area of imbalance, and work with that area... in learning it, they do these five [steps] but you're led by the person's energy, or the lack of movement of the energy. You might feel like a blockage or a coldness, or it might just go through you. It's a universal energy... you facilitate the other person receiving that energy. Like the other day I was doing Reiki on somebody, and I had to stay for a long time on his ears. My hands were just tingling. And I found out after that this person was suffering with sneezing... Allergic to pollen and stuff, and then by the time we were done, it was cleared."(Susan)

> "When you're training for Reiki, the Master Reiki practitioner does attunements, which helps facilitate your own energy centres. So that helps the person receive the universal energy. But the universal energy is very intelligent. So I feel less responsible in a sense when you're doing Reiki, because you've been attuned. So when the person is open... there might be a little more magic to Reiki. But it's not really magic – it's a process that works."(Susan)

Regardless of the specific type of energy work here, the common understanding relates to the existence of a universal energy – one that is apparent both within the body and the in universe at large. It is a benevolent energy, the proper "flow" of which is imperative for well-being. The role of those who can manipulate this energy, then, is to find "blockages", and to facilitate the free-flow of energy in these spots. Much like imbedded knowledge, those who work with energy describe it in very individualized, personal terms. The technique used to access and manipulate energy can, to a certain extent, be taught, but it is not something that is quantifiable in scientifically appropriate ways. As Susan explains,

"I think you can be taught certain things, but until you work with it yourself, and trust your intuition, you won't get comfortable with it. You really have to trust your own intuition. You can go through the motions, and follow the steps, but ... it's like playing all the right notes, but it's not quite music."(Susan)

As such, energy work is, in many ways, unique to the individual practitioner and patient, and based primarily on personal feeling. Energy-based practitioners who describe their first encounters with energy, for instance, emphasize how they were personally affected, or had an individual connection to it. As these two energy practitioners describe:

"My husband told me our friend had cancer, which had spread throughout her body. She was having such pain that she couldn't lift her arm. Someone had taken her for some Reiki, and in one session the pain had gone away. It didn't cure the cancer, but the pain was gone. I thought that was amazing, and then my fingers started to throb; to tingle. And whenever I thought about Reiki, it got stronger. The next day I was beginning to think that my body was trying to communicate something to me. So the next day I went to the library and got a book on Reiki, and the way they described what it feels like when the energy is flowing was exactly the feeling I was happening."(Culp)

"I was at a program in Toronto, and someone talked about energy. And I just experienced the ability to move the [body] energy and balance the body energy. In fact, I'll tell you what it was — somebody told me that if you placed your hands on the solar plexus, you'd have the ability to move the energy where it was needed in the body. I had tennis elbow for five years, because I had a job where I was traveling all over Canada and dragging boxes and suitcases etc. So that very first day, I [stayed with that ... intense level to heal] just on my own, before getting into any of this. So I knew the value of balancing the body energy from that."(Susan)

In various other modalities, energy can be understood slightly differently. In homeopathy or NAET (Nambudripad's Allergy Elimination Technique), for example, it is believed that substances have their own unique energetic identities, which interact

with and can affect the body, mind and spirit in different ways. Significantly, diagnostic techniques in some of these modalities are often a mix of that which can be seen, felt and described (as one would in a biomedical setting), in combination with the much more esoteric use of imbedded knowledge. A Fredericton-based CAM-user, for instance, described using NAET treatments, which she completely credits with bringing her from a state of near death to complete health:

> "They used energy testing — putting a vial in your hand that has the energies of various different things — and if you're able to hold your arm strong — they do initially do a muscle test — then they put the vial in your [hand] and do the muscle test again. If your arm remains strong, then you're not allergic to it. If your arm goes weak, they can actually determine what organ it affects by completing the circuit, but putting their hand on the organ on various spots on your body and seeing if you go weak."(Maggie)

She then goes on to explain a related technique wherein the practitioner asks questions silently, speaking directly to another person's body.

> "Now when I'm asking these questions, my hand is touching your body. But it's not necessary. Because as many energy healers are aware of, you can be on the other side of the world... but you don't have the arm then; there are other techniques for that. And sometimes if you think "what do I need to treat for?", try to figure it out, you can get a lot of information that way. You can discover if the problem that this person is experiencing is on a physical level, by doing the first finger and thumb energy connection, a chemical level with the second finger, and the ring finger for emotional. And that completes the circuit. Then you can zero in on the specifics, to find out what specifically it is. Because a lot times — in most cases — we don't know what it is."(Maggie)

Perhaps unsurprisingly, the evidence-base when assessing the efficacy of some of the more purely energy-related healing techniques is primarily anecdotal and experience-based, both with respect to practitioners and the people they treat. As

Pederson explains, "unlike most expert authority, which is usually rooted in training, esoteric skills or credentials, expert authority in the CAM context is also grounded in users' lay accounts and direct experiences of increased well-being rather than in 'hard scientific facts"' (Pedersen and Baarts 2010, 1073). The following quotes, taken from a range of CAM-practitioners (including Energy Workers, Massage Therapists and a Naturopathic Doctor) and CAM-users, show a variety of different examples:

> *"This woman just glared at me the whole time... I [had been] talking about how we think of ourselves as what we can see and feel, but there is an energy field around us and through us that is just as real. Then I went to this elderly lady who had been glaring at me and asked if there was anything I could help with or work on. And she said that she had had this leg amputated at the knee, and it turns out that the reason she was glaring at me was that her daughter had dragged her to this talk, because she thought it would help her. But she thought it was just a complete waste of time, and was really angry about being there. But as long as I asked, well she had this phantom pain in her leg. I had heard about that, but I had never talked to anyone who had it, so I asked what it felt like for her. She said it didn't actually hurt – the leg that wasn't there was cold all the time, and she could do nothing to heat it, and it drove her crazy. So I had this moment of panic, but then I realised I just said to this other woman about our energy being as real as our physical bodies, so ... I held my hands on either side of where her leg might have been, and in a few minutes, she said "that is starting to feel warm". Within a few minutes it felt as warm as the other leg. This was someone who was clearly not expecting anything to happen. Of all the things that have happened to me over the years, that was one of the most profound, because there was actually nothing there. There's so much that we don't understand about the world and our bodies."(Culp)*

> *"I had better results working with energy than I did working with the more conventional methods. Because with massage you aren't just working on their physical body; you're helping them work on their emotional body, and their spiritual body, in a sense. And it seemed that the healing was deeper, and it lasted longer than me just doing the regular patterns. Because these would be clients that I would have for while – recurring clients."(Mullin)*

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"Then in 1999 I had a journey about learning about energy – that was my spiritual journey at the time. I saw a poster about Reiki, and it spoke to me, and then I took level 1 and level 2. I've done a lot on myself, and it has helped me in many ways. Like anything else, you've got to practice it and get the energy flowing. There are countless stories literally being healed through the exchange of hands and the flow of energy. It opened the door to a bunch of other therapies, but it's a staple. I healed a dog once – it wouldn't stop scratching, so I grabbed my pendulum and I cleared away all the negative energy from past and present lives, and transferred it to something positive – I say my spiel. Then I do my Reiki. I call her a month later, and she said "my dog hasn't itched since". It really boosted my confidence."(Quigg)

"If I could get relief from the neck pain, it would follow through that I would get significant relief from the other areas. And it was all connected. So I started seeing someone who does a combination of Reiki and what is called "Quantum Touch", which is very Reiki-like... And my first treatment provided relief like I had not experienced. I would say – it's almost all gone. I probably need one or two treatments to fine-tune because occasionally I get a little twinge in the neck, and occasionally a get a little twinge in the hip. The big relief and final move towards wellness came when she discovered that my ankle, in the area of where my double bone break happened, just above the ankle – that essentially my foot was frozen. Many unmoveable parts – she said "these parts feel like dead wood", and she started to get energy flowing through there."(Maggie)

" A lot of people think Reiki is way out there because there's no concrete study or proof that it works, because how can you measure energy? But I mean, with my experience, receiving it and giving it, it's totally proven to work, for me. "(Oulette)

"The first [Reiki] practitioner I had working here – she's retired now — she was a lovely lady. She was young, but she came in and did a session on me, and she said "when I was doing your energy work, I had my hands over your abdomen, and these two little hands came up and wrapped their fingers around. You're going to have another baby." I was feeling that anyway, so I got off the table, did a pregnancy test, and it was negative. But a week later, I did a test and it was positive. She could read it and feel it, and the energy was there to pick it up. I knew I could trust her then."(Purcell)

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Regardless of specific terminology, or the particular ways that it is used and understood, the concept and techniques used in vitalism, or energy-based healing, not only lack a biomedical correlate, they also fall outside the allopathic explanatory framework, and "sit uneasily within the discourse of normative science" (Polich et al. 2010, 107). Historically, in fact, the reductive philosophy that came to play a big role in allopathic medicine began as a negative reaction to the notion "vitalism" – reductionists specifically sought to disprove the idea of a "life force", and replace it with the a philosophy that viewed the body and its workings as purely bio-mechanical (Tauber 2002, 182).

Certainly, within the interviews I conducted with allopathic physicians, energy work was met with much skepticism. When discussing CAM modalities within a perceived "acceptability scale", for instance, anything that was felt to be remotely related to energy healing was often categorically dismissed. As two different allopathic physicians explained:

> "I have to make myself not confuse the charlatans – the crystals and things that I don't believe in. But I don't know the fields that well... but the healing with your hands, the religious faith healing – I would have some difficulty with that... I would have more faith and interest in the vitamins and diet. Reasonable, healthy things... I don't go for the purple smoke. Maybe if I had the chance to talk to somebody who knows and uses it, I would be willing to think about it rather than dismissing it. I probably don't know enough." (Kati)

> "They seem to be migrating more towards the mainstream — like, if you put them in order of who's more mainstream medicine, I think massage therapy is getting close, acupuncture is in there maybe next, and I would think of naturopathic medicine maybe coming next, and then homeopathy, I think of next, then maybe — what is it — not touch, but — you know people who sort of just wave their hands; move their energy, and that sort of thing — is that Reiki? Reiki. I think of them kind of over here a bit further, for whatever reason, that's just my perception." (Moore)

Other physicians were very direct with reasons as to why they felt energy-related concepts were so unacceptable within a biomedical paradigm. As a gastroenterologist revealed,

> "[CAM healers] should police themselves in a way where they leave the obviously ridiculous things out. They should get rid of the 'putting your hand on the diseased organ and leaving it there for five minutes and make some movements' – this kind of nonsense. Magnetic fields, and these bracelets, and these kind of things. When you see that, the whole thing comes under this smoky umbrella – the obviously non-scientific. I would get rid of that... I cannot hear about energy, or energy manipulation, or these kinds of things. We shouldn't be in the belief system. We need to see facts, because otherwise, where is the limit? There is this world of evidence. The evidence in our education is divided – strong, less strong, circumstantial, and then there are different levels of recommendations. So where would you put the energy field or magnetic field, or energy manipulation? Where would that fit? That doesn't fit. There is no place for it."(OK)

Similarly, as a Halifax-based physician posited,

> "For people with gobs of money, I don't doubt that having people care about them and touch them is a good thing for them. I don't think that the energy traveling between them transmutes physical laws. I mean, how is it working? If it's working, how is it working? It's either working because the laws of physics are being broken by supernatural forces, or it is working because people who are stressed or unhappy are getting happy. I don't believe that the laws of physics are being routinely broken. We've got 6 billion people on earth, and as far as I know, none of them has broken any physical law. No decapitated person has ever come back to life, or lived to be 300 years old."(Workman)

The common sentiment here is that those concepts or modalities that fall outside of the explanatory framework of science, (and therefore allopathic medicine), are consequently false, non-efficacious, and/or dangerous. If they cannot be understood, seen, or tested within a scientifically-based paradigm, they are therefore unsubstantiated, misguided beliefs. This could, perhaps, be understood as a natural, dichotomous distinction to make in a system wherein knowledge and truth is linked to a very particular

kind of evidence, which must not only meet strictly mandated testing standards, but must also often pass a "Bayesian outlook" (Vandenbrouke and de Craen 2001, 510), or "theoretical plausibility criterion"(Hufford 2002, 16). As Hufford explains, rather than evaluating evidence based solely on its own merits, many feel that an important evidentiary determinant is the frequency with which this evidence has previously been reported. Therefore, if the "prior is zero, there will never be any acceptance that A occurs" (Hufford 2002, 16).

Inherent in this "prior plausibility" criterion are a number of assumptions, not only about the nature of reliable evidence, but also about the limits of knowledge. Perhaps most notable is the assumption that valid knowledge will "prove to be coherent with some characteristic of established contemporary science", and that "the likelihood that a claim will eventually have this coherent relation to contemporary science can be judged on the basis of present knowledge" (Hufford 2002, 17). With this type of evaluative criteria, it is not difficult to see how CAM can often be summarily dismissed out of hand – if the explanatory framework behind a modality or technique lacks theoretical plausibility, there is no reason to think that it might actually work. Not only is this a criterion that espouses expert paternalism, it also purports that "a process of free inquiry open to diverse views is unnecessary and counterproductive in science, except within narrow bounds internal to conventional science" (Hufford 2003, 207). While this is true of modalities and understandings that can generally be labeled as CAM, it is, clearly, especially true for modalities using the concept of energy or vitalism.

In both academic literature, and also in the popular media as of late, one of the most prominent examples of this particular type of clash between the worlds

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of allopathic medicine and CAM involves the practice of homeopathy. It is, some would argue, "one of the most controversial forms of complementary and alternative medicine" (Fisher 2012, 1669) – though millions of people use homeopathy worldwide, and it has even displayed positive results in clinical trial evidence, it is still "held in considerable disrepute by much of the mainstream medical and scientific community" (Sehon and Stanley 2010, 276). Invented by German physician Samuel Hahnemann in the late 18th century, the basic premise of homeopathy is 'let like be cured by like' – a principle referred to as the "law of similars" (Fisher 2012, Sehon and Stanley 2010). Essentially, Hahnemann purported that if a substance in sizeable doses creates certain symptoms in the body, that same substance, in extreme dilution, would be effective in relieving the symptoms (Sehon and Stanley 2010, 278).

It is, primarily, these dilutions which cause so much heated debate and skepticism – typical homeopathic remedies have dilution rates "ranging from a low of one part active ingredient per 1 million parts water, to a mind-boggling 1 part cure per 10^{2000} parts water" (Sehon and Stanley 2010, 278). As such, the remedies used in homeopathy are chemically indistinguishable from water, meaning there is an "impossibility of chemical effects" (Vandenbrouke and de Craen 2001, 508) . For Hahnemann, and for most people who use and practice homeopathy, the mechanism behind its curative effects involves energy, or vital force. If prepared properly, using a series of shakings called "succession", "the more "spiritual vital essence" is released, and therefore the more potent the medicine that is created" (Vandenbrouke and de Craen 2001, 507). As one homeopath I interviewed explained,

> " The other very important aspect to understand in homeopathy that
> distinguishes itself from any other modality (like herbalism, for instance), is
> that as a homeopath, we do not use material substances. It is not chemically

based — it is energetically based. That is the catch, and it is very hard to explain to the mainstream — to mainstream medical practitioners and medical science. That concept is a paradigm shift. "(Peisinger)

Much like other energy-based healing modalities, homeopathy clearly fails to meet the theoretical plausibility criterion. What makes it such an interesting case in point, however, is its large-scale world-wide usage, and the success rate that it has demonstrated, even in randomized clinical trials. As Vandenbroucke has pointed out, when summarized in meta-analysis, "the combined odds ratio showed a twofold benefit in favor of homeopathy, even after statistical correction for publication bias" (Vandenbrouke and de Craen 2001, 507). Despite these clearly favourable results, obtained using the allopathic gold standard of testing, most physicians continue to dismiss the possibility that homeopathy is a valid modality, and "find all kinds of counterarguments" (Vandenbrouke and de Craen 2001, 507).

This can be explained, in large part, to the ramifications inherent in accepting such results from a scientific or biomedical perspective. It goes beyond simply breaking Bayesian principles – to accept, for instance, that homeopathic dilutions have an effect on the body, would be to subvert the very physical and chemical foundations of science. As Sehon argues, "those who claim that homeopathy is effective have enormous unexplained mysteries, and answering those mysteries would appear to require massive revision of standard chemistry and physiology" (Sehon and Stanley 2010, 279). This is, Vandenbrouke points out, too high a price to pay – "too much knowledge that really works in our day-to-day world is built on existing chemistry and physics"(Vandenbrouke and de Craen 2001, 511). In other words, because phenomena cannot be explained using the current scientific understanding of the body and the

universe, they must therefore be considered false.

As many scholars have pointed out, however, to summarily dismiss evidence and results based solely on the fact that they can not be adequately tested or explained within a current scientific framework, is, in many respects, inherently unscientific in nature. As Hufford has eloquently stated, "to support refusal to seriously investigate "impossible" scientific claims actually demonstrates the reverse... it is the intransigent refusal to seriously investigate such claims scientifically, arising from dogmatic insistence on the prior plausibility criterion, that hampers the production of scientific knowledge." (Hufford 2003, 208). Succinctly put, "lack of evidence for effectiveness... is not evidence of the lack of effectiveness" (Hufford 2003, 204), and to criticize or dismiss CAM on these grounds "suggests the presence of negative bias against CAM rather than objective scholarly judgment." (Sade 2003, 185). This exact sentiment was expressed by a number of people that I interviewed, especially those who practice CAM. As a Quantum Touch practitioner and a Accupressurist both explained:

> "Some people will believe it and some people won't. My husband is a research scientist, and some of our friends have tried Reiki and it has helped them, and others – this one said that there was nothing I could ever do to prove to him that it works, - his wife told me that, actually – and I said to her, "tell him I'm shocked that as a scientist he doesn't have a more enquiring mind about this". I think imagination is more important than knowledge. Knowledge is limited. We know what we know, and many things that we knew years ago have been proven wrong. But when you know what you know, often you don't try to do something because you know it's not possible. "(Culp)

> " Even if we don't know exactly how, or what the pathways are, it doesn't mean that it's not happening. Anybody in the scientific community who says they've disproved something because they cannot adequately explain

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how it works doesn't know what science is. Just because you can't prove it works doesn't mean it doesn't work. Just because you can't explain how it works doesn't mean it doesn't work. "(Johnson)

Such quotes circle right back around to the aforementioned discussion of science versus anti-science. Those who accept, use and/or practice something as outwardly unscientific as intuition or energy healing could be easily argued to simply reject scientific principles. As O'Connor explains, however, this is not a straightforward dichotomy – CAM users clearly do "accept science as a key resource" in providing useful information about complementary modalities, but they "do not necessarily [accept] its authority in framing what the issues are", or accord it "undisputed epistemological status" (O'Connor 2002, 66). This is an important point to make, and one that came up repeatedly in the interviews I conducted. Of all the people I interviewed, including those who routinely use and practice healing modalities that lie outside of the biomedical framework, there was not one person who summarily rejected scientific principles, or failed to see the value in biomedical techniques. Allopathic medicine, and the scientific framework on which it is based, have made unparalleled discoveries and indisputably provided health outcomes that no other approach has been able to claim. On this point, most people seem to wholeheartedly agree.

To practice or use CAM, then, is not an a priori rejection of science or allopathic medicine, but rather an acknowledgement that other forms of knowledge, evidence and epistemological claims – even those that do not fit a scientific paradigm – must also be seriously considered. It is also, then, an acknowledgement of the current limits of science, and of the methods used to determine scientific "truth". Those who use and practice CAM are typically not rejecting one form of knowledge for another –

instead, they are "pragmatic pluralists with clear ideas about when CAM treatment is appropriate" (Segar 2012, 368). Different ways of knowing, and therefore treating illness, are used concurrently.

This blending of knowledge and techniques is actually a key component of many different CAM modalities – even ones that are commonly understood to be much closer to the medical mainstream. Massage therapy, for instance, a primarily biophysical, anatomy-based form of treatment, has become well accepted within the allopathic medical system. It is often prescribed by allopathic physicians as a viable form of treatment for their patients; is typically covered to a certain extent by healthcare plans; and in some cases, has even been incorporated into allopathic medical centres and hospitals. Significantly, however, there are many massage therapists, including the ones I interviewed, who incorporate energy-based techniques such as craniosacral therapy and Reiki into their practices. Acupuncture has been gaining a similar acceptance, but is based on an epistemological understanding of the body in terms of lines of energy and energetic blockages. Naturopathic Doctors undergo a scientifically-based training that parallels allopathic medical students very closely, with the exception that they also learn and incorporate energetically-based theories and techniques within their practice.

Such modalities, as well as the people who use them, are examples not of anti-science, but rather people and techniques who value a broad range of knowledge and evidence, including both that which is purely scientifically-based, as well as knowledge that has been gleaned from other sources. Keshet has used the theoretical concept of "hybrid knowledge" to describe the particular kind of knowledge being constructed or generated in CAM discourse (Keshet 2010, 337). Others, such as Wolpe, describe

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the debate in terms of differing forms of science: "The argument is not over science or no science, but *'which'* science... those entrenched in a particular set of cultural approaches to science have had difficulty in understanding that it is not *science* that many CAM supporters have rejected but a set of values that predispose *this particular form* of science to dismiss CAM as a serious healing modality a priori" (Wolpe 2002, 167, emphasis in original).

Regardless of how it is described or explained, the important fact to take away from this discussion is that CAM and allopathic medicine are not nearly as dichotomous as they are often portrayed. Similarly, the people who use and practice CAM modalities are typically interested and invested in multiple ways of knowing, rather than simply choosing to reject scientifically-based conclusions or techniques out of hand. This is true even with those who use and put stock in concepts such as energy or intuition, which are currently very far outside the realm of scientific explanatory framework. While science might reject energy-based theory and work, those who use energy do not so quickly reject science – instead, they typically argue that science has simply not yet found a way to describe or explain its existence. This can be understood, then, not as a dismissal of scientific knowledge or method, but rather an acceptance of the validity of a scientifically unexplained phenomenon while waiting for science to catch up.

4.4   Conclusion

Questions that surround the concepts of knowledge and belief are complex and diverse, and carry with them important cultural implications. Where official and unofficial communities are concerned, those that possess what is officially sanctioned knowledge

carry with them power and legitimacy, whereas communities understood to be steeped in belief can easily be disregarded as false, or unworthy of serious consideration. This is especially true within the world of health.

In North America, as well as many other countries in the Western World, a scientifically-based medical paradigm has become mainstream. As such, this "official" approach to health and illness has made particular claims about the nature of legitimate evidence and knowledge regarding the way the human body works, and how it should be treated and cared for. Reductionist and positivist scientific ideals have favoured medical evidence that can be heavily tested and controlled, with resulting techniques and outcomes that can be quantified and generally applicable to the human population. This allopathic medical approach has undeniably made invaluable advances and breakthroughs within the world of health, and continues to do so. The scientifically-derived evidence and knowledge base that inform allopathic medicine have an unparalleled rigour of method, and allow for a unique, extremely important understanding of health and illness.

Concurrently, however, there exists the world of complementary and alternative medicine – a sometimes disparate grouping of health-related practices, modalities, and epistemological claims that fall outside of the allopathic medical mainstream. Typical of many other types of unofficial culture, CAM is often easily dismissed. Depending on the type of modality and the particular situation, criticism of CAM includes notions that it is unsubstantiated, unscientific, purely placebo-producing, or a form of quackery. Such criticisms remain prominent, despite the fact that there is a large and ever-growing number of people who use and practice these forms of healing. While there are many who would maintain that those who go outside of the allopathic

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medical establishment are simply exercising the "right to be wrong" (Hufford 2002, 17), closer inspection reveals a much more nuanced reality. This is a reality wherein official and unofficial health culture are not so easily dichotomized as belonging to the realms of "knowledge" and "belief". Instead, they can be understood as possessing different *ways* of knowing, or different methods of producing knowledge.

In large part, this different knowledge base comes down to a matter of the kinds of evidence and outcomes that are valued. Allopathic medicine has developed a strict evidence-based hierarchically-ranked system of testing which places randomized clinical trials as the gold standard in measuring outcomes. Such a system has particular strength in minimizing bias and pinpointing exact functions and reactions to compounds and techniques. As many have pointed out, however, this type of strict evidential ranking often fails to recognize the types of knowledge and wisdom that can be gleaned from less quantifiable means, such as observation, experience and anecdotes, especially with respect to individual patients. This is exactly the type of evidence most valued by many within the world of CAM. Similarly, the results, or outcomes, that are valued can drastically change how knowledge is viewed. Allopathic medicine, for instance, is typically most interested in the mechanical workings of the body, and how different pharmaceuticals and techniques affect the body on a molecular level. CAM is much more concerned with assessments of more general factors such as holistic health and overall quality of life.

Tied in with the often disparate values placed on forms of evidence and outcomes between allopathic and many CAM practices, are some core differences in explanatory or epistemologically-based frameworks. A prime example of this is the concept of vitalism, or energy. Having no corollary in allopathic medicine, no scientific explanation

as to how they could exist or work, and no merit with respect to prior plausibility, energy-based theories and practices are often pin-pointed as being particularly egregious forms of quackery. As such, they are also shining examples for many of a mis-guided or uneducated reliance on belief rather than knowledge in matters of health. Nonetheless, vitalism plays a large role in most CAM-based modalities – even ones that are much closer to, and better accepted by the medical mainstream. For those that use energy for healing purposes, then, it is not so much a matter of belief, but rather of using different forms of knowledge, and different ways of knowing.

On the surface, CAM and allopathic medicine seem to have very little in common – CAM is, after all, a residual category of all ways of healing that fall outside of the medical mainstream. As the following chapters will help to reveal, the differences between CAM and allopathy, and the reasons why people choose between approaches, are varied and complex. The root, however, is truly a matter of knowledge – how knowledge is created, how it used, what forms are considered legitimate, and who is allowed to use them. If there was a common thread throughout the voices heard in this chapter, it would be the importance of continually examining, questioning, and evaluating knowledge-related issues, particularly as they relate to health and well-being. It has effectively been argued, by academic and vernacular voices alike, that allowing the pursuit of knowledge to stagnate, or to use prevailing theories or methods to summarily dismiss that which does not currently fit into an explanatory framework, is potentially detrimental to everyone involved. Perhaps as science and medicine progress, and fields of knowledge expand, the seemingly large gap between allopathy and CAM will continue to shrink, and the lines between what is considered knowledge versus belief will continue to blur.

Chapter 5

Role

5.1   Theory

Having explored the topic of knowledge and belief in the previous chapter, we move now to a related, slightly more tangible theme. It became apparent when conducting interviews for this project that there was a pervasive interest in discussing where individuals were personally situated within the realm of health and well-being. How did people understand their responsibilities and expectations with respect to their own health or their health-related practices, and how did they understand the responsibilities and expectations of those with whom they interact? Not only was this an important discussion point, it became increasingly complex to navigate as more players became involved in any particular scenario. How, for instance, does an allopathic practitioner understand his or her role in an individual's health compared to how he or she would understand the role of a CAM practitioner, and vice versa? How is this similar or different from the expectations of those seeking help? These questions are

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all intimately connected with Romanucci-Ross's early notions of "hierarchy of resort": sequential patterns of selection and use of health care resources (Romanucci-Ross 1969), and O'Connor's reimagined "order of resort", referring to how people combine selected resources to "provide an optimal broad-spectrum response to the health problem" (O'Connor 1995, 27). Indeed, roles and perceived roles have direct influence on the kinds of care sought, and the reasons behind choice.

Although it was a complicated theme to address, it was one that brought up fundamental concepts of worldview and identity – both with respect to individuals and the groups to which they belonged. It also highlighted areas where these perceived aspects of worldview and identity mesh or clash (especially within practitioner-patient interactions), and the resulting consequences. As it will become clear, this is a topic that has direct implications with respect to reaching a better understanding of how and why health needs are or are not being met, and where there is room for improved understanding, communication and outcomes in health-related scenarios.

Despite the predominance and importance of this particular topic, however, it was difficult to pinpoint exactly what people where discussing – how to label and frame the theme. I decided early on that the most useful and hopefully universally understood terminology to employ was the concept of "role". This was the term I began using in interviews when these themes came up, and it is the term I will now employ in this chapter.

5.1.1 What is Role?: a folklore-based theoretical discussion of key concepts

What, exactly, does the term "role" encompass? Arguably, it is a term much more closely associated with sociology than with folklore. Certainly, the work that sociologists have done with the examination of a person's position and function within society (including concepts such as "sick role theory" "role allocation", "role ascription", "role set" and "role other"), is both illuminating and relevant within the current context. My approach and analysis, however, come from a folkloristic background, rather than sociological. As such, while these sociological terms and concepts are important to acknowledge and consider, they must be understood within the context of how they have influenced and been understood within folklore theory. Before embarking on the ideas and resulting analysis in this chapter, then, it is first useful to explore some key theoretical folklore-based concepts, and how these play into or affect the notion of "role".

5.1.2 Performance

Having derived in the 17th century from the obsolete French roule, the term "role" originally referred to the roll of paper on which an actor's part was written (Oxford Dictionaries 2016). Subsequently, it has become a way to describe an "actor's part in a play, movie, etc", or, more broadly, "The function assumed or part played by a person or thing in a particular situation" (Oxford Dictionaries 2016). Similarly, Merriam-Webster offers another definition: "a socially expected behavior pattern usually determined by an individual's status in a particular society" (Merriam-Webster

2016).

It is these broader, more encompassing definitions that apply here – definitions that speak to how an individual behaves in various socially prescribed situations. Nevertheless, as a descriptive term, it is directly influenced by its theatre-based origins, and must be understood, at least partially, within the context of performance. From a theoretical folkloristic perspective, then, it is perhaps most obvious to begin with a brief look at performance theory.

In the early decades of folklore as a discipline, folklorists treated oral folklore as items of literature, where analysis concentrated on various aspects of the text (Titon 2003, 71). In the 1960s, however, folklorists began to "problematize text", with some arguing that folklore should be "conceived of and studied as an unfolding, living process, as performance, not as a product of a literary text" (Titon 2003, 76). Seminal pieces such "Toward a Definition of Folklore in Context" (Ben-Amos 1972), and "Verbal Art as Performance" (Bauman 1975) eloquently argued for a paradigm shift toward the study of living, changing, expressive culture; a "full-scale and highly self-conscious reorientation from the traditional focus upon folklore as an "item" – the things of folklore – to a conceptualization of folklore as "event" – the doing of folklore" (Bauman 1972, xi). This was a large, important theoretical reorientation for the discipline of folklore, where the concepts of performance and context were used as guiding, organizing principles.

In switching to a performance-based analytical framework, emphasis was placed on the act or event in which the folklore was performed. As Barre Toelken summarized: "If the active part of folklore can be called *performance*, then the actual total occurrence of that performance, including performer, audience, and context in a time-frame, can

be called the *event*" (Toelken 1979, 147; emphasis in original). This was heavily influenced by an "interdisciplinary confluence of work" (Titon 2003, 77) by prominent scholars in fields such as sociology, sociolinguisitics, and cultural anthropology. Erving Goffman, for instance, developed the concept of "framing" as a tool for "exploring the interrelations of alternative domains and everyday life" (Hufford 2003, 146). Like a frame on a wall, which differentiates the picture from that which surrounds it, performance begins with an act of framing that separates it from the surrounding flow of events (Goffman 1974). In other words, performance events were signalled or marked as separate from ordinary goings on. Goffman used the term "keying" to describe the way that framing is accomplished, making "the point of ethnography of performance ... to determine culture-specific means that serve to key performance in particular communities" (Bauman 1975, 297).

Moreover, performance was argued to allow us to "conceptualize the social base of folklore in terms of the actual place of lore in social relationships and its use in communicative interaction" (Bauman 1971, 33). As Deborah Kapchan has pointed out, performance "is public; it needs an audience"... it is "participative", and "transformative" (Kapchan 2003, 130). As such, it follows that an individual's role within a performance-based framework is also specifically understood within the context of that same socially interactive event. Merton, for instance, proposed that a person's "role set" involved the "complement of role relationships which persons share by virtue of occupying a particular status" (Merton 1957, 369), and Goffman argued that "the individual's role enactment occurs largely through a cycle of face-to-face social situations with 'role others', that is, relevant audiences" (Goffman 1961, 85). Also integral to this concept is the notion of "communicative competence", understood

to be a key aspect of a performer's "role set". As Bauman explains, "fundamentally, performance as a mode of spoken verbal communication consists in the assumption of responsibility to an audience for a display of communicative competence... [which] rests on the knowledge and ability to speak in socially appropriate ways" (Bauman 1975, 293).

So how does performance theory play into or affect the conception of role in this particular chapter? The fieldwork I conducted was not based on interpreting specific expressive performance events, and therefore does not technically fit the confines of what performance theory originally set out to capture. The conceptions of role here were ones that were discussed within the context of individual interviews, and therefore based on the understandings conveyed within these singular ethnographic fieldwork events[1]. As it will become evident, however, many aspects of an individual's understanding of their health-related role(s) was, in fact, directly tied to their relationships and interactions with other people, and had significant impact on communication and communicative competence within health-related events. In these ways, performance-based analysis can greatly contribute to an understanding of role and role relations. Finally, it is important to appreciate how the context/performance-based paradigm shift is important from a much larger, more encompassing theoretical perspective. As Titon has pointed out, there were significant large-scale gains that came with performance, such as "a more holistic enterprise and the possibility of doing justice to

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[1]Although the act of ethnography can also be understood as performance – as Deborah Kapchan has argued, "ethnography is first and foremost performative – aware of itself as part of a dynamic process from which meaning is emergent, not preexistent and forever etched in stone" (Kapchan 2003, 18). This is, however, not as relevant to the discussion at hand.

an intuitive sense of folklore as living process; ... an emphasis on persons as well as things, and emphasis on attitudes as well as acts; ... [and] a sensitivity to the human exchanges involved in fieldwork." (Titon 2003, 78). Certainly, these directly affect both fieldwork methodology and resulting analysis in a direct, fundamental way.

5.1.3 Group

When seeking interviews for this project, I divided potential participants into three very loosely structured groups: those who use or have used CAM; CAM practitioners; and allopathic doctors. These groupings were useful not only in identifying and choosing participants, but also for conducting comparative analysis. This is especially true with respect to role. Inclusion in one or more of these groups, both ideologically and occupationally, has, as it will become evident, direct impact an individual's understanding of their own role. Moreover, role is further defined, redefined, and influenced during the interactions between these groups. It is important, then, to turn to the theoretical folkloristic concept of "group" to understand where it does and does not align with this current study.

A seemingly commonplace and innocuous term, it has been suggested that ideas about group are actually "the most powerful and the most dangerous in folklore studies" (Noyes 2003, 7). Much like performance, concepts about group began to take a prominent role within the discipline during the context-based paradigm shift in the 1960s and 1970s. In 1965, Alan Dundes offered a purposefully broad, encompassing conception of the "folk", that steered away from what was then beginning to be considered fallacious ties linking folklore with orally-transmitted survivals. He proposed

that the folk should be understood as "*any group of people whatsoever* who share at least one common factor" (Dundes 1965, 2; emphasis in original). Similarly, in 1968, Américo Paredes suggested that "American folklorists think of their discipline chiefly as the study of 'special groups"' (Paredes 1968, 70). In 1972, Dan Ben-Amos proposed a now pivotal definition of folklore that was specifically meant to focus on performative, process-orientated, communicative aspects. As he argued, "folklore is true to its own nature when it takes place within the group itself", and therefore folklore can be understood as "artistic communication in small groups" (Ben-Amos 1972, 13). All of these definitions were intentionally attempting to overcome the "classist, racist, anti-modern connotations" that had long been associated with conceptions of "folk", and to promote the equally important understanding of people as bearers, rather than makers, of tradition" (Noyes 2003, 11).

More than just attempting to redefine the "folk", the idea of group within folkloristics became, much like performance, directly tied with interaction, co-presence and communication. Thus, rather than basing a folk group on notions of shared identity, definitions such as Ben-Amos' based it on regular interaction. This is consistent with scholars such as Ernst Klusen, who argued that "group defines an exact unity of people who interact... it must be guaranteed that they all can communicate directly with each other, and that they can interact directly" (Klusen 1986, 186). Similarly, Bauman stressed that while those with a "shared identity", and who "have similar social characteristics or statuses" could be designated by the sociological term "social category", the key factor when studying group is " the interaction which is a concomitant of the performance of folklore to others" (Bauman 1971, 35). As Noyes summarizes, "if individual acts of identification create the reality of social categories,

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the reality of a community with which to identify comes from collective acts" (Noyes 2003, 29).

This understanding of "folk group" does not directly correspond with the "groups" or categories in which people were placed in my fieldwork. Despite sharing qualities that link them together under broad occupational or practice-based categories, the individuals I interviewed did not, for the most part, have direct interaction with the other members of these "groups". Moreover, those who employed complementary and alternative therapies often used wide-ranging, sometimes disparate modalities; the CAM practitioners are, in many respects, a group only by virtue of not being a part of the medical mainstream; and allopathic doctors, while much more concretely connected by training and occupation, still demonstrated a wide range of specialties (and therefore approaches) within their vocation. In these respects, the "groups" as they appear in this thesis are much more akin to "social category" than they are to "folk group". This is not to say, however, that the concept of group is not useful here, or that a case could not be made for conceiving and studying these groups as folk groups. Alan Dundes, for instance, did work showing that medical professionals constituted a folkgroup – a feat which "fit into Dundes's general goal of demonstrating that elite scientific groups defined their group identity through folklore" (Bronner 2007, 249). Indeed, as it will become clear, perceived "membership" within these broadly defined groups did have an impact on role identity, as well as issues of interaction and communication between individuals and members of the other groups. Thus, while these groups do not correspond directly with notions of folk group, important folkloric understandings can be gleaned when using group as a defining characteristic.

5.1.4 Identity

A third theoretical concept is particularly relevant to the present discussion of "role". Directly connected to ideas of "performance" and "group", it is essential to consider the contentious concept of "identity". Certainly, "identity" is not unique to folklore – in fact, as Alan Dundes has pointed out, "the scholarship devoted to identity spans most of the social sciences" (Dundes 1984, 149). Moreover, it is a difficult term to pin down, with definitions that are "often vague and fuzzy" – a feature which can "mark the presence of a primitive concept; a concept that is so fundamental to thought and discussion, that is so protean and powerful, that it in large measure escapes – indeed, is defeated by – precise definition" (Oring 1994, 212). Similarly, Roger Abrahams suggests that identity is often broadly understood as "the encompassing term for cultural, social and spiritual wholeness", leading to a large disparity of uses and understandings depending on the particular discipline and discourse in which it arises[2]. (Abrahams 2003, 198). Within folklore, the term "identity" was "largely absent from the discourse" until the 1970s (Oring 1994, 211). As Elliott Oring argues, however, "folklore studies have always been vitally concerned with identity" – that, in fact, identity as been "*the* central concern of the field" (Oring 1994, 221,223; emphasis in original). He furthers this by adding, "the definition of folklore has been anchored to a concept of identity... when we define and redefine folklore, we are conceptualizing and reconceptualizing a set of cultural materials and their privileged relation to the identity of individuals and groups" (Oring 1994, 223).

It follows, then, that despite the ubiquity and prevalent cross-disciplinary use of

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[2]See, for example, Abrahams' comprehensive list of disparity of use of the term identity on pages 202-203 (2003)

"identity", folklore has a long and arguably unique approach to the understanding and analysis of the concept. Alan Dundes, for instance, maintains that folklore is "one of the principal means by which an individual and a group discovers or establishes identity" (Dundes 1984, 151). He also adds, "identity expresses a mutual relationship by connoting both a persistent selfsameness and a persistent sharing of essential character with others... it is with this 'essential character with others' that folklorists can contribute something to the understanding of identity" (Dundes 1984, 150). Abrahams roots the concept of identity within narrative – one of a folklorist's specialities. As he maintains, "one's identity emerges from the stories one tells on oneself or one's community... each incident, each report of past experience, is transformed as an emblem of both the uniqueness of the individual... and a badge of group membership" (Abrahams 2003, 201). Identity is, Oring proposes, "what binds an idea of folk to a notion of lore" (Oring 1994, 225). It has also been suggested that folklorists are particularly well suited to analyzing the concept of identity as it is presented within the context of conflict, marginalization or "othering". It is, as Abrahams points out, "difficult to discuss identity without invoking deep stereotyping of those designated as stranger or enemy... when used to refer to self or group identification, it seems to emancipate, but when used to refer to others it too often imprisons" (Abrahams 2003, 199, 207). Dundes asserts that "minorities experience opposition more than majorities, and it is they who have more stake in defining identity – especially their own" (Dundes 1984, 150). Finally, as Oring summarizes, "situations in which identity is challenged or denied – that is, situations of identity conflict – may prove particularly prominent for [folkloristic] investigation" (Oring 1994, 226).

Not only can identity be considered a key theoretical concept within folkloristics, it is also directly relevant to the current discussion and conception of "role". As it will become clear, how individuals identify themselves with respect to health and health practices has a significant impact on their actions, their interactions with others, and their expectations. In other words, from both the perspective of an individual, and the larger social groups or communities of which they are members, identity can be understood as one of – if not *the* – most important component of how they conceive of their role within the health-related realm. From an analytical perspective, this consideration of identity within or with respect to hegemonic power relationships is also particularly useful and revealing in the current context. A large part of how an individual understands his or her health-related responsibilities and/or the responsibilities of those with who he or she interacts, can be understood as tied to a concepts of education, competence, social status and acceptability.

5.1.5 The Esoteric-Exoteric Factor

Finally, it is essential to discuss Jansen's pivotal notion of the "esoteric-exoteric factor in folklore" – a particularly role-relevant theoretical concept that includes notions of "group", "identity", and, to some degree, "performance", as well (Jansen 1959). Essentially, the "esoteric-exoteric" factor has to with group identity, and perceptions of group identity. It is a complicated concept, as it includes how members of a group perceive themselves, how others perceive them, how they perceive that others perceive them, and vice-versa. As Jansen summarizes: "the esoteric applies to what one group thinks of itself and what it supposes others think of it... the exoteric is what one

group thinks of another and what it thinks that other group thinks it thinks"(Jansen 1959, 206-207). He goes on to point out that there are three major factors that make a group liable to the esoteric-exoteric factor: isolation, possession of a particular or peculiar knowledge or training, and being held in a peculiar respect (that is, admired or favoured).

While this may initially appear confusing, it is directly applicable to the worlds of allopathic physicians, CAM practitioners and patients. As it will become clear when delving into the thoughts and understandings found within the interviews, an extremely large part of an individual's role depends on these esoteric-exoteric factors. This is particularly relevant when trying to discuss "roles" within groups as large and often disparate and isolated from each other as "allopathic physician" and "CAM practitioner", while simultaneously considering the patient, who floats between both. An awareness of this esoteric-exoteric factor not only coalesces the core folklore theoretical concepts behind the notion of "role", it also allows for a nuanced and extremely telling analysis of how these roles are imagined and realized.

5.2   Analysis

Having discussed some of the most important folkloristic theoretical concepts behind the notion of "role", the chapter now turns to the analysis of the data collected from the interviews. As an organizational and comparative tool, I have divided the analysis based on the most relevant larger group or social network to which the interviewees belonged. These include: allopathic doctors; CAM practitioners; and those who use or have used CAM modalities. As such, it is possible not only to understand the

patterned nuances of role within the context of the group, but also to directly compare it with the individuals belonging to the other groups with whom they interact. Issues related to identity, performance, group, and the esoteric-exoteric factor have an impact on concerns related to communication, worldview and quality of health.

5.2.1   Allopathic Doctors

Out of the three sub-sets of people that I interviewed, allopathic doctors are, in many ways, unique. Certainly, they are the most cohesive group of the three – they have a well-documented history, allopathic physicians all undergo similar fundamental training despite their specialties, and allopathic medicine enjoys the distinction of being the dominant form of health care within countries that have adopted a Western medical paradigm. As such, there is a large body of academic literature devoted to the topic of the evolution of allopathic medicine, including many studies devoted specifically to the subject of the role of allopathic physicians. Before getting into a discussion of allopathic role from the perspective of those I interviewed, then, it is useful to quickly explore some of the historical roots and transformations allopathic medicine has taken since its inception, and the findings and discussions the academic literature has shed on the topic of role.

Within academic literature, allopathic "role" is predominantly explored within the context of the doctor-patient relationship. In congruence with historical changes in medical practice and knowledge, so too the role of the allopathic doctor (and therefore his or her relationship to patients), has undergone a transition over the years(Jewson 1976, Kaba and Sooriakumaran 2007, Morgan 2003, Tauber 2002). As was discussed

in the previous chapter, the mid-nineteenth century saw a shift in the development of Western Medicine, wherein there emerged a critical transformation toward a new "scientific ideal"(Tauber 2002, 179). Part of this transformation involved what Jewson described as a shift from "Bedside Medicine" to "Hospital Medicine" – in essence, patient care became centralized, and professional consensus was developed with respect to diagnosis and therapy (Jewson 1976). As such, greater emphasis and importance was placed on "physical examination of observable structures", rather than "relying on verbal analysis of subjectively defined sensations and feelings" (Morgan 2003, 56). Shortly thereafter, there was a third shift, which Jewson coined as "Laboratory Medicine", that involved the development of experimental physiology and histology" (Jewson 1976, 230).

These shifts in medical cosmology had a direct effect on the doctor-patient relationship. As Jacyna summerizes, in the "patronage model" of the eighteenth century, patient control was maximized, and the authority of the doctor was minimized; but with the reorganization in the mid-eighteen hundreds, a fundamental power shift occurred between patient and physician (Jacyna 2006, 55). As such, patients' perceptions of their illnesses were given drastically reduced significance – the patient ceased to be understood as a someone with whom doctors needed to negotiate with, or defer to (Jacyna 2006, 55), (Morgan 2003, 57). Instead, doctors assumed the role of specialists, employing fragmenting clinical science that "failed to address the person qua person" (Tauber 2002, 180). This was compounded by the nature of the typical hospital population – as Bynum describes, "the poor were often in hospital because they had no choice, and did what they were told, or rebelled in their own ways and risked dismissal from the hospital" (Bynum 2006, 204).

This, in turn, led to many doctors adopting what has since been described as a "paternalistic" role – an "asymmetrical or imbalanced interaction between doctor and patient" (Kaba and Sooriakumaran 2007, 57), with embedded assumptions that "doctor... knows best", thereby allowing them to make decisions on behalf of their patients without ever fully involving them (Coulter 1999, 719). Sociologist Talcott Parsons, who was one of the first social scientists to study and describe the doctor-patient relationship, was highly laudatory of the roles within this paternalistic model. Parsons described the "ideal" role of a doctor as a benevolent, objective, emotionally detached expert. Concurrently, the role of the patient was one that entailed obedience, deference and compliance with doctors' orders (Parsons 1951). Parsons saw this as an "inevitable consequence of the 'competence gap' between medical expert and lay patient" (Mead and Bower 2000, 1089).

It was not until the emergence of psychology and psychosocial theories in the 1950s and 1960s that this paternalistic model began to be seriously challenged in the academic arena. Two early proponents of a new approach were psychoanalysts Michael and Enid Balint, who encouraged general practitioners to "improve their capacity to understand their patients' thoughts, feelings and imaginations, and also to explore their own" (Johansen et al. 2012, 571). They eventually coined this new type of approach as "patient-centered medicine" (Balint 1969). Since then, an extensive body of literature has emerged advocating a 'patient-centered' approach to medical care, and it is the gold standard by which doctors are expected to model their relationship with patients.

This is a complex, important large-scale shift in both medical approach and the resulting concept of doctor-patient relationships within the allopathic medical system.

To adopt this patient-centered model of care, allopathic doctors are expected to assume a much different role than the one for which Parsons advocated in the 1950s. This includes shedding the dictatorial paternalistic leanings that are so firmly rooted in the discipline, and striving instead to enter into a partnership with their patients. Ideally, such a partnership includes acknowledging patients as individuals, respecting and considering patients' input, and arriving at goals, outcomes and treatment options that are mutually agreed upon. Communication skills are paramount (Kenny et al. 2010, 763), as is empathy. This relationship is, as Coulter describes, "based on mutual respect for each other's skills and competencies and recognition of the advantages of combining these resources to achieve beneficial outcomes... the key to successful doctor-patient partnerships is therefore to recognize that patients are experts too"(Coulter 1999, 719).

Further complicating the set of expected roles within doctor-patient relationships is another relatively recent, but very influential paradigm within the allopathic system. As was discussed in the previous chapter, the 1990s saw "evidence-based medicine" gain popularity right alongside the patient-centered approach (Bensing 2000, 17). It is, as Bensing describes a "positivistic, biomedical perspective", (Bensing 2000, 17), which often places disease and scientifically-attained diagnoses first – "neither the patient as person nor the doctor as person has central roles" (Johansen et al. 2012, 570).

The fact that these two dominant paradigms coexist poses a unique set of problems: can and/or should physicians be incorporating both approaches within their practices, and if so, how is this accomplished? Bensing suggests that both "evidence-based" and "patient-centered" approaches are generally accepted as important, and, moreover,

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considered imperative for offering high-quality medical care, but that in reality, these two medical paradigms "seem to belong to separate worlds" (Bensing 2000, 18). If these two approaches were to be integrated, a physician would need to adopt aspects of both – he or she would employ both scientific technical medical training and evidence, and also place a strong emphasis on the patient as an individual.

With this background in mind, it is then revealing to look at how this all plays out with respect to the interviews I conducted. How do doctors view their role as a professional, and how does this, in turn, affect the way that they understand the role of their patients? How does this parallel or differ from how patients understand these relationships? Where do allopathic physicians lie within the evidence-based/patient-centered continuum?

Before looking directly at these issues, it is, of course, first important to acknowledge that in a very practical sense, the "role" of an allopathic physician can differ dramatically depending on their specialty. A specialized surgeon, for instance, has a very different job than that of a general practitioner, and therefore also a much different type of relationship with his or her patients. Of the nine interviews I conducted with allopathic physicians, three were general practitioners, two were internists, two were geriatricians, one was a gastroenterologist, and one was a pathologist. Apart from the pathologist, the remaining eight physicians had specialties that involved daily direct contact with patients, despite having different titles and specialized training. There was also a fair amount of overlap with conceptions of what was involved in their role as a doctor, and what they felt was important when treating patients. Two main themes appeared across these interviews when discussing important aspects of their professional roles, both of which shed light on the aforementioned questions. These

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themes include offering advice, and focusing on preventative medicine.

5.2.1.1 Advice-givers

One aspect that was consistently highlighted throughout the interviews I conducted

with allopathic physicians was their role as an advice-giver. Though expressed slightly

differently, the concept was remarkably similar, as is evidenced in the following quotes,

from five different allopathic physicians:

> " I see my role as being to have this specialized knowledge that helps put
> things together, to make a diagnosis, to give advice, and to follow along and
> adjust the treatment plan as required. Not to dictate to the person what
> they should do. If someone actually needs something or they are going to
> die, then I'll push very strongly for that... but it has to be contextualized
> with their own wishes and their beliefs... It is more of a dialogue in that
> way, rather than a dictation. That is the ideal. The problem is that you
> can go too far that way. You can be too wishy-washy, and the patients
> or their families most of the time won't know the important ramifications
> or the important factors that will help them make the decisions. That's
> where it can fall apart. But I prefer to recommend, rather than say, "this
> is what you have to do"."(Andrew)

> " Ideally, if I'm a family doctor, and a patient comes in, it can be a
> number of things, depending on what the patient is looking for. If you
> have someone who is health conscious already, then I guess your goal is to
> be the medical expert. If they have questions – like "I'm already pretty
> healthy; what screening do I need, what vitamins should I be taking". So
> just to provide the best advice that I can."(Breen)

> " I give people as much information as I can, and let them make the
> decision. If they ask me directly what I would do or wouldn't do, then I
> can answer them on a personal level."(Megan)

> " I have no other role than as an advice giver. I tell people – "doctor's
> orders" – if you want to order people around, join the army. You're not in
> the army; you're not my soldier. People will say "can I leave?", I'm like

"do whatever you want. If you want my advice" – "well, if you say so". No, do what you want. Do what you want, and we'll go from there. I can't work with you if all you're doing is what I'm telling you to do while I'm in your face. Hey – you're in my office for and hour, after that, you're on your own. Do what you want... I can give them recommendations, I can see them again, but I can do nothing to make them do the things I think they should be doing. And indeed, I encourage them not to do things they don't want. I say "if you don't agree with my advice, then don't follow it. It's just my advice". But if you don't want my advice, then why do we have this relationship anyway? "(Workman)

" I'm just here... to give advice as best as I see it. I try to tell them that as far as I see, I have the broadest training in at least conventional medicine, and they can determine whether they want to take my advice or not."(Moore)

The consistent idea here is that physicians possess a unique body of knowledge, and a set of diagnostic skills, which they can use to assess both the nature of the problem, and what they believe the patient should be doing to improve his or her health. What is key, however, is the implication that the physician is there to offer advice, and therefore help a patient make health-related decisions, rather than dictate a proscribed course of action. This is, in some ways, an interesting mix of both evidence-based and patient-centered approaches. The relationship described here is not truly a partnership; nor is it a dictatorship. It is one that, to a certain extent, understands the patient as an individual, and acknowledges his or her unique beliefs and wishes. The patient is both expected and encouraged to make his or her own decisions with respect to health and health care. There is, however, little to no emphasis placed on working together on a problem, or acknowledging "lay" expertise when trying to come up with diagnosis and treatment plan. In this sense, the roles can be understood to involve an expert who offers advice, and a lay citizen, who has the opportunity to either choose to comply or not to comply with this advice.

Independent of where this "advice-giver" role can be understood to fall within the evidence-based/patient-centered continuum, it is significant to note that there is an implied assumption that these physicians are not (or at least should not) be overtly paternalistic in approach. The very notion that they are offering advice, rather than dictating orders, takes them outside of Parson's dictatorial ideal. This is particularly interesting when considering that throughout all three groups of people with whom I conducted interviews, one of the more prevalent themes that appeared with respect to the role of the allopathic physician involved variations of paternalism. This was true both with respect to a medical doctor's role in relation to their patients, but also generally in terms of what it was thought that patients expected from allopathic physicians. This paternalistic role is described in many different ways, but most often comes around to issues of power, authority, and expertise. As one geriatrician revealed,

> *"Working in an interdisciplinary team and valuing what other professionals do is not the norm, I think. I liken it to – I used to be a lifeguard, and there was this idea of a "bronze god" – the lifeguard who was there on the beach, and the protector of all. That is how a lot of physicians see themselves: as the centre of the health system. The protector of a person's health. Some doctors won't even consider the input that nursing can have, or physiotherapy can have, because it's all about what they can do."(Andrew)*

Certainly, this mentality is reflected in experiences that people have had with their allopathic physicians, many referencing instances where offering differing opinions was not tolerated, as these three people describe:

> *"My first doctor...was the one who denied any association of my [thyroid] illness and what I'd been exposed to. He wouldn't even talk about that. He wouldn't even let me go there. And when I tried to make the association, he denied it. And I saw him writing it down, as well – in his notes he was denying it. So I thought, "I'm not a stupid person. I am able to speak*

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and act for myself. This is the most ridiculous thing I've ever heard. I've got legs. I'm walking out of here. This is just ridiculous". To this day, if I see that man, I can't even look at him. No time. No time for such narrow, ridiculous thinking."(Maggie)

"With conventional doctors... I've had some who say "don't tell me what your problem is – how dare you come in here and tell me what my job is" – well, because I'm the one living it. So that person and I can no longer have a relationship, because our personalities don't match... But there's an approach so much within the medical community that [a surgeon] is a demi-god. I'm sorry, if you want me to stroke your ego – that's not what you get paid for."(Grasse)

"I've had friends who have questioned a specialist, and he's said "if you don't trust me, just get out the door"."(Madigan)

Even when describing a particularly positive relationship with her physician, another woman pointed to the difference in perception between how this relationship was understood from the doctor's point of view versus the patient's:

"Well it's interesting – if you asked my doctor, she'd probably say she thought we did have a partnership, more so perhaps with me, because I take a pretty active interest in my health and I've done a lot of reading. I would like it to be more even, I think. There is still that sense of doctors as all-knowing."(Monti)

One trained psychotherapist suggested that this paternalistic role is something that is firmly engrained within the training process:

"I think just from my own personal experiences with physicians – as professionals, we're trained to believe that we're experts, and we treat people as if we are experts. I think that people are reacting to that – "you don't know everything about me; I can do this too, and I'm going to"."(Julia)

Certainly, this idea of elite expertise easily lends itself to paternalistic leanings. As one allopathic physician pointed out:

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"If you look at hypertensive patients, the more they are involved in decision making, the higher their blood pressure is after six months. Who knows more about blood pressure control – me or the patient?"(Workman)

Unsurprisingly, understanding a physician's role as paternalistic also affects a patient's understanding of how they are being treated, and what their role is within an allopathic setting. Many describe a lack of recognition of their own intelligence – of having explanations omitted, or of feeling as though they had been treated in a condescending manner. One woman, in fact, highlighted this as one of the more prevalent differences between allopathic and CAM treatments:

"[CAM is] a very different module than the conventional western medicine, where you're told what to do and how to do it and how to think, and no one even explains to you necessarily what it all means, because they think it's too complex for you. Or if they do, they talk to you like you're 6 years old. Anyway, there's a lot of gray areas in both of those, and definitely no practitioner on either side is necessarily going to do this or do that, but the overall feeling with conventional Western medicine is that you do as you're told."(M)

One woman explained this lay/elite communication divide as changeable depending on perceived shared knowledge:

" I've always been pretty lucky with having good doctors, and I've rarely had to go to the doctor. I think where I have always been interested in health care, my doctors have known that and so they've felt more comfortable talking to me, understanding that I knew what they were talking about. Whereas I find that a lot of doctors don't want to get into it with people, because you have to go so back to basics, if someone isn't already at a certain level of education, or isn't already thinking in that way. It's much different to talk to someone in lay terminology, than if you're talking to a peer or a colleague."(Diana)

As a psychotherapist revealed, this lack of engagement and perceived paternalism can have much greater consequences than simply a matter of doctor-patient relationships and communication:

> *"I've personally been to physicians and been treated inappropriately, and thought "if I wasn't a professional who knew better, I would have been bullied into treatment that I wasn't comfortable with". And they tell you "it's the only thing"; they book you for a procedure without even explaining it to you."(Julia)*

Connected with this perceived paternalistic approach is the idea of medical heroism:

> *"Society has been taught the same thing since the second world war – medical heroism – we'll cure you with this magical medical pill... People aren't taught to look at the bigger picture. Often people are leading such stressful lives that they can just barely cope, let alone thrive, which is what we're meant to do in this world."(Jarone)*

What is particularly interesting about Jarone's reference to and explanation of medical heroism is the notion that people are taught to accept this understanding of allopathic medicine. Implicit here is the notion not only that allopathic doctors are trained to adopt a paternalist role within their professional careers, but also that, reciprocally, the population at large is trained to adopt a role that both accepts and bends to this same notion. Just as doctors are taught to be "all-knowing", patients are taught to be "humble" and "passive". For instance, as one woman succinctly suggested;

> *"We're in a society where you go to your doctor and they tell you what to do. People are used to that."(McCarthy)*

Or, as a physician pointed out;

> *"People will say "if you tell me I have to, then I'll take it"."(Workman)*

This notion was poignantly displayed in a narrative one woman shared about her mother:

"I think that's historically how it has been – the whole doctor patient thing was "I am so superior", and they never question the doctor... My mom, who is 72, broke her hip, and her doctor said "it's time for you to slow down". My sister and I were both very upset by that. She wasn't raised to question that, like "wait a second, yeah, I'm 70, but I still want to be active, and be able to go up and down stairs. I want to go to a physiotherapist, and I want you to write me that prescription right now"."(Madigan)

One woman even pointed to a situation where this understanding of allopathic role and power went beyond the clinic:

" For instance, the insurance adjuster said that they feel I didn't deserve to go see a chiropractor any more based on my doctor's advice. And I said "he didn't even touch me, and he has no expertise in whiplash", and she said "well [Jeanine], he is your doctor". It's a prickly area in my life."(Jeanine)

Interestingly, though many people I interviewed expressed this simultaneous predilection toward and large-scale societal acceptance of a paternalistic approach, there was often also a strong recognition that this situation should, or is beginning to, change. As one Naturopathic Doctor described:

" I think a lot of it is the old school mentality that "the doctor knows best". For example, if my grandmother was going to the doctor, she would never question what the doctor said or what he wanted to do. These were the pills, and she was to take them three times a day, and it didn't matter what they were for – she didn't seem to care what the diagnosis was. The doctor knew, and that was what she was to follow. However, our generation wants to know. They want to be more proactive."(McKeen)

Another woman, who had gone through a number of unpleasant experiences within the allopathic system, stated:

" That's what is taught – when your doctor tells you to do something, you do it. Like, My mom was on a menopause pill that her doctor told her to take, and then years later, they find that it causes cancers, or whatever. That's the absurdity to me – why would you put so much faith in one

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human being and not put faith in yourself? That doesn't make sense to me. And there's a difference between trusting your doctor, and assuming he knows everything that is best for you. How could that be? You're the one who knows what's best for you... Often, doctors will take away your power, rather than trying to enhance your power... A lot of people give away their power very quickly and say "you fix me". Here's my life, now tell me what to."(O'Reilly)

Similarly, a CAM practitioner offered:

" I think people are starting to see through the paradigm. What's happening is that we go to our doctor, and believe that they know everything about our health – more than we do. It's not true! And people are starting to have confidence in themselves, confidence in their own judgment, and confidence that just because a doctor recommended it doesn't mean that I have to do it. And it doesn't mean that there aren't any other choices that they're not telling me about, or aren't comfortable with."(Julia)

There is a large discrepancy here between the importance placed on the allopathic 'advice-giver', and the reality of how this role is actualized or perceived to be actualized within a typical doctor-patient scenario. The paternalistically inclined 'doctor-as-all-knowing' role seems to, in practice, far outweigh the much more patient-centred 'doctor-as-advice-giver' role that is proposed in theory. This is a complicated issue, which has implications both with respect to large-scale societal allopathic medical paradigms, and small-scale individual experiences, practices, and resulting doctor-patient interactions. This will be explored in greater detail further on.

5.2.1.2 Education and Prevention

The second prevalent theme that was addressed by most of the allopathic physicians I interviewed involved incorporating preventative medicine into their practice. For the most part, this meant that they felt that one of the key components as their role of

"doctor" involved educating their patients about preventative lifestyle practices and techniques, including an emphasis on diet, exercise, and mental well-being. In some cases, this also extended into providing treatments plans that included prescription drugs and behaviour alterations that were meant to prevent further ill health in the future. For instance, one general practitioner explained that in a typical day, she would provide her patients with:

> " … resources for learning about nutrition, how much exercise they should be getting, and those sorts of things. Then along the way, should things occur where they need treatment or are unwell in some way, then providing that diagnostic and then therapeutic management. So, trying to maintain that level of prevention or comprehensive approach with the patient, while at the same time treating acute things as they occur."(Breen)

Another allopathic doctor, who founded a clinic dealing specifically with patients suffering from environmental-related illness, stated:

> " We spend a fair bit of time listening to people. We invest a great deal of energy in educating people. The principles we use in educating people are really fundamental principles of good healthy lifestyle. Nothing bizarre or strange."(Fox)

An internist expressed this focus on prevention as such:

> " I think a large part of what we should be doing, and a large part of what we do do is try to treat symptoms, or try to relieve symptoms, and then a second part of what we do is a little more difficult – it's aimed at prevention. There's a lot of emphasis on preventative medicine. So in my field… I'm trying to… treat the symptoms, but [also] prevent the heart attack or the stroke down the road."(Moore)

This focus on prevention and education is, as will be revealed further on, a feature of perceived role that is shared by most CAM practitioners, and also one that resonates with many of the patients with whom I spoke. What is particularly significant, however,

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is the recurring belief I encountered throughout my interviews that a focus on teaching patients about preventative medicine and healthy lifestyle options was specifically lacking from allopathic medicine. A medical herbal practitioner suggested:

> " There is definitely a problem with the allopathic system. There is very little emphasis on prevention. You eat a standard North American diet, you work too much, you stress yourself out, you practice these habits, eat late at night – things that are easy to change, but people aren't made aware of them. So people get sick, and then they go to a doctor, and they're given surgery, or a powerful drug with side effects, to maintain the problem or subdue the symptoms. That's the problem. People aren't taught how to take responsibility for their health, and learn how their actions affect their health." (Jarone)

A massage therapist similarly expressed:

> " I think doctors are more concerned with putting out fires... They are very busy, and are looking to save lives. Looking for things that are potentially life-threatening. Playing things as safely as they can. They very rarely have time to get into preventative medicine, and they aren't specifically trained in preventative medicine. So they are really out of their element when they are looking at preventative stuff. This speaks to the larger role in the Canadian healthcare system. We're not looking at prevention in a way that encompasses the whole person. Even prevention for things like heart disease. It gets piecemealed. We have this one narrow bit of research that says if you eat tomatoes, then you'll prevent this. That's a stupid, dumb statement. If you're going to trust your health to that sort of logic, then you'll probably wind up being sick. It's the big picture – what we put into our bodies that is harmful, or what we don't put in that is beneficial. And the type of lifestyle and activities that we engage in. This will in large part determine our health. I think it needs to be switched more from a narrow-sighted preventative in terms of heart disease etc, to something like "this is a better way to live"."(Kemp)

Another woman told a personal story of an encounter she had in this regard. There was mysterious problem she had been having that involved a slight protrusion within her abdominal area, which sometimes involved a fair amount of pain and discomfort,

as well as other accompanying symptoms. She brought the issue to a number of allopathic practitioners without successful diagnosis. As she relates:

> " The last thing that a nurse practitioner said to me was "come back when it's more problematic". I was like – "I'm into preventative medicine! I want to know what this is! I want you to try and help me figure out what this is." ... I was so shocked... Because I'm not screaming in pain, they were like "come back when it hurts worse". "Wait until your bowel has exploded". And then something strange and horrible could happen, and it's way worse."(Anne)

By exploring even just these two prevalent themes that appeared with respect to the role of allopathic physicians, a fascinating discrepancy is presented. There is, in theory, a significant amount of agreement about the ideal role of an allopathic physician. This was true throughout all three groups of people that were interviewed – allopaths, CAM practitioners, and patients alike. A shared importance was placed on non-paternalistic patient-centeredness, education, and prevention as key components of an allopathic physician's responsibilities toward his or her patients. There was also, however, a disconnect between theory and practice, as there was dissatisfaction in the execution of these roles within the general medical system. This is an important discrepancy, and one that can be further explored upon examining the ideal roles of individuals and CAM practitioners.

5.2.2   Individuals (Patients)

Having examined conceptions of the most important aspects of role for allopathic doctors, I turn now to the concept of "role" from the perspective of the individual. This is a particularly important, and often underrepresented viewpoint in health-related literature. As it will become apparent, a vernacular understanding of an individual's

role in his or her own health forms the basis of subsequent interactions within both allopathic and complementary/alternative health systems.

The first question, however, is who I mean when I speak of "the individual". In this particular case, "the individual" is represented by those with whom I conducted interviews. These were all people who self-identified as using or having used complementary and alternative therapies, and had enough interest in the subject to contact me, and be willing to discuss their experiences and beliefs. As such, these were all people who had already devoted much time, thought and effort to their own health.

Unsurprisingly, then, the most prevalent theme in my interviews with respect to the role of the individual was one of active participation in your own health – taking responsibility, making decisions, and exercising control. Assuming such a role could be argued to be a relatively obvious choice to make. Many interviewees, however, made it clear that this was, in their view, counter to societal norms. There was an agreement that North American society that has, in many respects, adopted a very passive role with respect to individual health. This can present itself in a number of different ways. As these three different women explained:

> *"I think that a lot of things have made us passive about our health. I think we assume that we're going to be taken care of, on some level. Like, if you get cancer – either you have a chance to survive or you don't, but it's out of your hands. Either the medicine will determine, or god will determine or whatever. We've become really passive in a lot of ways."(Graveline)*

> *"We've given over the responsibility for our health care to an institutional system, rather than saying "we know how to be healthy", and transmitting that."(Joy)*

> *"(Julia) It's such a cultural thing – we go to someone outside of ourselves for help, rather than turning within."*

More than simply being understood as a societal norm, however, health passivity was often depicted as highly stigmatized. Being passive, in this respect, is understood as a form of laziness, or as an unwillingness to stop engaging in unhealthy lifestyle choices. This was voiced here by both a CAM-user and CAM practitioner:

> " There are a lot of people who don't care for themselves to begin with, then go to a doctor and say "I hurt. Make me feel better"."(Monti)

> " We're in a society where you go to your doctor and they tell you what to do. People are used to that. They don't want to do the work."(McCarthy)

Or, as one of the allopathic physicians I interviewed expressed:

> " I will see people who have diabetes and hypertension and are 70 pounds overweight, and they need me to tell them to lose weight and exercise? They don't need anyone to tell them to lose weight and exercise, they need to decide to lose weight and exercise."(Workman)

One woman, who works in a hospital setting, expressed her frustration by giving the following example:

> " There's a dad, who has type 2 diabetes. He's not managing his health at all. No one else is encouraging him to manage his own health. Everyone is sitting around him, weeping and crying, and beside his bed he's got this big 2 litre bottle of diet coke, and his pack of smokes. And he's in the hospital for a week and a half, because he's about to stroke. … take control of your own life, and stop putting that crap in your body."(Grasse)

This perceived large-scale societal health passivity is a marker against which those who actively engage in their own health begin to form a counter-identity. The natural conclusion becomes a case of cause and effect – you can actively choose to be healthy, or you can remain passive, and suffer the consequences of poor health. This decision to "take control" of your own health, or to "actively participate" in

your health decision-making processes is considered to be of paramount importance. It is also understood to be a significant amount of work. In particular, research and self-education was often construed as an important first step, and included learning about particular ailments or symptom sets, general health and wellness, and specific modalities and/or practitioners. Two CAM-users described their own relationship to health-related learning:

> " After I got chronic fatigue syndrome, I became a voracious reader on health, diet, and mind-body [interactions]. So I was practicing pretty good stress reduction, and I read a lot. I became pretty well-informed, which was pre-internet."(Douglas)

> " For me, learning has always been a hobby. I go to bed with papers, and I'm starting to understand the terminology. That's my reading at night... It's a lot of work."(Rostek)

Similarly, a CAM-user who has been battling bowel issues for many years shared:

> " As soon as I was diagnosed, I started reading about nutrition and what I could do myself. You need to pay attention to what works for your body. People should be doing their own research – they need to be more responsible for their own health. I know that not everyone has the time to do what I've done, but that's ok too. If you are going to go the natural route, take the time and do it right."(Anne)

She qualifies this by giving examples from her time spent working at an Organic Health Food store:

> " People will google "bladder infection", then come in asking for what they found on the first hit. If you're going to do research, do it properly. The internet is a wealth of info if you know where to look."(Anne)

And finally, as another woman pointed out:

"I do feel like almost everything I've done, I've had to seek out. It hasn't been easy. It's been having friends who are like-minded, it's been the reading that I've done... And you know, the more I read, – there's all these convergent things that come at you all the time – coffee's bad; coffee's good, do this, don't do that... I'm at the point where I do the best I can... It's not easy."(Monti)

More than just researching, however, there is great emphasis placed on the follow-through – the importance of choosing the right tools and engaging in the proper practices to maintain or achieve a certain level of health. Again, this is most often construed as taking a great deal of dedication, time and effort, and many times also entails a shift in worldview. Prevalent examples of this involve some of the most fundamental and commonly understood pillars of health – diet, exercise and healthy mental practices. For example, one woman explains:

"My philosophy has been for most of my life, particularly in my 30s and 40s, to do whatever it is I can to keep myself well. Certain thing we don't have control over – genetics, pollution, those sorts of things, but there are things we can take into our own hands, and as much as possible, I want to do natural and non-invasive things that keep me well and healthy and feeling good. So, no caffeine, no alcohol, yoga – I've been doing yoga almost every day... Taking good care has become my way of life."(Monti)

When I addressed the issue of the time it took to maintain such a lifestyle, she responded:

"Sometimes I feel like I'm so old-fashioned – but I still think that people can take the time. You can eat well, but it's just that you have to buy the carrots, and you have to chop them up. It's easier to buy the processed stuff, but you can eat well if you take the time to prepare things. Tomatoes, carrots, cabbage – they aren't out of this world, but you have to do something with them, too, and people don't want to do that.. And it can be simple food, but just starting from scratch."(Monti)

Similarly, another woman explains:

" Even the simple act of preparing nutritious food – that's something that people often don't do – a lot of people don't even know how to cook these days. You know, your grandmother going out and picking some herbs from her garden and making a tea to make you feel better – that's participation on a family level. You're watching her prepare that tea, you learn how to do it and then use it for your own children... Those basic steps have all been removed from our lives. People are struggling to get that back ... But our lifestyles are so hectic and busy that even things like food preparation – that is something that used to take a whole day. You'd have that pot stewing for the whole day. Well who does that anymore? There's no value in that anymore."(Graveline)

Another woman told the story of her father's miraculously healthy life:

" As an example, my father was told he wouldn't live past the age of 23, because of his degenerative kidney problems. But he was happy man, and we were physically always active – as a family we were always active... He got a new kidney, and didn't reject it, and now they're traveling the world. And I mean, they eat well, they live well, they don't smoke – but he's still going strong, even though the medical community said he should be dead. And they don't understand why he's still so healthy now – they can't understand the test results. Mind over body? Absolutely."(O'Reilly)

One young woman, when speaking about her ongoing quest for health, told me:

" Probably first and foremost for the last four years has been maintaining a good diet and exercise... I have a huge amount of energy, ... I exercise – I'm really fit. I feel good in my body. Those are huge things. And that's a really important part of my life now. So that was a huge change."(M)

She goes on to say:

" I feel like every day I've been learning. I feel like now more than ever I understand how to physically ... make my body work. I know how to eat, I know how to exercise, I know those sorts of things. So I feel like what I'm increasingly interested in focusing on is the contemplation – the mental and spiritual relationship with my body. So that's why I'm interested in establishing a daily meditation practice and journaling and doing things that require more inward thought, because I know that there's a lot of room for growth there."(M)

And, along similar lines another woman states:

" Exercise is a personal therapy – I would get depressed otherwise... Also, food – how do you approach food and your environment? ... For the most part, nothing pre-packaged. No soup from a can, things like that. Lots of fresh fruit and veg. We try to be as local as we can, no fast foods. ... We believe that if you put good things in your body, it will keep you well."(Grasse)

These descriptions of the tools and practices are interesting as a demonstration of the kinds of activities and level of commitment that are considered important along a path to health. Significantly, however, when discussing this form of personal health engagement and maintenance, many people were describing much more than simply achieving a certain level of health. Connected with this active participation, there was also a strong sense of empowerment. This empowerment came, in large part, from the understanding that the ability to be healthy ultimately resides within the person themselves. Taking this a step further, the ability to control one's own health outcome is not only about choice and commitment, but it is also about being able to listen to, and understand one's body from both a physical and much more spiritual or intuitive level. This is, in many respects, the same type of inner wisdom that was addressed Chapter 4. As Bonnie O'Connor has described, "knowledge that originates in the experience and sensations of the body gives rise to a "practical epistemology" or pragmatic knowledge... personal experiences of illness and healing carry significant evidentiary weight" (O'Connor 2002, 63). This realization and resulting empowerment was often a key shift in worldview for the people I interviewed, and presented itself in many different ways, as these four quotes demonstrate:

"It's about finding your body's inner voice, to guide your healing. And listening to yourself. Basically empowering your body and yourself to

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heal. That's what I think of as alternative treatment. So that moment for me was so powerful ... because in a very powerful way, I saw the choice that I had towards health, and towards not health. And my sessions with [my homeopath] I fully attribute to letting me choose that. They opened the door. She didn't do that to me, but she opened the door to let me do it... So that moment was for me about realizing in a very conscious way that I had the ability to make that choice, and that's why it was so profound."(M)

" You know, people will say "you're so lucky, you're so thin", I think, it's not luck. I eat well, I do yoga, I walk. I work at it, but because my body very clearly says – and don't get me wrong – I like cake as much as anybody else does, but there are many times when I think "I could eat that, but my body doesn't really want it"... That to me has been really amazing. It's just a clarity of what's good, to the point where I'll crave carrots, or I'll crave fruit. My body would really rather have the apple than the cheesecake sometimes... So once you start taking care of yourself in a certain way, your body responds to that and it lets you know what it wants because you're listening to it."(Monti)

"I can breathe this stuff in, but I can also breathe it out. At a cellular level, I can breathe it out. That's when the yoga practice and the visualization [taught me] that I had the power to release all those toxins that were in my body – that I could actually do that. It was one of those "ah ha" moments. A lot of it has to do with my belief in the power of the brain – the mind, and the connection between the mind and the body. Because the moment of realization that I could breathe this stuff out was life altering, because then I realized that there was a power that was in my body, that I just had to get it properly visualized. That I didn't have to be victimized by it – that I could be more proactive."(Joy)

" What has happened to me more recently is continued body work in ... yoga and Pilates... I started to become aware of how unconscious people were of their bodies. And a lot of the problems that a lot of these people had was that they seemed very disassociated with their bodies for one reason or another. So I started to get this gut feeling that an acupuncturist can only do what you can do for yourself anyway. But it really has a lot to do with the motivation of a person; the person's ability to be disciplined about body practice. But the big thing is that the person has to be empowered, and has to change it for themselves, and not look outside of themselves for that."(Johnson)

Taken to its philosophical extreme, this understanding of a person's ability to heal themselves would see the elimination of the need for outside help altogether. As one man described:

> "I believe that in truth, I can't be limited, which then really means that there's no power greater than you. If you take this radical view, then health is your choice. But if you come to me and tell me you have cancer, and I tell you that you created that, then that's not helpful. You will start to self-blame, which is what got you there in the first place. I truly believe that at some point we will heal ourselves. The body is a creation of the mind. But we don't know how, and we don't believe it. Belief is critical. But we're a long way from that. We have to give up the fear and guilt stuff. We're in utero in terms of healing ourselves. But people have done it, which means that the possibility is there."(Beck)

This powerful understanding of a person's own ability to heal, and take primary control of their own health has a number of practical implications. As the excerpts I provided demonstrated, these implications involve daily habits or practices, and shifts in worldview for the individuals involved. They also, however, affect relationships with other people – in particular, they have a direct affect on understanding and expectation for those providing health care services. People I interviewed typically described their role within a healthcare setting as that of an active partner, or as the chief decision-maker, as evidenced by these three examples:

> "I'm like the captain of the ship, but (my General Practitioner) would be the first mate or something. The staff you'd consult before any big decision, but the decision would be all mine. The other practitioners might be the other engineers that have specialized areas."(Douglas)

> "I'm the general manager. I make things happen. But I'm also the overseer of people's health. Like if your car breaks down, you go find a person who can fix it, same thing. I see myself as the overseer. I organize everything. I know the changes; I'm the monitor. But I find that I go to

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my health provider – whether it be my homeopath or my medical doctor, to say "this is what I see the problem is" . So I'm not going and saying "what do you think?" I'm going and saying "this is what the issue is". So it's not a passive role. To me, that's rather antiquated. I mean, yes, I'm going to you for advice, but... I'm not going to sit there and expect you to draw from a blank slate."(Grasse)

"I think that the patient's role is as an active participant. Someone should be an active participant in their own health, and the doctor is there to mediate or to guide, towards going in the right direction. Any health practitioner is a guide or a counsellor, or a facilitator towards going down the right path."(Diana)

Significantly, there was, generally, a sentiment that this type of partnership was much more easily attained with CAM practitioners than allopathic physicians. As one woman explains:

"I see my role as doing the best I can to keep well, and take good care of myself. I find that what I love about any alternative therapist that I've dealt with is that we are like a partnership. They have the expertise ... But I still feel as though we're working together on the problem. I feel a partnership. I have a wonderful, fabulous relationship with my doctor – I usually see her once a year, for my annual. I don't see her more often than that. And she spends lots of time with me, she takes my full medical history; how's your mother, how's your father, but it's still more "she is my doctor; I am her patient." I trust – it puts me in a slightly different – I don't like to use the word "power" ... it's not quite the same partnership feeling."(Monti)

For the individuals interviewed for this thesis, there was an overwhelming understanding that their role as an individual involves direct responsibility and control. It involves research and education, choosing and practicing healthy lifestyle options, selecting modalities and practitioners wisely, and taking advice rather than following orders. It involves developing a relationship with one's own body and mind, and learning how to listen and understand what it is saying. It is a large investment of

time, energy, and resources, and is an incredibly important part of an individual's life, belief system, and worldview. It is a role that is at once difficult, empowering, and rewarding. Certainly, the people who were interviewed for this study are not representative of the general population. They did, in fact, self-identify as acting and thinking in ways that transcended societal norms. But they can be understood as representative of the types of people who choose to use a number of different health practices – a demographic that is growing constantly. To understand their vision of role as it it relates both to themselves and to the practitioners from whom they seek help can have a significant impact within the context of patient-practitioner interaction and expectation, as will be discussed after exploring the third and final group – CAM practitioners.

5.2.3   CAM Practitioners

In many ways, trying to group CAM practitioners together in an attempt to explore the concept of "role" is a problematic exercise. Just as the designation of "CAM" can, in many ways, be considered a residual category, encompassing all those modalities that fall outside of the allopathic medical mainstream, so too can the community of people who practice complementary and alternative therapies. It is, in this sense, a fabricated group, incorporating a varied cross-section of modalities, training and approach to healing. Moreover, it became clear when conducting interviews that many CAM practitioners had very little contact or communication with each other, even within similar disciplines. Significantly, however, despite these differences and disparities, there were a number of important similarities in the understanding of role

that appeared throughout the interviews.

One of the most prominently reoccurring themes involved variations on the idea that one of the most important roles of a health practitioner involves empowering individuals to heal, or to help heal, themselves. This ties in directly with the previously discussed emphasis on individuals' active participation in their own healthcare. It also shares similarities with the previously discussed role of educator within the group of allopathic physicians. As it will become clear, however, there are also important differences here. As a Naturopathic Doctor succinctly stated:

> " I get people who say "I've been to so many different practitioners, and they haven't been able to help me – can you help me?", and my first reaction is "no". I can't help you, but I can help you help you." That flips it to "it's not my responsibility to help you; it's your responsibility to take on your own health and for you to help you." I can help you do that, but I can't do it for you."(Purcell)

Similarly, an alternative psychotherapist/counsellor revealed:

> " People ask me what I think, and I say, "why don't you check in with your body?" And I get them to take a few deep breaths, and then ask "what does your body say about that?"... And really, they're trying to throw that power at me, and I throw it back at them, and I think that's really helpful."(Julia)

There is, of course, variation in approach with respect to how best to help people "help themselves". Similar in nature to how many of the allopathic physicians I interviewed described aspects of their own role, several CAM practitioners understood a large part of their service to be that of educator. This was true across a wide variety of disciplines – the following examples for instance, came from a medical herbalist, a CAM-based physiotherapist, a NAET practitioner, and acupuncturist, and a chiropractor:

" As a practitioner, I assess people's health and connect them with the best remedies... and educate them on how to take care of their health at a holistic level. But as an herbalist, I'm also an educator. I teach the general public about herbal medicine. I have taught over 250 workshops in 6 years, on all things related to herbal medicine. Teaching is a big part of what I do... teaching people about holism – teaching about how to think of themselves as a whole person, and care for themselves as a whole person. To understand how their stress is affecting their constipation, or their high blood pressure. Or connect adrenal burnout with PMS – to help people connect with things that they may be doing that can improve or harm their health. Holistic practitioners like myself and other CAM practitioners teach responsibility, and for me, it's largely about self-care. People can use herbs as therapies and medicines, but people can also use herbs as tonics, to maintain health throughout the seasons, without needing to medicate all the time. Managing health through good sleep, good diet, which are two things that I see are a problem with most people I deal with. Secure those things, and get people living in a natural rhythm."(Jarone)

" There are different variations of acupressure... I found one that that works well for me clinically. It is not overly complicated, which some can be. I can teach people how to do it for themselves. I am all about empowering people to take charge of this, and to not feel helpless over what has happened. I give them as many tools as I possibly can. I never tell people you must do this or that. I say, "well, we can go this route or that route"."(Jacob)

" One of my favourite things is when patients learn how much control they have over their health just by changing their diet, getting some exercise – basic stuff that we know, but we don't really know. We hear it, but a lot of people haven't experienced it. And when they come in and they really experience that, you see, even spiritually and energetically they open up. Just to see that growth in them, and the confidence from the knowledge that they have so much more control than they thought they ever had. That's great to see."(Shea)

" I help guide a person in the development of their own awareness of what is going on with them and what is happening with them. Ideally, it is good for a person to be more aware of what is going on, so that they can be more in charge of their own health care."(Heffelfinger)

> *" A lot of people that I see don't associate the physical component with the psychological component. They think they have pain for no reason, then I ask what's been going on in the last six months, and they make the connection. You help put it all together for them."(Jane)*

In some cases, this education is understood to happen at a bodily, or tissue level. One man, for instance, who was studying acupressure and acupuncture, explained, "I believe that what acupuncture does is bring awareness to portions of the body that need healing" (Johnson). Another practitioner, who was trained as a professional Rolfer, described his role as such:

> *" Some Rolfers don't even call themselves "therapists"; they call themselves coaches or trainers. They're coaching at the tissue level, where they actually have to touch, because you can't talk to tissue. But you can show it things, in two ways. You can show it that it's all locked up, then you just keep your finger there until it lets go. Also, if Rolfing is good, you can interweave movement with structural sessions, in such a way that the movement session comes in directly after the most relevant structural one. What happens is that the tissue suddenly realizes that there is an easier way to do this. Then you don't have to repeat it. You're not teaching [people] exercises – the body gets the idea by itself. They have a memory for it."(Panter)*

This role of educator or guide – both at a basic, intellectual, lifestyle coaching level, and at a more esoteric, body/tissue level – is understood to empower individuals, and allow them (or, their bodies), to have a direct role in the healing process. Of course, each practitioner approaches this education slightly differently, and accompanies it with a unique set of tools or remedies depending on the particular type of modality. The underlying philosophy, however, is the same, and includes the important assumption that, if given the proper education and tools, people can, and will, take steps to empower and heal themselves.

The role of the "educator", however, was not the only function by which CAM practitioners felt they could empower their clients help themselves achieve a level of health. Many, in fact, described a very important part of their work as "facilitating". In most cases, assuming this role of "facilitator" involved helping a person – and more specifically, a person's body – at a much more intuitive level. This goes back to the idea of "imbedded knowledge" that came up in interviews with CAM users, and incorporates the belief that a body intuitively knows how to heal. In this sense, then, the role of the facilitator is to personally access and/or help a person tap into this intuitive and imbedded form of healing. As these four different CAM practitioners revealed:

> " A friend said, "you're a miracle worker", and I said "I'm a facilitator" –
> I just allow myself to be open to whatever your body is wanting to tell
> you. And then you're able to listen. It's happening because you're the
> one who's allowing it to happen. I'm just a facilitator. I'm not a healer. I
> don't call myself a healer."(Mullin)

> " It's not me who does the healing. I can't take credit for it... [I help
> people in] recognizing that they don't need me, because they have it. So
> that's part of what I do too – I have reminders. Thought baskets and
> today cards, and candles, and different things that will help people to
> remember to breathe – like rocks... We don't know we're not breathing. It
> all comes back to the breath. It's core."(Cull-Wilby)

> " I consider myself a facilitator in helping the person to receive the universal
> energy, which will help to balance the energy in the body. Because if we
> have the energy balanced in the body, it will help offset disease. The person
> has so much control, if they realize how easy it is to let this universal
> energy come. I just say... "you have an hour. You just have to relax
> and receive this universal energy, and it's very intelligent energy; it will
> go where it should". I stay quiet for the hour, and move around. It's as
> simple as that – so simple."(Susan)

" I try to take all of that information from [the patient], and all the information from my knowledge from what I've learned, and just push it out of the way, and try to connect with the bigger picture. I've learned to trust that a lot. So if I can just be there as a facilitator instead of a fixer – if I facilitate; then we get to certain areas that are extremely important. So it's just about remembering to trust that. To get out of the way – the body will take me where it needs to go."(Clavette)

Finally, as a yoga instructor/Reiki practitioner concisely summarized:

" If there were really good research was done, you could probably show that difference between facilitating someone's health and giving them health, and really that everyone is just facilitating."(Beck)

Understanding the concept of "facilitator" has a number of important implications when exploring how CAM practitioners view their role. Much like the role of "educator" or "guide", there is significant emphasis on helping people to heal themselves. "Facilitating", however, implies a greater healing power at work – one that exists within the body, or in same cases, within a universal energy. In this sense, there is a very pronounced distinction between being a "healer" – that is, actively doing something to change a person's health – and "facilitating" a person's body or imbedded knowledge to begin the healing process on it's own. When assuming the role of a facilitator, practitioners are, in effect, simply helping a person access something that they could, theoretically, tap into themselves.

One final role-related theme that appeared throughout many of the interviews with CAM practitioners involved the notion of forming a partnership with their clients. The specific form that this partnership takes, of course, is influenced by the particular practitioner and modality. For a number of Naturopathic Doctors that I interviewed, for instance, forming a partnership involved elements such as: helping a person wade

through research that they had done on their own, tweaking courses of therapy in which clients had already begun engaging, or even just listening with interest and sincerity to "gut feelings" or "intuition" about certain symptoms or ailments. For instance, as these three Naturopathic Doctors revealed:

> " People will often start themselves on supplements, and then say "I don't know if I'm doing this right"... So they'll make an appointment with me, and say "I just wanted to check and see if this is OK", or "I think I could do it on my own, but I just don't feel comfortable with it." ... that's where I come in."(Hayman)

> " I often see people come in with stacks [of paper] – "I found this on the internet, this is what I must have". I'll look through it – certainly in our training we know what is good information and what isn't... we sort through it, hopefully in a non-judgmental way."(McKeen)

> " I've had people that have come in with piles of paper that they've pulled off the internet and from magazines et cetera, and you just cycle through it. And you say "why do you think you have this"?, and it's often either that they've been diagnosed, or that they worry a lot. It's fine – you've got to meet people where they are and start from there. I like being at their level – I mean yeah, I went to medical school, but I'm a human just like you are. I have a lot of people who come in here and say "well, I didn't go to medical school, but I think that –", and you know, intuitively, you know that. And I have to evaluate that."(Purcell)

One Naturopathic Doctor revealed that this emphasis on partnership could be understood as one of the characteristics that sets a CAM-based approach apart from a typical allopathic approach:

> " Making your own health decisions as a patient is discouraged by the medical mainstream, especially over the past several decades. To have a patients say "well, I've done some research into this, and I feel this" – that would be taken in a very negative light. That too seems to be changing, but it's hard. I understand the difficulties – I have patients coming in all the time saying "this is what I have, treat it"."(Bunin)

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At its core, this type of partnership can be understood as respecting patients and their beliefs or opinions about their own health. It necessitates taking patients seriously, and valuing their input when it comes to diagnosing and forming a means of treatment. Similar to "educator" or "facilitator" approaches, it is also one that promotes individual autonomy and participation. As one CAM psychotherapist/counsellor asserted,

> *" As professionals, we need to have more faith in our clients, and really have more faith in their knowledge; respect their autonomy, and give them some credit."(Julia)*

When examining how CAM practitioners understood their roles within a health care setting, there is great consensus with CAM users. It is also clear that there are some strong similarities between the ideal role of CAM practitioners and that of allopathic physicians. Significantly, however, this conception often differs – sometimes drastically – from how allopathic doctors understand the role of CAM practitioners and the people who seek their help. One allopathic physician, for instance, believed that CAM practitioners – in particular, Naturopathic Doctors – do not have their clients' best interest at heart. He spoke at length about the importance of established standards, regulatory processes, and internal policing mechanisms within a profession – something that he felt set allopathic doctors apart from CAM practitioners. As he explained, the most important first mandate of a physician is to "do no harm" – something that he assumed was lacking in the realm of CAM. As he asserted,

> *" most naturopaths do not abide by this. They violate it... [they] are keeping patients away from important [medical] treatments"."(OK)*

In reality, however, Naturopathic Doctors – the very practitioners that he singled out – have a strikingly similar set of professional mandates to that of allopathic

physicians. As a Nova Scotia-based Naturopathic Doctor explained, their set of professional priorities are outlined in the following order:

> " Our first tenant is to do no harm. Our second is to cooperate with the healing powers of nature. The third is to get to the root cause, which is what mainstream medicine doesn't do. Don't put a band-aid over a symptom, because symptoms are clues to what is the real cause. And then, heal the whole person with individualized treatment, and then prevent. That is what we do every day."(Hayman)

In this particular instance, then, there lies an example of assumed disparity in worldview and approach, despite two very similar fundamental conceptions of role and policy between the two systems. This could be considered a poignant example of Jansen's aforementioned "esoteric-exoteric" factor in folklore(Jansen 1959, 206).

In another example, Workman, an allopathic physician, makes assumptions both about CAM treatments and the people who seek them out. Based on his own experiences with patients, he reveals:

> "People will say,[(Workman)] "I like my coffee, I like not exercising, I like smoking – who are you to tell me what to do?" And I think one of the characteristics of CAM is that it's always egosyntonic – don't worry about your health. Don't you do anything. Just come to me and let me fix you up. You'll be different. You don't have to change, but you'll be different. And people love that – I'm going to get better and I don't have to change – perfect! What more could I wish for?"

Here, Workman is describing a situation where stereotypically passive, uninvolved individuals look for quick fix – a "healer" to take control of their health and health outcomes on their behalf. This not only completely contradicts the most fundamental cornerstones of CAM expressed by both the CAM practitioners and individuals whom I interviewed, it also actually very closely describes the problems that these same people felt were inherent in the allopathic medical system.

This same physician went on to theorize:

"I'm sure if they see an alternative therapist, they'll feel a little bit better, because they're getting gobs of attention. And everyone feels better with gobs of attention. But unless they're going to do that every day all the time, they're going to burn out... You need to change how you are, and what stresses you."(Workman)

Such a statement reveals how these two worldviews might find some common ground. There would likely be little disagreement from both CAM and allopathic understandings that time spent with a patient can have a direct impact on health outcome. This allopathic physician's insinuation, however, is that this "gobs of attention" is the sole reason that people feel better after a CAM treatment or session, which of course belittles and undermines those who use and practice CAM therapies. Following from his previous statements, it is also clear that there is an assumption that the "gobs of attention" approach behind CAM-based therapies eventually enables people to continue along a path of health passivity, when what they really need to do is take control of their health and make life changes. Herein lies yet another core common sentiment between both CAM and allopathic worldview: in order to be healthy, individuals need to take control of their health. What is significant here is the misinformed assumption that CAM practitioners are actively stymieing this important part of a person's health journey – ironically, a sentiment that many I interviewed directed at the allopathic approach.

5.3   Conclusion

Having now examined all three perspectives, we come back to the question of satisfaction with the type and levels of care provided within the realms of both CAM and

allopathy, and how this is affected by the various conceptions of role. Significantly, one of the first important observations from these interviews was the seemingly similar conceptions behind the ideal role of the health-care practitioner, and the ideal role of health-care recipient. In theory, there is overwhelming agreement that practitioners, both of an allopathic and CAM-based nature, should ideally be providing non-paternalistic, individualized patient- (or client)-based care, with an emphasis on offering health-related education and guidance. In this respect, the role of a health practitioner encompasses both helping people heal, and providing individuals with tools to achieve some level of autonomy and knowledge in helping themselves heal or maintain a level of health. Similarly, there is a large consensus that one of the most important roles of the individual in any health-related scenario is that of an active participant. Being engaged, informed, hard-working, and willing to make changes in lifestyle and worldview are all seen as important identity markers in this respect.

Despite what might be considered surprisingly similar understandings of role between CAM and allopathic health providers, however, there is a large discrepancy in experiences and conception of how these roles are actualized. While there was agreement that these ideal roles were predominantly being met within the realm of CAM, there was dissatisfaction with how they played out in the medical mainstream. Why, then, is there a disconnect between the role and subsequent care that allopathic doctors aspire to achieve, and the reality of the situation? This is an incredibly important, nuanced, complex question, with many factors that fall outside the confines of this particular chapter, but will be discussed in detail in the following chapter, "In Search of an Ideal". There are, however, a number of highly relevant role-based conclusions that can be drawn.

First and foremost, despite the outward similarities in the intentions and actions behind the ideal roles of CAM and allopathic practitioners, the underlying conceptions and resulting approaches are often different. An excellent case in point is the shared importance placed on the role of "educator". From an allopathic perspective, educating a patient predominantly involves presenting different care options, demonstrating preventative techniques, and then offering advice on what he or she would recommend as the best way to proceed. While a CAM practitioner might well include these same aspects of "educator" within his or her practice, there is often a much deeper, more encompassing nuance behind it. As both CAM practitioners and CAM clients have demonstrated, there is a large difference between simply offering education and advice, and actually providing tools to empower a person to take a direct role in his or her own health.

While this may seem to be only a subtle difference, many would argue that it has a profound effect on the level and type of care that is offered. What then, is the core difference between "empowering", and simply "educating"? Part of the distinction can be attributed to some fundamental differences in worldview with respect to health and healing. This is directly related to the previous chapter on knowledge and belief. From an allopathic perspective, "educating" is based almost entirely on providing knowledge and advice gleaned from having a scientifically-based understanding of health and illness. While this scientifically-based understanding can certainly be present within a CAM-based system, there is often *also* what would be considered extremely important emphasis placed on more esoteric concepts such as imbedded knowledge and healing powers that lie outside of what has been scientifically studied or verbalized. In this sense, "educating" not only includes the transference of expert knowledge, but it also

incorporates helping an individual access different forms of healing for themselves.

Directly related to this, within CAM practices, there is often much less emphasis placed on the practitioner, and much more emphasis placed on the individual, and the powers that an individual has with respect to altering his or her own health and well-being. Inherent here are important assumptions: not only that individuals possess healing abilities, but also that, given the proper tools, they will take the necessary steps to use these abilities. This understanding and approach places value and trust in the individual, and his or her desire and drive to successfully participate in his or her own healing. It also places emphasis on the experiences, desires and knowledge that an individual already possesses, and incorporates them into the healing process. These are all aspects that were consistently felt to be lacking in an allopathic approach. This emphasis on the individual and his or her role within the health-care scenario also affects the patient-practitioner relationship, and how a CAM-based approach much more readily lends itself to a "partnership" ideal. While an important concept such as "educator" is shared within the ideal role of both CAM and allopathic practitioners, differences in how it is perceived and executed have a large impact on the type of care that is offered to patients. This, in turn, impacts how different individuals understand a concept as fundamental as "patient-centeredness", and what it encompasses. Finally, it must also be understood that while the allopathic physicians I interviewed predominantly agreed on these ideal aspects of a doctor's role, there was also an acknowledgement that there are many physicians who do not agree or comply with these same ideals. Consequently, part of the disparity can simply be attributed to differences in conceptions of ideal role within allopathy.

It is also important to note that the root of these differences in the understanding

and practice of ideal roles cannot be solely attributed to a disparity in education, training and worldview of the practitioner. It is also important to consider the individual who is seeking care. As was discussed earlier, the individuals that were interviewed for this project were all people who already possessed an active interest in their own health, and were motivated, educated, and engaged in achieving and maintaining a certain level of health. As such, they possess many qualities of what is considered the ideal role type for a patient or individual – qualities that, many of them argued, distinguished them from the general population. These are also the same individuals who seek out alternatives - they are the people who research different modalities and practitioners who fall outside the medical mainstream, in an attempt to best meet their health needs. It follows, then, that while allopathic doctors are consistently seeing an extremely varied cross-section of the population, including, arguably, a larger contingent of individuals on the non-ideal, passive-side of the spectrum, CAM practitioners are predominantly treating individuals who are far more oriented toward the active-ideal side of the spectrum. In other words, it could be argued that part of the reason CAM practitioners are so much better able to meet the needs and expectations of their clients, is that they are predominantly treating the very people who value these qualities.

Finally, it is necessary to touch on the pre-conceived notions that can exist from an allopathic perspective on the roles and resulting practices behind CAM modalities and therapists. This is something that I will discuss in more detail in the next chapter, but it is worth mentioning here as well. Overwhelmingly, the allopathic doctors I interviewed knew very little about the extensive world of CAM, other than the tidbits that their patients had told them, scientific studies that they had read about

specific treatments, herbs or supplements and the potential interactions with allopathic medicine, and/or, in some cases, treatments that they had personally experienced. As such, there was, at the very least, generally a sentiment that the world of CAM was unknown, and therefore should be treated with caution, or, on the other side of the spectrum, that CAM was often bogus, unproven quackery, performed by charlatans, and should be considered dangerous. As such, there were, in some cases, very strong assumptions made about the intent and resulting care given in a CAM-based setting – assumptions that placed the role of a CAM practitioner in a very different light than that of an allopathic doctor. As I have demonstrated, however, there are more often fundamental similarities between conceptions of ideal role than there are glaring differences – a fact that could have significant implications with respect to finding common ground and understanding between worldviews and approaches.

In a very practical sense, this exploration into the complex web of role ideals and resulting practices could have a very real impact on the type and level of care that an individual receives. Though it is important to look at overarching themes, and generalized worldviews and conceptions about health and health-care provision, in the end, most of the tangible results depend upon the individuals involved, and the interactions that take place in a clinical, or health-related setting. This circles right back to some of the theoretical conceptions discussed at the beginning of this chapter – especially those concerning performance and identity. The pieces that make up individuals's health-related identity directly impact how they conceive of their role with respect to health and health care.

Also important are the exoteric assumptions that individuals make about the identity and resulting roles of the people with whom they interact. When placed in a

performative setting, differences in how these roles are conceptualized and actualized can very quickly disintegrate into a break-down in communicative competence. This is consistent with relatively recent research, for instance, which directly assessed specific clinical encounters and how they were interpreted by both the patients and the physicians, and revealed that "doctors and their patients have a very different perspective of the doctors' communication skills occurring during routine clinical encounters"(Kenny et al. 2010, 763). Discrepancies in conceptions of role could help explain why these break-downs in communicative competence occur, and how they can be avoided. They also help explain how, despite apparent similarities in ideal role, patients who are inclined toward active participation in their own health often end up with better rapport and results in a CAM-based setting than with their allopathic physicians. Indeed, without a clear conception of of how an individual views his or her role, and what they do or do not expect from the other(s) within a clinical encounter, effective communication and optimal results will remain difficult to achieve.

Chapter 6

In Search of an Ideal

6.1 Introduction

As the previous two chapters have highlighted, the individual quest for health can be incredibly complex and, and times, difficult to manage. For many, this is in no small part due to differences inherent in the worldview and practice of the allopathic medical establishment with that of the world of complementary and alternative health. While many such challenges can be considered relatively universal in this respect, others must be understood within more specific parameters. Such parameters are marked by issues as personal as the individual patients and practitioners involved in a health-related scenario, or as broad as the inner workings of a nation's health care system. Though the predominant medical underpinnings of the Canadian health care system are part of a much larger Western medical tradition, for example, aspects such as Universal Health Care make certain experiences and practices within this system much different from their corollaries within other systems, such as those in the United

States. There are always a myriad of issues at play at any given time – issues related to access, ideology, economics, infrastructure, politics and hegemony.

Despite the complex web of often disparate ideas and approaches to health, there is arguably always a common goal. From the individual, right up to the most influential political, medical and academic groups, there is an ongoing quest to find some version of an ever-elusive ideal. In an ideal scenario, how would an individual's – or, indeed, a nation's – health care needs best be met? What would an ideal approach to health and health care look like? How would it work? Is such a goal even attainable? These important questions are ones that are constantly under review, from any number of different disciplines and approaches. While it does not seek to find any concrete answers, this chapter will explore issues related to the idea of an ideal health care scenario from a folkloristic perspective. It will investigate where the healthcare system works, where it fails, and how it might – if even incrementally – move toward a vision of "ideal".

6.2   Applied Folklore

To tackle a subject with direct and tangible applications, it is important to first understand the theoretical underpinnings and precedents set within the realm of applied folklore. The concept of applied work is not universally understood and agreed upon, especially throughout different disciplines. From within folklore, there have been a number of definitions, many of which at least share similarities. As a term, it was employed occasionally in the 1940s and 1950s, particularly by Benjamin A. Botkin, and then later "found currency by the late 1960s and early 1970s" (Jones

1994, 2). In 1971, there was a conference on applied folklore, wherein a definition of the term was agreed upon by a committee of prominent folklorists. The definition read: "We define applied folklore as the utilization of the theoretical concepts, factual knowledge, and research methodologies of folklorists in activities or programs meant to ameliorate contemporary social, economic, and technological problems" (Jones 1994, 11). Michael Owen Jones, in the introduction to his edited book aptly entitled Putting Folklore to Use, elaborates on this definition: "The field of applied folkloristics ethically utilizes concepts, methods, and theories from the discipline of folklore studies as well as its own specialization to provide information, the formulation of policy, or the initiation of direct action in order to produce change or stability in behaviour, culture, or the circumstances of people's lives including environment and technology" (Jones 1994, 13).

While both of these examples try to get at the core aims and uses of applied folklore, David Hufford arguably offers one of the most straightforward definitions. As he states, "the term applied folklore most usefully refers to the application of knowledge from folklore studies to the solution of practical problems" (Hufford 1998, 295). As he points out, this gets around the dilemma wherein definition is confused with description – a situation wherein one can inadvertently "exclude a variety of possible folklore applications and include many activities in which no specific application is evident" (Hufford 1998, 295). Hufford also felt it was important to recognize that, even when conceived of within the discipline of folklore, and from a folkloristic perspective, all applied work "*must* be multi-disciplinary, and it must be organized around the real world goals it seeks to address" (Hufford 1997c, 65, emphasis in original).

The notion of applied research and work within folklore studies can, and has, been

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used in a variety of genres. With the above definitions and guidelines in mind, however, it easy to see how applied work is a particularly good fit within folk medical studies. Hufford, for instance, contends that he has "always considered 'folklore studies and health' to be a primary example of 'applied folklore' " (Hufford 1994, 120). Indeed, there are a number of excellent examples of applied folklore and health work with which Hufford was personally involved, both with respect to research papers and actual projects that he developed and implemented.

One project in particular serves to effectively demonstrate this point. Hoping to help improve the medical education process, Hufford founded what became known as the "Diversity in Medicine Project". His contention was that physicians need to not only acknowledge vernacular illness experience and understanding as valid, but that they also need to have a way through which they can learn important pieces of information, such as "what kinds of health practices people use, who uses which ones, how they are believed to operate, what their impact on health and healthcare might be, and how to speak with patients about them". Along these same lines, he argued that physicians had to be taught how to properly approach the elicitation and analysis of illness narratives, and proposed that this be addressed within the medical education process. Working with the already established system, this project simply adjusted the use of cases – that is, written simulations of a medical encounter – which help medical students "learn problem solving skills in coming to diagnosis and deciding on treatment" (O'Connor 1997, 72).

Another classic example of applied health-related work from the perspective of folklorists is one that was described in the first chapter of this thesis, but deserves a closer look here: Briggs and Martini-Briggs' Stories in the Time of Cholera: Racial

Profiling during a Medical Nightmare. Using narrative and narrative analysis, Briggs and Martini-Briggs were able to highlight some incredibly important aspects of a devastating epidemic. Not only did they reveal the harsh reality from the point of view of those who suffered most from the epidemic, but they were also able to expose the often heavy handed, manipulating and unjust powers of the more official voices and authorities. Their goal in writing this book was therefore very much an exercise in applied research – as they stated; "we hope to provide everyone who is affected by social inequality, stigma and disease – that is, all of us – with new tools for figuring out how institutions can be run, studies carried out, and lives lived without resorting to a denigrating process that ultimately denigrates us all" (Briggs and Mantini-Briggs 2003, xvii).

Excellent applied health-related folklore research examples abound. Also discussed in the opening chapter to this thesis, Healing Logics, is a case in point. It is a collection of essays contributed by folklorists and other medical ethnographers, many of whom have worked directly with formal medical institutions. As the book's editor, Erika Brady explains, these researchers specifically aimed to apply their "ethnographic expertise to contemporary problems in medical education and practice" – what Brady describes as a "relatively new area of applied folklore" (Brady 2001b, 11). There have also been a number of recent publications using legend and rumour analysis to shed light upon timely subjects such as health epidemics and public health education. Diane Goldstein, for instance, has examined how AIDS discourse, in the form of narrative, not only shapes vernacular responses, but also influences official and scientific approaches to the disease (Goldstein 2004). The applied contribution here extends beyond discourse concerning AIDS itself, and extends into public health policy and practice. In a similar

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vein, Lee's recent book on the SARS epidemic attempts to shed light on how the particular types of vernacular narratives that emerge during health epidemics can harm public health efforts, and offers practical insight into the ways to help combat these types of rumour and legend circulation in the future (Lee 2014). Finally, Kitta tackles the controversial topic of "vernacular beliefs and practices that surround the decision to *'not'* vaccinate", with an eye toward providing "concrete recommendations for improving inoculation promotion programs" (Kitta 2012, 2).

The scope and quality of work conducted by folklorists within the field of applied health speaks both to the unique skills that folklorists can bring to the subject, as well as the vast potential for valuable application of the research. It is with this theoretical and practical background that I turn to the subject of ideal health care scenarios, particularly with respect to the interface of CAM and allopathic medicine. Though this is a subject that has broad, far-reaching implications, this particular set of interviews also sheds light on the New Brunswick and Nova Scotia perspective. As will quickly become apparent, this is a complex topic, with no easy or concrete solutions. It is, however, one that can offer much by way of highlighting and describing the most important issues and perspectives of stakeholders who – like all of us – are directly involved and affected by the healthcare system.

6.3   Challenges

To search for an ideal presupposes the need for change. Certainly, within a system as vitally important, multifaceted, comprehensive and far-reaching as that which caters to the health of a population, there are many areas at any given time that can be

pinpointed as needing to be changed or improved upon. The problem, of course, is that those parts of the system that are seen to present challenges vary widely depending on the individuals using the system, and the seemingly endless variables inherent in particular places or scenarios. From the perspective of those I interviewed, however, there were distinct topics that surfaced with some regularity – ones that speak both to the challenges faced by those within a Canadian (and more specifically, Atlantic Canadian) health care system, and more broadly those faced by people trying to navigate the official and unofficial worlds of allopathic medicine and CAM.

6.3.1 Time

6.3.1.1 Patient-Practitioner encounter

One particularly predominant challenge-related theme throughout the interviews I conducted involved the issue of time. In many cases, the concern involves the positive and negative impacts associated with the amount of time a practitioner is able to spend with his or her patients. Though the crunch for time within the allopathic system is one that has been clearly expressed as a general, system-wide concern, it is a matter that can differ in severity and consequence depending on what kind of physician a patient needs to consult. Arguably, it is seen most clearly and frequently within the realm of primary care. Overwhelmingly, there was a consensus among those I interviewed – from allopathic doctors, CAM practitioners, and patients alike – that the current health care system does not allow for allopathic general physicians (GPs) to spend nearly enough time with each patient. Many mentioned what is colloquially known as the "10-minute", or "one or two problem per visit" rule as the most obvious

indicator of this problem. Not only is this understood to foster poor therapeutic relationships, but to also potentially hinder diagnosis and subsequent treatment.

As these four separate people (three CAM practitioners and one CAM-user) explained:

> *"The issue of time is a big one, because [doctors] are constantly putting out fires, rather than dealing with preventative medicine."(Julia)*

> *"MDs often only talk about one condition. I've had patients tell me that their doctors have told them to book two different appointments for two problems, even though they're connected."(McKeen)*

> *"The other thing I hear a lot of is "I hate that I'm there for 3 minutes, and they reach for the prescription pad"."(Murphy)*

> *"You can't talk about mom and baby at the same time – to do that, have to book back-to-back appointments. There are huge things that need to change in the health care system, because right now it's not working."(Grasse)*

These criticisms were not only voiced from outside the allopathic system, however – many allopathic physicians also acknowledged the problem. These three doctors, for instance, a pathologist, a GP, and a gerontologist respectively, all voiced their concerns with the issues of GPs and time:

> *"You know, they have signs on the wall now that you cannot come with three problems — it has to be two. OK, so what is it now – my right ear was hurting yesterday, but I can't bring that up."(Kati)*

> *"As for the 10 minute rule – if you only have one thing, and it's acute, then that's probably enough time, but to then dig in and be more comprehensive, it's probably not. In terms of having a sign that says "one problem per patient" – at some point in my training, that was addressed as not a good*

approach, because how does a patient know that two of their symptoms aren't connected? If you have a whole list of things, you at least have to have the opportunity to go through the list. And whether or not you then schedule follow-ups to address other things – that's fair. But to think that a person can only mention their sore ankle, and not their sore hip... It's to the point that some doctors have signs; one problem per patient or per visit."(Breen)

"If you look at one problem at a time, you miss the complexity of whatever is wrong with the person. The medical system is crude now, but it was so crude when it started."(Andrew)

Significantly, while it was generally acknowledged as a problem, the fact that GPs get to spend so little time with each patient was also understood to be out of their control. The fault was seen to reside within the system, rather than the physicians themselves. Whether working within a fee-for-service paradigm, or a as a salaried position, the inherent difficulties were the same: to take longer than 10 or 15 minutes with each patient would mean a great financial and career sacrifice for the doctor. As one GP explained:

"There are no rules. But you only get paid 25$ a visit, and you have to pay all your overhead for your staff. So if you take more than 15 minutes all the time, you're going to be losing money. Some Naturopaths take a few hours for their initial visit, and I never get that much time with a patient, unless you pay out of pocket."(Megan)

Even CAM-users and CAM practitioners, however, acknowledged the fact the most GPs are simply working within a flawed system. These four individuals expressed this sentiment:

"The 10 minute/ 1 problem thing isn't the fault of the GPs. They wouldn't make a living otherwise. You're asking them to have a really fast-paced stressful job."(Hayman)

"If your GP is going to meet all his overhead and pay his secretaries and pay his legal fees and registration fees, he needs to see people every 7 minutes. So it's economics – it's not that they don't care; its that they don't have the luxury of time... I don't blame the GPs for that – they're just trying to do the best they can."(Murphy)

"I know a doctor who tried to spend an hour with each client, but after a year realized she just couldn't do it and make a living."(Clavette)

"You know, I think a lot of doctors really really care about their patients. They don't have the time – they're spinning their wheels with their caseload. Just being kept up to date on what's available and what's out there – I feel for them."(Rostek)

While the issue of time – or lack thereof – was certainly seen to be a problem within the realm of general practice, it was clearly not limited to GPs. As one gastroenterologist revealed, for instance,

"Ideally, you talk to people first in the office, to have a conversation, but the stats are staggering about how many are waiting. 1200-1600 people are waiting. General wait is around 1.5 years. Office visit is 7 months. It's getting almost impossible to meet with people in the office, because I do as much time in the clinic as possible. Even then, I'll at least have a conversation with people before I do a procedure. This is particularly bad in Fredericton, but it is a problem Canada-wide. I can't come close to meeting the guidelines."(OK)

Even when allopathic specialists are afforded a larger amount of time with patients, there is still a sentiment that it is not quite enough to be as thorough as they would like. As one Internal medical practitioner revealed,

"I think I'm a lot more fortunate than – well, it's different. I think I'm a lot more fortunate in terms of time than a family doctor is, who has, say, 10 minutes. Typically I've got consults booked for half an hour, and depending on how complicated it is, that's usually enough time to establish rapport, meet the patient, get all the background and examine them, then

give advice and make a plan. But it is tight. Especially if it's complicated. I think I'd like to have more time, but the volume of demand doesn't really allow it."(Moore)

Just as there is wide acknowledgment that allopathic physicians are typically unable to spend enough time with their patients, it is also generally accepted that ample time with clients is a particularly important aspect of many CAM practices.

As one Naturopathic Doctor stated:

"Medical doctors really only have 15 minutes with a client. I have 45 or 90 minutes. So the information I'm going to know about a client vs what they're going to know about a client is much more in depth on my part."(Purcell)

The importance of time within the CAM world was expressed not only by practitioners, but also by patients:

"My chiropractors and massage therapists and other CAM practitioners are fantastic, and as close to the holistic model of care as I've come across. They always want to know how I'm doing, and I get the feeling that they have more time to spend with me. There's time to get the whole health picture. For instance, I can bring up that my foot has been hurting, and they'll piece together the fact that this is affecting my hip. Whereas if you go to a doctor, you're only allowed one thing. What's that about? Where did holistic health go? I was so shocked! I told him one thing, and he went "Ok, thank you", and he got up and went to the door, and that was it."(Jeanine)

Significantly, when CAM practitioners were perceived to run their practice in a fashion more closely associated with the allopathic medical model, it was understood to be unacceptable. M, for instance, explained the following scenario, wherein she discontinued seeing an acupuncturist who did not spend enough time with her during repeated visits:

"[My acupuncturist] had a [long] sit down with me on my first day, and she was great, and I was really encouraged. I was like, "this is going to be awesome"" You know, she heard all about my story, was horrified I hadn't had a period in so long, said 'we're going to help you; we're going to bring it back'. I was really encouraged. But that was the most I ever spoke with them. After that, there was really no dialogue, and it was just very like – you go in, you change, they put pins in you, and you leave. It just didn't work for me."(M)

Though rare, there are also examples to be found within the allopathic system where time with patients is prioritized. Dr. Fox, for instance, who runs a centre for Environmental sensitivity in Nova Scotia, explained:

"it takes more time. Like a new consult for me – you know a dermatologist may spend 15-20 minutes, but when I see a patient it will take me an hour and a half. And when you're dealing with somebody where their life has changed dramatically and they lose their house or their marriage is falling apart because of their illness. Or they're losing their profession. It takes a bit to gather the information and to understand what's going on. And of course one of the challenges in medicine, the way it's paid for, is that that's not really recognized as being something worthwhile. So we spend a fair bit of time listening to people."(Fox)

Connected to the issue of time spent between healer and patient is that of the timescale involved with respect to proscribed treatment. Whereas the allopathic medical system has typically become characterized by fast-acting pharmaceuticals and surgeries, CAM modalities often rely on less direct treatments, or ones that take much longer to see results. As one accupressure practitioner explained;

"It's the time scale that these modalities work on that is a big difference between them. Body work, for instance – for me to notice significant changes in my body and in my posture, and in my well-being, it's going to take 10 years, maybe. Whereas certain ailments can be fixed really quickly with drugs. Or, temporarily by drugs. However, as a result of my new wellness and feeling good, I may not get sick as often, and may not have to take those drugs. I'll have a very strong immune system. That is the really

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significant difference. One works on a time scale that most humans can't grasp. What people want is a quick fix. They'll wait with this discomfort for a long long time, until it is severe. That's one of the big challenges for bridging these two types of medicines is the timescales. Time is huge. I know that the immediate benefits of yoga you'll feel after every session, but the long term effects you won't recognize yourself. If you can compare this person with this person, you won't even recognize yourself."(Johnson)

Though slightly less straight-forward, this issue of timescale is one that is directly connected to epistemology and worldview, and involves aspects both relating to the knowledge/belief dichotomy and the concept of role, which were discussed in previous chapters. It is also, however, intimately connected with how much time is spent between practitioner and patient, the argument being that short visits do not allow for much more than quick solutions.

The issue of time, then – predominantly time spent diagnosing and treating patients – is one that has been pinpointed as an important factor affecting people's health and wellness both within academic literature and from those who use and practice healing techniques. Though exceptions clearly do exist on both sides of the spectrum, there is a widespread acknowledgment that the allopathic medical model exhibits a failing in this regard – there is simply not enough time to spend with patients, especially within primary care. Though solutions continue to be presented from within the allopathic system, the problem continues to exist.

In many respects, most CAM practices are often perceived to fill in this gap, offering patients or clients significantly more time both with respect to diagnostics and treatment. Not only is this understood to promote a much better therapeutic relationship, it also creates the necessary conditions to treat a person from within a holistic perspective. Physical ailments, lifestyle, and often the health of the body and

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spirit all considered in tandem, rather than dealing with one isolated problem at a time.

As these experiences show, allopathy and CAM can be considered diametric opposites on the issue of time. Allopathic doctors are stuck in a system where they cannot provide enough time with their patients, and CAM practitioners are able offer a service that allows the time necessary. In other words, they are considered two very different systems, trying to internally manage the challenges they respectively face.

6.3.2 Money

"You can't be poor and healthy in this society, I don't think. You just can't."(Susan)

The issue of money was a theme that surfaced in most interviews I conducted, both from within allopathy, and the CAM community. This may at first seem surprising within a system that grants free universal healthcare to all of its citizens. When all people, regardless of income, are guaranteed to be covered by Medicare, what scenario would prompt quotes such as the one above, insinuating that in order to be healthy, one must also have means? The answer, of course, is complicated and multi-faceted, and and involves any number of different issues.

As many of the above time-related quotes demonstrated, one of the money-related problems within the allopathic system is a matter of the inability to both spend adequate time with patients and simultaneously make a living. When doctors – particularly, family physicians – get paid on a fee-per-service basis (as the majority of Canadian GPs do) (Wranik and Durier-Copp 2010, 35) , they must cycle through a large number of patients in a day, offering only short visits with each one. There is

therefore a direct relationship between time and money. As one GP explained,

> "It's hard. You run late; you get people coming back ... I don't like it. I don't like fee for service at all. It's the way it is with Medicare."(Megan)

For allopathic physicians, then, the issue is not one of patients being unable to afford healthcare, but rather of being caught in a cycle wherein their services are not always adequate or optimized. Within the CAM world, the problem is often exactly the opposite. For many CAM practitioners, time spent with patients is prioritized heavily. The trade-off, however, is that these services are often very expensive. As many interviewees revealed, even though a fair number of extended health care plans will cover some CAM services, these plans are always limited by the type of services covered, and the amount of coverage allotted to each one. They also typically cover only a percentage of a visit, leaving the client to make up the difference. Furthermore, to even have an extended health care plan, a person either needs to be employed by an institution or company that offers such additional coverage, or have the money to pay for the coverage themselves. Consequently, even those who prioritize CAM treatments, and feel these services are making a positive difference in their health, often have to make difficult decisions based on finances. These five CAM-users, from both Halifax and Fredericton, expressed these concerns and experiences in similar ways:

> "If it weren't for money, I would do so much more, because I know I could be so much healthier. If it was part of a lifestyle to have a weekly massage in this world, then I think the world would be so much nicer. I truly do. There would be a lot fewer major problems. A lot of people search, and never find."(OReilly)

> "I have always believed in massage therapy. It makes so much sense, but it really only makes financial sense if you are covered. I have been blessed

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with employment opportunities that have let me take advantage of CAM, but I think it's a crying shame that those that don't have as much don't have the same accessibility, which really peeves me. Because if we did have it, we wouldn't have all the illnesses we have. It's a never ending circle."(Rostek)

"Sometimes it's money. I'd love to go see a chiropractor right now, but I don't have the money. For awhile, when I had a plan, I'd go quite often. Money is often the main factor, I'd think, why people wouldn't go see an herbalist. The main thing with people."(Grasse)

"[My acupuncturist] was really good, and if I could afford her services, I'd see her every week. She gave me acupuncture treatments, and it was just amazing how much emotion those always bring up, and I love how they feel. I can feel all the points tingle, and I read about the points, and I know which ones are important to my condition, and I could really feel them. I have total faith that those were healing."(M)

"It's interesting, I'm now at St. Thomas [University], and my health plan there covers not very much. Some chiropractic, so there's a recognition. But what I've just been going through – at the beginning I was seeing him twice a week, and my health plan covers 250$ worth of visits. Well at 40$ a visit, it doesn't take long for that to be gone. So it's kind of a half-way recognition. It's recognition that people are entitled to that, but now I'm paying for my chiropractor, and I don't begrudge that, because it's helping me. But I have to make that decision. Not everybody can. And some people have no coverage at all."(Monti)

Also related to time and money is the previously discussed timescale factor. Many therapies within the CAM world can take multiple visits over an extended period of time for the client to truly gain the results they are looking for. This means, however, that it can become unmanageably expensive for people to continue a therapy the whole way through its course. This is not only true for those without extended coverage, but also true for those whose coverage is capped at a certain amount. Anything above

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and beyond that limit becomes purely out-of-pocket expense. This was expressed by both CAM-users and CAM practitioners, as the following three quote demonstrate:

> "If [a therapy] doesn't work, then you have to pay for another session, and then another session etc. So what happens in those situations is that someone will finally have to say "this isn't working", and they may bail out too soon, and it may not work because they didn't follow through. But on the other hand, enough is enough. So that is a very difficult thing to bridge."(Johnson)

> "I don't know how long I can continue with [my homeopath] – it comes down to finances. She says you need to give it a fair shake or else you're just throwing your money to the wind – you have to be committed it to it, which is hard for people to wrap their heads around. They're used to the pill and the magic solution. Then it often just comes back again."(Rostek)

> "So it's down to the people who afford it, and who have health care plans. For those people, it's great. Many of them don't have adequate access – they may need more treatments than they can afford, especially with the lymphatic drainage therapy. That's the case a lot of the time, because most conditions require a large number of sessions to get them under control. That might be ten sessions. So you're talking 750$ worth of services, just to get treated. And then there's maintenance, maybe once a month. For some people, it's worse."(Kemp)

To further complicate the issues of insurance and reimbursement, decisions related to the types of treatments that get covered, and what patients are allowed to claim can get very convoluted, and can sometimes involve third-party examiners who are not familiar with the internal workings of the various CAM modalities and systems. As one CAM-user explained:

> "Independent Medical Examiners are used by insurance companies to independently assess a person's condition. One of them that I went to see determined that I was "unwilling to work with the medical community, and experimenting with pharmaceuticals, and only wants passive interventions".

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He never actually touched me to assess my physical condition. I got a call from the insurance company a few weeks later, and they said "you're not getting anymore money from us". I was at the point right then where I was about to hock my guitar to get a chiropractor appointment."(Jeanine)

More than just the cost of the appointments themselves, there are CAM services that include extra cost to the client. Much like an allopathic doctor would prescribe pharmaceuticals to treat a symptom or ailment, practitioners such as Naturopathic Doctors, homeopaths, and medical herbalists will often recommend taking various different tinctures, remedies, or supplements as part of the therapeutic process. Whereas prescription pharmaceuticals are often covered in health care plans, however, these CAM remedies are not. Therefore this is either an (often large) extra expense, or it is simply not considered affordable by those to whom it is prescribed. As one Naturopathic Doctor described:

"I would say that 80% of my patients say "OK, my coverage is for services, but not for supplements. So basically, I can't afford it". Nova Scotians typically either have a lot of money, or you don't have a lot of money. There isn't a big in-between, which is why it works so well in a place like Calgary. It's people's incomes, or it's their own mindset, where they aren't used to paying for healthcare, so anything they have to pay for is expensive. It's a matter of where their priorities lie. For the people who can't afford it, I try to do as much as I can through nutrition, so they don't have to buy supplements and things. But sometimes supplements are needed and I just say "you're going to have to make a trade-off – stop buying your Starbucks coffee or whatever, and make a trade-off"."(Hayman)

Clearly, then, money is seen as an issue for both patients and practitioners of CAM. In a system where allopathic medical coverage is a right and benefit for everyone, CAM services are often understood to be accessible only to those who can afford it. This is especially true for services that are not covered by extended healthcare plans, therapies that work on a long timescale (necessitating repeat visits), and for

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any remedies that must be purchased above and beyond treatments. Though there have been no easy solutions offered in this regard, there are those who expressed ways in which they have work-arounds. For some, this is simply a matter of reprioritizing how to spend disposable income – in effect, breaking out of the mindset that all health services are, or should all be "free". As one Naturopathic Doctor revealed:

> "One of the barriers in Canada is that one of these is publicly funded, and one is privately funded. In the States, you are paying your MD and ND, and you would expect the same out of them; and expect them to work together. Whereas here, one is free and one isn't free."(Murphy)

A homeopathic practitioner expressed this thought more fully:

> "I have to say something to the defence of affordable – sure, if you're on welfare, then alternative health care services would be hard. That would be a special situation. But I know an awful lot of alternative health care practitioners who are willing to reduce fees. In a lot of cases, it's priorities. How much it is worth. I charge, in terms of professional fees, very modestly. You go to a psychologist or a lawyer, 150$ or 200$ minimum. Go to a mechanic – car mechanic or a plumber; 65$ an hour. It's a perception; what's important. Ultimately good health is priceless. I think that by just saying the government should pay for it – that takes the responsibility away from people. I think base services – that's really good. You don't have to decide between your health and being on the street. That's really good. But the rest is sort of interesting to look at."(Peisinger)

Similarly, a CAM-user, who credits her repeated CAM treatments with saving her life, advised:

> "Don't throw away a year of your life. Get on it. Spend the 70$ a visit or whatever it is. And if it's going to cost you 700$ to have your life back, well you'd spend that on foolish items. Spend it on something sensible. The medical system makes people expect everything is going to be covered, but you can spend 700$ and do the 10 visits or whatever it takes."(Maggie)

On top of advocating for a shift in priorities or mindset around health care spending, there were a large number of CAM practitioners who revealed that they offer special

accommodations or reduction in price for those who, for whatever reason, cannot afford their services. Often, these involved a sliding scale of payment depending on what clients could afford, but it also involved barter and exchange. The following examples, taken from a wide range of different modalities (medical herbalism, Rolfing, midwifery, life coaching, Quantum Touch, and naturopathy, respectively), offer a glimpse at the types of accommodations that are made regularly in this regard:

> "Some people with special health plans can be covered. There usually isn't a box for "herbal practitioner", but there is a box for "other", so some have had it covered that way – I just have to send a letter or my brochure or whatever. I also offer a sliding scale – I don't turn anyone away." (Jarone)

> "My base rate is 115$, and that's for anywhere from an hour to 1.5 hours. I give discounts for pre-payments of lots of sessions; I give discounts for students. If someone is really bad off, or can't work, I'll make a rate at whatever they can afford." (Panter)

> "We have a sliding scale, and try not to turn anyone away. We've had some clients who pay us almost nothing, but the usual scale for all of it is 1000-2000$. But there have been people who pay a few hundred. If it was regulated, it would be covered." (Muriel)

> "I saw someone the other day suffering from diabetes, and the conventional thing isn't working for him. I asked if he'd seen anyone alternative, and he said "no, I can't afford it — I'm on disability". I said, "if you want a life coaching session, I'm here for you – my first one is always free anyway. Maybe we can get you going in some positive directions." He hasn't taken the offer up yet, but he said "that's really cool of you". It's time for him to receive. I think there is a block for many people – it can be expensive, but I've managed to do it on a budget. I've done a lot of my stuff through exchange – I had this life coaching tool." (Quigg)

"People don't pay me until it works for them. If people can't pay now, they can pay me later. If it doesn't work and they can't ever pay me, I'm alright with that too. This can be not the most financially viable technique, but I decided I can't do this type of work and then just not help somebody. Most people are responsible about it. With Reiki, I was taught that there is supposed to be a monetary exchange. But I have occasionally run into someone who it doesn't help, and I would just as soon that they didn't lose anything or get ripped off. So I'm happy working that way."(Culp)

"There are probably people who would like to see me but can't, but people will approach me with alternatives. One patient pays me in paintings. I have students that will pay a drastically reduced rate. I don't advertise those, but if someone asks, I'll do everything I can to make it accessible. I have never turned anyone down. But some will just assume they can't see me."(Murphy)

In some cases, the solution involves finding ways that insurance companies pay for a service that they otherwise would not, such as the following two examples:

"A lot of times I'll combine the Reiki with the massage. Like if I'm doing hand positions on the head, and I'm underneath and I can feel that there's tension there I'll do some massage to release some of the tension in their neck and head muscles. So then, because I'm using massage, and if they don't have the Reiki under their coverage, I can claim it as massage."(Ouelette)

"Generally my services aren't covered by healthcare plans, so generally people come to me as a last resort. People are used to having health care costs covered. A lot of people don't know about Reiki or energy work, and a lot of doctors don't know about it either. However, I often work with people who've been in motor vehicle accidents and have tried for years to get relief, and gone through everything that the system has to offer, and 3-4 years later, are still unable to work or to function or move. Generally within 2-3 months, they're totally different. They're back to the way they were before the accident – they're able to move, to function, the pain is gone. So some auto insurers pay for my treatment because of that."(Culp)

Consequently, while the demographic of those seeking CAM treatments might initially seem to be predominantly only those with a higher income bracket, there are

clearly ways that people have found to work around the financial constraints. In some cases, this means a much more varied demographic using CAM than the prohibitive cost would suggest. As these two practitioners, a midwife and a medical herbalist recounted:

> *"There's a huge variety in demographic despite the pay-out-of-pocket factor. Students, unemployed, fairly well off, people who live in trailers, in basements. Especially in Montreal it was a huge range – in one day I did a visit to a huge Westmount mansion, and then a biker's den."(Muriel)*

> *"For the most part, even people with a low income make the choice. It's not just high-income people that I see. In fact, I get pretty much the full range, and some people are really committed, and believe in it already, enough to make it a priority."(Jarone)*

From the above examples, it is clear that the issue of money is one that affects all levels of healthcare. This is true both within the allopathic system and the world of CAM, although the nature and manifestation of money-related problems differs dramatically between the two worlds. Fundamentally, however, the fall-out remains very similar: money affects issue of access to and quality of health services, and the ability for practitioners and physicians to make an adequate living at their profession. Even with case-by-case solutions and work-arounds to money-related problems, the larger issues are still apparent, and complicated to try and fix, especially when navigating between official and unofficial health cultures. Nonetheless, money-related issues are an important piece of the complex puzzle in the search for a health ideal, and will be revisited when trying to assess all the concurrent problems as a whole.

6.3.3 Communication

6.3.3.1 Doctor-Patient Communication

Closely connected to both time and money is the issue of communication. For many people choosing to use one or more CAM therapies, CAM treatment happens in conjunction with treatment from allopathic physicians. As such, it is not uncommon for an individual to simultaneously be seeing any number of different practitioners at the same time. In some cases, people choose different practitioners to treat different ailments or symptoms, but more often, there is overlap between the conditions being addressed. As the interviews I conducted reveal, this scenario typically lends itself to a frustrating and potentially dangerous problem: a multi-level lack of communication.

The most obvious, and perhaps most common communication breakdown that can occur is between patients and their allopathic physicians. Due to factors such as fear of judgement, perceived irrelevancy, or inadequate amount of time or knowledge on the subject of CAM, "patients continue to refrain from discussing their use of CAM with their physicians" (Ruggie and Cohen 2005, 14). As these three different CAM practitioners revealed:

> "I think that clients are not comfortable telling their physicians – I've had my own experiences with that. And it makes me very angry that physicians are judgmental about the choices that their clients are making about their own well-being. And maybe there would be more communication if there was more openness and respect and professionalism."(Julia)

> "Communication a big problem with patients. I get a lot of patients who say "I use my doctor for prescriptions when I need it, I don't bother with them for anything else, and I don't want them to know that I'm seeing you; I don't want them to know what you're doing with me – I'm coming to you because I know that what I'm doing with you works"."(Jacob)

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"People are afraid of being made fun of or judged, which is why they don't talk to their doctor. There is certainly a lack of communication – it would be good if doctors had an idea of what they do."(McKeen)

One patient revealed a negative experience she had had when she did decide to openly discuss her CAM treatments with her GP:

"I told her. That's why she's not my primary care physician anymore. Her eyes glaze over. I don't know what it is. I really don't get it. I've told her about things like "I take something for that, but it's natural", like if I wasn't taking my B complex, I'd be a bitch. It just wouldn't be pretty. She just doesn't get it."(Rostek)

Though it is understandable why this breakdown in communication happens when people feel as though they will be harshly judged, or when their the therapeutic relationship between doctor and patient is weak, it is significant to note that it can also happen when individuals like and respect their doctors. As one CAM-user bluntly stated with respect to her various CAM beliefs and practices:

"I love my doctor, but do I talk to him about any of this? No, not really."(OReilly)

Another woman, who also felt she had an open, positive relationship with her GP, expounded on this a bit:

"A lot of us are behind closed doors. Look at me feeling like I have to say "first of all, I have two feet firmly planted on the ground. I'm not a flake, but this is what I've tried, and this is what's happened". Really, it's a part of my life that's kind of in the closet... I have to tell you, with my back that I've now had treated twice – one was an injury; a fall, and I love my conventional doctor, but I haven't told her that I'm seeing a chiropractor. I kind of sense – she gave me a prescription for massage therapy last time, but I mentioned something about chiropractic, and I got the sense that she was not – I just didn't get a comfortable sense that it was open for discussion. So I haven't told her – well, I haven't seen her since – and I

don't mean to be hard on my doctor; she may have been fine with it. But when I had this, my first thought was that "I'm going to a chiropractor, because I don't want to go on pain medication, that's not going to fix it. That's going to treat the symptoms". I sniffed around the topic a bit with her, and it didn't – she didn't say – I just got the sense that she wouldn't be recommending that I go to a chiropractor. They don't know enough about it, or have heard of the 6 cases where somebody died, so it's not part of their arsenal."(Monti)

There are even CAM practitioners who feel uncomfortable discussing the details of their profession with their allopathic doctors. As one colonics practitioner stated:

"I still haven't gotten up the courage to tell him that this is what I do. I don't know why. I told him I was in holistic nutrition, and he was very interested, but I just couldn't tell him yet that I do colonics. I don't know why – maybe it's because of the reaction I get from lots of people."(McCarthy)

From the perspective of many of the allopathic doctors I interviewed, there was a general acknowledgement that their patients did not bring up CAM treatments with them very often, and that when they did, they were typically trepidatious or guarded about it. As one geriatrician noted:

"The patient has to trust that I won't judge them negatively. Doctors don't hear about it because patients think MDs will discount them or think of them poorly."(Andrew)

There was also, however, a strong sentiment that as allopathic physicians, they would be open to such discussions, and that they consider many of the aspects of an individual's CAM treatments to be important in their own assessments, diagnoses, and prescriptions. This was especially true with regard to herbal supplements or other remedies that would have a possibility of directly influencing or interacting with pharmaceuticals. This is demonstrated nicely in the following three quotes, from an interalist, a geriatrician,and a GP respectively:

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"It does come up, but it doesn't come up as frequently as you might expect, and I'm not sure whether that's because I'm not specifically asking, or people aren't volunteering, or whether the numbers of people that are actively involved is smaller. I'm not sure which it is. I'm sure there are a number of people that just didn't mention it. The things that do come up – I always ask about medications, and I ask, "what herbal products are you taking?" So that tends to come out. But other things that they might be doing, like acupuncture and homeopathy, and so on, less commonly will come out."(Moore)

"I also think there's a stigma, where they don't want to tell you half the time. I have to ask it a lot. I specifically ask. The most times it comes up is the question of medications – asking if they take any medicines, anything over the counter, and supplements. I think everyone does that. But I don't think I've asked the question of if they're seeing someone else. I think it has come up indirectly, like if I've gotten a list, then I'll ask. But otherwise, the patient will mention it. I suspect that with me it might be a little easier [telling about CAM therapies they are doing]. And certainly some people have been hesitant, and have said "oh, I just didn't want to say anything". And it all depends on your reaction. I think it's very important not to give a negative vibe back to a patient on anything – on a symptom that they say "you might think this is strange", or treatments that they are getting, because then you've lost an alliance."(Rowan)

"When patients bring up CAM, they're often quite guarded. They'll mention it and say "I don't know what you'll think about this"; or maybe because I'm younger than the physicians I'm working with, they'll also say "you know, I'm also seeing this person, but I don't know how Dr. so-and-so", you know my supervising physician who is probably older than me, and the person they're used to dealing with, they'll say "I don't know what he thinks about that, but I'll mention to you that I'm also seeing this person on the side". But I think there's often a sense that they're cheating on their doctor, seeing someone else. Usually, I congratulate them on bringing it up, because I think the most important thing is that they're open about it, and they don't feel like they can't share and be frank about all the therapies that they're using and the people that they're seeing. And so usually I'd want to get as much info as I could."(Breen)

This communication gap is not only an indication of the seemingly prevalent problems in the therapeutic relationship between allopathic doctor and patient; it is

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also potentially extremely dangerous. This is one of the reasons allopathic physicians are particularly concerned with herbal remedies and supplements – in a profession that relies heavily on pharmaceuticals, the possibility for negative reactions between allopathic and "natural" drugs can be harmful, or – in extreme cases – fatal. One woman, who makes it her personal policy to bridge the communication gap between herself and her practitioners, relates the compelling story behind her reasoning:

> *"I will tell my doctor anything and everything I'm doing, and same with the homeopath. You can't be secretive. I worked at a hospital where there was a very very large Asian population coming to the hospital. A huge problem was that a lot of senior Chinese patients had a lot of tinctures and herbals that they followed, and absolutely believed it helped – obviously, why wouldn't you – and then had a massive stroke, and are on all these drugs, and the doctor doesn't know that they have been taking this Chinese herbal for three years. Then there's a drug overlap or incompatibility. So from that standpoint, you can't do that, you have to be open."(Grasse)*

Significantly, despite the fact that there are clearly a number of doctors who consider CAM an important part of an individual's medical history, and promote discussing it with their patients, and despite the fact that many individuals have a positive relationship with their doctor, this communication gap still exists. Patients are often reluctant to discuss anything that may have a stigma attached to it – treatments, beliefs or decisions that may weaken their credibility, or cause concern or derision from their physicians.

It was also clear that while many of the allopathic doctors were open to talking about CAM, they were not particularly knowledgeable about treatments or modalities that fell outside of either their personal experience, or the realm of herbal remedies and supplements. Even if there was no pre-existing stigma, then, there is also no common starting ground or shared knowledge in which such issues could be fully

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discussed or understood.

6.3.3.2 Practitioner-Practitioner Communication

The second communication breakdown problem that was pinpointed involves a lack of communication between practitioners. Certainly, when patients do not reveal any extra treatments or practitioners to their allopathic physicians (or, for that matter, to their CAM practitioners), communication between practitioners becomes a null point. Even when there is awareness or acknowledgement that simultaneous treatments are occurring, however, there is still rarely any back-and-forth that happens between the people who are treating an individual. This is, understandably, a particularly prevalent issue between CAM practitioners and allopathic physicians. For the most part, this lack of communication was seen to hinge on two major factors: time constraints and perceived lack of relevancy. As these two allopathic physicians stated:

> "I simply do not have the time. It would just not happen. It would maybe be nice if I had more time. I just have to say "that is your business". I wouldn't tell my patients not to do it – I don't have the knowledge to condone it, but if that comes up as a topic, that decision is not mine."(OK)

> "I don't think [communication] commonly occurs – why; I don't know. I haven't been in too many situations where I felt that it was really important for me to have that dialogue; that it was going to alter what I did or suggested, I guess. Time is very limited – it takes time to call somebody, and I think that's a large inhibitor. To track a person down and call them and make contact is going to take some time, and if I'm not sure that's going to change what I do, then I may just not do it. I mean, I do contact other physicians when it is important to me, or important to the patient in my view, because I need advice or something, I'll make the time to do it. But even then I do think twice about it, because I know it's going to take some time. So I would only tend to do that when I think it's important. So for whatever reason, I guess I perceive that it's not as important; that it's not going to change what I do as much. Be careful

how you word that, because I don't want it to come across wrong. But I don't think it's likely going to change my advice on what investigation or what medication to do. It's kind of like they're doing their bit to work through like a wholesome-type approach to supporting the patient, and what we do is somewhat different."(Moore)

From the perspective of CAM practitioners, the issues are the same, although it is clear that they have a very different take on the issue of relevancy. As this massage therapist and homeopathic practitioner respectively describe:

"There are times when I'm treating somebody, and I wish that I could talk to a doctor about certain things. If they would be just a little bit interested in what I'm doing, then we'd have a much better treatment plan for this particular individual. I find it very difficult to get doctors to call you back. Some of them will, and not all of them are like that. Some of them have been very generous with their time, and have called me back, and discussed a particular case. Other ones – you can actually hear it on the other line that they are not paying attention to what has been said. It's like they're listening for particular things they want to hear, and ignoring the rest. I have no doubt that they are overwhelmed, and I don't mean to slight them – I understand that they have a lot on their plate. But wouldn't it be great if they could distribute what is on that plate to people like myself. It would take a load off of them."(Kemp)

"If the other practitioners are open, I would communicate, definitely. There are different issues. The first issue is a medical doctor, versus me as a homeopath as an alternative. Often medical doctors are skeptical, or tell patients outright not to seek my services, and medical doctors are not particularly interested in communicating with me. There are doctors that have actually referred patients to me, but it's not like we are a team that works together. That would be an interesting project, to see how the medical profession and the homeopaths can work together. In India, for example, homeopaths are medically trained, so there is already an integration of those two professions together. They talk to specialists about tests, to get test results of blood etc to see the progress of the disease etc."(Peisinger)

More than just lack of time and relevancy, however, some people also revealed friction and animosity between CAM and allopathic practitioners, as these two people

(a CAM-user and CAM practitioner) revealed:

> "I always tell people how important full communication is. Like when I recommend people go to a naturopath, I say "tell them everything. That's the only way you're going to get results". The only time I've ever heard of doctors and naturopaths, for instance, communicating, is when they're pissed at each other. And I've heard of doctors calling nutritionists and saying "what are you saying to my patient". From what I've heard, it's like only when there is a problem."(Anne)

> "The biggest obstacle for the health care system we have now is lack of communication. I have patients where there is just no talk between the doctors. I even have some GPs who refuse to fax us blood work, or who get angry at their patients, for wanting to go see a naturopathic doctor. So the patient is then fearful that they are making the wrong decision, or that they don't want their doctor to find out about it. It makes no sense."(Hayman)

Though this lack of practitioner communication is certainly highlighted most clearly between allopathy and CAM, it is important to recognize that it is also a problem internally, both within allopathic and CAM spheres. One allopathic physician described the issue in detail:

> "We don't do as good a job at interacting with the other, what we call "allied" health professionals: the other people that are in the hospital, even, that we do involve a lot. So people like physical therapy and occupational therapy, and psychology and so on. We don't even do a very good job of interacting with them. Like, I'll ask for a physio consult, they'll come do their work from a phsyio standpoint, and write a long letter. And I often won't go looking, for whatever reason, in that part of the chart to find out what they said. I don't know why. I guess I look for what I need, and I just figure they're taking care of that aspect. So we don't do a good job of communicating. We do if there's a problem – like if so-and-so is in bed and not getting up, and I can't figure out why they're not getting out of bed, then I'll find the [physiologist], talk to them, and ask what's going on. But we don't do that a lot – we're just not crossing paths directly as much. So that's already sort of an issue, and then the alternative medicine practitioners are one step removed, because we don't even see them in our day-to-day practice."(Moore)

For CAM practitioners, this problem is arguably even more pronounced, as there is typically no physical institution or system wherein different modalities or practitioners are in any way linked or "allied" to begin with. Many CAM practitioners and patients with whom I spoke mentioned this lack of coherence or networking as an impedance to communication. As one Naturopathic Doctor reflected about her own profession in particular:

> "I wish the naturopathic community was closer, so that I could say "you know what, your energy would really work well with this ND". Or "this ND focuses on this modality", or "this ND does a lot of this". But I don't know – for some reason, there is just a lot of disconnect. It makes me sad. It's everywhere."(Purcell)

Similarly, a massage therapist stated,

> "I think health professions need to begin dialoguing a bit more. It think that's part of the solution. I don't think there's any one solution, but I think there are steps along the way that we can take."(Kemp)

Despite this multi-level lack of communication between individuals' various CAM and allopathic healthcare practitioners, there are those who do try very hard to bridge that gap, with some success. This is, at the very least, a discussion – a sharing of knowledge and diagnosis and treatment. In some cases, it can become, in a limited sense, a collaboration between practitioners. As these two allopathic physicians revealed:

> "we now routinely have a multidisciplinary assessment on new people, and one of the things that we've been doing for years is that every person that we see, we write a consultation report, which is supposed to go to the referring doctor, which it does, we always give a copy to the patient. Inform them. And that appears to be unique in Capital health. We've actually had to find a way to work with the system so we could do that. Because other doctors don't routinely let the patients know what they think."(Fox)

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"In geriatrics, we take the time to call whoever they can get information from. I have never called a CAM practitioner, but that's because I haven't encountered people who were regularly followed by someone like that. But if I thought it would add, then I would. I call GPs, pharmacies, other specialists – I see that as part of the job."(Andrew)

CAM practitioners have also given excellent examples of cases wherein a good deal of back-and-forth occurred between themselves and and an individual's allopathic doctor, as evidenced by this CAM physiotherapist and massage therapist respectively:

"I had an elderly lady who had had heart surgery in the last little while, and had varicose veins in her feet, and a number of heath problems. She came to me with leg pain. So I noticed the varicose veins on her legs, and had taken her history, and had identified priority areas from a treatment standpoint. So I sent a letter off by courier this morning saying "I notice your patient has varicose veins on her feet; I'm just wondering if you thought it would be helpful to assist venous return by getting her into at least a light support sock, and that would take the load off her heart as well as help with some of the swelling she'd getting in her feet, and maybe even some of her leg cramping that's gotten worse in the last little while. At the same time, the scar tissue from her surgery was impacting on two of her three thoracic sympathetic ganglia, which was affecting vascular return in her leg. So I manipulated that, sent her back to her doctor for the support sock opinion, and will eventually address some of the issues she has going on."(Jacob)

"Just before Christmas, there was a doctor who used to come see me for massages – she has referred a lot of clients to me actually. She has a patient who's an elderly lady and she has neck problems, and she thought that maybe her patient would benefit from a cortisone injection, but she wanted me to find the exact spot where I thought the injection should go in her neck. And so actually, my client didn't want to go that route. So I called the doctor and said, "this is where I think you should inject the cortisone, but I think you should really talk to her more about it because she has some fears and some concerns and I don't think she's ready for it yet"."(Ouelette)

Though there was an overwhelming acknowledgement of the communication-related problems within the health care system, examples such as the ones above have led

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some of the people I spoke with to optimistically suggest that, with the increased number of people seeing multiple practitioners, and with some of the stigma being put aside, this lack of communication is necessarily starting to change. This was expressed both from within the worlds of CAM and allopathy. One geriatrician, for instance, nicely summed up both the problem and the need for change. When asked if she communicated with other practitioners, she answered:

> *"No, not at this point. I mostly do not interfere with what they're doing. I think I would feel as if I was inadvertently being intrusive. That's maybe not good thinking, and it would be likely helpful to have an understanding and work together. If they were open to it, I'd be open to it, for sure. There is a huge disconnect there. It's an important point. I cannot deny the fact that I think that they think I'm doing something wrong, and they probably think that I think that they're doing something wrong. Dialogue and communication is a huge aspect of medicine, and it's even bad when things fall apart with being in the hospital with a family doctor – all this stuff happens in the hospital, and then suddenly they have to deal with all these medicine changes, new diagnoses, and usually communication is lost, even within the medical system. It is such a huge and important thing, and I can't help but say that I also contribute that lack of communication and optimized patient care by not interacting with anyone else that the person is going to. For me it will happen more and more, because even though in my mind there are few geriatric patients who are seeing multiple practitioners, I think that is going to change; it is changing."(Rowan)*

More than just acknowledging the need for change, however, some offered examples of leaps that have taken place in the recent past. This Fredericton-based Naturopathic Doctor, for example, described the changes he had seen since starting his practice almost a decade earlier:

> *"when I first started, it was like a secret – patients would come in and say, "don't tell my doctor", and it was on the sly. But that has changed a lot. Most doctors are no longer negative. I won't say that they're positive, but they're most often neutral. I'd say that would be the most normal or expected reaction. Like, "OK, that's fine, but just don't stop taking*

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any medication without my permission". Something like that. Some are actually quite positive. In many cases where we have a patient that we would call a 'difficult case', where they are not responding to treatment – it's not usually a life-threatening condition, but a chronic condition – then they are encouraging them to go to a naturopath. We've actually had some doctors come see us as patients, and that has always so far gone well, and that opens up the referral network as well. So it's changing from the perspective of the doctors' attitude. It's also changing in that I've had patients becoming more proactive – not only telling their doctor, but also asking me to communicate with their doctor. Saying "please write a letter to my doctor", and wanted their doctor to send me the lab test reports. So maybe it's not the ideal thing, but it's the reality that if the patient is willing to be the link, in the centre of the health care team, then it does work well."(Bunin)

One CAM-user even described an instance where she opened up to her doctor about a treatment that she considered otherwise completely taboo within the world of allopathic health, with positive results:

"I'm also more circumspect about who I tell about these things. I often don't even tell my kids. There's a real notion of "fringe" healthcare. For instance, I've been on a vision quest, and had spontaneous healing occur. At the time, I had a prolapsed pelvis, and I could barely move. I had prepped the shaman, saying "I can't carry my own pack", etc, but when I drove into the driveway, I was suddenly spontaneously healed. I was in denial about it at first, but then realized that I was completely healed. I didn't tell anyone that I was spontaneously healed – it was like a social script where I was "careful", but there was really no need. I don't know what possessed me, but when I went in for my follow-up doctor's appointment, I told the nurse that I was completely healed, and about the vision quest, and the power of self-healing. So she was writing it down, and I was like "god, [Jeanine], why don't you shut your mouth". So the doctor came in and said, "so I hear you're healed. Tell me about it". And there was that look in his eyes – you know, when you know whether you're safe or not. So I told him everything. And he said, "you know what? I'm actually doing research on that." "(Jeanine)

Clearly, lack of communication is a significant issue with respect to individual health care. Though it can be endemic internally within allopathic and CAM spheres,

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this lack of communication is especially prevalent when patients are straddling different types of modalities, approaches and practitioners. The barriers are multi-levelled and multi-faceted. On the practitioner level, communication barriers exist due to issues such as time restraints, epistemological differences, perceived lack of relevancy, animosity, and lack of awareness or education (both in terms of what their patients or clients are doing, and the differing epistemological and practical approaches to health). This has meant that, with some notable exceptions, practitioners typically do not communicate with each other about treatment plans, theories or approaches to health for the individuals that they all simultaneously treat. This leaves the individual patient to act as the lynch pin – the one connecting factor between the various practitioners within their particular health world, and the resulting collection of diagnoses, approaches and treatments. This comes with its own set of problems, which are in turn exacerbated by the fact that many patients choose not to reveal or discuss their CAM treatments with their allopathic physicians. The communication issues in these cases are similar to those preventing inter-practitioner communication, but there is a particularly strong fear of the potential for stigma and judgement associated with their CAM-related choices. On a positive note, it does appear as if the communication problem is at least beginning to show signs of improving, as awareness grows, stigma lessens, and individuals become more open to the idea of dialogue between disciplines and approaches.

Time, money and communication: three important issues facing health care services in Canada. Though they can manifest differently depending on the system, these are issues that face both the allopathic and CAM worlds, and have a direct influence on the care patients receive. They pose particularly interesting problems for individuals who

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choose to prioritize and access these sometimes disparate forms of care, highlighting both internal issues, as well as issues particular to where CAM and allopathy intersect. The question, then, returns to the notion of an "ideal". There have, as the above examples demonstrated, been ways that individuals have found to work around, or at least ameliorate, particular problems. Is there, however, a potential solution the helps address these issues together? Overwhelmingly, many those I interviewed were similar minded in this regard – in one form or another, the potential ideal solutions involved the notion of integration.

6.4 Integration

The idea of integrating the worlds of CAM and allopathy in Western industrialized nations such as Canada is one that has, as Ning suggests, "garnered intense scholarly attention" (Ning 2008, 237). Andrew Weil, a Harvard-trained allopathic physician and "renowned holistic health guru", is often credited with coining the term "integrative medicine" (Baer and Coulter 2008, 333). In 1994, he established what he described as an integrative medicine program, which offered a fellowship to family physicians and internists interested in how to combine the "best ideas and practitioners of conventional and alternative medicine, with a strong emphasis on healing, natural healing, mind-body interactions, etc" (Baer and Coulter 2008, 333). Despite the subsequent scholarly and practical interest in integrative health care, however, it has proven to be a complicated concept, problematic both in terms of its definition and actualization (Templeman and Robinson 2011, 85). There are, as Coulter has determined, "almost as many organizational exemplars of integrative medicine as there

are actual clinics" (Coulter, Khorsan, Crawford, and Hsiao 2010, 691). Similarly, the literature to date has focused much more heavily on how best to create an integrative health care practice, and much less on researching actual outcomes (Coulter, Khorsan, Crawford, and Hsiao 2010, 695) (Templeman and Robinson 2011, 86). As such, even though it has been two decades since it was introduced, integrative medicine is still what many would refer to as an "emerging field" (Coulter, Khorsan, Crawford, and Hsiao 2010, 695), simultaneously steeped in both problems and potential.

In its ideal form, integrative medicine has been described as "the medicine of the future"; the "ideal foundation on which to base the future of health care" (Sierpina 2004, 201). It is "patient centred, healing oriented", and much like Weil envisioned, it "embraces conventional and complementary therapies" (Maizes, Rakel, and Niemiec 2009, 277). Although definitions abound, the core concepts or goals tend to remain relatively consistent: there is an importance placed on the therapeutic relationship, a "focus on the whole person and lifestyle", a "renewed attention to healing", and perhaps most obviously, a "willingness to use all appropriate therapeutic approaches whether they originate in conventional or alternative medicine" (Maizes, Rakel, and Niemiec 2009, 277). Consequently, integrative medicine is also theoretically ideally positioned to fill in various "gaps in treatment effectiveness", and lead to "enhanced safety of primary health care" (Grace and Higgs 2010a, 945), with "immediate and significant health benefits and cost savings" (Guarneri, Horrigan, and Pechura 2010, 308).

From a certain perspective, integration is already happening on a daily basis. Those patients who choose to simultaneously use both CAM and allopathic medicine can arguably be understood to be using a "patient-directed model" of integrative

care – in essence, coordinating the various treatments and practitioners on their own behalf (Maizes, Rakel, and Niemiec 2009, 283). In this respect, "CAM providers and biomedical physicians have always been connected in an informal network through their patients, even if this connection was unacknowledged" (Coulter, Khorsan, Crawford, and Hsiao 2010, 692). Though this form of integration is certainly real, and important to acknowledge, the types of integration primarily discussed within both the literature and the interviews I conducted, point to a more formalized ideal. The differing interpretations on how best to implement these goals is where the complications start to arise, and where nuances, power relations, and often clashing epistemologies start to come into play. What follows, then, is a discussion the various visions of the integrative ideal, and the ways in which they can potentially flourish and fail.

6.4.1 Integrative Clinics

The form of integration that came up with most frequency in the interviews I conducted involved what was envisioned as an integrative clinic. The idea here is that a range of different practitioners, from both allopathic and CAM specialties, share the same physical space. As such, the practitioners are theoretically not only aware of each other's modalities and their strengths, they can also easily collaborate, refer, and discuss aspects of their shared patients and diseases with ease. Ideally, this encompasses both a "process of collaboration and mutual respect between systems of medicine" (Wiese, Oster, and Pincombe 2010, 329). Many CAM practitioners had similar visions in this regard, with variations on the specifics, as evidenced by these five different practitioners:

> "What is ideal, and actually one of our long-term goals is having a multi-

disciplinary clinic with various types of practitioners – both conventional and complementary – under one roof. If not physically under one roof, then at least near-by locations that are convenient to everybody, where patient info is shared to any of the members of the health care team that are working together. We would have GPs, MDs, as well as NDs. What I think makes sense is that a patient would have the option of what they choose to be their first person. But regardless of whether they saw their MD or their ND first, their treatment would still be the same. It will have to be coordinated by someone, which is most often a ND or a very open-minded MD. In the real world, it's that person who hand-picks who participates. And it has to do with modalities, but also with personalities. We can't forget that every practitioner is a human being who has to work with other people."(Bunin)

"Integrative health is coming. It is a large integration – multi-disciplinary. You'd want psychologists, psychiatrists, occupational therapists, chiropractors, energy therapies. I don't know if you could have them all in one space at the same time. You'd need a big office building. But even if you had psychiatrists rotating every Thursday, or chiropractors there Monday to Friday, or whatever. There'd be a central location with a team. The team would be an allopathic, a naturopathic, probably a massage therapist, and energy worker, and then a receptionist to coordinate it all. Then that team would discuss the client, and come up with a team plan to decide what that client ultimately needs for treatment."(Purcell)

"I would like to see integrative clinics. I think it could be almost any combination of practitioners, but they would need to be regulated, and therefore more credible, carry malpractice etc."(McKeen)

"If you had a centre where they have different practitioners, and they could share files and consult each other, and see what would be the best way to help that person. So they could communicate their progress that they see in that field, or that specific area that they're working on. You hope to find ways to have them working together... I think you'd have to kind of assess the situation, and pick one therapy or two therapies in one session, and then maybe offer something else another time. Or develop a treatment plan, let's say over two months, so come four times – once every two weeks – and this time we'll work on this, and then this time we'll work on this, and I could use this and see how that works and if that does then next time I could combine that with another new therapy."(Ouelette)

"So I'd like to see centres where we use acupuncture to prep for surgery; naturopathic meds for post-op. To not just say we're going to have to cut this out – to integrate them, is what I'm trying to say. To have more integration."(Mullin)

Others described centres that they have been to, and find inspiring, as these three practitioners revealed:

"A friend of mine works in Calgary, and it's actually an integrative medicine clinic. It's run by naturopathic doctors, but there is an allopathic doctor on site, and a Chinese medical doctor as well. So any blood-work that you might want or need you just go to the medical doctor, who will sign off on it, and then they sit down and do case reviews once a week. It's called the IMI - Integrative Medical Institution."(Hayman)

"In the US, one of the courses I took was held in an integrative oncology centre... and you walk into this place, and it's a huge wall, floor to ceiling with glass, overlooking a pond with ducks and swans and plants, and piped in classical music. And you could go left and go to yoga, meditation, Reiki and massage; go right and have your chemotherapy, or have both together. And they were doing research on the value of these approaches there. I also took an acupressure course on serious illnesses. The instructor was a practitioner of acupressure, and she had had leukaemia herself, and she was hired by her oncologist based on how well she did with the treatment for leukaemia, which is a horrible treatment. She bounced back so much quicker than anybody else that he hired her, and they co-founded (this was in California), what was probably one of the first integrative oncology units. And in it they had a number of oncologists, Reiki practitioners, massage therapists, a Shaman – everything imaginable in one centre. So they had what I would have to say was an ideal situation going on. I think it's doable – it's a whole different energy."(Jacob)

"Balance Clinic has three naturopaths, a yoga person, a chiropractor, a colonics person. There was someone there who was a traditional doctor, but she retired. So there's about 9 or 10 – they've expanded twice since they've opened. It's very comprehensive."(Susan)

Significantly, this vision of an interdisciplinary clinic was one espoused not only by CAM practitioners and patients, but by allopathic doctors as well, as these two physicians reveal:

> *"At the end of the day, it has to be one team – that's what they do at Mayo, or any of those other wonderful clinics. You have a team of experts listening, worrying together for you. And it doesn't take days or weeks to get from one to the other. I don't know how they do it, but make it into a team. It should include CAM practitioners – the aches and the pains and the bad feelings; massage – the whole idea that it's OK to seek a well-rounded treatment; to treat your mind and spirit."(Kati)*

> *"Probably as family physicians are more taxed, treating an aging population, there's going to be more room for treating those more subtle illnesses or somatic manifestations of stress. I think that might be the breaking point, where more alternative therapy can get in the door. Ideally, clinics that have a family doctor, a social worker, a physiotherapist, a nurse or nurse practitioner, and maybe other alternative practitioners there as well would be really ideal, because just being able to know that there is support to refer easily to other people in your group would be really ideal."(Breen)*

There are of course a large number of obstacles in the face of forming an integrative clinic. The first goes right back to the problem of knowledge, belief, and legitimacy. Though there are clearly allopathic physicians open to the idea of teaming up with CAM practitioners, there are also others who are solidly entrenched in the CAM-allopathic dichotomy. As one Internalist stated,

> *"Is an interdisciplinary clinic model a good idea? So then can I put a big blue bottle of pills on my desk and say "here. I made them. Buy them, you'll feel great". I can't do that. That's not the medical – the current Western tradition, for better or for worse, is that I can't knowingly offer ineffective therapy, without being unethical."(Workman)*

There is also the question of which modalities and practitioners would be deemed appropriate or acceptable in such a scenario, and how the integrative clinic would

be run. Even from the above quotes, it is clear that there is not one particular ideal model. Issues for practitioner inclusion include aspects such as type and length of training, which therapies are legislated and/or covered by insurance, which parts of a person's health are best met, and simply personal experience with practitioners with whom individuals have had or seen success. Often, there is a clear line drawn between that which people feel could feasibly fall into a scientifically-based paradigm, and that which could not. As one physician explained,

> "If I was a director of an alternative hospital, I would get rid of the obviously non-scientific therapies. Then turn to things that could be helpful: chiropractor, acupuncture, massage, dietary, herbals – these are the areas I could see some use, and would be easier to work with as a therapist. I cannot abide energy therapies."(OK)

Even a Naturopathic Doctor, who was part of a CAM-based integrative clinic, described her reservations about including energy healers as part of the team:

> "There's a lot of people who do [energy work], but we don't necessarily feel like we have to do that right now. While being holistic, at the same time we want to maintain a certain level of professionalism and science-base. Naturopathic Medicine is science-based. Chiropractors are science-based. We do want to maintain a certain level of that. And you can have people who are good at [energy work], and people who aren't. So usually we'll just refer out for that, right now."(Hayman)

Another potential pitfall that was brought up involved the possibility of an integrative clinic simply becoming a shared space, rather than a true team-based approach to healing. As one Naturopathic Doctor revealed:

> "[A local GP] says that even though she works in an "integrative clinic", all they really do is share a hallway. She wanted to practice with me where we'd have weekly meetings to discuss difficult treatments etc. That's what's needed."(Murphy)

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Apart from issues of ensuring true collaboration and communication, and the potential for having to negotiate differing notions of epistemology and modality/practitioner legitimacy, there is also the very important considerations of both money and power dynamics. As was discussed previously, the services offered by allopathic physicians in Canada are almost entirely covered by medicare, whereas those offered by CAM practitioners are not. Therefore an individual simultaneously consulting with different practitioners in an integrative clinical setting would not be an easy or fluid process. It would involve a complicated billing system, wherein the patient would typically end up paying for some of the services out of pocket, which could affect the collaborative process. Secondly, depending on how the clinic is organized and run, power dynamics can directly affect the collaborative ideal. Hollenberg, for instance, studied two integrative health care settings in Canada, one of which was a clinic style such as those mentioned above. He found that even in such a scenario, "dominant biomedical patterns of professional interaction continue to exist", by measures such as "dominating patient charting, referrals and diagnostic tests", regulating CAM practitioners to only a certain "sphere of competence", and "using biomedical language as a primary mode of communication" (Hollenberg 2006, 731).

6.4.2 Assimilation

Similar in many ways to the integrative clinic, another very popular form of integration is one that I have chosen to use the term "assimilation". This involves CAM modalities working within an allopathic hospital-based system, alongside allopathic physicians. The difference between the idea of assimilation and that of integrative clinics, however,

is typically a matter of power and control, and it is the reason why assimilation is often met with much controversy. To work within the allopathic system, there is often by necessity a very strict protocol that must be followed, which, as was previously discussed, follows a hierarchy of scientific evidence to meet certain standards. Therefore, even "proponents of collaborative and non-hierarchical relations between conventional and CAM practitioners" tend to advocate for an integrative health care system that "only considers bio-scientific evidence" (Ning 2008, 238). Consequently, those modalities that become integrated into the hospital setting run the very real risk of having their "holistic, philosophical elements" removed, thereby potentially altering some of the more fundamental epistemological or procedural aspects(Keshet, Ben-Arye, and Schiff 2012, 586). In such a scenario, it becomes a case of "co-opting CAM into biomedicine at the level of therapy", rather than truly integrating a full system or modality(Keshet, Ben-Arye, and Schiff 2012, 586).

Taken to its logical end, such modalities would, in effect, become a part of the allopathic system. As Wiese has summarized, "'integrated medicine' is generally understood by the biomedical sector to mean the 'selective incorporation' of elements of CAM into comprehensive treatment plans alongside solidly orthodox methods of diagnosis and treatment" (Wiese, Oster, and Pincombe 2010, 328). Indeed, as two allopathic physicians mused:

> "all these other practices would like to become standards, and they might do that. And they would become a part of "conventional" medicine. That might happen."(OK)

> "Ideally, the accepted and the wonderful parts of alternative medicine should be more incorporated."(Kati)

The potential conflicts associated by co-opting or assimilating CAM therapies into a hospital setting were expressed by many informants, both from within and outside of the allopathic mainstream. The concerns were in line with those noted in the literature, such as a fear of "biomedical dominance and distortion" of CAM practices, wherein a modality or therapy becomes nothing more than an adjunct (Wiese, Oster, and Pincombe 2010, 333), or the possibility that losing the context of a modality will also lose what makes the CAM therapy work in the first place (Barry 2006, 2651). As one allopathic physician suggested,

> "It might not work as well if they're integrated. It might take away some of the – there must be a certain aura surrounding that type of a practice – a certain belief, and putting in the hospital may take that away, and it may not work. "(Moore)

Significantly, however, it was also acknowledged that certain modalities would be better suited to such an integration, while others would do well to maintain their autonomy. As a geriatrician suggested:

> "I think you could bring it into your mainstream, and adopt it, but I don't know if that would work. I think you need to have people who are specialized. You know, there are certain things that are easier to bring in, like acupuncture and massage therapy. There are other things that are appropriate to say – you know, I think a naturopath is a naturopath, and I don't think they should necessarily have to conform in any way. Because that degree of integration necessitates conformity in some way, and so I think they should have their own practice; away and separate."(Rowan)

Though the above physician did not extrapolate on why modalities such as acupuncture and massage therapy would be better suited to integration, it is interesting to note that both of these examples are forms of CAM that can, and have, been selectively incorporated into an allopathic setting. In other words, these are both modalities that

can be stripped of their foundation or epistemological core, and subsequently practiced and used in a fashion that much more closely resembles an allopathic framework and knowledge base.

One Naturopathic Doctor speculated that in some cases, it is a matter of whether individual practitioners are well-suited to such an integration, rather than the specific modality:

> *"It's a little scary to think that everything would be – like, I kind of like being off on my own. If everything was integrated, everybody would be part of the big system, and I don't know if I'm personally cut out for that. But I think there are a lot of people who are, and who would do very well."(Hayman)*

Despite the potential pitfalls, however, there are many CAM practitioners – especially ones offering some of the more "easily" assimilated modalities, that believe the benefits of being in a hospital setting outweigh the potential downsides of being assimilated within the system. This midwife, for instance, who has worked in system where midwifery was integrated into a hospital setting, details the pros and cons of such a system:

> *"On the positive side, most of it is positive. It means that women who want or need access to midwifery care have it. It's publicly funded; you don't have to pay out of pocket, it's also regulated which means that you can be pretty sure that any midwife that will be working with you is properly qualified, competent, meets standards. So the main issues are access, I think also that midwifery can make a difference to the culture of obstetrics and maternity care. For sure, integration in provinces where integration of midwifery has occurred undeniably involved a certain number of tensions. What happens, though, is that as you develop relationships, when it becomes human being to human being in the same room, when there are corridor chats, when people can see what you're doing, when you're learning from each other, when you're actually dealing with people in that full way, there's a change. There are places where there are still relations between hospital staff, physicians, nurses, midwifes that are still*

tense, or occasionally with maybe an individual practitioner, but by and large the midwifes who have managed to be integrated into the hospital teams and so forth, there is agreement. There are points of agreement. Like, everyone in obstetrics understands that such and such a situation is much more risky, and therefore, OK, you're not doing that at home. You're calling in paediatrics, having a consult with your obstetrician. There are some gray zones, but by and large agreement isn't so hard to achieve. At the same time, what has happened, and this is what I hear – you know, the situation when I worked in Quebec as a regulated midwife, I felt that the way we practiced was safe, competent, clear, but not really any different than how we practiced before we were part of the system. I think there are places, however, in which the policies and protocols of the hospital will, to some extent, shape and change how a midwife works, because if you want admitting privileges, you have to – [play by their rules], to some extent. I don't want to set up any adversary thing where the hospital's protocols or rolls would be necessarily something that I wouldn't agree with. Because most of the time I would."(Muriel)

Other practitioners were particularly interested with the good that could come from being able to work alongside doctors in cases specific ailments or emergencies – in essence, being able to treat the patients when they could do the most good, rather than waiting until after the hospital stay was over. This was expressed well in the following three examples, by two massage therapists and an acupuncturist:

"I think what people should start considering – and I know that massage therapy associations are working towards that – is to have a centre, like a rehab centre at the hospital, to work with let's say, people who are recovering from strokes. I know that my dad had a stroke in 2004 and I went to his physio treatments with him in the basement of the hospital, and they went over exercises with him, and if they had massage therapy in there, then you could have treatment offered, or available to people who don't have insurance coverage. They may have to wait longer, but at least its there as an option for them."(Ouelette)

"In some situations, the hospital setting would be better, especially with the lymphatic drainage. There are a lot of applications – for instance, burn victims, or amputation stumps. Doing lymphatic drainage the day after a mastectomy. You could be making huge differences – not just little ones."(Kemp)

> *"I would love to see some CAM practitioners in hospitals. For instance, for patients after surgery, who don't want to do so much narcotics, that they could have an acupuncturist come in, because it works great for post-operative pain. Even with an anesthetic, I've had patients who've had dental work done, who've had bad reactions to local anesthetic, and don't want to take it, and I've done acupuncture as their anesthetic. I had one patient who had 4 extractions who used just acupuncture, and a little bit of topical anesthetic. She did great, and the dentist was quite surprised, and said she tolerated it well, and had very little swelling."(Shea)*

Finally, there are very intriguing examples of CAM modalities working within a hospital setting, but skirting a fully assimilated status. One such example is a rather anomalous room within an oncology ward in Halifax, called "The Sunshine Room", which offers CAM services, many of which are energy-based, to cancer patients. As one volunteer practitioner explained:

> *"The Sunshine Room is for cancer patients. All staff volunteer their time. There might be a massage therapist there from 10:30 to 12:00, then I come in at 12:00 for a couple of hours and offer therapeutic touch. There's a coordinator there, who organizes everything. You have to sign a contract that you're not going to do any harm. Mostly nurses refer people there, but some doctors do as well. This is the only hospital in Canada that offers this kind of room within the hospital. There are CAM people and nurses from across the country to check it out and see about setting it up where they work. It was started by someone with cancer, who really wanted a homey place in the hospital where she could relax. So patients go there – they can just sit if they want. There are wigs there for people, and stylists to help. It is also good for support people who are there for their friends and family – they can get very exhausted, and the services are open to them as well. It gets very busy. It is a free service for any cancer patient that wants to access it."(Susan)*

Another example, related by a Nova Scotia-based physician, involves hospital-bound patients specifically requesting CAM practitioners to be allowed to come in and treat them.

"I have some friends in the States who work in different hospitals who are healers, who will go in and will, as part of the care, will develop a relationship with somebody and then help them through this difficult phase. And there's pretty good evidence that when you start doing this kind of thing you enhance the results and you improve outcomes. People have more resilience, they have more capacity to deal with whatever the challenge is. One of my patients though, he fell out of a tree and fractured his pelvis and he ended up in hospital. He had a hard time being in the hospital being very chemically sensitive, and he was in a lot of pain and his tolerance of medications is very limited. He knew the pain clinic used acupuncture. So he was in the orthopaedic ward, to be there six weeks, and he said "I need acupuncture". And they said, "well you can't have acupuncture". And he said "Why not?". And they said, "Well, it's not available." He said "it's in the hospital, why can't I have acupuncture in here?" and he got acupuncture. And there is now a bylaw in the hospital that alternative practitioners can actually go in, and I can't remember what the wording of it is, but there is – if people really try, there is a certain amount of access that is available."(Fox)

Assimilation is a form of integration wherein there are potentially very clear benefits and downfalls. It often necessitates a scenario wherein parts of a modality's epistemological, and sometimes procedural protocols must be at least partially altered to conform to the much larger allopathic system. Those who have conducted studies on already existing hospital-based integration have noted a high level of "physician resistance" to CAM programs (Ruggie and Cohen 2005, 14), strong allopathic hegemony wherein the doctors were the sole "gate-keepers" of care and procedure (Shuval, Mizrachi, and Smetannikov 2002, 1745) , and "lack of communication and lack of any real efforts by biomedicine to integrate CAM" (Wiese, Oster, and Pincombe 2010, 331). Even when the notion of integrative medicine is accepted, it is typically viewed by the allopathic mainstream as "merely a series of adjustments to the current social and professional biomedical context, rather than a true integration" (Keshet, Ben-Arye, and Schiff 2012, 597). CAM practitioners, in this case, are understood to

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be experts that are brought in to "treat patients' unmet needs", typically thought to be psychological in nature (Keshet, Ben-Arye, and Schiff 2012, 590). Therefore, CAM treatments are "perceived very narrowly", and restrictions are placed on aspects such as "repertoire of treatment methods", duration of treatment, and "treating only certain symptoms" (Keshet, Ben-Arye, and Schiff 2012, 592).

Assimilation is also, however, a form of integration that allows patients to access services that would typically otherwise be unavailable to them, at crucial points in their healing process. Therefore, there are CAM practitioners that are willing to overcome the obstacles in their way, and attempt this type of integrative care. Certainly, such a form of integration more easily accommodates certain modalities, and certain practitioners or personality types. As examples such as the "Sunshine Room" demonstrate, however, even practitioners and modalities that typically fall outside of acceptable biomedical standards can be incorporated fully in the right circumstances. Also, Keshet et al. found that even when biomedical practitioners had a very limited view of the scope and practice of the CAM treatments within their hospital, the practitioners and often the patients understood their treatments in a much more integrative manner. As they eloquently summarized, "while operating beyond the 'clinical gaze', CAM practitioners create islands of holism within a sea of dualism". For those that can find a way to effectively work within such a setting, then, the benefits of a hospital-based integration are potentially incredibly important.

6.4.3 Integrative Practitioners

In this third model, practitioners become experts in more than one modality. Though it could include any combination of different specialties, the most prevalent examples offered were ones in which allopathic medical doctors also become proficient in one or more CAM techniques – a phenomenon that has been described variously as "*intra*grative" medicine (Grace and Higgs 2010b, 1185), and "dual embedded agency" (Keshet 2013). As one woman, with plans of personally becoming both an allopathic physician and a Naturopathic Doctor explained:

> "I think that a general practitioner should have training in all areas. To be able to not only have the pharmaceutical training. Because really, medical doctors are pharmacological experts. They know pharmacology. But I think they get one nutritional course in the first year, and nutrition is such a big component of health. I think if you're going to be a medical doctor, there should be courses in nutrition, in herbal methodology, and all sorts of areas of practice. People are going to want to know, they're going to be curious, and you are going to want to inform them accurately. After the MD, I want to get my doctorate of natural medicine. I want to do both. I think if someone is prescribing drugs, they should also know about the supplements that someone is taking. People are going to take them, and often there are a lot of interactions. I think that patients should be able to choose the kind of therapy they want, and know that they're getting valid, educated information, from someone who is trained and certified, so they don't hurt themselves. I think that it's one of the few ways that these two types of healthcare are going to integrate."(Diana)

A CAM practitioner envisioned the future of healthcare in a similar fashion:

> "How could I see the medical system looking down the road? Based on my gut feeling and the extrapolation of what I've seen of the interaction between these two or more models of medicine, I see ... centres where you have doctors trained as acupuncturists, as psychiatrists – which they already are, but maybe more well-rounded – doctors that do yoga, which there are plenty of now any way. Physiotherapists who do acupuncture, which there are now. People who are very interdisciplinary."(Johnson)

One Naturopathic Doctor described the impetus toward personal integration as a form of humbling, or a realization that arises when a practitioner becomes aware of the shortcomings or limits to his or her particular discipline:

> *"If you've been around for a long time, I think, you start to realize the pitfalls of your own things, and you start to be more open to other things. Like, the doctor who was here before us – a medical doctor – was practicing mainly homeopathy. Then he went and became a Buddhist monk. So they're out there. They're the ones who go to conferences other than Merck-Frost; they're the ones who belong to ACAM – the American College for the Advancement of Medicine. I go to a lot of conferences put on by them. And these are all medical doctors talking about nutrition and energy healing and counselling and exercise."(Hayman)*

Some of the allopathic trained practitioners I interviewed had, in fact, already taken on an integrative role in their own practices. One, a trained physiotherapist, opened his own practice in order to be able to use some of the more holistic methods he had been trained in. Though he still uses his more conventional training, he prefers using the CAM techniques when he can:

> *"I integrate, but I prefer to use complementary approaches. I use a complementary approach in my practice. But the people I see have already tried a lot of the conventional stuff and it hasn't worked. So what I do either works by itself, or it gets people to the point where I can then say, "OK, you can do some core stability stuff. You're ready for that now – it's not going to hurt when you do that now". Or "now you can start up with your walking program, and it's not going to cause leg pain". Or whatever it is. Sometimes it stays purely within a complementary approach, whether it's qi gong, which is a tai chi-like exercise that I do, or whether it's yoga, or some other thing like that."(Jacob)*

Two physicians I interviewed, an environmental sensitivity specialist and a GP, also incorporated CAM based-techniques into their practice, in different ways. As the environmental sensitivity physician revealed:

"So what we have done over the years is developed a multidisciplinary approach where we try to look at the whole person. And we will treat what we can treat, using whatever is possible... In the centre we've incorporated, for example, classes which teach [mindfulness based stress reduction]. What I teach is essentially a form of bio-feedback, a bit like meditation, where the person will actually use their heart and will use the magnetic field around the heart to bring themselves back into balance. And there's a lot of scientific research has actually been done on that to show that it actually works. We measure a phenomenon called heart rate variability, which is recognized and written about in mainstream medicine, and in this particular practice it's giving people, empowering people the ability to actually manage stress and emotions themselves, and also to get some positive physical benefits like lowering their blood pressure, reducing their reactivity, giving them a little bit more space to make choices instead of just acutely reacting to situations."(Fox)

The family doctor described her practice in slightly different terms, being sure to point out the order of resort that she uses:

"I give people as much information as I can, and let them make the decision. If they ask me directly what I would do or wouldn't do, then I can answer them on a personal level. I have to do the regular medical stuff first. Medical history, physical exam, and whatever lab tests are required. To hold my medical license, I have to fulfill all that, or at least offer those things. I also have to offer the conventional medical treatment. At the same time, I can also offer other options. If someone is interested in it."(Gold)

While the benefits of having a single individual who is both knowledgable and trained in multiple different approaches to health and healing are obvious, there are also a number of potential problems with such a scenario. The first is simply a matter of limitation – how many different modalities can one person truly master? As one practitioner pointed out:

"If you look at the number of therapies out there, it's tricky. You can't know them all. And you can't expect your doctor to know them all."(Kemp)

There is also a concern with the kinds of modalities chosen, and, more importantly, the level of expertise and commitment to the underlying philosophy of the modalities. As was discussed in the assimilation segment, modalities allowed into a hospital-based setting are often stripped of their epistemological underpinnings and therefore practised only as adjuncts to mainstream medicine at therapy-based level. Similarly, allopathic physicians that incorporate CAM-based therapies in their own practice can often do so at a very basic level. As Baer explains, "biomedicine often views CAM as providing tools that are simply added to the curative model, one that attempts to understand healing by studying the tools in the toolbox" (Baer and Coulter 2008, 336). Consequently, the CAM-based modalities that a physician chooses to integrate can end up bearing little resemblance to the modality as practiced by a practitioner with full training and expertise. As Barry has suggested, for instance, a modality such as homeopathy, when it is practised by allopathic medical doctors, is "so different from that of homeopaths as to be unrecognizable as the same therapy" (Barry 2006, 2651). This can translate into many other CAM-based modalities as well. As one acupuncturist explained, for instance, there is often a very big difference between how a medical doctor would use acupuncture in his or her practice versus a fully-trained acupuncturist:

> "Massage therapists are able to take acupuncture training in instalments, and are doing it for musculo-skeletal issues, but can use it outside of their scope of practice. That scares me, because a needle is an intervention, and you have to really respect what is being done. The same with doctors and physiotherapists and chiropractors taking weekend modules in acupuncture – I hear horror stories about them not knowing which needles to use. But then I also hear about physiotherapists being able to unfreeze someone's shoulder through acupuncture. So as long as they're safe; as long as they know their limits, then there can be a lot of really good. The difference between them and me is that they have occidental medical training, and

then use recipes. For me it's full training, with knowing how to assess with patterns, etc."(Clavette)

A particularly good example of integrative practitioners and specialties can be provided when looking at the discipline of naturopathy. Naturopathic Doctors are, by the nature of their training, integrative. Their intensive 4-year training involves both allopathic approach to health and a fully extensive range of CAM modalities as well, including acupuncture, homeopathy, and herbal supplements. Despite this diverse training, however, most naturopaths tend to gravitate toward the specialties with which they resonate most deeply, with the option of referring the patient to someone else who specializes in a different modality if they feel it is needed or would be beneficial. In this case, then, there is integrative training and knowledge, but also a recognition of strengths and limitations to one's own capabilities. As these two Naturopathic Doctors explained:

> *"There are Naturopathic Doctors in the province that are very good at doing chelation, or homeopathy. Then there's me, that does a lot of counselling and energy work and fertility and chronic illness. I like that, because I like the counselling part of it. I don't do much homeopathy, but I really like acupuncture. I resonate well with it. I use it. It's a matter of doing what you're good at, and supporting each other through that."(Purcell)*

> *"I mean, some people don't respond to me. If you respond to energy work and Reiki and Cranial Sacral, maybe that's the only real thing that you'll respond to. And you'll always get the adrenaline release and the endorphins etc., and the body will respond. Auricular stuff, acupuncture – I love it, but I might just not do it, because I don't have that gift. I don't have the body work gift, so I don't do any of the manipulative work that I've been trained in. So I'll refer to people."(Murphy)*

Another problem with integrative practitioners has to do with the rules and regulations put in place within the allopathic system. Many of the allopathic physicians

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with whom I spoke did not feel they could even refer people to modalities or practitioners that fell outside their own personal knowledge or the allopathic scope, let alone incorporate CAM into their own practice. One geriatrician, who was explaining why she felt she would recommend massage or acupuncture, but never chiropractics, for instance, stated:

> "That is where the risk-benefit comes in; how sure I am in my own mind that I'm not going to support something that potentially has risks that are unknown to me."(Rowan)

Similarly another physician offered the example:

> "I don't commonly refer people for say homeopathic medicine or... naturopathic medicine, and mostly that's based on that I just don't know the evidence, and/or if there is evidence to support it. So I don't typically refer that route. But things like massage or acupuncture, I'd be open to people trying at least."(Moore)

Even a chiropractor, who is technically part of the CAM sphere, described the strict limitations she put in place in her own practice with regards to other modalities:

> "So say you need acupuncture. I can't send you to an acupuncturist, but I can send you a physiotherapist who does acupuncture or a physician who does acupuncture. Osteopathy isn't regulated here, so I don't refer patients. I use it – I have no problem with it, but I won't refer patients to something that isn't regulated."(Jane)

Similarly, even those within the allopathic system who choose to integrate CAM into their practice must do so very carefully. As an allopathic physician concisely stated:

> "You could practice CAM as a doctor, but you have to be accountable for that if something did not go the way you wanted it. So if a doctor does things beyond the guidelines, the person has to be very brave or secure or desperate or all of the above to do that."(OK)

Indeed, one Naturopathic Doctor, describing the practice of a local integrative family physician, revealed:

> "[The integrative physician] also has her hands tied because she has a medical license. She wants to prescribe fish oils, but can't actually write that down. Instead, she can just suggest it."(Murphy)

6.4.4   Collaboration

A final form of integration is the act of collaboration. Collaboration entails different practitioners discussing, sharing, and working together on an individual's health. Certainly, collaboration would ideally take place within an integrative clinical setting – it is, for many, a large part of the appeal of such a solution. The differentiation, however, is that collaboration can occur with or without a shared physical space. It is, in essence, the concept of the previously discussed communication, but used in a very deliberate, direct sense.

For some, the idea of collaboration is indeed very similar to that of integrative clinics, in that different health care providers are envisioned as a team. One Naturopathic Doctor, for instance, described how a CAM/allopathic collaborative team would work in an ideal setting:

> "How I envision it for my patients – and I tell them this – is that their GPs and I are a team. We are meant to work together. Anything new that comes up, both should know about it. And it would be ideal to actually work together to say "OK, what can we try? What is the minimal level of invasiveness we can come up with, to maybe rebalance what is going on?" Ideally, you have your GP for your primary care and screening. I'm trained in primary care, but because I have my arms tied behind my back, I can't order an x-ray if I think you need one or an ultrasound. So it's nice for me to know that you have someone checking your blood pressure every three months, or doing colonoscopies or mammograms or pap smears – the screening stuff. Then you have me – I always tell my patients that

for anything they would go to a walk-in clinic for, they could call me. The idea of not wanting to wait and let things get so bad that you eventually need antibiotics. Instead, call me at the first sign of a cold or flu, and we knock it out. Right there we've lessened the burden on the health care system."(Murphy)

This type of GP-Naturopathic Doctor collaboration does, in fact, happen in some cases, depending on the relationship between the GP and the practitioner. As one Naturopathic Doctor explained:

"I have a medical doctor who refers patients to me a lot. The doctor will take care of the blood-work and things like that, and assessing things on a blood level. Once there is a diagnosis, she'll send her to me, and say "OK, how do you work with this?" So you'll meet some doctors who are very gung-ho about this, but why shouldn't they be? It takes the burden off of them, and it's better patient care. Patients get well. Patients on drugs don't get well. It is in their best interest, but not a lot of them know that. And there's some defensiveness there as well. But that would be best case scenario, for sure."(Hayman)

Though not as involved, collaboration can also occur through referrals and written correspondence, as this chiropractor explained:

"I get referral letters, and then if I need any previous reports, they'll send them to me – like, any previous imaging that's been done. I always follow up with a letter back to them saying "thank you for referring so-and-so, this is what I've found, and this is what I think I should do". So then the physician says to the patient ""OK, bad back" or whatever, because it takes a long time to do a thorough examination on the musculo-skeletal system. "You should see the chiropractor. Here is her contact info. She'll take really good care of you, and then she'll let me know what we need to do". So then I'll get back to the doctor and say "we need a cat-scan, or we need an MRI, we need some x-rays or blood-work, or meds", whatever. So they're referring to a back specialist, which is what we are."(Jane)

Often, the collaboration that occurs is not as direct. This can take the form of simply demonstrating an interest in, and acknowledgement of simultaneous treatments.

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The following example, given by an acupuncturist/NAET practitioner, demonstrates this nicely:

"My mother-in-law was diagnosed with ovarian cancer, and did radiation and chemo, but the whole way along they also did natural and herbal things to help her tolerate chemo and keep her detoxified. She did acupuncture through everything for pain and nausea. She's done really well with the two, and both her surgeon and her medical oncologist in Moncton were very open to me. Her medical oncologist especially was a new doctor from Sweden, where they probably use a little more alternatives than we do here. In Europe it's a little more accepted – the integration is a little more accepted. He asked right away, because she was tolerating her chemo and seeing results more quickly than he expected, so he was asking about what we were doing, and said "just keep doing what you're doing, because she's responding well to this"."(Shea)

In perhaps the most passive manifestation, collaboration can simply involve referring patients back and forth as needed:

"Depending on what patients come for, I try to be really responsible, so I don't get any doctors thinking I'm irresponsible. If a patient comes in with abdominal pain, I'll say "you've got to go to your doctor first, to rule out that you don't have an ulcer, or a tumour – I don't want to be treating you for food allergies when it's something else." So I usually encourage them to go be tested. And then if everything else has come back, then I'll test them, and usually it's quite obvious that it's food sensitivities. And then I'll encourage them, for instance, if they want to come off medication, most people can come off if they're on like Prevacid, or any of the antacids once their diet has change a little bit and their sensitivities are treated, but even that I'll say "if your doctor prescribed that, don't come off of that yourself – go back to him, tell him that you've changed your diet, and you can tell him if you want that you've done some treatments to desensitize – some acupuncture based treatments – and that you're not getting any breakthrough heartburn any more, and that you'd like to try coming off of the medication", and usually they're open to that if that patient talks to them about it."(Shea)

Clearly, there are highly variable degrees of collaboration that can take place in this form of CAM-allopathic integration, and they are all potentially affected by

the previously discussed constraints, including issues such as time, epistemology and perceived relevancy. What they share, however, is at least some level of acknowledgement on the part of the practitioners that simultaneous treatments are, and (in most cases) should continue to occur. This not only takes the entirety of the onus of communication and health management out of the patient's hands, but it also highlights the "complementary" nature of most CAM modalities and treatments.

The notion of CAM-allopathic integration, in all of its various manifestations, is one that has justifiably received a great deal of attention from an applied standpoint. If integration started to become more ubiquitous, it could theoretically help solve some of the more pronounced problems that many are currently facing within the Canadian healthcare system. Time, money and communication are certainly all large issues that cannot be solved quickly or in their entirety, but they are also all issues that could potentially be vastly improved if allopathic and CAM modalities were able to start working together in a more deliberate, thoughtful manner.

Of course, the obstacles in the way of this type of movement are diverse, and not easily surmounted. As was demonstrated when discussing each of the forms of integration, the root of such obstacles goes back to the issues of knowledge, belief and acceptability. To have physicians within the allopathic medical model work alongside, or incorporate, CAM, is by definition to either accept the merits and safety of modalities that have not been proven using the gold standard of medical scientific testing, or to only allow the often stripped away parts of a modality that have been deemed acceptable.

To further complicate matters, CAM modalities are so numerous and often disparate that there is no coherent or even obvious body of therapies or practitioners with which

to integrate. Many have pointed to internal regulation as an important benchmark of a disciplines's claims to legitimacy and accountability, offering the promise of certain standards of training and competency. To be regulated carries with it a certain authority that many would be willing to recognize, even if the practices themselves did not conform to the allopathic mainstream. In reviewing the literature, Wiese found that a number of Canadian studies identified one of the primary goals for "both leaders and practitioners of traditional CAM systems is achieving statutory self-regulation for their occupations", hoping for outcomes such as "improving education standards, improving practice standards, engaging in peer reviewed research, and increasing group cohesion" (Wiese, Oster, and Pincombe 2010, 338). Unfortunately, this is also a difficult and complicated matter, especially for modalities that do not have the necessary numbers of practitioners, institutions, or funding to become legislated and regulated within their province or territory. As was discussed in an earlier chapter, this is a particularly common problem in New Brunswick and Nova Scotia, where there are very few modalities that have provincially regulated.

6.4.5 Potential Paths Forward

This chapter has pinpointed some of the main challenges that people have identified with respect to accessing and providing ideal health care. It has also offered a potential applied solution to these problems, through the discussion of various forms of integrative healing. The question then becomes a matter of if and how integration should be implemented. Due to the complicated nature of the various forms of integration, immediate and large-scale change is, I would argue, unrealistic. Steps can,

and have, however, been taken in this direction on a much smaller, more individualized scale. If change is to occur, it will most likely happen as experience and education begin to broaden understandings between official and unofficial culture.

6.4.5.1 Education

Many of the difficulties inherent in any of the forms of integration can be widely cast as a conflict of approach and epistemology. While this is often a very apt description, much of the time this division is not a direct condemnation of particular practices, but rather a general ignorance or unawareness of the types of modalities and services offered, and the specifics of the practices themselves. As one Naturopathic Doctor summed up:

> *"It's like anyone. You're trained one way, and if it falls outside of your training, why would you think that it's good? It's just different ways of thinking. "(McCarthy)*

As such, dialogue, and recommendations are not likely to occur, let alone integration of any kind, if a practitioner has only a vague idea of what other practitioners have to offer. As one woman explained:

> *"A doctor obviously can't recommend something if they don't understand it. If they don't know anything about it, they're obviously just going to say "don't do it"."(Diana)*

To help fix this problem, many have suggested that allopathic doctors should be better educated about CAM-related matters. These two allopathic physicians, for instance, both acknowledged the need for such:

> *"Somehow the physicians should know more about what else is offered. They should be able to answer questions instead of dismissing."(Kati)*

> *"Patients are coming to me more and more with either a list of medications or that they're interested in different therapies, or that they're doing a therapy and want to know what I think about it. More and more, doctors – especially older ones – are saying "I need to start thinking about this and learning more, because otherwise I'm ignorant"."(Rowan)*

A Naturopathic Doctor echoed this sentiment, explaining how she often takes it into her own hands to educate allopathic physicians about specific herbs or supplements if the need arises:

> *"There is a tonne of scientific research about herbs and supplements, but they are not taught it. You don't know things that you're not taught. For the most part, they are against it, because they fear what they do not know. Ignorance is fear. So sometimes I write them a letter, saying, for instance "the studies on milk thistle are that it is protective for the liver, even when you are taking [Methotrex]", and they'll say "oh, I didn't know that", and I'll give them a reference, and they'll say "oh great, my patient can take Milk Thistle, then". They just didn't know."(Hayman)*

One of the large problems, of course, comes back to a matter of time. Physicians have a clearly demonstrated difficulty being able to spend enough time with their patients and keep current on their own field. To find extra time to educate themselves about the large range of CAM modalities would certainly be considered a low priority, if not an impossibility. Consequently, many have suggested, and begun implementing, CAM-specific modules within the training of medical students from the very beginning of their education. As one practitioner suggests, for example:

> *"How about starting by having someone go the medical schools and talking to the students. It's like anything else. When you live with it on a day to day basis, you become familiar with it."(Kemp)*

More than just acknowledging the need for better CAM-based education within medical schools, there have been many steps taken toward improving this situation. As

Sierpina notes, for instance, "interest in integrative health has let to interdisciplinary educational initiatives at undergraduate and graduate levels" (Sierpina, Kreitzer, Burke, Verhoef, and Brundin-Mather 2007, 174). One of the main problems, however, is that in Canada, as in many other countries, attention to CAM within the course of a standard medical education is "limited, varies across each of the 17 schools, and depends on local factors" (Sierpina, Kreitzer, Burke, Verhoef, and Brundin-Mather 2007, 175). To help ameliorate these issues, initiatives such as the "Complementary and Alternative Medicine in Undergraduate Medical Education (CAM in UME)" project have been developed. CAM in UAE, in particular, was designed to "change medical education from within", with the hope of instilling "an appreciation of the importance of principles of integrative medicine, such as healing, wellness, and patient-centered care, and also to cover basic CAM concepts and issues, policies and resources" (Sierpina, Kreitzer, Burke, Verhoef, and Brundin-Mather 2007, 176).

Despite such efforts, however, much of the CAM-related curriculum in place at medical schools still varies widely in terms of content and comprehensiveness. [1] Depending on a multitude of factors, such as the background and training of the

[1]A helpful resource detailing (among other things) a summary of CAM education resources offered at all the 17 Canadian Medical Schools in Canada can be found at the CAM in Undergraduate Medical Education website: (CAM in UAE Project 2016b). They caution that the summaries offered may not capture all teaching, particularly material that may be, for instance, embedded in lectures, or raised by student questions. At Dalhousie University in Halifax, NS, it is indicated that CAM content is integrated into a case on chronic pain, and that there are CAM electives available. At Memorial University in St. John's, Newfoundland (which has an affiliation with the University of New Brunswick), there are four hours of introductory content on CAM issues offered for 1st year students, as well as elective web modules.(CAM in UAE Project 2016a)

professor or teacher, the approach that this person takes, the length of time spent on the subject, and whether a course is deemed mandatory or elective, can all drastically effect the way CAM is presented. As Grace has noted, for the most part, "focus on CAM training for MDs has been on selective application of CAM products, versus the type of training that would allow for deeper collaboration" (Grace and Higgs 2010b, 1189). Therefore, while CAM-related education for students of allopathic medicine has the potential to positively further or deepen understanding and exposure to CAM, it can also have exactly the opposite effect. As one woman pointed out:

> "A two week module on this area that so much study has gone into isn't enough. Also, in the whole 4 years of med school, you're going to forget what you were taught in a two-week module. You can only hold so much information. Also, you need to take it seriously. A little two week module is kind of making fun it – we'll throw it in there for looks."(Diana)

Education about CAM is clearly recognized as a critically important factor not only with respect to taking steps toward a more integrative approach to healthcare, but also in the day-to-day treatment of patients. Unfortunately, the task of actually implementing such forms of education are not straightforward – while there is potentially much benefit that can come with even a small amount of awareness and understanding, a lack of comprehensiveness can sometimes be more deleterious than no education at all. Nonetheless, with research and insight into how best to communicate and update the most salient aspects of CAM, people have, and will, continue to figure out how to incorporate CAM-related education and information to allopathic healthcare providers. This could eventually aid greatly in shared understanding and potential integration.

6.4.5.2 Individual Experience and Relationships

Throughout the interviews I conducted, the most compelling and powerful bridges of understanding which formed between the worlds of CAM and allopathy happened at the level of individual experiences and relationships. This was also a phenomenon discussed in the literature. With respect to integrative assimilation, for instance, Shuval found that CAM practitioners came to practice in hospitals not by a formal screening and interview process, but rather "by informal processes... personal acquaintances between biomedical MDs and CAM practitioners" (Shuval, Mizrachi, and Smetannikov 2002, 175). These relationships and experiences are, at some level, a type of informal, and sometimes unintentional education.

In some cases, this sharing of knowledge occurs due to circumstantial relationships, or first-hand witnessing of the effects CAM can have. As one energy worker explained:

> "Right now a lot depends on the relationship between CAM practitioners and doctors. There is a dentist in Charlottetown, for instance, whose wife does therapeutic touch, and he never does a dental procedure without first getting her to do some therapeutic touch. We might get a call occasionally from patients in other areas who have heard what we're doing and want help. I sometimes hear people in the OR asking for people to be there. And some doctors have noticed a difference when that happens. So they have to see it, and they have to learn. It happens gradually. My niece, who is a Naturopathic Doctor, has a sister who is a traditional medical doctor. These things are happening all the time – this kind of sharing. So it's got to be in the relationships."(Susan)

In other cases, the experiences, and the resulting knowledge gained are first-hand. This allopathic doctor, for instance, who started having severe back issues at one point in her life, relates the following anecdote:

> "I started off taking back meds. It wiped me out – I couldn't function and it didn't help. Suddenly I had to look around, because I was desperate

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and depressed. I started going to physiotherapy, which was great, and the physiotherapist did acupuncture, which was good too. But I think what actually changed my life was the massage therapy. You can't convince me otherwise. The reason I got better, I believe, was the stretching and the massage therapy. I try not to be biased, but I'll very highly recommend massage therapy to anyone who wants to have it. It was the biggest part of my recovery. So it's not that I'm not interested in acupuncture, and I've always thought I should do more, but you only have time and money to do sessions, so it's always been massage therapy for me."(Rowan)

Similarly, a NAET practitioner/acupuncturist gave an excellent example of an allopathic physician who had positive results under her care, and subsequently trusted her enough to start making referrals to his own patients. As she explains, it was this experience that changed his skeptical, negative attitude – an attitude that she encounters from many other physicians who are not as familiar with shat she does:

"I do have a doctor who's a plastic surgeon, and he was very skeptical in the beginning, but I treated his wife and his son, and he eventually came for treatments. He's had acupuncture, NAET, JMT for his arthritis, and has done really well with it, and actually refers patients to me, mainly for acupuncture. He doesn't think he can really refer anything else, technically, but he does for acupuncture. We've had good success. He had one patient who had had chronic pain for years – sympathetic reflex dystrophy or something – chronic pain from trauma that didn't respond to anything else – and they were actually looking at doing maybe some nerve blocks, and he sent him here. It took a lot of acupuncture, maybe 4-5 months, but we were able to resolve that pain, and get him off of narcotics. So he was really pleased. So I've got a few doctors that a very open, but there's still a lot who tell their patients not to bother – that it's a scam. My own family doctor tells patients not to come here."(Shea)

Even simply meeting a person face-to-face, and getting a feel for him or her on a personal, or instinctual level can have an effect on how that person is perceived, and the willingness to trust them with patients or clients. As this CAM psychotherapist reveals, however, in her experience allopathic physicians need to already have an

openness or comfort with the CAM world in order to make those connections in the first place:

> "I prefer to refer to people that I've met. What I find interesting is that people come to me – an acupuncturist sees my ad somewhere, and we go for coffee and talk. And you get a sense of someone right away. And no, I may not know their profession, but I know enough about it, and I've had a sense of this person – I trust them, and I feel they'd be good with people, and I'd send my people there. I've tried to network with a few doctors, but I've only had 10 minutes, and it's really hard to get a sense of someone in 10 minutes, and for them to get a sense of you, and of the 10 doctors I tried to contact, only 2 would meet with me. So I feel like on some level, physicians are too busy to take the effort to connect with the alternative health community to get to know people a little a bit. So I think it's only doctors who are comfortable, or have some personal connection with the alternative health community that they'll make that effort."(Julia)

Finally, it is worth noting that individual experiences and relationships can have an effect not only at the level of personal healthcare, but at the level of policy as well. As this Naturopathic Doctor explains:

> "Right now there are quite a few high-up political people in NS that are either going to see Naturopaths or their kids are, or they are friends with Naturopaths. So in that environment, they are pushing for either full regulation, or protection of title, so that not just anyone can put a shingle out and call themselves a Naturopathic Doctor."(Murphy)

When trying to unravel and piece together the nuances of something as large and complicated as an entire health care system, it is easy to see challenges and issues large-scale. Certainly, when it comes to matters related to CAM and allopathy, fundamental differences in approach and epistemology can easily be pinpointed as the main factors that divide these two extremely large, diverse groups of health practitioners. Such a grand division makes common understanding, and therefore any

of form of integration, seem unattainable. As one practitioner aptly stated, however, "so much comes down to individuals" (Susan).

Indeed, as this sample of quotes has demonstrated, the lived experiences and the relationships formed by and between individuals can often become catalysts for change. To experience something new at a personal level is to gain an understanding, a perspective, and a comfort with concepts that were previously foreign. Similarly, to meet and form relationships with people who do or understand things differently can lead not only to a broadening of one's own perspective, but also a level of trust that can transcend specific modalities or epistemologies. It is exactly these experiences and interactions that can begin to forge the links of realities such as integration.

6.4.6 Conclusions

This chapter set out to explore ideas concerning the optimization of healthcare, in particular for those who juggle both the worlds of allopathic and complementary and alternative medicine. By first discussing some of the most common and problematic challenges or concerns expressed by those who use or practice within this system, the goal was to then take an applied approach to begin to understand how we could possibly start to find solutions. With time, money and communication pinpointed most frequently as problems within the current system, it was, predominantly, various forms of CAM-allopathic integration that were proposed as potential ways of moving closer to an ideal. Certainly, this is not intended as a grand solution to all of the challenges that people are faced with daily within the current Canadian healthcare system, or even as a solution that could, or should, feasibly be implemented in any

large-scale, or immediate fashion. The truth is that all solutions also have their own set of challenges and set-backs, which will quite possibly never be solved.

This is not, however, to say that change cannot or should not occur, or that integration is a foolish or lofty goal. The key, I would argue, will be to continually strive toward a better understanding and cross-fertilization in whatever form that takes. In the end, it is the small-scale changes that will most likely begin to make a difference to the system at large. With respect to integration, for instance, if this is indeed an applied path toward a smoother, more ideal health-care system, it is quite possible that it will only begin to to occur sporadically, with the joining and vision of open-minded, or like-minded individuals, crossing some long-established boundaries. In this sense, as one practitioner pointed out, the focus is not so much on fixing problems, or striving for a specific, elusive ideal, but rather on allowing the system to gradually evolve into something better. As he states,

> *"My feeling is that rather than saying "there's a problem and we need to fix it", I think it's fair enough to say that there are always going to be problems when people and theories and paradigms interact. But they will interact, cross-pollinate with each other, grow and change over time. I believe that's happening, whether people are doing anything about it or not. It is the natural evolution of our healthcare system. It is an immense drive to feel well. If you're not feeling well, everything in your life sucks. It's an immense motivator for people to go out and try new things. So it's got its own powerhouse moving it. Whether there are any official centres for it – like a national institute for health – or not, people are motivated to make themselves better."(Johnson)*

Indeed, people are highly motivated to make themselves better – it is a large impetus behind the existence and use of such a wide array of healing modalities, both in and outside of the allopathic medical system. Perhaps as more voices and experiences of those who have had success continue to be heard, greater understanding,

education, and curiosity will evolve. As these fundamental components begin to change, evolution of the system will hopefully follow, and result in something that comes ever-closer to the elusive ideal.

Chapter 7

Conclusion

7.1 Chapters in Review

To pursue the academic study of health-related issues is, by its very nature, complicated and potentially overwhelming. Health and illness are universal concerns, and therefore attract the attention of an incredibly wide array of different disciplines and scholars, with a correspondingly diverse set of approaches, goals, and lenses through which the research is conducted. Within health-related studies, the stakes are high, opinions and beliefs are pronounced and often political, and resulting findings and discussions can have direct, personal affects on both participants and the population at large. This is, I would argue, especially true when exploring a broad topic such as complementary and alternative health – one that so often crosses what many deem to be clearly-set parameters for discerning true, safe, reliable data. But these are also the characteristics that make such a study important, fascinating, and continually relevant and evolving. It was this broad, complex, messy world that I was interested in exploring, to find

out why it exists, how it is navigated, and why it is so prevalent and significant to so many people.

From the very beginning of this project, I was intent to let the flow, the themes, and the research interests emerge organically. This was true both with respect to the interviewing process, as well as the resulting shape and direction of the thesis itself. As I explained in the methodology chapter, while there were broad issues that I was particularly interested in exploring, I did not enter the fieldwork, the coding process, or the thesis construction with preconceived notions of exactly how I wanted the chapters structured, or which subjects were the most important to address. I let these decisions present themselves, based on the topics the interviewees felt most relevant, and the themes that coding revealed to show up most frequently. The result is what I consider to be three extremely complex, important topics, which are simultaneously distinct and elaborately intertwined. Ranging from philosophical and esoteric, to pragmatic and practical, the issues that are addressed in this thesis all share the common core of illuminating aspects of the official/unofficial health culture continuum, and of expressing the voices and experiences that lie at the heart of health beliefs, choices, practices and worldviews.

7.1.1 Chapter 1: Overview: Introduction, Themes and Theory

After briefly setting up the large-scale goals and outline of the thesis itself, the introductory chapter was used to highlight and discuss some of what I considered to be the most important over-arching themes, issues, and literature related to

complementary and alternative health beliefs and practices. As the thesis itself was to take on broad topics, these themes were correspondingly broad. Covering both esoteric and practical concepts, the chapter focused primarily on issues of the vernacular, narrative, health-related folklore research, and a semantic/research-oriented discussion of the term "complimentary and alternative' medicine", or "CAM". While the vernacular, narrative, and CAM sections were, by necessity, cross-disciplinary in nature, I was ever-conscious of providing an overview of where folklore fits within these particular issues, and how it compares and/or contrasts with other disciplinary approaches. The "folklore and health" section, by contrast, was included to specifically discuss what folklorists have contributed to the large topic of health beliefs and practices, and how this research has changed and evolved over time. Together, these thematic discussions were meant to provide the context for the more specific work to come – placing my own research both within the folklore and cross-disciplinary literature and the theory that came before it.

Of particular relevance are the related notions of "vernacular" and "narrative". These are arguably two of the most important cornerstones of folkloristic research generally, and ones that directly influenced my entire approach, from fieldwork right through to analysis and writing. While folklore can certainly not claim sole ownership or use of these concepts, it can boast a strong and early interest in them, relative to most other disciplines. More importantly, however, is how narrative and vernacular are conceived, and used by those who choose to incorporate lay voices and understandings into academic research. There is an underlying acknowledgement within the field of folklore that vernacular narrative is a powerful means of opening a window into the world of expressive culture. It is a fluid, dynamic, ever-changing glimpse into

perspectives, understandings and worldviews that often run counter to some of the more dominant or institutional narratives, and can therefore also often go unheard or silenced. They are a means of accessing different ways of knowing, steeped in unique experience and interpretation. Too often, however, depending on the the discipline and/or scholarly goals, such narratives can become misrepresented, manipulated, and/or appropriated. This is especially true within the world of health-related research, and medically procured illness narratives. This not only an important point to note when accessing vernacular and health-related research from a cross-disciplinary perspective, it is also of significance for contextually placing my own fieldwork and analysis.

The "health and folklore" section was as straightforward as it sounds. There is a long history of both health and belief studies within the field of folklore – the approach to which has changed drastically since the discipline first began. As such, in order to place contemporary folklore health research into context, it was first necessary to offer a brief discussion of its roots and its evolution. In the dubious beginnings of health belief studies, folklorists adopted a collectanea-based approach, focusing on peasant culture and the "primitive", "superstitious" beliefs and practices found therein. Over the decades that followed, health belief scholarship developed – thanks in large part to David Hufford and his contemporaries – into the experience-based approach that has influenced my own work so fully. As such, after outlining the historical evolution of approaches, the rest of this section offers a discussion and literature review of what I consider to be some of the most influential contemporary health and belief folklore scholars, and their most notable research contributions to the field.

Finally, I felt it was imperative to offer a brief but thorough discussion of the term

"complementary and alternative medicine", or "CAM" – what it means, why I chose to use it, and how it has been studied, both within folklore, and throughout a vast array of other disciplines. CAM is, by its very nature, a residual term. At its core, it is meant to denote any and all practices that fall outside of mainstream, biomedical medicine. Consequently, it is also an extremely loaded term – one that presents a clear dichotomy between official and unofficial culture, complete with often derogatory presuppositions about any beliefs that are not backed by rigorous scientifically-based research and paradigms. I had no intent to promote this dichotomy or any preconceived notions about validity of CAM, or lack thereof. I did, however, consciously choose to use this term, due in large part to its ubiquitous nature, and large-scale recognition. This section, then, offers a thorough look at that decision-making process, complete with a discussion on how CAM came to be used broadly, how it is understood, and how this influences research. This is followed by a brief outline of the relatively recent interest in CAM-related research, the types or forms that this research takes, and a literature review of some of the most relevant ethnographically-based work that influenced my own research.

7.1.2   Chapter 2: Methodology

This short, straightforward chapter was designed to cover both the philosophical and technical details of the fieldwork methods undertaken for the thesis. It details: the decision-making process behind choosing a geographical or regional means of limiting the study; the various recruiting methods that were used; the interview process itself; as well as the methods I used for transcribing and coding the material. Also included

are tables displaying a breakdown of the people I interviewed, based on factors such as type of informant (CAM user, CAM practitioner or allopathic physician), place of residence, and occupation or speciality. Finally, this chapter makes reference to helpful pieces of information, such as CAM-modality definitions, and various forms and recruitment material used throughout the fieldwork process, all of which can be found in the appendices at the end of this thesis.

7.1.3 Chapter 3: Regional Context

Before delving into the larger themes and issues that form the body of this thesis, it was first imperative to put the narratives and analysis into context and perspective. This chapter accomplishes this feat in a few different ways. The first is to offer a brief but thorough description of Canada, and more to the point, the Canadian healthcare system, and how it works. In particular, it highlights the national health insurance program, known as Medicare – a program that was designed to provide universally accessible health care to the Canadian population. Tracing its history, its scope, and its evolving strengths, challenges and weaknesses, the section offers a backdrop against which further discussion of the official (allopathic), and unofficial (CAM) health systems can become much clearer.

Secondly, and perhaps most importantly, this chapter offers a detailed introduction to the two cities where the fieldwork was conducted: Fredericton, New Brunswick, and Halifax (or the Halifax Regional Municipality), Nova Scotia, and the broader Atlantic region of which they are a part. After providing statistically-based descriptions of geographic, political, and demographic features, the focus then turns specifically

to the subject of the region's complementary and alternative health scene. While there has been relatively little research done in this particular niche, one particularly interesting factor stands out. While CAM practices are clearly being offered and used in this region, statistical evidence has long suggested that interest and use of CAM significantly lags behind the rest of the country.

In order to explore this important distinction, this chapter then turns to the experiences and thoughts about the subject from the perspective of those I interviewed. While this puzzle is certainly complex, nuanced, and can vary considerably depending on specific modality and location, three main themes emerged. The first involved an often expressed sentiment that CAM practices felt very "new" within New Brunswick and Nova Scotia, as compared to much of the rest of the county. Consequently, those who practiced or used such modalities likened themselves to pioneers – forging difficult new ground, and starting from scratch. In this way, there was an insinuation that, rather than a matter of disinterest or apathy, CAM use was lagging behind the rest of the country as a result of individuals simply having relatively few options, or being unaware of what was available.

Secondly, there was a common reference to, or description of the "conservative" nature of these two provinces. This rather nebulous term did not seem to be associated with a political or religious conservatism, but rather a preference for doing things they way they have long been done. This could go a long was toward explaining a reluctance to embrace the relatively "new", unofficial nature of CAM. Significantly, however, there was also a prevalent counter notion that, in particular, Halifax-based individuals were actually incredibly open to change, and were quick to embrace CAM when made aware of it. As I argued, these conflicting observations can perhaps be

seen to point to a growing trend to use CAM – one that is potentially influenced both by a young University-based population influx, and the power of word-of mouth. While there may be a "conservative" bent toward this region's population, then, this may well be in the process of evolving and changing.

Finally, there is a long discussion in the chapter about the related notions of money, legislation, and regulation. This is an extremely complicated topic – one that crosses political, economic, and hegemonic boundaries. In its most condensed form, the crux of the issue involves the fact that, because CAM modalities are not, for the most part, included within those services covered by Medicare, it is typically only those with private insurance and/or disposable income who are truly able to use them. This is further complicated, however, by the issue of legislation and regulation. If a CAM modality is not officially regulated, it is therefore also often not recognized by places such as insurance companies as providing a reimbursable service. This, of course, makes it even more difficult to justify for many people from a financial standpoint. For many reasons, there are very few CAM modalities within New Brunswick or Nova Scotia that have achieved official legislation or regulation – a fact that no doubt heavily influences the use of CAM for any number of different reasons.

7.1.4 Chapter 4: Knowledge and Belief

The first of three main chapters, "Knowledge and Belief" covers what I consider to be the core or backbone of any research related to official and unofficial health-related practices, decisions, and culture. It is through a discussion of these key concepts that it becomes possible to highlight preconceived notions of the nature of truth and

validity, and to discover how variations in worldview and epistemology drastically influence and alter health-related choices, power dynamics, and care. With respect to the the worlds of allopathic and CAM health practices in particular, a discussion of knowledge and belief can also help to illuminate where and why a dichotomy exists, and how this affects the relationship and understanding between those who provide care, and those who come seeking help.

Before turning to voices and experiences found in the interview-based narratives, this chapter begins with a discussion of some key concepts and theory. Naturally, the first important subject is an overview of the concepts of knowledge and belief. The dichotomy between knowledge and belief is widespread and longstanding, as are the notions that equate knowledge with truth, and belief with error or falsity. This is apparent even when examining the approach that folklorists took to belief studies in the early days of the discipline. When concepts such as worldview and complex belief systems began to be developed, however, the approach to belief studies started to evolve.

It is in this context that David Hufford developed his pivotal theories of methodological symmetry and populism, proclaiming that in any comparison of traditions – particularly ones involving official and unofficial culture – one must start with the assumption that the unofficial position might be correct, and must also aim to ask the same questions of both sides. Following from this, it becomes clear that every individual, whether they are a part of official or unofficial culture, have their own unique belief system, and that notions of truth, proof and validity are therefore *all* culturally defined. As such, knowledge and belief must be understood as not nearly as oppositional or dichotomous as they might initially appear – the difference

between them is often positional and political in nature, rather than absolute. This is a fundamental concept to understand, especially when delving into the nuance of allopathic and CAM-related health practices.

The second large topic to tackle was that of allopathic knowledge – a discussion of the history and reach of scientific imperialism. While science is pivotal to both the epistemological and practical roots of biomedicine, it truly only became such a large influence in the nineteenth century, when twin theories of positivism and reductionism emerged, drastically changing the face of medicine. Positivism sought to find "true knowledge", espousing scientific method as the only reliable means of accessing truth, while reductionism declared that the body should be understand and treated as a machine. These theories were joined in the twentieth century with that of logical positivism – a theory which enthused over the possibility of scientific proof.

These prevailing and guiding biomedical theories and approaches culminated in the 1990s, with the emergence of "evidence-based medicine", or EBM. Simply put, the contention of EBM was that all medical decision making be based on the best possible evidence, using biostatistical and epidemiological evidence as standards. Multiple different hierarchies of evidence were subsequently developed, almost entirely determined by a "causal" versus "less causal" scale. Within these various hierarchical scales, however, the model of randomized clinical trials (RCTs) almost exclusively became the gold standard of evidence. The RCT is considered the optimal tool in conducting objective, thorough medically-based trials. Despite being such an influential, widely accepted paradigm, however, the EBM movement (and the associated reliance on RCTs as the gold standard in evaluating effects of health interventions), has garnered much interdisciplinary criticism.

Similarly, though it is usually accepted without question, and is indisputably at the core of the most important medically-based advancements in the last century, a reliance on science and scientific evidence is not nearly as unequivocal as it is so often assumed to be. There are many who have pointed out, for instance, that while the "truth" of scientific method rests, in large part, on the notion of divining objective fact, there is, in reality, a great deal of politics, differences in study design and interpretation, and human error that influence results. Therefore, what is presented as infallible truth is actually, in many respects, a heavily influenced social construction. These unavoidable aspects of scientific method and inquiry within medicine are not meant to invalidate them as methods of obtaining knowledge. They are, however, important in that that they act as reminders that the results obtained while using scientific principles cannot automatically be assumed to be infallible or irrefutable – and therefore, by extension, many would argue that they are also not always the most pertinent ways to obtain knowledge.

This history and the current priorities within the world of allopathic medicine are important to understand for a number of reasons. The first is simply to grasp the prevailing paradigm under which biomedicine evaluates information, and obtains knowledge, and therefore, how it functions. It is also imperative to understand the criticisms that have been lobbied against these paradigms, and why, despite this, they continue to hold so much sway. Undeniably, the world of allopathic medicine has developed a "knowledge monopoly", based on a bio-scientific framework for knowledge acquisition.

It is with this background in place, that the chapter then turns to the notion of health beliefs and practices – and the acquisition and use of knowledge – from the

perspective of complementary and alternative medicine. CAM is, as was previously discussed, a broad, residual category. Many have argued that much of this residual nature lies in the fact that those modalities and treatments found in the world of CAM are simply those that have not been proven – through the scientifically-based EBM methods of testing – to be safe and/or effective. The underlying theme here is about legitimate forms of knowledge, the production of which involve proof, regulations and standards. If a form of therapy is truly "proven" to work, then it ceases to be CAM, and becomes a part of allopathic medicine instead. The assumptions inherent here are two-fold: that there is a very limited method to determine "true" knowledge, and that all types of healing can – and should – be subjected to the same standards of testing upheld by the allopathic medical model.

From the perspective of those who use and practice CAM, however, what constitutes valid forms of knowledge is not so narrowly defined, and proof or evidence of efficacy is determined by various different means. Understandings of health and wellness are viewed from an expanded – and often very different – epistemological lens to that of allopathic medicine. This is not to suggest that there is a universal, shared understanding of knowledge found in those who use and practice CAM, but rather that there are important similarities with respect to what is valued and accepted as valid ways of knowing and understanding. Exploring some of the more prominent, over-arching epistemological understandings offer a broad and potentially enlightening glimpse into the mosaic of health-related knowledge. It is here that the voices from the interview-based narratives truly come into play.

The first of these large over-arching themes explored in the chapter was the notion of holism. Directly counter to a reductionist or mechanistic approach to the body, the

epistemic roots of holism view an individual as comprised of interrelated, connected aspects, which include the body, the mind, and, for many, also the spirit. In this sense, a person is not reduced to a purely biomedical body – to look only at the physical aspects of a person's well-being or illness is considered to be incomplete. As such, it is clear why a holistic ideal can set CAM apart from allopathic medicine. While there have been genuine attempts to incorporate a more "holistic" approach within biomedicine, the allopathic medical system has evolved to function in a manner that does not easily allow for holistically-minded diagnostic or therapeutic interventions. Furthermore, a holistic approach engenders different emphasis on, and sources of, knowledge. These can include the length of time (historically) that a modality or approach has been used, personal experiences with illness or health, and personal observations. Steeped in holistic ideals, these "less rigorous" forms of evidence are particularly useful at gauging the effectiveness of interventions in a very broad, multifaceted manner, rather than a particular bio-mechanistic function within the body. They are, paradoxically, also often more effective at sorting out the particular nuances of an individual, rather than heaping people in with clinical trial results.

The second theme the chapter explored involved intuition and energy. These concepts are particularly loaded, as they truly fall outside the confines of the EBM hierarchy, and, arguably the scientific paradigm more generally. The first, variously described by terms such as "intuition", "embedded knowledge", or "internal wisdom", is a concept that is widely understood but commonly discounted as unsubstantiated, highly unreliable, and potentially dangerous. Essentially, it involves the notion that there is important knowledge and wisdom that is embedded in each individual – being able to access this knowledge involves conditioning yourself to listen and trust what

your body or intuitive sense is trying to communicate. It is a form of knowledge that one cannot learn, teach, or test in a manner that has any correlation to allopathic medicine, and can therefore easily be discredited from such a perspective. It is also, however, considered an essential, and extremely powerful tool by many of those who use it.

Similar in some respects is the notion of "energy", also commonly referred to as "chi", "vitality", or "life force". This is a concept that varies considerably dependant on the type of modality or health concern, and even on individual practitioners or patients. In the broadest sense, however, it involves an ever-present force or energy that can, from a health-related perspective, affect physical, mental and emotional well-being. It can be understood in terms of the philosophical or epistemological underpinnings of the way the body, mind, and spirit work together, and how they relate to the larger, universal understanding of life and wellbeing. More specifically, the concept of energy is understood as a very direct, tangible, and key component within the healing process – a force that can be manipulated, redirected or used to improve both general and specific health-related factors. This is true both respect to modalities that are purely described as "energy work", such as Reiki or Quantum Touch, but is also prevalent within a large number of other disciplines, such as homeopathy or acupuncture.

Not only do the concepts and techniques used in vitalism, or energy-based healing, lack a biomedical correlate, they also fall outside the allopathic explanatory framework. They are consequently viewed with extreme skepticism, and often patently regarded as false. A particularly prominent example of this, especially in more recent years, is homeopathy. Though it is a form of CAM that has relatively large-scale usage world-wide, and has even shown favourable results in clinical trial evidence, it is still

held in disrepute by most of the Western medical and scientific community. This is due in large part both to underlying philosophical principles, and the resulting remedies that are used within homeopathy. From a scientific perspective, remedies are so dilute as to be chemically indistinguishable from water. From a homeopathic perspective, however, the energetic essence of the substance has been maintained, and it is this that works within the body to produce results.

What makes this homeopathy/allopathic medicine divide such a good example is the way in which it demonstrates an inability or unwillingness to accept a modality or practice whose explanatory framework falls outside the scientific mainstream. As many have pointed out, however, to summarily dismiss evidence and results based solely on the fact that they cannot be adequately tested or explained within a current scientific framework, is, in many respects, inherently unscientific in nature. Also important to understand is that, conversely, belief in concepts such as energy or vitality does not automatically denote a rejection of science or scientific principles. Many who use or put stock in such concepts also accept science as a valid explanatory framework. The key difference, however, is that they do not view it as the *only*, or in some case, the *best* explanatory framework. This is evidenced in many CAM modalities. Even practitioners that tend to be viewed much closer to biomedical models, such as massage therapists, will often incorporate energy-related work such as Reiki or cranio-sacral therapy into their practices.

The conclusion of this chapter reiterates the complex, important nature of the study of knowledge and belief, especially when dealing with official and unofficial culture. To possess officially sanctioned knowledge is, by definition, to possess power, authority, and legitimacy, whereas unofficially sanctioned claims to knowledge are

often quickly dismissed simply as belief, and therefore false, or unworthy of serious consideration. This is particularly evident within the world of allopathic medicine and CAM. Closer inspection, however, reveals a much more nuanced reality – one that does not maintain a dichotomy between knowledge and belief, but rather a continuum of different ways of obtaining knowledge. The types of evidence that are valued, the desired outcomes, and differences in core epistemological underpinnings all influence the types of knowledge that are sought, and the resulting notions of truth. The common sentiment that ran through the voices captured in this chapter point to the importance of continually seeking, evaluating, and re-evaluating sources of knowledge. Inherent in this was the necessity of broadening epistemological lenses to the possibilities inherent in various means of acquiring knowledge, rather than letting it stagnate in a pool of preconceived notions. Perhaps if this became a more prevalent practice, the lines between allopathic medicine and CAM would truly begin to blur.

7.1.5   Chapter 5: Role

This chapter examines what I decided to describe as an individual's "role" as it relates to health – where individuals are personally situated within the realm of health and well-being. It brings up questions of how people understand their responsibilities and expectations with respect to their own health or their health-related practices, and how they understand the responsibilities and expectations of those with whom they interact. It is a complex question, especially when it involves a large number of players, often acting simultaneously, but separately from each other, sometimes with very disparate ideas of what various "roles" should, and do entail. Although it was

a complicated theme to address, it was one that brought up fundamental concepts of worldview and identity, and which illuminated where these concepts coalesced or clashed. This is, as it became clear, particularly relevant with respect to practitioner-patient relationships and interactions, both within CAM and allopathic medicine. It also had direct implications with respect to reaching a better understanding of how and why health needs are or are not being met, and where there is room for improved understanding, communication and outcomes in health-related scenarios.

To try and pinpoint a definition or understanding of the concept of "role", this chapter begins with a theoretical discussion. Arguably, the term has a larger connection to disciplines outside of folklore – sociology, for instance, is well known for its examination of a person's position and function within society, and includes concepts such as "sick role theory" "role allocation", "role ascription", "role set" and "role other". There are, however, key folklore theoretical concepts that strongly influenced this chapter – in particular, performance, group, identity, and the esoteric-exoteric factor.

Having explored the theoretical underpinnings and contributions to the concept of role, the chapter then moves on to analysis of the interview narratives. Due to the fact that role is so intimately connected to group identity, I opted to structure the analysis based on the larger group to which individuals were a member. The first one I tackled was that of "allopathic physician". In academic literature, the concept of "role" within allopathic medicine is typically examined within the context of the doctor-patient relationship – a relationship that has changed dramatically over time. As the mid-nineteenth century saw a shift in medicine toward a scientific ideal, so too was there a shift toward a more centralized and professional consensus regarding

diagnosis and therapy. This meant that physical examinations became more important than patients' experiences and verbal accounts of their illnesses. There was also a subsequent shift toward laboratory medicine, using experimental physiology and histology to obtain results.

These shifts in medical approach had direct impact on on doctor-patient relationships. Whereas patient control was once maximized, the power relations shifted completely. Doctors began to take on a paternalistic relationship with their patients, infused with the underlying assumption that doctors "know best", and should be tasked with making decisions for their patients, rather than directly involving them in the process. This model began to be seriously questioned in the mid-twentieth century, which paved the way for what became known as "patient-centred medicine". Adopting such a model entailed shedding the dictatorial paternalistic leanings that are so firmly rooted in the discipline, and striving instead to enter into a partnership with patients. Ideally, such a partnership includes acknowledging patients as individuals, respecting and considering patients' input, and arriving at goals, outcomes and treatment options that are mutually agreed upon.

With this background in place, the chapter then turns to the experiences of those I interviewed, examining what allopathic doctors felt were their most important roles, and how this meshed or contrasted with concepts from their patients, and from CAM practitioners. One of the most prevalent roles that physicians brought up was that of "advice-givers". Essentially, this is the notion that allopathic physicians possess a unique body of knowledge, and a set of diagnostic skills, which they can use to assess both the nature of the problem, and what they believe the patient should be doing to improve his or her health. What is key, however, is the implication that the

physician is there to offer advice, and therefore help a patient make health-related decisions, rather than dictate a proscribed course of action. For patients, however, this relationship tended to be much different in experience than in theory. Even in cases where they had positive relationships with their physicians, there was an underlying feeling that this relationship was more dictatorship than partnership.

The second large role that allopathic doctors described was that of incorporating preventative medicine into their practices, in large part through acting as an educator for their patients about preventative lifestyle techniques and changes. This is particularly significant for two reasons. The first is that this focus on prevention and on lifestyle coaching is one that is largely shared by CAM practitioners and CAM users. The second is that this was specifically an aspect that many I interviewed felt was *lacking* from an allopathic approach.

By exploring even just these two prevalent themes that appeared with respect to the role of allopathic physicians, an important discrepancy is presented. There is, in theory, a significant amount of agreement about what the ideal role of an allopathic physician should look like, both from the perspective of allopathic physicians, as well as from patients and practitioners. There was also, however, clearly a disconnect between theory and practice, as there was felt to be a clear dissatisfaction in the execution of these roles.

The second group analyzed was that of individuals, or patients. Clearly, the "individuals" represented in this thesis are not necessarily representative of the population at large. Not only did they all have a keen interest in CAM, they also offered their time to speak to me about health-related matters – they had, therefore, already devoted much time, thought and effort to their own health. Unsurprisingly, then, one of the

most prevalent themes that was brought up was one of active participation in one's own health – taking responsibility, making decisions, and exercising control. As many pointed out, however, they felt that this was in many respects counter to the societal norm, which has adopted a very passive role with respect to individual health. As such, health passivity often acts as a clear marker against which those who actively engage in their own health are able to form a counter-identity, wherein they actively choose to be healthy. Many described this as a very labour-intensive, time-consuming process, involving self-education and research, as well as experimenting and choosing the most effective tools and practices.

More than just describing a certain level of health awareness, commitment and maintenance, however, many people who spoke of adopting this individual quest for health also described a sense of empowerment that went along with it. This empowerment came, in large part, from the understanding that the ability to be healthy ultimately resides within the person themselves. Incorporating notions of intuition and imbedded wisdom, there was a prevalent understanding that, when truly in tune with our own bodies (and, many would add, minds and souls), a large component of an individual's ability to heal is within his or her control. This type of understanding of one's own role understandably has direct impact on their relationships and expectations regarding both CAM and allopathic practitioners. People I interviewed typically described their role within a healthcare setting as that of an active partner, or as the chief decision-maker. This is a role that can play out very differently depending on the type of practitioner involved.

Finally, the chapter moves on to CAM practitioners. This is, by its very nature, a problematic grouping – there are a vast number of complementary and alternative

healing techniques, many of which bear little outward resemblance to each other. As such, to group CAM practitioners under a broad umbrella is, in many ways, a futile endeavour. Not only do training, techniques, and approaches vary widely, it was clear from interviews that there was no real community – CAM practitioners only rarely had contact or communication with each other. Significantly, however, despite these differences and disparities, there were a number of important similarities in the understanding of role.

One of the most prominently reoccurring themes throughout interviews with CAM practitioners involved variations on the idea that a practitioner's role involves empowering individuals to heal, or to help heal, themselves. This bears resemblance to the role of "educator", as expressed by allopathic physicians, but also has important differences. More than simply offering salient pieces of information or techniques to live healthier lives, there was a prevailing understanding that one of a practitioner's main roles should be to help or teach individuals how to access their own healing powers – to enable them to take a large part of the healing process into their own hands. Some practitioners even described this form education as happening at a bodily or tissue level – that is, teaching the body directly how to heal itself. This is clearly very similar in nature to the concept of the individual's role as active health participant.

Directly connected to the CAM practitioner's role as educator or guide was a strong emphasis the concept of acting as a health "facilitator". In most cases, assuming this role of "facilitator" involved helping a person – and more specifically, a person's body – at a much more intuitive level. Once again hearkening back to concept of "imbedded knowledge", and the body's intuitive or innate ability to heal, the role of a facilitator,

then, involves facilitating or helping the body through this process. Understanding the concept of "facilitator" has a number of important implications when exploring how CAM practitioners view their role. Much like the role of "educator" or "guide", there is significant emphasis on helping people to heal themselves. "Facilitating", however, truly implies a greater healing power at work – one that exists within the body, or in same cases, within a universal energy.

Finally, a significant number of CAM practitioners – particularly Naturopathic Doctors, noted their desire to work in a partnership role with their clients. The type and specifics of such a partnership varied, of course, depending on type of modality and/or practitioner, but at its core, such a partnership involved respecting patients and their beliefs or opinions about their own health. Similar to "educator" or "facilitator" roles, it is also one that promotes individual autonomy and participation. Significantly, there was speculation that this type of role was much more prevalent in CAM practitioners than in allopathic doctors – a sentiment that had also been expressed in interviews with CAM users, or individuals.

When viewing these three highly interrelated roles of CAM practitioners together, it becomes clear that there are significant similarities with conception of role from the perspective of individuals, or CAM users. Active health participation, forming partnerships, and facilitating intuitive or innate healing are all places of common ground. To share these understandings of role can therefore clearly aid in the therapeutic relationship and communication between client and practitioner. While there were also outward similarities between conceptions of allopathic doctors' roles, it is significant to note that these did not seem to align as clearly in practice – a fact that potentially has negative implications with respect to these same therapeutic

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relationships.

Also important to note is the fact that, while CAM users and practitioners seemed to have very similar concepts of role, it was also clear that this conception often differs – sometimes drastically – from how allopathic doctors understand the role of CAM practitioners and the people who seek their help. Allopathic physicians that I had interviewed, for instance, expressed concerns including the fact that those who sought and provided CAM treatments were interested only in a "quick fix", and were not concerned with ethical or safety standards. This conception of role not only differs drastically from that which was expressed by those who actually use and practice CAM, but it is also points to how misconceptions or misunderstandings can created a gulf or divide between what might otherwise be similarly-minded approaches and concepts of health.

To understand these similarities and differences in role conception offers an important means of beginning to unravel the larger picture of where health care can fail or flourish. It can also go a long way toward explaining, in a grand scheme, some of the reasons why people make the health-related decisions that they do, and why they resonate with certain practitioners or modalities more than others. By examining these conceptions of role closely, however, it is possible to do more than to understand the nuances of these understandings and practices from a distance – there is also potential to greatly affect individual relationships. Indeed, without a clear conception of of how an individual views his or her role, and what they do or do not expect from the other(s) within a clinical encounter, truly effective communication and optimal results will remain difficult to achieve. When such matters are addressed overtly, however, there is a much greater possibility of reaching common understandings, and

obtaining a much higher level of care.

7.1.6   Chapter 6: In Search of an Ideal

This final chapter sought to explore the concept of an "ideal" in healthcare. Despite the sometimes seemingly irreconcilable differences in epistemology and approach, it could be argued that there is, ultimately, a common goal for those seeking and providing health and wellness: to achieve some version of an ever-elusive "ideal" healthcare scenario. This, of course, is not a straight-forward quest, and raises a number of important concerns. What would an ideal healthcare scenario entail? How would it work? Is such a goal even attainable? "In Search of an Ideal" approaches these questions from a folklore perspective, within the context of the Atlantic Canadian provinces.

Before getting into specific discussions, however, the chapter first tackles the concept of "Applied Folklore" – a crucial theoretical unpinning to both this topic, and my own work. While the notions and definitions surrounding an applied approach to folklore studies are varied, I typically go back to the concise understanding that applied folklore involves the application of knowledge from folklore-related studies to the solution of real-world, practical problems. With such a definition in mind, it becomes clear how much potential there is in health-related folklore work for an applied bent. Numerous examples abound, the most personally influential of which I detail and discuss. With this background in place, it becomes apparent the present discussion of an ideal healthcare scenario – particularly with respect to the interface of CAM and allopathic medicine – is both relevant and appropriate.

To discuss a theoretical ideal healthcare scenario, however, one must first look at the problems and challenges identified in the current system. Certainly, within a system as vitally important, multifaceted, and comprehensive as that which caters to the health of a population, there are many areas at any given time that can be pinpointed as needing to be changed or improved upon. To further complicate matters, the nuances and understandings of these problems can vary considerably depending on influences such as the types of people involved, and the particular time, place, and individual health journeys and experiences. Despite such widely differing variables, however, there were nonetheless some major themes that appear with regularity throughout the interviews. As such, this chapter proceeds to offer a thorough discussion of the three most commonly discussed problem-related themes from the perspective of those I interviewed: time, money and communication.

The main "time"-related problem was overwhelmingly presented as an issue of allopathic physicians not having enough time to spend with their patients. This was seen not only as detrimental to the therapeutic relationship, but also carried with it potential for less-effective diagnoses and treatments. Significantly, while this was a widely acknowledge problem – both from the perspective of those within and outside the allopathic system – it was also predominantly understood as a system-related issue, rather than the fault of the physicians themselves. On the flip side of this, it was also often explained that one of the most important aspects of CAM practices was the ample and adequate amount of time that practitioners are able to spend with their clients. Related to the issue of time (or lack thereof) within the therapeutic relationship was the notion of timescale – that is, the amount of time expected for healing to occur. Much of allopathic medicine is built on quick pharmaceutical fixes

to problems and symptoms, whereas much of CAM relies on less direct treatments that can take much longer to see results.

The second challenge – that of money – was one that surfaced in almost every interview. The realities of money-related problems for those seeking or providing healthcare are complicated and multi-faceted – especially when adding in those related to CAM. Within the allopathic system, the most pronounced money-related issue involved trying to strike a balance between spending enough time with patients, and making a living. This was particularly prominent for GPs within a fee-for-service payment structure.

Much like time-related issues, CAM practitioners experience exactly the opposite problem – while they can optimize their time spent with clients, their services tended to to be very expensive for those who came seeking their help. This was true even when individuals had private insurance, as many services are not covered, or only partially covered, up to a set amount. Consequently, even those who prioritize CAM treatments, and feel these services are making a positive difference in their health, typically have to make difficult decisions based on finances. This is further complicated by the fact that CAM treatments can often take many repeated visits to see optimal results, and can require the purchase of extra products (such as natural supplements), both of which increase the financial burden on clients.

CAM is consequently considered by many a luxury that only those with means can afford to use. While there are no easy solutions to this conundrum, there are work-around that have been expressed or put into place. The first is simply a change in mentality; a re-imagining or re-visioning of how to spend disposable income. In effect, this is a matter of breaking out of the mindset that all health services are, or

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should all be "free". Secondly, there were a large number of CAM practitioners who revealed that they offer special accommodations or reduction in price for those who, for whatever reason, cannot afford their services. Often, these involved a sliding scale of payment depending on what clients could afford, but it also involved barter and exchange, or finding ways to have insurance companies reimburse for services that they might otherwise reject.

From the above examples, it is clear that the issue of money is one that affects all levels of healthcare. This is true both within the allopathic system and the world of CAM, although the nature and manifestation of money-related problems differs dramatically between the two worlds. Fundamentally, however, the fall-out remains very similar: money affects issues of access to and quality of health services, and the ability for practitioners and physicians to make an adequate living at their profession. Even with case-by-case solutions and work-arounds to money-related problems, the larger issues are still apparent, and complicated to try and fix, especially when navigating between official and unofficial health cultures.

The final large-scale problem was that of communication – an issue that manifested itself both within doctor-patient relationships, and practitioner-practitioner interaction. This is an especially relevant dilemma when it involves patients who see both allopathic physicians and CAM practitioners, as this typically means that one individual is accepting health advice (and often undergoing treatment), from multiple practitioners simultaneously. This scenario typically lends itself to a frustrating and potentially dangerous problem: a multi-level lack of communication.

The most of obvious of these is a lack of communication between a patient and his or her allopathic physician. Due to any number of different factors, ranging from fear

of judgement, perceived irrelevancy, or inadequate amount of time or knowledge on the subject of CAM, many patients revealed that they do not discuss their CAM use with their doctors. This is, significantly, even true when patients have what they consider to be an open or positive relationship with their allopathic physicians. Also of note is the fact that, while doctors acknowledged this same lack of CAM-related discussion in their practices, they simultaneously pointed out that they felt such discussions were important to have for their own diagnosis and treatment recommendations. This was particularly relevant when CAM treatments involved herbal supplements, which have a very real danger of interacting negatively with pharmaceuticals. Despite this acknowledgement from both perspectives that this doctor-patient CAM-related communication gap exists, and that it is not optimal (and potentially dangerous), it remains a problem.

Communication gaps do not only exist between allopathic physicians and their CAM-using patients, however – they also become apparent in practitioner-practitioner interactions. Even when there is awareness or acknowledgement that simultaneous treatments are occurring, there is still rarely any back-and-forth that happens between the people who are treating an individual. This is true, not only between CAM practitioners and allopathic physicians, but also between allopathic physicians, and between CAM practitioners. It is rare, it would seem, for much patient-related consultation or communication to happen at all. For the most part, this lack of communication is seen to hinge on two major factors: time constraints and perceived lack of relevancy. Also important, however, was friction between ideological and epistemological leanings, training, and approach.

Despite this multi-level lack of communication between individuals' various CAM

and allopathic healthcare practitioners, however, there are those who do try very hard to bridge that gap, with some success. This is, at the very least, a discussion – a sharing of knowledge and diagnosis and treatment. In this way, even though there is a large-scale acknowledgement that a communication gap exists between practitioners, there was also an optimism that this lack of communication is something that can, and should change. This was expressed both from within the worlds of CAM and allopathy, and examples were given of the glimmers of change that have already begun to occur.

Having explored the large, interrelated problems of time, money, and communication, the chapter than returns to the notion of the search for an "ideal". In an applied sense, is there a way to address these problems, and implement solutions? Obviously, this an incredibly large, complex question, with no definitive answer. Overwhelmingly, however, there was one concept that came up consistently – the idea of integrating the worlds of CAM and allopathic medicine. This is certainly not a new concept – it is, in fact, one that has garnered attention from a wide range of disciplines. Despite both scholarly and practical interest in integrative health care, however, it has proven to be a complicated concept, problematic both in terms of its definition and actualization. In some respects, integration can be understood as happening on a daily basis – individuals using both CAM and allopathic medicine are taking integration into their own hands, coordinating the various treatments and practitioners on their own behalf. While this certainly has its merits, many people were interested in discussing a more formalized ideal.

While different forms of integration are not consistent or clearly defined, the chapter goes on to break the possible forms of CAM-allopathic integration into four different

models: integrative clinics, assimilation, integrated practitioners, and collaboration. What follows is a description of each, as well as a discussion concerning their potential benefits and pitfalls. What becomes evident is a dual-faced truth. On one face, it is possible that if integration, in any number of different forms, truly started to become more ubiquitous, it could theoretically help solve some of the more pronounced problems within the Canadian healthcare system. On the other face, obstacles in the way of this type of movement are diverse, and not easily surmounted. The root of such obstacles truly goes back to the issues of knowledge, belief and acceptability. To have physicians within the allopathic medical model work alongside, or incorporate, CAM, is by definition to either accept the merits and safety of modalities that have not been proven using the gold standard of medical scientific testing, or to only allow the often stripped away parts of a modality that have been deemed acceptable. To further complicate matters, CAM modalities are so numerous and often disparate that there is no coherent or even obvious body of therapies or practitioners with which to integrate.

Finally, having identified some of the large-scale problems, and discussed potential solutions (in the form of different kinds of integration), this chapter then outlines some potential paths forward. The question, in this case, becomes a matter of if and how integration should be implemented. Clearly, the issue of integration is large, complex, and heated, and therefore, I argue, not feasible for rapid, large-scale implementation. If change is to occur, it will most likely happen as experience and education begin to broaden understandings between official and unofficial culture. Education mainly takes the form of figuring out how best to disseminate information about CAM-related practice and epistemology, particularly to allopathic physicians. If such information

and understanding came into place, there would be much potential for integration on many different levels.

Primarily, however, the most compelling and powerful bridges of understanding which form between the worlds of CAM and allopathy happen at the level of individual experiences and relationships. Such experiences often take the form of witnessing the positive CAM-related effects, or experiencing them first-hand. Even simply meeting a person face-to-face, and getting a feel for him or her on a personal, or instinctual level can have an effect on how that person is perceived, and the willingness to trust them with patients or clients. Truly, the lived experiences and the relationships formed by and between individuals can often become catalysts for change.

7.2 Challenges, Weaknesses, and Possibilities for Further Research

7.2.1 Challenges and Weaknesses

This thesis was a long, sometimes painful, labour of love. It involved a large corpus of fieldwork, followed by extensive coding and narrative analysis. The result is a document which I truly believe hits on all the most important themes relating to CAM health beliefs and practices, both from the perspectives of those who shared their thoughts and experiences with me, and from the other research that has been done in this field. With that having been said, however, the process contained a number of challenges, and there are consequently weaknesses that need to be addressed and discussed.

The most glaring challenge for me when trying to shape and write this thesis was its overwhelmingly broad nature. This was a conscious choice – one that presented a number of potential benefits from both a fieldwork/methodology perspective, and also as a means of getting as comprehensive a picture as possible. Such a broad approach does, however, also have its downfalls. Each of the chapters, for instance, could easily have warranted its own thesis. While I was able to present what I considered to be the most important concepts, backgrounds and theories in each case, I was truly only ever able to scratch at the surface of the complexity and nuance inherent in each of the topics.

Secondly, there is the significant issue of demographic representation. While this thesis was broadly situated within the larger region of the Atlantic Provinces, the interviews were limited to Fredericton, NB and Halifax, NS – two capital cities of only two of the four provinces. It could rightfully be argued, then, that this was only a select representation. The capital cities, for instance, are decidedly urban, and therefore do not reflect a more rural perspective and experience. Also, while these four provinces are collectively known as "Atlantic Canada", each one most certainly has its own unique distinguishing factors, characteristics, and challenges, which would in turn change experiences and understandings relating to complementary and alternative health. This is especially true when accounting for the fact that the allopathic healthcare system is under provincial jurisdiction, and therefore always differs from one province to the next.

Similarly, my policy when conducting interviews was to speak with anyone who expressed an interest or willingness to participate. As I explained in the methodology section, while I would leave my information in key locations, and make requests to

anyone who seemed to be a good fit, I did not specifically target certain demographics, or try to ensure equal representation across gender, economic, or cultural lines. I *was* conscious of ensuring I had representation from the three "categories" of interviewees – that is, CAM users, CAM practitioners, and allopathic physicians, but beyond those requirements, I simply interviewed anyone who expressed an interest, or contacted me. Consequently, those I ended up interviewing did not, as a group, represent an accurate or full demographic picture of the provinces in which the interviews were conducted. There was, for instance, a disproportionately large predominance of women, most interviewees were Caucasian, had a relatively high level of education, and though I did not request information about income or economic stability, it was clear that those I interviewed were not among the area's poorest populations.

None of these facts concerning the demographic representation within my thesis can be denied – my two chosen fieldwork locations could never fully represent the Atlantic region as a whole, nor could the individuals I interviewed claim to cover the vast demographic spectrum within the area. I did not have the means or the time to conduct a study that comprehensive in nature. While this may be true, I do not believe these facts ultimately impact the research or findings in a negative way. Without question, expanding the fieldwork parameters to include these lacking pieces of representation would have uncovered a wealth of enlightening narratives, thoughts and experiences. Nonetheless, I feel as though the narratives and experiences that were shared with me formed the basis of some important findings, regardless.

For instance, specifically targeting two provinces within Atlantic Canada allowed for, at the very least, a cursory but significant discussion of some of the factors that make this area unique in the context of demographics and other factors contributing to

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health-related services and decision-making processes. While I was not able to pinpoint each Atlantic province separately, or delve into specific factors that differentiate between urban and rural experiences, I *was* able to highlight a very understudied and underrepresented part of the country with respect to CAM-related research, and therefore contribute to an ongoing and important discussion. The voices of those who were interviewed cannot claim to speak for *everyone* who shares their region of the world, but they are, nonetheless, part of a larger picture, and their experiences are both valid and illuminating in that regard. Furthermore, though defining the fieldwork and the confines of the thesis regionally was deliberate, and has meaningful implications, many the themes that ended up forming the body of the thesis can be argued to transcend regional confines. Certainly, the context of place is always relevant, and is tightly woven into both experience and worldview, but the specifics of place were not the only – or sometimes even the most significant concerns – when tackling such broad, universally applicable issues.

Also, though my interviewees could not be described as a demographically diverse group, they are relatively representative of those who are, statistically, more apt to use CAM [1]. This is perhaps unsurprising, as my recruitment methods generally attracted those people who had preexisting interest in, and experience with, with world of complementary and alternative health. This is not to suggest that those are not within these demographic markers do not have their own CAM-related experiences or narratives to share – there could be any number of reasons why people who fall outside of these lines were not interested in participating, or were not aware of the project. It does suggest, however, that the people I ended up interviewing were, at

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[1]See Chapter3

the very least, representative of the statistically most prevalent group of those who have presented a familiarity and predisposition to using CAM.

Finally, it must be acknowledged that it took a relatively long period of time between the year in which the interviews were conducted (2008), and the final writing stages of the thesis itself (2015). This brings up the issue of dated interviews and research, and potentially the subsequent questioning of relevance. Personal experience narratives are, by their nature, in constant flux and evolution, as are the internal workings of some essential players in this equation, such as healthcare systems, provincial and national politics, and CAM-related regulation and legislation. In the time since my interviews were conducted, for instance, Naturopathic Doctors in Nova Scotia had the "Naturopathic Doctors Act" passed, protecting their title (Office of the Legislative Counsel, Nova Scotia House of Assembly 2008), massage therapists in New Brunswick became legislated (The Asscociation of New Brunswick Massage Therapists 2015), and Nova Scotia midwives have become regulated (Midwifery Regulatory Council of Nova Scotia 2015b). These are undoubtedly just a few of the changes that have occurred in the seven years since the interviews were conducted.

I would argue, however, that while such evolution and change is noteworthy, and, in the above examples, points to positive advancements for many within New Brunswick and Nova Scotia's CAM world, the over-arching issues and themes discussed in this thesis remain as relevant now as they were then. Though change is constantly occurring, large-scale advancements never happen overnight. Furthermore, much of what was discussed in this thesis involved a long-standing history involving health and healthcare, and the places where official and unofficial epistemologies, understandings, and approaches to health collide or overlap. These are issues that will remain relevant

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as long as these often dichotomous systems exist.

7.2.2 Possibilities for Future Research

Following this thesis, there are a seemingly endless number of directions that future research can, (and I would argue, *should*) take. The first is, quite simply, a need for more ethnographic, vernacular-based health-related research generally. Within the scholarly realm of health-related research, there is a predominance of statistical information, scientific studies, and results-based work. These are irrefutably of great value, offering unique and important perspectives on many health-related issues.

There are also, of course, a large number of excellent ethnographic health-related studies, from a wide range of disciplinary perspectives, offering crucial insights that can have far-reaching implications. They are, however, very much overshadowed by their statistical and trial-based counterparts. This is true both with respect to sheer volume, as well as (potentially) with respect to perceived validity and value, particularly within the realm of allopathic medicine. As such, there is a real and ever-present need for high-calibre ethnographic, narrative-based health-related fieldwork and analysis. While this is true in a very broad, over-arching sense, it is also particularly relevant in the realm of CAM-related research.

Secondly, it would be of potentially great value to conduct a study, or series of studies, that offer a more thorough look at CAM within Atlantic Canada. This would include fieldwork in all four provinces, accounting for both rural and urban experiences. In this way, it would be possible to gain a much more detailed, nuanced picture not only of what is happening with respect to CAM practices and healthcare systems,

but it would also be possible to understand what could feasibly be very important similarities and differences in experience between regions.

If this more detailed Atlantic Canadian CAM-related research was undertaken, it would then also set the stage for any number of comparative CAM-related ethnographic studies within Canada. This could illuminate much larger trends, approaches and understandings of health, and how different provinces and larger geographic regions of the country coalesce or contrast with each in this regard. Though it would be a massive undertaking, a comprehensive country-wide amalgamation of these individual region-based studies would then allow for some very important comparison work between Canada and other countries. To understand both the demographic, statistically-based inner-workings of different countries and their healthcare systems, with the real-life lived vernacular experience of its people, could lead to potentially ground-breaking revelations for our own system and approach to health.

With respect to CAM-related research specifically, it would be interesting to conduct a number of in-depth ethnographic studies exploring specific modalities. This thesis was, by design, broad and inclusive, with very little attention paid to specific nuances within particular forms of CAM healing approaches and practices. By choosing a particular modality, however, it is possible to create an extremely thorough picture of how it is used and understood, and how it fits into the CAM-allopathic epistemological and practical continuum. This is a particularly relevant undertaking in the ongoing quest to create a more comprehensive understanding of CAM-related practices, and to illuminate both the similarities and differences in an often very disparate group of modalities. The better individual practices are understood from the perspective of those who use them, the better the chances of creating shared bridges

of understanding.

Finally, from an an applied perspective, it could be both interesting and very informative to follow and research instances of CAM/allopathic integration, whether this be at an individual or clinical level. Such studies have been undertaken in various different localities, but none, to my knowledge, in the Atlantic Canadian region. It would be a particularly compelling case study, for instance, to be present at the inception of an integrated clinic, in order to document the thoughts and decision making processes involved, and how these change or pan-out over time. If change is, as my research suggests, to happen more slowly, at a case-by-case basis, there is much to be learned from exploring these cases as they occur and evolve.

7.3   On a Personal Note

As I was in the final writing stages of this thesis, a good friend of mine offered her thoughts and experiences concerning the concluding chapter. Having gone through the process herself some years before, she offered a bit of advice, in the form of an anecdote. After writing and successfully defending her dissertation, one of the examiners told her that what he felt was most obviously missing from the final chapter was *her own voice*. As she recalled,

> *"He said something like, "You did this study, it took you years to complete, now you are the foremost expert in this one particular area, so I want to know what YOU think. What would you tell me if I was sitting across from you at a dinner party about this topic?""(Bidlake)*

As a result, she ended up adding a few pages to the end of her conclusion, offering exactly that – a more personal, reflective discussion of her research, in her own voice.

She consequently suggested that I do the same.

This seemed like a particularly appropriate bit of advice, especially for a thesis (and a discipline), that puts so much emphasis on vernacular experience. It is also an appropriate addition when considering the fact that the topic of complementary and alternative health beliefs and practices is one that has, and continues, to affect me personally. I was invested in the topic before I pursued the research from an academic perspective, and will continue to be invested from a personal perspective long after the dissertation is complete. As with anyone else, I have my own health-related life-story – one that is ever-evolving, and informed by my beliefs, experiences, and worldview. Perhaps unsurprisingly, this personal narrative involves experimenting with and using a large variety of CAM modalities. It also involves a number of key experiences wherein my choices and beliefs regarding a CAM approach were called into question, especially from the perspective of allopathic or scientific-based reasoning.

As a result, the topic that initially pulled me into this project, and the one that continues to most deeply spark my interest, is the issue of knowledge and belief. This fascinating knowledge-belief continuum is at the core of issues related to vernacular voice and official versus unofficial culture – particularly in the world of health. So much of knowledge generation and "truth" is taken for granted within an official paradigm, that it becomes extremely easy and ever-prevalent to silence, ridicule, dismiss and misrepresent the voices, experiences and knowledge of those who have notions of the world that stray outside of the accepted, officially sanctioned ways of knowing. I have experienced this personally, but also continuously witness it in popular and social media, in policy and procedure, in research, and in every-day interactions.

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This is, in large part, why I consider the issue so important – not to definitely prove different forms of knowledge acquisition as right or wrong – not even to fight for the underdog or poke holes in officially sanctioned worldview and approach. The biomedical model and its insistence on scientific proof has accomplished incredible feats since it became the dominant paradigm, and continues to do so. It has provided advancements that have drastically improved life expectancy, cured diseases that were once incurable, and provided a means of addressing emergency situations that were once unthinkable. There are very few people, even among those who use and value CAM, who would ever imply otherwise.

I did, however, want to highlight the very opposite of this perceived dichotomy – to show that there are, indeed, different ways of knowing, which are just as real, just as important, and just as legitimate to those that hold them. They are not "right" or "wrong", they just *are.* What's more, these different ways of knowing are at the heart of health-related decision-making for many people. They affect the practices and modalities that are undertaken, the desired outcomes, and the way they interact with the allopathic world. In short, they affect everyone involved.

My aim, therefore, was never to champion the unofficial "cause", or CAM "belief system". I would argue, in fact, that there is no such thing. Beliefs are as varied as the individuals who have them, a fact which is just as true for the allopathic world as for the CAM world. My aim, rather, was to introduce these various different paradigms within the structure of Hufford's methodological symmetry and pluralism – to present different understandings and approaches to health in a way that did not automatically assume that they were in some way fundamentally flawed or erroneous. It is, I would argue, crucial to gain a comprehensive understanding of why people

make health-related decisions, and how this affects both individual interactions, and the system at large. So much can be gained by allowing for increased understanding and communication – to allow a view of the world from a a perspective outside of one's own, firmly positioned lens.

Many of those whose voices appeared throughout this thesis shared what could easily be described as ways of understanding health and well-being that fundamentally run counter to the official bio-scientific explanatory framework. These same people, however, were, by and large, very optimistic that the prevalent dichotomy and friction between the worlds of CAM and allopathic medicine have been changing and evolving, and will continue to do so. It is only though the creation of dialogue and shared understandings and experiences that such a feat can occur. I sincerely hope that this thesis can add to that ongoing dialogue.

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Appendix A

Recruitment Materials

Figure A.1: Recruiting Pamphlet

Dear _____;

My name is Tara Simmonds. I am a PhD student researching beliefs and practices associated with complementary and alternative health in New Brunswick and Nova Scotia. My fieldwork consists of interviews with allopathic doctors, CAM practitioners, and those who have used alternative therapies, to see what these three groups of people have to say on the subject.

One of the people I interviewed recently passed your name along as someone who might be very interesting to talk to. I thought it would be worth sending along this note, as well as a brief description of the project in case you are at all interested in participating, and/or know of anyone else who might be. I have included my contact information below, as well as on the enclosed pamphlet.

Thank-you so much for your time –

Sincerely,

Tara Simmonds

Figure A.2: Generic Recruitment Letter

An Ethnographic Exploration of Complementary and Alternative Therapies in New Brunswick and Nova Scotia

Study Purpose:
    This project will investigate the use of complementary and alternative medicine in Fredericton, New Brunswick and Halifax, Nova Scotia, using these provinces as ethnographic case studies to explore how individuals make choices related to systems, practitioners and techniques. In particular, the goals of this study are to:

1) Conduct a series of face-to-face interviews with alternative therapy users, alternative practitioners and conventional practitioners, specifically focusing on issues related to *therapy choice* and practitioner attitudes toward simultaneous *multiple modality usage*.

2) Critically assess ethnographic and contextual data related to *regional differences* in use of alternative and complementary medicine in Canada. It will also take into account immigration demographics in the provinces and healthcare choices that might be related to cultural diversity.

3) Explore *correlations between medical condition and choice of practitioner or treatment*.

4) Examine criteria that have recently been used by scholars to explain *patient perceptions of conventional and complementary services*.

5) Investigate the possible applications of ethnographic research for *collaboration between conventional and non-conventional healthcare*.

General Procedure and Time Commitment:
Each participant will be asked to participate in one face-to-face interview at the location and time of his or her choosing. Each interview will likely last between 1-2 hours. This will include the interview itself, the time taken to explain the project in more detail or answer any questions the participant might have, and also the time taken to sign a consent form. After the interview, the researcher will either fully or partially transcribe the interview. The participant may be contacted at a later date with follow-up questions if necessary.

Foreseeable Risks and Benefits:
There are no foreseeable risks involved in participating in this research. Benefits include contributing your thoughts, experiences, beliefs and understandings of complementary/alternative health and health choices to a wider understanding, especially within the relatively understudied Atlantic Canadian region.

Figure A.3: Short Research Synopsis

Appendix B

Consent Forms and Demographic Information Sheets

Consent Form

An Ethnographic Exploration of Complementary and Alternative Therapies in New Brunswick and Nova Scotia

I, _____, hereby grant Tara Simmonds permission to use the following voluntarily recorded materials from this interview for research towards the completion of PhD degree in the Department of Folklore, Memorial University of Newfoundland. I understand that the purposes of this research may include the following: PhD thesis, class/conference/scholarly papers, published work, and presentations. I give Tara Simmonds permission to collect and use the following materials for all academic purposes. (Please circle choice):

Digitally recorded audio interview	YES	NO
Photographs and/or Diagrams (Where applicable)	YES	NO
Direct quotations from the interview	YES	NO

I understand that to protect my privacy, I may choose how I am named in all public/published references to the information provided in this interview. I choose to be identified by (Please circle choice):
A) My given name (as indicated above)
B) A Pseudonym: _____

I understand that the materials will be archived with the researcher for a minimum of 5 years. If applicable, I agree to have the materials deposited in a public archive for subsequent professional use:

Audio Material	YES	NO
Visual Material	YES	NO

I may be contacted for follow-up comments or questions after the interview.

I understand that I may withdraw my participation in this research at any time by contacting Tara Simmonds at 902-422-3989 (home) or 902-222-5275 (cell) or tarasimmonds@gmail.com and that I may request to have all copies of the materials associated with my participation returned to me or destroyed. If I have any concerns about this research which cannot be resolved by Tara Simmonds, I may contact Dr. Diane Goldstein (Thesis Supervisor), Department of Folklore, Memorial University of Newfoundland, at 709-737-8366 or 709-737-2374 (fax), or dianeg@mun.ca.

- Individuals with questions and concerns about this research may contact: Tara Simmonds Tel: 902-422-3989 (home) or 902-222-5275 (cell) (Halifax NS). Email: tarasimmonds@gmail.com
- The proposal for this research has been approved by the Interdisciplinary Committee on Ethics in Human Research at Memorial University. If you have ethical concerns regarding this research (such as the way you have been treated or your rights as a participant) , please do not hesitate to contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-737-8368.

Figure B.1: Consent Form (page 1 of 2)

_____

Signature of Participant   Date

_____

Name

_____

Address

_____

_____

Email

Figure B.2: Consent Form (page 2 of 2)

Demographic Information

Allopathic Physicians:

Name: _____

Date of Birth: _____

City of Residence: _____

Other places I've lived (with dates):

Specialty: _____

Parents' Profession: _____

Partner's Profession: _____

Religious Beliefs: _____

Complementary/Alternative Therapies I've tried (Please circle the ones you use most):

Complementary/ Alternative Therapies I am currently using:

Figure B.3: Demographic Information Sheet given to Allopathic Physicians

Demographic Information

CAM Practitioners and Patients:

Name: _____

Date of Birth: _____

City of Residence: _____

Other places I've lived (with dates):

Profession: _____

Religious Beliefs: _____

Highest Level of Education: _____

Parents' Profession: _____

Partner's Profession: _____

Complementary/Alternative Therapies I've tried (Please circle the ones you use most):

Complementary/ Alternative Therapies I am currently using:

(For Pracitioners)
Complementary/Alternative Therapies I am Trained to Practice:

Figure B.4: Demographic Information Sheet given to CAM Practitioners and CAM

users

Appendix C

Modalities, with Brief Descriptions

The following is a list of some of the more frequently mentioned complementary and alternative (CAM) modalities which appeared throughout the thesis. Where possible, I have offered definitions or explanations that come from the official local-based (New Brunswick, Nova-Scotia, or Canada-based) websites for the modality in question. Where that was not possible, I found definitions from other sources. All sources are referenced. This is not meant as an exhaustive list of modalities, nor as definitive set of definitions. It is, however, meant to provide a useful tool for anyone who is otherwise unfamiliar with the terms and practices, and to be as closely representative as possible to those whose voices appear throughout the thesis.

Acupuncture   "Acupuncture is part of an ancient system of healing developed over thousands of years ago. It is part of the traditional medicines of China, Japan, Korea, India and other Eastern countries. The earliest records of acupuncture date back over 3,000 years and today there are over three million practitioners worldwide..

Using very fine, once-use-only, sterile-stainless needles, an Acupuncturist or Orien-

tal Medicine Practitioner aims to correct the flow of energy in the body by stimulating several acupoints. Officially, there are 409 acupuncture points on the body... Acupuncture points are located on channels (also known as meridians). They can be thought of as channels of water. Just as if a tree has fallen and dammed up a river, disease/disharmony can result if the acupuncture channels are blocked.

It is the Acupuncturists goal to not only stimulate the body to rebalance itself (and therefore heal itself) in regards to the chief complaint of the patient – but fuel a holistic change for the better. This is done by looking at the patient as a whole person to see how their chief concern is related to other signs and symptoms that are present.

Often, just as many branches on the same tree are fed by one root system, the body's signs and symptoms are closely related. As holistic practitioners, Acupuncturists put their patient's symptoms together, along with other diagnostic methods such as looking at the tongue and checking the wrist pulse, in order to paint a picture of how the entire body is functioning. Other techniques may also be used such as Chinese herbs, Five Elements, Yin-Yang theory, cupping, moxibustion, and tuina" (Nova Scotia Association of Acupuncturists 2016).

BodyTalk "First developed in the 1990's by Dr. John Veltheim, the BodyTalk system is an astonishingly simple and effective form of consciousness based health care that allows the body's systems to be re-synchronized so they can operate as nature intended.

Each system, cell and atom in our bodies is in constant communication with each other at all times. Through our exposure to the stresses of day-to-day life, these lines of communication become compromised, leading to a decline in physical, emotional

and/or mental well-being. Reconnecting these lines of communication enables the body's mechanisms to function at optimal levels, thus preventing disease and rapidly accelerating the healing process.

The BodyTalk System allows the practitioner to properly and professionally address the patient's need in a totally safe, holistic way that does not involve drugs, surgery, or extraordinary costs. It enables the practitioner to know when and how to address the patient's issues, and when to refer the patient to another medical specialist. BodyTalk can be used as a stand-alone system to treat many health problems, or it can be seamlessly integrated into any healthcare system to increase its effectiveness. By stimulating the body's innate ability to heal itself at all levels, it reduces the patient's dependence on current medical systems." (BodyTalk Nova Scotia 2015).

Chiropractic   "Chiropractors are health experts trained in the neuromusculoskeletal system. They diagnose and treat disorders of the spine and other body joints by adjusting the spinal column or through other corrective manipulation. Your spine is the key highway for your central nervous system, and since your nervous system determines how well you feel physically, mentally, and emotionally, many problems you are experiencing may be related to a problem with your spine and nervous system" (New Brunswick Chiropractors Association 2016).

Herbal Medicine   "An herbalist is a person who collects, studies, and uses plants – generally in a medicinal manner.

Herbalism, also known as Phytotherapy, is the use of plants to treat common ailments and promote wellness. It is the oldest form of medicinal healing known to

man. Although it is classified as an alternative therapy, it is the most widely practiced form of medicine used worldwide, with over 80% of the world's population relying on herbs for health. Currently over 50% of all new pharmaceutical prescriptions contain at least one ingredient either produced directly from plants or discovered from plant sources and later synthesized. Modern medicine draws it origins from early herbal therapies. Until the advent of synthetic medicine within the past 50 – 100 years, all medical doctors prescribed herbs routinely.

Herbal medicine uses plants that do not have the aggressive and invasive action of modern drugs, but instead support the body's own natural tendency to heal itself. Herbal products are derived from roots, stems, flowers or leaves of plants and are frequently sold in liquid extracts, capsules, tablets or teas. Herbalists prefer to use remedies extracted from a part of the whole plant, with all its bio-chemical constituents, rather than individual standardized extracts. It is believed that the active constituents are naturally balanced within the plant, and consequently aid in working on the body, mind and spirit in a less invasive manner" (Canadian Herbalists' Association of BC 2015).

Homeopathy   "Homeopathy is a system of natural medicine that uses micro-doses of natural remedies from the plant, animal and mineral kingdoms to stimulate the body's self-healing abilities. It is based on the principle of "like cures like" where a substance that causes symptoms in a healthy person can be used to cure those same symptoms in a "sick" person. Homeopathy is a holistic practice which treats the symptoms of the body and mind as a totality. Homeopaths recognise that symptoms of ill-health are expressions of disharmony within the whole person, and that the whole

person needs treatment, not just the isolated symptoms of a particular illness. This will ensure cure on a mental, emotional and physical plane that is non-invasive, gentle, quick, safe and permanent. Homeopathic medicine can be used preventatively, for chronic conditions as well as for acute conditions" (Ontario College of Homeopathic Medicine 2014).

Massage Therapy   "Massage therapy is the manual manipulation of the soft tissues of the body, to achieve a therapeutic response. It enhances the function of muscles, joints. It improves the circulation of the blood and lymph, relieves pain and stress, and may reduce blood pressure. Massage therapy has a sedative, calming effect.

Massage therapy is designed to rehabilitate, maintain or improve physical function by performing manipulation techniques. Massage therapists are also trained in hydrotherapy and remedial exercise. The therapeutic effects of massage therapy benefit men, women, pregnant women, infants, children and the elderly and can provide relief from a wide variety of mild and acute conditions"(Massage Therapists Association of Nova Scotia 2016).

Midwifery   "A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during

pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units" (Midwifery Regulatory Council of Nova Scotia 2015a).

NAET (Nambudripad's Allergy Elimination Techniques) "Nambudripad's Allergy Elimination Techniques, also known as NAET, is a non-invasive, drug free, natural solution oto eliminate allergies of all types and sensitivities (mild sensitivity, to severe hypersensitivity reactions, to severe anaphylactic reactions)... and allergy-related disorders... all with lasting results. NAET uses a blend of selective testing and treatment procedures from acupuncture/acupressure, allopathy, chiropractic, nutritional, and kinesiological disciplines of medicine to balance the body bioenergetically with various unsuitable electromagnetic energies found in one's living environment. Using NAET methods, one can also learn to balance the body from most adverse reactions that happened in the body from the interactions between certain unsuitable energies and the body itself; for example: depression or crying spells after eating certain food, hyperactivity or mental fog after exposure to pesticides, insomnia after

applying a certain body lotions... etc.

NAET was discovered by Dr. Devi S. Nambudripad in November of 1983" (Nambudripad 2002, xxxix-xl).

Naturopathy "Naturopathic Medicine is a distinct primary health care system that blends modern scientific knowledge with traditional and natural forms of medicine. Naturopathic medicine is the art and science of diagnosis, treatment and prevention of disease using natural therapies including botanical medicine, clinical nutrition, hydrotherapy, homeopathy, naturopathic manipulation, traditional Chinese medicine, acupuncture, and lifestyle counselling. It is based on the healing power of nature and the ability of the body to heal itself when supported and stimulated.

Naturopathic doctors are primary care practitioners. Naturopathic doctors also complement and enhance health care services provided by other health care professionals. NDs cooperate with other healthcare professionals, referring patients to other practitioners for diagnosis or treatment when appropriate. Naturopathic Doctors provide patients with a truly integrative form of health care"(Nova Scotia Association of Naturopathic Doctors 2015).

Quantum Touch "Quantum-Touch is a method of natural healing that works with the Life Force Energy of the body to promote optimal wellness. Life Force Energy, also known as 'chi' in Chinese and 'prana' in Sanskrit, is the flow of energy that sustains all living beings.

Quantum-Touch teaches us how to focus, amplify, and direct this energy, for a wide range of benefits with surprising and often extraordinary results.

Quantum-Touch is an effective method for reducing back pain , realigning structure, balancing organs, glands and systems, reducing muscle aches, healing injuries, healing burns, and so much more"(Quantum-Touch 2016).

Reiki   "Reiki is a Japanese technique for stress reduction and relaxation that also promotes healing. It is administered by "laying on hands" and is based on the idea that an unseen "life force energy" flows through us and is what causes us to be alive. If one's "life force energy" is low, then we are more likely to get sick or feel stress, and if it is high, we are more capable of being happy and healthy"(The International Centre for Reiki Training 2016).

Rolfing   "The word Rolfing describes a unique form of bodywork. Rolfing structural integration is a certified, registered practice, conducted by professionals known as Rolfers^{TM}. This type of bodywork is not to be confused with massage. Where massage works all soft tissues, Rolfers focus their work on a layer called fascia, the sheathing membrane that covers muscles, tendons, and organs. This fascia, like a girdle, gives shape and length to soft tissue. Over 50 years ago, Dr Ida Rolf discovered it was possible to reshape fascia with manipulation and that it would stay in the new shape. She realized it was possible to treat painful issues like scoliosis and sciatica without surgery, using this reshaping on a whole body basis.

Today Rolfers work with clients to address issues of the whole body – how it is ordered and balanced, how it moves, and how one issue can lead to problems elsewhere. Rolfers are specialists at assessing and treating body alignment issues by reshaping fascia, and educating clients" (Canadian Rolfing Association 2012).

Therapeutic Touch "Therapeutic Touch® is a holistic, evidence-based therapy that incorporates the intentional and compassionate use of universal energy to promote balance and well-being. It is a consciously-directed process during which the practitioner uses the hands as a focus to facilitate the healing process. The intent is to re-pattern the client's energy field toward wholeness and health thereby enhancing their own ability to heal. Therapeutic Touch can be used by itself, or as a complement to other interventions" (Therapeutic Touch Network of Ontario 2013).