Communication in Homoeopathic Therapeutic Encounters

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Abstract

In recent years, homoeopathy has become one of the most widespread forms of complementary or alternative medicine (CAM) used in the UK, and it is now at the forefront of moves to provide a greater integration of alternative perspectives into conventional medicine. It would appear, however, that most research in this area has concentrated on investigating the specific effects of the ultra-dilute remedies that the system utilises. This has to some extent resulted in the significance of other key features of the approach being underplayed. Homoeopathy relies not only on the use of remedies, but also on the fundamental application of holistic principles – treating the person as a whole, rather than concentrating solely on focused symptomatic relief. Because of this, factors such as communication and interaction within the homoeopathic consultation and not only the workings of homoeopathic remedies need to be considered if a balanced picture of the therapeutic process is to be obtained.

While there is a well established sociological tradition of micro-interactional and ethnographic research related to medical environments (mainly conventional ones), the field of complementary and alternative medicine – and specifically, homoeopathy – is largely unexplored. Similarly, there is little work utilising conversation analysis and ethnography together. This study uses conversation analysis and ethnography in linear combination to provide a contextualised micro-analysis of the interactional activities that are engendered by the homoeopathic approach.

Declaration

Some of the raw data utilised in this study was origininally collected for the PaPaYA (Patient Participation in York and Aberdeen) project. This was funded by the Department of Health: Health in Partnership Programme ('Patient participation in decision-making', reference number 3700514.) The following analysis, however, is the original work of the author and the opinions presented are not intended to be representative of either the Department of Health or the PaPaYA Project.

Preface and acknowledgements

encounter • *n* **1** a meeting by chance. **2** a meeting in conflict.
(Oxford English Dictionary)

The title of this thesis may appear to be a little incongruous. The work is, after all, largely concerned with an examination of the interactional detail of homoeopathic consultations – what goes on between homoeopaths and their patients as they perform the idiosyncratic dance that is holistic medicine. So to refer to these interactions as 'encounters' might seem to imply the invocation of apparently random or destructive elements. On a very broad esoteric level, and thinking in terms of holistic interconnectedness, this may well have an element of truth, but the real reason for using the word 'encounter' stems from a desire to acknowledge that, as with so many forms of complementary and alternative medicine, the micro-interactions that occur between homoeopaths and their patients can often appear to be as therapeutically significant as any of the practical treatments and remedies that might be prescribed.

As far as I am aware it was the homoeopathic doctor David Reilly* who coined the term 'therapeutic encounter' in order to describe the essentially humanistic and open attitude to medicine that a truly holistic approach can engender. Although my focus in this study is specifically on the work of homoeopaths, I think his phrase succinctly captures the atmosphere of many of the exchanges I have been able to observe in a way that 'consultation', with its implications of power, medicality, and hierarchies of knowledge, simply does not.

The process of researching and writing this study has been paralleled by something of a personal holistic journey, and I would like to thank my supervisor Paul Drew who has been exceptionally supportive and helpful at every stage of the work. Without his subtle guidance my research would have become hoplessly un-focused and tangential. I am extremely grateful for his professionalism, generosity and enthusiasm. The advice and encouragement of Sarah Collins has also been highly valued and I owe her a great deal. I am similarly indebted to Richard Wrightson, keeper of the dark sanctuary that was 'the lab' (sadly now demolished and replaced by something modern and airy). I would finally like to thank all the homoeopaths and patients who were kind enough to allow their consultations to be recorded, and particularly Maggie Gravells for her patience and support in helping me to work through the frequent periods of confusion when an academic career seemed particularly un-holistic.

* From an original interview with David Reilly

Contents

Introduction

In the last decade or so, general interest in and acceptance of, alternative and complementary medicine in Britain and the developed world has grown at an exponential rate (House of Lords, 2000). A study carried out for the Department of Health in 1997 (and revised in 2000), for example, concluded that as many as 5 million people are now consulting practitioners specialising in alternative or complementary medicine (CAM) (Mills and Budd, 2000). A multitude of therapies, such as acupuncture, Chinese herbal medicine, chiropractic, osteopathy and homoeopathy – despite being traditionally marginalized by the Western medical establishment – are now actively sought out by ever-growing numbers of people, many of whom would hitherto not have considered themselves to have particularly 'alternative' attitudes towards health and medicine. A recent survey by the Consumers' Association, for example, found that one in four people use some form of complementary medicine each year. This was double the number found in a similar survey conducted in 1986. (*Which?* Nov. 1992). Similarly, growing numbers of orthodox physicians are beginning to accept that there may be other, equally effective and often less damaging, systems of medicine and approaches to healing. As long ago as 1983, a survey in the UK revealed that over three quarters of general practitioner trainees wished to learn about therapies such as hypnotherapy, homoeopathy and acupuncture (Reilly, 1983). And although it is still fairly patchy, a number of medical schools in the UK now offer some teaching in CAM related areas. In other countries, most notably the United States, moves to incorporate complementary systems of medicine into mainstream training appear to have advanced slightly further, and organisations such as the Consortium of Academic Health Centers for Integrated Medicine have plans to establish programmes in a fifth of all US medical schools (Rees and Weil, 2001).

Even in the current era of apparent paradigmatic liberalisation, however, there is still widespread resistance within orthodox medicine to therapies that do not conform to current scientific models. (See, for example, Fitzgerald, 1983; Lerner, 1984). Those holistic systems of medicine that are tolerated are rarely, if ever, fully assimilated on their own terms, and it appears that the tendency is for isolated elements or procedures to be cherry picked depending on how well they can be shoe horned into the allopathic model. Similarly, fragments of alternative practice that have been incorporated have generally been used with little reference to the knowledge base that produced them. Certain acupuncture techniques, for example, are now used routinely in chronic pain management by surgeons and dentists, (Clinical Standards Advisory Group, 1999), but within conventional medicine there is apparently little genuine acknowledgement of the principles upon which Chinese acupuncture is based. Western incorporation of the system has depended to some extent on the degree to which its fundamentally esoteric elements – such as the network of invisible meridian lines that form the basis of the acupuncturist's view of the human body – have been successfully explained away. The deeper, and many would argue, equally significant philosophical and holistic elements that remain unexplainable in these terms are largely dismissed.

This is not to say that there have been no benefits – in terms of the raised profile that certain therapies have gained, and positive effects for patients – accruing from the selective adoption of CAM by conventional medicine. There is now, for example, a growing movement within the medical profession that aims to '. . .imbue orthodox medicine with the values of complementary medicine' (Rees and Weil, 2001), and the call for *integrated medicine* (or *integrative medicine* as it is in the US), although still grounded in an orthodox paradigm, has at least allowed those medical practitioners who might wish to explore the possibility of other approaches to do so more openly.

Along with the direct adoption of 'holistic' principles, there have been attempts by a significant number of orthodox practitioners to develop styles of

consultation behaviour that, although they may not be directly acknowledged as such, have strikingly similarities to many of the principles underpinning overtly complementary approaches. The concept of *patient-centred* medicine has resonated with many doctors as being crucial to the delivering of high quality care. (Mead and Bower, 2000.) Boyd and Heritage (forthcoming) point out that there is a growing literature aimed at teaching new doctors to conduct sensitive and complete medical interviews that encourage patients to '. . .reveal their observations, concerns, and fears' (p.2). Although this advice is often given with the proviso that the activity should not take up too much of the doctor's (Coulehan and Block, 1987). Similarly, In the BMJ recently, for example, there have been a series of articles focusing on the concept of *narrative based medicine* (see: Greenhalgh and Hurwitz, 1999; Hudson-Jones, 1999; Elwyn and Gwyn, 1999; Greenhalgh, 1999; Launer, 1999). This is an approach to consulting that aims to integrate more than the purely symptomatic information that a patient brings; the 'story' of the patient's illness, and how the illness fits into their lifeworld paradigm is incorporated – something that resonates strongly with homoeopathic perspectives. (See chapter 7 of this thesis for a more detailed discussion of the use of narrative in the consultation arena.)

At both a 'grass-roots' and policy level too, the idea of 'concordance' is widely regarded as being of benefit to both patients and doctors (see, for example: Lask, 2002; Dickinson *et al,* 1999). Concordance is basically the opposite of 'compliance' and is a non-authoritarian and negotiated approach to treatment giving which is engendered by '. . an agreement reached after discussion between a patient and healthcare professional that respects the beliefs and wishes of the patient in determining whether, when, and how medicines are to be taken.' (Bryan, 2002:425) In calling for the adoption of this paradigm by all practitioners, however, Bryan, (2002) also points out that compliance (and by implication, the traditional notion that 'doctor knows best') is still apparently widespread within the medical profession.

What these trends possibly illustrate is that regardless of whether or not orthodox medicine embraces the theoretical underpinnings of CAM therapies,

there is a growing recognition of elements within the methods that complementary therapists *in general* utilise that have an apparent value – whether they are directly therapeutic, or more tangentially connected to issues of equality, respect and empowerment. These do not necessarily involve a rejection of orthodox methods, or even the validation of CAM treatments; what they relate to is in essence, interaction, or more specifically, the quality of the interactions that occur between practitioner and patient.

Both critics and supporters of alternative medicine have argued that a high proportion of the therapeutic effect that accrues from complementary methods may be generated by the process that permeate the 'therapeutic encounter' (see: Reilly, (unpublished); Reilly, 2001), and that it is often qualities within the patient / practitioner interaction that somehow stimulate a naturally occurring healing response. It is significant that people who have experienced both holistic and orthodox approaches often draw a contrast between the different interactional environments that conventional and complementary medicine seem to generate (See; Montbriand, 1998). Similarly, studies have found that people are attracted to alternative therapies mostly out of a desire for a more holistic and humanistic approach, (See: Furnham, 1996; Astin, 1998) and for many who become regular adherents of CAM, much of the appeal appears to be grounded in the perception that the meeting with their practitioner will embody interactional elements that have become attenuated in conventional medical encounters (Chatwin and Collins, 2002). On a very broad level, this can be reflected in the feeling that a complementary practitioner has, for example, more time to listen to what they have to say, or is somehow more able to be empathetic than their allopathic counterpart. Subjective evaluations like this, however, although they give an indication of broad interactional areas that might be relevant, are not of much practical use on their own; feeling that a group of people are empathetic is not the same as mapping the way in which they go about 'doing empathy'. If this and other apparently therapeutically relevant components of complementary interactional practice are to be explored, what is required is a fuller picture of the mechanisms that generate and maintain them at a micro-level.

Aim of the thesis

It is with the intention of providing an initial outline of how the micro-interactional routines within one particular strand of complementary medicine – homoeopathy – are enacted, that this study is undertaken. I will utilise ethnography and conversation analysis (hensforth CA) to investigate the micro-interactional environments generated during homoeopathic consultations, and focus on explaining how specific activities, such as listening, reflection, closing etc., are incorporated. The study does not seek to investigate how particular features of homoeopathy or homoeopathic interactions might affect therapeutic outcomes, or make therapeutic comparisons between conventional and homoeopathic medicine. It will, however, address some of the ways in which homoeopathic knowledge is transmitted to patients, and the relevance that this and other activities may have in deleniating and defining the homoeopathic approach.

Chapter outlines.

Chapter 1: **Methodolgy**

This will provide a basic outline of principles of ethnography and conversation analysis, and justification for the use of these distinct methodological approaches in linear combination. A detailed account of the sources and methods utilised in the collection of data is also given, and the study is positioned in relation to other strands of sociological analysis.

Chapter 2: **Homoeopathy**

This ethnographically focused chapter provides a discussion of the principles that underlie the homoeopathic approach and positions the therapy within a socio-medical context.

Chapter 3: **An exploratory attitudes survey**

This chapter focuses on the analysis of a short exploratory email survey conducted with 98 registered members of the Society of Homoeopaths during the initial stages of the research. The aim of the survey was to gain contextual information relating to attitudes towards the role of communication in homoeopathic practice which would help provide themes to inform the micro-analysis undertaken later in the study.

Chapter 4: **The homoeopathic consultation: A case study**

This chapter is based on a detailed case study of a 'typical' homoeopathic consultation and provides an illustration of how the system of medicine is routinely conducted at an interactional level. A structural comparison is made with broadly equivalent allopathic practice and key points of divergence and similarity are highlighted.

Chapter 5: **A feeling of equality**

This chapter focuses on the role of empathy and rapport in the homoeopathic consultation and provides an analysis of some of the key interactional activities that practitioners are able to use to generate and maintain these states.

Chapter 6: **Activity boundaries**

Although an underlying mutualistic or collegial perspective is often pervasive in the homoeopathic encounter, there appear to be certain points in a consultation where the practitioner's talk is likely to display this orientation more overtly. Furthermore, it can be predicted that these points or nodes are likely to be located where there is the possibility of a misalignment between mutualism (letting the patient set the agenda, for example), and the practical needs of the consultation process (the performance of certain routine tasks, for example, such as shifting from one activity to another.) In this chapter I suggest that because the 'ideal' holistic encounter is patient-led and focuses on what the patient brings in terms of narrative and direction, areas of possible imbalance are likely to occur most frequently at junctures when the homoeopath needs to impose some degree of directional control – on or

around practitioner initiated activity transitions, where the inherent inequalities of the expert / lay relationship are most exposed.

Chapter 7: **Patient narratives**

The homoeopathic approach is renowned for being amenable to a very broad definition of what is considered to be symptomatically relevant. In this chapter the formats in which patients produce and deliver narratives about their illnesses, and the type of behaviours that homoeopaths exhibit to encourage or attenuate their delivery are analysed. I suggest that narrative structure in patient talk is a significant way in which holistic encounters can be differentiated from more mainstream interactions.

Chapter 8: **Explanations and the rationalisation of the homoeopathic process**

This chapter is primarily concerned with an analysis of how the reproduction and propagation of holistic and allopathic perspectives are accomplished through the talk formulations that practitioners use when discussing treatments and treatment options. I demonstrate how to a significant degree, these formulations and the sequential positions in which they routinely occur can betray underlying paradigms even when 'surface' activities appear to indicate that quite different perspectives are in play.

Methodology

The primary methodology used in this research is conversation analysis (hensforth CA). However, to a significant degree, the work is also grounded in ethnography. CA and ethnography may seem to be an unlikely combination. Ethnography is, after all, concerned with relatively subjective descriptions, observations and conclusions, and incorporates researcher engagement with the environment under investigation as one of its key elements (Massey, 1998; Atkinson *et al,* 2002). CA, on the other hand, is a micro-sociolinguistic approach aimed at providing an observation based science of verbal behaviour (Drew, 1994). It deals with the isolation of the universal communicative structures underlying talk and questions the notion that there is an intrinsic causal relationship between language and the social contexts in which it is produced (Hutchby and Wooffit, 2001). At its purest, CA is an objective discipline, actively antipathetic to subjective speculation. The data it utilises is naturally occurring and the micro-social environments where this data is collected must be free from any form of researcher involvement. Specifically, CA assumes that analysis can be generated purely from information available in the data of interaction, and that the analyst is not required to speculate on the contextual background, motivations or orientation of interactants (Heritage and Atkinson, 1996).

On the face of it then, combining these two methodological traditions of sociological analysis would appear to be problematic. One is largely subjective and deals with cultural contextualisation. The other is objective and operates at a level outside or 'beyond' contextual influences. There are, however, pertinent reasons why I have chosen to use them together, and to a large degree these relate to the kind of information I am trying to uncover. Firstly, I am concerned with isolating micro-interactional features of the

homeopathic environment – a task ideally suited to CA. Secondly, however, I am also interested in making connections between these features, behavioural motifs and sequential idiosyncrasies, and the way in which they help to define or engender the homoeopathic therapeutic process. In order to do this effectively I suggest that the overarching contextualisation of the broader socio-cultural environment in which the homoeopathic consultations take place (provided by ethnographic analysis) can be used as a means of isolating potential areas of interest. CA can then be applied to relevant data in order to uncover and describe the mechanisms that underlie these areas.

It is important to emphasise here that I am not advocating that CA and ethnography should be combined at an *analytical* level. Rather, that the data that each can supply when applied to a given arena – in this case homoeopathy and homoeopathic encounters – need not be mutually exclusive. There can be a useful level of cross-information. I do not suggest either that there be a dilution or adaptation of the technical procedures which underpin each methodological approach. I am not proposing, for example, that CA be applied to ethnographically derived data such as researcher / patient interviews (although this could of course be done if the researcher / patient interview as an arena in itself was to be analysed). The approach I have chosen to take is effectively linear; ethnography is initially utilised as a means of providing context and direction. Then, with subjective themes and interactional issues isolated (say, for example, the distinctively collegial atmosphere that homoeopathic patients often describe when talking about their consultation experiences – see chapter 5), I have selectively applied CA to relevant collections of naturally occurring interaction (i.e. consultation recordings) to provide an objective analysis of how these processes may be generated and maintained. I have tried, therefore, to use broad ethnographic and observational data as a means of isolating behaviours, or behavioural themes onto which the microscope of CA may be focused.

A significant advantage of this approach in terms of the information that it has produced is that it has allowed for the isolation of behavioural motifs which CA might not have routinely uncovered, or that because of temporal

characteristics, would have been unwieldy to collect. In chapter 6, for example, I present CA data that illustrates a form of 'circling' behaviour in the talk of some homoeopathic patients, the sequential elements of which are routinely separated by extended periods of unrelated interaction. Without prior (ethnographically derived) information that this kind of behaviour might be occurring it is likely that the connections between such extended and fragmented sequences of talk would not have been evident.

CA and ethnography have already been used together in the investigation of medical arenas. Heath (1986), for example, in a study of doctor-patient interaction, presented CA analysis on material embedded within an ethnographic framework. Similarly, in his study of AIDS counselling interactions Perakyla (1995), demonstrated that the two methodologies could be successfully combined; ethnography providing contextualisation, and CA, a means of generating objective descriptions of the themes and interactional questions that arose. The way in which I have approached the present study is similar, although using CA and ethnography together - even in the relatively linear method I have adopted - is not without difficulty. Tensions can arise when subjective descriptions of behaviour indicated in the ethnographic data (such as what people say in interviews about the way in which they think they interact in consultations) appear to be different to the behaviour revealed by the objectivity of CA. This kind of discrepancy is evident in chapter 8, for example, where the talk formulations of some medically trained homoeopaths who are ostensively conducting homoeopathic consultations appear to indicate an underlying orientation to the conventions of orthodox medicine. Overall, however, I have tried to deal with these kinds of misalignments creatively, and use them as a means of indicating how the expressed qualities of, say, the homoeopathic consultation process (holistic, patient-led and so on), can be in conflict with institutional requirements (such as the need for the homoeopath to undertake certain routine procedures during a consultation, or collect certain types of information).

Essentially, I can justify my approach on the grounds that the way in which I combine CA and ethnography is mutually informing and does not

compromise either approach. By allowing ethnographically derived observations to provide hints as to those behaviours that might prove fruitful for study at a micro-level it is possible to make much more economical use of CA data and produce a broader and more rounded description of the homoeopathic interactional environment than would have been provided by either methodology in isolation.

Data

CA data

The original CA data utilised in this study was largely collected as part of my involvement with the PaPaYA project as a researcher between 2000 and 2002. This was a Dept of Health funded project (reference number 3700514) which aimed to use a multi-discipline approach to investigate patient participation and decision making in health care. It focussed on five clinical settings: ENT oncology, diabetes, genetic counselling, family planning and homoeopathy. My particular role focused on collecting data in the homoeopathic settings. Specifically, this included conducting pre and post consultation interviews with patients and homoeopaths (both qualitative and quantitative – see next section), and making full length audio and video recordings of their consultations. The majority of the CA examples that I present are derived from the video and audio recordings made during PaPaYA. I have also utilised a small amount of data from the consultations of a holistic practitioner that I collected independently before becoming involved with the project. This included interviews, non-participant observation and video recording of consultations. (See table 1, below). All of the CA transcription of the homoeopathic extracts included in the present study was undertaken by me. Most of the data relating to the orthodox medical consultation examples I have cited were transcribed by other CA researchers working on PaPaYA. In all, the homoeopathically related CA data amounted to over 30 hours of real time consultation recordings with 8 different practitioners and 20 patients. This was augmented by a large corpus of conventional medical consultations (from the ENT oncology, diabetes and genetic counselling already mentioned), 6 of which were utilised as major data examples and are included in table 1. Original recordings were

transcribed using CA conventions. (An outline of the CA transcription symbol conventions is included in appendix III.)

Table 1 (below), shows the makeup of the CA consultation data. To preserve anonymity, a random letter code has been assigned to all of the participants. The first two letters of the code represent the practitioner and the second two the patient. The last part of the code is the date on which the recording took place. So for example, in the consultation represented by 'RF-NP-6-9-00', RF is the practitioner code, NP is the patient code, and 6-9-00 is the date of the consultation. These consultations represent a reasonably even spread over the two key homoeopathic practitioner typed, i.e. 'professional' or non-medically trained homoeopaths (HOM), and 'medically trained homoeopathic doctors' (MED-HOM). The table also indicates whether a consultation was a patient's first or return visit (the relevance of these categorisations will be explored later in the thesis), whether the original recordings were video or audio only, and the approximate duration of each encounter. The orthodox consultations that were utilised are indicated by 'MED'.

Table 1. Consultation data

Consultation no.	Video	Audio	Date	Cons	Type	Duration
RF-NP-6-9-00		✓	06-9-00	HOM	1st	+ 1.5H
RF-J-27-04-00	✓	✓	24-04-00	HOM	1st	+ 1.5H
RF-J-21-07-00	✓	✓	21-07-00	HOM	Ret	+ 1H
RF-JO-07-07-00		✓	07-07-00	HOM	Ret	+ 45m
RF-JO-02-05-00		✓	02-05-00	HOM	Ret	+ 45m
RF-GR-11-05-00		✓	11-05-00	HOM	Ret	+1H
RF-G-27-04-00		✓	27-04-00	HOM	Ret	+1H
LH-S-3-10-00	✓	✓	03-10-00	HOM	Ret	45m
LH-GZ-01-12-00	✓	✓	01-12-00	HOM	Ret	45m
DR-MC-25-04-01	✓	✓	25-04-01	HOM	Ret	1H
DR-CM-18-08-01	✓	✓	18-08-01	HOM	Ret	1H
DR-RC-28-03-00	✓	✓	28-03-00	HOM	1st	+1H
DR-ML-28-03-01	✓	✓	28-03-00	HOM	Ret	1H
DR-RM-25-04-00	✓	✓	25-04-00	HOM	Ret	1H
DR-NB-08-08-00	✓	✓	08-08-00	HOM	Ret	1H
JS-JP-3-10-00	✓	✓	03-10-00	HOM	Ret	+45m
DF-B-03-06-00		✓	03-06-00	HOM	Ret	+30m (15m recorded)
AE-RP-14-03-99	✓	✓	14-03-99	Holistic	Ret	+1H
AE-NP-14-03-99	✓	✓	14-03-99	Holistic	Ret	+1H
H-DOC-HS-1-12-00		✓	01-12-00	Med-hom	Ret	+30min
H-DOC-NP-20-10-00		✓	20-10-00	Med-hom	1st	+45min
H-D-NP-20-10-00		✓	20-10-00	Med-hom	1st	+45min
HD-NP-21-11-00		✓	21-11-00	Med-hom	1st	+45min
Y-202-207-26-09-00	✓	✓	26-09-00	MED	1st	+30min
PS-VT-21-06-00	✓	✓	21-06-00	MED	Ret	15min (split cons)
DB-OP-09-10-01	✓	✓	09-10-01	MED	Ret	+20min
FP-RP-(AB)26-03-01		✓	26-03-01	MED	1st	+15min
DI-MP-17-01-01		✓	17-01-01	MED	Ret	+20min
FP-NP-26-03-01	✓	✓	26-03-01	MED	1st	+15min

Ethnographic data

As well as the micro-interactional CA data upon which the bulk of my empirical analysis is based, the more ethnographically informed portions of the work are grounded in the conventional methods of the field; observation (in this case, mainly non-participant), interview and document analysis. Again, to a large degree I have been able to utilise data that was collected by me as part of the PaPaYA project. Specifically, this included ongoing non-participant observation at homoeopathic, and, to a lesser extent, conventional medical sites where consultations were being recorded, and in-depth semi-structured interviews with homoeopathic practitioners and patients. I was also able to utilise relevant interview data collected by other researchers working on the project. (Mostly qualitative interview data with conventional GP's, specialist consultants and other health professionals.) All participants who were interviewed, recorded or observed (either solely for the PaPaYA project, or as part of the independent data collection I undertook), were provided with an information leaflet explaining the purpose of the research and that participating would in no way affect the medical treatment that were receiving. They were also asked to sign a standard consent form confirming that they were willing to take part.

During the early stages of my research I also undertook an exploratory quantitative attitudes survey with homoeopathic practitioners. This was conducted via email and is explained in more depth in chapter 3. The internet was similarly used to augment the investigation of the broad ethnographic themes – many of the homoeopathic training colleges, for example, (see appendix I) provide websites giving information on training issues etc., and there are similarly a wealth of sites dedicated to homoeopathic, holistic and CAM issues.

Literature sources

Much of the literature cited throughout the thesis was identified using *BIDS, MEDLINE,* and the AMED complementary medicine database. From relatively broad initial searches, more specifically focused references were

identified as thematic areas developed. Similarly, sourced texts provided further referencing resources.

Other sources

There are two other sources of ethnographic data that have influenced the analysis that I present. These are significant because although I do not claim to categorise them in the same context as data collected using conventionally grounded ethnographic methods, they have undoubtedly informed my perspective, and furnished me with a degree of empirical understanding related to the fields of homoeopathy and communication. Firstly, with the initial intention of rounding out my appreciation of what the homoeopathic consultation process is actually like – at least in a subjective sense – during the early stages of the research I began to see a homoeopath as a private patient. This continued throughout the entire process of data collection, analysis and writing, and has given me an insight into what the process can actually involve from the perspective of a patient. It has also helped sensitise me to some of the subtler aspects of the consultation data I have analysed. My homoeopath has always been fully aware of this study. However, although I routinely canvassed her for her professional outlook on issues emerging from the work, our consultations together were not recorded and do not form part of the CA data presented here.

A second factor which is relevant to a reading of the empirical chapters relates to communication training that I have myself undertaken, but which is not directly connected with the study. Specifically, during the later part of the research, I began training as a counsellor, and for several years before this I worked as a volunteer on a national telephone crisis line. Again, as with becoming a homoeopathic patient, these activities were not specifically undertaken in order to gather ethnographic data, but I acknowledge that my experiences are likely to have had an unavoidable (and, I hope, useful) impact on the underlying 'gaze' with which I have approached my analysis. I am well aware of the dangers of utilising ungrounded data, however, and at the occasional points where I have found it useful to include information derived from my own experience, I make a clear differentiation between

personally or reflexively derived observations, and ones that are result of my conventional ethnographic work.

limitations of the data

Although I feel that the CA and ethnographic data I was able to collect relating to homoeopathic consultations was relatively representative of the homoeopathic environment, I am aware that it is probably still too small a corpus to support categorical claims about the universality of the behaviours that I describe. The data cited from the conventional medical consultations can similarly only be regarded as an indication of possible behavioural themes. Conventional medicine, much more so than homoeopathy, is composed of so many different environments, approaches and specialisms that apart from very basic structural underpinnings it would be impossible to say realistically that interactionally, there is now any single 'allopathic approach' (see: Hughes, 2003). Diverse working environments and objectives necessarily engender different interactional methods, and as is evident from the relatively eclectic range of conventional consultations I had access too (see above), the kinds of behaviours (in terms of activities, structure, pace, focus, and so on) observed in, say, a GP consultation, can differ significantly from more specialised encounters. Similarly, as more and more conventional doctors incorporate concepts such as 'concordance' (see: Dickinson *et al*, 1999; Lask, 2002), or 'narrative based medicine' (See: Greenhalgh and Hurwitz, (1999); Glyn and Gwyn, (1999); Launer, (1999); Silverman, (1987)), and seek to develop a more 'holistic' understanding of their patients, the dynamic, reflexive and evolving nature of much interaction in conventional medicine needs to be acknowledged when attempting to make effective comparisons between systems.

It should also be noted that conclusions reached in a study which necessarily involves the analysis of data collected from individuals who have consented to take part, needs to take account of the possibility that by giving this consent, these individuals are already defining themselves as a group of people who may share a particular perspective - one that as an element of

communication awareness. Although, for example, there were surprisingly few homoeopathic practitioners and patients who, when approached to take part in the PaPaYA study (i.e. to be interviewed and have their consultations recorded etc.), refused to do so, there is always an underlying concern that it might well be those individuals and interactions that are not accessible which might have provided a more rounded picture. Similarly, the various conventional practitioners who were good enough to become involved might, by their willingness to engage with the idea of having their professional behaviour analysed (and by implication, judged), be consciously or unconsciously providing data that is more representative of 'good' communication practice, rather than 'average' or even 'bad'.

The wider sociological context of the work

In order to illustrate where the present study stands in relation to other approaches to the sociological investigation of CAM, this last section is a brief overview of some of the perspectives that have been developed. More specific analytical contextualisation will be included in the various empirical chapters.

In broad terms, the sociology of CAM is an area of enquiry that is both young, theoretically underdeveloped and empirically under-investigated (Siahpush, 1999; Tovey *et al*, 2003). In the twenty years or so since it began to become a recognisable entity in its own right, much work has been concerned with positioning it within the context of orthodox medicine and wider social trends, and examining the motivations and reasoning behind the apparent upsurge in interest. The importance of research that incorporates the perspectives of lay culture as well as those of the medical (and CAM) community has been emphasised (see: Kronenfield and Cody, 1982), but in tandem with studies aimed at providing definitive information about developing CAM usage, patient and practitioner motivations and beliefs etc., there has also been work seeking to unravel issues of legitimation, professional dominance and agency. Within this strand of investigation the 'medical' aspects of CAM become relatively incidental and issues of proof and efficacy are similarly marginalised. Shama (1993), for example, has been concerned with defining

the anthropological and socio-medical context within which CAM should be approached, highlighting what she described as a collective uncertainty over where the new discipline should lie. Early work by Fulder (1992), was similarly aimed at grounding what had hitherto been a relatively defuse arena. As the field has become more delineated, however, issues such as the dynamics of professionalization, and integrational conflict between CAM therapies and the orthodox system have attracted attention. This has mainly centred on specific therapeutic traditions. With particular relevance to the present work, for example, Cant and Sharma (1996) were concerned with the progression towards professionalization followed by homoeopathy in the UK, and examined the ways in which claims for legitimacy, status and authority can be linked to the presentation of homoeopathic knowledge (see introduction). A similarly therapy based ethnographic approach was taken by Briggs (1989), in relation to chiropractic developments in Canada (see also, Briggs, 1994). Miller (1998) focused on the professional identity of osteopaths, while Boon (1996) analysed the world views of naturopathic practitioners, and how the conflict between their holistic and scientific socialisation informed their practice behaviour.

There seems to be as yet, however, little sociological investigation into the dynamics of more esoteric and newly coalescing (in terms of professionalization and structured organisation) forms of CAM in the UK. Some ethnographic work has focused on the situation in other countries, both developed and developing, however, which may help to inform the situation here. Ngokwey (1989), for example, made connections between diagnostic specificity and definitions of the 'healer' role in three faith healing institutions in Brazil. Similarly, Lindquist's critique of the 'culture of charisma' surrounding healers working in contemporary urban Russia, demonstrates how devices of legitimation (such as the appropriation of religious imagery) are crucially dependent on cultural references (Lindquist, 2001).

CAM has also attracted the attention of social theorists. Rayner and Easthope (2001), for example, position the rise of CAM within a post-modern paradigm and highlight the way in which the features that have come to

define CAM (in terms of its commodification) – such as its development into niche markets and the promotion of life-style values – can be seen as accurately reflecting features predicted by theories of post-modern consumption. (See also: Featherstone, 1991; Langer, 1996). One of the first writers to describe the commodification of the value systems associated with much CAM was Coward (1989). She argued that a 'new consciousness' was emerging that challenged many of the taken for granted assumptions of the western world. The elements of this new consciousness being a preference for the 'natural' over the scientific and technical, a rejection of expertise, an increasing awareness and concern about risk, a moral imperative to take responsibility for one's actions, and coupled with this, a valuation of personal choice.

Coward's theoretical position in relation to CAM has stimulated some empirical work. Siahpush (1998, 1999), for example, used a small scale telephone survey of residents in the Australian town of Albury-Wodonga (1998), to evaluate the differential influences of what he described as 'post-modern values' on attitudes toward 'alternative' medicine. The research was later expanded to include the State of Victoria, and the larger (1999) study incorporated questions designed to measure dissatisfaction with medical outcomes and dissatisfaction with the medical encounter. Siahpush found that post-modern values (a preference for the natural, rejection of the technical and so on) were associated with a positive attitude towards alternative medicine. He was also able to identify trends towards belief in responsibility for one's own health, and holistic views on health. Significantly, in neither study was dissatisfaction with medical outcomes or of the medical encounter a major factor.

Although the various strands of CAM therapy currently enjoying popularity in the UK have received a high degree of causal analysis (in terms of quantitative analysis of their levels of use etc. – see introduction), the internal dynamics of such systems at a professional level, and the interrelationship between them and orthodox medicine, are relatively unexplored. Similarly, and perhaps of more direct relevance to this work, a key feature of much

research into CAM use has been a polarisation between the individual and the individualised consumer and practitioners (Adams, 2000). Although there are a multitude of quantitative studies focusing on the attitudes of patients towards CAM (See, for example: Thomas *et al,* 1991, 2001; Bourgeault, 1996; Furnham and Kirkcaldy, 1996). Or the attitudes of health professionals towards CAM (See, for example: Jump *et al,* 1998; Adams, 2000; Easthope *et al,* 2000), a synthesis of the two perspectives at a broad sociological level is not apparent.

A final area of investigation that is currently developing, and into which the present study fits, is the application of micro-interactional methodologies – most notably conversation analysis – to the arena of medical interactions. From its early development by Harvey Sacks in the 1960's and early 1970's (Heritage and Atkinson, 1996), CA has been rigorously applied to the analysis of the structures of talk that occur within these environments. (see: Drew *et al,* 2001; Heritage and Stivers, 1999; Peräkyla, 1998; Heath, 1995; West, 1983). At a broad level, 'pure' CA has been used to map the interactional dynamics of doctor-doctor, doctor-nurse, social worker-client, and counsellor-client communication (see: Atkinson 1995; Beckman and Frankel 1984; Drew (forthcoming), Frankel 1983, 1984; Frankel and West 1991; Hak 1994; Have 1991; Heath 1981, 1986; Heritage and Lindstrom 1998; Heritage and Strivers 1999; Hughes 1982; Maynard 1989; Peräkyla 1989; Pomerantz, Ende and Erickson 1995; Rost, Carter and Inui 1989; and West 1983). CA based work has also focused on the reproduction of structural frameworks and professional knowledge (see: Paget, 1983; Boyd, 1998). Few studies, however, have sought to position their micro-analysis within a wider ethnographic contextualisation. Notable exceptions being the work by Peräkylä (1995), and Heath (1986), which have already been mentioned. It is also evident that despite the major role that CAM is now playing in many patients' therapeutic perspectives, this particular area of medical sociology is relatively unexplored.

Essentially, then, in this chapter I have provided an outline of, and justification for the combined methodological approach I will take in this ethnographically

informed micro-interactional study of the homoeopathic therapeutic encounter. I have also given a detailed description of the empirical data I will be utilising, how this was collected, and what other relevant factors have informed the research. I have discussed some possible limitations that my approach may have, and finally, I have presented a brief sociological contextualisation which positions this study in relation to other work that is focussed on the CAM arena.

Chapter two

Homoeopathy

In this chapter, I wish to give a little background information that will enable those unfamiliar with homoeopathic medicine, or its position relative to conventional medicine, to more easily relate to the analysis of empirical data that will be presented later.

Principles

According to the World Health Organisation, homoeopathy is the second most widely used form of medicine in the world – Chinese medicine is first, herbalism is third, and conventional medicine is fourth (Chapell, 1999). In contrast to therapies that have their roots in Eastern or other esoteric healing systems, homoeopathy in its present form, is relatively new. Even though its philosophical underpinning – based on the notion that '*similia similibus curentur*', or 'like may be cured by likes' can be traced back to Hippocrates and Paracelsus, the integration of this principle into a structured healing system was not attempted until the beginning of the 19th century by the German physician Samuel Hahnemann (1755-1843) (Fulder, 1996).

Acquiring a conventional medical training in Leipzig, Vienna and Erlange, Hahnemann's early experiences as a country doctor coloured his view of the medical practices of the time and he quickly came to the conclusion that many orthodox treatments were actually damaging to patients. This was reflected in his 1786 work *Uber die Arsenikverigiftung: ihre Hilfe und geriche Ausmittelung* (On Poisoning by Arsenic – Its Treatment and Forensic Detection.) In many ways, the unease that stimulated Hahnemann's search for a safer system of medicine was a reflection of wider social concerns. As Porter (1997) points out, the early 19th century was a time of social upheaval

and opportunism, and is distinctive as a period in which a large number of alternative healing movements were introduced.

Hahnemann tried to find ways of reducing the toxic effects of medicine, and in the course of his experiments noticed that when the malaria drug quinine was given to people who were not ill, they produced symptoms that were indistinguishable from those of malaria (Inglis and West, 1983). After further investigation, he discovered that this 'law of similars' was true for a great many other drugs, plants and mineral substances. More importantly though, when given in small doses, substances that produced specific symptoms could be successfully used to treat diseases that generated these same symptoms. Arsenic poisoning, for example, produces symptoms that are very close to those of cholera. So, following homoeopathic reasoning, a highly diluted preparation made with arsenic can be used as a remedy to treat cholera. Similarly, insomnia might be treated with a remedy made from a minute amount of a stimulant such as caffeine.

In an attempt to reduce the harmful effects of his own remedies – often produced from highly toxic substances – Hahnemann began to experiment with dilution and discovered, rather surprisingly, that far from decreasing in potency, the more dilute a preparation was, the more powerful its therapeutic effect. Hahnemann tested the homoeopathic properties of many thousands of substances on healthy volunteers during his lifetime (a process known as 'proving'), and organised them together in a book called the *Materia Medica*, a reference work which is still evolving today and forms the backbone of homoeopathic prescribing.

The extreme dilution process has, understandably, always been a contentious area for homoeopathy. The idea that the less concentrated a preparation is, the more potent it becomes goes against common sense, and homoeopathic remedies are routinely diluted to a point well beyond which

there should be any molecules of the original substance left in solution.[1] An important factor in the preparation process according to homoeopaths, however, is that at each stage of dilution the mixture is shaken violently or *succussed.* Hahnemann found that when remedies were prepared without succussion, their effect was greatly reduced. Until recently, this element of the production of remedies appears to have been largely overlooked – possibly because non-homoeopathic investigators regarded it as a ritualistic and meaningless activity – but some (admittedly contentious) research has suggested that succussion causes a structural change at an atomic level so that the 'memory' of the original substance is somehow transferred to the solution (Sudan, 1993).

Regardless of the actual mechanics of the remedies, another important tenet of homoeopathic thinking relates to the way in which they produce a healing effect. In conventional medicine, disease is regarded as being caused by outside agents – such as bacteria – attacking the healthy organism. From a homoeopathic perspective, however, the symptoms of a disease or illness are simply the last and most noticeable stage in a process that has its roots in a disruption of what Hahnemann called the *vital force.* This is seen as an abstract form of energy that sustains life and, when weakened, leads to illness (Cant and Sharma, 1995). The appearance of a noticeable symptom – a skin rash for example – in the patient might be traced back by the homoeopath to a much earlier and seemingly unrelated disruptive event in the patient's medical (or psychological) history. There is much concern within homoeopathy, for example, about the destructive effect that childhood vaccinations may have on a person in the long term.[2] These are usually described in terms of the 'suppressive' effect that they inflict on the developing immune system. Many chronic yet seemingly unrelated conditions such as asthma or eczema are often regarded by homoeopaths as being

[1] Avogadro's constant ($6x10^{23}$) is often cited to support the fact that many homoeopathic dilutions have nothing of the original 'active' substance left in them. This has never been disputed by homoeopaths themselves, however, and when considered in terms of their medical paradigm, is seen as an irrelevance.

[2] From interview data (homoeopath).

directly related to the damage that has been caused to the immature immune system by the early use of vaccines. This is perhaps a little ironic, because the process of vaccine production – utilising very dilute preparations of an active disease – is, on the surface at least, very much in line with homoeopathic principles.

The effects of disruptions to the vital force, which might include anything from a severe childhood illness to a small but significant traumatic event later in life, are not limited to the patient themselves, or their personal medical narrative. In a way that is reminiscent of psychotherapeutic approaches (although Hahnemann predated Freud by about a century), some illnesses are seen as being the indirect result of trauma suffered by bloodline relatives – most often the patient's mother. Homoeopaths call these cross-generational weaknesses *miasms*, meaning 'ghost of an illness'.

In line with holistic ideals, Hahnemann outlined the principle that each person has a particular type of psychophysical makeup, or what he termed their *constitution*, and that the characteristics of this predisposed them to certain kinds of symptomatic reactions, or patterns of behaviour (Sharma, 1992). Someone who has a *Nux vomica* constitution, for example, might be irritable, have strong sexual energy and be prone to ulcers. Having a *Nat mur* constitution on the other hand, might indicate a tendency for headaches, claustrophobia and a liking for salty foods. Homoeopaths believe that it is the body's own healing abilities (which, if a comparison with conventional medicine is made, could be regarded as the body's immune system), that are stimulated by their remedies in order to cure an illness. The remedies do not work by acting on particular symptoms as most allopathic drugs do. In selecting a remedy, a practitioner will use symptoms mainly as an indication of where support or stimulation is needed. Detailed information about the person as an individual is also required in order to select the remedy that will be most effective. Homoeopathic remedies cannot, therefore, be prescribed in the same way as allopathic drugs because two people who present with

exactly the same symptoms are unlikely to have similar constitutions and will rarely be given the same remedy.

The individualistic nature of homoeopathic treatment has meant that there are, according to homoeopaths, difficulties in evaluating it using established scientific criteria. Reproducing the effects of remedies in samples of patients with the same complaint – as would be the conventional way of testing a drug or procedure – has always been difficult. While allopathic treatments are well suited to conventional clinical trials, when specific homoeopathic remedies have been put through similarly designed randomised controlled trials (RCT's) the results have been predictably inconclusive. There has recently been some official acknowledgement, however, that research into the efficacy of complementary medicine in general – not only homoeopathy – needs to take account of the paradigmatic framework of the therapy involved. A recent report by the House of Lords Science and Technology Committee on CAM (2000), for example, recognised that there was a considerable amount of evidence suggesting that the structural features of randomised controlled tests made them basically unsuitable for evaluating therapies that relied to any great extent on the idiosyncrasies of individual patients – something that is a basic tenet of much complementary medicine, and of homoeopathy in particular.

Homoeopathic theory, bizarre as it may initially appear to be, has been shown to produce tangible results – even if the homoeopathic community would claim that conventionally structured RCT's are not the most suitable way to illustrate this. There is a growing body of research that attempts to place the discipline beyond being simply a placebo effect (See, for example: Taylor and Reilly, 1986; Benveniste, 1988.) – although this may indeed play a useful role in some circumstances, as it does with all systems of medicine.[3] It may be, as Fulder (1996) points out, that there is little point in searching for explanations that rely on current modes of scientific thought because

[3] Anl argument against the action of a placebo effect in homoeopathy is that it has been used successfully for many years to treat animals and babies; subjects who are presumably not susceptible to psychological influences.

homoeopathy might be acting at a subtle level on energy bodies that cannot, as yet, be detected. Homoeopaths would argue that it matters little that scientific methods are not currently able to explain exactly why their therapeutic processes work because for so many people, they apparently do. Furthermore, they would claim that in the spirit with which Hahnemann originally conceived the system, the successful use of ultra-dilute drugs is infinitely less toxic and disruptive to the body than many allopathic treatments that have a similarly unexplained functioning.

Homoeopathy in Britain

Along with acupuncture and chiropractic, homoeopathy is one of the most widely used forms of complementary medicine practised in Britain today.[4] Its emergence here can be traced back to the cholera epidemics of the early 19th century when it was used successfully as an alternative to some of the more dubious medical practices of the time (Inglis and West, 1983). In 1858 when the medical act established the medical profession in Britain, it allowed for medically qualified doctors to train as homoeopaths. Due to the antagonism that many allopathic doctors felt towards the discipline, however, there have never been significant numbers of graduates willing to train after qualifying in conventional medicine. Medically qualified doctors who do train in homoeopathy become members of the Faculty of Homoeopathy (FH), and at present it is estimated that there are only around 1000 doctors in the UK who have homoeopathic training (Morrell,1998).[5] Of this number it is likely that the majority practise part time as a subsidiary to their allopathic work; the general pattern appears to be that GP's who have a deeper commitment to their

[4] A quarter of people interviewed for a *Guardian* survey (09/01/96) claimed to have used homoeopathy, and in the *Which?* survey of 1992 (*Which?* 1992), it was placed third in popularity after osteopathy and chiropractic. In the Survey of Knowledge and Understanding of Unconventional Medicine in Europe. (Research Council For Complementary Medicine, 2000), from a list of 60 complementary therapies, homoeopathy was rated as the one in which respondents expressed most interest.

[5] The Faculty of Homoeopathic Medicine currently claims to have around 1200 members worldwide. (see: *Overview.* Faculty of Homoeopathic Medicine. http://www.trusthomoeopathy.org

homoeopathic work, as opposed to those who might just occasionally prescribe a generic homoeopathic preparation, tend to make a clear distinction between their homoeopathic and allopathic patients – holding a homoeopathic clinic once a week for example. The temporal demands of homoeopathy, and the paradigmatic shift that is necessary to practise it effectively make it very difficult to incorporate homoeopathic sessions alongside ordinary clinical work.[6] Despite the small number of practising homoeopathic doctors there are currently five hospitals in the UK – Glasgow, Liverpool, London, Tunbridge Wells and Bristol – that are either committed homoeopathic establishments, or have dedicated homoeopathic wards.

Lay Homoeopaths

The current position of homoeopathy in the UK is interesting because despite its questionability in the eyes of many allopathic physicians, provision for the discipline was built into the NHS in 1948 (Porter, 1997) – probably due in part to the tradition of enthusiastic royal patronage that it has always enjoyed (Nicholls, 1988). Along with medical doctors who trained in homoeopathy there have always also been non-medically qualified or 'lay' homoeopaths working in Britain. This term is little used now, however, and qualified practitioners tend to refer to themselves as 'professional homoeopaths'. After a period of fairly patchy interest, the late 1960's and 70's saw a big resurgence of popularity. The flourishing of homoeopathy that is taking place now appears to have been mainly stimulated by the work of John Da Monte (1916-75), and Thomas Maughn (1901-76). Da Monte and Maughn began teaching homoeopathy alongside other '...more philosophical and Druidic forms of knowledge.' (Cant and Sharma, 1995), and inspired a group of twelve lay practitioners to set up The Society of Homoeopaths (SH) in 1978. This organisation has been largely responsible for establishing a professional basis for non-medically qualified homoeopaths in the UK. They publish a journal *The Homoeopath*, and qualified members may use the initials RSHom (Registered Member of the Society of Homoeopaths), or FSHom (Fellow of

[6] From interview data (medically qualified homoeopathic doctor).

the Society of Homoeopaths). The society also grant a Licensed Member certificate to student homoeopaths after three years at an accredited college, which allows them to commence supervised clinical training. Membership of the society has risen steadily over the last decade or so and is now at around 1400. At six monthly intervals a register of active members is published, and the current edition (June 2000), lists approximately 700 members.

Although the Society of Homoeopaths is the largest professional homoeopathic organisation in the UK, a survey by Mills and Budd (2000) for the Department of Health identified three other national groups representing non-medically qualified homoeopaths; The UK Homoeopathic Medical Association (UKHMA), the International Register of Consultant Herbalists (IRCH), and the Guild of Complementary Practitioners (GCP). All of these groups require members to graduate from a professional college, and demand a certain level of ongoing professional training. Periods of minimum training before professional qualifications are awarded do vary however, and can range from three years of full-time study, to three years part-time (Mills and Budd, 2000).[7] All four organisations require practitioners to hold professional indemnity and public liability insurance, and publish codes of ethics. The levels of membership for the three smaller organisations are relatively small when compared to the Society of Homoeopaths; the UK Homoeopathic Medical Association having around 450 members, while the Guild of Complementary Practitioners, and the International Register of Consultant Herbalists (which incorporate a number of CAM therapies), only currently include 44 and 35 professional homoeopaths respectively. Unlike the Faculty of Homoeopathy, none of the above organisations utilise a formal accreditation process to screen members, or publish disciplinary codes and sanctions.

Overall, it has been the Society of Homoeopaths that has taken on the role of informally policing the educational standards of the smaller organisations.

[7] Some homoeopathic colleges offer compulsory introductory courses that can effectively lengthen the training period to four years.

There have been moves, for example, to establish a National Occupational Standard in homoeopathy (HLSTC, 2000), and this appears to have had a generally positive effect on cohesion and mutual understanding within the homoeopathic community, as well as strengthening the credibility of the discipline.

An exploratory attitudes survey

Because this thesis will focus largely on an empirical investigation of the interactional environment of the homoeopathic encounter, I do not feel that it is necessary to concentrate too heavily on the finer details of homoeopathic medical knowledge. What is relevant ethnographically, however, is a broad understanding of how opinions and approaches which might relate specifically or obliquely to patient / practitioner communication are incorporated into homoeopathic methodology, and how practitioners view the role of communication in their professional activities.

In order to begin to address these areas, during the initial stages of fieldwork a short survey was conducted among 98 registered members of the Society of Homoeopaths. This was intended to augment information gathered in in-depth qualatitive interviews conducted with the professional homoeopaths and homoeopathic doctors who had been recruited as part of the York and Aberdeen Patient Participation Project (PaPaYA), as well as data obtained from a number of informal contacts working in the homoeopathic field.

The email survey

The survey was conducted by email among members of the Society of Homoeopaths in July and August 2000. It consisted of a short statement explaining the purpose of the research, followed by ten questions. Respondents were asked to complete the survey on-screen and send the completed form back as an email reply. It was considered acceptable to attempt to use this rather experimental method for a number of reasons:

1) Because it enabled a large number of practitioners to be canvassed very quickly, and at virtually no cost – either to myself, the practitioner, or the environment (in terms of waste paper).

2) Because it was hoped that the relatively small amount of effort it would take for a person to complete the form would encourage a high response rate.

3) To get some impression of how viable this method was and how it could be refined and applied to a larger sample.

The email addresses of the practitioners involved were obtained from the register of the Society of Homoeopaths (June 2000 edition). Although the fact that the sample was necessarily limited to those who chose to provide an email address, around 10% of the practitioners on the SH register now do this. As with society in general, access to and use of email has become fairly ubiquitous, especially among professional people, and is no longer limited to those who have a particular interest in computers. The statistical inaccuracies that might have been generated by the makeup of the sample were not thought to be too significant because the focus of the survey was largely qualitative and it was simply aimed at gaining a broad impression of those elements that might inform practitioners' perspectives on communication; apart from a small number of questions relating to training background etc., the majority were worded in an attempt to generate some degree of comment, but could, if desired, be answered simply with yes or no.

In order to maximise the response rate and avoid the survey being misconstrued as junk mail or marketing, each mailing was personalised by being individually addressed to the practitioner concerned. The 'covering letter' section was customised where possible, and a full mailing address, phone and fax numbers for the Department of Sociology at York University were also included to add further credibility – as was a note inviting doubtful parties to telephone me personally if they wanted to discuss the research.

In order to ensure that the survey generated as balanced a sample as was possible given its base limitations, all 126 entries that listed an email address as part of their register details were initially included on the mailing database.[8] Because of entry duplication (some practitioners having entries in more than one geographical section, or separate entries for their home and clinic), printing mistakes in the register, and various other errors, the final mailing went out to 98 practitioners. Of this number, 10 emails were returned as 'address unknown', and 41 completed surveys were received, giving a healthy response rate of 46% (or around 6% of all those on the register). Of those who replied, over 80% returned their emails within one week of the start of the survey. It was also gratifying to find that many practitioners took the time to give full and considered answers to some of the more open questions, reflecting, perhaps, the degree to which they recognised that research into communication might be relevant to them. There was also a sense that professional homoeopaths in general have a strong belief in their system of medicine, and welcome any serious research into areas that might present their approach in a realistic or unbiased way. Two homoeopaths, for example, initially refused to take part in the survey, citing mistrust of motives as a reason. After discussing the research with them, however, they were reassured and provided some interesting opinions.

The following is a copy of the email survey as it was sent out:

****

Dear {name}

COMMUNICATION IN HOMEOPATHY SURVEY

As part of a Ph.D project in communication and alternative medicine, I am currently researching the ways in which professional homeopaths communicate with their patients, and how important they consider this element of the therapeutic encounter to be. In an effort to get the views of as many homeopaths as possible, I am conducting a short email survey of all those members of the Society of Homeopaths who have included an email address in their register entry. This method is fairly experimental, but seems to make more environmental sense than sending out a great deal of paper!

The survey is very short and is printed below this message – I'd be really grateful if you could take a couple of minutes to complete it. All you need to do is to click 'reply',

[8] Entries in the Register of Homoeopaths are arranged by region and only include the name of the practitioner, their address, telephone number, email and possibly an internet address.

remembering to include the text of this original message, then type in your answers and email it back. Any information you give will be treated in the strictest confidence and will only be used by me for research purposes. If you would rather not complete the survey in this email form, however, but would still be willing to take part, I'll be happy to send you a paper version with a prepaid envelope that you can return anonymously.

Please don't hesitate to contact me if you have any queries or would like to talk to me about the research.

Best wishes.

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SCROLL DOWN TO QUESTIONS>>>>>>>>>

****

Please type your answers – as short or as detailed as you wish - in the space below each question and ignore anything you don't want to answer.

1. How long have you been practising as a homeopath?
2. What are the particular elements of the homeopathic approach that appeal to you, and how would you describe your approach?
3. Do you use/incorporate other therapies as part of your homeopathic work? (If you do, please list.)
4. Where did you do your homeopathic training?
5. Did your training include any specific elements relating to communication – listening skills, for example?
6. Do you have any interest in counselling or other types of talk based therapy?
7. Would you consider yourself to be a naturally good listener?
8. Do you think that communication skills are particularly relevant to the way that homeopaths work?
9. If you do, has this informed the way that your particular method of working has developed?
10. In terms of your own experience, would you say that homeopaths, and other alternative / complementary therapists, are likely to have better communication skills (in terms of

empathy, ability to connect with patients etc.), than other health professionals (particularly allopathic doctors)?

Thank you for taking the time to complete the survey – now just email it back to me. If you have any other comments or views relating to the questions I'd be very interested to hear them - please type them below.

****

Analysis

Given the evidently limited scope of the survey and the deliberate inclusion of a number of open ended questions, it was only my intention to draw broad thematic conclusions from the information that was obtained. An obvious problem in using an email based method – apart from the fact that not everyone uses email – is that the people who do use it and choose to respond may reflect a certain underlying perspective, and this may colour the information that they give. However, as it was very much a broad exploratory exercise intended only to help build up a 'feel' for some of the areas that might inform subsequent ethnographic work, this was not considered to be a major issue.

Demographics

Among the homoeopaths who were canvassed, and those who responded, the demographic spread was relatively uniform; most English counties had at least one practitioner who supplied an email address, and of these, over half produced one or more respondent. There were no areas that had an unusually high reply rate, and in general the level of homoeopathic activity in any given area was reflected in the number of addresses available, and the level of replies received; the London area, for example, produced 7 replies, while areas such as Cornwall, Norfolk, and East Yorkshire, which have relatively small numbers of professional homoeopaths, produced only 1 each. Similarly, Scotland and Wales produced 3 replies between them and there were 3 from British trained homoeopaths working overseas.

Training colleges attended

No respondents refused to give information relating to any of the questions in the survey. However, in relation to the question on training (Q4), some of the replies were not particularly clear. This may have been because the question did not specifically ask which college a practitioner trained at, just where they did their training. As a result of this ambiguity, a number of people answered in broad geographical terms – some having trained in several different countries. Of those who did specify where they trained, three main UK colleges were mentioned: the London School of Homoeopathy, the Devon school of Homoeopathy, and the Northern College of Homoeopathic Medicine. The majority of practitioners (around 50%) appear to have trained in London, which reflects the fact that until relatively recently, this was one of the only professional colleges.

Length of time in practice

The sample represented a wide range of practitioner experience – the shortest length of time in practice being 3 years and the longest 21 years. The average for the whole group was 10.5 years. Information relating to the age of respondents was not requested.

Thematic issues raised

Listening skills

Holistic practitioners in general, not just homoeopaths, have a reputation for possessing good communication skills (Kaplan, 2001; Chapel, 1999). That is, they are likely to be perceived as being particularly good at *receptive* communication. This was reflected in the attitudes of respondents; the overwhelming majority considering themselves to have good listening skills, and many appeared to view this as an integral part of the homoeopathic process. One respondent suggested, however, that it would be surprising if anyone admitted to having poor listening skills, but in relation to this, a number of (overwhelmingly male) practitioners commented that although they considered themselves to be good listeners in their professional role, this was

not a communicative mode that came naturally to them, and required a certain degree of effort.

The importance of communication

There was great awareness among the respondents of the multitude of levels at which the activity of 'listening' can be approached, and there appeared to be a clear distinction in many cases between the kind of analytical and diagnostically based action that is engendered by 'taking the case', and the more reflective process in which activities such as active listening actually become an element of the ongoing therapeutic process. One practitioner described how it had specifically been her homoeopathic training that had forced her to develop listening skills and had given her more of an ability to 'hear' what people were really telling her. It was significant also that a number of practitioners did not appear to consider it relevant to single out particular interactional skills, preferring instead to emphasise that, from their perspective, the homoeopathic consultation was a process designed to enable a practitioner to collect all that they needed regardless of their communicative approach.

The reasons why some practitioners seemingly down-played the role of communication *per se* in their work might stem from a belief that too much weight given to the effects of therapeutic processes other than homoeopathy – in the context of the homoeopathic encounter – might strengthen the hand of sceptics who are eager to undermine the medical efficacy of the discipline in favour of attributing its success to anything but the homoeopathic component. It is interesting to note here, however, that there were other practitioners who went to the opposite extreme and freely admitted that in certain situations, they might get remarkably good results by simply listening to a patient talk, and offer no remedy at all. A practitioner interviewed during a later phase of this project, for example, related how there are apparently homoeopaths who leave as much as a year between remedial doses – so although they may continue to see a patient on a regular basis to observe changes that might be taking place, it can be assumed that, for psychological

or emotionally based problems at least, the therapeutic focus of these encounters is necessarily skewed towards interaction.

The nature of training

Several of the more well established practitioners in the survey mentioned that they considered the homoeopathic training that is offered today to be superior, in terms of its communication component, than that of a decade or so ago. It might be argued that in the past the reputation that the therapy has gained for having empathetic practitioners originated from a loose correlation between the type of person who finds homoeopathy appealing, and the type of person who naturally exhibits, for example, good listening skills. The perception of the profession, as one respondent suggested, as somehow embodying 'feminine' characteristics may mean that it is people who already have empathetic and reflective tendencies who are attracted to it in the first place. The fact that a higher proportion of women become homoeopaths, as opposed to men, is perhaps also relevant in this context[9] – even if it is dangerous to predict the likelihood of receptive communication abilities along gender lines. One female respondent described, however, how she felt that homeopathy seemed to attract gentle people, while allopathic medicine – particularly surgery – embodied destructive masculine qualities.

Another factor to consider when making connections between motivation and particular types of communicative ability is the way in which, for the majority of practitioners, opting for homoeopathic training represented a major life and career change – something that presented itself as a result of previously formative experience rather than a planned progression from school or university. This life / work trajectory was hinted at by a number of survey respondents, and was largely confirmed by the homoeopaths I was able to interview at other stages of the research. The training process itself was described by most homoeopaths I was able to talk to in terms of a self-revelatory and cathartic experience, one that can trigger fundamental

[9] In the current Society of Homoeopaths register (June 2000), there are around three times as many female homoeopaths as male.

changes in a person's view of themselves and others. It would not be unreasonable to speculate, therefore, that people who move away from conventional jobs and careers to pursue one that is likely to involve a radical overhaul of their basic assumptions, and a need to battle constantly against entrenched scepticism, are likely to be more than usually self aware, and are likely to have developed the empathetic sides of their natures.

Further training

If it is significant that the majority of respondents to the survey (67%) indicated that their clinical training contained little or no emphasis on communication skills, it is also interesting that a considerable proportion (57%) mentioned that they had subsequently chosen to undertake further study in the field – almost universally this was counselling training – or said that before becoming homoeopaths, they had taken an interest in, or done some basic communication related therapy. These included psychotherapy, transpersonal therapy, and neurolinguistic training. It should be noted again, however, that a small proportion of respondents regarded the incorporation of specialised communication skills such as counselling to be largely irrelevant to the actual process of homoeopathy. One homoeopath commented, for example, that:

> 'To take a case you have to listen and then to question around, but nothing more than this.'

In a similar vein, another illustrated how, in their view, the art of performing a successful homoeopathic consultation was, by definition, a demonstration of the assimilation of highly developed receptive communication skills – regardless of whether these had been specifically singled out and taught separately:

> "Listening IS [original emphasis] the art of taking the patient's case and as such does not need to be taught separately – it is integral."

It appears that many homoeopaths would probably agree with this point in principle and that as with orthodox medicine, a reasonably accurate process of prescriptive deduction can be performed without any one-to-one contact

with the patient as long as sufficiently detailed and relevant information is provided. The benefits that homoeopaths gain from developing more communication awareness often seem to come into play later in the therapeutic process, once the treatment is having an effect. As I outlined at the beginning of this chapter, taking the case and ascertaining the correct remedy may quite literally be reduced to a mechanical process, but for many patients, the emotional support and trust that is built up between them and their practitioner often has an equally high therapeutic value. For a significant number of patients, regardless of the nature of their presenting problem, embarking on the homoeopathic process can stimulate periods of emotional release, or the surfacing of previously un-addressed life issues,[10] so it can be assumed that in situations like these, there would be definite benefits from having counselling related skills – even though a number of homoeopaths were keen to emphasise that they did not consider what they did in their clinical work to be counselling as such. One respondent who mentioned that she planned to do further training in this field commented that:

> 'I actually think some counselling training should be part of all our training. We meet people who have to face death, women who have been abused and who remember this as a result of our prescribing. We have to know how to respond appropriately in these situations.'

So it seems that for many homoeopaths, the connection between the effects of the clinical work that they do and the role that patient / practitioner interaction has in supporting these effects is well established – even if specific techniques and approaches that are idiosyncratic to homoeopathy might be difficult to pin down. In terms of training, an examination of the course content currently on offer at the various training colleges appears to confirm that communication skills and interactional awareness are key elements of modern homoeopathic courses, although there was definitely a sense from a number of respondents in the survey, and from homoeopaths I

[10] The possibility of events like of this occurring especially with new patients – is sometimes mentioned in the information leaflets given out by homoeopaths, and is also described as a possible reaction in virtually all other forms of CAM. It can be supposed that for a significant number of people, the possibility that their treatment will somehow help them to deal with nebulous psycho-emotional problems is one of its attractions.

was able to discuss this with, that the practical needs of their clinical training is sufficient to equip them with the basic interactional tools that are needed for them to be effective practitioners.

The Homoeopathic Consultation: A Case Study

Having explored some of the historical, interactional and communicative elements that inform homoeopathic practice in the UK, I now want to ground this a little by using an actual consultation to illustrate what might be expected to occur in a homoeopathic encounter, and what an 'average' practitioner and patient might be like. This will hopefully act as a contextual guide for the more detailed analysis that will be undertaken later on, and make the connection between homoeopathic principles and consultation structure a little clearer. Although this chapter is largely focused on one interaction, I will also draw on the more general ethnographic material I was able to collect with other homoeopaths and patients. Similarly, to some degree, the picture I present has been informed by my own subjective experiences as a homoeopathic patient.

Data

The encounter focused on here (extract 1: JS-JP-3-10-00) was video recorded, and the verbal interaction that occurred was subsequently transcribed using the conventions of conversation analysis (CA). A full version of the resulting transcripts can be found in appendix III. In order to obtain background information, informal interviews were also held with both the practitioner and patient before the consultation. The problems of capturing 'natural' behaviour when both practitioner and patient are aware that they are being recorded are well documented, but from talking with subjects after consultations, it appears that generally, once interactions were underway, the participants' became quickly focused on the matter in hand, and their awareness of the camera or recorder became greatly attenuated.

In the case of homoeopathic consultations in particular, the situation is helped considerably by their relatively long duration; the average length of time a GP in Britain can spend with a patient is around ten minutes,[11] whereas the homoeopaths observed for this study spent an average of fifty-five minutes on a consultation. The shortest encounter observed lasted thirty minutes, and the longest ones over one and a half hours (see table 1, page 20) In a number of cases, several consultations involving the same practitioner and patient were recorded which allowed the participants even more time to become desensitised to the recording equipment. It can be assumed, also, that for the broad structural outline of a consultation that this case study is intended to illustrate, even if the presence of recording equipment had had an effect in micro-interactional terms, it is unlikely to have significantly altered the consultation at the organisational level – filming a play may make the actors nervous, but is unlikely to affect the order in which the scenes are presented. In terms of being representative of an 'average' consultation, this encounter was chosen for a number of reasons: Firstly, the homoeopath was very experienced and used the 'classical' approach which is most common in the UK. Secondly, the patient was also very familiar with the homoeopathic process and her presenting complaint was typical of those often seen in homoeopathy. Thirdly, the interaction did not involve anything unusual or extreme (in terms of disagreements, misalignments, etc.), and incorporated virtually all of the structural conventions that are engendered by the 'routine' homoeopathic consultation, ranging from the kind of setting it occurred in, to the types of questions asked by the homoeopath. Lastly, the consultation was a follow up – i.e. not an initial consultation. As will be examined in more detail in later sections, although the interactional and structural framework engendered by a first-time encounter may be considered to be more overtly 'homoeopathic' in terms of the activities that are engaged in (such as the relatively formulaic sequence of questioning that usually underpin an initial 'taking the case', for example), homoeopathic patients will only ever have one initial consultation. They are likely, however, to have any number of

[11] On their website (http://www.rcgp.org.uk/rcgp/), the Royal College of General Practitioners outline a 'gold standard' by which patients must receive on average at least seven and a half minutes in routine consultations.

subsequent follow-ups. So in this sense, a follow-up consultation could be said to more readily reflect the 'routine' interaction of the homoeopathic process.

Although the conventional precautions have been taken to maintain the anonymity of the participants described in the case study, it is possible that the necessary level of detail offered might make them identifiable – particularly to people who know them well. With this in mind, both the homoeopath and the patient focused on here were asked to give (and gave) specific permission for their consultation together to be presented in this way.

The consultation setting

The practitioner involved, Anna (all names mentioned are pseudonyms) ran a private homoeopathic practice based in the North of England in an affluent county town. In line with all the other professional homoeopaths who provided data for this research, she was a qualified member of the Society of Homoeopaths, and as such can be assumed to have assimilated an approach that will be broadly in line with other 'classical' homoeopaths. There are variations of course, in the way that individual practitioner styles develop once they have qualified, as there are for any form of professional practice. But even taking this into account, the structural underpinning of the encounter should be recognisable to most homoeopaths and homoeopathic patients as something that is representative of conventional procedures.

In common with many full and part time professional homoeopaths, Anna held the majority of her consultations in a dedicated room in her home, although occasionally, as in this consultation, she would sometimes utilise her living room. Working from home appears to be widespread among professional homoeopaths and is driven primarily by economic considerations – especially among those practitioners who see only a few patients and cannot justify the expense of renting surgery space. Another common practice setting is within the natural health centres that are now a feature of

most towns; homoeopaths and other complementary therapists will often use the facilities of these collective spaces and hire out consultation rooms as and when they are required. Several of the homoeopaths I interviewed, however, did not feel the need to use a dedicated consultation space; they were happy to meet with patients in more informal settings or places where the patient felt particularly at ease. One particular practitioner in the study, for example, had a number of elderly patients and spent a lot of time visiting them in their own homes.

Although Anna did do occasional homoeopathic consultations in a local health centre, she generally preferred to use her own dedicated surgery space. She felt that the environment she had developed over time played an important, if intangible, role in the success of her therapeutic encounters. This didn't relate to any specific change in the dynamics of her consultations, but rather to her own sense of well being in a familiar personal space – a feeling which presumably had a positive effect on her interactions with patients. If working in a health centre once or twice a month had any particular appeal for her, it was largely related to the personal support she gained from contact with other homoeopaths and complementary practitioners; she described how constantly working alone can be very isolating.

The room where Anna took most of her patients was situated on the first floor of a listed farm building and overlooked a tranquil country garden. Her surgery was small and intimate, measuring around twelve feet square. A desk was positioned against the wall but during consultations Anna and her patients tended to be positioned alongside it, rather than in the more conventional 'across the corner' arrangement; whether consciously or not, the room promoted a degree of interactional equality. The almost face to face seating arrangement was also common in most of the other homoeopathic settings I observed and appears to have developed not only as a means of removing physical barriers between the patient and practitioner (to equalise the encounter for the benefit of the patient), but also so that the practitioner could get an unobstructed view of the patient; to obtain an accurate picture of

a person's constitution, the homoeopath relies a great deal not only on what the patient tells them, but also on detailed observation relating to how they present themselves – whether they fidget, whether they favour certain gestures, how they choose to sit, etc.[12] When Anna saw patients in her living room, she also tended to sit in a position that allowed her to get a full view of them.

Another feature of the consultation space was the general absence of homoeopathic or medical paraphernalia. Although she would, on occasion, use medical equipment such as a blood pressure meter with a patient, this was not left out on display. Neither were any of the multitudes of remedy bottles that practitioners need to hand when prescribing. Virtually the only items in the room that betrayed it as the workspace of a homoeopath were a selection of reference books on a small shelf, and a low table with a display of commercial homoeopathic first aid preparations, homoeopathic toothpastes – the strong flavour of peppermint being something to avoid when using homoeopathic remedies – and a selection of leaflets explaining homoeopathy. There was also a strategically placed box of paper tissues, a ubiquitous feature in any therapeutic environment where raw emotions are likely to be exposed. These features were common to most of the homoeopathic consultation environments I observed and appear to partly reflect an effort to avoid making the working environment too distracting or stimulating for patients.

The practitioner's background

At the time of this study, Anna had been a professionally registered (RS. Hom) homoeopath for 12 years or so. Her background prior to training was similar to that of many homoeopaths in that becoming a practitioner represented a significant career and life change, and the various influences

[12] When treating babies or animals, the practitioner is obviously forced to rely much more on what can be directly observed. Strangely enough, however, some homoeopaths interviewed said that rather than making their job more difficult, not having an extra layer of verbal interpretation to take into account actually enabled them to focus their treatment more successfully.

that brought her to it can be traced back to some extent to disillusionment with conventional medicine. In Anna's case, this didn't necessarily translate into a total rejection of allopathic principles; she wasn't involved because allopathy had failed her in a medical sense. Rather, she explained, she was disturbed by what she saw as the objectification and unequal power relationships that are engendered within the structure of conventional medicine. Prior to training, she had spent twenty years as an SRN working first in a public hospital, then as a theatre nurse in the private sector. Although she found the work stimulating, she was never quite at ease with the 'arrogance of the surgeons', and their '.....macho, aggressive way with patients.' In the early 1980's, she was introduced to homoeopathy through a friend who had been treated successfully by an anthroposophical practitioner[13] after a serious road accident. This proved to be a turning point for her:

> ".....he seemed to get better and better, and he just said to me. 'You really shouldn't be doing conventional medicine, you should be looking for alternatives.' When I [Anna] was in hospital, the feelings I got were so negative and it just didn't feel right, and you know, there's another way to healing. So I always felt that, well, when I was in the theatre there was something that didn't quite gel with me ..... so I got a bit fed up with it, a bit not happy with it, with the surgeons in particular, and just the general feel of the theatre, and I came back from holiday and that was the end of it."

From then on, Anna developed a serious interest in homoeopathy, and decided to train. She enrolled at The Northern College of Homoeopathy in Newcastle while still working full time as a theatre nurse, and spent four years attending their weekend school. After qualifying, she spent two years seeing patients on a part time basis while continuing to nurse, and describes the process of building up her practice to its current (very busy) level as a slow struggle; in common with allopathic doctors, professional codes of conduct do not allow homoeopaths to actively advertise their services, and the process of establishing a viable business is almost wholly dependent on an entry in the

[13] This is a strand of homoeopathic medicine incorporating the philosophical ideas of Rudolf Steiner.

Yellow Pages and the recommendations of satisfied clients.[14] Unlike allopathic medicine, however, professional homoeopathy is almost exclusively restricted to the private sector and practitioners cannot rely on a subsidised pool of NHS patients. This, Anna suggested, is part of the reason why alternative practitioners might be generally perceived as taking more care over their interactions; patient satisfaction (and by implication, repeat business), bearing a more direct relationship to livelihood.

The patient

The patient, Emma, was a woman of forty-two who had first contacted Anna in 1996 with a problem relating to the after effects of liver failure, which had been brought on by (conventional) drug treatment she had been receiving for rheumatoid arthritis. She had been coming fairly regularly – every eight weeks or so – since that time and described herself as the ideal advertisement for homoeopathy; with the support of her GP and local hospital (who had told her she would be in a wheelchair by the time she was forty), she had weaned herself off conventional medication and progressed from being virtually immobile to regaining almost all of the movement in her affected joints.

According to Emma, it was the shock of liver failure that prompted her to investigate the possibilities of alternative medicine. She was in no way dissatisfied with what her conventional doctors had done for her, but was aware that beyond the management of her symptoms, there was a limit to what they could achieve. Also, she felt that after almost dying from liver failure, the side effects of the drugs she was taking were too risky.

Before becoming a patient of Anna's, Emma had tried to find alternative treatment on the NHS and had been referred by her GP to another doctor

[14] One homoeopath in the study commented that informal referral within family groups was common, although it was often a female partner who first sought out the homoeopath, the men being drawn in later. This may be related to the perception that homoeopathy somehow engenders 'feminine' qualities.

who was also a trained homoeopath. The experience of seeing this practitioner, however, was disappointing; Emma found that the initial consultation, although ostensibly homoeopathic, had too many of the trappings of a conventional examination; she described how, after expecting a patient-centred holistic experience, the practitioner approached the encounter very much as a traditional doctor / patient encounter and appeared, for example, to be obviously 'clock watching'. Emma summed this up by saying that '... there was too much of the doctor in him.' After deciding not to go back to this GP she resigned herself to the expense of having to find a private homoeopath. She was given Anna's number by a friend, made an appointment, and in her own words '....never looked back.'

Emma's experience with allopathic medicine is in some ways slightly atypical of those who seek homoeopathic treatment. As in her case there may occasionally be a deep seated rejection of conventional medicine, but more often it appears that it is a dissatisfaction with the attitudes and interactional methods of conventional doctors that drives people to seek alternatives, not necessarily that their treatments are ineffective (Furnham and Smith, 1988). In a sense, Emma's case is a good illustration of this. Her experience highlights how directly relevant aspects of communication and interaction are in defining what patients might find lacking in allopathic environments, and by implication, what they might look for in complementary medicine. For Emma, it was, broadly speaking, factors relating to misalignments in communication between her and the GP-homoeopath she consulted that fuelled her feelings of dissatisfaction – his apparently superior attitude and obvious 'clock watching', for example. It was not that she necessarily saw him as a bad doctor in a medical sense. In contrast to her initial impression of him, however, Emma described how in her first telephone contact with Anna, a high a degree of empathy was immediately evident, and that this was an important factor in her decision to go ahead and make an appointment.

For Emma, and one can assume for many people who find CAM appealing, the base upon which an effective therapeutic relationship is built often relates as much to a person's perception of an interactional compatibility as it does to

the mechanics of treatment. This is evident in Emma's experience with her original GP; even though the treatment he was able to provide was, in medical terms, relatively ineffective, she was extremely satisfied with his efforts – largely due to the empathetic and compassionate way with which he dealt with her. Ironically, this satisfaction meant that even though her condition was not responding to conventional treatment, she was prepared to continue with it and was only 'driven' to homoeopathy after significant damage had been done by the side effects of conventional drugs.

Features of the consultation

In its entirety, Emma's consultation took approximately thirty-five minutes to complete, and although a conventional primary care encounter lasting this long – even in private practice – would be rare, by homoeopathic standards (and in terms of the consultations I was able to study), this is relatively short. It should be noted, however, that this session was a follow up, rather than an initial consultation. In homoeopathy, the activities undertaken in an initial consultation are in many ways distinct from those that occur in subsequent meetings, and to use one of these consultations as an illustration of a general encounter – although it is likely to be more obviously 'homoeopathic' – might be slightly misleading. Structurally, an initial visit to a homoeopath may be more readily compared to certain specialised allopathic consultations, rather than those of primary care, but as a general guide, the first visit that a person makes to a homoeopath will be a more lengthy procedure than subsequent follow ups – lasting anything from forty-five minutes to two hours. The average length of the first time consultations included in this study was around an hour and this is apparently the norm. Follow up consultations can be as short as fifteen minutes and generally last no more than an hour. Again, this is largely reflected in data.

It is during the initial visit that the homoeopath needs to gather information on relatively specific topics, and because of this the encounter is likely to incorporate sequences of more or less pre-determined and direct questions

to establish a holistic picture of the patient. Again, although this procedure is essentially a universal part of the homoeopathic process, it is open to various levels of interpretation ranging from the use of relatively structured question and answer sessions, (a process that medically trained homoeopaths in the study appear to favour), to approaches in which the practitioner might simply allow the patient to talk about themselves and use direct questions sparingly in order to guide them into revealing some of the more obscure information that might be required.[15] The interrogatory groundwork that occurs in the initial visit is known as 'taking the case', and in conventional medical consultations (say, those in primary care) would be roughly analogous to studying the medical records of a new patient, taking a history and physically examining them.[16] The objective for the homoeopath, however, is not to reach a diagnostic conclusion, but to develop as complete a picture as possible of the patient's 'constitution'.

How regularly the patient sees their homoeopath once treatment is underway depends to some extent, as it does in conventional medicine, on the nature of their complaint and the treatment strategy that the practitioner decides on. Follow up sessions are likely to be focused more specifically on the results of remedies that have been given to the patient in prior consultations and will be scheduled depending on factors such as the nature of the presenting complaint, and the way in which the patient perceives the homoeopathic process. At this stage in her treatment, for example, Emma commented that she continued to see Anna for the general emotional support she was able to give, as much as for her arthritic problems.

Factors such as the patient's practical understanding of the homoeopathic process, and the nature of their presenting problem, are also likely to affect the overall structure of a person's treatment. Many people visiting a

[15] An unprompted person is unlikely to spontaneously volunteer information on their like or dislike of thunderstorms, for example, or which side they prefer to sleep on - both questions that are likely to crop up as part of an initial consultation.

[16] The phrase is sometimes also used by homoeopaths in a wider generic sense to indicate the entire homeopathic process.

homoeopath for the first time will only have a vague idea of the principles that the discipline embodies and what their treatment could involve, so this might initially necessitate time spent discussing with the patient whether the approach is right for them, and the exploration of deeper levels of detail in later sessions – as and when the patient is receptive. It can be seen that in a curative model that is centred on mobilising the body's ability to heal itself, a positive and informed attitude towards the process is undoubtedly going to be an advantage.

Structural elements

To the majority of people socialised into Western culture, the allopathic model can be taken as the basis for what might be expected to occur in a conventional medical consultation – the kind of medical interaction that the average person is likely to regard as familiar. So in order to give more of a sense of what a homoeopathic encounter is really like, I will now use Emma's consultation to illustrate some of the interactional elements that appear to be idiosyncratically homoeopathic, or overtly different from those that might be expected to occur in conventional allopathic settings.

Activities

Like most professional / client interactions, homoeopathic consultations can be seen as incorporating a number of different activities. Byrne and Long (Byrne and Long, 1978) have outlined what has come to be the standard model for the organisation of the medical encounter. In GP / patient interactions (and the majority of other orthodox encounters), the procedure is:

1. Opening
2. Presenting problem
3. History taking
4. Examination
5. Diagnosis
6. Treatment
7. Closing

Generally speaking, although it is possible for these activities to crop up 'out of sync', they are not usually sequentially interchangeable – obviously opening and closing are likely to be sequentially fixed – but there are scenarios, such as might occur if a patient remembers a relevant piece of information once the treatment process is underway, when earlier activity phases may be revisited by the practitioner later in the consultation. Routinely, however, a practitioner is likely to try and structure a consultation in the order given. From an examination of Emma's consultation, it can be seen that there are a number of ways in which both the sequential arrangement of activities and the enactment of the activities themselves differ from those in the allopathic model. (A more detailed analysis of issues relating to non-sequentiality within homoeopathic consultations, is given in chapter 6.)

The transcript extract shown below (extract 1) is taken from the beginning of Emma's consultation. The one immediately following it (extract 2) is from a routine ENT consultation at an oncology clinic in a city hospital. This is included as a comparative example which I will use to point up particular features of the homoeopathic consultation. It was selected from the orthodox consultation data I had available because it is a very clear illustration of the structural framework that underpins much conventional medicine. As it is a meeting between a patient and a specialist (rather than, say, a GP), however, it is not intended to be specifically representative of, 'routine' medical consultations (or good or bad practice). In fact its clarity of structure makes it a relatively extreme example, and probably somewhat more 'clinical' than the average GP consultation that most people are used to having.

Complete transcripts of both consultations can be found in appendix IV.

Extract 1 (JS-JP-3-10-00)

((researcher leaves room))

(2.0)
Hom: Right emma? **(00:10)**
(1.5)
Pat: °I've been doing° quite well.
(.)
Hom: Have you
Pat: Yes
Hom: Well that's good news
Pat: I know
(1.2)
Hom: So **(18:00)**
(2.0)
Hom: saw you what, about
(0.5)
Pat: .h (0.5)erm I'd- this is where I'd been doing even better because I've been writing it down again
(0.5)
Pat: I['m (back to weight n- ? / waiting)
Hom: [Saw you on the fifth of the ninth wasn't it
(0.5)
Pat: Yes it was (0.8) yes (1.0) and you gave me those tablets (.) on the fifth as well didn't you **(00:30)**
Hom: Yea? I sent you some arnica oil
Pat: Yes.
(0.5)
Hom: So,
(1.1)
Pat: °Tk° .h er[::
Hom: [how was everything
(2.2)
Pat: Yeath-er- I think (.) sort of: erm (0.3) within about (0.4) five to (0.4) five to eight days (.) I definitely felt an improvement (.) tk .h y'know with the mood swings and the (0.5) well not mood swings but y'know-a e-i-<y'know> the slightest if you went boo (0.3) I'd-a-^h.a-h.a I'd-a burst into tea[rs .h well thankfully=
Hom: [<↑H↓hm>
Pat: =that's:: (0.9) sort've (.) cleared up
(3.0)
Hom: Th-so that's gone comple[tely **(01:00)**
Pat: [It has yea (0.5) yea
Hom: °Tk°-so the weepiness (1.2) °has gone°
(2.4)
Hom: °°(n-)the mood swings°° ((sounds of writing / paper rustling))
(3.9)
Hom: <Tht's right↑>, cos ths-the remedy that you had (1.0) I looked back in the notes and you hadn't had it for ages and ages have you=
Pat: =Right at the begin[ning you gave me that **(01:30)**
Hom: [Right at the beginning

50		(.)
51	Pat:	and [it was a higher potency as well [tht I think you said
52	Hom:	[It- [That's right
53	Hom:	That's right n it worked quite well then
54		(1.0)
55	Pat:	Well it definitely worked again this time
56		(1.9)
57	Hom:	Good so .h (1.2) erm: (1.0) thr was your shoulder though.
58		(.) Your shoulder was beginning to ache.
59	Pat:	Tk-h. e-well it's sortuv- it's moved it's not-cos that was
60		the right shoulder wasn't i[t .h erm: the problem I'm=
61	Hom:	[H-hm
62	Pat:	=having at the moment is sort of my left- it's my left
63		hand, and my left shoulder .h (0.5) which (.) is quite erm
64		(.) I've not had this for quite a long time (0.5) erm
65		y'know it's sort of .h I can't e-do a- prop- I can do a
66		fist but I couldn't grip anything .h really tightly (.) erm
67		and they're quite swollen are my fingers **(02:10)**

Extract 2 (PS-VT-21-06-00)

1	Nur:	If y'd like to come through misses ((name))
2	Doc:	Hello there?
3	Pat:	H'llo
4		(15.0) ((doctor studies notes))
5	Doc:	Right (.) how are you doing
6	Pat:	Fine apart from a bad ear
7	Doc:	Bad ear?
8	Pat:	Y:es hu[h
9	Doc:	[Right wh[at's the problem
10	Pat:	[You asked me last time if I had ear ache or
11		not 'n I said no h-'nd the following week I st-ha:ar:ted
12	Doc:	Right?
13	Pat:	And I went to the doctor and he said it was an ear infection
14	Doc:	Right
15	Pat:	And he put me on antibiotics
16	Doc:	Uhu=
17	Pat:	=It hasn't cleared it
18	Doc:	Right
19		(.)
20	Doc:	so what's the symptom: th't you've g- pu- you're getting pain. . .

The opening

It seems that from the very start of their interaction, Emma and Anna's consultation, although recognisably a practitioner / patient encounter has

elements that serve to generate a 'feel' that is less overtly structured and more informal than that evident in the ENT example. The sense of a more relaxed interaction is obviously helped by the environment in which it occurs. Unlike in the busy hospital ENT clinic (which although an extreme example, still reflects features – such as the crowded waiting room and impersonal surroundings – that are familiar in many 'medical' settings), Anna's working environment put her at an advantage in terms of helping her patients feel at ease. For Emma, the lead up to her consultation did not generate the kind of negative feelings that often become associated with conventional medical settings – especially hospitals. Emma saw her visit, and by implication, the homoeopathic process, as an event that was likely to be peaceful and calming, rather than an occasion associated with stress and unease.

If the working environment that Anna tried to create can be seen as an indication of the kinds of elements that her interactional approach is likely to embody, one of the first points in the consultation when this becomes evident occurs once the pre-consultation activity of greetings, etc., have taken place:

(From JS-JP-3-10-00))

1 Hom: Right emma?
2 (1.5)
3 Pat: °I've been doing° quite well.

As might be expected, it is Anna who signals that the consultation proper is to begin (her 'right' on line 1 serving to mark the conclusion of the un-related conversation that had been going on as the researcher left the room. (See: Jefferson, 1996). What happens next, however, appears unusual. Following the one and a half second pause on line 2, Emma volunteers a summary of her progress. She does not wait for further prompting by Anna, and Anna does not, it seems, feel the need to draw Emma onto a particular topic. This, in effect, means that she surrenders control over the direction that the interaction will initially take and gives it over to Emma. Emma has the opportunity to initiate the topic that she wishes to focus on. In the

conventional consultations I was able to observe (ranging from primary care through to more specialised encounters) it was atypical for the patient to initiate talk in this way. A more 'standard' (see: Heath, (1981); Robinson, (1998) opening is evident in the ENT example:

(From PS-VT-21-06-00)

3 Pat: H'llo
4 (15.0) ((doctor studies notes))
5 Doc: Right (.) how are you doing

Here, the patient waits for the doctor to ask a specific opening question before beginning to talk and does not attempt to initiate a topic. It is significant that the patient is prepared to wait 'on hold' for 15 seconds or so before the doctor signals that the consultation can begin – a situation that contrasts sharply with the relatively smooth flow of the homoeopathic encounter, and which possibly provides a subtle reinforcement to any interactional inequality that exists between the patient and practitioner. In a busy clinic environment, however, situations in which practitioners are forced to greet a patient while still studying their notes – or worse – completing the notes of the preceding patient, are likely to occur regardless of attempts to avoid them. [17]

A second feature of the opening of the homoeopathic consultation is the way in which Anna addresses Emma by her first name – something that helps to reduce the sense of formality in their interaction. Similarly, although it is not evident from this particular transcript, when Emma addressed Anna by name, or referred to her in the third person during subsequent interviews, she too routinely used Anna's first name rather than 'Mrs X' etc. In the orthodox consultations I studied the use of first names (except when dealing with children), was unusual, although the reasons why a doctor, such as the one in the ENT example, might not choose to use a patient's first name may be related more to practical reasons – such as the limited amount of time

[17] From practitioner interview data (GP).

available to develop informal relationships with patients – rather than deliberate attempts to maintain professional distance or formality. It is significant, however, that none of the practitioners in my homoeopathic data addressed patients formally.

The presenting problem

In terms of lay perspectives, the most well known characteristics of the homoeopathic approach – apart from the apparently paradoxical nature of the remedies – is probably the fact that practitioners are likely to be able to spend more time with their patients than conventional doctors. Although, assumptions about a direct correlation between the amount of time a doctor has with a patient and greater patient satisfaction may be misleading.[18] One result of the homoeopath generally working under less rigid time constraints is that the enactment of certain routine consultation activities can be allowed to take place in an apparently less formalised and prescriptive way. A feature of Emma's consultation is the amount of talk that goes on between them before a specific presenting complaint is mentioned. In conventional medical settings, strategies have evolved (largely related to the temporal constraints that modern doctors have to work under), for moving the interaction along efficiently. In most situations it is usual for the practitioner to attempt to focus the patient's talk on their presenting problem as quickly as possible. Heath (1989) describes how in conventional medical consultations (and other types of client-professional encounters), topic initiating turns such as 'what can I do for you' are utilised to move the interaction out of 'introductions' and onto 'business'. Similarly, Robinson (1998) has pointed out, that depending on the nature of the visit, the practitioner is likely to routinely use predictable question formats. First time visits are likely to stimulate formats such as 'what can I do for you today', or 'how can I help you'. For follow up visits, 'how are you doing', or 'how are you feeling' are more common. The ENT example

[18] Homoeopathy is a process that by its nature requires a great deal of time, and although many overworked doctors would undoubtedly welcome the chance to give each of their patient more than the allotted 5min, the average allopathic diagnostic process simply doesn't require an hour or more to complete.

follows this pattern quite closely. The practitioner uses 'how are you doing' (line 5), and the patient responds by reporting the problem that is uppermost in her mind: 'Fine apart from a bad ear' (line 6). What is significant is the rapidity with which the practitioner and patient focus on this specific concern – the whole process taking only a few seconds.

When the trajectory of the same activity is traced through the homoeopathic example, it can be seen that it is not until around two minutes into the consultation (as opposed to 20 seconds in the ENT example), after Anna and Emma have discussed several other topics, that Emma brings up what could be regarded as her primary current concern:

(From JS-JP-3-10-00)

57 Hom: Good so .h (1.2) erm: (1.0) thr was your shoulder though.
58 (.) Your shoulder was beginning to ache.
59 Pat: Tk-h. e-well it's sortuv- it's moved it's not-cos that was

60 the right shoulder wasn't i[t .h erm: the problem I'm=
61 Hom: [H-hm
62 Pat: =having at the moment is sort of my left- it's my left
63 hand, and my left shoulder .h (0.5) which . . .

The fact that Emma does not raise the issue of her hand earlier on in the interaction is a reflection, perhaps, of the different temporal perspectives that the homoeopathic consultation embodies, and how both patient and practitioner orient to these. Because lack of time is not really an issue, Anna is able to let Emma express her concerns as they crop up in the context of their ongoing dialogue, rather than feeling that she needs to probe for them right at the start of the interaction. Similarly, Emma orients to this informality by waiting until a point in the conversation that allows her to make a smooth topic transition from one of Anna's enquiry questions into her current main concern; Anna asks about Emma's shoulder (line 57-58), and Emma is then able to shift the topic slightly to focus attention on her left hand and shoulder.

History taking

History taking can be loosely defined as the period during which the practitioner collects background information from the patient about their presenting problem. In relation to conventional medical consultation, Stoeckle and Billings (1987) describe it as one of the key components of medical diagnosis, while Cassell (1997) regards it as the foundation of the relationship between physician and patient. In both conventional medicine and homoeopathy, history taking in a follow up visit is likely to involve questions relating to what has occurred since the last encounter – the effects of treatment etc. – rather than to the patients general or long term medical history. This, if relevant, is likely to have been discussed in the initial consultation. Anna engages in asking the type of questions associated with history taking from early on in the consultation. On line 28, for example, she begins the process by referring to some arnica oil [19] prescribed in a previous consultation and asks 'How was everything.' She then follows up Emma's description of how the current treatment has affected her emotional state with confirmatory questions:

(From JS-JP-3-10-00)

38 Hom: Th-so that's gone comple[telly
39 Pat: [It has yea (0.5) yea
40 Hom: °Tk°-so the weepiness (1.2) °has gone°
41 (2.4)
42 Hom: °°(n-)the mood swings°°

What may be significant about the kind of enquiry questions subsequently used by Anna is that they all appear to be connected with concerns that have been raised by Emma in previous consultations – issues that relate to elements of her particular ongoing experience of her condition, rather than ones based on the practitioner's expectations of symptomatic trajectories – in this case arthritis. On line 102, for example, Anna enquires about Emma's sleep pattern:

[19] Arnica is a commonly available 'generic' homoeopathic remedy often used for treating bruises etc.

(From JS-JP-3-10-00)

102 Hom: 'What about your sleep (.) cos your sleep was awful you
103 were waking at three n four.'

Similarly, a little later on (lines 106-108), she asks about the emotional effects of a stressful trip that Emma had made:

(From JS-JP-3-10-00)

107 Hom: '. . .an::d (4.5) yea↓ (0.5) cos last time there'd been a
108 lot going on you'd had that sort of (0.9) awful trip to st
109 – er: to snt ives hadn't you.'

There were also enquiries relating to weepiness, mood swings, general mood, Emma's food binges, and the effect that drinking orange juice had on her joints. The incorporation of questions about what may appear to be tangential and relatively unrelated (to arthritis) topics is an indication of the way in which the holistic model allows for a high degree of 'patient centredness' at a structural level.

Presented with a different arthritic case, Anna's questions would have connected directly to that person's individual set of symptoms and experiences – mood swings, sleep patterns and weepiness are not part of a homoeopathic model for arthritis, they are elements that, along with arthritis, make up a model of Emma.

In orthodox medicine the focus is very much more on symptoms. In the ENT consultation, for example, it can be seen that once the patient's presenting complaint is clear (i.e. the problem with her ear) it is this that the practitioner's questions and subsequent examination concentrate on. First he asks the patient to be specific about the symptoms she is experiencing: 'So what's the symptom: th't you've g- a- pu- you're getting pain are you.' (line 20). Then, through a number of follow up questions; 'Hearing still down is it' (line 45), 'Swallowing alright?' (line 49), and '...no feeling of blockage or anything' (line

55), he begins to construct a picture of the condition. His questioning is guided by a logical process of elimination based on his expectations and experience of a particular disease trajectory. In contrast to the holistic approach, it is likely that given the same condition in a different patient, the practitioner would proceed in a similar way – enquiring about swallowing, hearing, where the pain was etc. Although many orthodox doctors undoubtedly see a benefit in being able to get to know about their patients in a more holistic way – particularly when treating depression, psychological problems and other 'post-modern' conditions that often have ill-defined symptomatic pictures – at a purely functional level the allopathic model does not routinely require the same level of abstract information as the homoeopathic model in order to work. So, when time is at a premium, as it frequently is in conventional medicine, a practitioner may not be inclined to ask questions that are not directly related in some way to the presenting complaint.

The absence of a physical examination

When interviewed about her homoeopathic experience, Emma stated that one of the reasons why she had become disillusioned with the GP-homoeopath that she visited was the way in which he incorporated a complete physical examination into his initial consultation – something that in her opinion gave the encounter too much of a 'medical' feel. Emma's first visit to Anna did not include this activity. This is significant because it may be an illustration of the way in which homoeopathic practitioners tend not to incorporate elements of allopathic practice that are likely to generate interactional inequality between the practitioner and patient – as undressing for a physical examination might. In none of the homoeopathic consultations that I have been able to study – even those that were first visits – was there anything approximating to a distinct physical examination phase. This is not to say that physical examinations never occur in homoeopathy, rather, that if they take place they are likely to be generated as a result of ongoing interaction, rather than as part of a predetermined diagnostic sequence.

This is evident in Emma's consultation; at one point (lines: 363-374) she does show Anna her swollen fingers, but this is not initiated by Anna and arises as part of a description of symptoms that Emma is giving. There is little sense that, for Anna, the examination forms an important part of the consultation process – she does not, for example, palpitate the fingers in order to isolate particularly sore joints or feel for swelling, and neither does the examination stimulate any in depth interrogative questioning. Her only comment being that '...it's much more swollen than the other one isn't it .' (line: 377-378). It could be argued that this activity, although it might technically qualify as an examination, was not performing the same function as an examination might in an orthodox setting. It was initiated by the patient as a means of illustrating a point, and not by the practitioner as a means of gathering medically relevant information.

In general, it appears that professional homoeopaths do not routinely incorporate a formal physical examination in order to gain the information they require from their patients, and this may be one incidental way in which the 'equal' interactional dynamics that are often perceived to exist between patients and practitioners are maintained.

Absence of the diagnostic statement

The absence of a recognisable diagnostic statement in Emma's consultation is another departure from the orthodox model and is an illustration of how, in holistic medicine, presenting symptoms may be seen as indicators of where systemic weaknesses might lie, rather than as dysfunctions that can be treated in isolation. In the ENT consultation, for example, after the practitioner has completed an examination of the patient's ear, he delivers his diagnosis: '... well that- confirms that you've got some fluid in <u>that</u> ear.' (lines: 125-126), and proceeds to outline the treatment he plans to give to relieve this. There is a sense that the diagnostic statement forms a definite boundary between the end of the examination phase and the onset of the treatment phase. In the homoeopathic consultation, however, because of the non-symptomatic focus, overt causal connections in the form of diagnostic statements are not

necessarily relevant. The fact that a patient may have arthritis is regarded as only one element of many that define them as a whole person. In practical terms this means that the transition from history taking to the interactional activities associated with the treatment phase are not necessarily distinct. It can be seen that there is, for example, a period of the consultation that, although not diagnostic in the conventional sense, does indicate that Anna is beginning to shift her attention away from the pure information gathering of history taking. She does not, however, move directly into a recognisable treatment phase. Instead, what appears to happen is that in an attempt to narrow down a remedy for Emma's current condition, she begins to probe for more abstract information that has not been mentioned previously. On line 481, after Emma and Anna have finished discussing Emma's potato crisp eating habits, Anna says: 'Tk- ·h Yea: so where do we go from here.' This forward projecting question appears to mark the end of pure history taking and, in a conventional consultation model might have been the point at which a diagnostic statement was produced. In this case it can be seen that Anna embarks on a sequence of questions that are directly related to information in her *Materia Medica:*

(From JS-JP-3-10-00)

481	Hom:	Tk-.h Yea: so where do we go from here (0.5) erm
482		(10.5)
483	Hom:	Cos that remedy r^h.eally picked you up a bit
484		didn't i[t
485	Pat:	[It did definitely
486		(31.8) ((homeopath consulting book))
487	Hom:	And you have no trouble with your spine do you
488	Pat:	No
489		(26.0) ((homeopath consulting book))
490	Hom:	Y-joints (.) e-th-th (.) they never sort (.) of change
491		colour they never go sort of bluish.
492	Pat:	No, they go red
493	Hom:	Red.

On lines 487 and 490 Anna's questions do not directly relate to items that Emma has mentioned before, and are preceded by fairly lengthy periods of silence while she consults the *Materia Medica* (lines: 486 and 489). They can

be regarded, therefore, as an attempt to match up symptomatic details with recorded homoeopathic knowledge rather than simply a continuation of the history-taking phase. This kind of 'reasoning' activity is evident for the next two minutes or so as Anna makes more enquiries aimed at matching actual symptomatic details with information in her reference books. On line 515, for example, she asks specifically if Emma's condition is worse in 'damp cold weather', and 'cold air'.

This question is illustrative of another feature of holistic medicine – the way in which there appears to be far more acceptance of non-medical or subjective information as pertinent to the treatment process. The connection made by Anna between the weather and Emma's condition does not appear to have elicited a surprised reaction, which implies that having become familiar with the holistic perspective, Emma had come to regard her well-being as affected by a far greater range of seemingly unrelated influences. Perhaps the most extreme example of the incorporation of non-medical or subjective information in this consultation can be found when, after talking about hot sweats, Anna reminds Emma about an aspect of her psychological makeup that matched up with a description found in the *Materia Medica*:

(From JS-JP-3-10-00)

546 Hom: Your b- ah your mood in particular and your sort of erm
547 (3.0)
548 Hom: Y'know y-your romantic (.) dreaming (.) sort o[f
549 Pat: [Hm:
550 Hom: and I read e-a- (0.4) passage out of this

The reference to 'romantic dreaming' as a relevant factor in the context of a consultation dealing with the treatment of arthritis is an indication of how all encompassing the elements that are homoeopathically relevant can be.

The treatment phase

Although the absence of a conventional examination or diagnostic statement means that the transition out of the history-taking phase may be less obviously defined in the homoeopathic encounter, it appears that the activities associated with the actual giving of treatment are recognisably similar in both homoeopathic and allopathic consultations. Basically, this part of a consultation will be signalled by the practitioner outlining to the patient what, in the context of their medical paradigm, needs to be done, and what, if any, remedies, drugs or procedures are to be considered. In the ENT example, the onset of the treatment phase occurs after the patient has returned from an on-site ear test:

(From PS-VT-21-06-00)

125 Doc: Hello again. (.) .hh (.) well that- that confirms that
126 you've got some fluid in that ear
127 Pat: yeh
128 Doc: And I think if it's causing you bother (.) it would be a good
129 idea to get you in °as a day case (.) drain the fluid off

Directly after the doctor delivers his diagnosis on lines 125-126 he proceeds to outline the treatment he plans to give (lines 128-129). In the homoeopathic example, however, because of the diffusion in activities relating to the absence of a diagnostic statement, the treatment phase proper can be said to begin when Anna, on line 532, makes a statement that appears to relate directly to a possible treatment option: 'I wonder if it's (.) w-h-orth repeating the (0.2) (now)...' This choice of words is significant because although Anna obviously has a course of action in mind, she does not simply state what it is, but uses a display of apparent ambivalence as a means of eliciting Emma's perspective – perhaps as a device to allow her to feel more fully involved.

Anna's choice of words is also interesting in the context of the preservation of her position as 'expert'. 'I wonder if..' is in effect an outward expression of uncertainty. In this case, however, Anna's regular use of this and similar

ambivalent phrases during the treatment stage ('So I just wonder whether it's worth...' (line: 574), and, 'Well I'm a ↑bit tempted t- to give you..' (line: 597), for example), possibly has the indirect effect of helping to balance the expert / lay relationship between herself and Emma. By implying that she may be a little unsure, Anna is able to begin describing why this is, and at the same time, allow Emma to become involved in the decision-making process about which remedy is most suitable at this juncture. A little later on in the sequence, for example, Emma is able to provide a reasoned assessment of Anna's treatment suggestion:

(From JS-JP-3-10-00)

574 Hom: So I just wonder whether it's worth (1.8) y'know giving
575 you a one (.) off (.) of that (0.5) just s[eeing if that=
576 Pat: [(°°seeing°°)
577 Hom: =settles things down
578 (0.4)
579 Pat: Yea .h cos I'm not- I'm not having the hot flushes any-
580 it was literally .h a period of-of sort of o-over my period
581 for about four days .h but they were bad

This kind of discussion, in which the patient is in effect assessing the possible relevance of a particular course of action, is a feature of 'holistic' approaches that can be said to have crossed over into mainstream medicine – especially in the form of 'concordant' approaches to prescribing for people with chronic illnesses. Behavioural routines similar to this one were particularly evident, for example, in some of the PaPaYA family planning and diabetes consultations I was able to study. Concordance is basically a framework for prescribing in which the patient is able to negotiate with their doctor as to whether, how, and when medicines are taken (Dickinson *et al*, 1999). It appears that Anna's approach here enables Emma to become involved at a fundamental level – that of deciding whether a particular treatment is relevant in the first place. Emma's accumulated lived experience of the effects of her treatment are actively utilised by Anna as a resource in the decision making about her treatment options.

The questioning structure

The design and type of question that homoeopaths are likely to utilise, and by implication, the kinds of responses and narrative trajectories these questions are likely to generate can also be contrasted with those in conventional consultations. Broadly, while in the ENT example, the practitioner's questions tended to be short, direct and economical (see above) – prompting a degree of focus in the patient's replies, Anna's questions tended to be framed in a more open way and had a more informal, conversational quality. On lines 45-47, for example:

(From JS-JP-3-10-00)

45 Hom: <Tht's rightˆ>, cos ths-the remedy that you had (1.0) I
46 looked back in the notes and you hadn't had it for ages
47 and ages have you

Similarly on lines 497-501, when asking about an aspect of Emma's arthritic symptoms, she incorporated direct quotation from the *Materia Medica* she was using:

(From JS-JP-3-10-00)

497 Hom: Oh that's right I got you some- a remedy called foomicaroofa
498 (1.2)n that- this is the wondering arthritis (1.3) en (.)
499 pains come with marked swelling redness and heat (0.8) °nd
500 the joint is inflamed p- pain is worse n the slightest
501 motion° (1.5) n that's you isn't it

The main exception to the general pattern of open questioning was in the apparent history / treatment crossover phase. Here, for a short time, it was evident that the structure of Anna's questions became more closed and focused – resembling far more a kind of 'forensic' questioning. Instances of this can be seen, for example, on line 487:

(From JS-JP-3-10-00)

487 Hom: And you have no trouble with your spine do you
488 Pat: No

and:

(From JS-JP-3-10-00)

490 Hom: Y-joints (.) e-th-th (.) they never sort (.) of change
491 colour they never go sort of bluish.
492 Pat: No, they go red

Another feature of Anna's enquiries was the way in which replies that implied that there was 'trouble' or 'a problem' were always pursued, whereas 'no problem', or 'improving' replies generally did not generate any further topic related questions or enquiry. On lines 102 and 107, for example:

(From JS-JP-3-10-00)

102 Hom: What about your sleep (.) cos your sleep was awful you
103 were waking at three n four
104 Pat: Erm: (0.8) better I mean I'm- I can go through to till
105 sort of six now which is a lot better
106 (8.5)((Hom consults notes))
107 Hom: ^Tk-h. (0.7) an::d (4.5) yea↓ (0.5) cos last time there'd
108 been a lot going on you'd had that sort of (0.9) awful
109 trip to snt- er: to snt ives hadn't you

Here, it can be seen that after receiving an encouraging report in response to her enquiry on lines 102-103, Anna does not pursue the topic of Emma's sleeping patterns; after the 8.5 second pause in line 106 during which she consults her notes, she brings up the new topic of Emma's trip to St Ives. The construction of Anna's initial question is also interesting in terms of the response it might be designed to generate. Although it acknowledges that Emma's sleep had been a problem, it is framed quite neutrally and does not project an expectation that it necessarily should have improved. She does

not, for example, say: 'Is your sleep any better?' This neutral question formulation enables Emma to more easily produce a candid response. It does not put her in the position of – had her sleep in fact been worse – having to frame a negative reply to an enquiry that implied a preferred positive response. If this is compared to what happens following a question that stimulates a 'problem' reply it can be seen that Anna subsequently pursues the topic in more depth:

(From JS-JP-3-10-00)

261 Hom: .h And what about the feet how are they
262 Pat: Tk-.h not too good.
263 Hom: Not good.
264 Pat: No↓, no definitely (.) definitely they're very very tender
265 (4.7)
266 Hom: So tell me about (0.3) how they feel
267 Pat: Well, h-gain it's-it's sort of the-they are worse first thing in
268 the morning when I get out of bed (1.5) erm .h (0.6) an I tend
269 t- it's my right one that's the worst cos I tend to walk on the side
270 a little bit until I get ((thumping sound)) (0.5) into the bathroom
271 where the tiles are and then I put my feet flat on the tiles (.) n
272 it feels wonderful
273 (0.6)
274 Hom: You like the cold ([don't you)
275 Pat: [Oh it feel- yea (0.2) feels really good
276 (10.3)
277 Hom: So that's quite strong isn't it (.) cold on your feet
278 Pat: Hm
279 (3.6)
280 Hom: And like now are they aching.
281 Pat: Tk-.h n-no it's not- it's not the continual ache like they used to
282 be it's just if I put the pressure on them
283 Hom: °Hm°
284 (0.2)
285 Pat: It's if I get up and start to walk about then I can feel it ·h but it's
286 not that continual ache that I used to (0.5)have before (1.9) I
287 mean I can't feel them now there's nothing there now but when
288 I stand up
289 (4.5)
290 Hom: They're sore
291 Pat: Hm

Following Emma's assertion on line 262 that her feet are 'not too good', Anna again utilises a neutral formulation in response and provides an attenuated summary of what Emma has said: 'not good' (line 261). This prompts Emma

to expand on her original assessment and she then gives a much stronger description of the situation – emphasising that her feet are '. . definitely. . . very very tender' (line 261). The 4.7 second pause after this turn suggests that Anna is perhaps waiting for Emma to provide more details about this, and when Emma does not, she prompts with 'So tell me about (0.3) how they feel.'(line 266).

The subsequent questions in this sequence are significant because as well as demonstrating that a particular kind of patient response – ie: one that implies 'trouble' – is likely to stimulate further investigative questions from the practitioner, it also illustrates the kinds of things that a homoeopathic practitioner is likely to find relevant. In an allopathic consultation, knowing that the patient was suffering from arthritis, the practitioner may well have focused in on trying to find a treatment that would provide specific symptomatic relief – in this case, for Emma's painful feet. In the ENT consultation, for example, the practitioner asks a focused question in relation to the patient's ear: 'so what's the symptom: th't you've g- pu- you're getting pain are you (line 20).

Subjective descriptions about the nature of the patient's pain, while possibly useful in generating an empathetic interactional environment, are essentially a luxury when time is at a premium. Again, this is evident in the ENT consultation; the practitioner does at one point prompt the patient for a subjective assessment of how she is doing: '. . but overall you feel you're making good progress.' (line 86), but this general question comes right at the end of the history-taking stage, and seemingly serves more as a device for closing this activity down, rather than as a means of obtaining more medically useful information. It must be acknowledged that the ENT consultation is probably an extreme example though – there are evidently other less pressured orthodox medical settings in which subjective descriptions might be more actively incorporated.

A significant proportion of Anna's questions, however, are seemingly aimed specifically at generating subjective descriptions, and it appears that these

not only serve to foster patient / practitioner empathy, but are also an important way in which relevant information is assimilated into the ongoing homoeopathic process. After Anna's follow up question on line 266, for example, ('So tell me about (0.3) how they feel.), she explores Emma's positive feelings about how having her feet on a cold floor helped to relieve the pain. What is significant is that Anna treats the information given in this subjective assessment ('Oh it feel- yea (0.2) feels really good.'(line: 275)), as an important element in the idiosyncratic makeup of Emma's case; on line 277, Anna directly refers to it as such: 'So that's quite strong isn't it (.) cold on your feet.' Elsewhere too in the consultation it is clear that information gathered from subjective descriptions form an important resource. On lines 421-424, for example, Emma is asked whether she has noticed a connection between her moods and the pains in her joints:

(From JS-JP-3-10-00)

421 Hom: ·h ↑Would you say↓ emma tht (1.2) tht- do you ever (0.7)
422 notice that if your mood is (1.0) good (0.5) then your
423 joints are worse (.) an if your mood is (1.0) bad (1.0)
424 °then your joints are better

Summary

To summarise then, in this chapter I have outlined the relationship between the allopathic and homoeopathic approaches, initially using the 'conventional' allopathic sequential model of Byrne and Long (1978) as a point of departure. I have also begun to isolate some of the elements within the homoeopathic encounter that will be the focus of analysis in subsequent chapters. It should be evident that despite the stereotypical image that alternative medicine is often the domain of people who are similarly 'alternative', nothing that occurred in the case study consultation appeared to be particularly bizarre or strange. In terms of organisation, what took place might have been observed in any professional / client encounter. What should also be evident, however, is that closely entwined around this conventionally professional framework

are the sinews of a collaborative holistic process that makes the homoeopathic consultation fundamentally different, as a form of therapeutic encounter, from conventional allopathic consultations. It is on the interactional detail that serves to generate and maintain this difference that I would now like to focus.

A feeling of equality

> *"The classical homoeopath is obliged to listen carefully to every word uttered by his patient. This is exactly what makes our profession special. The undivided attention of the homoeopath to his patient creates an atmosphere in the room in which the patient feels respected, understood and even loved. This is the elegance of the homoeopathic conversation."*
>
> Brian Kaplan (2001)

In this chapter I would like to start unpacking some of the interactional motifs that appear to be significant in generating the characteristic feeling of mutuality that homoeopathic consultations seem to have. More specifically, I would like to suggest that this mutuality might be connected to a process of holistic socialisation that patients undergo when they first encounter homoeopathy, and that this socialisation is connected to the subsequent generation of two closely entwined psycho-social states – rapport and empathy – that infuse the homoeopathic paradigm.

Research into patient motivation has suggested that the appeal of much complementary medicine lies not only in the belief that therapies are efficacious, but also in the perception that the kinds of consultations that patients can expect to receive will embody qualities that have, for whatever reasons, somehow become attenuated in conventional medicine (Chatwin and Collins 2002). This is significant because medical encounters – whether conventional or complementary – are frequently regarded as having a potentially therapeutic value in their own right (as well, of course, as the potential for being anti-therapeutic) (see, for example: Reilly 2001; Glyn and Gwyn, 1999) At a basic level, the interactions between patients and practitioners have been shown to have a direct impact on factors such as the degree to which a person feels satisfied with the therapeutic relationship

(see, for example, Drew *et al,* 2001; Hall *et al,* 2002; Schofield *et al*, 2003.), or on the level of commitment that they are willing to invest in their treatment. Frankel and West (1991), outlined how patients are more likely to follow through with treatment recommendations – such as finishing a course of drugs – if they feel they have been involved to some extent in discussion or negotiation about the planned treatment (see also: Rost *et al,* 1989; Drew *et al*, 2001; Squier, 1990). Again, in an allopathic context, Little *et al* (2001), undertook an observational study of patients attending in a general practice setting and found that there was a strong preference for a patient-centred approach that included an awareness by health professionals of the value of elements such as communication and partnership. Much research has also focused on promoting and evaluating patient involvement in decision making within conventional medicine. Entwistle *et al* (1998) highlight the current enthusiasm for more patient-centred approaches to medicine in the West, and draw an interesting comparison between the kinds choices that people already routinely make in relation to their health care, and the areas where there is apparently far less active involvement: decisions about when to seek professional help, whether to consult an orthodox or CAM practitioner, whether to continue with treatment programmes that are recommended to them, and so on, are described as being relatively common. Whereas involvement in decisions about matters within the consultation, such as tests and treatment prescriptions are far less actively sought. Entwistle *et al* (1998) further highlight that a number of interventions have been developed with the aim of improving the level at which people can actively participate in such decisions, and point to research-based information-giving about treatments (see, for example: Barry *et al,* 1995), structured decision tools (see, for example: Whealan *et al*, 1995; Bradbury *et al*, 1994), and the use of behavioural training (see, for example: Butow *et al*, 1994). The amount of attention being given to developing and evaluating more active involvement opportunities for patients by orthodox practitioners (and by implication, the incorporation of more 'egalitarian' or even holistic elements into the consultation process) is perhaps sometimes overlooked, or at least undervalued, by the more radical elements within CAM.

There is a significant paucity of research indicating how particular interventions might affect issues such as participation and decision-making within the homoeopathic consultation. In some ways this is understandable. There is a sense in which the kinds of interventions that are currently being focused on in orthodox medicine are already regarded as a key part of the homoeopathic process (as well as many other forms of CAM). From a homoeopathic perspective, it may be realistic to argue that there are more relevant areas on which to focus scarce research resources. Specifically, because an underlying aim of homoeopathy is to be holistic, much of what orthodox doctors are seeking to gain from 'patient-centeredness' (more equality in the encounter, participation in decisions about treatment, and so on) would appear to be 'built-in' to, or to more naturally arise from, the homoeopathic consultation method already.

In homoeopathy, the development or maintenance of a person's commitment to the healing process, and the supporting role of the practitioner can be seen as being particularly relevant because of the degree to which the discipline regards the stimulation of the patient's own natural healing abilities as underpinning the therapeutic process. This is not only because of the direct humanistic impact that deep emotional and intellectual connections between a patient and practitioner might have, but also because the art of isolating homoeopathic remedies can involve the interpretation of many subtle psychological, non-verbal and narrative cues – cues that are likely to be more accessible, it is believed, if the homoeopath has a good rapport with a patient. In a process that is resonant of the transference and counter-transference that occurs in the psychotherapeutic environment, experienced homoeopaths often describe how they try to allow themselves to be open to the feelings and emotional reactions that their patients stimulate in them, and how these can become a creative tool in the isolation of remedies.

Empathy and rapport

Before going on to examine some of the ways in which patients can be socialised into an holistic environment where empathy and rapport are fundamental therapeutic tools, I would like briefly to outline what I see as the main characteristics of these states. For the purposes of this analysis I will take empathy as being a largely intellectual state of understanding that originates with the practitioner and is projected back to the patient – it exists when the practitioner is able to 'put himself in the shoes of the patient' and successfully communicate that he or she appreciates the patient's perspective. Although deeper kinds of emotional empathy are by no means out of bounds to the homoeopath, these are probably less common, and if they do occur may almost be regarded as a by-product of the intense investigative process that the patient and practitioner engage in; the very act of prompting a patient for detailed subjective descriptions of how various aspects of their condition make them feel is likely to give the impression that the homoeopath is trying to understand them on a deeper personal level – even if these questions form part of an underlying prescriptive strategy. In practical terms an intellectual empathetic connection appears to be adequate enough to allow the homoeopath to gain greater insight into a patient's symptomatic conditions. To gather homoeopathically relevant information the practitioner does not necessarily, for example, need to feel the patient's pain along with them, it is sufficient for him or her to demonstrate an abstract appreciation of the pain and what it means. The following short sequence demonstrates a couple of ways in which empathy or empathic listening may be exhibited in an interaction between a patient and homoeopath:

Extract 3 (HC-R-J-27-4-00)

1	Pat:	. . . but that was probly the start of-what that would
2		have been ninety two tk-h· Of when (1.0) erm (4.4)
3		things started getting much more (0.6) work
4		orientated at home.
5	Hom:	I'm with you, (0.7)·h right ·h so: (2.4) so y-re
6		having to bring work home or needing to and-
7	Pat:	·h Ye[s.
8	Hom:	[Yes. ·h (2.4) d-y –ch-isn't easy is it
9		kh·*h··h[a-
10	Pat:	[No:·h

This extract comes from fairly near the beginning of a consultation. The (new) patient has been describing the events that she feels have influenced her presenting problem. A key feature of the sequence is the way in which the homoeopath not only *tells* the patient that she is listening and understands: ('I'm with you' - line 5), she also follows this up by rephrasing, feeding back and building on what the patient has said: '·h right ·h so: (2.4) so y-re having to bring work home or needing to and-' (lines 5-6). This is the kind of basic empathetic listening technique that forms a part of much of the communication training that health (and other related) professionals often undertake (see: Glaser, 1995; Kemper, 1992; Watts, 1983). It also forms an important part of most counselling training courses and its frequent use in the homoeopathic context may be one of the reasons why consultations can often have the feel of counselling sessions, even if counselling as such is not occurring (see Sacks, 1998), for a discussion of 'claims of understanding' vs 'exhibited understanding'). On line 7 the patient confirms that the homoeopath has made an accurate summary, and then on line 8 she (the homoeopath) is able to develop her turn into a display of empathy. She demonstrates that she not only appreciates the underlying meaning of what the patient has told her, but that she can see the situation from the patient's perspective – she understands how the patient must feel about it. She says 'd-y –ch-isn't easy is it kh·*h··h a-', which generates a confirming 'No: ·h' (line 10) from the patient. There is a definite sense of the sequence having directional qualities – it is the practitioner who empathises with the patient and not the other way round. It is the homoeopath who is 'doing empathy', the patient's role here is that of a receiver.

When compared to therapies such as counselling that are based purely on talk, in the homoeopathic encounter it appears that a slightly different emphasis is placed on the role that empathy plays. In counselling, the generation of an empathic connection can be seen to have a more direct impact on the therapeutic process because it is through the projection of an understanding of the client's perspective that the practitioner is able to work with them on their concerns (see: Rogers, 1961). The homoeopath, on the other hand, has a primarily medical agenda and this to some extent attenuates the depth to which they may usefully exploit any empathetic connection. While empathy can be very helpful in an indirect sense (as in the above example), for drawing out particular threads of a patient's narrative, the homoeopath does not try to be completely 'with the patient' in the same way that a counsellor or psychotherapist might. To some extent a homoeopath will always be engaged in logical sub-processes of medical deduction and categorisation. Some part of them needs to be constantly listening out for symptomatic anomalies, and it can be assumed that this meta-perspective will limit the degree to which they can become empathetically immersed. Similarly, although a high number of homoeopathic cases do have an overtly psychological element, many patients will present with primarily physical concerns, and for them, there will be an expectation that empathetic connections – no matter how deep and satisfying they may be in their own right – will be backed up and balanced with some kind of physical treatment. In homoeopathic practice, then, the generation of empathic states may be regarded as being useful but basically subordinate to the wider homoeopathic process. Similarly, because in the consultation setting empathy is routinely a one-way process – 'flowing' from the practitioner to the patient – it can possibly be seen as an interactionally asymmetrical activity, and one that therefore has limitations in the wider context of holistic mutuality.

Rapport, on the other hand, is a more obviously 'mutual' interactional state, and one that is able directly to embody and augment the balance that permeates much holistic interaction. When a patient and homoeopath develop a rapport the implication is that both parties are equally involved in its

generation. Rapport is a reflexive two way process. Even if it is the practitioner who initiates the sequential activities that create the right conditions for it to develop, the patient must to some extent also initiate his or her own alignment strategies if this development is to continue. It might be suggested that rapport is more versatile psychosocial condition for the homoeopath because unlike empathy, once it has been established it need not remain associated with any particular problem, symptomatic description or emotion, and can enrich communication in a more general way. When a patient and practitioner have achieved a good rapport there is often a sense that some of the formal boundaries that routinely inform their interactions become relaxed, and this undoubtedly has a positive effect on the quality of information that flows from the patient. This is not to say that roles are abandoned, or that the maintenance of boundaries within the consultation is routinely detrimental. Rather, that *both* parties somehow default to a level of mutual understanding which allows them to temporarily circumvent the behavioural filtering that inevitably informs any expert / lay interaction. Rapport can therefore be seen as a more mutually balanced state because both parties really do know how the other feels, and both know that the other knows – one individual is not encumbered with the task of understanding and communicating that understanding. The example below illustrates what I take to be evidence of a rapport between a patient and a homoeopath:

Extract 4 (DR-AH-13-06-01)

1	Pat:	. . . .noth-nothing comes when I wan-it
2	Hom:	N-nh
3		(0.6)
4	Pat:	d'y'know e-it comes like in threes fou[rs
5	Hom:	[Yea? (.)
6		you get the answer to that let me know^-h·=
7	Pat:	=I will [do
8	Hom:	[^H-ha-ha-ha-ha-ha-[ha-ha ha-ha ha ^·hu-hu
9	Pat:	[but if you (0.2) find
10		it out first let [me know
11	Hom:	[^h-oh-kay-e-he=
12	Pat:	=but=
13	Hom:	=^ah-·hh[a
14	Pat:	[y'know it's like . . .

Here, the patient has been talking about how she could not take full advantage of a lucky incident that had happened to her because it came at the wrong time. A feature that stands out is the way in which the homoeopath is willing to engage in a kind of gentle teasing of the patient – something that in regular conversation could indicate that a certain level of mutual understanding was already in play (as when friends tease each other). In the context of a medical interaction, however, this might be risky. Drew and Heritage (1992) highlight how physicians are trained to appear as unruffled experts, and to '. . withhold expressions of surprise.' (p.24). Similarly, for the practitioner to attempt to introduce humour in response to a relatively serious comment by the patient could be taken as signifying disrespect. Haakana (1999), for example, has shown how this may be one of the reasons for the asymmetry frequently observed in the initiation and reciprocation of laughter by conventional doctors and their patients. He argues that on many occasions when a doctor fails to react to an ostensively humorous comment or situation involving the patient he may simply be ". . . doing the right thing." (Haakana, 1999) That is, by not laughing he may be avoiding a situation that could be construed as laughing *at*, or making fun of, the patient's concerns. In this case, the homoeopath makes a humorous comment that follows a relatively serious turn by the patient, and by doing so he demonstrates that he finds their interactional connection stable enough for him to risk not 'doing the right thing'. In response to the patient's assertion that '...nothing comes when I wan-it.' etc., (lines 1-4), he chooses not to express sympathy, but rather is able to say: 'Yea? (.) you get the answer to that let me know^-h·=' (lines 5-6). The turn has an element of challenge that allows her to come back with a quick response '=I will do' (line 7). The speed with which she does this helps to convey that she has accepted the humorous irony with which the homoeopath's comment was delivered, and this allows him to respond by laughing (line 8). The homoeopath's hearty laughter (which again, as West (1984), Haakana (2001) and others have observed, is of a length and level that is unusual in the context of a conventional medical interaction) can be seen as being indicative of a rapport. It seems to

communicate a sense that a deeper element of the human condition has been invoked (that of the random nature of good luck), and that both parties can enjoy feeling mutually helpless in the face of it. The invocation levels the interaction and generates a feeling of base human equality. Regardless of the current social, psychological or interactional dynamics between them, the homoeopath and patient are able to display alignment. This is further evident when the patient (on line 9) begins to overlap the homoeopath well before the termination of his laughter. This ensures that he is not left in the awkward position of 'laughing alone' (See: Jeffeson *et al,* 1987), and from here, the sequence develops a kind of bantering quality that is also indicative of a good rapport.

Although highly valued by practitioners – both holistic and conventional – instances of genuine empathy and rapport may be relatively infrequent and serendipitous occurrences. The feeling of having 'clicked' with someone is apparently as rare and pleasant in the consultation setting as it is in everyday life. It seems also that because these nebulous states, rapport especially, are to some extent dependent on both parties performing a kind of psychological lowering of barriers, they are likely to be even more difficult to attain when the complication of a professional / client relationship is factored in. Things will be trickier still if the patient or practitioner has the subliminal feeling that the therapeutic relationship will be somehow inferior if these states are not present. The generation of empathy and rapport in the homoeopathic consultation, then, even if they are transitory and not consistently maintained across the lifetime of a therapeutic relationship, needs to be seen as something that can have much more bearing on therapeutic outcomes than simply making the patient (and the practitioner), feel good about the encounter. In the context of their everyday work however, homoeopaths may need to overcome significant socio-cultural assumptions in the minds of their patients before they can begin to use these states creatively. Homoeopaths know that they are purveying an approach that is based on assumptions that the average person will find strange. Similarly, the practicalities of this approach (particularly in terms of the kinds of apparently tangential questions they may ask, or the level of detail they will require) may not be what patients

are used to. With new patients especially, there is likely to be a need for a degree of 'deconstruction' before the mutualism that the holistic approach engenders can develop, and there may need to be a period of acclimatisation in which the patient's current idea of what a consultation model looks like is gently brought to a point where its rules and norms become malleable.

Where the encounter takes place

The places where homoeopaths work tend to be significantly different to those of conventional practitioners; their surgeries rarely have the 'medical' atmosphere of hospitals or doctors' practices, and are generally free of the bureaucratic structures that reinforce an institutional separation between a doctor and his or her patients. For many patients, once they have been socialised into the homoeopathic mindset and know what to expect, the prospect of a visit to their practitioner is likely to be viewed as a positive experience – something to be looked forward to almost. One patient interviewed for this study summed this up when she said of her homoeopath:

> "She's very easy to talk to . . . she's more sort of like a friend really. I suppose I've been going for about three and a half years now and as I say, seeing her, it's more like seeing a friend."[20]

In purely practical terms too, the homoeopathic patient is likely to view where their treatment takes place differently from a conventional medical setting. They will, for example, probably not encounter long delays in crowded waiting rooms, or have the feeling that they are in an environment where time is always at a premium. If, as in Emma's case in chapter 4, the homoeopath has their surgery at home, patients are likely to find themselves in surroundings that are consciously designed to be calm and relaxing – somewhere that exhibits what Ball (1967), described as a *'rhetoric of legitimisation'*. In the homoeopathic arena, this rhetoric (which includes everything from visual and audio cues to symbols and scents) is used as a means of generating an interactional space that, while 'professional', is consciously and conspicuously different from conventional medical

[20] From interview data (patient).

environments. All of the homoeopaths involved in this study, for example, appeared to have made deliberate efforts to downplay the 'medicality' of their workspaces as much as possible. In more 'institutional' homoeopathic settings too, such as the NHS run Glasgow Homoeopathic Hospital, the overall design of the environment – including, even, details such as the colour scheme and the frequency at which the fluorescent lights operate – has been given a great deal of thought and stimulates the kind of positive reactions from patients that conventional medical settings would be unlikely to evoke:

Patient Interview extract (18:03:01)

Interviewer:	We went to visit [the GHH] and the whole building seems completely different to a hospital.
Patient:	Isn't it nice. It's lovely. Did you ever see the old building?
Interviewer:	No, no.
Patient:	Oh, right. Quite impressive but it was dull and sort of dingy if you like. . . but this is so nice open and airy and it's lovely.
Interviewer:	Do you look forward to going to your appointment?
Patient:	Yea, cause it's a nice environment, yeah. I do.

This kind of response from a patient is significant because, appropriately enough for a holistic discipline, there seemed to be a heightened awareness among the homoeopaths that I spoke to that the business of creating a successful therapeutic relationship spills over into the seemingly superfluous or marginal interactions that take place before – sometimes well before – the consultation proper begins. As with any medical encounter, a homoeopathic consultation does not occur in isolation but is entangled within a psychological and social framework of preconceptions, past experiences, and satellite encounters. Both patient and practitioner bring with them well ingrained ideas of what traditional medical consultations look and feel like, and this naturally colours the way in which they view what takes place as their interactions together unfold. In the case of some homoeopaths, it seems that a latent awareness of the conventional consultation model, and the implicitly unequal power dynamics that it can engender, act as a gauge of how *not* to proceed.

For the new homoeopathic patient – that is, the kind of patient who has little knowledge of the homoeopathic process and has never before visited a homoeopath – the events leading up to and including the first consultation are important. They are likely to evoke feelings of novelty and strangeness. Perhaps even a vague sense of unease at stepping outside the socially sanctioned world of orthodox medicine. For some people, the move towards seeking out alternative medicine can even be a reflection of deeper subconscious drives and processes. It may, as one homoeopath suggested,[21] reflect the first stirrings of a kind of psychological or even spiritual self-development, of acknowledging that there are other perspectives on health and scientific reality. People who try holistic medicine, then, may find that the experience represents much more than simply going to a 'different kind of doctor', even if at a conscious level this is all they are doing. As with counselling or psychotherapy, the knock-on effects of the homoeopathic process can have a profound impact on a person's outlook and persona, and again, maybe at a subconscious level, this is what some people are seeking.

Regardless of the psychological and social convolutions that deposit a new patient at the door of a homoeopath, however, at this point in the process they will be highly sensitive to the entire bundle of interactions and impressions that surround the experience. This may be especially true of those drawn to homoeopathy after hearing stories of how 'different' or 'not like going to the doctor' the experience will be. If genuine trust and rapport are to be built up as the therapeutic relationship develops, everything the patient encounters and assimilates as their socialisation proceeds ideally needs to be synchronised with holistic principles so that discordant elements are reduced to a minimum.

[21] From interview data (practitioner).

First Contact

Unlike conventional doctors, most professional homoeopaths don't appear to routinely employ receptionists or secretaries unless they work as part of a collective or in a health centre of some kind. In terms of beginning to prepare a fertile backdrop for mutualistic interaction, this can have subtle advantages. When the patient arrives for their appointment the homoeopath is likely to be the first or only person that they see. Similarly, not having to give details or share information with a third party (receptionists will often ask the nature of your visit when you make an appointment to see your GP), helps reinforce a feeling of exclusivity. In the homoeopathic environments I was able to study, where secretaries and receptionists were employed, they seem to be utilised in a slightly different way from those in conventional practices. Although they did, of course, perform conventional duties such as making appointments and fielding enquiries, their role as a buffer between the patient and the practitioner rarely appeared to be framed overtly as such. It seemed quite common, for example, for homoeopathic receptionists to be in training to be homoeopaths themselves, or have other complementary health interests. Again, this might help to produce an environment that has a subtly different dynamic to that of a conventional practice. The underlying hierarchical distance between an allopathic practitioner and receptionist is likely to be more defined than in homoeopathy. By implication, this may help to reduce the underlying feeling of professional distance that patients experience when they interact with their homoeopath – they may find the subliminal deference evoked by the traditional patient role is attenuated, making the establishment of an interactional rapport easier and more natural.

For the practitioner, having the opportunity to interact with the patient, however briefly, in an informal pre-consultation setting may have practical therapeutic uses too. Because, in the homoeopathic model, every aspect of the patient's behaviour may prove to be diagnostically relevant, the opportunity to observe them interacting outside the consultation can be valuable; how do they hold themselves as they move, how do they talk and act when they feel that they are not under the homoeopath's professional

gaze etc. Informal pre-consultation activities such as the small talk that takes place as the patient and practitioner settle down can also perform the function of making the transition into the actual homoeopathic interaction more diffuse; elements of mutuality that crop up during the pre-consultation interaction can be carried over into the consultation itself making the activity boundary less abruptly defined.

Getting started

The interactional environments that border the homoeopathic consultation can be seen as embodying a kind of preparatory groundwork, but it is once the consultation proper begins that the homoeopath can start to make more concrete inroads into developing a working relationship that is rich in mutuality. In order to illustrate some of the ways in which this process may be managed I would like to concentrate initially on examining the opening minutes of a consultation involving a patient new to homoeopathy – someone who is, as they make contact with the homoeopath, unfamiliar with the rhythms and routines of holistic medicine. This type of first time consultation is where interactional strategies for the generation of mutuality are likely to be close to the surface because, as with any medical encounter, the initial 'feel' that a patient gets from a practitioner (and vice versa), represents an important datum upon which subsequent contacts are founded. If there are serious misalignments at this early stage of the relationship, a good deal of effort is likely to be required later on to repair them – effort that would obviously be better directed towards the therapeutic process itself. In extreme cases, misalignments at this baseline level may prove to be unrecoverable. In the case study in chapter 4, for example, it was interactional misalignments during an initial consultation that made Emma decide not to return for a second consultation with a homoeopathic doctor. It can be assumed therefore, that this is a sensitive point in the consultation sequence (especially as the patient is likely to be paying for the consultation, or if they are not, has probably had a long wait for a referral). To some extent then, the homoeopath is likely to be capitalising on every means available to ensure

that the image that they project will be the most efficacious in aligning them with the patient on as many levels as possible.

Extract 5 (below) is an illustration of how, in the hands of an experienced homoeopath, virtually any aspect of interaction with the new patient may be utilised in the holistic socialisation process, and lay the foundations for the subsequent generation of empathy and rapport. The patient here had been referred to this practitioner (who is a medically qualified homoeopathic doctor) by his GP, and had been on a waiting list for some months. In terms of how typical this encounter is, it should be acknowledged that this particular practitioner was actively interested in developing these kinds of consultation elements. The encounter may therefore be something of a 'showcase' of good practice. As the data is presented largely to illustrate the potential that various details of interaction and environment can have, however, I feel justified in using it. The extract covers the first four minutes or so of the consultation. Just prior to the beginning of the transcript the homoeopath met the patient in the surgery waiting area and some informal talk had taken place. The homoeopath had checked, for example, that the patient was still happy to be videoed, and thanked him for agreeing to take part in the study. The talk begins as both parties are seated in the consultation room:

Extract 5 (DR-RC-28-03-00)

1	Doc:	. . . so as I say (0.2) if (.) either of us (0.3) want
2		that off (0.4) or afterwards chucked
3		(0.5)
4	Pat:	Right
5	Doc:	We- either of us must feel free to <u>say</u> that
6	Pat:	H-hm
7		(.)
8	Doc:	Yea? (0.3) ok<u>ay</u> (0.5) ah my name's Alan Benway
9		(0.3)
10	Pat:	Right
11		(0.3)
12	Doc:	So I-I'm (0.2)·hh (0.5) some-some patients are
13		comfortable just to call me Alan or Doctor Alan,
14		or Doctor Benway (0.2) whatever's natural
15		(0.4)
16	Pat:	W'll- what do <u>you</u> (0.3) prefe[r
17	Doc:	[Ye- (.) wh- you just
18		wh- any way you want

Pat: ^Wh-[h·-hu-[hu-hu
Doc: [Okay [what-what – what do you like to be called w[h-
Pat: [Er- (0.2)Billy
Doc: Billy (0.4) okay thank-s: Billy
(0.5)
Pat: °Er:° (0.4) my wife's got various names for me [°(though)°
Doc: [^KH·<ha-ha> °picked up a pen that doesn't work – there it is° (0.2) °I bet you she does°
^k-h·-hu (0.7) let me just (.) re-read the letter that doctor smith wrote
(0.2)
Pat: Right
Doc: If I could (0.3) erm ((doc reads letter))
(21.0)
Doc: tk-·h actually maybe I could read you the letter out
(0.3)
Pat: Aie=
Doc: =That will let you know what I know (0.3) [then we=
Pat: [Right
Doc: =can kick off on the story ·hh

((Doc reads aloud from referral letter))

. . wonder if you could have a look at this gentleman who has asked for a referral to the hospital. . .

((Doc continues reading aloud for approx 1 minute))

Doc: . . the doctor also tells me that you suffered from proctitus
Pat: H-hm
(0.7)
Doc: ((Reading aloud)) *'which can f:- range from mildly inconvenient to totally disabling'*
(0.3)
Pat: That ws:- (0.7) when you asked me about lunch
(0.5)
Doc: Okay
Pat: ((unclear))
Doc: Okay ((reading aloud)) *'we seem to have reached a point where we've exhausted the treatments for auticaria that we've offered, and he wondered about homoeopathy. I'd be interested to know if you feel that this sort of thing can be helped.'*
(0.7)
Pat: °H-hm°
Doc: So that's what I- that's th- that's what I know so far so ·hh you kick off at any point you want really with the [story
Pat: [W'll that-that's – that's more or less it. . .

Even in this relatively short extract there are three distinct sequential activities or phases that stand out as having a directly mutualistic function. Broadly, these are:

1. The sequence at the start of the interaction (lines 1 to 6), where the homoeopath re-checks that the patient is happy to be videoed.

2. The discussion relating to names, and what the homoeopath and patient should call each other. (Lines 8-26)

3. The section from around line 43 in which the homoeopath reads aloud from the patient's referral letter.

Talk about the video

I have chosen to include the apparently superfluous sequence that occurs at the very beginning of the consultation (lines 1 – 6). Ordinarily, this kind of transitional talk would probably not be of interest, or even, because of its subject matter, treated as something that detracts from the 'naturalness' of the interaction. The practitioner, for example, is referring to the presence of the recording equipment being used by the researcher. In the context of the mutuality that I am trying to map, however, the way in which this talk is undertaken plays a significant role in grounding the subsequent interaction. It occurs as a kind of bridge between the informal talk that occurred on the way to the consultation room, and the 'formal' beginning of the consultation (which I take to be line 8). What is interesting is the way in which the practitioner is able to utilise its apparently tangential topicality as an effective way of beginning to acclimatise the patient into the more overt mutuality of the holistic approach. Although reference to the camera is treated as a sub-issue, and is separate from the 'real' business of the consultation (the homoeopath's 'okay' on line 8, and the 0.5 second pause that follows it serve to delineate the end of the topic), the way in which the homoeopath frames his comments conveys to the patient a sense that issues of privacy and mutual respect

really are of genuine concern. I am not suggesting that this kind of activity would not occur in other medical settings, rather, that in this case the homoeopath chooses to actively capitalise on it as a means of conveying mutuality. He knows that the patient has given permission for the camera to be present and could simply have indicated where it was, or even, as in the case of one consultant I was able to record, make no reference to it whatsoever. On line 1, however when he says: '. . . so as I say (0.2) if (.) either of us (0.3) want that off (0.4) or afterwards chucked.', he is doing something more than simply checking with the patient that the camera is still acceptable, he is revisiting the topic within a more formal contextual frame. The two parties are no longer chatting informally in the corridor, but are now seated in the homoeopath's room where their respective roles as patient and practitioner are more defined. For the patient at least, this is likely to imbue anything the homoeopath says with a higher degree of significance. Similarly, when he speaks about the camera, the homoeopath is in effect drawing attention to the fact that it is recording what is being said at that moment, and this further serves to reinforce the gravity of his comments. He treats them as worthy of being recorded, of becoming part of the record of their interaction. By being able to utilise this initial transitional period when the neophyte holistic patient is likely to be highly sensitive to the newness of the encounter, the homoeopath is able to start setting a precedent for the subsequent interaction without overtly appearing to do so – the apparently 'administrative' nature of the sequence effectively masks the underlying message that it generates.

A second sub-textual function that may be attributed to this sequence is that the practitioner is able to communicate the feeling that to a certain extent, both he and the patient have a joint responsibility for what transpires, and that both have an active role to play. The practitioner's language, for example, is collusive; rather than saying 'if you want the camera off. . .', he says '. .if either of us. .' (line 1). Similarly, he says 'We. . must feel free to say that', rather than 'You . . must feel free..' (line 5). The use of 'we' rather than 'you' may initially appear to be slightly disempowering, however, at this point the homoeopath is apparently most concerned with emphasising mutuality and

trades off the possible disempowerment against the potentially more useful gambit of creating a common enemy. He in effect casts both himself and the patient as equal under the alien gaze of the camera. The camera becomes a means by which the collegial nature of the homoeopath / patient relationship begins to coalesce. It is as if the practitioner deliberately picks on the camera's intrusive and mechanical presence to emphasise the value of the human connection he wishes to create; the camera is referred to as 'that' (line 1), and its tapes can be '..afterwards chucked.'(line 2). Similarly, by acknowledging that it is not only the patient who may wish the camera to be turned off, the homoeopath communicates a subtle sense of vulnerability which may further help to equalise the interactional dynamics of the developing relationship.

The naming sequence

Line 8 represents the transition between the pre-sequence and the actual start of the consultation proper; the practitioner's 'Yea?', delivered with a questioning intonation, is followed by 'okay', and this serves to indicate the termination of the talk about the camera. At this point both parties still appear to be orienting to the conventional interactional roles of doctor and patient, and as this traditional model is routinely practitioner led, it is left to the homoeopath to initiate the next topic. Following a 0.5 second pause, he introduces himself: '. . .ah my name's Alan Benway.' (line 8). The following twenty lines or so of talk (roughly from line 9 to line 26), then relate to the business of introductions. As with the pre-sequence, however, this activity also frames a subtext that continues to draw the patient into regarding the relationship with his homoeopath as being subtly different from those medical relationships he may be used to. The fact that the homoeopath chooses first to give his name without the prefix 'doctor' is interesting as this immediately implies a degree of de-formalisation and distances him from the medical associations that the more formal title obviously engenders. What may be more significant, however, is that in an extended turn following the patient's 'Right' on line 10, he goes on to offer a number of alternative naming options

that are progressively more formal: 'Alan', 'doctor Alan', and 'doctor Benway'. This indicates that the homoeopath is wary of forcing informality on the patient; not everyone will feel at ease calling their doctor by his first name, especially at this early stage in the relationship, and to insist that they do so would be no less of an authoritative act than insisting they use 'doctor'. At the beginning of this turn too, (line 12), the practitioner says: '. . some patients are comfortable just to call me. .' So by invoking the acts of previous patients, and effectively sanctioning them, he implies that any choice this patient makes will be similarly sanctioned. This again displays an awareness of the patient's position. As they are ostensively in a hospital environment, at this sage his 'default' option is probably going to be 'doctor'. However, this may feel slightly at odds with what is actually being implied in the talk – that '. . whatever's natural.' (line 14), is not likely to be a formal title.

On line 16, the patient displays that, as yet, he is not quite comfortable with the proactive role that the practitioner is steering him towards. This is evident after the 0.4 second pause on line 15 when, rather than volunteering a name that he would like to use, he asks: 'W'll what do <u>you</u> prefer'. In order to maintain a non-directive stance here the practitioner has to continue to leave the choosing of the name up to the patient – to give his preference at this point would possibly generate a feeling of discordance and devalue the act of offering a choice. So on line 17, the practitioner hedges. He says 'Ye- (.) wh- you just wh- any way you want'. By not making a choice for the patient here, the homoeopath also sets another important precedent. It is as if, in a subtle pre-echo of the self-empowerment that is so important in holistic medicine, his reticence conveys the message that the patient will be able (required almost) to take an active role in deciding what is right for him – even at this basic level. It also helps to establish the authenticity of possible future choices that may arise by being a concrete demonstration that the patient's preferences will be respected.

By line 19, the patient is still unwilling to commit to a name and produces a short burst of laughter which the practitioner overlaps with: 'Okay – what-what – what do you like to be called wh-.' (line 20–21). This is, again, a significant

move because the homoeopath, realising that the patient really isn't going to answer the question, could, as on line 17, easily have given in here and supplied a preferred name option. In choosing to turn the question around, however, he not only avoids doing this, but also manages to convert the sequence into something that is empowering for the patient. By asking him a question that he will almost certainly answer, and which allows him to demonstrate a definite and self-supplied preference, the disjunctive flavour of the previous sequence is largely counteracted. Most significantly here, however, is the way in which the practitioner's line 20-21 request is framed so that it elicits the patient's first name: When asked what he likes to be called, the patient is unlikely to produce a formal title such as 'Mr Smith', the default will be 'Billy'. This has the effect of subtly establishing that first names can to be used from then on.

This naming sequence is interesting because it demonstrates how the creative use of alternative or tangential moves by the homoeopath can rescue sequences that have become 'stuck', without the need for an abandonment of the topic. Peräkylä (1995), for example, outlines how, in family systems therapy (which routinely involves two co-counsellors) this may be achieved by the intervention of the second counsellor. The similarity here is that these interventions frequently seem to involve the asking of a question that offers a way out for the client but that '. . . preserves the activity that was initially being perused.' (Peräkylä, 1995.) In this case, as well as preserving the activity of deciding on names, the homoeopath's turn in line 20-21 also has the effect of defusing a situation in which the patient might begin to come across as uncooperative; he is not placed in a position where he appears to be continually blocking, or not aligning with, the practitioner. By avoiding the perpetuation of a disjunctive sequence the practitioner continues to build a feeling in the patient that he respects his wishes and preferences. In a broader sense too, the relatively involved naming sequence begins to project a kind of extended temporality; it helps to frame the current encounter in the context of a longer ongoing process in which names, and the levels of intimacy associated with the various levels of formality that they imply, will be important. This is emphasised a little further on by the way in which the

practitioner acknowledges the name that the patient gives; he repeats it twice (line 23), the first time in a rhetorical way with a little intonational stress on his pronunciation, and then again after a short pause, when he prefixes it with 'okay thank-s:'. It is significant that the actual question of what the patient should call the homoeopath is not pursued to resolution at this juncture, but remains open. In light of what I have suggested so far, however, this might be seen as being a sequential inevitability; the practitioner still doesn't want to force the issue, and whether or not the patient actually makes his choice now or later on in the interaction is not particularly important.

In conventional consultations, although doctors obviously routinely introduce themselves to new patients, it seems that it would be unusual to find this much attention being given to naming options. One GP that I was able to ask about this commented, for example:

> **. . . I mean [it's] not based on any science but of an age or just appearance or my own personal prejudice as well, which one [I use]. One is slightly more informal than the other. What is interesting is what people choose to call me. I don't lay down any rule, I'll respond to anything. It is interesting what people, particularly sort of repeat patients will end up calling, some refer to you still as doctor or Dr Smith and some people will call me by my first name, and I don't know how they decide that or why they decide that, it's a mystery to me. I still like to keep it slightly more formal, that's why when I introduce myself it's either John Smith or Doctor. But the way that you name yourself can have a bearing on the rapport and the formality. Other than that it's straight down, you know, the first question then is, "well what can we do for you" – straight into that.** [22]

It can be seen that although this doctor is obviously concerned that the way in which 'naming' is enacted, will have an effect on the rapport he is able to generate with his patients, this is not foremost in his mind. His main focus is on ascertaining the patient's presenting complaint. In terms of empirical data, a similarly 'standard' approach to naming in an orthodox consultation is given in extract 6 below:

[22] From interview data (GP).

Extract 6 (Y-202-207-26-09-00)

1 Doc: Well mrs jones, as I said welcome to the genetics
2 clinic,·hh and I'm doctor Brown, and ahm (0.3) . .
3 this is a clinic where we see folks with (0.5)
4 something in the family.
5 Pat: Yes
6 Doc: Sometimes people are born with a problem ·hh and
7 folks are wondering what is- that it can happen
8 again.

This sequence is taken from the beginning of a consultation with a new patient at a genetics outpatient clinic and it can be seen that rather than an extended two-way interaction, the doctor simply greets the patient and gives her own name. There is an assumed level of formality in the use of the patient's married name by the doctor, and similarly, the practitioner refers to herself as 'doctor Brown'. Other naming options are not offered, and within the same turn as the introduction the doctor begins to focus on a description of what goes on at the clinic: ' . . . and I'm doctor Brown, ahm (0.3). . . this is a clinic where we see folks with (0.5) something in the family.' (lines 2-3). This is not to suggest that this approach is somehow inferior or wrong, rather it illustrates how the different structural demands and assumptions of allopathic and homoeopathic consultations may be reproduced in the most basic aspects of interaction. It seems that the practitioner in extract 5 is more sensitive to how the conventions associated with naming in the medical encounter might perpetuate structural inequalities – inequalities which in conventional medical encounters such as extract 6 might not be particularly significant, but in homoeopathy, could be a barrier to the generation of rapport. By implying that, although this is a medical encounter, the issue of what the parties might call each other does not have to follow conventional rules, the practitioner in extract 5 is in effect asking the patient to begin looking at the consultation process in a different way. If the patient is aware that even the most basic way markers in his internalised model of a medical consultation are subject to alteration, he may start to abandon, or at least question, what the encounter should look like. He may then become more receptive to the balanced interaction that the holistic process seeks to engender.

Contact

Shifting away slightly from the issue of how the homoeopath is socialising his patient, at the end of the naming sequence (line 25) there is perhaps the first overt evidence of a rapport developing between the homoeopath and the patient. Significantly, the fragment of talk that brings this into the open is initiated by the patient rather than the practitioner. The patient makes a humorous comment relating to the prior talk about his name: '°Er:° (0.4) my wife's got various names for me °(though)°. . .' The generation of rapport can in one sense be regarded as an aim of the homoeopath, but because of its mutual nature, turns at talk or behavioural routines that directly indicate its presence need not be limited to him. The times at which rapport or empathy are evident in actual talk routines can perhaps be seen as high points when the socio-emotional undercurrent breaks the surface of the surrounding interaction and becomes focused on a particular sequence of behaviour. Even if a consultation generates the overall impression of being mutualistic, and the parties are aware of a rapport, there may only be a couple of 'peaks' during the ongoing talk when we can say that these states are definitely in play. The picture may be further complicated by rapport and empathy sometimes being marked by an *absence* of talk or overt interaction, something that might conventionally indicate dissonance or misalignment.[23] Presumably, however, as I have argued so far, the cumulative effect of mutualistic behaviours that are consistently in tune with the generation of these states (such as the camera and naming sequences already discussed), keep them near the surface where they can reflexively permeate the ongoing interaction.

Certain kinds of behaviour, such as the patient's attempt at a humorous aside on line 25, not only serve to indicate that a rapport may be developing, they can also be regarded as prompts by one party for a verification of the new interactional dynamic. Even though it may be the practitioner who has steered the interaction to a position where there is a certain amount of sub-

[23] In her personal reflection on how her nursing practice was affected by loosing her voice, Kacperek, (1997), related how this apparent disability actually enhanced her ability to generate empathetic relationships with patients.

textual connection, either party may initiate the verification. It may, as in this case, be the patient who actually risks a turn that brings it into the open. The 'risk', for whoever tries to concretise the rapport is that they may have misjudged the degree to which the other party is projecting receptiveness – remember that at this stage in extract 5, neither parties have had more than a couple of minutes to evaluate each other. In initiating a turn that in effect asks for confirmation that they may now move to or incorporate another level of intimacy, the person who does this leaves themselves open to rejection – in this case, to the patient's joke falling flat. This is reflected in the way he delivers his turn. Line 25, has a flavour of experimentation, of testing the water; the initial '°Er:°' is spoken quietly and followed by a relatively long 0.4-second pause. Similarly, the final part of the comment: '. . me °(though)°' is fairly attenuated. These dynamics help to emphasise a feeling that he is not entirely sure about the appropriateness of his comment, or the response he will receive. There is a rhetorical quality to the line too, which, had the practitioner failed to give a reciprocal response, would have allowed the patient a degree of face saving. A comment like this, which is spoken almost as an aside to oneself, can be said to 'work' whether or not it generates a response from the other party. In fact, the patient's comment generates laughter from the practitioner: '^KH·<ha-ha>' (line 27). This turn is significant. Partly because, as I have already mentioned, it is well established that conventional allopathic doctors are relatively restrained in their reactions to the humorous comments of their patients (Drew and Heritage, 1992), but mainly because the homoeopath then utilises the turn to build on the patient's 'joke'. After an incidental sub-element relating to his pen (. . °picked up a pen that doesn't work – there it is°. .) He produces a collusive follow up and says: '..°I bet you she does°' (line 28). The way in which this part of the turn is spoken, with a quiet, almost conspiratorial tone, deepens the sense of fellowship between the two parties and hints at the beginnings of a deeper rapport. His '°I bet you she does°' seems to briefly shift the interaction into a different mode, one that is almost intimate. Like the patient's feed line, this too has a 'testing' quality, as if the practitioner allows his professional persona to drop for a second, but quickly restores it. He lets the patient see

that more intimate dynamics are acceptable, while at the same time, he doesn't overtly push the interaction in that direction. The comment has an authentic 'I know what you mean' quality, but is subtle enough not to rush the acclimatisation of the patient. The short laugh that follows the comment (^k-h·-hu), (line 29), has a similarly attenuated quality, but is again perfectly matched to the feel of the sequence; too hearty a laugh here may have come across as false, whereas no laugh at all might have given the homoeopath's comment a slightly sarcastic edge.

Deeper socialisation

The approach that the homoeopath in extract 5 has taken so far may have been relatively 'progressive', but can still be accommodated within a conventional model. The final activity I would like to examine, however, pushes the expectations of behaviour in the consultation setting a little further. It is not uncommon for practitioners and therapists from orthodox disciplines to go through a process of explaining to a new patient 'ground rules' such as confidentiality, trust, openness, and so on, although the cultural assumptions that come with visiting a GP might make this kind of activity relatively rare. In conventional medical encounters, these elements can be taken largely for granted. If they need to be highlighted for any reason, simply talking about them might be a perfectly sufficient means of communicating them to the patient. In a homoeopathic setting, however, there may be little in the way of background cultural knowledge for the new patient to fall back on, so along with words, the practical behaviour of the practitioner can help to convey elements of holism that might otherwise remain relatively nebulous. By ensuring that early on in their relationship the patient is exposed to examples of the practitioner *actually performing* behavioural routines that demonstrate trust, openness, respect and so on (and, importantly, that directly involve the patient), the essence of the holistic approach can be quickly communicated in a tangible way.

Immediately following the extended naming activities of lines 8-28 the practitioner engages in an activity that is an extremely good example of this. On line 29, after the 0.7 second pause, he indicates that he would like to re-read the referral letter sent by the patient's GP. The patient, naturally enough, concurs with this and for the next 20 seconds or so the homoeopath carefully studies the letter. What is interesting is that once he has done this, the homoeopath says: 'tk-·h actually maybe I could read you the letter out.' (line 35). Also, the way in which he qualifies his action is significant: On line 39, he says: 'That will let you know what I know', which is a concrete example of the homoeopath actually using the principles of transparency and mutualism that he is trying to convey to the patient. Similarly, as the patient is acknowledging that this is acceptable ('Right', line 40), the homoeopath continues with '. . then we can kick off on the story.'(lines 39-41). This, again, may have the effect of reinforcing affiliation and equality because it casts the information in the letter (and by implication, the relevance of the patient's other medical experiences) as less important than the interactions that the homoeopath and patient will subsequently have together. It communicates that in this new environment it is the patient's story that is important, not what his doctors may have said about him in the past. Even the homoeopath's use of the word *story* here helps to begin subtly socialising the patient into regarding the encounter as somewhere where, unlike a conventional consultation, narrative and subjectivity are welcome.

The implied equalising of the practitioner / patient dynamic that starts on line 39 is further echoed once the homoeopath has completed his narration of the referral letter. On lines 69-71 he says: 'So that's what I- that's what I know so far 'hh so you kick off at any point you want really with the story.' Again his repeated use of the word *story* builds on the feeling of holism – he does not ask specifically focused symptomatic questions but rather prompts the patient to think of his problem as part of a wider life narrative. There is a sense too that the homoeopath is casting himself and the patient as co-workers who have equal rights in deciding the direction of the interaction. The directive role of the homoeopath as professional is significantly downplayed – he actively

hands the decision about where to begin the story over to the patient and provides no prompts to indicate which elements might be of significance. By sharing information that might normally be unavailable to the patient (even though it is not be particularly sensitive, and may not be aired for practical reasons, such as time constraints in the consultation etc.), the homoeopath is demonstrating in a practical way that his approach embodies openness and transparency. In the same way that, once he offered a name choice to the patient, he left the decision open and avoided making it for him, the reading out of the letter and the reasons he gives for doing this become tangible proof of his integrity. His words are backed up by action – he literally does let the patient know what he knows. It might be interesting to note, however, that the practitioner is careful to read the referral letter to himself before he reads it to the patient, possibly to ensure that its content is sufficiently neutral for the patient to hear. Presumably, had there been elements in the text that were contentious or implicitly critical of the patient, this gambit would not have been attempted. Similarly, this particular practitioner may in some respects be extreme in his approach to openness. On other occasions I was able to observe, for example, if he felt that it would help make something clearer for a patient, he would show them pages from their notes. This kind of openness was expressed by other homoeopaths too, but rather than actually showing a patient what was written about them, it was more common to hear short passages being read out – usually subjective descriptions that demonstrated a 'fit' with a particular remedy.

Summary

So far I have concentrated on the beginning of one homoeopathic consultation to try and give a flavour of how a skilled practitioner can utilise virtually any aspect of their behaviour during the interaction (and the environment in which the interaction takes place), to begin socialising a patient into the holistic approach and lay the groundwork for empathy and rapport. I suggest that the latent effect of the discreet interactional sequences that I have highlighted from extract 3 (the initial talk about the video camera,

the extended naming sequence, and the reading aloud of the referral letter), will have been to begin to disrupt for the patient any established or stereotypical expectations of the power dynamics that he may have had regarding his relationship with the practitioner. Through a subtle adaptation of his approach to the activities at the beginning of the consultation (none of which are particularly unusual and might also occur in a routine allopathic consultation), the homoeopath in this consultation has been able to modify the patient's paradigm of what a medical encounter needs to be like. By backing up his talk with concrete behavioural way markers, he has given the essence of the holistic approach an active reality. Even after these first few minutes the patient has been given the opportunity to view him in a way that is slightly different from the way he views other practitioners. His perspective on how he and the homoeopath can interact together will have been allowed to begin to shift, and although at this early stage he may not be able to specify exactly what it is that 'feels' different, he will be aware of the possibility that their working relationship is based on a different, more mutualistic dynamic.

Although the main data extracts used in this chapter came from a single homoeopathic encounter, and because of the practitioner's self-acknowledged interest in developing these particular aspects of his consultation style, it could be argued that the details highlighted are not universally seen in homoeopathic environments. This may well be true. Not all homoeopaths will have the same level of motivation in this area. However, judging from the consultations I have been able to study, although the one given here is relatively extreme in terms of the lengths to which the homoeopath went to tune his encounter, many of the kinds of activity that were discussed did routinely crop up in other consultations.

In the next section I would like to focus my analysis on certain kinds of predictable activitiy that have a more generic structural function within the homoeopathic consultation; activities which although they may have the incidental effect of reinforcing the holistic environment, are not necessarily

pursued with the overt intention of generating or indicating mutualism, or of acclimatising new patients.

Activity boundaries

I have so far outlined how the holistic and actively inclusive nature of homoeopathic medicine (the way in which subjectivity and life-world concerns are valued equally alongside purely medical factors) is reflected in the kinds of linguistic resources that practitioners consciously or unconsciously incorporate into their talk during consultations. I would now like to suggest that, although an underlying mutualistic or collegial perspective is often pervasive, there are certain points in a consultation where the practitioner's talk is likely to display this orientation more overtly. Furthermore, I suggest that it can be predicted that these high points or 'nodes' are likely to be located where there is the possibility of a misalignment between mutualism (letting the patient set the agenda, for example), and the practical needs of the consultation process (the performance of certain routine tasks, for example, such as shifting from one activity to another.)

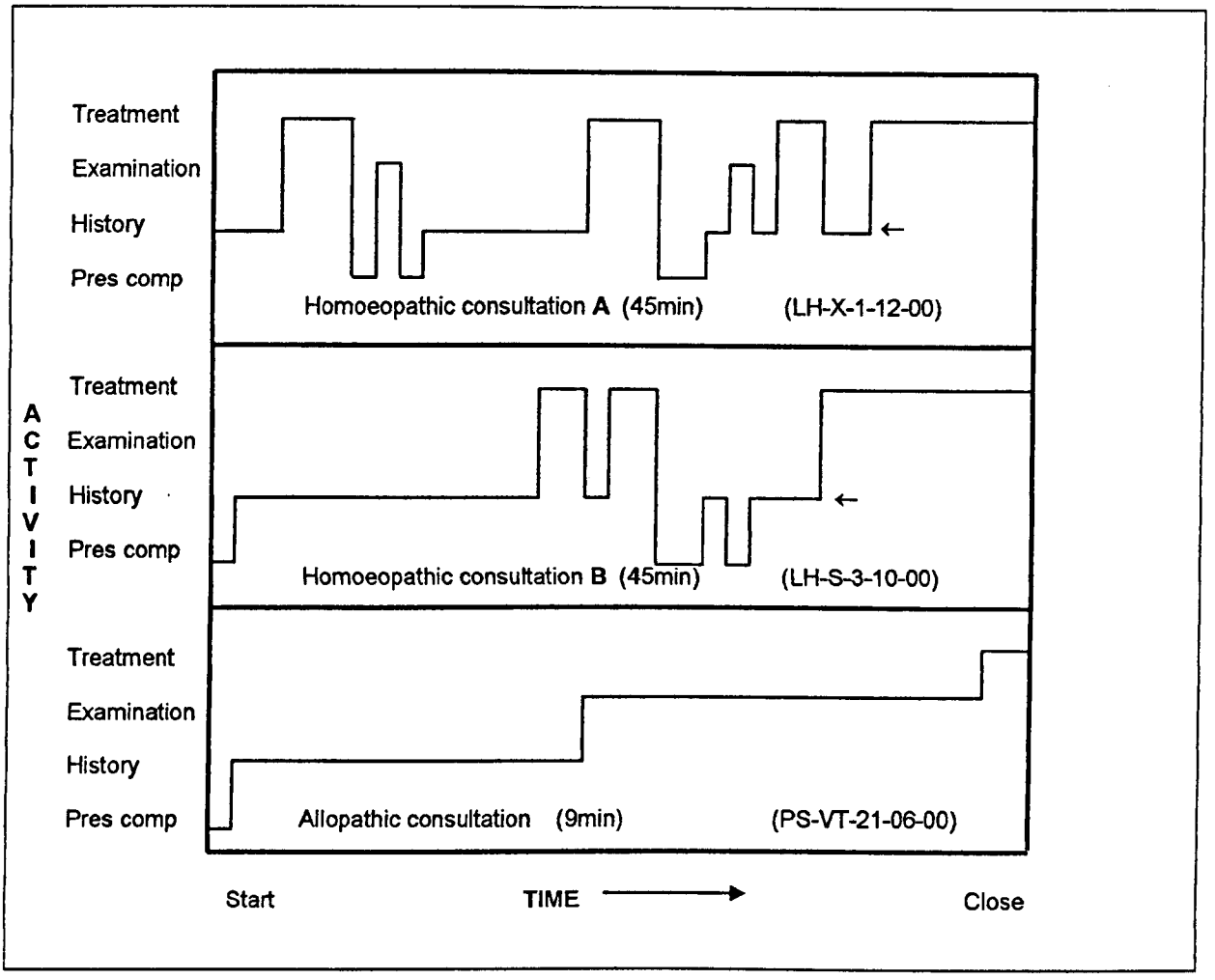
In work analysing the the sequential construction of conventional medical encounters, Ten Have (1989), has outlined the idea that doctors and patients routinely use a variety of interactional (conversational) formats to structure their encounters, but that episodes of seeming 'disorder' can often be attributed to the enactment of activities that are different to those routinely engendered by the 'ideal' consultation sequence. Drew (forthcoming) similarly focused on the development of the misalignments which can occur when patients calling an 'after hours' medical line orient to different objectives from those of the doctor. Because the 'ideal' holistic encounter is focused largely on what the patient brings in terms of narrative and direction, I would like to suggest that areas of possible imbalance in these types of encounter are likely to occur most frequently at junctures when the homoeopath needs to impose some degree of directional control – on or around practitioner initiated

activity transitions, where the inherent inequalities of the expert / lay relationship are most exposed.

Non-sequentiality

Even though the homoeopathic encounter may incorporate the same kinds of activities that crop up in allopathic consultations – history taking, examination, treatment giving etc. (See; Byrne and Long, 1978), the relatively fluid nature of the process means that the temporal or sequential placement of the crossovers between discrete activities is much less predictable. In homoeopathy there is more *structural* leeway for the process to be patient-led than in conventional encounters, and this leads to an apparent unpredictability in terms of the sequential nature of consultations. Of the homoeopathic consultations I was able to analyse, some resembled the 'classic' Byrne and Long (1978) allopathic model (see chapter 4 of this thesis), while others had seemingly jumbled activity phases. The table below (table 2) shows the kind of sequential activity variations that was observed occurring across three different consultations in my data corpus:

Table 2. Activity transitions



The table includes two homoeopathic and one allopathic interaction,[24] and illustrates the order in which four main consultation activities: presenting complaint, history taking, examination and treatment giving, were observed to occur. It also shows the relative proportion of time given to each. For clarity I have not attempted to include some of the sub-phases such as 'joint reasoning' that can often occur but which appear to be idiosyncratic to homoeopathy. The allopathic consultation is included as an example of the 'standard' progression pattern outlined by Byrne and Long (1978). In this particular consultation, the history taking and examination phases are roughly the same length, with relatively short presenting complaint and treatment phases. What is most evident, however, is its linear progression – none of the

[24]Homoeopathic consultations LH-X-1-12-00 and LH-S-3-10-00, and allopathic consultation PS-VT-21-06-00.

activities are visited more than once, and although the time that might be given over to each one is variable, they occur in a predictable sequence; the patient offers their presenting complaint, the doctor takes a history, conducts a physical examination and finally outlines a treatment. Although the two homoeopathic consultations (A and B at the top of the table) were both recorded with the same homoeopath and are therefore likely to reflect any underlying sequential approach, there appears to be little pattern or structure governing the order in which activities are introduced. Similarly, all of the activities are re-visited at various points.

In consultation A the interaction begins with a history-taking or narrative phase rather than with the patient stating a particular symptomatic complaint (see extract 7):

Extract 7 (Consultation A from table - LH-X-1-12-00)

1	Hom:	Right then °h what's been going on hh°
2	Pat:	Ri:ght: (.) erm the first thing which you mentioned last
3		night (0.2) an I thought ooh yea I-I quickly jotted some
4		things down °hh (.) after having Hannah I went on the
5		pill for two months
6		(0.5)
7	Hom:	Did you?
8	Pat:	Yea (0.5) becaus:e. . .

This appears to be a relatively common format when the patient has been seeing the homoeopath for a length of time; there is not necessarily an expectation that the patient should come with a new set of symptoms at each visit. Follow-up homoeopathic consultations often begin with a kind of spontaneous narrative that may or may not make direct reference to the patient's original reasons for seeking treatment (see chapter 7). Extract 8, however (relating to consultation B in the table), has an opening that conforms much more to the conventions of the allopathic model:

Extract 8 (Consultation B from table - LH-S-3-10-00)

1 Hom: So (0.3) lets talk about your chest.
2 (0.6)
3 Pat: Right. ^hhh.
4 Hom: .h This cough
5 Pat: .hh Yes (0.5) I notice when this: (0.9) I- I don't think
6 it's been a hundred percent since I(.)I had the operation 7
because I'm on the anaesthetic. . .

Here, even though it is the homoeopath who initiates the topic of the patient's chest there is more of a sense that the consultation is starting from a specifically symptomatic focus (or 'presenting complaint') similar to that found in conventional interactions.

What table 2 and these two short examples begin to illustrate is that although certain activities can be expected to take place in the homoeopathic consultation there are few junctures (other than opening and closing routines) where their sequential placement can be predicted. Even the placement of a presenting complaint can be to some extent variable. There is one transition, however, that can be virtually guaranteed to take place. That is the crossover from the broad mix of activities that form the bulk of the consultation, into a final treatment giving phase (indicated by arrows in consultations A and B in table 2). Regardless of what occurs beforehand, or the order in which activities take place, a transition into a final treatment-giving phase can be expected to occur in some form towards the end of a consultation – usually, as in the allopathic model, just before, or as part of the close of the session.

Apart from its sequential predictability, the onset of the final treatment phase is also significant because it is one of the main junctures where an expert / lay imbalance is unavoidable. Regardless of the mutuality that routinely characterises homoeopathic interactions, once the patient's symptomatic condition has been explored, or their narrative listened to, there will be the expectation of some form of action. In the final-treatment phase the practitioner is required to provide a degree of overall guidance. That is, he or she has to engage in an activity which will inevitably cast them – even if only

temporarily – in an expert role that is slightly at odds with the mutualistic atmosphere that is nurtured during the rest of the interaction. I suggest, therefore, that the onset of the final-treatment phase is likely to generate systematic interactional adaptations that are designed to overcome this apparent misalignment.

So, to summarise so far:

- The homoeopathic consultation process utilises many of the same activities or phases as the conventional allopathic model, but (possibly because they are more overtly 'patient-led') these tend to occur in an unpredictable sequential pattern.

- There are junctures in the ongoing interaction when there is a higher likelihood of conflict or misalignment between the underlying holistic model and the practical / structural needs of the consultation process. These are likely to occur at or around the points at which practitioners are required to move the patient between activities.

- The final-treatment transition point is one of the few predictable way-markers in the consultation and homoeopaths are likely to have developed routine ways of managing it. These should be reflected in the ongoing talk.

Pre-transition and sub-treatment phases

The final-treatment phase can be thought of as engendering both patient and practitioner expectations. There is some research focusing on general patient expectations in homoeopathy (see; Frank, 2002),[25] however, there appears to be a paucity of studies focusing on the expectations of homoeopathic patients

[25] Frank (2002) suggests that at a general level the homoeopath / patient dynamic can be just as susceptible to disagreement and dysfunction as any other professional relationship – he cites fees, and differing views on the length of the consultation as being particularly problematic.

within the consultation (that is, studies dealing with alignments and misalignments due to conflicting expectations at an interactional level). In terms of the micro-analysis we are concerned with here it is reasonable to assume that having visited with a specific medical complaint, a patient will expect to leave the encounter with a remedy or at least some form of related guidance. Similarly, the homoeopath will (presumably) expect to focus on providing this. This means that there will be some degree of mutual orientation to the transition onset observable in the interaction that leads up to it. In my consultation recordings there is, for example, rarely a sense that the patient is surprised by or unready for the homoeopath to begin treatment activities. In fact the reverse appears to be true – patients and homoeopaths appear to engage in routine behavioural motifs that display a *mutual* orientation towards the onset of a final-treatment giving stage.

Although, as was illustrated in table 2, there may be discrete treatment-giving episodes occurring at various junctures throughout a consultation, the talk that leads up to or precedes these earlier phases appears to have slightly different characteristics to the talk immediately before the final-treatment phase. These differences can be seen as a means by which treatment giving – which in a conventional allopathic consultation occurs at the end of a consultation – can be incorporated without necessarily implying that the interaction is drawing to a close, or that the homoeopath has 'heard enough'; sub-treatment phases are constructed in such a way that, even though they may halt the free flow of a patient's narrative, they have a sequentially parenthetical quality and allow for its subsequent continuation. The association between treatment giving and the natural close of the interaction is therefore circumvented.

In treatment sequences that occur within the main body of the consultation the focus tends to be on a particular symptom or symptomatic problem. The examples below (extracts 9 and 10) illustrate typical sub-treatment sequences. Extract 9 is from the middle of a routine follow-up consultation:

Extract 9 (RF-JO-02-05-00)

Pat: . . .in any case these were (0.3) ·hh °eh°- clothes I
bought h·^eg-I bought a dress and- (0.2) eh you know
°something° °(an I bought that book)° ·hh ^a-ha-ha↑
Hom: ^h·-ah ·hh=
Pat: =and-er - it's-er by the time you get it home you see it's
p-it's- getting heavy
Hom: Yes
(0.3)
Pat: ^Pk-·hh (0.4) a-and er- e-hh· (0.8) p-I-d-I don't know-
really what else I can do (0.2) I shall stop shopping I
supp^hhose- h-hu-·h-h·[u
Hom: [But it-I-s-it's very hard isn't it
cos you- you know ·h
Pat: Yes (0.4) hm .) I mean [I w-e-I do keep p-·hh (0.2) I keep=
Hom: [°You have to-
Pat: =a summer frocks an- (.) an I've found a couple n- (*)-e
put them and didn't think they'd be heavy you see (0.2) an-
an- (0.3) °got them° ·hh[h °(??)°
Hom: [Well I wonder if I could give you-
e-did I give you ant extra tablets to have – here I was
just thinking what you could do ·hh was if you come back
from a shopping trip (0.2) and you have (.) you know have
to – use your arms quite a bit I could give yo:u- the
remedy you could take ·hh that helps with [like=
Pat: [(Hmm?)
Hom: =erm (0.5) tk-strain (.) muscle-muscular strain
Pat: Yes (.) ye[s
Hom: [Did I ever (g)- did I- (0.5) I didn't leave you
any for that did I:: (0.4) didn't leave you any for that
did I ([??)
Pat: [Only th- only the three or four that you left me
eh-after- h· after this bus[iness
Hom: [Right=
Pat: =tht-
Hom: Y[es
Pat: [y-know- (bad business) th[t was:
Hom: [Yes, yes it was slightly
different
(0.2)
Pat: Hm
Hom: (We) could do that (0.2) then you know, if you'd been
shopping and you had a lot to [carry
Pat: [So keep those on one side
(0.2)
Hom: Yes
Pat: and then [(??)
Hom: [you know (.) yes and then if- [a-when you got=
Pat: [Yes
Hom: =back home if you took take them regularly (0.2) and-er (1.0)
·hh I don't want anything that's stronger e[ither
Hom: [No-
Hom: Well we could try that[you know I could let you have- ·hh=
Pat: [Hmm

67 Hom: =you [know (.) [some – for you
68 Pat: [S:: [a few tablets to have by me-
69 Hom: And then you know if you've been out shopping you've got
70 (0.3) p- you know-
71 Pat: Yes
72 Hom: something else okay? ((pat and hom laugh about the tablet
73 case the homoeopath produces)) (?) -chunky box (0.3) then
74 you know have one when you get back and just [see if that=
75 Pat: [Yes
76 Hom: =helps ·hh th-they're- it's a remedy to help with sort
77 of- (0.4)well basically with strain you know when you'[ve-
78 Pat: [Yes
79 (0.3)
80 Hom: over strained yourself a bit – a bit of- more than you
81 would normally do and it just helps-
82 Pat: Yes:
83 Hom: That- and to ease that really and for that not to be a
84 problem
85 Pat: Well I shall try that
86 Hom: Do that? So I could-
87 Pat: Good idea
88 Hom: So at the moment you've got a bit of that and then this
89 hip giving you a bit of trouble again?
90 (0.6)
91 Pat: Yes it is really erm. . .

In this sequence it can be seen that the offer of treatment (the turn beginning on line 19) arises in relation to a specific symptomatic anomaly – the patient's trouble with her shoulder, and carrying her shopping. This has in turn developed out of a narrative that is part of a history-taking sequence in which the current state of ongoing symptoms are being reviewed. Taken in isolation the sequence has a relatively orthodox medical flavour in that the homoeopath suggests the use of a remedy that has general (i.e. not holistically focused) prophylactic qualities; she describes it in terms of being specifically for muscular strain: '. . I could give yo:u- the remedy you could take ·hh that helps with like-erm (0.5) tk-strain (.) muscle-muscular strain.' (lines 23-26).

This specificity in relation to a problem that has cropped up in the course of a history-giving narrative, but which is not necessarily the patient's most pressing concern (the patient had in fact originally presented with high blood pressure), imbues the sequence with a para-medical quality which is seemingly at odds with the holistic principle of treating the person as a whole.

The apparently incongruous symptomatic focus here plays a role in communicating that this treatment giving is not likely to be the main or final treatment phase. Similarly, it helps to indicate that the encounter as a whole is not being drawn to a close; both parties can orient to the sequence as a kind of sub-routine or short aside from the narrative that is, for the moment, on hold. In this particular extract, orientation to the parenthetical nature of the sequence is displayed in other ways too. The terms in which the homoeopath prescribes the remedy, for example, seemingly downplays its holistic qualities, and by implication its importance. When offering the treatment she says: 'Well I wonder if I could give you – e-did I give you any extra tablets to have – here . .' (lines 19 – 20). The talk is framed in a way which implies that the remedy is something to augment an already established treatment regime; the tablets are '. . extra', and they can be taken as and when they are needed rather than as part of a prescriptive timetable. Later too, towards the end of the sequence, as she is about to produce the remedy, the homoeopath further stresses its augmentative role:

(From: RF-JO-02-05-00)

69 Hom: '. . .and you know if you've been out shopping you've
70 got (0.3) p- you know
71 Pat: Yes
72 Hom: something else ok? ((pat and hom laugh about the tablet
73 case the homoeopath produces)) (?)-chunky box. . .

The homoeopath makes a direct association between the remedy and a specific activity – shopping (line 69) – and describes the remedy as being 'something else. .' (line 72); i.e. something other than an underlying or ongoing treatment.

On a practical level, the way in which the homoeopath actually produces the tablets (from the 'chunky box' mentioned on line 73) and gives them to the patient there and then (during lines 72-74), also helps to reinforce the sense that this part of the interaction is insufficiently 'holistic' to be a final-treatment phase. The homoeopath not only has the tablets to hand (bearing in mind

that this is a home visit, and the selection of remedies she carries with her are not likely to be extensive) but also gives instructions about their use that are seemingly discretionary and only loosely connected to whatever other treatments are currently active.

There is a similar degree of orientation by the patient to the remedy having a subordinate or supporting role; once the homoeopath has outlined that it might be taken if she has pain after shopping she says:

(From: RF-JO-2-5-00)

52 Pat: See- I could get (1.0) possibly (0.4) or not prap-praps
53 not the quite the same effect but I could take paracetamol
54 but I try to avoid it you see
55 Hom: Right (.) yes, yes it's not- terribly good for you is it
56 Pat: N[o no
57 Hom: [<paracetamol> no. .

The comparison with paracetamol suggests that the patient views the remedy in the same way that she might view a generic painkiller – as something that is not a 'holistic' treatment, i.e. something that has not been tailored to her individual constitution as part of a homoeopathic process. This again helps to frame the sequence as a self-contained sub-routine.

With both parties orienting towards a closure of the talk about the remedy (lines 85-87) it is the homoeopath who produces a turn that consolidates the transition from the treatment-giving back into history-taking:

(From: RF-JO-2-5-00)

85 Pat: Well I shall try that
86 Hom: Do that? So I could-
87 Pat: Good idea
88 Hom: So at the moment you've got a bit of that and then this

89 hip giving you a bit of trouble again?
90 (0.6)
91 Pat: Yes it is really erm. . .

On line 88 / 89 the homoeopath alludes to the relatively transient significance of the symptoms that they have just been discussing: '. . .at the moment you've got a *bit* of that. .' (line 88), but she also re-establishes the interaction as a narrative / history taking phase by prompting the patient to talk about different symptomatic conditions.

A similar parenthetical trajectory can be seen occurring in extract 9. In this case, which like extract 8, comes towards the middle of a consultation, the relatively brief duration of the routine makes the sub-sequential qualities slightly easier to trace:

Extract 9 (JS-JP-31-10-00)

1 Hom: . . . an-your fingers are they only sort of erm (3.0) bad
2 most of the time [though
3 Pat: [Yes
4 (0.6)
5 Hom: That [doesn't wander at all does it
6 Pat: [Yea
7 (0.5)
8 Pat: No it sta- it stays there all the time
9 (10.2)((hom consults book))
10 Hom: °Hm::° (1.2) °Hm° (1.5) so (0.2) the- big remedy for that
11 is a remedy called colofilum which is a big hormonal remedy
12 (0.8) er:m (1.3) I think I've given it you an I-(1.8) (??)
13 (11.0)((hom consults book))
14 Hom: What I'm tempted- °yeah° (0.5) er
15 (3.4)
16 Hom: that's right cos the first sign was after child birth
17 wasn't it
18 (0.5)
19 Pat: Yes (0.4) yea
20 (3.3) ((hom consults book))
21 Hom: What about your toes how are they
22 (0.8)
23 Pat Er:m my toes are okay it's-it's the ball of my foot (0.4)
24 that causes the problems. . .

It can be seen that the sequence is bounded by two distinct questioning turns made by the homoeopath; on line 1 she asks about the patient's fingers: '. . . an-your fingers are they only sort of erm (3.0) bad most of the time though.' Then at the end of the sequence, after the 3.3 second pause on line 20 there is: 'What about your toes how are they (line 21).'

As in extract 8 the patient treats the sequence as embodying a different kind of activity from the exploration of her ongoing narrative. In this case, her fairly concise replies to the symptom focused or 'forensic' (see; Drew (forthcoming)) questions that the homoeopath ask in lines 5 and 16 ('That doesn't wonder at all does it. .' and 'the first sign was after child birth wasn't it. .'), along with her non-continuation during the extended pauses when the homoeopath is checking things in her *Materia Medica* (lines 9, 15 and 20) indicate that she is orienting to the homoeopath being engaged in a professional reasoning activity which she can not be directly involved in. Again, it is through the use of a question which both changes the topic and re-invites the patient to continue with her narrative (line 21) that the homoeopath signals a shift out of the treatment sub-routine, and back into a history taking / current situation activity.

The final treatment pre-phase

A feature of the 'embedded' treatment phases examined so far is that they tend to have a recognisable parenthetical quality that helps to delineate them as discrete sub-routines. These treatment offers are oriented to by patients as relating to specific elements that crop up in the ongoing interaction. There are not taken as indications that the homoeopath has enough information to move to a definitive (that is, holistically derived) treatment suggestion, or that, by implication, the consultation is drawing to a close.

Pre-summaries and global narratives

The interaction that routinely heralds a final treatment phase is slightly different. Extracts 11 and 12 (below) include the talk occurring just prior to the final treatment-giving phase in two separate consultations:

Extract 11 (DR-AH-03-06-01)

1	Pat:	. . .but I don't have the f:- I mean I [don't have-
2	Hom:	[Not true
3	Pat:	·hh but I'd-I'd-t^-oh-h[h·
4	Hom:	[That's not true [you're improving
5	Pat:	[It's the emotion
6		bit I can't-
7		(0.2)
8	Hom:	I a[m - more – aware - of w[hat I need
9	Pat:	[°(do it)° [What I need
10		(0.6)
11	Pat:	but it's the emotion thing that I can't-
12		(0.2)
13	Hom:	Sure
14	Pat:	deal with
15		(1.0)
16	Hom:	sh:- absolute[ly
17	Pat:	[And that is:- [the only thing that is:-
18	Hom:	[Yea
19	Hom:	Yea
20		(0.2)
21	Pat:	is:- (0.4) always been a stumbling block
22	Hom:	The chick and the plant ((Hom means chick and 'egg'))
23	Pat:	H-hm
24		(1.0)
25	Hom:	eh-dealing with our emotional thing is less
26		impor[tant
27	Pat:	[H-hm
28		(0.7)
29	Hom:	than just dealing with the basics
30	Pat:	Ahuh
31		(1.0)
32	Hom:	Okay (0.4) erm let's stop
33		(0.5)
34	Pat:	(??)
35	Hom:	(??) we go on till next-
36		(14.0) ((Doc writing))
37	Hom:	At this stage in the picture of it all
38	Pat:	H-hm
39	Hom:	d-does homoeopathic medicine play any role or not – of
40		any relevance or not where [are we at
41	Pat:	[It seems to help

Extract 12 (RF-G-27-04-00)

```
1     Pat:   . . .whereas I have (0.2) this pressure in the head ·hh
2            all these physical symptoms to deal with every day
3     Hom:   Yes (0.7) ·hh it's the every day bit which it can be so
4            difficult can't it [so-
5     Pat:                     [And it just drains m[e
6     Hom:                                          [Yes
7            debilitating [(?-vering) you know
8     Pat:                [Hm↑
9     Pat:   H[m↑
10    Hom:     [having to cope day [after day after day
11    Pat:                       [Hm
12    Pat:   Hm=
13    Hom:   =week [after week you know=
14    Pat:         [Hm
15    Pat:   =Hm (0.7) hm
16    Hom:   ·hh Wht-[erm
17    Pat:           [°(I'll Just put my jacket on)°
18           (2.0)
19    Hom:   °S-what° ·hh what-I mean fr-m hh· this end-
20           (0.2)[e-what are-e you- (0.2) you f-eeling ((--))=
21    Pat:        [H-hm
22    Hom:   =from- (0.3) you know from this end that you would like
23           (2.0)
24    Pat:   Obvious[ly I'm looking - for (.) complement (1.0) to- if=
25    Hom:          [s:-
26    Pat:   =I have to take something (0.2) which is s:tronger the
27           orthodox medicine to help. . .
```

In both of these extracts, although the homoeopath formalises the ending of the patient's narrative (on line 32 in example 11, and lines 19-22 in example 12), and initiates the treatment phase, there is evidence that the patient too is beginning to display an orientation towards topic closure; they are reaching the end of what they wish to say, and are 'winding up' their story (see: Schegloff, 1996 for a discussion of story completion formulations in 'regular' conversation, also; Schegloff and Sacks, 1973). In contrast to embedded treatment sequences, a motif common to the pre-final treatment sequences I was able to isolate is that the patient's narrative will start to take on a more global perspective – their talk begins to reflect an overall view of their illness or psychological state rather than focusing on purely symptomatic issues. Similarly, what the homoeopath volunteers during this period often has a broader 'summing up' quality which tends not to be a feature of the history / treatment crossovers that occur deeper in the body of the ongoing consultation. Statements by patients that routinely generate in-depth enquiry

or exploration when they are introduced early in the consultation will tend to elicit more attenuated reactions if they occur once the lead-in to a final treatment phase is underway. In extract 11, for example, before the onset of the treatment phase at line 32, the patient is talking in a resigned way about how she can't deal with the '. . emotion bit. . '(line 5/6), and the '. . emotion thing. .'(line 11). These broad self-summaries are not, as might be expected, explored by the homoeopath, they are in fact forcefully challenged and contradicted. On line 2 the homoeopath overlaps the patient's hesitant and fractured self-assessment with 'Not true'. Then on line 4, as the patient continues to try and express her emotional confusion, he overlaps again with the blunt summary 'That's not true you're improving.' These assertive interventions, followed by the rhetorical summary on line 8 '. . .I am - more – aware - of what I need.', create a sense of impending closure, as well as starting to shift the mutualistic balance of the interaction away from the patient and towards the homoeopath. They begin to generate an environment where the homoeopath becomes progressively more dominant – he asserts an increasingly overt control over the direction of the consultation as the transition point approaches, culminating in the instruction 'Okay (0.4) erm let's stop.' (line 32).

If this is compared to a sequence occurring during an earlier part of the same consultation the contrast can be seen:

Extract 13 (DR-AH-03-06-01)

1	Pat:	. . which I don't think's wrong cos people have used me
2		all my life
3		(0.2)
4	Doc:	H-hm
5		(1.0)
6	Pat:	(??)
7	Doc:	What do you mean by use you mean you're negatively
8		exploiting? him? or-or what do you mean by (.) °and use°

On line 1 the patient here is making a general self-summary which is very similar to the one she makes on lines 11 and 13 of extract 11 ('. . .But it's the emotion thing I can't- deal with.'), but at this earlier juncture the homoeopath

responds with a much more typically 'therapeutic' response. On lines 7 and 8 he picks up on an element in the patient's statement (her choice of the word 'use'), and probes for her to focus on exploring this. His turn remains fixed on the patient and her interpretation of how she feels, and there is no sense of the topic closure evident later on.

Circling

A feature that is closely connected to pre-transition summarising is the way in which the narrative thread that is being explored just prior to the onset of the final treatment phase will often represent a re-visiting, repeating, or rephrasing of an issue or concern that has already been addressed at some earlier point in the consultation. This occurs at a different level from the kind of re-phrasing within discrete sequences that is taken to indicate a move to topic closure. It represents a much broader cycle of repetition in which a whole topic area is re-addressed and in which the separation between introduction and repeat can be extremely long.

For structural reasons, I would suggest that this kind of circling behaviour is more likely to be observed occurring in encounters that follow an 'open' format, that is, ones in which the homoeopath makes minimal interventions and lets the patient's talk dictate the direction of the interaction. In the majority of follow-up consultations in my data corpus where the patient presented with specific symptomatic problems, the interaction tendd to become loosely pinned to specific updates relating to these symptoms – as is exhibited in the enquiry questions which border the sub-treatment example given in extract 10. It can be seen that this kind of topic segmentation can restrict the likelihood that the patient will have sufficient space for long-range narrative circling to develop. In consultations that followed a relatively 'psychoanalytic' structure, that is, ones in which the talk of the patient was allowed to develop in a more or less free-form fashion, they were more common.

It appears that long-range circling routines are not necessarily developed in an overt or deliberate way by the patient (as they might be if a topic had been curtailed or given insufficient attention when it was first explored). Rather, they can be said to indicate that the patient has gone as far as they need to in this particular part of their narrative. In this sense the onset of circling displays a kind of patient-centredness on the part of the homoeopath. It indicates that they have not restricted the patient's narrative space. It can also be a means by which control over the sequential direction of the consultation is left largely in the hands of the patient. The homoeopath can use the onset of circling or re-visiting as an indication of when the patient is ready to move into a different activity phase, rather than imposing the shift on them. The technique has similarities with the kinds of interactional cues that counsellors are trained to look for; in environments that are based on listening with minimal intervention (such as the crisis line I worked on while undertaking this study) the onset of circling by the client may be taken as an indication that the counsellor can make moves towards more active interventions without restricting the clients' expressive space. The implication is that re-cycling a particular topical element indicates that the 'talking-out' process is nearing completion.

The two examples below (extracts 14 and 15) illustrate how the onset of patient circling can be associated with shifts into a final-treatment phase in the homoeopathic consultation. Each extract consists of two parts, the first showing the talk surrounding the initial occurrence of a particular issue, and the second showing the talk that follows its re-occurrence later in the consultation, and how this leads onto a final-treatment phase.

Extract 14 (HDOC-HS-04-08-00)

Part 1 ((From history / patient narrative from 10 minutes into the consultation))

1	Pat:	. . .they were always <u>there</u> y'know like n-
2	Hom:	H-hm
3	Pat:	(e)-y'know it did sort've ·h so I've ad a like (0.3)
4		respect for both of them and stuff [n
5	Hom:	[H-hm
6		(0.2)

7 Pat: did have a lot of time y'know
8 Hom: H-h (0.2) yes (??) wh-when obviously the re- the
9 relationship developed
10 Pat: Ae[y I think so e-just in the last few years
11 Hom: [apropriately didn't it really (there)
12 (.)
13 Pat: So-[a
14 Hom: [Yea
15 (0.8)
16 Hom: An-and-eh i-i-I mean obviously this'll have taken up by
17 the visit t[(??) and things n [it won't- n it wont have=
18 Pat: [Aey [Yea
19 Hom: =a chance kind've to look at your own life I wouldn't
20 [have thought but .h ehm
21 Pat: [°Neh°
22 (0.2)
23 Pat: W[l-I've cracked on wh- I mean I've got a couple o-=
24 Hom: [(wh-ea)
25 Pat: =interviews next week [fr a job (I'll be doin) so .h
26 Hom: [Oh, oh very good
27 Hom: A-[hu
28 Pat: [quite hopeful something 'I (0.4) co[me of that cos=
29 Hom: [A-hu
30 Pat: =.h it's annoying in a way (.)cos I woulda l- maybe
31 liked a job. . .

Part 2 ((Final treatment phase onset from 25 minutes into the consultation))

1 Pat: . . . she would a hatet li[ke (.) °so- erm°
2 Hom: [Yes, staying (in)
3 sitting down n-n not being active=
4 Pat: °↓Yeah°=
5 Hom: =Yea
6 Pat: ↓°It would've been a-°
7 Hom: Yea

8 Pat: I don't (<think>) many (.) people would like ([that /it)=
9 Hom: [H-hm
10 Pat: =I think maybe (0.5) she wasn't one fr s::itting (.)
11 ar[ound
12 Hom: [H-hm (.) h-hm
13 (1.0)
14 Hom: No (good) .hh kh (.) let me give you a time te- te
15 come back [n- n see
16 Pat: [H-hm

In part one of this extract the patient has been talking about the recent death of his mother, the effect this has had on him, and his relationship with his father. This topic begins to close as he produces a summary: '. . so I've ad a

like (0.3) respect for both of them and stuff n- did have a lot of time for them y'know.' (lines 3,4 and 7). The sequence from line 19 to 25 is of particular relevance here, however, because it is the juncture at which the topic actually changes. It can be seen that following the homoeopath's reciprocal summary beginning on line 19 the patient continues by utilising this to produce a 'stepwise' transition (Jefferson, 1996) into his next topic; he is effectively free to continue with the original topic should he wish to do so but on line 23 he talks about how he has 'cracked on' with his life. This leads onto specifics about the job interviews he has arranged. By line 30 he is beginning a new troubles telling related to jobs he would have liked and this subsequently becomes the next part of his narrative. The homoeopath facilitates the patient's choice of topic by giving way as he starts to talk (dropping her overlap on line 24) and also by producing an enthusiastic 'Oh, oh very good.' (line 26) when he mentions the positive moves he has made. The overall effect is that the homoeopath allows the patient to develop their narrative freely without overtly imposing topics or topic boundaries; the patient moves easily from the talk about his mother into the talk about the job interviews etc.

Part 2 of extract 14 shows the talk occurring just prior to the onset of the final treatment phase. It can be seen that the patient has re-introduced the topic of his mother's death. The terms in which it is presented have changed, however. His focus has shifted from the examination of his own feelings, characterised by part 1, to something more anecdotal; the topic is revisited but in a relatively abstract way. This time, when the patient closes with a summary turn 'I think maybe (0.5) she wasn't one fr s::itting (.) around.' (lines 10-11). The homoeopath does not prompt for a continuation of the narrative but rather initiates a final-treatment / closing sequence (line 14). In this case the patient's remedial routine is well established and, as may be the case with a psychotherapist or counsellor, 'treatment' can be regarded largely as being the interaction he has with the homoeopath. The final-treatment phase therefore, may simply involve the offer of another appointment.

Extract 15 (below) illustrates another example of circling:

Extract 15 (HDOC-HS-01-12-00)

Part 1 ((History / patient narrative form 8 minutes into the consultation))

Hom: . . .so your concentration can:
(0.3)
Pat: It can=
Hom: =It can: [get focused can it (0.6) h-hm?
Pat: [yea
Pat: Yea, I mean h· sometimes <when> h· like °(if-)° I go through the morning I'm-n-I haven't been great an then I pick up n then (.)I-I'm fine you know I feel quite good because I've came through that h· bt h· (0.8) it's almost like ·h having came through all that rubbish two years ago (.)
Hom: H-h[m
Pat: [I was just glad to get away from that and get- m- (.) my mobility back and get out in the world ·h and now I think [I've (.) jst really frustrated I just want t- now=
[((sound of patient tapping on table))
Pat: =go the- [neh- the [final step n-
Hom: [Hm [h-hm
Hom: H-hm (0.2) h-[hm
Pat: [en-e-he– bt it's disheartening e^f:ry – ih·-it's j[h·st horrible=
Hom: [H-hm
Hom: =An-eh-t- thes:e-this: (0.2) periods tht you ge[t happen=
Pat: [Yea
Hom: =every da:y do they?
Pat: Aie – yea, my health'[s never (0.2) I never get like a-=
Hom: [Yea:
Pat: =a day when I'm fine . . .

Part 2 ((Final treatment phase onset from 25 minutes into the consultation))

Pat: . . because when I do wake up with a headache (0.6) y'know I've got t- (0.9) just get through it until I do feel better then I could start concentrating ·hh bt-et- there's always an adverse side that if I pick up an I get on with things an I enjoy my day ·h[h
Hom: [H-hm[:
Pat: [my evening e-it can maybe start swinging round- maybe it's tiredness or w[hatever bt (.) it's almost like it's payback (0.2)=
Hom: [H-hm, h-hm
Pat: =en-eh- th[e process °starts again° ·hh that's why=
Hom: [H-hm
Pat: =·hh I jst-eh (0.6) I mean (0.4) I jst want-eh feel (1.7) fine y'k[now
Hom: [Yea

16 Pat: I jst want [theh-
17 Hom: [Yea (0.3) tk-·h[h
18 Pat: [fres[h ^h·uh
19 Hom: [Okay le-leave it with
20 me [and I will get back to you this week
21 Pat: [Aie

Here, it is the patient's sense of frustration at the intangible unpredictability of her symptoms that forms the basis of her circling behaviour. In this case, however, rather than being an incidental symptomatic element, this is closely related to her main presenting complaint. In part one of the extract she describes how she wants to: '. . go the- neh the final step.'(lines 15-17). And how her experience of illness has been '. . disheartening [and] horrible.' (lines 20-21). This prompts the homoeopath to respond by probing for more specific detail by encouraging the patient to continue with her narrative. He asks if the periods of illness happen every day, and this allows the patient to begin to focus on the specific elements that are frustrating her.

This is in contrast to the response that the homoeopath gives when, in the second part of the extract, the patient has begun to re-visit the topic. In a sequence which has similar flavour to her narrative in part 1, ('. . go the- neh the final step.' (lines 15-17), for example), she produces a summary in which she emphasises that 'I jst- want-eh feel fine y'know.' (lines 13-14). This time, however, the homoeopath does not attempt to prompt for continuation but moves to initiate the final treatment phase: 'Okay le-leave it with me and I will get back to you this week' (lines 19-20).

What these last two examples illustrate is that in moving to the final treatment stage the homoeopath may be orienting to two simultaneously occurring circling routines. On a broad level, the patient's re-introduction of a topic that has already been fully explored (in that a topic change is not imposed by the homoeopath) indicates that their current narrative may have run its course, and the homoeopath can legitimately (that is, 'patient-centredly') assert more directive control over the interaction. They can move to the final treatment stage reasonably confident that the patient has said all that they wish to. On a

more micro level, the homoeopath also orients to the conventional markers in the patient's ongoing talk that indicate an impending topic closure (see: Schegloff, 1996). The move to final-treatment can therefore be timed to occur at a natural topic juncture in the patient's talk where, had this been the first occurrence of the topic, there would routinely have been a continuation prompt or exploratory question.

Transitional formats

Broadly, based on the consultations I was able to study, it appears that homoeopaths routinely use one of four main transitional formats when initiating the onset of the final-treatment phase. For convenience these can be arranged on a continuum running from practitioner-led through to 'holistic, or 'patient-led' (see table 3 below), but it is probably more useful to consider them in terms of the context in which they occur – what kinds of outcome the homoeopath is working towards, how familiar the patient is with the holistic process, or what kind of treatment regime may already have been established, for example. Attempts to provide a definitive categorisation are also complicated because there is sometimes a degree of mixing or crossover, with elements from different formats becoming combined.

Table 3: Main transitional formats

	Format	Main characteristics
	Practitioner led	
1	Categorical	Homoeopath states unilateral treatment decision.
2	Delayed	Homoeopath defers a treatment decision.
3	Open	No direct treatment is offered. Patient is actively encouraged to reflect on what is appropriate for them.
4	Reversal	Patient suggests their own treatment or homoeopath orients to patient having overt control in treatment decision.
	Patient led	

Format 1 – 'Categorical'

The following extracts (16, 17 and 18) are all examples of a 'categorical' transition into the final treatment phase. (The turn or turns representing the actual transition point are highlighted.)

Extract 16 (LS-S-03-10-00)

Hom: But at the end of the day if-as long as your not just
(0.3) just using (.) as long as you don't just lu- y-
y'know you can back up why you're giving something .h[h
Pat: [Yes=
Hom: =you're al[right .h then no ths-ths no ginger in (0.3)in=
Pat: [Yes
Hom: =the food so I don't know-
(1.0)
Pat: Right
(0.5)
Hom: Interesting remedy RIGHT .hh I'm going to give you thouia today
(1.0)
Pat: (??[??)
Hom: [(You hav[e
Pat: [(↑Oh [yea)
Hom: [Yea
(.)
Pat: Y[ea
Hom: [You've never had thouia before
Pat: ^H.HHM
Hom: Er:m (.) e-because it's the- the other big psychotic
remedy- the over production- you've had the medarinum
(0.2) didn't do an awful lot .h[h
Pat: [Righ[t
Hom: [But
(0.5)
Pat: .hh ^A-K-H.[H.
Hom: [See what happens to this watery thing cos
obviously it's a big remedy for overproduction (.) and
warts (.) .hh and fibroids. . .

Extract 17 (DR-ML-28-03-01)

Pat: ([) I don't know where I was in among it
all [I just- ^·hhh
Hom: [Very very draining
Pat: °·h-A-ha°
(1.0)
Hom: Er:m
(0.2)

8 Pat: I hope I'm not giving you a headache doctor Smith
9 Hom: Not remotely
10 (1.2)
11 Hom: I'm going to give you a tonic medicine Debbie
12 that'[s for- (1.4) people (0.5) that- let me read you a=
13 Pat: [Yes
14 Hom: =wee bit (1.0) about this can I?
15 Pat: Yes (.) please
16 (2.0) ((hom consults book))
17 Hom: It's a salt (.) a mag-<magnesium carbonate>- it's a
18 salt ·h[h
19 Pat: [Yes
20 Hom: but the sort of constitutions that it helps. . .

Extract 18 (LH-X-1-12-00)

1 Pat: . . .if you sort of said (*) listen to him he's daft when
2 he sings this he'd find that very very hurtful[l
3 Hom: [Right
4 (0.7)
5 Pat: He'd-r-y'know- he'd really ed-sort of go no he'd really
6 find that quite-erm
7 (14.0) ((Hom consults book))
8 Pat: What's w^rong w^hith ^him th^en=
9 Hom: No he's having-<he's having> (.) he's having bareetacarb
10 not calp carb
11 Pat: Ri:gh[t
12 Hom: [bareetacarb
13 Pat: Right
14 (1.0)
15 Hom: Er::m (1.0) and that (0.2) that e-covers more of the-
16 (1.5)it covers the biting as well
17 (0.3)
18 Pat: Ri:[ght
19 Hom: [So it covers the – erm ^tk- (2.3) mistrustful (.)this
20 erm (1.3) shyness and (0.2) n-be a bit wary more than. .

The 'categorical' format appears to be relatively uncommon in homoeopathy and only occurred in about one in ten of the consultations I was able to analyse. This is understandable because it is a format that most readily invokes a sense of the authoritarian (or at least instructional). In none of these extracts, for example, does the homoeopath engage the patient in any discussion about the treatment they are to be given. What we find is the unilateral construction 'I'm going to give you. .' (line 11 in extract 16 and 17), and 'No he's having. .' (line 9 in extract 18), coming as a new topic initiator. It

does not form the second or third turn of a more overtly holistic discussion or 'options' sequence. The categorical format also routinely incorporates a naming of the remedy that is being prescribed, usually as part of the initial treatment turn: 'I'm going to give you *thouia* today' (line 12, extract 18), and '. . .he's having *bareetacarb*. .' (line 9, extract 18).

Interestingly, although this fairly abrupt and instructional formulation opens the treatment-giving phase, in all of the above cases, in the turns immediately following the treatment-turn the homoeopath begins to provide an account of their reasoning in selecting the remedy. This accounting has a much more holistic flavour – almost as if it is an over-compensation for the direct instruction that initiates the phase. In extract 16, the homoeopath (from line 20 onwards) engages in a fairly technical rationalisation of the treatment she has decided on. She mentions how it is a '. . big psychotic remedy. .'(line 22), and goes on to detail its relevance in treating one of the patient's current symptoms – her fibroids (line 31). Similarly, in extract 16, the homoeopath engages in rationalising his decision by asking the patient if he can read an extract from the *Materia Medica* (lines 12 and 14) which explains the characteristics of the remedy. And in lines 15-20 of extract 13 the homoeopath again delivers an outline of what the remedy should help with the '. . biting. . mistrustfulness. . and shyness.'

A further feature of the 'rationalisation' sequences that occur straight after the treatment-turn is the way in which the talk of the homoeopath begins to become fragmented and hesitant – displaying none of the forthright certainty with which the initial treatment-turn ('I'm going to give you . .' etc.), is delivered. In extract 16 this becomes evident after the homoeopath says (again, in a direct way) 'You've never had thouia before.'(line 20). On line 22, as she begins to explain her reasoning her talk becomes much less fluent: 'Er:m (.) e-because it's the- the other big psychotic remedy- the over production- you've had the medarinum. . .' This contrast can also be seen in example 12 and is somewhat more noticeable. On line 12, directly after his initial treatment delivery, the homoeopath begins to explain why he thinks it is relevant to the patient, and again, his talk has a fragmented quality. He says:

'. . .that's for- (1.4) people (0.5) that- let me read you a wee bit . . .'. It is as if in the context of an interactional environment where mutuality is at a premium, the incongruity of the categorical presentation needs to be countered with something that re-equalises their relationship to the patient. A display of what lies behind the treatment decision given in accessible language helps to achieve this and builds trust by making the process more transparent. The authoritative treatment instruction is the result of professional deduction that by definition, the patient is excluded from, and the stumbling, hitches and fragmentation that follow it seem to reflect an unease with this kind of overtly prescriptive instruction – as if the forthrightness of the statement invokes a specificity that is out of step with the routine holistic display of mutuality. In displaying a degree of perturbation the homoeopath is effectively de-professionalising his or her delivery, which again, helps to re-equalise the interactional dynamic.

The 'categorical' format is probably the most straightforward treatment phase transition because (in its initial stage at least) it closely resembles what occurs in a conventional allopathic encounter. The focus has traditionally been on what the practitioner sees as the correct treatment (although current moves towards concordance in general practice have obviously been aimed at broadening the influence that patients can have in treatment decisions) (see: Dickinson *et al*, 1999). In these homoeopathic extracts there is a follow up routine in which mutualism is re-invoked, although the implication is that a treatment decision has been made and the patient will follow it through.

Categorical treatment turns are also effective in unambiguously communicating that the period in which extended narratives are acceptable is over; once the categorical format has been invoked there is a mutual orientation to closing the consultation and this follows relatively quickly – any subsequent talk tends to relate to the mechanics of the treatment, descriptions of the remedy, instructions on dosage etc. In the data I had available, patients involved in this kind of treatment presentation were not observed attempting to re-establish a narrative thread.

Format 2 – 'Deferred'

The deferred format was extremely common in homoeopathic encounters I studied, largely because the structural framework in which practitioners work often incorporates carrying out investigative or deductive reasoning after the consultation is over. It is routinely necessary for homoeopaths to defer a definitive treatment decision until they have had time to consult wider sources of reference – the *Materia Medica,* for example, or more commonly now, computerised repertories. This creates the need to organise the treatment-giving phase so that the patient is aware that the consultation has reached the point where the activity of 'final-treatment' is current (that is, they are not in a sub-treatment phase where a reversion back into their ongoing narrative is an option), while simultaneously deferring an actual treatment decision. Extracts 19, 20, 21, 22 and 23 (below) are examples of final-treatment phase onsets that incorporate a treatment deferral:

Extract 19 (RF-J-27-04-00)

1 Hom: . . it's: [it's
2 Pat: [Yes
3 (2.2)
4 Hom: Right s:o -<so> ^k-hh·-h· ·hh (2.5) f:rom all this
5 what I'll do-I-I- spose I have got quite a good idea of a
6 remedy but it would- (0.2) yea I don't actually bring
7 remedies with [me here
8 Pat: [·hh ah right

Extract 20 (H-DOC-NP-20-10-00)

1 Mum: . . her [get on with it these days
2 Doc: [^heh-heh-heh ˙hhhhhh well (.) th-thanks very much for
3 your time [anyway that-that's-eh given me a nice sort of=
4 Doc: [A-hu
5 Doc: =comprehensive (0.2) [picture of how things are ˙hh w-what=
6 Mum: [A-hu
7 Doc: =I do now - I don't actually give you the remedy today
8 because I actually have to (.) take the- the case away. .

Extract 21 (JS-JP-31-10-00)

```
1    Hom:  (14.0) ((hom consulting book – occasional self speak
2           fragments))
3          °Okay° °(that's what I thought)°
4          (12.0)
5          What I'd like to do anyway is just (0.5) for at least
6          (0.8) another couple of weeks. . .
```

Extract 22 (HDOC-HS-01-12-00)

```
1    Doc:  H-hm because it's no-t (.) such-a- a quick change [(in=
2    Pat:                                                  [YEA:
3    Doc:  =you)tht-eh-tht eh you get more frustrated I think
4          (0.3) yea ·hh but <(as I say)> I think [what I would want=
5    Pat:                                         [°Yah:°
6    Doc:  =to do is-is .h take things away and look at it(0.2)again
7          [so I could actually individualise it a bit better foryou
8    Pat:  [Yea:
```

Extract 23 (RF-J-19-06-00)

```
1    Hom:  . . you notice
2          (2.0)
3    Hom:  Right (1.4) and (1.0) so should I- (1.0) have a think
4    Pat:  Ye[a
5    Hom:     [first about where - to go to-
6    Pat:  [Yea
7    Hom:  [next
```

The first two extracts here, 19 and 20, come from 'first time' consultations, that is, they are from interactions in which the patient is new to homoeopathy. As was outlined in chapter 2, the activities that the homoeopath is required to do in these types of consultations are significantly different from those in follow-up consultations. The first-time visit is characterised by a relatively prescriptive checklist of observations and questions that go to form a picture of the patient's underlying constitution. These are not systematically repeated in subsequent follow-up visits, but rather form an underlying baseline position from which relative progression can be assessed. A new patient is unlikely to be familiar with the much broader temporal framework on which treatments can be based, but is almost certainly going to expect that at the end of what will have been a relatively intense and prolonged (when compared to the

average allopathic encounter) consultation, the homoeopath will deliver some sort of treatment decision.

Because of the large amount of fresh information which the homoeopath is required to process when taking the case of a new patient, however, it appears that this is exactly the type of consultation in which there is most likely to be a delayed decision on which remedy to give. This generates the need for the homoeopath to produce some form of account for the delay, but before this can be done the new patient needs to be aware that the information-gathering / history-taking etc. is complete. In both extract 19 and 20 the homoeopath incorporates into their treatment turn a reference to the value of what the patient has told them. In extract 19 there is: '. . .from all of this. . I've got quite a good idea of the remedy. . . .' (line 4-5), and in extract 20 there is a more overt '. . .th-thanks very much for your time. . . that's given me a nice sort of comprehensive (0.2) picture. .' (lines 3-5). The homoeopaths then circumvent the implied expectation of an immediate treatment by producing the account element: 'I don't actually bring remedies with me here.' (extract 19 – line 6), and the slightly more informative '. . w-what I do now – I don't actually give you the remedy today because I actually have to take the case away. . ' (extract 20 – lines 7-8). There is an emphasis on the homoeopath *informing* the patient about what will occur next rather than presenting them with options. This is a significant point in the socialisation of the new patient because it projects a longer-term temporal expectation than might be the case in a conventional medical encounter; the implication is that the homoeopath is sufficiently concerned with them to give more time to their case and that there will be a continuation of the therapeutic relationship.

This slightly unilateral or categorical flavour ('what *I'll* do. .', 'what *I* do now. . ', '*I* don't. ' etc.) is less evident in the other 'delay' extracts (21, 22 and 23). These are taken from follow-up consultations in which the patient is familiar with the non-immediacy of homoeopathic prescribing. It can be seen that there is a degree of attenuation in the instructional quality of the treatment-turn; a softening of the certainty that is communicated in the categorical

format, as if returning patients are less likely to be phazed by displays of mild uncertainty or experimentation. Although in these extracts the homoeopaths still make unilateral treatment decisions these are presented in a more reflective and mutualistic way. The treatment turn becomes phrased as a request, even if the request is rhetorical. We find '. . what I'd <u>like</u> to do.' (extract 21 – line 5), '. . I think what I would want to do is. .' (extract 22 – line 4-6), and '. . so should I – (1.0) have a think first about where - to go to – next.' (extract 23 – lines 3-7).

As with extracts 20 and 21, the account element is still in evidence, although rather than being part of a socialisation or informative process, it becomes more focused on the holistic individuality of the patient. In extract 22, for example, the homoeopath specifically mentions that she is delaying giving treatment in order to '. . individualise it a bit better for you.' (line 7).

The deferred format, then, depending on the type of patient involved (new or returning), will have unilateral or instructional qualities (the focus still being on what the homoeopath has decided is appropriate), but these will be relatively attenuated. There will also routinely be some form of 'accounting for' that balances the absence of immediate treatment with the promise of something more effective (and holistically individualised) at a later juncture.

Format 3 – 'Open'

An open format is characterised by overt displays of patient-centredness and mutuality. It is also characterised by the use of suggestions and offers as a means of eliciting the patients' perspective. Unlike the categorical or delayed formats, which are necessarily based around particular treatment decisions, the homoeopath may use an open format to initiate an exploration of broader issues relating to how the patient feels about the global progression of their treatment:

Extract 24 (DR-AH-13-06-00)

Hom: Okay (0.4) erm let's stop
(0.5)
Pat: (??)
Hom: (??) we go on till next-
(14.0) ((Hom writing))
Hom: At this stage in the picture of it all
Pat: H-hm
Hom: d-does homoeopathic medicine play any role or not – of any
relevance or not where are we at

Extract 25 (RF-G-27-04-00)

Pat: . . °Just put my jacket on°
(2.0)
Hom: °S-what° ·hh what-I mean fr-m hh· this end- (0.2)[e-what=
Pat: [H-hm
Hom: =are-e you- (0.2) you f-eeling ((–)) from- (0.3) you know
from this end that you would like
(2.0)
Pat: Obviously I'm looking - for (.) complement (1.0) to-
if I have. . .

Extract 26 (H-DOC-FR2-21-11-00)

Doc: = ((to child)) . . what is in the box, good question- you
were saying he's always asking questio[ns
Pat: [Oh he is (.) yea
Doc: ^P-·hh e-I suppose the question is you know we've tried (.)
two homoeopathic remedies (0.2) neither of which have-
(0.7) s-well (0.2) well I think we've [(??)
Pat: [It was like (0.2)
chicken po=
Hom: =the-the chicken pox [(dose)(.) which was sort of like an=
Pat: [Ye:a
Hom: =extr[a
Pat: [Yea
(0.2)
Hom: ^p-·hh erm (1.0) did you th- (0.4) and that's (.) you know,
about a month ago
(0.6)
Pat: N-ye:a none of them have (0.2) really done anything
(1.0)
Hom: Do you want to pursue the homoeopathy (0.4) n maybe try a
different remedy?
(0.3)
Pat: Yea one that'll (0.2) make him sleep . . .

With these extracts there is a sense that the interaction represents a period of 'taking stock'; the homoeopaths are not dealing in specifics but are asking in general terms whether or not the patient is happy to continue with the treatment regime they currently have. Not only this, the homoeopaths appear to be openly acknowledging that their patients' may not wish to continue with homoeopathy at all; the treatment turns have a quality of neutral enquiry. In extract 24 the 'either / or' option relating to the continuation the treatment is unambiguous: does homoeopathy '. . play any role or not. .' (line 8). The homoeopath empowers the patient to make a fundamental treatment decision and this formulation is echoed in extract 26 when the homoeopath asks: 'Do you want to pursue the homoeopathy. .' (line 19).

Implicit in all three examples is an underlying orientation towards the patients' ability to decide what is right for them. The homoeopaths avoid imposing a particular line of action by making their offers balanced. In extract 24, for example the practitioner stresses that homoeopathic medicine may '. . play a role or not. . [may be] of relevance or not. .' (lines 9-10). Similarly, in extract 26 there is frankness about the failure of the remedies that have been tried so far: '. . you know we've tried (.) two homoeopathic remedies (0.2) neither of which have- . .'. In the open format, the options that the homoeopath outlines are not presented in the form of lists or multiple choices (which by definition would be chosen by the homoeopath, and in the manner of their presentation might communicate an underlying preference), they are given using non-assertive language and have a holistic flavour; the emphasis is on subjectivity and evolving processes: 'At this stage in the *picture of it all. . .*' (extract 24 - line 6), for example, and '. . what are you *feeling*. . .you would like.' (extract 25 – line 5-6). This gives the patient a great deal of leeway to respond honestly by legitimising their subjective experience.

The open format appears to represents an attempt to empower and include the patient but can only really be fully utilised if the patient is to some extent familiar (and comfortable) with being pro-active. It was not observed in any of the first-time encounters I recorded, and it can be assumed that it would be

routinely be excluded from this type of encounter; without a therapeutic relationship that is already grounded in mutual experience and trust it could come across as insufficiently focused.

Format 4: 'Reversal'

The final format was relatively uncommon in the data corpus but represents the opposite end of the treatment-giving spectrum from the categorical approach. Reversal could be said to most fully embody the principles of holistic patient-centredness. It involves the homoeopath allowing the patient to take the initiative in deciding what their treatment should be:

Extract 27 (RF-JO-07-01-00)

1 Pat: That's not going to happen
2 (2.0)
3 Hom: ·hh Well- (1.7) <just wondering> what to say really
4 whether we- (.) should we-
5 Pat: Carry on shall [we
6 Hom: [Shall we carry on for another- (0.2) two
7 weeks
8 Pat: Yes

Extract 28 (RF-JO-21-7-00)

1 Hom: . . .s:o e-h [I if possible-
2 Pat: [Praps it ma-needs a little more time to
3 <^huh>·h[h
4 Hom: [should we try another one (.) after you've had
5 your-
6 (0.2)
7 Pat: Yes
8 Hom: remedies
9 (0.5)
10 Pat: Yes (1.0) ·hh=

Extract 29 (RF-J-19-06-00)

1	Pat:	. . . .because (.) it'd be like another three weeks .h
2		I'll go and pick them up (from the) doctor's in a weeks
3		time. He said if- I was going to start in a week .h he'd
4		give them (.) me there and then
5	Hom:	Right
6		(1.0)
7		·h so-e- so what would you want to do: (0.3) I was just
8		thinking in relation to the- (0.9) remedies. (0.5) I mean
9		e-u-e- are you- .h (0.7) what are you thinking you-you
10		might do-
11		(0.5)
12	Pat:	Well can I carry on- <I mean I'd> like to carry on with
13		the remedies.

Although in all three of these extracts the homoeopath has initiated the transition into the final treatment phase it is the patient who actually makes the treatment suggestion. As with the open format, reversals are most likely to occur in ongoing treatment situations. This is partly because they require a degree of mutual alignment in order to work (the homoeopath must be reasonably sure that the patient understands the limitations and mechanics of the current treatment process), and partly because even though the patient is ostensively making a treatment decision, they are not routinely in a position to utilise the same level of expertise as the homoeopath. Their treatment suggestions will necessarily relate to experientially derived information; they may be able to comment on dosages and treatment patterns for treatments that they have already experienced, but are unlikely to suggest an entirely different remedy.

In the first two extracts (27 and 28), the close mutual alignment between the patient and homoeopath is particularly evident. In extract 27 the homoeopath displays a degree of uncertainty (or at least an unwillingness to force an opinion on the patient) in her treatment turn. She holds back from giving the patient an overt choice of options while simultaneously communicating that there is a decision to be made. She uses 'we' to help imply that the decision has a mutual element, while her incomplete and stalling formulation '. . whether we- (.) should we-.' (line 3-4) indicates to the patient that a

suggestion is appropriate. The underlying alignment of the two parties is evident in the homoeopath's reformulation and embellishment of the treatment turn (line 5), which she delivers in slight overlap. Extract 28 is similar; although the homoeopath solidifies the treatment option with 'Should we try another one. .' (line 4), this comes in direct response to a suggestion by the patient that 'Praps it ma-needs a little more time to. . .'(line 3).

If the patient is to be encouraged to think about and make their own treatment decisions, the language used by the homoeopath will necessarily be relatively non-categorical, even to the point of expressing a degree of uncertainty. There is a need to downplay the patient's (presumed) orientation towards the treatment phase being solely under the directional control of the practitioner. This is evident in all three extracts; the homoeopaths use formulations that are overtly non-directive: '. . ·hh Well- just wondering what to say really. .', (extract 27 – line 3), '. .I was just thinking. . . I mean e-u-e are you (0.7) what are you thinking you might do-' (extract 29 – lines 7 -10), and in extract 27: '. .s:o e-h I if possible.' (line 1). The hitches and perturbations that are a recurrent feature of these turns also help to develop a sense of non-categorality.

An interesting final point relates to the reactions of patients to this unusually empowering formulation. It appears that even though they make treatment suggestions in a relatively unproblematic way (I did not find any instances where a patient who was offered this kind of format refused to cooperate, or insisted that their homoeopath *tell* them what to do, for example), the ways in which they construct their treatment-turns indicate that they still orient to the homoeopath as having a controlling role. Patients' own treatment suggestions are, like the practitioners' initiation turns, non-categorical and framed as mutualistic enquiries or questions. In extract 29, for example, the patient frames her treatment suggestion as a request for approval rather than a clear statement of preference: 'Well can I carry on- <I mean I'd> like to carry on with the remedies.' (lines 12-13). Similarly, the patients in the other two extracts do not make categorical statements but use the language of

compromise: 'Praps it ma-needs a little more time . .' (extract 28 – line 2), and mutuality: 'Carry on shall we. .' (extract 27 –line 5).

Summary

This chapter has been concerned largely with an analysis of the specific interactional activities surrounding the treatment-giving phases that occur in homoeopathic consultations. I have tried to highlight the non-linearity and relatively unpredictable sequential positioning of these phases, and how unlike in conventional consultations, there may be several instances of the activity spread within a single consultation – culminating in an interactionally differentiated 'final treatment phase'. I have also explored the circumvention routines that have developed to overcome the apparent incongruity of 'instructional' treatment giving formats occuring in the overtly 'patient-led' and mutualistic environment of the consultation. The characteristics of narrative 'circling', in which certain elements of a patient's story are re-visited or re-explored just prior to the onset of the final treatment stage have also been examined, as have four main transitional formats that practitioners can be observed using to actually shift the focus of the interaction into a final treatment stage.

Patient narratives

In conventional medicine there is currently growing interest in the role that patient narratives can play as a therapeutic resource. 'Narrative based medicine' (See: Greenhalgh and Hurwitz, (1999); Glyn and Gwyn, (1999); Launer, (1999); Silverman, (1987)) involves the careful attending of the doctor to not only the symptomatic information that a patient gives but also to the contextualisation provided by the way in which they present the 'story' of their illness and of their wider life concerns. In a sense, this spirit of '. . interpretive, practical reasoning.' (Hunter, 1991) that is becoming manifest appears to reflect a push for the regaining of elements in medicine that may have been 'lost' or neglected – i.e. the more humanistic parts that have somehow become obscured but which can provide depth and richness to the therapeutic process. In their discussion of narrative based medicine, for example, Greenhalgh and Hurwitz (1999) refer to the application of narrative awareness in the (conventional) medical consultation as a tradition '. . . that should be revived in the teaching and practice of medicine.'(p.7175). They further suggest that a patient's narrative can be a means of deciphering '. . .how, why and in what way [a person] is ill.' (p.7175). An outlook that is very resonant of holism. Launer (1999) points out, however, that although clinicians from different therapeutic traditions (particularly in psychiatric settings) are ' . . moving away from the search for a normative explanation of someone's problems and towards the search for an appropriate story for each patient. .'(p.117), in conventional medicine there can be a tension between the complex stories that patients bring and the doctor's understanding of what is really going on in terms of a diagnosis. There is a sense, perhaps, in which the practicalities and technicalities of much modern medicine conflict with the essentially atechnical process of narrative

assimilation. What is significant too about narrative incorporation within conventional medical consultations is that doctors who might wish to more fully utilise the therapeutic technique are still likely to be frustrated by the time and resources constraints that engender much modern practice. Glyn and Gwyn (1999), however, highlight that even by taking a small interest in the mechanics of the talk they enact with their patients, doctors might be able to allow a more 'democratic arrangement of voices' (Silverman, 1987).

The homoeopathic approach, on the other hand, is already renowned for having a 'democratic arrangement of voices', and for being amenable to very broad definitions of what is considered to be symptomatically relevant. In homoeopathic terms, virtually anything that the patient says, does, reports or reacts to can be usefully incorporated into the individualistic 'constitutional picture' that the homoeopath is trying to figure out. This means that the patient's narrative experience of the life-world through which they navigate (and, perhaps more importantly, the ways in which they describe this experience) is every bit as important as a therapeutic resource as the more obviously 'medical' issues that concern them. (See, for example, Kaplan, 2001.) In a sense, homoeopathy has always been a narrative based system of medicine. A key feature of the holistic consultation process is the way in which the patient appears to be free to talk at length about virtually anything they care to bring up. This is not to say that topics they introduce are *likely* to be medically tangential, rather that anything that happens to crop up in the context of the consultation becomes, by definition, homoeopathically relevant. The formats in which patients produce and deliver narratives in the homoeopathic consultation, and the type of behaviours that homoeopaths exhibit to encourage or attenuate their delivery are therefore a highly significant way in which holistic encounters are defined.

Allopathic narratives

In order to contextualise the analysis that follows, I would like to briefly highlight some of the features that can be found in the allopathic arena in terms of the way that practitioners utilise, stimulate or control the narratives of

their patients. It should be emphasised here that none of the the doctors in allopathic examples that follow (or indeed, any of the other allopathic doctors in my data corpus) expressed a particular interest in narrative based approaches to the consultation.

In conventional medicine, and particularly in general practice, there is a recognised convention that the practitioner needs to try and focus the patient as quickly as possible on their 'presenting complaint'. (See, for example: Beckman and Frankel,1984.) Similarly, socialisation into the conventions of consultation behaviour, with its focus on the valuable nature of the doctor's time etc., mean that extended narratives, while not entirely absent, are not routinely attempted by patients. In fact, patients who do attempt to engage in this kind of behaviour are likely to be perceived as problematic.[26] As the current interest of narrative based approaches to medicine may indicate, this is a structural feature of modern allopathic encounters that has more to do with the desperately short contact time that GPs in particular have to work with than with an underlying resistance to the value of subjective exploration. Ironically, the curtailing of narrative exploration could be said to have a doubly regressive effect on the kinds of patient for whom the encounter itself is the major therapeutic element. The kind of patient who simply needs to talk around their problems, or who may just require sympathy, reassurance, and more than the five or six minutes available is just the kind patient who is likely to have their narrative explorations curtailed.

For the patient, the impact of narrative attenuation, of being shifted into a relatively restricted topical environment before they have had the opportunity to fully express their concerns (regardless of how extraneous these may appear to be to the mechanics of the consultation process) can have the effect of communicating that the doctor 'doesn't care', or that the material that the patient is presenting is somehow trivial or irrelevant. They may feel rushed, or pressured into focusing on physical or psychological symptoms, even if these only form the exposed tip of a deeper underlying life-world

[26] From interview data (GP).

problem (See: Waitzkin, 1984). This may be especially true if the doctor has poor communication awareness or has not developed 'soft' approaches to guiding the patient back into symptomatic exploration. Extract 30, below, however, is from an allopathic encounter at a regular GP diabetes clinic (where consultation time is routinely 15 to 25 minutes) and is an example of how narrative attenuation can be achieved in a gentle and relatively subtle way:

Extract 30: DB-OP-09-10-01

1	Doc:	Did you see the dietician right at the beginning of
2		all of this:[:
3	Pat:	[No
4	Doc:	diabetes lar[k
5	Pat:	[No
6	Doc:	You didn't
7	Doc:	No (0.8) what, you-you thought- didn't fancy it- cos your
8		wife- is a health visitor isn't she so she-
9	Pat:	Yes she was a health visitor an-and her ·hh her-her one
10		of her prime things was diabetes
11	Doc:	Right
12	Pat:	She-she was she-er used to go on courses for ·hh diabetes
13		and diabetics
14	Doc:	Right
15	Pat:	Erm- (0.8) and (2.5) what can I say erm- she makes
16		certain that I have a reasonable amount of fruit-
17		vegetables
18	Doc:	Sure
19	Pat:	but she doesn't ·hhh how shall I say w-we don't become
20		fanatical about it
21	Doc:	No
22	Pat:	erm: [if we go out to dinner somewhere ·hh erm- ·hh I=
23	Doc:	[No
24	Pat:	=can- what did I have last time I went out to dinner (.)
25		oh last time I had gammon (0.8) haven't had gammon for
26		ages
27	Doc:	Hm
28	Pat:	but I might have a curry
29	Doc:	Hm
30	Doc:	maybe a curry, a chicken curry or even a vegetable ·hh
31		and last week we had erm: (1.8) lasagne (1.2) twice was
32		it- oh yea once my daughter did it (°think we had lasagne
33		twice°) ·hh we had two lots of-erm- (0.5) fish last week
34		in fact I had fish (.) last night (1.0) w-with curried
35		rice (1.8) erm- (1.7) we had-erm- savoury meat balls the
36		night before (3.0) I made a fish pie ·hhh the day before
37		that
38	Doc:	Hm
39	Pat:	with prawns-

40 (3.0)
41 Doc: I think- you know I wouldn't want to get too s:t- ^Pf-hh·
42 (0.3) <you know> too- too involved with your diet it-
43 sounds like (1.5) you're eating (0.9) probably a – fairly
44 balanced diet (0.3) with lots of fruit [and veg and so=
45 Pat: [^K-hm
46 Doc: =on (0.8) but it's still a high fat diet (.) but as you
47 correctly say (0.2) what we're really concerned f:- about
48 your cholesterol ·hh is your cholesterol and if your
49 cholesterol is okay. . .

The 'problematic' nature of this patient narrative is relatively straightforward; it is the level of detail that the patient tries to include that is the issue. The narrative (of which the main extended part starts on line 15 as the patient says: 'Erm- (0.8) and (2.5) what can I say. . .') does not have particularly tangential qualities and in fact remains relatively closely tied to the doctor's original prompting question on line 1: 'Did you see the dietician right at the beginning of all this. .' What the patient volunteers in his talk can be seen as an attempt simply to provide as much relevant, or what Heritage (2002) describes as 'doctorable', information as possible. Being a diabetic, diet will after all have been something to which the doctor had previously asked him to pay careful attention. This makes topical redirection at this point an even more sensitive problem; the doctor does not want to alienate the patient by implying that much of the information in his account is superfluous (the specifics of what he had eaten at each meal during the last week (lines 24-39, for example), but at the same time he needs to focus on an issue that underlies it – the patient's awareness of his cholesterol level. In order to achieve this trade-off the doctor, in his turn running from lines 41-49, utilises two main interactional elements. Firstly, he does not interrupt or overlap the patient during the body of his narrative, but allows him to continue until he reaches a natural turn juncture (the 3 second pause on line 40: '. . with prawns-'). Even though the 'hanging' intonation ('-') with which this turn is completed suggests that there is more to follow, the extended pause allows the doctor to begin his turn without appearing to override the patient. That the doctor chooses this particular juncture is significant because the narrative contains a number of other extended pauses that would have allowed the doctor to interject earlier had he wished to do so. (On line 31 there are

pauses of 1.8 and 1.2 seconds, line 34 has a pause of 1.0, line 35 has 1.8 and 1.7 second pauses, and on line 36 there is a 3.0 second pause.) The fact that he did not utilise these prior openings suggests an awareness of the interactional damage (in terms of rapport etc.) that cutting the patient off earlier might have caused. Similarly, by not interjecting at an earlier point and allowing the patient to continue, the doctor is actually able to display attentive listening and thus *enhance* rapport.

The second interactional strategy adopted by the doctor relates to the structure of his narrative attenuation turn (line 41 onwards). This is constructed in such a way as to mitigate or downplay any 'authoritarian' or instructional qualities that might be inferred, and framed so as to communicate a certain degree of respect for the value of what the patient has been saying. He begins relatively hesitantly with 'I think- you know I wouldn't want to get too s:t- ^pf-hh· (0.3) <you know> too- too involved with your diet. . .' This turn construction, with its hitches, perturbations and repeated words, helps to soften what is basically going to be a dismissal of what the patient has been saying. The patient is ostensively displaying a degree of concordance here – demonstrating that, as a diabetic, he takes his diet seriously, even if the detail of what he is actually saying is largely irrelevant to the doctor. The fragmented quality of this initial part of the doctor's turn betray that he is aware of the tricky balance that needs to be maintained at this point if he is not to alienate the patient.

The sequence of elements that follow (lines 43-49) make an interesting combination too. The doctor sandwiches a criticism of the patient's diet between two positive statements, thus communicating his concern while simultaneously maintaining a relatively 'collegial' feel to the encounter: on line 43-44 he affirms that the patient probably has '. . a fairly balanced diet. .'. This is followed with the negative '. . but it's still a <u>high</u> <u>fat</u> diet.' (with the emphasis on <u>high</u> <u>fat</u>), and then by another positive affirmation '. . .but as you correctly say (0.2) what we're really concerned f:- about is your cholesterol.' (line 46) Both the initial and final elements have the added benefit of referring back to something the patient had suggested earlier, and again, this helps to

maintain a collegial dynamic in the interaction. The doctor, then, manages subtly to curtail a largely extraneous narrative sequence (that is, a narrative that is becoming, or is likely to become too far removed from symptomatic issues) without significantly disrupting the interactional relationship with his patient.

Pre-narrative attenuation

If the curtailing or attenuation of extended patient narratives can have the effect of forcing the practitioner to display apparent non-patient-centredness, this might be something to be avoided. A more subtle method of keeping the patient focused on the specifics of the allopathic process is to adopt interactional strategies that prevent, or at least discourage, them from embarking on these kinds of narrative in the first place. The following extract is an example of this. It comes from towards the middle of what has already been a relatively long allopathic family planning consultation:

Extract 31: (FP-RP- (AB)26-03-01)

1	Doc:	. . .·hhh (.) it's still relatively early days. But as I
2		said of course coming on top of all the other bleeding
3		problems you've had in the past (0.2) ·h[hhh it seems
4	Pat:	[Mmm
5	Doc:	(0.6) to you I'm sure that you've been bleeding
6		forev[er
7	Pat:	[It (does) u·hhh (0.7) ((sniff))
8	Doc:	Okay
9		(3.7) ((Doc writing))
10	Pat:	°(?)° (0.6) my life's up and down all the time
11		(13.6) ((Doc writing))
12	Doc:	·hhh now the other thing I need to do today is just do an
13		examination as we:ll (.) and internal (.) examination (0.2)
14		just to make sure. . .

The patient's presenting problem has been excessively heavy bleeding, apparently resulting from the contraceptive coil she had been fitted with and the short summary that the doctor produces on lines 1-6 indicates that at this point in the consultation she is coming to the conclusion of the history-taking

phase. That is, she has presumably got as much information as she requires from the patient in order to proceed to the examination stage (which she refers to overtly on lines 12 and 13: '. . .the other thing I need to do today is just do an examination as we:ll. .'). The focus of the encounter at this point is very much on the present symptomatic situation – the doctor does acknowledge that there may be other things troubling the patient, and that her current problem is part of an ongoing process, related to the '. . other bleeding problems you've had in the past. .'. But these too are framed in the specific context of the presenting complaint. Understandably, at this point in the consultation, as the doctor prepares to shift activities and conduct her examination of the patient, the introduction of a narrative relating to tangential or subjective information is likely to be problematic (in the sense that it may not fit particularly well with the technical task that the doctor will shortly be engaged in). So when, as the doctor is writing up her notes on lines 9-11, the patient says: '. . my life's going up and down all the time.' (line 10), there is, significantly, no acknowledgement of the turn. The doctor continues writing and then on line 12 introduces the topic of the examination procedure. The cue that the patient presents on line 10 might, in different circumstances, have prompted the doctor to encourage an exploration of what lay behind the remark (rhetorical comments of this sort often indicating the presence of an underlying issue – something, perhaps, that the patient is reluctant to address overtly). In this case, the doctor appears to avoid picking up on this – possibly utilising the writing activity that she is engaged in as 'cover'. The contrast between the patient's subjective life-world comment and the pragmatic symptom focused talk that preceded it is striking also. In this extract, and much of the preceding talk that is not transcribed here, the doctor actively restricted the onset of anything that appeared to be diverging from the directly symptomatic. It can be said, therefore, that an effective (if blunt) way to avoid having to curtail extended patient narratives is to maintain conditions that are unlikely to allow them to develop in the first pace – even to the point of disregarding cues that indicate a narrative-based sequence may be therapeutically indicated.

Topical focus

In general, from the allopathic data I was able to study, it seems that where relatively extended narratives are observed in consultations – extended in the sense that the patient describes issues at length, but also that they may include information that is not directly 'medical' – what patients choose to include usually bears a direct and relatively uncomplicated relation to a specific symptom or complaint (at least in terms of the logical framework and knowledge that any given patient is working within.) The two extracts below illustrate this. The first one comes from a routine follow-up consultation at a diabetes clinic (extract 32). The second from a follow-up meeting between a surgeon and a post-operative oncology patient (extract 33).

Extract 32: DI-MP-17-01-01

1	Pat:	. . .(When) yuh give me that strong tablet (at first it
2		kn[ocked me back)>
3	Doc:	[y e a h
4		(0.6)
5	Doc:	(yuh didn't like thur)
6	Pat:	hih [hih hih (d(h)idn't like m(h)[e d i d-)
7	Doc:	[(uh) [(didn't sui- that
8		ih suit yuh that one did it=
9	Pat:	=Hih .hh no I'm not kidding you ER ER ERM I wuz sat
10		like (watching) television (0.4) <un I'll describe it>
11		·hh un I goddup (0.6).hh(.)an I walked the length of me
12		hallway which is about the same length [as tha:t
13	Doc:	[H m m
14		(0.7)
15	Pat:	An I got tuh thuh doo::r, (0.7) .hh (°un I thought°)
16		I'm gunna pass out 'ere
17	Doc:	Mm hm
18	Pat:	Anyway I got ru- dizzy un yuhknow an I 'ad tuh grab
19		hold uh (door jamb)
20		(0.9)
21	Pat:	°thought° (crumbs) am I having a stroke? or what?
22	Doc:	Mm
23	Pat:	Yuhknow (0.6) un anyway I stood for a couple uh minutes
24	Doc:	°Mm°=
25	Pat:	=it cleared itself up
26	Doc:	°M[m°
27	Pat:	[but it did frightened me did that.
28		(0.8)
29	Pat:	.hh und er- that's why I rang you up straight away?

Extract 33: PS-VT-21-06-00

Doc: ↑Swallowing alright?
(.)
Pat: Erm yeh it's ev'ythin's more lack of survivuh saliva th-
Doc: R[ight
Pat: [things get stuck yuh kno[w
Doc: [right nothing
Doc: >th-uh-th-uh-[th-uh-< feeling of any blockage or a[nything
Pat: [It doesn't hurt or anything [oh no
Pat: .hh But the nigh- (.) before .hh this started (.) erm when a go t- bed a gargle
Doc: Ri:ght
Pat: An:d we'd been out for a meal actually now whether this had anythin' tuh do (.) with it but I'd had a prawn cocktail
(.)
Pat: It w's a bit strong (.) I had a job getting it down and something- shot out of (m- mouth)
(.)
Pat: it felt like I was bringing a marble up
Doc: Ri[:ght
Pat: [bu- er:m: (.) un then everything- seemed hollow
Doc: Right
Pat: A:ll uv that side of muh head
(.)
Pat: Y'know [up muh nose un do[wn ma throat
Doc: [mm hmm [oh right - mm hmm
Pat: .hhh un ah just thought wel it's better out than in wha-h.- t-h.-ever h.-it was 'cause it just went zumm down the plug ^ho-ho-le=
Doc: =Ri[ght
Pat: [^.hh[^hh
Doc: [okay=
Pat: =Er:m
Doc: Sounds a bit like the alien. [story.
Pat: [y-huh ^huh y-hand yeh ^.hhh=
Pat: =und it just the following day it felt crackly un then that's when me ear ache started after that so whether it wus any connection a don't know
Doc: Okay
(0.2)
Doc: Okay but overall you feel you're making good progress. . .

These extracts have a number of significant commonalities. The first is the way in which both narratives are relatively concise and self-contained (especially if compared to the kind of diffuse narrative structures that can, as I shall illustrate shortly, crop up in homoeopathy). A listener unacquainted with the intricacies of either patient's illness would be able to learn as much from the accounts as someone who knew their medical histories. They can also be

said to 'work' as stories in their own right even if taken out of the context of the consultation; the patient in extract 32 describes the effects of a drug he had been prescribed on a previous occasion. His narrative opens with a direct reference to how '. . when you give me that strong tablet (at first it knocked me back)>. .' (lines 1-2), which contextualises the account. The 'at first' heralding the likelihood of more details to follow. There is a 'middle' section (running from lines 9-27) in which these details are presented. And finally, on line 29, a turn that completes the cycle of the narrative: '. . and .hh und er- that's why I rang you up straight away?' This turn also has the effect of emphasising the 'doctorability' of what he has been saying by re-establishing a direct connection between the various elements of the account and his current presenting complaint. Similarly, as the patient in extract 4 begins to relate an account of how she coughed up something unusual, her narrative is initially grounded in the context of her presenting complaint. '. . but the night- (.) before ·hh this started. .' (line 9). Her formulation in this turn projects a trajectory along which events have unfolded and prepares the doctor to expect more details to emerge. Again, after a 'middle' sequence in which these are developed (running from the end of line 9 to line 28), the narrative is rounded off with a turn that re-establishes a direct connection with the patient's presenting complaint: '. . und it just the following day it felt crackly un then that's when me ear ache started. .' (lines 35-36). The 'doctorability' of what she has been saying is also invoked in the final part of the turn: '. . so whether it wus any connection I don't know.' (line 36-37).

A second feature of both accounts is that they are presented as a means of illustrating specific symptomatic anomalies. As well as the overt attempts that these patients make to establish the 'doctorability' of these particular narrative episodes, and the implied reasoning behind why they have decided to relate them (line 29 in example 32, and lines 36-37 in example 33 etc.), there is also a sense in which the narrative (or 'story') format itself performs a broader legitimising function in terms of bridging the gap between the patient's ongoing experience of their illness (their 'non-medical' life-world), and the narrower symptomatic focus represented by their understanding of what is likely to be of use to the doctor. The patient's life-world is

(presumably!) made up of a range of events, experiences and encounters, that will fall on a continuum of relevance relating to their illness. The doctor, on the other hand, is concerned primarily with those elements that have direct symptomatic relevance. So this kind of short narrative format is extremely useful because it allows the patient to present their lay medical reasoning in a way that is directly related to their ongoing experience. At the same time, the 'story' format, with its own internal logic (these particular examples are essentially linear narratives, in that one element follows another forming a natural or self evident connection), serves to help emphasise the unusual or 'out-of-the-ordinary' nature of what is being described by placing events in the context of conventional reality.

Story format

The narratives presented in both extract 32 and 33 have trajectories in which the most important element (to the patient) is preceded by, or grounded in, a number of other relatively mundane details – something which is a common technique in many types of presentation and performance. Before beginning to focus on the specifically medical elements of his story, the patient in extract 32, for example, 'sets-up' his story with a formulation that projects the announcement of something unusual or curious: '. . .hh no I'm not kidding you ER ER. .' (line 9). He then proceeds to build his account, starting with relatively innocuous background information:

(From: DI-MP-17-01-01)

9	Pat:	. . . hih ERM I wuz sat
10		like (watching) television (0.4) <un I'll describe it>
11		·hh un I goddup (0.6).hh(.)an I walked the length of me
12		hallway which is about the same length as tha:t

The latter part of line 10 is particularly salient in helping to frame the elements of the patient's story as something unusual – something that is worth describing. The narrative then builds with the disclosure of progressively more concerning detail: he describes thinking that he is going to pass out

(line 16), getting dizzy (line 18), grabbing the door handle (line 18), and thinking that he is having a stroke (line 21). A climax is reached as he explains that he became so frightened that he felt justified in phoning the doctor straight away (line 29). In extract 33 a similarly dramatic trajectory takes place. The patient begins with innocuous background details – she talks about how she gargles before she goes to bed (lines 9-10), then how she went out for a meal (line 12), and the food was strongly flavoured (line 15). The trajectory builds as she projects the potential for trouble ahead by mentioning how she had problems 'getting it down' (line 15), then it reaches a peak as something dramatically '. . shot out of (m- mouth).' (line 16).

In the context of the allopathic consultation, these short narratives with their dramatic trajectories serve to reinforce the immediate medical relevance of the patient's concerns. The patients in examples 32 and 33 keep the details of their narratives closely tied to the specifics of their condition (patient 32's drug experience, and of patient 33's assumption that what she coughed up related to the throat surgery she had recently had). This, along with the 'dramatic' format, helps to imbue the various elements that they describe with a heightened degree of interconnectedness, and by extension, a greater depth of authenticity. The connections that the patients make, both directly as in extract three (the patient claiming that the strong tablet '. . knocked me back.' (line 1)), or indirectly (the patient in extract 33 wondering '. . .whether this had anythin' tuh do (.) with it. .' (lines 12-13)) are relatively unambiguous and provide justification for the processes of lay-reasoning that each has been involved in. The narrative structure, in effect, allows the patient to demonstrate that their lay-reasoning (which, unless they have a medical background, is the main way in which they make sense of, and thus feel in control of, their disease process), is balanced and considered, giving them a more pro-active role in the consultation process. The practice of packaging concerns in the form of a narrative (setting the scene, building up, dramatic occurrences etc.) is therefore a means by which patients can effectively balance the life-world experience of their illness with the specific demands of the allopathic process; the coherent presentation of what may be complex

interrelated information becomes a way by which the patient can most effectively communicate to the practitioner the significance of what they are saying. Both of the patients here could easily have described what had happened to them in a much simpler and direct way: '. . *the last tablet you gave me made me a little dizzy, but it cleared up.*', for example, or '. . . *I coughed something up the other night and my ear started aching.* . .', but these formulations would have conveyed virtually none of the concern that the narratives as they were actually presented help to communicate.

So these kinds of allopathically contextualised examples show how certain types of extended (though still relatively brief) narrative can be used by patients to help communicate the relevance and seriousness of what concerns them. What is significant from a holistic perspective, however, is that in these cases there is very little indication that this kind of short narrative fragment is treated by either the patient or the practitioner as having a therapeutic role in its own right. (This is not to say, of course, that this behaviour can be generalised to all allopathic contexts.) In the extracts I have presented narrative episodes tend to remain focused fairly closely on the kind of information that is likely to be of practical use to the doctor. What the patients say is relatively concise and to the point, and has little of the self-exploration often evident in homoeopathy.

Self-censorship

Another significant (and perhaps surprising) structural feature that is evident in extracts 32 and 33 is the way in which it appears to be the patient who remains in control of the trajectory of the narrative. That is, it can be seen from the turns that the practitioners make in response to the various elements that arise as the patients unfold their accounts that unlike in the earlier extracts 30 and 31, the doctors in these examples do not attempt to curtail or close down the narrative. The patient is allowed to give a full and rounded account. An important consideration here, however, may be the temporal positioning of the narrative episode. In both extract 30 and 31 the patients are attempting to develop a narrative at a

relatively late stage of the consultation, that is, outside of, or during the close of, the initial history-taking phase. Patients 32 and 33 are utilising their accounts right at the beginning of the consultation to introduce key elements of their presenting complaint. This suggests that patient narratives in allopathic encounters (which tend to have their activities organised along relatively structured lines – *presenting complaint*, *history-taking, examination, diagnosis delivery,* etc. (See: Byrne and Long, 1978) may be more or less likely to be attenuated depending on where they are initiated.

Although longer sequences of talk between the doctor and patient are obviously not limited solely to particular phases, the period allotted for the patient to relate their concerns and describe their symptoms tend to be the initial *presenting complaint* and *history taking*. This is when the doctor will be most actively able to listen to what the patient is saying. The various other activities of the consultation demand that he or she be more focused on the performance of other specific tasks – the practicalities of a physical examination, for example, or the delivery of a diagnosis.

Attentive listening

In both of the allopathic narratives that come from the presenting complaint / history-taking phase (32 and 33), once the patient begins to give their account the practitioners display attentiveness and restrict their turns to relatively unobtrusive continuation prompts (See: Gardner, 1997):

From: DI-MP-17-01-01

15	Pat:	. . . I got tuh thuh doo::r, (0.7) .hh (°un I thought°)
16		I'm gunna pass out 'ere
17	Doc:	Mm hm
18	Pat:	Anyway I got ru- dizzy un yuhknow an I 'ad tuh grab
19		hold uh (door jamb)
20		(0.9)
21	Pat:	°thought° (crumbs) am I having a stroke? or what?
22	Doc:	Mm
23	Pat:	Yuh know (0.6) un anyway I stood for a couple uh minutes
24	Doc:	°Mm°=

25 Pat: =it cleared itself up
26 Doc: °M[m°
27 Pat: [but it did frightened me. . .

And in extract 33:

From: VT-PS-21-06-00)

9 Pat: .hh But the nigh- (.) before .hh this started .) erm when
10 a go t- bed a gargle
11 Doc: Ri:ght
12 Pat: An:d we'd been out for a meal actually now whether this had
13 anythin' tuh do (.) with it but I'd had a prawn cocktail
14 (.)
15 Pat: It w's a bit strong (.) I had a job getting it down and
16 something- shot out of (m- mouth)
17 (.)
18 Pat: it felt like I was bringing a marble up
19 Doc: Ri[:gh]t
20 Pat: [bu-] er:m: (.) un then everything- seemed hollow
21 Doc: Right
22 Pat: A:ll uv that side of muh head

Similarly, it can be shown that the patients' accounts are allowed to come to a 'natural' end, that is, they exhibit generic indications of topic completion, and the practitioners refrain from initiating new topics or delivering more active exploratory turns until these become evident. In extract 32, for example, the combination of turns in lines 27 and 29 have components that indicate that the patient's narrative is drawing to a close:

From: DI-MP-17-01-01

27 Pat: . . .but it did frightened me did that.
28 (0.8)
29 Pat: .hh und er- that's why I rang you up straight away?
31 (.)
32 Doc: All of the s e things it's gotta be. . .

These turns consist of a relatively subjective summary (line 27) that contrasts with the objective details that the patient had presented during the rest of his narrative (the dizziness, the grabbing of the door handle etc.) Also, the patient leaves an extended pause at line 28, and when the doctor does not initiate a reply, volunteers a follow-up account turn (line 29) which is

simultaneously more focused, but also, in its inclusion of an upward 'questioning' intonation on the final word (. .away?), betrays a slight unease. As if, after the doctor fails to produce a turn immediately following the completion of the narrative, the patient wished to check that he was in alignment over the 'doctorability' of what he had been saying (he has, after all, requested an urgent appointment). There is also slight perturbation at the beginning of the line 29 turn ('. . und er-'), which reinforces the sense of the patient reading 'trouble' when the doctor does not immediately begin to speak. Taken in the context of this particular interaction, however, as has already been explored, (particularly in relation to extract 29) this delay in replying can be regarded as an indication that the doctor is displaying close attention to what the patient is saying – deliberately refraining from initiating a reply until they have definitely completed what they wish to say. In the rest of the narrative it can be seen that this particular patient tended to leave relatively long pauses between the various phases of his story (see lines 4, 14 and 20, for example). So by not offering a turn at the first indication that the narrative was complete, the doctor may in fact be exhibiting a degree of patient-centredness.

Indications that the patient has been able to draw her narrative to a relatively natural conclusion, rather than being overtly shepherded into closing by the doctor can also be seen in extract 33:

From: VT-PS-21-06-00

24	Pat:	. . .Y'know [up muh nose un do[wn ma throat
25	Doc:	[mm hmm [oh right mm hmm
26	Pat:	.hhh un ah just thought wel it's better out than in wha-h.-
27		t-h.-ever h.-it was 'cause it just went <u>zumm</u> down the plug
28		^ho-ho-le=
29	Doc:	=Ri[ght
30	Pat:	[^.hh[^hh
31	Doc:	[okay=
32	Pat:	=Er:m
33	Doc:	Sounds a bit like the <u>alien.</u> [story.
34	Pat:	[y-huh ^huh y-hand yeh^.hhh=
35	Pat:	=und it just the following day it felt <u>crack</u>ly un then
36		that's when me ear ache started after that so whether it
37		wus any connection a don't know

38 Doc: Okay
39 (0.3)
40 Doc: Okay but overall you feel you're making good progress. .

In this case, what appears to be the beginning of a termination of the narrative is displayed around lines 26-28. This turn contains elements that might typically indicate this to a co-participant: the patient, for example, uses a figurative expression: '. . it's better out than in. . ' (line 26) – figurative expressions belonging to a category of formulations which often crop up on or around topic change boundaries (See: Drew. P. and Holt, 1988). The patient also indicates that her narrative may be complete because of the way in which the final part of her turn (line 28) tails off into a fragment of attenuated laughter: first there is: '. .plug ^ho-ho-le. .', and then: ' ^·hh - ^hh' overlapping the doctor's 'Right' on line 29. It is the second fragment of laughter on line 30 that possibly communicates to the doctor that there is no more that the patient wishes to add, and his orientation to moving onto a next phase of talk is indicated by the way in which his 'right's' become the more generically final 'okay' (line 31, and subsequently on 39 and 40). So although the short sequence of turns around lines 31-33 does indicate that the doctor is orienting to the narrative being complete, it appears that this is because the patient, through the sequential formulation of her talk, has indicated this to be the case. The fact that the patient overlaps the doctor on line 34 to re-start her account and add information relating to her ear ache is not as a result of the doctor 'shutting her down' before she had chance to complete her narrative, but rather, as in extract 1, that he is closely following what she is saying. In this case, he simply makes a slight misreading of the patient's use of a closing formulation. His careful attending is further confirmed by the way in which, after the patient has delivered her supplementary turn (lines 35-37), he appears to check more overtly that the narrative is in fact complete by leaving a short pause on line 39 before making a definite move into his next diagnostic question: '. . .but over all you feel . . .' etc. (line 40).

What the examples considered so far begin to indicate, then, is that the relatively short duration of narrative episodes in allopathic consultations, and the symptomatic focus that these narratives tend to have can be said to arise

out of a combination of patient socialisation, patient self-censorship, and the practicalities of effective communication – rather than simply because of straightforwardly directive approaches on the part of doctors (although the active attenuation of narrative exploration undoubtedly can occur if patients attempt to develop accounts in phases of the consultation that are reserved for more 'doctor-centred' functional activities, such as during the physical examination or treatment giving stages). In attempting to play their role as helpfully as they can, both for their own benefit, and for that of the doctor, patients package what they have to say in ways that reflect the medically relevant 'work' that they need to accomplish. In the allopathic context, where there is routinely a significant imbalance between the technico-medical expertise of the doctor and that of the patient, this is likely to be directly related to communicating the apparent pertinence of symptomatic information and lay reasoning. The act of presenting an account or developing a narrative, therefore, can be seen as having an essentially functional role in helping the patient to effectively convey (and make sense of) the relevant details of their illness experience. Its role as a therapeutic tool in its own right, although undoubtedly gaining increased popularity through initiatives such as the narrative based medicine outlined earlier, however, may be limited by the functional constraints of the modern allopathic process – time, compartmentalisation of activities etc.

Socialisation and the homoeopathic narrative

Homoeopathy is renowned for being an environment where the patient can expect to be given time and space to express themselves without the overt (or covert) pressures that are common in conventional medicine – pressures ranging from the modern truism that the doctor is likely to be extremely busy and overworked, through to the subtle undercurrents of social deference that still lead many people to believe unquestioningly that the 'doctor knows best'. It might be expected, then, that on encountering the homoeopathic environment (often, as was examined in chapter 4, as a result of a basic dissatisfaction with the underlying structures of the allopathic consultation

process) that the behaviour of the new homoeopathic patient will be noticeably different – perhaps 'freer' or less restricted in some way.

It appears, however, that new homoeopathic patients (that is, those who are likely to have few pre-conceptions about what their homoeopath will require of them interactionally) can still be ovserved utilising short concise narrative forms. Although the corpus of 1st time homoeopathic encounters that I was able to analyse was relatively limited (See table 1 – page 20), this kind of behaviour was evident to some extent in all of the consultations I had available. The following extract comes from a first-time homoeopathic encounter and is a particularly good illustration of the phenomenon.

Extract 34: DR-RC-28-03-00

((Practitioner has just outlined the contents of the patient's referral letter))

Hom: . . so that's what I- that's th- that's what I know so far
so ·hh you kick off at any point you want really with
the [story
Pat: [W'll that-that's – that's more or less it. I mean ·hh
er: (0.4) I've been going to the skin clinic (0.3) off and
on fr- nineteen eighty five (0.4) °a[nd it's-° (0.8) it really=
Hom: [°Yes°
Pat: =started (0.8) I don't know if this is in any way
connected but er- ·hh (0.6) I first got proctitus (0.5) in
nineteen- (1.5) the first sort of- symptoms are from
nineteen eighty five it was diagnosed in nineteen eighty
six
(0.3)
Hom: Right
Pat: Er: (.) nineteen eighty six was (0.4) more or less when I
s- first (.) went to my G P
Hom: Right
Pat: and told him I'd got itching
(0.7)
Hom: Right
(0.5)
Pat: Er:- (.) I don't know if there's any connection or not
Hom: Okay
(0.8)
Pat: Everything else (.) is more or less summarised in that
letter

It can be seen that the format and structure of this narrative fragment has many similarities with the previous allopathic examples. There is almost a reticence on the part of the patient to impart more than the most salient symptomatic information. There is, too, an absence of subjective detail relating to how his condition has been making him feel, the impact it has on his life, or any other generically holistic information. He does choose, however, specifically to highlight his symptomatic chronology ('. . I've been going to the skin clinic (0.3) off and on fr- nineteen eighty five.' (lines 5 and 6); '. . the first sort of- symptoms are from nineteen ninety five . .' (line 11), etc. He sticks closely to giving an objective and factual account: 'I've been going to the skin clinic off and on. . '(lines 5-6); 'I first got proctitus in. . .' (line 9), '. . it was diagnosed in. . '(line 11); 'I went to my GP. . and told him I'd got itching.' (lines 15-18). There is also a similarity with the allopathic examples (particularly extracts 32 and 33) in the way that the narrative is constructed as a self-contained account with a recognisable topic closure: on line 22 the patient re-cycles a suggestion he made at the start of his account about there being a connection between the two symptoms that most concern him (his proctitus and 'itching'), and again, as another indication that his narrative is complete, his opening turn '. .W'll that's more or less it. . .' (line 4) is echoed on line 25 with: 'Everything else is more or less summarised in that letter.' This final turn, and the extended pause that precedes it on line 23, also helps to generate a 'two-element' or 'two-stage' ending that has similar sequential characteristics to those that occur at the end of the allopathic narrative examples (extracts 32 and 33, lines 27-29 and lines 37-40 respectively). In this case, on line 22 the patient begins to indicate that he is concluding what he has to say with the speculative summary '. . Er:- (.) I don't know if there's any connection or not.' (a turn which is itself an echo of line 8 '. . I don't know if this is in any way connected but. .'). Then, through his use of 'Okay' (line 23) – with its terminal emphasis contrasting with the 'Right's' that formed his preceding continuation prompts (lines 14, 17 and 20) – the homoeopath communicates an acknowledgement of the narrative's closure. The extended pause that follows this on line 24 therefore, while probably indicating that the homoeopath wants to ensure that the patient has finished talking, in fact also

has the effect of prompting him to re-summarise – to re-confirm that his narrative offering is complete. So, as in extracts 32 and 33, the format of this interaction suggests that it is the patient who is in control of when the narrative will close rather than the practitioner – the homoeopath reacts to, rather than prompts for the winding up of the narrative sequence, and its relatively short duration is largely due to the patient designing it to be concise and symptomatically focused.

The framework of responses and continuation prompts that the homoeopath produces during the narrative are also very similar to those of the allopathic extracts. His holistically coloured opening prompt: ' . . you kick off at any point you like really with the story' (lines 2-3) does communicate that a relatively in-depth narrative may be acceptable – the use of the word 'story' being particularly significant here, and the phrase 'kick off at any point' too, invoking an all encompassing and circular holistic process, the starting point of which is immaterial. The depth of implication in the turn is subtle, however, and provides very little in the way of explicit instructions relating to what is expected or acceptable – nothing overt in the homoeopath's talk suggests to the patient that he should proceed in a way that is particularly different from a regular allopathic consultation. The fact that the patient produces a compact and focused summary that closely resembles those in the allopathic examples is therefore not surprising; faced with what, at this early stage of the consultation, appears to be an interactional environment that is very similar to the one he has been socialised into he simply reacts by relying on the set of behavioural conventions he is familiar with.

The occurrence of this form of narrative in the 'first-time' context is significant because it suggests that the socialisation of the patient, and not simply the interactional approach that the homoeopath takes in prompting or leading them, must play an important role in determining the way they present themselves.

Displays of uncertainty

The tendency for new or 'un-socialised' homoeopathic patients to display a preference for aligning with the 'default' conventional medical model is understandable, but it can cause interactional problems in the initial stages of the therapeutic relationship. This is pronounced if the homoeopath sticks too rigidly to the holistic principles of patient-centredness and fails to give an initial directive frame of reference from within which the interaction can develop. It seems that being too 'open' can sometimes lead to 'trouble'. The homoeopath therefore needs to be aware of the level at which the patient approaches the interaction, and balance efforts to be overtly non-directive with the new patient's need for a degree of topical guidance. The patient in the last main extract (extract 34) apparently adapted well to the open approach of the homoeopath, and being invited to '. . kick off at any point you want. .' (line 2). Although he produced a relatively attenuated narrative there was little sense that navigating the interaction caused him any particular 'trouble'. There was a little evidence of uncertainty informing the patient's talk during the initial part of the sequence – as he begins to speak (line 4) his talk is fractured by a number of hitches and perturbations:

From: DR-RC-28-03-00

4 Pat: . . .W'll that-that's – that's more or less it. I mean ·hh
5 er: (0.4) I've been going to the skin clinic (0.3) off an
6 on fr- nineteen ninety(0.4)°and it's-° (0.8) it really...

These hesitations however, were more likely to have been due to the mundane practicalities of arranging the relevant elements of his story and expressing them coherently – the patient may have been a little surprised at the 'openness' of the homoeopath's opening turn, but his talk was not irrevocably disrupted and his narrative quickly developed into a coherent presentation. In some of the consultations that I was able to observe, however, there was evidence of more serious misalignment. This was particularly noticeable in the opening stages of 'new-patient' encounters. The first two extracts below (35 and 36) come from such first time consultations, and the third from an encounter in which the patient was making her second

visit. All three exhibit indications of interactional 'trouble' arising out of discrepancies between the homoeopaths' 'open' approach to initiating a narrative from the patient, and the patients' apparent difficulty in relating to this:

Extract 35: RF-J-19-06-00

Hom:: Is tha[t (*)k.hh -
Pat: [Yes, yes that's ([fine).
Hom:: [.hhh – Right, so - <(so over
to you)> so I mean- [I know you said tht - it's-
Pat: [Right.
(0.8)
Hom: y'know
(0.5)
Pat: Yea.
Hom:: periods- period related, so d-do you want to [just-
Pat: [Right(0.2)
Erm:
(4.5)
Hom:: I spoze re:ally -it's really (1.0) a-h. –things
like –we-h-a-how did it begin, do you want to tell-
explain where: -how long ago:-
(1.4)
Pat: Erm. (1.0) yea I've always –always had just normal
periods
Hom:: Right
(1.0)
Pat: always within like twenty eight-twenty nine days.
So, always been regular (.) Always lasted about the
same amount of time. .h erm:

Extract 36: AN-RP-14-03-99

Hom: (yu) Halright
Pat: (yea)
Hom: (Write down) the date. Fifteenth (was it)
Pat: yea.
(7.0) (Hom writing)
Hom: Right. Jus- (0.4) how y-been really.
Pat: (Hu)h - hm it-
(0.2)
Hom: Go on. Go-a (.) <tell me> what's been [happenin.
Pat: [Well I've just bin
(1.0) (muscular) n pain all over really (0.7) My wrist is
atrocious n (1.5) breakin out(3.0) badly. . .

Extract 37: RF-NP-6-9-00

1	Hom:	So. (0.2) well I know we've- sort of (0.2) gone
2		ove[r
3	Pat:	[Hm:
4		(0.5)
5	Hom:	the- (.) gist of it <haven't we> on the- phon[e
6	Pat:	[Yes
7		(0.3)
8	Hom:	B-I-mean do you - want – to –jst-
9		(3.0)
10	Pat:	°Wheh°-I-mean-yea-a-yeah- a-yes=
11	Hom:	=Ye[s
12	Pat:	[i-i- it's mainly menopausal (0.3) °a-yes°-erm I've
13		c-urm (0.5) I've come off h-r-t (2.2) ^tk ·hh and I was
14		already concerned about the flushes coming back. . .

All three of the above extracts can be categorised as being of an 'open' format in the sense that the initiation turns utilised by the homoeopaths have non of the directness or focus that can be a feature of allopathic encounters (See: Robinson (Forthcoming)). The approach that is evident here, while aimed at stimulating the development of broad patient narratives, involves the deliberate avoidance of an enquiry formulation that might transmit any expectations relating to the form that these narratives might take, or the specific content they should include. (There is a striking difference between the way that these turns are formulated, for example, and the more allopathically generic '. .What can I do for you. .', or '. .What seems to be the trouble. .' etc.) (See: Robinson. J. (Forthcoming); Heath,1981.)

The initiation turns (highlighted areas on the transcripts) contain a number of common features: Firstly, they all have an initial element which serves to delineate them from the preceding talk: in extract 35 there is '. . right, so -<so over to you>. .' (lines 3 and 4); extract 36 has '. . Right. Jus-. .'(line 6), and the homoeopath in extract 37 utilises '. .So: .' (line 1). These topic closure / transition markers are possibly more relevant in extracts 35 and 37 because with these first-time patients there had been a significant amount of talk prior to this point that covered the principles of the holistic approach – although nothing specifically relating to how the patient should proceed once the

consultation was underway. Being a second-time encounter, the talk that preceded the initiation question in extract 37 was of a more brief and general nature. These transition markers, while being completely unremarkable and conventional ways for a participant to introduce a new topic (See, for example: Button and Casey, 1996), are significant in the context of a holistic encounter because they represent a point when the homoeopath needs to overtly direct the interaction – something that where possible, they generally try to avoid. (See chapter 6 of this thesis for a discussion of the management of other transitional phases in the consultation.)

The second commonality in these turns relates to their overall construction and the contrast between the directness of the delivery of the initial element and the fractured nature of the following talk. In all three cases the main body of the initiation turn is significantly delineated by a high degree of hesitancy, extended pauses, false starts and other perturbations. This is particularly evident in extract 35, for example:

From: RF-J-19-06-00

3		. . . .([]).hhh – Right, so - <(so over
4		to you)> so I mean- [I know you said tht - it's-
5	Pat:	[Right.
6		(0.8)
7	Hom:	y'know
8		(0.5)
9	Pat:	Yea.
10	Hom::	periods- period related, so d-do you want to ([])just-

Following the decisive '. .Right, so. .' on line 3, the remainder of the homoeopath's turn has a much looser and disjointed quality.

The third common feature is the way in which the initiation turn is left 'hanging', that is, the terminal elements are left incomplete. In extract 35, the homoeopath's turn fades out with '. . so d-do you want to just- .' (line 11), and similarly in extract 36 there is 'Right. Jus- (0.3)' (line 6); extract 37 has '. . B-I-mean do you - want - to - jst - . .' (line 8). This apparent reluctance fully to complete the instructional element of the turn, and concretise its meaning

may, again, relate to the underlying holistic influence of patient-centredness – the homoeopath, in trying to ensure that every aspect of his or her behaviour in the consultation is as 'un-authoritarian' (this may perhaps be too strong a word) as possible, finds that even unavoidable functional instructions such as these openers become locations for the avoidance of directionality.

Trouble

It is mainly as a result of the open and non-directive nature of the initiation turns in the three extracts that significant interactional misalignments develop between the homoeopaths and their patients. There is no smooth transition into a patient narrative. In extract 35 'trouble', in the form of difficulties for the patient, begins to occur at line 10 as she attempts to frame a reply to the homoeopath's initiation turn. It can be seen that although she begins to speak, her 'Right (0.2) erm:' dissolves into a lengthy pause (4.5 seconds on line14), from which the homoeopath is forced to initiate a repair turn: on line 15 she suggests some topics that the patient might like to talk about:

From: RF-J-28-19-06-00

15 Hom: I spoze really -it's really (1.0) a-h. –things
16 like –we-h-a-how did it <u>begin</u>, do you want to tell-
17 explain where: -how long ago:-

Even the fairly broad directionality of this turn, however, appears to be given with a degree of reluctance. There is no straightforward assertion such as 'why don't you tell me how it started.' Instead, the homoeopath approaches the turn in an oblique, almost vague way; '. . I spoze re:ally. . . .ah-h· -things like. .' etc. This does to some extent retrieve the situation, but there is still a sense that the patient is having difficulties in the construction of her subsequent turn, indicated by the extended pause that precedes it (line 18).

The situation is similar in extract 36. Here, the homoeopath's initiation turn is initially extremely attenuated: 'Right. Jus- (0.3) how y-been really.' (line 6), the patient displays a degree of uncertainty: ' (Hu)h - hm it-.' (line 7), and the homoeopath initiates a repair turn that helps prompt the patient to begin a narrative. In this case, the repair turn shifts the focus of the encounter away from the symptomatic by invoking more of the patient's life-world experience – the initial prompting turn by the homoeopath '. . how y-been really.' (line 6) has an implicit focus on health and well-being, while the repair 'Go on. Go-a (.) <tell me> what's been happenin.' (line 9) has a broader holistic inclusiveness.

Extract 37 is very much like extract 35 in that 'trouble' initially begins to be evident in the form of an extended pause. Here, this occurs after the homoeopath has finished a 'hanging' initiation turn (line 8). In this case, however, although the patient displays a degree of uncertainty and discomfort as she eventually begins her narrative: °Wheh° -I-mean-yea-a-yeah- a-yes. .' (line 10), the homoeopath does not attempt a repair or clarification, but instead lets the patient work her way into her narrative, which becomes more coherent and less hesitant as it develops.

It can be seen, then, that if a homoeopath adopts an overly open approach with a patient who is relatively new to the holistic process, there can be the danger of interactional misalignment, and, ironically for a system that relies so heavily on the natural development of the patient narrative, the attenuation of free flowing and subjective talk. With patients who are familiar with the dynamics of the consultation process, however, the situation can be completely different. Still focusing for the moment on the way in which patients are prompted to talk at the start of the consultation, the following two examples involve 'expert' homoeopathic patients who have been attending for some time:

Extract 38: DF-B-03-06-00

1	Hom:	·hhh h. –okay Barbara ·hh
2		(1.0)
3	Pat:	Well ·h you know-erm (0.8) I took the sulpur
4	Hom:	Yea=
5	Pat:	=when I came to yah
6		(.)
7	Hom:	Yea
8	Pat:	·hh and- (2.0) got some aqua cream (0.4) instead
9		of[that other
10	Hom:	[Oh yes
11	Hom:	<Yea>
12	Pat:	and that- n-e (0.3) that really has done well. . .

Extract 39: JS-JP-31-10-00

1	Hom:	Right Hannah, so
2		(1.0)
3	Pat:	Funny times I've been [having
4	Hom:	[Tell me about these funny [times
5	Pat:	[Oh::↓
6		(3.0) ((patient consults notes)) right where are we
7		(5.0) Right I came to see you on the Tuesday (0.8) the
8		third of October didn't I. . .

The difference in the interactional qualities that these extracts have when compared to the 'new-patient' examples is striking, and apart from their direct relevance to the onset of patient narratives, in many ways they seem to capture the essence of the holistic consultation. Firstly, in both cases the opening, or narrative initiation turns that the homoeopath utilises are extremely minimal: '. . – h· -okay Barbara ·hh.' (line 1, extract 38); 'Right Hannah, so.' (line 1, extract 39). The initiation turns here have virtually no instructional or topically directive element, and serve only to denote a boundary between the preceding casual talk (un-transcribed, but relatively brief in both cases), and the formal start of the encounter They simultaneously project that the homoeopath is ready and attentive, and that the patient 'has the floor'. In their brevity, the turns also exhibit a quality of non-assumption in the sense that they do not implicate that medicality, symptomatically focused information, or any other issue directly related to the

patients' original presenting complaint should necessarily inform their narratives. The formulation of the turns reflects an underlying holistic perspective; the homoeopaths are not displaying any expectations relating to the current symptomatic state of the patient and there is nothing as explicit as 'how have you been', or 'how do you feel' etc., which might conventionally form part of a medically oriented repeat visit opener, and perhaps indicate a preferred response. Similarly, without these kinds of focusing elements, the patient is released from having to begin their narrative with an assessment of their 'progress' in symptomatic terms (although, of course, the open formulation means that they are free to do so should they wish). They are effectively free to start talking about anything that concerns them; 'anything', from a holistic perspective, being as relevant as any purely 'medical' information they may volunteer.[27]

A second significant difference between these narrative initiation sequences and the earlier extracts is the way in which the dynamics between the homoeopaths and their patients appear to be extremely well tuned. There is little evidence of hesitancy or misalignment from either party in either extract, and the overall impression is one of participants who are familiar and comfortable with the interactional environment in which they are working. After the apparent ambiguity of the initiation turns, both patients immediately take the initiative and proceed to embark on their narratives (which, as I shall explore in the next section, do in fact initially focus on symptomatic and health related topics). They exhibit none of the apparent difficulties exhibited in the 'first-timer' examples. The patient in extract 38 for example, begins with a very definite 'Well' (line 3), communicating her active engagement with the role of current speaker, and, although the details of how she will formulate her account are not concretised at this point (note the 0.8 second pause after '. . you know-erm. .' on line 3), she appears to have a clear idea about what she is going to talk about and where she wants her narrative to go. There is

[27] In my own experience as a homoeopathic patient I have encountered initiation prompts that are even more attenuated than these examples. On occasion, no words at all have been spoken by the homoeopath and the cue to begin has been nothing more than a nod and a smile.

no evidence indicating a reticence relating to whether or not it will be something the homoeopath will be interested in (whether it is 'doctorable') (Heritage, 2000) – her account begins strongly and proceeds to develop into a coherent narrative. (This contrasts sharply with the new patient in extract 37, for example, who, after a delay of 3 seconds responded to the homoeopath's initiation turn with a hesitant: '°Wheh° -I- mean-yea-a- yeah- a-yes. .' (line 11).

In the second example (extract 39), the ease with which the patient takes control of the direction of the interaction is even more striking. Her narrative opening turn 'Funny times I've been having' (line 3), like the one utilised by the patient in extract 38, communicates both a certainty of topical intent (indicated, for example, by the absence of any hitches or hesitations etc.), and an underlying familiarity with the narrative based consultation format; her turn unequivocally generates the expectation of 'details to follow', and is grounded in a knowledge of holistic expectations (in the sense that 'funny times' hints at a wider life-world perspective that incorporates other experiential issues along with the purely symptomatic.) Similarly, the homoeopath, on line 4, responds in terminal overlap to this opening turn with 'Tell me about these funny times', demonstrating a close alignment in both topical and functional terms; she prompts for continuation without attempting to narrow the patient down onto specific elements, communicating that, whatever the patient is about to say, it will be treated as relevant and interesting. The patient's turn beginning on line 5 (again, representing a close functional alignment by being produced in terminal overlap with the homoeopath's prior turn), is also interesting; as she embarks on the body of her narrative, she makes overt reference to notes that she has prepared – presumably made during the period between her last visit and the present one, and again, this exhibits in a very practical way that she is comfortable taking the initiative in guiding the direction of the consultation. [28]

[28] This particular extract has similarities with the *reversal* format of treatment offering discussed in chapter 6, in that the interaction becomes 'open' or collegial to the point where the patient offers sequences of talk or action that, in a more conventional arena, might have been readily attributed to the practitioner. In this case, for example, the patient produces and refers to her own set of detailed case notes and uses them to

These two opening narrative initiation sequences, then, and the 'new-patient' ones that preceded them (extracts 35, 36 and 37), illustrate the significant difference that socialisation into the holistic consultation process can make to the way in which patients begin to construct their narratives. With a long-term patient the homoeopath is able to effectively design an initiation turn so that it embodies a genuine sense of holism; they can be actively non-directive and non-assumptive to a degree that, as was illustrated in the earlier extracts, creates immediate misalignment and interactional difficulties if the patient does not know how they are expected to proceed. Ironically, this can produce a situation in which the homoeopath, in trying to make the interaction as un-directed as possible, actually creates a situation in which the patient may be forced to fall back on the consultation model they are familiar with – hence the symptomatic and non-subjective focus evident in the initial narratives of some first-time homoeopathic patients.

Longer narrative features

Finally I would like to move on to examine some of the characteristics that delineate homoeopathic patient narratives as they can occur in the body of a consultation – particularly focusing on the structure of accounts given by the more 'experienced' patients I was able to study [29] – and how the results of holistic socialisation can be tracked through the broader trajectories of the talk they produce. The next example, which incidentally comes from a consultation involving the same homoeopath as in extract 34 (though with a different patient), exhibits a number of significant features that I found to be common to these kinds of homoeopathic encounters:

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inform the direction of the consultation. In a conventional primary care consultation this would be unusual. The nearest approximation to this behaviour that I was able to observe, for example, occurred at a specialist diabetes clinic where patients were encouraged to keep a record of their diets etc.

[29] 'Experienced' in this context meaning that they had been to at least three or four homoeopathic consultations.

Extract 40: RC-DR-28-03-00

((Hom confirms patient is happy being recorded))

Hom: . . . so we're gona kick off anywhere you want really
(1.5) (Jus[t)
Pat: [The last time I seen yus (1.0) remember y'ses to me teh- (1.0) teh try to get to know myself
(0.5)
Hom: Hm (0.8) h-hm
(0.4)
Pat: For some reason (3.0) I couldneh get to know my self
Hom: H-hm
(1.5)
Pat: °(?)° (2.5) (I thought) (1.3) I was (0.7) maybe getting to know James ((patient's brother who died as a child))
(1.0)
Hom: H-hm?=
Pat: =(looking) for James
(0.4)
Hom: H-hm
(1.5)
Pat: an I –I just <I just> don't-s don't want to find out merh n merh about him (1.3) and I-f:-I've found out a lot about him (0.4) then eventually we had a- (0.8) the two of us had a set to if you want to put it that way
Hom: H-hm
(2.5)
Pat: And it came out (0.3) well he-(1.4) he told me all the pain and all the rest tht I've been getting over the years that he's caused it (2.5) an it's throu:gh (1.5) when he died (0.8) meh father (0.8) like (0.3) doted himself on James (0.9) he ws never away from his grave (2.0) and when (.)I was born (.) meh father stopped going to see him (5.5) and he flashed through all the things that I'd done when I was young – y'know the- (1.3) jumps that I should never have done (2.0) an he says bt- he says just think he says you w'r urged on to do them (??) something urged me on to do these things (1.2) he says but me urged you on to do them (1.5) all the (??) that you've (??)I-I've forced you to do them (2.5) then he- (1.3) he started screaming out for my ma (1.3) and I sort of explained to him that sh- (0.3) y'know tht she'd died? (1.2) he said she's the only one who can take the pain away (2.8) and then he left me at that and then he came back an says (1.8) I want you to show me where I'm buried (1.4) an-eh that was november and I've (0.5) I've had neh (more) touch with him since
(1.0)
Hom: H-hm (0.4) h-hm
(2.3)
Pat: But ((unclear)) I wonder if (.) maybe I'm carrying his pain? (0.7)
Hom: H-hm?
(1.0)
Hom: Cos he had a bad right leg and (0.8) ^m-h·y right leg is

52 bad
53 (0.9)
54 Hom: H-hm (1.8) °°h-hm°°
55 (0.3)
56 Pat: (He had) walking sticks (1.9) until he died
57 (3.8)
58 Hom: °°Hm°° (4.0) what do you think? (1.2) what is your deepest
59 instinct at the moment
60 (1.2)
61 Pat: Well I think he's there
62 (1.5)
63 Hom: Right (0.5) okay=
64 Pat: He's definitely there . . .

Embedded symptomatic reports

A significant interactional characteristic that is closely related to the process of holistic socialisation, and which to some extent begins to become evident in extract 39, is the way in which descriptions relating to specific symptomatic anomalies appear to be more recognisable as primary topics in the narratives of 'new' patients (see extracts 34, 35, 36 and 37). In many of the consultations of the 'experienced' I was able to study it appeared that, as they became more familiar with the homoeopathic / holistic approach (over a number of encounters), the presentation of specific symptomatic information took on a less prominent position relative to other life-world detail.

Once the (socialised) temporal pressures of the conventional consultation have been superseded by an environment in which subjective exploration is actively encouraged, the introduction of new symptoms, and updates on the progress of old or ongoing ones, can begin to take on a more integrated position within the narrative. Similarly, the introduction of relevant 'doctorable' symptoms by the patient (an activity that in the allopathic environment is routinely regarded as central to the business of the consultation, and generally occurs at the start of an interaction) can be observed happening at various unpredictable points along the span of the whole consultation, rather than only as its initial focus.

For this patient, the invitation to '. . kick off anywhere you want really. .' (line1) presents no problem. Unlike in extract 34 (which, it will be remembered, was with a first-time patient) there is no indication that he is uncertain about the way his presentation should proceed, in fact, he overlaps the practitioner on line 2 at exactly the point at which a well synchronised conversational turn would begin (at the terminal position of 'Just'). What the patient chooses to begin with does have a topical connection with something that was discussed in their prior meeting:

From: RC-DR-28-03-00

3 Pat: ([)The last time I seen yus (1.0) remember y'ses
4 to me teh- (1.0) teh try to get to know myself

However, this is apparently not an issue that has an overtly symptomatic relevance. (The patient's original reason for visiting this homoeopath related to the onset of intense and debilitating cluster headaches, and was not ostensively related to the personal development work that the sequence appears to be concerned with.) It is immediately apparent too, that the patient is comfortable incorporating psychological (or even psycho-spiritual) elements into his narrative. These too are seemingly introduced without any particular concern about their symptomatic relevance. There are, for example, no hitches or perturbations associated with the turns in which the patient embarks on the topic of 'getting to know' his deceased brother, and this sequence of talk (beginning at line 11) is presented in an unproblematic and direct way; it has none of the 'accounting for' or 'justification for presenting' that might be expected to accompany such a statement, had it been given in a conventional medical setting. (See: Herritage, 2000.) The hitches and perturbations that do occur in the narrative, most notably around lines 19-20: '. . an I – I just <I just> don't-s don't. . . I - f: - I've found out a lot. .' are not associated with a recognition that the story may be unusual, or have questionable relevance, they are, rather, indicative of the patient's fears and concerns as they relate to the narrative topic itself – at this point the patient is struggling to express a sense of confusion and unease, rather than conceal one, and the presence of perturbations is an expression of this.

Symptomatic information, however, is embedded within the narrative. In this case it can be seen surfacing around line 51 as the patient refers to his 'bad leg':

From: RC-DR-28-03-00

51 Hom: Cos he had a bad right leg and (0.8) ^m-h·y right leg is
52 bad

This reference follows the main body of the opening narrative and is the first reference that the patient makes to a relevant physical symptom. It is, however, presented obliquely as an incidental detail arising out of his account so far – there is little sense of his narrative being constructed in order to prepare the ground for its delivery. This embedding effect appears to be a recurring feature in these kinds of accounts – once patients have become allopathically de-socialised enough to regard symptoms simply as relative elements in a holistic framework (i.e. no more or less important than anything else) they start to incorporate them into accounts of a more general nature – particularly ones that relate to their wider ongoing life-world experience. A much more striking example of this kind of symptomatic embedding can be found in extract 41 (below). This relatively long extract is given to illustrate the temporal positioning of embedded symptomatic elements in the context of an ongoing narrative. The account comes from midway through a consultation and the patient has just finished reporting on the effectiveness of a remedy prescribed for her during a previous encounter:

Extract 41:: DF-B-03-06-00

1 Pat: . . .however (0.5) it has got a lot better (.) but you
2 know you said to me ·hh (0.2) about stress- (0.2) have I
3 got any [stress
4 Hom: [Oh::: yes (0.2) we did yes
5 (0.3)
6 Pat: Right (.) well ·hh I-mean-a you said- your family or you
7 know is there- ·hh an I mean there really isn't we're all
8 -you know that's all okay that ^tk (1.0) but (0.4) ·hh I
9 did say to you about (1.2) the heath °didn't I° Bradford
10 health authority ·hhh

(1.2)
Hom: ·hh Yes
Pat: Well (.) I'm [still arguing (0.2) arguing the toss with=
Hom: [tell me more
Pat: =them ·hh (0.5) er:m (0.8) I've had a go this morning (0.4) erm (0.2)they're really quite intransi- transigent ·hhh and I do find that when (.) I do that my face goes right hot
Hom: ·hhh (0.7) ^k-oh[::?
Pat: [Now, I first noticed- my face going hot when- last- (0.3) you know the first day of these- floods sort of thing
(0.5)
Hom: Yes
Pat: I think it was last Monday ·hh now I didn't have my own car ·hhh it was in for servicing I had this- (1.0) car
Hom: What a courtesy car
Pat: Yea courtesy car
Hom: Yea
Pat: Yea ·hhh now I'm not that bothered about driving- any other car and we've a (.) a- reasonably big car (0.3) so I'm not bothered that much (0.2) but you're never quite the same are you
Hom: No
Pat: ·hh well I set off to go to work (1.0) got to a road and I couldn't- couldn't go on it I was blocked off because of the water you see the police were there- had to go back ·hh so (0.3) I'm frantically thinking where (0.2) am I to go – you know this kind of thing which is my best way to go now °and so on° ·hhh and I got there- (0.2) okay (1.0) ^tk now then at night coming home (1.2) ·hh I thought I was doing really well ·hh and then they turned me back in Ilkley again and it was dark (0.3) by this time ·hhh and- (1.0) so I had to go down the middle of the road- he told me I had to go back to Menston well there was a right long queue at Menston ·hh so I went down towards Otley- when I went down to Otley (0.7) the road that I was going to go on- that was closed ·hh so I had to go right into Otley- I thought well the only way across is to go across the back road- you know across to (Weston)·hh <so I had to go> well I could feel that I was getting hotter (0.2) and hotter (0.3) because I were getting –agitated ·hh because (.) you know ·hhh I'm thinking I've got tis blummin car-oh and I had to get it back f:-S:-·hh f:-six o'clock (0.3) well I didn't do- I mean I didn't get [back while nearly seven o'clock ·hh=
Hom: [Right
Pat: =I was supposed to be getting it back for six o'clock (.) I rang Alan and said will you ring (0.4) the garage and tell him that I've been cut off-you know tht-I-I'll but I'll try and get it back cos he'd said will you try and get it back for six o'clock – he'd wait till six (0.8) it was absolutely belting it down ·hhh I went across °the°- I don't like this road anyway cos it's all narrow and it's dark and there's no light- and by the time I got

across I was really really agitated I'm going through (1.3) big er:m puddles of water and so on ·hhh and my face (0.4) was just burning (0.3) just burning (0.2) absolutely ·hhh (0.3) er:m (0.2) so then (0.2) erm (1.0) I noticed I- (0.2) we're also arguing about residential parking at our place ·hhh ([see-)

Hom: [Who are you arguing with?

(0.3)

Pat: Bradford council

Hom: Oh righ[t

Pat: [They've done this study- three years (0.8) and (0.4) it's (1.3) °th-°they've now they've (1.2) they've done all the tests (0.2) they were going to put in a sort of- use the national scheme in Bradford ·hhh and everybody in Bradford that (0.6) fulfilled the criteria would get residents parking (0.4) °cos (.) it's hopeless for us° ·hhh (1.0) we fulfilled it (0.3) they were going to start doing it but then we've ch- had a change of council ·hh and the chairman has decided that-that she want's a new scheme (.) after three years ·hh well I'm- (1.0) I-I rang up the chap who's dealing with it and I mean he's as frustrated as I am ·hhh I said they're a waste of money- you now it gets-it really gets to me does thing like this ·hh[h it really-it don't get to=

Hom: [H-hm

Pat: =anybody else but I- I just think all this injustice- y-know ·hh it's just silly (0.2) er:m

(0.3)

Hom: What this injustice d-you say?

Pat: Yea ·hh [I mean it is int it ·hh and-an the stuff (0.2)=

Hom: [Yea

Pat: =wasting money (0.2) like that

Hom: Ye[a

Pat: [they reckon they've no money ·hhh and it's just the same with the national (0.4) health this- (0.2) you know this thing that I'm arguing the toss with them at Bradford ·hh now Bradford health authority would pay for me to ·hh but my- my- (.) my primary care (0.3) trust (0.2) won't (2.0) the pri- the Bradford health authority said for me to go to Liverpool (.) I went to Liverpool (0.5) the primary care trust have just ignored everything that that man said-just ignored everything

Hom: Because they don't like it?

(1.2)

Pat: Well they keep (0.2) I mean they- the stock phrase is they come out with ·hhh well it's not proven? (2.5) it's not proven ·hh so I-I've just rung up this morning now there's a really nice person at Bradford health authority (1.2) and she gets all my moans ·hhh and I said-I said to her but ·hh (1.5) y-mean-s- y-know I said what I can't get is (1.8) the tablets are proven are they (0.3) these that have all these side effects (0.2) like I said I- I was seven months wh- (.) bloated my hair wouldn't grow ·hh my bones are big ·hh because- (1.0) ye-I took the- the (0.3) er:m

Hom: Stero[ds
Pat: [steroids
Hom: H-hm
Pat: ·hh I said that's proven ·hh and I said at least if you take homoeopathy ·hh and it doesn't work- fair enough it doesn't work ·hh (0.8) you try something else- but at least you've not been messed about inside your body your whole system's not- (.) you know ^tk-·h[hh
Hom: [It is proven by the way
(0.9)
Pat: Well evidently (0.5) they've told me in a letter that the medical journal this month (0.3) has said that there's no: (0.4) no evidence
(2.4)
Hom: there's plenty of back ish-back issues and articles and back issues of the B M J ·hh that say that there is? evidence
Pat: Right well
Hom: An:d the- there's a- (0.4) chap at the- (0.3) er:m (0.8) Glasgow homoeopathic hospital who's done lots of research and has published research (1.8) °so-°
Pat: Well (.) I mean they just tell- ·hh this is it you see they put the same thing down every time (0.8) you know ·hh er-and-and this is what's making me mad – it's really getting to me I'm re-·hh (.) a-an Alan said well just forget it, just pay (0.8) but (0.5) I feel (0.4) I feel it's wr- (0.4) I feel it's wrong (1.0) I mean Alan don't m- (0.8) he don't think I should be arguing he said just give it up ·hh (1.3) I-d-I- can't it's part of my (0.3) makeup (0.4) and I-d-I just (.) argue but ·hh I think it probab- ·hh that probably made me s:- (1.0) me:- stomach bad (0.4) <·h> plus the fact that- (0.5 the garage at the end of the road are- (0.7) er:m (0.3) I had a big argument about that you see (.) the building of that and (1.0) we had it ref- not just me I mean it was the whole road but ·hh things like that just get to me er:- (3.2) so I'm-I'm (1.0) I'm going to have t- (.) try n- (1.0) forget it but you see (0.2) my face gets right- right hot though I've never been hot ·hh I've always been cold (0.3) my fingers are cold now but-
Hom: So you think it's when- d-you get - hot when you're angry as well so [like
Pat: [Yea
(0.3)
Hom: when they come back to you it's <it's never been> not proven do you get angry
Pat: Yes, I do (0.2) really really angry
Hom: Right (.) I don't want to be putting words into your mouth
Pat: No I get angry
Hom: Yea
Pat: Can't- (2.2) they don't answer things proper- you know ·hh they just put the same thing time- you write a letter to them ·hh and you ask them a question ·hh

176 ask them a question and they just put-come out with the
177 same – thing again and again and again ·hh and they
178 won't- (2.0) they don't (0.2) take what you've said ·hh
179 (0.4) and work on that (0.5) they just (0.4) they just
180 reiterate. . .

This extract, which runs for well over 8 minutes, is characterised by extended sequences of uninterrupted talk in which the absence of verbal continuation prompts by the homoeopath is striking. Although he might have given non-verbal prompts this particular consultation was unfortunately not video recorded. The sequence starting at line 35 and running to line 71 is a good example, as are the blocks of talk from lines 76-94, and 143-61. Initially, this patent's account has functional qualities that are very much like those of the allopathic narratives given earlier (extracts 32 and 33). The sequence that runs from line 1 through to line 18, for example, is relatively self-contained and symptomatically focused. The patient begins by displaying her reasoning behind giving the account. In this case, as in extract 40[30] there is an overt reference to the narrative being connected to something that the practitioner has mentioned at a prior meeting:

(From: DF-B-03-06-00)

1 Pat: . . . .it has got a lot better (.) but you
2 know you said to me ·hh (0.2) about stress- (0.2) have I
3 got any stress. . .

This has the effect of framing what is to follow as something 'doctorable', illustrating that even in an environment where the patient understands that the homoeopath will treat anything they say as relevant, there is still perhaps an underlying need to anchor the narrative in a framework of accountability. By making reference to a request, comment or suggestion that the homoeopath has previously made, patients can effectively casts what they

[30] In extract 40, even though it quickly develops into something significantly more esoteric, the patient's account starts in a very similar way:

3 Pat: . . The last time I seen yus (1.0) remember y'ses
4 me teh- (1.0) teh try to get to know myself. . .

are about to say as an act of concordance, which helps to legitimise topical introductions that might otherwise be difficult to integrate.

In this extract, the relatively short 'pre-narrative' contains a complete and succinct summary of the symptomatic connections that the patient will subsequently develop during the narrative itself. The core elements of the account – what causes her stress, the observations about her face going 'red hot', and the relationship that these two elements have to one another, are already present. The trajectory changes, however, at line 20. Here, after the homoeopath displays a degree of surprised interest: '. .^k-oh::?' (on line 19), the patient embarks on a far more detailed and wide-ranging narrative account in which she introduces a succession of sequentially related, but apparently tangentially relevant elements. If the trajectory along which the narrative develops is explored, however, it can be seen that although on the surface it appears to be focused largely on descriptions of mundane events, there are embedded within it a series of specifically symptomatic references and observations. These serve to ground or legitimise what might otherwise be relatively superfluous (in medical terms) information. On line 51, for example, after an extended sequence in which she describes how she got lost coming home in the dark, the patient inserts:

(From: DF-B-03-06-00)

51 Pat: . . . ·hh <so I had to go> well I could <u>feel</u> that I was
52 getting <u>hot</u>ter (0.2) and <u>hot</u>ter (0.3) because I were
53 getting –agitated ·hh because (.) you know. . .

This relates directly back to the onset of the narrative where she mentions that her face ' . . goes right hot.' (line 17-18), and has the effect of re-establishing the medical relevance of the story. After continuing her account she returns again on line 67 to underpin it with a description of how she was '. . .just <u>burning</u> (0.3) just <u>burning</u>.' And subsequently throughout the rest of the extract there are three more occasions on which the patient incorporates specific symptomatic anomalies into her account. On lines 117-122 there is:

(From: DF-B-03-06-00)

117 ..... side effects (0.2) like I said I- I was
118 seven months wh- (.) bloated my hair wouldn't grow ·hh
119 my bones are big ·hh because- (1.0) ye-I took the- the
120 (0.3) er:m
121 Hom: Stero[ds
122 Pat: [steroids

Then, on lines 152-153, as she outlines her feelings of injustice and frustration: she makes connections between events and the onset of her stomach pains, and finally, on lines 159-160 there is a return to the initial topic of her face and how it '. . get's right- right hot. .'. These symptomatic fragments, although scattered thinly within the narrative, are sufficient to keep it within the realms of 'doctorability'. The patient is giving information that she sees as being relevant, and like the patients in the allopathic extracts I gave at the outset of this chapter, is utilising the story format as a means of presenting it as effectively as she can. The way in which she allows her narrative to develop such involved characteristics simply reflects the fact that she is less inhibited and displaying a high degree of de-socialisation from the convention of narrative attenuation in the medical encounter. It is also evident that she is orienting to a holistic perspective in which no single type of element (symptoms, for example) is given priority.

The therapeutic role of the narrative

For the long-term homoeopathic patient, the process of talking at length about life-world concerns can be a means by which deeper or more obscure psychological issues are allowed to surface, and the disclosure of this kind of 'submerged' information might be exactly what the homoeopath is trying to achieve.[31] In the same way that a psychologist may encourage a patient to free associate in order to expose an underlying complex, the homoeopath can utilise the details, inclusions and omissions that comprise a patient's narrative presentation in order to isolate relevant homoeopathic information of which the patient is unaware. The relative attenuation of continuation prompts

[31] From practitioner interview (homoeopath).

during some long narrative sequences (as in extract 41), and, when the homoeopath volunteers more significant turns, the tendency for these to be clarification requests rather than 'forensically' focused questions, is evidence of this occurring. Patients are then less likely to subconsciously tailor their narratives to please the homoeopath if they have no idea what it is that might be important. Experienced practitioners appear to be very adept at giving few cues or clues that might pollute the spontaneous integrity of the patient's account. They are similarly aware that they inevitably bring their own internal agendas, prejudices, and biases to an interaction, and that these can subliminally affect those details that they are likely to pick up on. If their responses can be kept to a minimum during periods when a narrative thread is developing there is less likelihood that they will influence the patient or disrupt the flow of subconscious cues – cues that will usefully betray deeper and more significant patterns in the patients 'constitution'.

The active attenuation of responses was highlighted by one of the homoeopaths in this study who described how, if a patient appeared to be 'hedging' or circling an issue, she sometimes held back from making any response when they had finished talking. The assumption was that without external prompting the patient would eventually introduce the topic that was really concerning them – even if they were largely unaware of it as an issue.[32] What is holistically relevant here is that although a homoeopath may know, or think that they know, exactly what the patient is struggling to communicate, by allowing elements to emerge gently in a form that is the patient's own (even if this involves an apparently rambling and irrelevant narrative journey) they can be more confident of getting to the root of the issue. Similarly, and possibly more importantly, if the patient has arrived at the point where they are comfortable disclosing what might be sensitive or painful information without overt prompting from the homoeopath, there is a sense in which the patient has more 'ownership' of the process – information has not been winkled out of them, they have, through their talk gradually revealed themselves at a rate that is entirely theirs.

[32] From interview data (homoeopath).

The following extract is another lengthy narrative from an experienced homoeopathic patient. It illustrates how minimal prompting can allow the gradual development of subtle and tangential details in a patient's account. The sequence is taken from towards the middle of a consultation and follows a section of talk in which the patient has been describing feelings of annoyance at her partner's behaviour:

(Extract 42: LH-GZ-1-12-00)

1	Hom:	. . . have you got an example of that?
2		(1.2)
3	Pat:	Er::m (1.2) well probly if he'll say like- erm (0.6) well
4		like the other night I made a cup o tea right (1.0) en-en
5		I was:-a (0.2) like you do I was in't middle of bathing
6		kids wih two (<f'rit>)it were grace (0.2) Sarah's little
7		girl (.) stoppin fr a bath an fr tea (.) Rachael stopping
8		for er bath an for tea an my two °hh so I've got em all
9		in't bath so I've probably a bit understandably so-b he-
10		d-sez here's y tea °hh (.) an I said yea well I couldn't
11		leave em all in't bath cos they're little anyway she was
12		in °hh en eh-I said put it on the side an he came
13		upstairs an e sez thers's y tea an I just said Dave, yes
14		said I've seen the tea I said I can't – bath the kids an
15		av the tea <an e went> ohh for god's sake that's just
16		what I mean yu-yu so short tempered °hh but I was
17		actually doing (.) y'know what I mean (0.5) I was annoyed
18		cos e sort of couldn't see why I couldn't leave it an av
19		this cup o tea ed made meh (0.4) tk-°h (1.2) er:m (0.7)
20		I'm still never wrong-^k-hh°- h°-^bt I don't think we'll
21		cure that °hhh (0.8) er::m (2.5) Yeah now this is – this
22		is another issue °hh the kids (.) always come first (0.3)
23		I'm very well aware of this Dave says it's not a problem
24		(0.3) but I think it must be °hhh e-e-es-a he's-ort of
25		er: in my mind (0.5) e sort of (.) quite lags way behind
26		at the end of the day he should be sort of up there with
27		um: (0.8) °hh (.) y'know I said to im before it's not a
28		case that I love them more °hhh (.) bt they're so
29		defenceless but I do: °e°-eh (.) I don't know everything
30		sort of seems to revolve around children y'know [what I=
31	Hom:	[Hm
32	Pat:	=mean (0.3) en basically if I av any time left for him at
33		end of ut'day and any (0.5) energies to bother speaking I
34		do but otherwise i-it's: (0.7) I don't know I can't
35		explain that really d'y'know what I mean?
36	Hom:	H-m?
37		(1.0)
38	Pat:	Y'know an e- I sorta °hh (1.3) like the other week we
39		were avin er:m a bit of an argument an-i-an-i said I

can't cope wi this cos kids mek (.) noise on a night like
they do an im being like he is (.)drives im barmy °hh (.)
so I just said to i- well (.) go I said if you can't cope
with it go (0.8) an-er: (0.3) i said what d'yu mean wh-
(.) oh no e didn't (.) e-didn't say any thing an a bit
later on I said to im (1.0) I said something about it
again e says (0.2) no- d-you can't tell me to get out of
my house I said where am I gona go Dave- two kids and
two dogs he said ↑were you that serious I said wul °hh e-
y'know I said e-we've got children Dave I said at the end
of the day I can't stop em being quiet they're children
°hh an I said if you can't cope with it (0.2) I can't
(0.2) cope wi the next twenty years of y moaning n you'll
af to go °hh an I said to im w-h-^worrying thing is °hh
the next day e said to me I'll ring mi dad an see about
goin an I thought oah (.) I-d-a really don't want- (.)
y'know obviously (.) I don't want im to (0.8) but I said
to mi mum before we have the kids an they've been (.)
devastated °h whereas now I tend to think °hh (.) well
I'd be devastated but I've got me kids sorta thing
(1.7)which as I say is e-im b(e must be ? ?)
(3.5) ((baby cries – pat tends to it))
Hom: So has e mentioned it since
(1.2)
Pat: Goin?=
Hom: =Hm
Pat: No becus we went out f'ra: if-i- I dropped im off at work
an e said to me I'll-I'll phone mi dad and see what (.)
what ow the lands layin for me goin ome (1.0) an I said
e-because we'd been -bickering cos e's not working again
either
Hom: Righ[t
Pat: [at the moment (0.5) e's actually waiting for
something to come up which should start within er nother
fortnight (1.0) erm (0.7) so we've been [sort of just a
Hom: [You've been
bit on at each oh- oh no=
Pat: =we've been just a bit on at each othah (1.0) an-eh (0.3)
so I've just said to im well don't you think we should
talk cos we always do that's one good thing we always –
discuss everythin °hh I said well w-don't you think we-d-
should discuss this °hh he said well you've made it (.)
perfectly clear ow you felt I know when I'm not wanted
(0.8) an e said I'll so I said no we'll discuss it n-so
me mum had kids we went out an we just sort of discussed
everythin °hh (0.7) w'll probly it's happened really
since((child b))'s been- y'know like talked over
everything th't wiv- th't wiv both felt so-i °h sort've
cleared air n wi-were- wir a lot better now (3.2) bur I
said to im I am aware that I'm like this hi said w-yea
but it don't bother mi e-(js / <usually>) stuff like that
because (0.2) they are kids an they do tek a lot of time
(0.6) I said yea they do I said but at the end of the day
one of the most important things for them (0.5) t-me when
I think of aving children is avin a mum an dad together

95 Hom: °Uhu°
96 (1.2)
97 Pat: Y'know I said it's alright givin them all this time
98 playin n: doin things with them but e-if-y- if e-the
99 dad's not here (0.8) y'know basically [obviously=
100 Hom: [Yea
101 Pat: =it's-a big (0.8) a big thing you're sort of messing up
102 Hom: Did you say you were sorry for saying that or weren't you
103 sorry for saying it
104 (1.6)
105 Pat: What to go? no cos that's how I felt at the tim[e
106 Hom: [Right
107 Hom: Did you tell im you don't want im to?
108 Pat: Oh yea (0.7) yea an a s- y'know I said a do 'hh a said I
109 love you as much as I ever did an I s:- I sort of still
110 s:- (0.4) e- when I'm imagine uz gettin old I still (0.2)
111 I can't imagine life without you an I always see 'hh if I
112 think like when I'm sixty 'r seventy I see im with meh
113 Hom: Righ[t
114 Pat: [which is ow I would want it
115 Hom: Hm and you told im that
116 Pat: Yea=
117 Hom: =Oh right
118 (0.5)
119 Pat: Yea (2.0) er:m (1.2) NO interest –e-ya-this was the
120 other [main thing as well no interest in sex AT all it
121 Hom: [Yes it were yea
122 (0.2)
123 Pat: wouldn't bother me if somebody told me I'd never av sex
124 again (2.3) ju-it just seems (0.9) too (0.6) much ^h-en-
125 ergy an- ^effort (.) 'hh (1.9) er:: (0.7) I don't know
126 whether it's cos I'm-I'm tired getting up with Anna or: -
127 b-I- yea I've just n:ot- no interest at all.
128 (3.0) E[r:m
129 Hom: [How long's that been
130 Pat: ^K'hm=
131 Hom: =Really since Anna=
132 Pat: =Probably since Simon yea now with Anna(0.8)<as I say I
133 w- I-was> feeding im a lot less cos I do have this
134 trouble with disociati- cos wi mi breast feeding (0.8) I
135 av a big (0.2) thing I- I'm sort've (0.8) mother plus
136 she's-a-she's-a s-still in our bedroom cos we separated
137 the bedrooms an that's another thing (0.9)if she whimpers
138 or if there's any (0.6)if there's like a toy at the side
139 of the bed a child's toy (0.5) a-f-
140 Hom: Right
141 Pat: can'[t
142 Hom: [Right=
143 Pat: =no: (.) y'know all-toys are to be moved away int lounge
144 they've all to be int toy box I can't-erm (0.9) I can't
145 seem to sort of swing mi mind round ter=
146 Hom: =Righ[t
147 Pat: [ter that way of thinking if there's any sort of
148 sign of them
149 (0.5)

150 Hom: And she's a-still in your bedroom
151 (0.3)
152 Pat: Yea

In a way that is analogous to extract 41, this narrative sequence is characterised by extremely long runs of uninterrupted talk by the patient. Similarly, the turns which the homoeopath makes once the narrative is underway are relatively attenuated; once she has prompted for '. . .an example of that.' (line 1) she limits her input during the first few minutes of the account to 'Hm' (line 31), and 'H-m?' (line 36). She does not initiate her first full turn '. . .so has he mentioned it since.' until line 62, and this takes the form of a clarification request rather than any attempt to divert or focus the patient.

Although this narrative does not have the same level of regularly embedded symptomatic information as extract 41, the patient does ground her talk in the 'issues' that are bothering her. In this case, it can be said that the patient's complaint is relatively psycho-spiritual in nature, so here, for symptomatic anomalies we can perhaps substitute 'life-issues'. About a third of the way into the first continuous narrative block (lines 3-61), she introduces a problem she is having that relates to the amount of attention she has been giving her partner: '. . Yeah now this is – this is another issue ·hh the kids (.) always come first. .' (lines 21-22). These lines come during a sequence of talk in which she describes a specific incident involving herself, the children and her partner – that is, they arise out of and are topically connected to the initial account and become elements of the ongoing narrative. Just prior to their introduction, however, there are indications that the patient has finished part of her account – she delivers a mini-summary and leaves significant pauses that might otherwise have prompted the homoeopath to take a turn:

(From: LH-GZ-1-12-00)

17 (Pat:) . . . . . y'know what I mean (0.5) I was annoyed
18 cos e sort of couldn't see why I couldn't leave it an av
19 this cup o tea ed made meh (0.4) tk-ˇh (1.2) er:m (0.7)
20 I'm still never wrong-^k-hhˇ- hˇ-^bt I don't think we'll
21 cure that ˇhhh (0.8) er::m (2.5) Yeah now this. . .

The 0.8 and 2.5 second pauses on line 21 are particularly significant because they follow an expression '. . I don't think we'll ever cure that.' of a figurative type often associated with topic closure (See: Drew and Holt, 1988), and signify a point in the talk where a response would have been appropriate. By holding back here and demonstrating a degree of active attenuation, the homoeopath encourages the patient to continue talking. This has the effect of allowing her to go more deeply into the real significance of the situation. It appears that the homoeopath deliberately allows the patient to continue talking until the mundane detail of the events surrounding the problem are exhausted and she can no longer avoid disclosing what is really bothering her. What the patient describes as '. . . another issue.' (line 22), is in fact very much connected to the events she has been describing. Had the homoeopath taken advantage of the turn completion unit in line 21, the underlying flow of the patient's narrative may well have been disrupted. The homoeopath, for example, did not attempt to explore the patient's anger about the incident with the tea (line 3 onwards) – something that might have been tempting for a less experienced practitioner. Whether or not she already sensed at this point that there was something deeper behind the patient's story is not clear from the data, but if we assume that this was the case her gambit here paid off. Rather than becoming sidetracked in an exploration of background details (the specifics of the incident), the patient spontaneously produced an embedded turn that subtly betrayed a deeper level of significance. The focus of the narrative shifts from a relatively insignificant description of tension in a relationship to something deeper – the patient begins to hint at more entrenched inequalities between herself and her partner. Active attenuation by the homoeopath is evident again at line 36. Here, as the patient struggles to articulate exactly how she feels about her attitude towards her relationship she says: '. . I don't know I can't explain that really d'y'know what I mean?' (lines 34-35). The homoeopath's response is simply 'H-m?' (line 36), she makes no attempt to reassure or prompt for what the patient might be trying to express. Instead, she leaves a 1 second pause (line 37) and lets the patient continue to develop her narrative.

I would like to suggest, then, that for the thoroughly socialised holistic patient, the account-giving process takes on a function that is structurally distinct from that of the allopathic or neophyte homoeopathic patient. There is, in effect, a shift away from the narrative as a subsidiary vehicle for interactional clarification (a tool for getting the relevance of symptomatic concerns across to the practitioner) and towards its development as a spontaneous therapeutic activity in it's own right – one in which symptomatic anomalies are only one of many possible relevant details. Presumably, although there is currently insufficient data to confirm this, there will be a continuum along which a given patient's narratives can be mapped, that displays increasing degrees of symptomatic embedding as their holistic socialising deepens.

Summary

This chapter has dealt with an exploration of the idiosyncratic role that patient narratives play in the homoeopathic therapeutic encounter. In allopathic medicine there are a growing number of practitioners interested in incorporating narrative as a therapeutic tool, and it is one of the activities at the forefront of moves toward more patient-centred medicine. I have examined some of the contrasting interactional behaviour that both allopaths and homoeopaths utilise to stimulate or attenuate the development of extended narratives, and these behaviours have been mapped on the structural progression of consultations. I suggest that in homoeopathy the level and formulation of spontaneous narrative episodes, and the sequential position in which these are found, can be an indication of the level of 'holistic socialisation' that the patient has assimilated. Patients who are familiar and comfortable with the homoeopathic consultation process (and who, by inference, have become less likely to regard the socially reproduced behaviours that define conventional medical encounters as relevant) being more likely to produce extended narratives.

Explanations and the rationalisation of the homoeopathic process

It is often argued that one of the biggest barriers to the complete mainstream assimilation of CAM, and particularly homoeopathy, is the fundamental problem of providing satisfactory explanations for treatments that lie outside the framework by which scientific 'proof' is conventionally measured. (House of Lords Science and Technology Select Committee, 2000.) Despite a noticeable softening of attitudes towards CAM in the last five years or so (see: Chatwin and Tovey, (forthcoming)), an underlying mistrust of CAM still runs through to the core of orthodox medicine – particularly among specialists and consultants at the upper end of the medical hierarchy (Cassileth and Chapman, 1996; Tovey, 1997). This often appears to have its roots in misalignments over the criteria by which treatments and CAM therapies are judged to be effective. Willis and White (2003) describe the conflicts that have arisen due to the rise in demand for patronage of CAM services (i.e. public provision for), and the challenge of legitimising it using the theoretical tools available to evidence based medicine (EBM). Naturally enough, conventional practitioners trained within rigorous evidence based disciplines are reluctant to give ground to what may be – at least within the frame of reference that they are used to – practices and practitioners that they at best regard as unproven but essentially harmless, and at worst, dangerous examples of 'quackery' (see, for example; Novak and Chapman, 2001; Christie, 1991). The question of whether, as many CAM adherents belonging to holistic disciplines such as homoeopathy would argue (see: Guyatt, 1993), CAM constitutes a completely different evidential paradigm from the 'gold standard' double blind trial and longitudinal study is understandably contentious (Coulter, 1981); orthodox practitioners who, in the eyes of their peers, go too far in adopting the rationales of CAM are treading on dangerous ground. It

was recently reported, for example, that a family GP was facing a professional conduct committee for, among other things, her '. . . .enthusiasm for alternative and natural cures.' (Wright, 2003).

For homoeopathy, regardless of whether or not RCT's are suitable for testing the underlying bio-spiritual mechanics of the system, there is also the thorny issue of how (in terms of 'common sense') remedies can possibly work. While many people can accept the idea of holism (in that it may be relevant to incorporate more than just the symptomatic complaint of the patient, for example) the claims made for the functionality of ultra- and hypa-dilute remedial preparations tends to push the envelope of 'lay' as well as 'scientific' or rational tolerance. This creates a number of interactional problems for homoeopathic practitioners. Particularly problems related to how they go about explaining their practices and beliefs to their patients. New patients, as I have already suggested, will not necessarily have a particularly well formed awareness of the principles that underpin homoeopathy when they first present. So firstly, there is the question of the relationship between understanding and therapeutic effect; how much (if any) of the homoeopathic perspective the patient needs to be familiar with or accepting of in order to engage with (and benefit from) homoeopathy.

Although much of my analysis so far would appear to indicate that current homoeopathic practices are essentially based on cumulative information gathering, the homoeopathic system of medicine was not originally designed with the intention of being a 'process' (in the way that counselling or psychotherapy are) (see: Rodgers, 1961). Many homoeopathic practitioners would claim, for example, to be able to treat illness whether or not their patients 'believe' or understand in the principles behind the system, and point to work on the application of homoeopathic remedies in animal medicine that appears to support this position (see: Turner 2001; McLeod, 1978). Like orthodox medicine, homoeopathy is supposedly grounded on reproducible cause and effect. The various versions of the homoeopathic *Materia Medica*, for example,

(see: Boerick, 1990; Tyler Kent, 1983) are extraordinarily specific in their descriptions of 'symptom pictures' and the effects that remedies will reproduce. In practical terms, then, it appears that for the patient, beyond learning rudimentary details such as how to handle and take the remedies, there is no *overt* 'conversion' or learning trajectory through which they are required to proceed in order to benefit or engage with the homoeopathic process. It will, however, also be evident from much of the data already presented, that what occurs in the homoeopathic encounter itself – i.e. the interaction between homoeopath and patient – is often of fundamental importance in terms of therapeutic outcome, and sometimes becomes an end in itself. In chapter two, for example, the patient I presented in the case study talked in interview about how, although her homoeopathic treatment was relatively successful in managing the arthritic symptoms she was enduring, this had long ago ceased to be the main reason why she visited. What motivated her now was the feeling of sanctuary and understanding that she obtained from talking with her homoeopath. What her 'treatment' had become at this advanced stage, was ostensively the result of a broad assimilation of holistic principles and the ongoing development of trust and empathy, combined with a heightened degree of self awareness (both in terms of her physicality and her emotional makeup), that this had engendered. Although the process of holistic reinforcement and homoeopathic awareness had evolved largely through talk about and around remedies, to the outside observer at least, these now played a relatively small role in the actual treatment.

A second major challenge for homoeopaths in terms of communication is the more detailed interactional question of how they go about tailoring both the background and specific homoeopathic information that they do decide to give in such a way as to preserve the credibility of the system in the eyes of the patient. Again, I would suggest that this relates to some degree to the level of homoeopathic socialisation that the patient has been exposed to, and is in a sense a circular problem; the homoeopath can't be sure that the patient will be receptive to the more contentious or esoteric elements of the system until a relatively long-term relationship has been established; but in

order to establish this kind of meaningful relationship (in therapeutic terms), the patient needs to be comfortable working to the reference points and perspectives that can only come with socialisation.

Talking about treatment

In order to unpack the interactional forms that reflect both the broad and more narrowly focused strategies relating to the overt and implied reproduction of systemic principles, I would like to begin this final chapter with a selection of examples that reflect the way in which allopathic and homoeopathic practitioners, and the GP-homoeopaths who occupy a kind of middle ground between them, can routinely approach the task of talking about or referring to the treatments they are recommending – their drugs and remedies etc. Focusing on this fairly specific and ubiquitous cross-paradigmatic activity I will attempt to show how some of the underlying principles and assumptions of allopathic and homoeopathic medicine are reproduced in the routine formulations of functional tasks.

The allopathic doctor

The extract below comes from the treatment phase of a consultation between an allopathic doctor and a patient at a family planning clinic:

Extract 43: (FP-NP-26-03-01)

((The doctor has been describing various contraceptive options))

1	Doc:	. . .well ↑ I'll ask (0.3) your doctor to check through
2		your (0.5) notes in the practi[ce
3	Pat:	[Ok[ay
4	Doc:	['hh ('cause) I'll be
5		writing to your doctor just to say you've been along
6		today
7		(.)
8	Pat:	Okay
9		(.)
10		And (.) obviously that we've <had a chat about things>
11		(0.4) 'hhh because it sounded as if you (0.7) thought the

progesterone tablets would be a better bet than-
(.)
Pat: M[m hm
Doc: [Pill (0.3) tablets
(0.3)
Pat: I ne- (.) I'm (0.4) nae really keen on going back on the coil (0.4) I'm too scared uh huh
Doc: ·hhhh Uh huh (.) ·hh (0.2) if it's not the copper coil (0.5) w:e would say that this is more effective than female sterilisation
(0.3)
Pat: M[m hm
Doc: [It's failure rates one in five hundred (0.2) ·hh which is a very low failure rate (0.2) ·hhh (.) I mean there's always exceptions to every r:ule (0.3) uhm (0.4) we haven't as far as I- (0.2) I'm aware (.) ·hh ha- come across (.) any (.) failures related to the (marena) device
(0.2)
Pat: Mm hm (0.3) that's not what I've got in my arm
(0.8)
Doc: There have been no reported failures with that either (0.2) ·hh which is why I'm a l:ittle bit hesitant (.) to be taking out (0.4) such a good contraceptive (.) ·hh (0.7) r:elatively early in the day ·hh (0.3) w-w- the other thing I'll get you to do: (0.3) ·hh is to keep a wee chart (0.5) of your bleeding for me if you w[ould be good enough that's just a little card=
Pat: [°Right okay°
Doc: =that you can [mark your bleeding patterns on to
Pat: [Yeah
(0.7)
Pat: Heh
(2.2)
Doc: before I see you for review because I will be planning to see you for review (.) ·hh I would suggest (0.3) that (0.3) you- you have a wee (.) <read through this>
(0.5)
Pat: Mm [hm
Doc: [·hh ·hh And (0.2) we'll check with your doctor (0.2) I suspect it was a copper one that you had
(0.2)
Pat: Right=
Doc: =so I've left in (0.3) copper (.) coils (.) tend to make periods a wee bit heavier
(0.7)
Pat: Mm[hm
Doc: [and a wee bit more crampy. . . .

This extract is a particularly good example of the way in which the allopathic perspective and the allopathic basis for reasoning can be deeply embedded

within the talk formulations that doctors utilise to describe available treatment options – in this case, the characteristics of different types of contraceptive.[33] Apart from the issue of the asymmetrical power dynamics that are evident between the two parties (the patient, for example, clearly has concerns about the option the doctor has settled on: 'I ne- (.) I'm (0.4) nae really keen on going back on the coil (0.4) I'm too scared uh huh.' (lines 17-18), but the way in which she formulates her turn suggests that she is at an interactional disadvantage; she does not categorically state that she does not want to go back on the coil, but rather frames her turn in a much weaker way ('nae really keen. .'), at this point in the interaction as the doctor embarks on the treatment phase, the level of assumed patient compliance (i.e. how far the patient will unquestioningly cooperate with the suggestions that the doctor makes) is extremely high. In the sequence from line 1 to line 6, for example, the doctor tells the patient that she will '. . ask (0.3) your doctor to check through your (0.5) notes in the practi([])ce. .'(lines 1 and 2). This is delivered in a 'unilateral' (See: Collins, Drew, Watt and Entwistle, (Forthcoming)) format – there is no suggestion that the patient might have, or would want, any active part in authorising it. Similarly, the lines that follow this are equally unilateral in flavour: '('cause) I'll be writing to your doctor just to say you've been along today. .'(lines 4-6). Again, this formulation reinforces an underlying assumption on the part of the doctor that certain elements of the consultation (in terms of its mechanics) can be considered to be outside the patient's jurisdiction and do not even require confirmation or accounting for; in making reference to contacting the patient's regular doctor, and the sharing of medical information that this implies, this doctor makes no attempt to gain 'permission' for this from the patient – even in the broadest interactional sense. She does not, for example, use turn constructions such as 'What I need to do now is. .', or: 'What'll happen now is that I. . .' etc., that would have softened the delivery and been more inclusive. The assumption is that

[33] For an analysis of the functional reproduction of 'morality' in medical encounters see: Heritage and Lindström, 1998. The paper examines informal interactions between nurses and first-time mothers and explores '. . the unobtrusive but insistent enforcement of a range of obligations by the medical profession.' (p.398) It also examines how 'problematic' moral issues (such as how a nurse frames talk when questioning an unmarried mother about the father of her child), are dealt with.

the sharing of information (i.e. information that is essentially inaccessible and hidden to the patient), and the way that the patient apparently has little say in how, or to whom it is propagated, is procedural. It is part of the underlying framework by which the allopathic doctor works. Even if he or she is committed to a patient-centred and inclusive consultation style (see; Mead and Bower, 2000), this kind of procedural assumption may become detached from the purely 'medical' business of the consultation and in its directive aspect, undermine collusive or non-authoritative interactional work engaged in during other phases. Towards the end of the extract too, there is another example of assumed concordance:

36 Doc: . . . .r:elatively early in the day ·hh (0.3) w-w-
37 the other thing I'll get you to do: (0.3) ·hh is to
38 keep a wee chart (0.5) of your bleeding for me if you
39 w[ould be good enough that's just a little card=
40 Pat: [°Right okay°
41 Doc: =that you can [mark your bleeding patterns on to
42 Pat: [Yeah
43 (0.7)
44 Pat: Heh
45 (2.2)
46 Doc: before I see you for review because I will be planning
47 to see you for review (.) ·hh I would suggest (0.3)
48 that (0.3) you- you have a wee (.) <read through this>

Here, the doctor introduces the issue of a review or follow-up visit, but again, the way in which this is framed implies an assumption that the patient will (or should) go along with the request. On line 37, she begins to outline (using a directive and non-accounting format: '. .the other thing I'll get you to do. .'), how the patient should keep a record of her bleeding. This activity is directly related to the need for a follow-up consultation (the implication being that there will have to be one), but rather than positioning an explanation of this prior to giving her instructions, the doctor delays mentioning it until line 46: '. . before I see you for review. .'. This sense of the review consultation being mentioned almost as an afterthought again betrays an underlying assumption that the patient will comply, and similarly, the construction of the second part of the turn '. . because I will be planning to see you for review. .' (lines 46-47),

emphasises this by being extremely unilateral, leaving little room for any discussion or ratification by the patient.

Connections to the system

Closely related to the issue of procedural assumptions is the way in which, in extract 43, underlying professional authority is implicit in the talk of the allopathic doctor. In making direct reference to asking the patient's doctor to: '. .check through your (0.5) notes. .'(lines 1 and 2), for example, this doctor is displaying her ability to access a professional network from which the patient is largely excluded. Even if she should want to, it would be difficult for the patient to obtain her medical records, yet the doctor has complete freedom to read, modify and discuss them with other doctors who are in a similar privileged position. In mentioning, also, that she will be: '. . writing to your doctor just to say you've been along today.'(lines 4-5) she is not only displaying an assumptive and unilateral position (the patient is not offered a choice about whether or not this is done), she (the doctor) is also subtly invoking the whole sub-structure of medical organisation and control; a framework of contacts and hidden (from the patient) lines of communication.

The following extract (extract 44) is given as a brief contrasting example from a homoeopathic consultation that illustrates how, by displaying more awareness of the impact that procedural assumptions might have, a more inclusive interaction may be framed:

Extract 44: (RF-JO-02-05-00)

1	Pat:	. . . why e- why it was up – I haven't actually
2		asked him because it's difficult to get hold of him so I
3		haven't (0.4) haven't bothered b-ki thought-
4		(1.5)
5	Hom:	·h Praps I shoul[d-
6	Pat:	[And he said tk-hm (0.7) ·h Id-I don't
7		know if it might be a good idea if you had a word
8		wit[h him
9	Hom:	[If I rang him, yes
10	Pat:	Nd [gave him your figures
11	Hom:	[Just to clarify which- ·h[h
12	Pat:	[Yea–wha-what we're
13		wanting out. . .

Here, the homoeopath is in roughly the same position as the allopathic doctor in extract 43 in that there is a need for her to contact the patient's regular GP – in this case to check on the validity of some blood pressure readings. Unusually for a private homoeopath, this practitioner had a close working relationship with the patient's GP and had been in regular contact with him regarding the case. So although the situation is not strictly procedural in the sense that the homoeopath is 'required' to inform him of the situation, this particular activity had become a relatively routine part of this patient's treatment experience. What is striking about the sequence is the way in which the homoeopath frames her intention much more collusively: ''h Praps I shoul([])d-. .' (line 5). This comes across as a suggestion rather than a statement of intent and as such generates a high degree of inclusivity for the patient (or perhaps more accurately, simply does not generate a sense of *exclusion).* Similarly, although it is the homoeopath who is the initiator, it subsequently becomes the patient who, using a form of collaborative completion, is actually able to verbalise the proposition and bring it into the open: '. . .I don't know if it might be a good idea if you had a word wit([])h him.' (lines 6-8). This in effect allows the patient and the homoeopath to maintain a degree of collegiality that is entirely absent in the allopathic sequence and demonstrates the underlying significance that the careful formulation of even the most functional activities can have.

Cause, effect and certainty

Another key feature of the language and turn formulation in extract 43 is the way in which the doctor frames her references to particular aspects of the treatments and procedures that she is describing. These are performed in a way that clearly reflects the scientifically based method that underlies allopathic medicine. Implicit in her talk is the sense that what she is describing has proven and predictable effects; that these are concretised, standardised and repeatable. The first instance of this begins after the patient expresses some concern about the effectiveness of a contraceptive coil she had tried in the past:

(From: FP-NP-26-03-01)

17	Pat:	I ne- (.) I'm (0.4) nae really keen on going back on the
18		coil (0.4) I'm too scared uh huh
19	Doc:	·hhhh Uh huh (.) ·hh (0.2) if it's not the copper coil
20		(0.5) w:e would say that this is more effective than
21		female sterilisation
22		(0.3)
23	Pat:	M[m hm
24	Doc:	[It's faiure rate's one in five hundred (0.2) ·hh which
25		is a very low failure rate (0.2) ·hhh (.) I mean there's
26		always exceptions to every r:ule (0.3) uhm (0.4) we
27		haven't as far as I- (0.2) I'm aware (.) ·hh ha- come
28		across (.) any (.) failures related to the (marena)
29		device

On line 19, the doctor responds to the patient's subjective reticence ('I'm too scared uh huh. (line 18)), by supplying a sequence of *objective* reasoning. Her turn contains references to specific and predictable consequences: how the coil is '. . more effective than female sterilisation. .' (lines 20-21), for example, and how it has a '. . very low failure rate. .'(line 25). These elements allude to the underlying basis of certainty upon which the doctor grounds her comments; she is invoking not only her own experience of the effects of prescribing these contraceptives, but also the wider experience of doctors and medical science in general. She uses the incorporated formulation 'we', for example, which is an effective way of placing her argument beyond the reach of the patient: '. .w:e would say. .'(line 20), and: '. .we haven't as far as I- (0.2) I'm aware. .'(lines 26-27). These give her turns an unequal weight when balanced against the patient's subjective fragment of life-experience and can be said also effectively to devalue it.

The specificity with which the doctor presents supporting information for her argument also has a characteristically allopathic feel. The elements she chooses to include as she embarks on persuading the patient to go along with the treatment option she is suggesting are largely statistical and grounded in logic. Rather than address the subjective aspect of the patient's concern – perhaps by exploring the underlying psycho-emotional reasons for

her currently negative experience – the doctor chooses to concentrate on providing a statistical argument that focuses on the efficacy of the treatment. On line 24, for example, following her comment about the patient's coil being more effective than sterilisation (line 23), the doctor describes its failure rate as '. .one in five hundred. .', and outlines how '. .we. . haven't as far as I'm aware. . come across any failures related to the (marena) device.'(lines 27-29). And as the patient points out that this is not the type of contraceptive she is currently using ('That's not what I've got in my arm.'(line 31)), the doctor's response is again focused on specific statistical information: 'There have been no reported failures with that either.' (line 33), which as well as betraying a sense that the patient is almost being 'fobbed off' (the doctor appearing to be caught out by the patient's technical awareness of the contraceptive she is using), further illustrates the underlying allopathic focus on proven cause and effect. The emphasis is on the objective experience of 'others' (the four hundred and ninety nine women out of five hundred, for example, who had no trouble with the coil), rather than the subjective experience of the individual patient. In effect, the doctor is subtly implying that the problem is likely to be with the patent.

The GP-homoeopath

The medically trained homoeopath can be thought of as occupying the middle ground between private homoeopaths on the one hand and allopathic doctors on the other. As I outlined in chapter 2 however, for both homoeopaths and conventional practititioners this position can be difficult to rationalise. The essentially polarised theoretical perspectives from which both systems approach medicine mean that the process of combining the two may involve a high degree of compromise – compromise that to many at the extremes of both camps is basically untenable.

There are two main types of medically trained homoeopaths, the first type is generally a regular GP who has a post-graduate qualification in homoeopathy at a recognised college and treats its practice as essentially separate from

their every day activities as a doctor – their homoeopathic patients are seen in separate organised clinics and when involved in homoeopathy these practitioners proceed very much as a regular homoeopath would; they give longer holistically focused consultations etc. The second type is a doctor who incorporates elements of homoeopathic prescribing without necessarily having any professional holistic training, or any in-depth knowledge relating to how the system is supposed to work. They may, for example, not make use of an extended holistic consultation method to determine a patient's 'constitution', but instead rely on a relatively small number of generic remedies that they prescribe as they would their allopathic drugs. In their study of GP-homoeopaths, May and Sirur (1998) highlight an underlying inequality between medically trained homoeopaths and their professional colleagues; qualified professional homoeopaths are required to undergo extensive training and face strict controls on the way in which they practice if they are to remain members of the society of homoeopaths. Medical doctors on the other hand are permitted to practice homoeopathy on the strength of their orthodox training, regardless of whether or not they are 'qualified' in homoeopathic terms.

Understandably, this type of apparent inequality is not popular with the professional homoeopathic community because, they argue, without the holistic preparatory process that professional homoeopaths conduct, the likelihood of a remedy being sufficiently tailored to a patient to work effectively is small.[34] The knock-on effect of this might be that patients who engage with homoeopathy in this tangential and 'un-holistic' way will be disappointed and form a false impression about what the process can really achieve. Admittedly, I have been unable to find empirical data to support the suggestion that GP-homoeopaths have success rates any worse than professional homoeopaths, so this argument must remain subjective. However, if there is an element of truth in it there could be a case for making connections between possible higher failure rates of homoeopathic remedies in allopathic consultations and the therapeutic role that empathetic

[34] From interview data (homoeopath).

communication can play. From a sceptical perspective it might be suggested that this adds weight to the argument against the efficacy of homoeopathy: If the only apparent difference between a homoeopath successfully prescribing a remedy and an allopath being unsuccessful with the same remedy is that the homoeopath is able to engage in a much more lengthy and attentive consultation process, any success that the homoeopath has can be attributed largely to the attention they have been able to give the patient rather than the remedy.

Perhaps a more significant finding (in terms of this study) that arises from the work of May and Sirur (1998) relates to the underlying medical perspectives displayed by the ten GP-homoeopaths that they interviewed. They report that although all of the practitioners had a serious commitment to their homoeopathic work (seven were members of the Faculty of Homoeopathy, two were training to be members, and only one had no plans to do so), they were clear about how they saw themselves: they did not regard themselves as homoeopaths, but as doctors. May and Sirur (1998) also point out that the overall paradigm by which these practitioners defined their practice was similarly delineated from the 'classical' homoeopathic model: their use of homoeopathy was '. . limited to particular experiences of illness, rather than categories of disease.'(p.186). This kind of ethnographically derived observation is supported by the (admittedly limited) empirical consultation data I was able to collect.

The next example comes from a consultation involving the type of practitioner who selectively incorporates homoeopathy into an allopathic consultation. The selective mixture of homoeopathic and allopathic principles is particularly evident (mainly in what the practitioner *does not* say), and the formulation of the descriptive and explanatory talk relating to the properties and actions of the homoeopathic remedy she is prescribing exhibit several characteristics that, in my data at least, are idiosyncratic of this kind of hybrid perspective. Extract 45, then, (below) is taken from an encounter that took place in a regular GP surgery. The doctor had a basic training in homoeopathy (although she was not a fellow of the Faculty of Homoeopathy) and

occasionally incorporated the experimental use of homoeopathic remedies into her usual five to ten minute clinical appointments. When interviewed after this encounter the patient involved said that she had not presented with a specific wish to be treated homoeopathically and was largely unaware of what homoeopathy was. The sequence comes from the onset of the treatment phase:

Extract 45: (HD-NP-21-11-00)

((Patient is describing an allopathic treatment she had been using))

Pat: . . . came off-er the stematol, I got recommended by
doctor Benway (0.2) to come [off-off it after (.) m- it=
Doc: [H-hm
Pat: =was ten [days after I saw him the l[ast time
Doc: [H-hm [H-hm
Doc: H-hm (0.8) erm but (.) have been keeping [things do[wn
Pat: [H-hm [H-hm
Doc: now ·hh (.) I'm just wondering if you want to try one of
my homoeopathic tablets fr- (0.4) sickness
Pat: °°H-hm°°
Doc: There's noth[ing-
Pat: [It's just-It's just often I mean (.) today
now I [feel neh too bad to[day
Doc: [H-hm [Right (is it / does it) - a-ha
Pat: then the next day I could feel- (.) last week – it was
last week or the week before I had a migraine I was
sic[k
Doc: [A-ha a-e-ill then (.) a-ha ·hh but still every
[day just the smell and-[and er the thought of food
Pat: [H-hm [H-hm
Pat: H-hm
Doc: er:m (.) (?) °triggers it° ·hh what do you think then, do
you want to try one of my (0.2) homoeopathic tablets or-
Pat: ^tk- hm spose I could tr[y (it / yea)
Doc: [Give it a go
Pat: H-hm
Doc: ·hh I cn – erm <just a quickly> (??) I'll look in my-my
book en ·hh there's-there's noh-a number of (.) on[es=
Pat: [H-hm
Doc: =we can try you see ·hh and I have had some success
with [homoeopathy ·hh er:m (1.0) so °s: - stomach-°
Pat: [H-hm
((doc consults book)) (1.8)
Doc: this takes a minute to (.) [to find one-
Pat: [°Hm°
(5.0)
Pat: N- when you compare what I was like before n- (.) before
there was (.) °hm° ·hh n- I was in hospital that last

time I was there I was in ten days and it (was) just ·hh
constant
(0.5)
Doc: The last time I saw you, you were really (.) er::
Pat: H-hm that was – well I've got tooken in again after you
had admitted me that time
Doc: Right
Pat: I was taken in a third time (1.0) and (0.5) that time I
would say was my worst
Doc: Righ[t
Pat: [I dropped an: I lost a lot of weight
(1.5)
Doc: So when you're just looking at- s:mell of, the thought
of-
Pat: H-hm
Doc: Food
Pat: H-hm
Doc: All these things just make you feel really unwell (0.8)
are you dizzy or anything
Pat: ^Tk-·hh not so b[ad no before I was I must admit I mean=
Doc: [No
Pat: =the first good few weeks I was (0.8)[(you know ??-??)
Doc: [Well try this –
this remedy
Pat: H-hm

Doc: called (chicome) ·hh a:n[d (1.0) I'm sure they'll need=
Pat: [°°H-hm°°
Doc: =to order it
Pat: H-[hm
Doc: [they won't have it
Pat: H-hm
Doc: ·hh Er:m (0.5) but it should just take a couple [of days=
Pat: [H-hm
Doc: =·hh and then you just chew one three times a day
Pat: H-hm
(0.8)
Doc: Won't do any harm
Pat: H-[hm
Doc: [and it's safe to take in pregnan[cy whereas
Pat: [H-hm
Doc: =·hh [the other tablets are °er° (0.5) arn't
Pat: [H-hm
(3.8)
Doc: How's connor doing. . .

In terms of the reproduction of a particular medical perspective, although this doctor is ostensively using homoeopathic medicine, the way she frames her talk as it relates to the remedy places the encounter far more towards the allopathic end of the spectrum. In fact, the interaction exhibits nothing of the

holistic underpinning that you would expect to find in a 'purer' homoeopathic consultation. This is not to say that the doctor's intentions are in any way erroneous. Ironically, the reason why she appears to be pushing the patient to try '. . one of my homoeopathic tablets. .' (lines 8-9), seem to be related to her view of them as essentially harmless, and therefore something that the patient may safely take while she is pregnant. On line 75, for example, she explains that '. . it won't do any harm. .', and then draws a comparison between it and an allopathic drug which is not safe to take during pregnancy (lines 77-80). This formulation reflects a relatively common allopathic position in relation to CAM, and homoeopathy in particular. With the growing popular demand for 'natural' and holistic treatments encroaching on mainstream medicine, a significant number of doctors who have little or no commitment to an all-out holistic approach are willing to tolerate some aspects of CAM because they see it as essentially innocuous and having a similar function to placebo treatments. This doctor's emphasis on the harmless nature of the remedy she is prescribing also reflects a fundamental duality in her approach, and, by implication, her attitude to homoeopathic medicine in general; she highlights the non-negative or at least neutral effects that the remedy is likely to have rather than its possible potency or effectiveness. So although she is ostensively recommending homoeopathic treatment (note the way in which she 'pushes' the patient to consider trying it, first on line 8, then later, on line 22, and how she mentions that she has '. .had some success with homoeopathy. . .'(lines 30-31), for example), she is effectively framing it as something that is almost like a novelty or curious medical anomaly, something that is somehow subordinate or less 'powerful' than allopathic medicine, but that can be safely experimented with for this very reason. The short extract below comes from another GP-homoeopath encounter and exhibits similar characteristics:

Extract 46: (H-DOC-NP-20-10-00)

1	Doc:	. . .put onto the tablets so °hh it could never (.)
2		poison you as su[ch because it's basically is (.) so
3	Pat:	[°°H-hm°°
4		dilute [°h erm (.) e-so=

5 Pat: [Right (.) °˙hh°
6 Doc: =it's not like herbalism (0.2) it-a-it is actually quite
7 distinct from herbalism ˙h (0.5) erm so e-I say you can
8 never do harm (0.5) cn really only ever do goo:d [I mean
9 Pat: [°H-hm°
10 Doc: =(0.3) it can never- you can never have any (0.5) side
11 effects or (0.7) erhm (0.5) poisonous effects from them
12 you know (0.3) so er. . .

In this extract the doctor has just been outlining to a new patient the difference between allopathic and homoeopathic medicine. (This practitioner falling into the category of GP-homoeopaths who treat their homoeopathic patients as a distinct group and follows the complete holistic consultation process – including an initial discussion with the patient relating to how homoeopathy works.) It can be seen that like the doctor in extract 45, she is keen to emphasise the innocuous properties of the remedies she will be using. She mentions how '. .it could never (.) poison you as su([])ch. .'(lines 1-2), and how '. .you can never have any (0.5) side effects or (0.7) erhm (0.5) poisonous effects. .'(lines 10-11). Similarly, she draws a contrast between homoeopathic remedies and other apparently more toxic treatments – in this case herbal medicine (lines 6-7).

Returning to extract 44, the way in which the doctor introduces the option of a homoeopathic treatment is also interesting because it again betrays a thoroughly allopathic perspective. On line 8 she says: '. .now ·hh (.) I'm just wondering if you want to try one of my homoeopathic tablets fr- (0.4) sickness. .'. This in itself is a perfectly reasonable offer; however, it could be said to demonstrate a marginalisation of the holistic principles along which homoeopathic prescribing needs (according to most professional homoeopaths) to be organised. Rather than concentrating on the patient as a unique individual and tailoring the selection of a remedy to her, the doctor displays an underlying symptomatic (i.e. allopathic) focus. She describes the remedy as being '. . for sickness. .', which implies that it will work in the same way that a conventional medicine does (that is, on the symptoms rather than the patient). Similarly, the sequential positioning of her homoeopathic remedy offer – introduced at the onset of the treatment phase – further reinforces the

idea that this is simply a 'different kind of medicine', rather than something that in fact embodies a fundamental paradigmatic shift.

Within this consultation sequence there is a mingling of allopathic and homoeopathic elements, and ultimately, perhaps, a compromising of the latter. The doctor's introduction of the homoeopathic option is entwined with the patient's attempts to continue describing her symptomatic trajectory and is only vaguely differentiated form the allopathically based talk that the parties are engaged in; on line 10, after the doctor makes her first offer of a homoeopathic remedy, the patient's response is highly attenuated ('°°H-hm°°') which indicates a degree of reticence, however, as the doctor, on line 11, begins what appears to be a turn aimed at pre-empting a negative or unenthusiastic response ('There's noth([])ing-. .'), the patient tries to continue to talk about her symptoms. This suggests that she in fact failed to see the offer as anything out of the ordinary and took it rather as an indication that the doctor was attempting to close her down and move into the treatment phase (which routinely involves the cessation of 'troubles telling' (Jefferson, 1996) talk) before she had communicated her concerns. It is possible, of course, that having had no introduction to it, the patient may simply at this point have been unclear as to what it was the doctor was offering her – this too could account for her attenuated response and subsequent topic continuation, but either way, the vague differentiation between the homoeopathic and allopathic elements is striking.

Judging from the data I was able to examine, it appears to be relatively common for GP-homoeopaths with this approach to use the treatment phase as the broad sequential position in which they choose to place their offers of homoeopathy. In extract 45 it is clear that the patient has previously been taking allopathic medicine and that this has not been successful:

(From: HD-NP-21-11-00)

1	Pat:	. . . came off-er the stematol, I got recommended by
2		doctor benway (0.2) to come [off-off it after (.) m- it=
3	Doc:	[H-hm
4	Pat:	=was ten ([])days after I saw him . . .

The current doctor's first offer to try a homoeopathic remedy comes directly after this sequence (lines 8-10) and is therefore framed as a kind of secondary option – something to be tried now that the conventional medicine has failed to have an effect. This sense of the homoeopathy taking a subordinate position can also be seen occurring in the short extract below (extract 46). This too comes from an 'incorporating' GP-homoeopath and exhibits the same sequential properties. Here, the doctor is outlining treatment options:

Extract 46: (AB-NP-21-11-00)

1	Doc:	. . . let's try changing the (0.5) er-antidepressant
2		firs[t
3	Pat:	[H-hm – h-hm
4	Doc:	And see if that does anythi[ng
5	Pat:	[°H-hm°
6	Doc:	And if that does- e-if a change of anti-depressant
7		doesn't work
8	Pat:	H-hm
9	Doc:	·hh (.) And you've still have (0.3) months to wait for
10		the:-
11	Pat:	H-hm
12	Doc:	psychologi[st
13	Pat:	[H-hm
14	Doc:	maybe (1.0) °try the homoeopa[thy° (??)right?
15	Pat:	[Yes, en-hem- h-hm
16	Pat:	h-hm

In this case, as the patient's current anti-depressant has not been effective, the doctor's preferred course of action is first to try a different (i.e. allopathic) drug. The second treatment she mentions (on lines 9-12) is an appointment with a psychologist (also allopathic). The homoeopathic option is left until line 14 and framed relatively unenthusiastically; homoeopathy is made contingent on the second allopathic anti-depressant failing, and the likely length of the waiting list for the psychologist. The elements of the turn relating directly to the homoeopathy are also relatively un-categorical; while the allopathic options are outlined unambiguously: '. . let's try changing the (0.5) er-antidepressant first. .', etc., (lines 1-2), line 14 begins with a tentative '. .

maybe .'. And the subsequent '. .°try the homoeopathy°. .' is spoken at a lower level than the preceding talk.

The framing and sequential positioning of the talk about the efficacy of remedies utilised by the 'incorporating' GP-homoeopath in the next extract also betray a sense of low expectation and uncertainty regarding the results of the homoeopathic treatment with which she had been experimenting:

Extract 47 (H-DOC-FR2-21-11-00)

1	Doc:	^P-·hh e-I suppose the question is you know- we've tried
2		(.) two homoeopathic remedies (0.2) neither of which
3		have- (0.7) s-well- (0.2) well I think we've- [(??)
4	Pat:	[It was like
5		(0.2) chicken po=
6	Doc:	=the-the chicken pox [(dose) (.) which was sort of like=
7	Pat:	[Ye:a
8	Doc:	=an extr[a
9	Pat:	[Yea
10		(0.2)
11	Doc:	^p-·hh erm (1.0) did you th- (0.4) and that's (.) you
12		know, about a month ago (0.6) n-ye:a none of them
13		have (0.2) really done anything. . .

This extract comes from the treatment phase of a routine (i.e. short) clinical consultation. The GP-homoeopath has begun to review treatment options, one of which is to revert back to allopathic drugs following an experimental period in which the patient took homoeopathic remedies. Although the practitioner does not overtly display her disinclination to continue with homoeopathic treatment, the various elements of her turns taken as a whole appear to convey an underlying sense of resignation to the failure of the approach. She begins on line 1 with: '. .I suppose the question is . . .' etc., which is framed as a kind of 'pre', suggesting a selection of possible options is to follow, but in subsequent sections of the turn important elements relating to the continuation of the homoeopathy are left incomplete. On lines 1-2, for example, there is: ' . . you know we've tried (.) two homoeopathic remedies (0.2) neither of which have- . .', and this is followed by what is likely to be the

initial part of a negatively framed summary: 'Well I think we've- .'(line 3). This, coupled with the other 'troublesome' elements of the turn (the hesitant 'P-·hh e-I suppose' (line 1), '. . s-well- (0.2) well. .' (line 3), and the '. .you know-. .'(line 1)) suggest that the doctor is about to say something along the lines of 'Well I think we've given it a good try. .'. Even without knowing what she was really going to say at this point, the 'hanging' and incomplete qualities evident in the formulation of her final '. . n-ye:a none of them have (0.2) really done anything. . .'(lines 12-13) help to consolidate an impression of ambiguous commitment to the homoeopathic option.

The underlying sense here is of an allopathic approach at work. In this extract it is particularly evident in the way in which the practitioner's talk about the remedies indicates that she perceives them in very much the same way as allopathic drugs. On lines 1-2, by saying that '. .we've tried two homoeopathic remedies. .' (and implying, in the context of the rest of the turn, that this sufficient to treat homoeopathy as ineffective), the focus is on the limited connections that can be made between certain generic remedies and the patient's symptoms. Rather than using the holistic homoeopathic process to refine her choice of remedy, the doctor demonstrates that she is limiting herself to try a small number of broad remedies, i.e. remedies that because they are not likely to be a sufficiently close match to the 'constitution' of the patient, are unlikely to be fully effective – or effective at all.

Returning again to the main GP-homoeopath example (extract 45), another feature that grounds the talk in an allopathic perspective is the way in which the doctor engages in the process of isolating a remedy. The relevant sub-sequence here comes after the doctor has made her second offer of homoeopathic treatment ('. . what do you think then, do you want to try one of my homoeopathic tablets. .'(lines 22-23)) and runs from line 24 to line 61 when she suggests the remedy *chicome*. A first point here is the way in which the doctor immediately focuses her attention on the *Materia Medica* and tries to isolate a remedy broadly based on the symptoms that the patient has been describing: '. .so °s: - stomach-°'(line 31). It appears to be that from early on in the extract it is the stomach pains and feelings of sickness that prompt the

doctor to consider a homoeopathic remedy – that is, she displays an underlying orientation to this particular collection of symptoms as something that a homeopathic *remedy* as opposed to the homoeopathic *process* might be able to treat. This is emphasised by the way in which, once she has begun to consider the various remedies she might prescribe, she does not ask the patient any other homoeopathically relevant questions. Her only 'focusing' questions come on line 51 when she confirms that it is the smell and thought of food that makes the patient feel ill, and then on line 57 when she asks '. . are you dizzy or anything.'. There is nothing, however, that remotely approaches the level of detailed questioning that a professional homoeopath engages in when outlining the constitutional picture of a patient (this basic ground work being a vital component of successful homoeopathic prescribing).

The overall effect is one of someone using an 'expert system' and working by rote through a relatively uncreative (in the sense that the important holistic intuitive skills are largely absent) and pre-determined procedure. The wider holistic interactional qualities of involvement and collegiality are similarly absent; throughout the homoeopathic deduction sequence the patient is largely excluded (again, something that is to some extent a structurally determined feature relatively common to allopathic consultations) (See: Have, 1991). In fact, the patient continues to talk about her symptomatic concerns and appears largely disengaged from the activity that occupies the doctor. On line 37, for example, as the doctor continues to consult her *Materia Medica* the patient begins a narrative fragment relating to her recent hospitalisation: 'N- when you compare what I was like. . .' etc., and this continues up until the point at which the doctor is prescribing the remedy:

(From: HD-NP-21-11-00)

58 Pat: . . . not so b[ad no before I was I must admit I mean=
59 Doc: [No
60 Pat: =the first good few weeks I was (0.8)[(you know ??-??)
61 Doc: [Well try this –
62 this remedy. . .

It can be seen that the doctor in fact overlaps the final part of the patient's narrative turn in line 60 in order to prescribe the remedy.

This kind of allopathically focused approach is – inevitably, according to most professional homoeopaths – going to result in relatively poor therapeutic outcomes. Prescribing remedies without recourse to the full holistic consultation procedure, they would claim, will at best result in success rates approaching those of equivalent placebo treatments, and it is therefore understandable that the approach used by this particular sub-species of GP-homoeopath does little to further the overall aims of full holistic integration into the mainstream.

The Homoeopath

The final main illustration in this section comes from towards the end of a 'pure' homoeopathic consultation, that is, one involving a professional homoeopath with no allopathic medical background. In this sequence the talk relates to a young child who is not present, but who is being treated via his mother:

Extract 48 (RF-J-27-04-00)

1	Hom:	Right (2.0) (eyea) Kh.h. So, now then ·h erm (4.5) lys-
2		(tz) I'ts a bit like trying to [work out a y'know like=
3	Pat:	[*K·ha h·
4	Hom:	=what–where to begin [n what-what angle to
5	Pat:	[Y-yea,
6	Pat:	Yea
7	Hom:	take – so I did spend quite a bit of time thinking (*·hh)
8		about it [an:d (.) what I thought - it might be good Jus-
9	Pat:	[Appreciate that
10	Hom:	=·h with it having been there for him ↓ (.) th-the
11		language [difficulty from an [early age ·hh erm: (0.5)it=
12	Pat:	[Yes [yea – yea
13	Hom:	=could be that it goes back t – t – the birth [trauma=
14	Pat:	[Yes – yea
15	Hom:	=·hh or: (.) very early on in babyhood
16	Pat:	Yea
17	Hom:	·hh So one thing I thought it would be good just to
18		address: at this stage seeing as, y'know-it's a- bit of
19		an unknown ·hh[is whether there may have been=

20 Pat: [Yea.
21 Hom: =any (.) ill effects from (.) vaccination
22 Pat: Oh right.
23 Hom: Erm: ·hh (1.5) Er ·hh (0.8) Jst-a-in a sense tht – it-it-
24 ·h cos it happens at a very early stage a vaccinatio[n y=
25 Pat: [Yea.
26 Hom: =you: (.) don't(o-uh) y'know – sa- there's the obvious
27 things that can happen ·hh but sometimes the less obvious
28 things-
29 Pat: Right
30 Hom: E-urm: don't [become (<apparent>)-n: get over looked=
31 Pat: [Get overlooked sort of thing.
32 Hom: =yes and don't [become more apparent till later ·hh when=
33 Pat: [Right.
34 Hom: =they aren't always linked to the vaccination
35 Pat: Ar right [yea.
36 Hom: [Erm: (0.8) and ·hh(0.5) i-it was just (1.0) th-
37 the ·h thinking that it would be good to address that. At
38 least seeing if we could (0.8)erm: work through that as a
39 possibili[ty
40 Pat: [Yea?
41 Hom: k-h· Erm: so these are all rather, vaccination– °linked°
42 ·hh cus there is this – this erm: - idea that some of
43 the side effects from vaccinations can be (.) learning
44 difficulties uv-
45 Pat: [Right.
46 Hom: [(°??°)(0.8) ·hh (0.5) It's a range of possibilities and–
47 y'know, obviously not always - not all children=
48 Pat: =[Yea – somet- right, ok
49 Hom: =[Bt-bt – that-that – (eh)·h sometimes can happen. So ·hh
50 I just thought if we could-
51 (0.8)
52 Pat: Right
53 (0.8)
54 Hom: L[ook at that
55 Pat: [°is-ma°-start with that=
56 Hom: =Start with that [and then see ·h[h- se- see where we go=
57 Pat: [Yep- yes. [See what happens (°from
58 there°)
59 Hom: =so [these are all related [so if I can ·hh go through=
60 Pat: [Right [Right.
61 Hom: =the different packets. . .

The approach taken by this homoeopath as she talks about the treatment she is prescribing contrasts strongly with both the allopathic doctor in extract 43, and perhaps more significantly, the GP-homoeopath in extract 45. The whole sequence displays a subtle and deep-seated holistic orientation as well as more overt and deliberate attempts to convey and clarify this perspective. A

first feature of the talk formulations that are utilised is the way in which a sense of complexity and individualisation is invoked relating to the choice of remedy. Unlike extract 45, where the GP-homoeopath displays the use of a comparatively narrow and focused selection of remedy options, here, the homoeopath displays that she is incorporating into her treatment decision a far greater number of elements, many of which, however, are framed as being relatively nebulous and uncertain. This helps to evoke a background of complexity that simultaneously creates a patient-centred atmosphere (in that the patient and their problem are cast as interesting and unique), and also underscores the homoeopath in the role of 'guide' – someone who can understand and work out the unique puzzle that the patient represents. On lines 1-8, for example, as she initially outlines the approach she will take, both the way she formulates her turn, and its content begin to contextualise her approach to the patient's problem as something that will incorporate much more than the purely symptomatic:

(From: RF-J-27-04-00)

1	Hom:	Right (2.0) (eyea) Kh.h. So, now then ·h erm (4.5)lys-
2		(tz)I'ts a bit like trying to [work out a y'know like=
3	Pat:	[*K·ha h·
4	Hom:	=what–where to begin [n what-what angle to
5	Pat:	[Y-yea,
6	Pat:	Yea
7	Hom:	take – so I did spend quite a bit of time thinking (*·hh)
8		about it. . .

This is particularly evident on line 4: '. . what-where to begin. .', and is also apparent in the way she describes the process of deciding where to approach the problem as requiring a degree of thought (line 7). This also starts to reflect the underlying holistic framework to which the homoeopath is working; it reveals an assumption of interconnectivity that even influences the choice of a starting point when isolating a remedy. The sequence as a whole also begins to communicate to the patient that the therapeutic process is likely to be complex and tangential – something that will involve the incorporation of far more elements than just the symptoms that the patient has presented with. The homoeopath, for example, begins to suggest that there may be a

connection between the patient's current problem (language and behavioural difficulties) and events that may have occurred during or shortly after birth: '. . it could be that it goes back ([)t – t – the birth trauma ·hh or very early on in babyhood. .'(line 15).[35] This reference to the incorporation of a relatively contentious (in allopathic terms) connection is further used as a 'pre' to the introduction of another, even more controversial issue, that of the effect of vaccination. The formulation of the sequence in which the homoeopath outlines the role that vaccination might have had (running from lines 17-35) is of an 'semi-overt / rejection' type (the various formats that homoeopaths can be observed utilising when describing allopathic medicines are discussed in more detail in the section beginning on page 238), in that although she displays an underlying antipathy or reticence relating to the allopathic issue she is describing, she does not refer to this overtly – her perspective is displayed largely through the structure rather than the content of her talk. The way, for example, in which she introduces the vaccination topic by first highlighting how the effects of it are '. . a bit of an unknown' (lines 18-19), frames what is to follow in the context of ambiguity, that is, this turn element begins to imply an erosion of the allopathic 'certainty' behind vaccination, as does her use of the phrase '. .ill effects' (line 21). The implication that a fundamental allopathic treatment may possibly be damaging is reinforced in the sequence from lines 23-34. Again, in formulating her turns in an ostensively balanced and neutral way, the underlying impression of the vaccination process (and by implication, the allopathic system of medicine) as being somehow suspect, or at least questionable, is not made overtly but subtly implied through the invocation of uncertainty. On line 26 the homoeopath describes how although '. . there's the obvious things that can happen. .' (i.e. obviously *negative* things such as brain damage etc., that the patient's mother may well be aware of), there are also '. . less obvious things-' (lines 27-28). The phrase 'less obvious' evoking insidious and hidden effects that are by implication more frightening because they are left unnamed. This

[35] Although at this point the homoeopath chooses not to embark on a more esoteric elaboration of homoeopathic principles, an important tenet relates to the predisposition for certain diseases and illnesses to be fixed before birth - sometimes many generations before. This idea has obvious similarities with modern genetic and psychological approaches (see: Chapel,1999).

helps to create a sense that the holistic perspective is one that readily assimilates the complexity of effects that can influence a person well beyond the purely visibly or logically connected. At the same time it casts a conventional treatment in the role of something that actually *causes* unseen 'damage'. This, again, helps subtly to differentiate and elevate the holistic position relative to the allopathic.

Another interesting comparative feature of this sequence is the way in which the homoeopath presents 'evidence' to rationalise her approach and support her argument. Unlike the allopathic doctor in extract 43, who is able confidently to fall back on statistical certainties relating to the effects of the contraceptives she is prescribing, (. . it's failure rates one in five hundred. .'(extract 43, line 24), etc.), the individualistic nature of homoeopathy and the lack of a significantly codified body of research mean that homoeopaths can not usually rely on such a high level of predictability – at least not relating to the specific effects that a particular remedy can be expected to have on an individual patient. In terms of the way in which this is exhibited in this homoeopath's talk formulations, it can be seen that as she explains to the patient her reasoning for focusing on the issue of the possible effects of vaccination (from lines 36-54), the unavailability of conventional evidence (i.e. evidence that would be accepted outside the homoeopathic arena) leads her to adopt a significantly 'hedged' approach. On line 42, for example, there is: '. . cus there is this – this er:m – idea that some of the side effects from vaccinations can be (.) learning difficulties. .'. And then: '. . .it's a range of possibilities and- y'know, obviously not always – not all children..'(lines 46-47). So in effect, the uncertainty that the homoeopath has been able to associate with the issue of vaccinations earlier on in the sequence is undermined slightly by her inability or unwillingness to be more specific (i.e. to provide 'evidence') about exactly what the '. . range of possibilities' might be. Her openness about the complex realities that embarking on this course of deductive prescribing might involve begin to work against her slightly, creating the (possibly correct) impression of the impending activity as something that can be no more focused or predictable than the unfocused and unpredictable effects of the allopathic treatment it is trying to overcome.

How the difficulty of effectively defending the holistic perspective may be reflected in the talk formulations of homoeopaths when faced with an 'opposition' that, for the most part, can rely on large amounts of repeatable research data, is further illustrated in the extract below: [36]

Extract 49 (DF-B-03-06-00)

((Pat has been explaining how her allopathic doctors have told her that homoeopathy is 'not proven'.))

1	Pat:	. . . . .and I said at least if you take homoeopathy
2		·hh and it doesn't work- fair enough it doesn't
3		work ·hh (0.8) you try something else- but
4		at least you've not been messed about inside your body
5		your whole system's not- (.) you know ^tk-·h[hh
6	Hom:	[It is proven
7		by the way
8		(0.9)
9	Pat:	Well evidently (0.5) they've told me in a letter that
10		the medical journal this month (0.3) has said that
11		there's no: (0.4) no evidence
12		(2.4)
13	Hom:	There's plenty of back ish-back issues and articles and
14		back issues of the B M J ·hh that say that there is?
15		evidence
16	Pat:	Right well
17	Hom:	An:d the- there's a- (0.4) chap at the- (0.3) er:m (0.8)
18		Glasgow homoeopathic hospital who's done lots of research
19		and has published research (1.8) °so-°
20	Pat:	Well (.) I mean they just tell- ·hh this is it you see
21		they put the same thing down every time (0.8) you know
22		·hh er-and-and this is what's making me mad – it's
23		really getting to me

While the patient here is obviously already in alignment with the homoeopath and displays affiliation to the holistic approach: '. . at least you've not been messed about inside your body your whole system's not- (.) you know. .' etc. (lines 4-5), there is evidence of 'trouble' when the homoeopath attempts to back up his position against the allopathic argument that the patient is reporting. The sequence in general highlights a paradox that anyone attempting to argue for or 'prove' homoeopathy on the same terms as

[36] This sub-sequence is taken from a longer extract that is included in the section on patient narratives (chapter 7).

allopathic medicine will often face. In the allopathic system the failure of individual drugs and treatments is seldom used as an argument that the whole system is flawed. However, the failure of homoeopathy in specific cases (i.e. the failure of a specific remedy utilised in a non-holistic randomised trial) is routinely cited by allopathic doctors to imply that the homoeopathic approach *in general* does not work. In this extract the patient alludes to this strategy being used in relation to her when she mentions how her local health authority: '. . .told me in a letter that the medical journal this month (0.3) has said that there's no: (0.4) no evidence.' (lines 9-13). This in turn develops out of an initially defensive remark by the homoeopath on line 6: 'It is proven by the way.', which, in the light of the patient's subsequent line 9-13 turn effectively places him in an awkward position. Even though the patient is not in any way questioning the validity of what he is saying, or the validity of homoeopathy in general (in fact, she displays an even greater level of affiliation in the closing turn of the sequence '. . this is what's making me mad – it's <u>really</u> getting to me. .'(lines 22-23)), as she continues to report what the allopathic doctors have told her, the homoeopath, is placed in a position where evidence to support his position needs to be produced. The reply turn he delivers on lines 17-19, however, is very weak and reflects the underlying lack of concrete research data that dogs homoeopathy. The homoeopath can not, like the allopath in extract 43, point to specific statistical data relating to his remedies, but rather, has to rely on alluding to '. . a chap at the. . Glasgow homoeopathic hospital who's done lots of research. .'(lines 17-18). Ironically, the homoeopath is, even here, having to refer to allopathically based rather than holistic research – research done in order to 'prove' the efficacy of particular remedies on specific complaints. The delivery of his relatively defensive turns similarly suggest 'trouble', particularly in the initial and terminal stages. Immediately following the completion of the patient's report of 'no evidence' on line 11, for example, there is a significant 2.4 second pause before the homoeopath delivers a response (line 12), and on line 13, and at the beginning of line 17 there is noticeable perturbation ('An:d the- there's a- (0.4) chap at the- (0.3) er:m. .') – his turn eventually fading out after a 1.8 second pause into '°so-°'(line 19). Overall, the sequence illustrates how direct 'attacks' on homoeopathy can be awkward effectively to

defend against when so much of the homoeopathic process is nebulous and difficult to pin down.

Pre-emption

The presence of this kind of basic evidence-based inequality understandably means that homoeopaths will encounter situations similar to the one in the last extract fairly regularly – particularly with patients who are new, or who may only be familiar with some of the more contentious elements of homoeopathy, such as ultra dilution. Practitioners are, therefore, likely to have to some degree evolved strategies that make these potentially troublesome elements easier to deal with. One approach that was evident in much of the data I was able to collect involved the pre-empting of predictably difficult issues. This was particularly apparent in all of the 'new patient' consultations I observed. In these interactions it was a routine procedure for homoeopaths to ascertain the level of holistic understanding that patients brought to the encounter before the consultation proper began – that is, before any specifically 'medical' business relating to a presenting complaint etc. was undertaken. The next two examples illustrate this:

Extract 50 (H-DOC-NP-20-10-00)

((Three participants: The homoeopath, the teenage patient and patient's mother))

Hom: . . . right (0.4) °h (.) eh- do you know a little bit about homoeopathy
at al[l
Pat: [Em (.) not really
(.)
Hom: No? h- mum? (.) do you know a little bit=
Mum: =A-l-a tiny amount (0.3) [tiny
Hom: [A-hu
Mum: A-hu
Hom: A-hu I mean I'll just briefly (se-) give a description of [it=
Mum: [Yea
Hom: =so you're kind of aware °hh erm p-°h (.) obviously it's been around for (.) a hundred and fifty years so it's been around a long time (.) and- er it's-it's obviously quite a different approach to (0.4) usual conventional sort of medicines °hhh and eh I mean most of the (0.2) remedies are based on plants but they're not all based on plants
(0.4)

17 Pat °°Hm°°=
18 Hom: =and the way that the medicines are prepared is ˚hh that the-
19 whatever you're using say it was a
20 (0.8)
21 Pat: °°Hm°°=
22 Hom: =Erm (.) marigold or something
23 Pat: A˚hu
24 Hom: It's (.) i-w-h-it's er- obviously the- the juices are taken and diluted and
25 diluted and dilu- e-deluted (0.2) till basically there's none of the plant
26 there but the way that it's actually prepared ˚hh is it sort of imprints
27 onto (0.4) water or whatever the solution there is . . .

Extract 51 RF-J-27-04-00

1 Hom: Di-did erm: (0.5) did-it all make sense f-the le- did I give you a
2 leaf[let about homeopathy –
3 Pat: [Yes. (definitely) – - [that's fine
4 Hom: [nd that makes sense n- any (.)
5 Pat: Yep.
6 Hom: Questions from - that [or-
7 Pat: [I'm always intrigued by how ·h (1.5) kh· cos my
8 cousin told me this as well n-n y-you said the same thing. ·h about if
9 (.) something is causing you to be (0.7) ill or not right or whatever ·h If
10 you give a little bit of it – then that - helps cure i[t
11 Hom: [E-yes - yes, (wh-s)
12 exactly (y'see) the same as
13 we're [doing with the vaccinations the[re-
14 Pat: [Yea. [But why
15 Hom: Why. ·h well it's becuz the-the remedies are: erm: (1.5) they're
16 dynamic. Thet-they're ·h h· erm:: (0.4) it's the-s-minute dose but it's-
17 it's a dynamic dose cos the remedies are made by (.) diluting – n
18 shaking and dilu[ting and shaking ·hh and in that process=
19 Pat: [Yes - yea.
20 Hom: =(0.8) homeopaths believe (*) hh· ·h y'know not ·hh– k-y'know not-not
21 everybody does, but y'know, the homeopathic point of view is that-
22 you release energy from the- substances (1.0) so although it's very
23 dilute (0.5) it i[s
24 Pat: [(d-you release some [of energy)
25 Hom: [You're releasing the energy. . .

The first extract comes from a consultation involving a homoeopathic GP of the type who utilise a 'full' holistic consultation style (so the entire consultation subsequently focused wholly on homoeopathy), and the second is form a professional homoeopathic encounter. There are three main features that are salient here. The first is structural: in both sequences it is evident that the practitioners use an initial enquiry as a means of 'setting-up' an arena where

they can begin explaining what homoeopathy is and how it works. This, as I have already suggested, relates to some degree to the need for the patient to be involved and have a positive attitude towards the therapeutic experience. However another reason for the practitioner to begin a first-time consultation with an explanation sequence, may relate to the strategic advantage (in terms of possible homoeo-allopathic system conflict) of having elements that are possibly contentious out in the open early on. If matters such as ultra-dilution and the non-universiality of remedies are sufficiently well explained at an initial stage, for example, (as well as being explained in a sequential format that is initiated under the direction of the practitioner, and not the result of the kind of defensive action), the homoeopath can utilise previously prepared (i.e. familiar and often repeated) fragments of narrative in which they are, by default, cast as the figure of authority.

In formulating the questions '. . do you know a little bit about homoeopathy at al([])l.' (extract 50: lines 1-2), and 'Di-did erm: (0.5) did-it all make sense f-the le- did I give you a leaf([])let about homeopathy. .' (extract 51: lines 1-2), the practitioners are creating for themselves subsequent slots into which they can fit a relatively unrestricted explanatory sequence. Similarly, because they have created an interactional space in which they are ostensively responding to a request by the patient to explain things, the comparatively extended and monologic format with which they present their turns can stand outside or above the holistic conventions of patient-centredness; at this point in the encounter the focus is not yet fully on the patients' narrative etc., so an 'authoritative' (i.e. one-way or transmissively biased) explanation sequence may be delivered here without creating too much disruption in terms of free narrative development and so on.

The second significant feature of these two extracts is connected more with the specific topical elements that the homoeopaths choose to use once their explanation turn sequences are underway. In both cases they shift their talk relatively quickly to descriptions of the remedy dilution issue and frame their turns around the positive practical features that it engenders. In extract 50, for example, after outlining the 'natural' ingredients from which most remedies

are made, the homoeopath attempts to gives a relatively straightforward explanation of how the dilution process is thought to work: [37]

(From: H-DOC-NP-20-10-00)

25 Hom: . . . . the- the juices are taken and diluted and
25 diluted and dilu- e-deluted (0.2) till basically there's none of the plant
26 there but the way that it's actually prepared °hh is it sort of imprints
27 onto (0.4) water or whatever the solution there is . . .

By including the topic of ultra-dilution as part of a list of other relatively uncontentious elements (i.e. homoeopathy as a different approach; the ingredients of the remedies being natural; how in the preparation something imprints on the water etc.), attention is largely drawn away from it reducing its illogicality and improbable aspect. Similarly, in extract 51, although it is the patient who brings up the topic of dilution right at the beginning of the sequence the homoeopath incorporates within her explanation elements that effectively draw attention away from the specific incongruities that the process invokes and instead, emphasise its relative position among other more familiar elements:

(From:RF-J-27-04-00)

7 Pat: . . . .([])I'm always intrigued by how ·h (1.5) kh· cos my
8 cousin told me this as well n-n y-you said the same thing. ·h about if
9 (.) something is causing you to be (0.7) ill or not right or whatever ·h If
10 you give a little bit of it – then that - helps cure I([])t. . .

Later on in the extract too (lines 11-13), she draws a comparison between the homoeopathic process and the allopathic technique of vaccination (i.e. the use of small doses to stimulate a reaction from the body). This serves to associate 'smallness of dose' with an allopathic idea that the patient likely to

[37] Interestingly although the 'natural' ingredients that most remedies are made from, such as flowers or herbs, are completely innocuous to begin with, there are many that evoke images of poison and toxicity, and would be dangerous to take in anything other than homoeopathic doses. The remedy 'Carsinosin', for example is extracted from active cancer cells, while others are made from syphilitic discharge, arsenic, dog milk, and even dog excrement. Understandably, these kinds of details are not routinely included in the explanation sequences offered to new patients.

be familiar with, and hence to some degree begins to de-mystify it and places it in an apparently less polarised position. Similarly, the homoeopath attributes ultra-dilution with positive qualities of power and effectiveness, describing how '. . They're dynamic. . .it's the-s-minute dose but it's-it's a dynamic dose. .'(lines 16-17). And like the GP-homoeopath in extract 8, she frames dilution as a single element within a *process,* alluding to a lengthy specialised procedure that involves hidden esoteric complexities: '. . cos the remedies are made by (.) diluting – n shaking and dilu([])ting and shaking ·hh and in that process= (0.8) homoeopath's believe (*) hh· ·h y'know not ·hh– k- y'know not-not everybody <u>does</u>. . .'(lines 17-21).

Strangeness

An interesting side issue that relates to the final elements of the above turn is the way in which the homoeopath alludes to the credibility of the process she is describing, and, by invoking the need for 'belief', essentially casts it as distinct form the world of allopathic certainty where effects are proven or displayed as being such, and faith plays little part. (Doctors would not, for example, routinely refer to 'believing in' allopathic medicine because the functioning of the system thrives on being represented as securely grounded in pragmatic reality.) The openness with which this homoeopath acknowledges the role that belief might play in homoeopathy is significant because it is one of the only instances I was able to collect in which a professional homoeopath referred to their system in these terms. More frequently, as is explored in the next section, the nebulous aspects of holistic treatment are downplayed or reflected more subtly through the types of evidential formulations that accompany explanatory talk. Allied to this is another comparative point that relates to the way in which homoeopaths and GP-homoeopaths approach the issue of incorporating some of the more obscure questions that they need to ask the patient. In general it appears that professional homoeopaths tend not to draw particular attention to, or categorise these questions as especially unusual. In GP-homoeopath consultations I was able to observe, however, during initial 'case taking' sequences with new patients, it appeared to be common for practitioners to make a point of commenting on them – of making it clear to the patient that

they were aware of how unusual the questions must appear. The following two extracts both come from consultations with GP-Homoeopaths and illustrate this. In order to shorten what would otherwise be a lengthy extract, in the first example (extract 52), the extended reply turns of the patient have been ommitted.

Extract 52 (H-D-NP-20-10-00)

((Pat has been describing illnesses that run in the family.))

1	Pat	. . . other than that nothing (1.2) °no (2.2) no°
2		(0.5)
3	Doc:	Right, right
4		(1.3)
5	Doc:	E-ah (.) just to sort of run through sort of the homoeopathic eh•- which
6		obviously can be a bit quirky but they're erm: (.) th-they're obviously
7		what's helped me p-•h[h eh- (0.3) e-w=
8	Pat:	[°H-hm°
9	Doc:	=d-eh:- d'y- e-w- d'y like outdoors or indoors are y- would y'be (0.7)
10		happier indoors or happier outdoors out in the open air.
12		(1.0)
13	Pat:	Erm (2.0) I'm happy indoors but if it's like (0.8) nice (0.2) and like hot
14		(.) I'm happy outdoors.
15	Doc:	Right w-what sort of weather's do you like. . .
16		:
17		:
18	Doc:	. . .and you like the warm> what about the sun, how do you feel about
19		the sun
20		:
21		:
22	Doc:	. . .right, right •hh and d-e-h rain? (0.2) how do you feel about rain and
23		thunder
24		:
25		:
26	Doc:	. . .right, right p-•hh an are you a warm person or a cold person
27		:
28		:
29	Doc:	. . .and time of day? what-er e-when are you better mornings or
30		evenings
31		(1.1)
32	Pat:	°Erm°
33		(0.5)
34	Pat:	Probly afternoons (0.2) cos I get kind've (0.2) tired (0.7) more tired
35		towards °evenings but°
36		(4.0)
37	Doc:	Okay
38		(1.9)
39	Doc:	Eh::: (0.5) and f-s- food likes and dislikes what sort of foods do you
40		like (0.7) and anything ([)you dis- dislike. . .

Extract 53 (H-D-NP-20-10-00)

Pat: . . . .yea, that's maybe my resentment.
Hom: Yes: (0.6) and quite often (colosynthis) is the indicated medicine when there's been like a swallowing
Pat: Ye[a?
Hom: [there's a bit of a swallowing of some resentment?
Pat: H-hm
Hom: ·hh going on yea? ·hh (0.3) er::m-
((Hom consults notes)) (15.0)
Hom: couple of homeopathic questions ·hh these days th-your body's-
(0.4) chilly or warm
(2.0)
Pat: Both
(0.4)
Hom: Both
Pat: °H-hm°
Hom: Ok[ay
Pat: [I still feel cold most of the time
Hom: °Most of the time°
Pat: but I think through the humid weather I'm sweating but I still feel cold
Hom: Oka:y
(3.2)
Pat: but I still often feel the heat in my face and my head but nowhere else
(3.0) ((hom writing))
Hom: A::nd how irritable are you aware of feeling
(4.5)
Pat: Well I'm certainly aware of it. . .

It is as if the underlying professional identity of allopathic doctors leads them to engage in a degree of role distance as they reach a point in the interaction where they need to ask obscure (i.e. apparently tangential or 'un-medical') exploratory questions. Functionally, this can be achieved by the demarcation of particular questioning sequences as ones that are especially 'homoeopathic'. Likewise, once highlighted as unusual, these particular types of question appear to be frequently asked in groups that follow a similar theme. They may also formulated to be relatively 'closed' (i.e. they contrast with open ended narrative prompts in that they effectively require minimal and fairly specific replies, and occur towards the end of the consultation once the patient has completed the body of their narrative). This 'demarcation' is evident in both extracts. In extract 52, the practitioner pre-empts the onset of a sequence of relatively unusual questions by announcing: '. . E-ah (.) just to

sort of run through sort of the homoeopathic eh·- which obviously can be a bit quirky. .' (lines 4-5). She highlights the 'homoeopathic' nature of the questions even though this sequence comes at the end of a relatively long consultation that has focused exclusively on homoeopathy. The practitioner, having engaged in a full homoeopathic 'case-taking' process, has already asked a whole series of specific homoeopathic deductive questions. These, however, could not be classed as 'unusual' in a medical context and it is only as issues such as whether the patient is happier indoors or in the open air (line 10), or how they feel about thunder and rain (lines 22-23), that she draws attention to this as information that is needed for the 'homoeopathic' process. Similarly, although less obviously defined, the practitioner in extract 53, delineates as 'homoeopathic' two questions that also come at the end of a consultation that had been entirely holistic: ' . . couple of homoeopathic questions ·hh these days th-your body's- (0.4) chilly or warm. .'(lines 9-10). In both extracts too, there is evidence of the question formats of which the sub-sequences comprise being relatively closed: in extract 52, for example, the practitioner uses the phrase '. . .just to sort of run through. .' (line 5) as a precursor, which implies a sense of brevity to the patient. And the same approach is evident in extract 53 as a '. . couple of homoeopathic questions. . .' (line 9) are announced. Once the questions are asked too, their construction, especially in extract 52, is largely of an 'either-or' type, as in: '. . are you a warm person or a cold person. .' (line 26), and '. . are you better mornings or evenings. .' (lines 29-30), which, taken in the context of consultations that have up until this point been focused on the open exploration of the patient's narrative, also help to reinforce the sense of demarcation that the initially overt categorisation of the questions sets up.

Explanatory formats

In my data corpus it appeared that talk about allopathic drug treatments and experiences (particularly relating to information or advice given to patients when they visit their doctor) was routinely initiated by the patient as part of a 'current situation' narrative. It was very unusual for a homoeopath to ask unprompted questions relating to the specifics of a patient's allopathic

experience unless (as in extract 44) the two health professionals involved had agreed to work collaboratively. As mentioned already, however, this kind of situation is still quite unusual – most homoeopaths work with a degree of separation from conventional health care systems. A common sequential formulation for the introduction of 'allopathic talk' is illustrated in extracts 54, 55 and 56 (below):

Extract 54 (RF-GR-11-05-00)

((Patient has been describing how her bag had been stolen the day before))

1	Hom:	. . . I mean these things happen don't they bu[t=
2	Pat:	[Yes
3	Hom:	=y'know it's just (.) reall[y unfortu^nate timing=
4	Pat:	[Yes
5	Hom:	=re[ally to be-
6	Pat:	[Yes
7	Pat:	Yes because (.) I actually didn't want to start taking
8		the dithiopin ((allopathic prescription drug)) but the
9		doctor 'hhh was hoping I would because she felt I was
10		coping better on-it
11	Hom:	Yes

Extract 55 (DR-AH-13-06-01)

1	Pat:	. . .I fell in the house (1.4) °must've been° (0.4)
2		beginning of april an I really hurt my back bad
3		again. . . . I'm really suffering from that now
5		(0.2)
6	Hom:	Right
7	Pat:	Er:m (0.4) I went to the osteopath and (he has done)
8		brilliant (.) but I'm still in pain
9		(0.6)
10	Hom:	°Right°
11	Pat:	Erm (0.6) I mean I've (0.3) they gave me (.) all the pain
12		killers back and vallium back (0.8) (um/and) I try not to
13		take them (1.3) but (0.8) I am suffering (0.3) er:m (0.8)
14		can't bend to put shoes on (0.4) can't bend I can't clean
15		in the bath now (1.0) stairs I've really quite (.) I get
16		really panicked going up and down stairs. . .

Extract 56 (LH-X-1-12-00)

Hom: Right then °h what's been going on hh°
Pat: Ri:ght: (.) erm the first thing which you mentioned last night (0.2) an I thought ooh yea I-I quickly jotted some things down °hh (.) after having Anya I went on the pill for two months
(0.5)
Hom: Did you?
Pat: Yea (0.5) becaus:e er:m
(0.2)
Pat: Dave- (0.6) we decided soon as we had er (0.2) as soon as we'd had Simon °hhh (.) we'd said that was it cos (.) he didn't want any children so he agreed that two [was=
Hom: [^K-hhh°
Pat: =sort of like a fair com[promise an [I thought well yea=
Hom: [°hh [^R-hi-ght
Pat: =you can't argue with that . . .
:
:
Pat: . . .so I went back on the pill for two month n then (0.9) just basically just didn't feel right at all an I think the main thing there were this thing at the back of me mind °hh after having come to you and had everything cleansed
Hom: Righ[t
Pat: [I were then putting it (.) [all back in again=
Hom: [Yea
Pat: =which (.) I think really-
(0.5)
Hom: Tk
Pat: An I kept saying to ((name)) oh I'm not happy about it
°hh so in't end he just said oh look (.) just come off n: if need be we'll. . .

All three of these examples come from right at the start of consultations and represent the introduction of a first topic by the patient. As is common with the 'open' format that these opening sequences are the result of (in that the homoeopaths utilised opening formulations designed not to influence the patients' choice of opening topic - see chapter 5), the patients begin their narratives with reference to significant 'life-world' events that have occurred in the period between since they last had a consultation. These, as in extract 54, do not necessarily have an immediate or obvious connection to the presenting complaint (the patient in this extract, for example, has begun the consultation by talking about her stolen handbag), but rather, may be

tangentially related to the patients' overall (i.e. holistic) health concerns. The initially holistic oriented topics are used to introduce or lead into talk related to allopathic issues. The patient in extract 54 connects the upsetting effect of the handbag incident with the need to fall back on an allopathic prescription drug: 'Yes because (.) I actually didn't want to start taking the dithiopin. . .'(lines 7-8). In extract 55, the reintroduction of an allopathic regime relating to: '. . all the pain killers and vallium. .'(lines 11-12) follows an initial account of a fall the patient had had some time earlier. And in extract 56, the patient begins by referring to a deductive process she had been engaged in at the request of the homoeopath: '. . erm the first thing which you mentioned last night (0.2) an I thought ooh yeal I-I quickly jotted some things down. . .'(lines 1-4), before developing her narrative into an account relating to her experience of allopathic contraceptives.

It is significant that in the formulation of the turns that refer directly to allopathic drugs and treatments, all three patients orient to these as being somehow unsatisfactory or inferior to their current holistic regime – the use of such drugs is presented as representing something retrograde in the therapeutic process, something that they would have avoided if they could. In extract 54 for example, the patient makes direct reference to having to resume taking an allopathic drug despite having reservations about this: '. . I actually didn't want to start taking the dithiopin. . . but the doctor ·hhh was hoping I would . . .'(lines 7 and 8). This formulation is significant because it contains not only an expression of unease on the part of the patient at the prospect of using the drug, but also an account or rationalization explaining why she might have to. She distances herself from taking responsibility for the use of the medicine (which being allopathic might therefore be potentially disruptive to her homoeopathic treatment) by quoting the opinion of the doctor – who represents medical authority – to justify her actions. The formulations used by the patients in the other two extracts exhibit similar characteristics. In extract 55 the patient says: '. . I mean I've (0.3) they gave me (.) all the pain killers back and the vallium back (0.8) (um/and) I try not to take them. .'(lines 11-13). She displays both a reluctance to take the allopathic drugs, coupled with a rationalisation for doing so in the form of the

allopathic doctors ('they'). Extract 56 is slightly different in that the patient acknowledges that it was her own choice (rather than something her doctor suggested) to take the contraceptive pill, but again the sense that she tries to display an orientation to this allopathic treatment as being 'bad' for her on a fundamental level is evident: she describes how she is '. . not happy about it. .' (line 30), and how in the back of her mind was the thought that '. . after having come to you and had everything cleansed . . I were then putting it (.) all back again. .' (lines 22-25).

If a homoeopath routinely presents an incorporative and non-antagonistic attitude towards conventional treatments, the patient can use these kinds of 'anti-allopathic' formulations to display an active affiliation, not only in terms of the ongoing one-to-one interaction, but also with the holistic system in general. Their support and acknowledgement of homoeopathic principles can be displayed if they use a negative standpoint when framing their talk about allopathic treatments. In all three cases, then, the patients exhibit an overt orientation towards the allopathic treatments they have had as being something 'un-holistic' and possibly retrogressive in homoeopathic terms. It seems that unlike the relatively hedged or 'balanced' approach that homoeopaths were often observed taking when they discussed the merits of conventional medicine (see next section), patients can be far more overt in their displays of orientation and preference. They are likely, after all – particularly if they are long-term patients like the ones in these three extracts – to have invested a significant amount of emotional and intellectual energy in the holistic mindset. These formulations evoke a sense of movement or progression away from a system of medicine that for many people represents restriction and powerlessness, and into one that is open and humanistic.[38] The trajectory of medical experience for homoeopathic patients, after all,

[38] I have not been able to find any instance, anecdotal or otherwise, for example, that involved someone rejecting a background of holistic medicine to keenly embrace allopathic principles. The situation in the West, however, with its deeply ingrained allopathic tradition is likely to be different from that found in developing countries. It might be suggested that in areas of the third world where people have had to rely on folk medicine (holistic or otherwise) for generations, and have consequently fallen victim to many of the diseases and conditions that western medicine has been able to prevent, are likely to experience 'conversion' in the other direction.

routinely involves a 'journey' from the allopathic to the holistic – one in which movement in the reverse direction is rarely seen.

The reasons why homoeopaths might appear to be reluctant to initiate talk relating to the activities of their allopathic counterparts, and leave it to the patient to do so, may be connected with an underlying disregard for conventional medicine. They may also simply reflect a reluctance to disparage other professionals. It may be just as likely, however, that there are purely practical interactional reasons for reticence, i.e. sequentially related ones. Given the overtly patient-centred approach that is fundamental to homoeopathy, and the 'open' topic initiation formulations that are so prevalent during the initial stages of consultation (see chapters 2 and 3), I would suggest that that homoeopaths in fact tend to avoid overtly initiating *any* specific topic during the early parts of an encounter, not just ones relating to allopathic medicine. So it may be argued that it is largely because patients choose to bring up allopathically related topics at these early points that they appear to cluster around their initial narrative reports.

It seems that from the patients' perspective, a visit to their GP, or a decision to use an allopathic preparation, is likely to have been a significant event in terms of their general health and well-being. From my own experience as a homoeopathic patient I know that one very quickly becomes familiar with the concept of a fundamental interconnectedness regarding apparently disparate health issues, and this casts any significant development as 'news'. As the patient is routinely handed topical control early on in the consultation it is therefore to be expected that these newsworthy topics are things they choose to mention.

Talking about allopathic treatments

As with the way in which an underlying allopathic perspective can be recognised in the way in which doctors formulate and frame their talk – and as we have seen, some homoeopathic GP's – it is also evident from my data that for homoeopaths, the holistic perspective can be displayed not only when they talk about homoeopathy, but also when they discus allopathy with their patients. Unlike conventional medical settings where only a relatively small proportion of patients are likely to have had active contact with CAM practitioners, in homoeopathic environments the vast majority of patients in the West will – even if they are enthusiastic supporters of holistic medicine – have had at least some contact with a regular GP and the network of conventional health services that go with them. This means that the treatments and allopathic preparations that allopathic doctors prescribe can become a topical focus for patients when they consult their homoeopath. In general it appears that although there are a number of sub-formulations that crop up in relation to factors such as the perceived impact that the allopathic medicine is likely to have on the patient's current homoeopathic treatment regime, or the position on the 'holistic continuum' that the homoeopath perceives the patient to occupy, homoeopaths in my data were likely to take one of two approaches when discussing allopathic drugs and treatment. These can be broadly categorised as: 'Rejection', and 'Incorporation'.

Rejection

In its most overt form, this formulation is uncommon. As I have shown in earlier chapters, in the name of patient-centredness, homoeopaths generally avoid categorical or instructional turn constructions when talking with their patients. I have, for example, only been able to find one instance when a homoeopath told a patient outright to stop using an allopathic drug, and this was an anecdotal account obtained during a background interview.[39] It

[39] At interview, this patient described how, when she first consulted her homoeopath she (the patient) was suffering from the side effects of taking an allopathic arthritis drug. While phoning to arrange their first meeting, the homoeopath instructed the patient in no uncertain terms to stop taking the medication immediately. As a recording of this original

appears to be more common, when homoeopaths engage in talk about allopathic medicine, for categorical formulations to be attenuated and for comparatively subtle and sequentially extended approaches to be used. While an underlying antipathy towards, say, a particular drug or allopathic treatment may still be relatively clear in the formulations of talk that they choose to make use of, outright rejection is rarely produced in any overt way. Extract 57 (below), and extracts 58 (page 240), and 59 (page 243), are examples of more 'covert' or 'semi-overt' rejection sequences:

Extract 57 (LH-S-3-10-00)

1	Hom:	So how many cortizol ((allopathic drug)) have you got
2		left
3		(0.5)
4	Pat:	Oh: not many=
5	Hom:	=not many=
6	Pat:	=no not many about (.) erm [(??)
7	Hom:	[And how long are you going
8		to be doing this no- nasal spray for
9		(0.5)
10	Pat:	Erm (.) I see the consultant (.) I mean I could stop
11		it now if=
12	Hom:	=Yea
13	Pat:	really shall I stop it now
14	Hom:	Yea IF IT'D WORKED I'D'VE SAID NO Keep going with it but
15		it's NOT WORKED .h [then I wouldn't bother
16	Pat:	[No I don't think it has. . .

It can be seen that in this sequence, which occurs just prior to the treatment phase, it is the homoeopath who actively introduces the topic of the patient's use of two allopathic drugs. From the way in which she frames her enquiry turns; 'How many cortizol have you got left. . .'(lines 1-2), coupled with: 'And how long are you going to be doing this no- nasal spray for. .' (line 8), the patient picks up on the underlying message that the preferred option would be for her to stop the allopathic medication. This is confirmed by the way in which, on line ten, she says: '. . I mean I could stop it now if. .'. – the homoeopath's closely latched 'Yea' at this point (line 12) making her position

interaction is not available, however, the actual structural formulation that the homoeopath used to do this is unclear.

more overt. An interesting point here is the way in which, although the homoeopath would clearly prefer the patient to undertake a particular course of action – in this case to stop using her prescription drugs – she approaches the issue in such a way as to let the patient be the one to bring this into the open. She does not use an unprompted instructional format (such as: '. . I'd like you to stop using the cortizol. .'), rather, her position becomes explicit through responses to the patient's clarification questions ('. . I could stop now. .' (lines 10-11), and '. . shall I stop it now.'(line 13)) – questions that she (the homoeopath) has projected or 'set-up' during the earlier parts of the sequence. What is also relevant here is that, as if to mitigate for her uncharacteristically direct delivery, the homeopath is keen to provide the patient with an account of the reasoning behind her position. On line 14, using a relatively fervent tone (denoted by the capital letters), she implies that there is a clear logical deductive process involved and not simply an ungrounded antagonistic attitude towards allopathic treatments: '. . .IF IT'D WORKED I'D'VE SAID NO keep going with it but it's NOT WORKED ·h then I wouldn't bother. .'(line 14).

Extract 58 (below) is more extended, but has very similar characteristics to extract 57:

Extract 58 RF-J-27-04-00

((Pat is asking about the effects that homoeopathic treatment might have on her son – also a patient))

1	Pat:	Will that get worse- is-w-is that another way of that
2		coming out=
3	Hom:	=W'll it m-yes- it cou-might do– might well do
4		that [is=
5	Pat:	[It might(°do°)
6	Hom:	=definitely one way things can come out is on the skin
7	Pat:	So should we stop using the creams from the hospital or
8		just carry [on
9	Hom:	[That would be good yes cos that's the-
10		((Hom consults notes))
11		:
12		((Hom clarifies types of cream with pat))
13		:
14	Hom:	. . .I spoze it – w(.h)- if you felt alright about

15 it
16 Pat: The only thing is if we don't carry on (.) then it's
17 liable to get worse anyway.
18 Hom: That's true?
19 Pat: And I won't [know
20 Hom: [D-does it seem as if it is – does it seem
21 to help
22 Pat: If we've- if we don't put it on for four or five
23 days, then (.) it gets worse.
24 Hom: Does it
25 Pat: It needs to be – y'know – kept on.
26 Hom: ·h I don't know what donovex is. (.)d-dovon-
27 oh d[ovonex ((allopathic skin cream))
28 Pat: [(dovon)-yes.
29 Hom: Hm (??) dovonex- do you know if that's- ·hh
30 (4.0) °·hha° (1.0) wonder whether I should just check
31 that is – I don't actually know- (0.5) there's
32 obviously some things – what we're trying to avoid is
33 things that are too suppressive (.) If you have e-erm:
34 some creams-
35 Yes
36 (1.0)
37 Hom: Lots of allopathic creams can be quite suppressive
38 ·h [and
39 Pat: [How do you mean sup-°suppre[ssive°
40 Hom: [Well, ·h erm: (.) it's
41 almost like cleari – clearing the symptoms by-by
42 pushing them i[nside. - - - [D'you know what I mean.
43 Pat: [Ah· Right. - [Yes Yes.
44 Hom: What homeopathy's trying to do[is to clear symptoms=
45 Pat: [You bring the symptoms
46 out
47 Hom: =and bring them out=
48 Pat: =Yes, bring them to the su[rface
49 Hom: [·h So you sort of have
50 this – th-thum rather reacting against each other –
51 <not that that's> [harmful in any way.
52 Pat: [·h I mean w-we–we-we[could stop=
53 Hom: [(but you know)
54 Pat: =cos I don't think it's actually putting him in any pain
55 Hom: No. No. (0.5) No, and it's not – it wasn't too itchy
56 for him was it – it wasn't unsettling him too much –
57 upsetting him too much.
58 Pat: No(.) No
62 (1.0)
63 Hom: Well I suppose if you felt alright abou[t that
64 Pat: [bout it-<do
65 it for a week or s –
66 (1.0)
67 Pat: [Wait and see
68 Hom: [Yes. (.) Yes. (.) Yes. So it may well get worse ·hh
69 but I think if it –if it doesn't trouble him
70 Pat: Then i-
71 Hom: Then if you[can let that work through.
72 Pat: [yi-

73 Pat: Yea.
74 Hom: Er[m:
75 Pat: [Ok.

It is clear from the formulation of the homoeopath's initial response to the patient's enquiry about giving up an allopathic skin cream that, although she avoids directly telling the patient what to do, her fundamental preference is for the treatment to be dropped. Her initial response is an overt agreement: 'That would be good yes . . .'(line 9), and the construction of several of her turns in the subsequent interaction also support this position. Although on line 14 she produces a slightly moderated turn: '. . I spoze it – w (·h)- if you felt alright about it.', this construction is sequentially fitted to the patient's original enquiry '. . so should we stop using the creams' (line 7) and begins to capitalise on her fairly neutral stance at this point. When the patient introduces the issue of not being able to tell whether it is the lack of allopathic medicine or the taking of the remedy that might be causing the symptoms to return ('. . the only thing is if we don't carry on (.) then it's liable to get worse anyway. .'(lines 16-17), the homoeopath finds it necessary to strengthen her position by introducing an illustration of homoeopathic reasoning. This confirms and makes clearer her negative stance towards the use of the allopathic cream while still falling short of a direct or overtly instructional statement. On lines 29-31 her relatively fragmented and rhetorical turn 'Hm (??) donovex- do you know if that's- ·hh. .' etc., communicates the possibility that the unknown properties of the cream may indeed be homoeopathically hazardous (implying 'better safe than sorry'), while the remainder of the turn, again, becomes slightly more overt without being instructional: '. . .what we're trying to avoid is things that are too suppressive. . .lots of allopathic creams can be quite suppressive.'(lines 33-37).

This sub-sequence is interesting because the homoeopath begins to incorporate an explanation in which she outlines a fundamental difference between the actions of allopathic and homoeopathic medicines – the idea of symptom suppression. This in effect allows her to use the negative outcome that the patient has highlighted – that her son's skin rash will get worse – as

something positive; even if the rash initially worsens this can be portrayed as a possible indication that the remedy is working.

A third semi-overt 'rejection' example is given below. Again this sequence is the result of a patient initiated enquiry:

Extract 59 (JS-JP-31-1-00)

((Pat has just asked Hom if she saw a TV article relating to a new allopathic treatment for arthritis))

Hom: ·hh Well I didn't really I just sort of erm (0.8) it was
on the news an-h· (0.8) I'm not sure what it is it's
about (1.8) I think it's about knocking off some- (0.5)
part of your immune syst[em
Pat: [It's to do with the cells
s[he said that much (.) e=
Hom: [Yea
Pat: =like-like ys- it-yu-it's °yr°- (0.3) which cells (0.5)
(?) there's one set of cells that attack the other
Hom: H-hm
Pat: ·hh er:m (0.8) and that's what sort of (0.2) causes the
rheumatoid isn't it (0.2) it's sort of- ·hh whereas
[normally
Hom: [Normally
(0.3)
Pat: [it-
Hom: [turns on itself=
Pat: =That's [right an it's- apparently stops that=
Hom: [doesn't it
Pat: =they've - they've found a drug that will stop (1.0) the
cells from attacking their own cells
Hom: But they're having to in order to do that I think (0.8)
<um-um> (1.0) get rid of (1.0) part of the immune system
(1.2) which (0.2) another doctor was (.) not so sure
(0.2) was a good idea (1.3)
Pat: Well I just feel anything like that (0.3) it's: y'know
it's good on one hand but it is going to (0.2) I think
cause problems somewhere else
(1.3)
Hom: Yes
(1.4)
Pat: An again
(.)
Hom: I don't think it's the answer at all

Unlike the homoeopath in extract 58, this homoeopath is not being asked a question specifically concerning the patient's treatment (although the topic is

broadly related). In a sense the interaction is focused on more general opinions – it could be thought of as a sequence in which the homoeopath is likely to be freer openly to display elements of her holistic perspective because she does not need to focus too closely on the intricacies of the patient's particular treatment regime (the actions of drugs as they might specifically affect her condition, for example). At the beginning of the sequence it is evident that the homoeopath displays a non-overt but relatively negative attitude to the topic that the patient has introduced; her initial response is somewhat non-committal: '. . I'm not sure what it is it's about (1.8) I think it's about knocking off some- (0.5) part of your immune system.'(lines 2-4).' Once the patient has begun explaining what she understands to be the functioning of the new treatment, however (in the sequence running from lines 5-21), the homoeopath begins to display a more overt orientation against what is being described – or more accurately, against the allopathic principles behind what is being described – and reveals that she in fact has a greater background knowledge of the issue than she initially displayed. In response to the patient's categorical suggestion that they (the doctors and scientists that represent conventional medicine) have '. .found a drug that will stop (1.0) the cells from attacking their own cells. .' ((i.e. in arthritis)) (lines 20-21), the homoeopath's turn on line 22 is framed to indicate that, while the patient may well be correct, there are other factors that need to be considered – factors that are at odds with holistic and homoeopathic principles. Firstly, by introducing her turn with 'But they're having to in order to do that. .', she is already indicating that she has reservations about the apparently straightforward process that the patient has outlined. As the homoeopath continues, too, her phrasing generates the sense that she sees the idea as being over simplistic (in terms of it embodying an allopathic approach that is unlikely to take account of holistic interconnectedness). In a comment that evokes a similar bluntness and mechanisticality as her initial '. . . knocking off some part of your immune system. .'(line 3), the homoeopath now emphasises how the treatment will '. . get rid of (1.0) part of the immune system. . .'(lines 23-24). Both formulations in their non-technicality betray an underlying view of the treatment as intrinsically damaging. Interestingly, as if to emphasise that her

unenthusiastic perspective is balanced and grounded, she invokes the evidence of an *allopathic* doctor to support her argument: '. . which (0.2) another doctor was (.) not so sure (0.2) was a good idea. .'(lines 24-25). That she chooses to call upon support from this quarter rather than volunteer an holistic explanation as to why such a procedure might be detrimental is significant because it highlights the way in which, even though it may represent a polarised and often hostile outlook with regard to homoeopathy, the conventional medical establishment can still be invoked as a source of authority. In the context of this section of the interaction, however, the homoeopath is in fact able to subtly undermine this by highlighting that there is descent and disagreement over the procedure - even in allopathic circles. Similarly, her use of the phrase '. . not so sure.' (line 24) in relation to the doctor's opinion helps to further develop an impression of uncertainty around the issue. This sequence, then, illustrates how 'rejection' of an allopathic process or procedure can be achieved in a relatively subtle and non-overt way – even the homoeopath's final summary turn 'I don't think it's the answer at all' (line 34), is in effect offered as an affiliative response to the patient's own summary on line 26 ('. . anything <u>like</u> that. . is good on the one hand but it's going to (0.2) I think cause problems somewhere else.'), rather than an unprompted statement of antipathy.

Incorporation

As I outlined at the beginning of this section, in contemporary homoeopathic practice the holistic practitioner will be unlikely to come across a patient who is having, or has had, no contact at all with the mainstream allopathic system. Homoeopaths are necessarily in a position where they need to accept that patients who have been taking allopathic medication for life threatening illnesses such as heart disease, cancer or diabetes – or treatments to control extreme behaviours and forms of mental illness etc., are likely to need to continue with these alongside their homoeopathy. In spite of the positive claims that homoeopaths make for their system of medicine, it may not be adequate to deal with many of the more acute illnesses that conventional medicine has been able to fight successfully. This means that sometimes the

'rejection' option is not really appropriate (a diabetic patient, for example, might eventually die if encouraged to stop taking their insulin, regardless of anything the homoeopath could prescribe.)[40] With patients who have these types of acute illnesses then, the homoeopath must somehow work alongside the allopathic treatments that have been prescribed, and will display through their talk sequential formulations that reflect various levels of incorporation ranging from the 'full' or 'unconditional' through to the 'reserved'. In the consultation data I had available there were no cases involving seriously life threatening or acute illnesses, however, there were a number of patients who were taking prescribed medication alongside their homoeopathic treatment and it is from this corpus that the categorisations suggested in this section are derived.

Full incorporation

The characteristics of the full incorporation format type involve the homoeopath talking about or referring to an allopathic treatment that the patient is involved in without any underlying implication that it needs to be reduced or removed from the treatment regime. This is in effect an assimilation of an allopathic medicine into the homoeopathic 'picture' of the patient. Because the patient is unavoidably reliant on, say, a heart drug, this becomes as holistically relevant as any other element of their life-world. And as such, the homoeopath may display an interest in elements such as frequency of dose, the active ingredients of the drug, its effects and side effects, and so on, in very much the same way that they might enquire about particular preferences for certain types of food, for example. Once a drug or other allopathic treatment is fully incorporated into the homoeopathic picture of the patient, unlike with the 'rejection' formats, the homoeopath is unlikely to make any attempt at persuading the patient to alter or reduce their

[40] There are a small number of homoeopathic purists who will have nothing whatsoever to do with any medical system apart from their own. This occasionally leads to some of the more sensationalised accounts of people dieing as a result of homoeopathic medicine – or more accurately, lack of conventional medicine. Homoeopathic 'extremists' have occasionally been reported, for example, refusing to admit themselves or their children to hospital until serious illnesses such as meningitis or TB have taken hold.

prescriptive dose unless this has been suggested by the patient's allopathic doctor. (This kind of situation will obviously be different from one in which a patient, as in the case study in chapter 2, has deliberately decided to try and use homoeopathy as a means of reducing an allopathic medication that has become troublesome or overly toxic.) The example below (extract 60) illustrates the sequential characteristics that indicate this kind of 'full' incorporation:

Extract 60 (LH-S-3-10-00)

Pat: . . .I had to literally shout to talk to them .h and I
couldn't talk to them .h because every time I ts-
I shouted to talk to them .hh I'd start coughing <y'know>
have a cough[ing attack.
Hom: [(You'd start)
Pat: .hhhh (.) An I ended up having to go in the toilets n
take erm (0.2) .hh some squirts of erm (0.5) salbutomol
((allopathic drug))[to help me
Hom: [right
(2.5)
Hom: So how many inhalers- what inhalers are you doing at
the moment
Pat: Tk-.hh jst the: erm (0.2) ventalin inhalers the
salbutomol and erm (0.2) p-.hh seratide (0.8) that's one
(.) twice a day (0.8) seratide isn't it js-(3.0) ((pat
consults notes))
Hom: And that's your steroid one
Pat: .hh No th-the nazan[ex is er (0.3) a serotide <I don't=
Hom: [Nex is a st- right
Pat: =know if that's steroid> or not actuall[y
Hom: [Is it bro[wn
Pat: [(I can
tell is) .hhh no it's purple
(0.6)
Pat: .hh It's a round one
(.)
Hom: Hm
Pat: It's a purple one now is it steroid or
not (1.0) er:[m
Hom: [Probably
(0.8)
Pat: I would imagine it prob[ably would be yea f:: h.-m: .hh
Hom: [Yes
Hom: K-.hh So ANY ERM (0.7) tk (2.0) gave you- what's your
ear doing (0.5) at the moment. . .

This extract involves a long-term patient whose main presenting complaint was hormonally related. She was also, however, a long-term asthmatic and

needed to take regular doses of allopathic drugs in order to keep this under control. Here, the talk concerning the patient's use of her asthma medicine comes during the history-taking phase of the consultation. It can be seen that the turns relating directly to the allopathic drugs form a discreet sub-sequence that arises out of a section of patient narrative falling between line 11 '. . .how many inhalers- what inhalers are you doing at the moment. .', and lines 34-35, when the homoeopath introduces a new and unrelated (to the allopathic drugs) topic. '. . what's your ear doing (0.5) at the moment. .'. During the sequence the homoeopath displays a purely functional interest in the patient's current use of her inhalers etc., and her turns have none of the implicit disapproval evident in some of the earlier extracts (particularly extracts 58 and 59, for example). This is significant because the kinds of powerful steroid medications that the patient is referring to would, under normal circumstances, be anathema to the homoeopathic perspective (it can be assumed that a homoeopath would never sanction their use or encourage a patient to take them unless it was absolutely unavoidable). Here however, with both parties accepting that the patient is inescapably committed to fairly regular use of these drugs, the homoeopath restricts her comments to straightforward clarification questions. On line 11 there is '. . So how many inhalers- what inhalers are you doing at the moment.'. Similarly, her next question on line 17 is a simple clarification request: 'And that's your steroid one.' – a turn that confirms her prior knowledge about the nature of the patient's medication. In none of her turns does the homoeopath indicate overt disapproval at the use of the conventional medicine, even though it is likely to have an impact on the way she approaches the treatment process (in the sense that she may need to 'work round it' in her prescribing).[41] Rather, she uses the sequence to efficiently gather relevant information relating to the patient's current usage of the drugs, and details relating to their possible composition. Once she has the facts she needs, she shifts efficiently onto the next topic: '. . .what's your ear doing (0.5) at the moment. . .'(lines 34-35), without making any overt reference to the incongruity of the situation.

[41] From interview data (homoeopath).

The requisite incorporation of the allopathic medicine is similarly evident in the way in which the patient frames her initial introduction of the topic. This is formulated as a plain factual description of events: '. . I ended up having to go in the toilets n take erm (0.2) ·hh some squirts of erm (0.5) salbutomol. .'(lines 6-7). It has no 'accounting for' element in the form exhibited by the patients in some of the earlier extracts such as: '. . I actually didn't want to start taking the dithiopin but the doctor ·hhh was hoping I would.'(extract 54, lines 7-9); or: '. . . they gave me (.) all the pain killers back and vallium back (0.8) (um/and) I try not to take them. .'(extract 55, lines 11-13)). Here, the patient communicates little sense of viewing her allopathic treatment as anything other than necessary and helpful.

In the next extract the homoeopath also exhibits a high degree of incorporation. However, there are significant differences to the 'unconditional' format as displayed in the last extract:

Extract 61 (RF-J-19-06-00)

((Pat and Hom are discussing what approach to take regarding the balance between homoeopathic and allopathic medication))

1	Pat:	. . .what I could do is take the remedy (.) now.
2		(0.5)
3	Hom:	Yes
4	Pat:	Let – it – roll through three or four weeks – see
5		what happens
6	Hom:	Yes[:
7	Pat:	[·h because these ((allopathic)) tablets seen to have
8		a fairly instant (0.8) effect from the sound of it
9	Hom:	Righ[t
10	Pat:	[·h So if I was still getting (0.8) the really heavy
11		bleeding in a months time
12	Hom:	Yes:
13		(1.7)
14	Hom:	You co[uld-
15	Pat:	[I could actually take them
16		(0.9)
17	Hom:	Yes, yes-y-I spoze you could let this cycle
18	Pat:	Yes
19	Hom:	roll thr[ough couldn't [you
20	Pat:	[Yes [Yea
21		(0.4)

22 Hom: If you [took the remedy y-know – [in the next few da[ys=
23 Pat: [Yea [Yes [Yea
24 Hom: =erm given that you've got to- get the- tablets anyway
25 [have you?
26 Pat: [Yea I'm-a haven't [got them yet – [yea I don't know=
27 Hom: [Yes [No,
28 Pat: =what they [are so [that might [be-
29 Hom [No, [·h yea
30 (0.5)
31 Pat: Yea I could do that
32 Hom: Should you see a dramatic improvem[ent K-hhh·
33 Pat: [But-I then I wouldn't
34 take them
35 Hom: ·h Yes (0.3) yes=
36 Pat: =Yea=
37 Hom: =So y-you got both options covered then really haven't
38 you. . .

This sequence comes from the treatment phase of a consultation with a new patient who, unlike the one in extract 60, has been taking prescription drugs to deal with the same problem that she has come to see the homoeopath about – her heavy periods. This creates a slightly more complicated situation because there is likely to be a degree of correlation between the effects of the allopathic medication and anything the homoeopath tries to do. A particular problem being that, as the patient herself points out earlier in this same consultation, with both systems working simultaneously on the same symptomatic problem, the efficacy of one over the other would be difficult to establish. Significantly, and perhaps reflecting this new patient's developing understanding of the holistic process, it is she who initially proposes a compromise that involves staggering the two different treatments so that they are less likely to interfere with one another: '. . what I could do is take the remedy (.) now . . .let – it – roll through three or four weeks – see what happens.'(lines 1-4). This compromise favours the homoeopathic treatment and allows the homoeopath to pursue a strategy that subtly reinforces her preference that the allopathic drug is not taken – indicated by '. . .given that you've got to- get the- tablets anyway ([) have you? . .' (lines 24-25). This turn especially, communicates that there is a choice here – its underlying message being that that even if the patient collects her prescription there is still the (favoured) possibility that she may decide not to take the drugs; her

condition is uncomfortable but not life threatening, and the homoeopath can build on her developing sense of a distinction between the two types of treatment. On line 32, for example, she provides a concrete rationale for delaying the allopathic treatment, but one that also projects the impending success of the homoeopathic remedy and casts it as a 'first choice': '. . Should you see a dramatic improvem([])ent. . .' (line 32). Which stimulates a collaborative completion by the patient: '. .([])But-I then I wouldn't take them. .'(line 33). The collaborative quality of this turn is particularly relevant in this context because it effectively means that the patient has been able to make the proposal of a treatment strategy (her initial ' . . what I could do. .' on line 1, etc.), and develop a more specific plan of action (confirming that she wouldn't take the allopathic drugs if the homoeopathy worked). Both these activities remain very much in line with the homoeopath's underlying preferences, but actually appear to be 'patient-led'.

The 'incorporation' format, then, reveals in varying degrees, an adaptation on the part of the homoeopath to the fact that patients are likely to have contact with at least some allopathic medicines, and this cannot always be avoided. Presumably, as the demand for CAM grows and is felt more and more by conventional doctors, this kind of incorporation format will have its allopathic equivalent – practitioners in both camps knowing that the position of neither system is strengthened in the long run by conflict and antagonism (i.e. interactions that rely too heavily on 'rejection' formats). For homoeopaths in particular though, displays of incorporation are one way in which assimilation into the mainstream may be made easier.

Summary

This chapter has been primarily concerned with an analysis of how the reproduction and propagation of holistic and allopathic perspectives are accomplished through the talk formulations that practitioners use when discussing treatments and treatment options. I have tried to illustrate how to a significant degree, these formulations and the sequential positions in

which they routinely occur can betray underlying paradigms even when 'surface' activities appear to indicate that quite different perspectives are in play.

Conclusion

I began this study with an explanation of why I chose to use a title that referred to homoeopathic 'encounters' rather than 'consultations', and I hope that my reasons for highlighting this are now clear. I have tried to illustrate how in homoeopathic medicine the idiosyncratic interactional environments that develop between practitioners and their patients are key elements in determining not only how the therapeutic process evolves, but also in defining the essence of the homoeopathic experience. In a general sense I have used the relatively unusual methodological combination of ethnography and CA to provide a basic 'map' of the homoeopathic interactional arena that begins to describe the most salient features of the landscape; what it is about homoeopathic encounters that makes them interactionally distinctive.

Summary of findings

Following a discussion of the data collected for the study in chapter 1, and an outline of how ethnography and CA would be utilised, Chapter 2 dealt with an outline of the current position of homoeopathic medicine and its relationship to conventional medicine. This is salient because although homoeopathy holds a position as one of the most established forms of CAM in the UK, it is still some way from being completely integrated. The current push for greater acceptance into the mainstream of medical care can be seen as having an influence on the micro-interactional detail of the consultation process. Chapter 3 described the results of a short exploratory survey conducted by email with a sample of homoeopathic practitioners in

order to begin to isolate thematic strands that might be salient to the subsequent micro-interactional analysis.

In chapter 4 a case study based on a 'typical' homoeopathic encounter was presented. My intention here was to give an impression of how, at a broad level, the overall format and 'feel' of homoeopathic encounters are distinct from those found in allopathic medicine. This ethnographic theme continued as I outlined how the holistic therapeutic process can often be something that carries over into the life-world perspectives of the participants; the formative experiences with conventional medicine of both practitioners and patients were explored, as were the trajectories and connections that led to their involvement in this area of complementary medicine.

Chapter 5 was an attempt to begin formulating at a micro-interactional level exactly what it is about the way in which homoeopaths work that creates the apparently egalitarian and collegial consultation dynamic or 'atmosphere' that is commonly reported by patients. Initially focusing on interactional techniques utilised in the generation of empathy and rapport, I outlined the role that the sub-interactions and the apparently superfluous fragments of behaviour that border the consultation might play in stimulating or attenuating the development of these states. I also showed how, in the hands of an experienced practitioner, virtually any element of the patient's consultation experience can be utilised to this end. Factors such as the design of the 'naming sequence' and the open sharing of information with the patient were highlighted as being particularly useful in this respect.

In chapter 6 the focus shifted onto an examination of those interactional sequences within the homoeopathic consultation that can, to some extent, be predicted. Although I showed that there are similarities between certain discrete elements of the homoeopathic consultation format and those

often found in conventional medicine (the presence of phases such as *presenting complaint, history-taking, treatment-giving etc.)*, it was suggested that the underlying tendency for homoeopathic consultations to be 'patient-led' is evident in the routine non-predictability of when in the consultation these categories of behaviour might occur. The only routinely predictable phase was found to be 'final-treatment', which highlighted interactional issues relating to the avoidance of authoritarian or instructional formats by homoeopaths as they prescribed remedies. Similarly, I was able to isolate four main formats that are used to introduce this final-treatment phase. These ranged from 'categorical', in which the homoeopath stated a unilateral treatment decision, through to 'reversal', in which it was the patient who both initiated the treatment phase and made suggestions as to what the treatment should be. Again, this highlighted issues of active patient-centeredness in the homoeopathic environment because incidents of 'categorical' (and apparently directive) behaviour appeared to occur far less frequently than more collegial or negotiated formats.

The significant role that is played by the generation and incorporation of patient narratives was examined in chapter 7. The analysis here built on earlier observations that virtually anything patients bring to the homoeopathic consultation (in terms of symptomatic and non-symptomatic information, life-world concerns etc.), is routinely treated as medically relevant or 'doctorable' both by the homoeopath and the patient – a key feature of this being an apparent trajectory along which patients progress as they become increasingly socialised into the conventions of the holistic consultation process. Some 'new' or inexperienced homoeopathic patients were shown to be relatively restrained in their use of narrative formats and tended to exhibit an orientation to conventionally socialised 'rules' relating to expected behaviour in the medical setting. They were inclined, for example, to restrict their narrative explorations to information that was

directly relevant to their presenting problem, and they generally showed less inclination to deliver extended tracts of unprompted narrative. More experienced homoeopathic patients, on the other hand, were observed delivering spontaneous and extended narratives incorporating detailed information that was apparently tangential to their presenting complaint – their references to symptoms or symptomatic processes often being 'embedded' within the psycho-social, life-world or even psycho-spiritual elements they were describing. The way in which patients construct narratives may therefore be one way in which the relative level of 'holistic socialisation' that has been attained might be indicated.

The final chapter focused on how underlying holistic or allopathic medical perspectives are reproduced in the formulations of talk that practitioners choose to utilise when referring to treatments and remedies. The interactions of GP-homoeopaths were of particular interest here because of the significantly 'allopathic' characteristics that they appeared to display through their talk – even when they were ostensively engaged in homoeopathic work. Issues relating to how and when homoeopaths explain the possibly contentious elements of their system to patients were also highlighted, as was the way in which they referred to allopathic medicine, because, again, this can be shown to be an important means by which the transmission of holistic values is accomplished.

Reflections on the study

At the start of the thesis I outlined how I intended to utilise a relatively unusual combination of ethnography and CA, and to a large extent, I think I have successfully achieved my aim of letting the different perspectives that the two methodologies provide mutually inform one another. It was mainly with the intention of aiding the narrowing down of relevant themes to which CA could be applied that the ethnographic elements were undertaken, and as I described in the methodology section (chapter 1), the ethnography and

CA were kept separate at an analytical level. I used them in a linear fashion; the analysis of ethnographic data informing the thematic focus of the CA. I feel that this approach has proven to be largely successful in that it has allowed me to present a relatively rounded description of the homoeopathic environment – far broader and more pragmatically informative than would have been possible had my focus been initially guided from a purely micro perspective. What I may have lost in the 'purity' of my CA approach has, I hope, been made up for by the richness of the themes that I have been able to explore.

The other main reason for combining these methodologies related to contextual positioning. Most readers coming to a study of orthodox doctor-patient interaction could be expected to possess a high level of empirical knowledge based on their own experiences as patients. But it is realistic to suppose that far fewer people will have this degree of knowledge concerning the homoeopathic encounter; the field of homoeopathy being relatively unexplored in the context of communication and interaction. On this level alone I feel that the provision of a detailed ethnographic element would have been justified. From a more pragmatic analytical perspective, however, as the study aimed to provide a broad picture of the homoeopathic environment, the paucity of CA or micro-interactional work in this particular area made it important to be able to isolate the most salient elements for analysis so that the relatively limited data corpus that I had available could be most economically utilised. CA purists would, I am sure, argue that contextual information is largely (or completely) irrelevant in gaining an understanding of the underlying mechanisms of talk as interaction. I would agree with this. However, the primary aim of this work was not to further the technical vocabulary of CA or to discover more of the universal 'rules' that it seeks to uncover. It was to use the analytical perspective and tools that CA provides to help describe a particular institutional environment.

Although I am relatively pleased with the way in which the two methodologies have meshed, it is important to acknowledge some of the criticisms that this approach may attract. An obvious one being how to resolve conflicts that arise when analytical results from one discipline appear to contradict or to be misaligned with those from another; should results from one be given more credence than the other, and if so why? As will have been evident from the way in which my analysis was presented, this kind of conflict was largely avoided by paying careful attention to the relative areas to which each methodology would be applied. In the study, CA and ethnography are used to provide information on those aspects of the arena to which they are most suited, and are not set against each other. When misalignment did arise – and I think the only major example of this occurs in chapter 8 where analysis of some GP-homoeopath interactions indicated an underlying bias towards allopathic perspectives – neither approach was given more weight and there was no real methodological issue to answer; ethnographic data indicated that the GP-homoeopaths considered what they were doing to be homoeopathic. Subsequent CA analysis of their actual consultations indicated an approach that was essentially very different from that of the professional homoeopaths. The data from the two approaches, however, while technically misaligned, in fact helped to illustrate a wider sociological issue: the difficulties that professional homoeopaths face when trying to keep their discipline at a certain level of professioanlization, and the inconsistencies that are symbolised by medical professionals who are allowed to practice it without the same level of training.

Another, more practical issue that might be raised relates to the size of the data corpus that was available (in terms of CA). It could be argued that it was too limited to give a true representation of the universality of the interactional motifs that I describe. In answer to this I would emphasise that I do not make any such universal claims, and the behaviours that I present

should be taken only as an initial indication of where more concrete sequentialisation may be occurring. I would also argue, however, that the combination of ethnography and CA that I utilised effectively helped to place many of the behaviours beyond the idiosyncrasies of individual practitioners. Even though the numbers of examples of any given activity - say, the narrative 'circling' described in chapter 7 - may have been relatively small in terms of a 'conventional' CA collection, the argument for it being a widespread and routinely occurring sequential process is significantly strengthened by the fact that it was first isolated in the broad ethnographic data.

Another criticism of the study may relate to how representative the consultation examples that I cite can be of the myriad of different specialisms and environments that the conventional medical field engenders. Again, I would argue that the way in which I present this kind of comparative data has been consistently informed by an awareness of its representational limitations. Also, unlike the homoeopathic environment, the conventional arena is one already well served by interactional analysis, and being able to incorporate this established base of research alongside my own empirical work added depth to the validity of the observations that I made.

A final criticism of the work could be that, as I outlined at the beginning of the thesis, my acknowledged involvement as a participant in various informal localities on the CAM 'scene' (my training in counselling, and regularly seeing my own homoeopath, for example) leaves me open to accusations of having 'gone native'. In answer to this I can say that being actively aware of the potential for this to become an issue from the onset of the research has made me extremely careful about maintaining an analytically neutral gaze, and that this is evident in the analysis. Significantly too, although I maintain an enthusiasm for homoeopathy and the

incorporation of CAM and holistic principles into mainstream medicine, the process of deep engagement with the field has ironically had the effect of increasing my scepticism about the underlying medical efficacy of much CAM. I realise that at the beginning of the research process I considered the interactional essence of conventional medicine and homoeopathy to be relatively polarised, whereas now I acknowledge that there is far more of a crossover; homoeopaths do not have the monopoly on holism. Many in conventional medicine take an active interest in improving the communicational connections they have with their patients, the way they negotiate treatment decisions, the incorporation of more 'holistic' information, and so on. I hope that the work reflects this and does not read as a reinforcement of counterproductive polarisation between systems of healing that in reality have the same underlying objectives.

Future work

This was to be the first study of the interactional environment of the homoeopathic consultation, and as such it is only beginning to reveal some of the significant behavioural elements that go to make up this approach to healing. Further work in this area, particularly utilising CA and larger data sets, will undoubtedly uncover additional interactional characteristics. In terms of more general research that might develop from this work, I think there are several possibilities. Firstly, as the focus of the study has been very much on the specifics of interactional behaviour, I have avoided arguments relating to proving or disproving the homoeopathic system. With a more extensive and sequential data collection, however, (i.e. recordings of complete sets of consultations with patients, following them from their initial contact through to the point where they are no longer receiving treatment), it might be possible to use the underlying structural frameworks that have been identified as the starting point for more evidence-based work on therapeutic outcomes. Although homoeopathy is very much at the forefront of paradigmatic liberalisation, it

still faces an underlying mistrust in many quarters of the medical and scientific establishment. This is largely due to the lack of verifiable evidence that the system works. So it would be valuable from both an allopathic and homoeopathic perspective, for example, to be able to use micro-interactional work (which is essentially neutral in terms of each systems' paradigm), as a means of creating a research arena for the study of the long-term therapeutic trajectories of homoeopathic patients.

Secondly, I think that the sequential and functional characteristics of 'first-time' homoeopathic encounters would be a fruitful area for continued investigation. Due to limitations on the amount of available data, I was unable to conduct an extensive analysis of interactions involving this particular type of patient / practitioner dynamic, but in many ways the management of fragility and newness in these encounters makes them extremely interesting. As I was able to outline, there are significant differences in homoeopathic practice between the 'first-time' encounter and subsequent follow-ups. Not only in terms of functional elements (the procedural requirement for the incorporation of an initial set of relatively fixed investigative questions, or the need for the inclusion of an explanation of the homoeopathic process, for example), but also because this is where the holistic socialisation of the patient begins. It is likely, therefore, to be the place at which any conflict between conventionally socialised ideas of what a medical encounter looks like, and the holistic perspective, will be most evident.

A final area that I regard as holding possibilities for more in-depth study relates to the interactions of GP-homoeopaths. It will have been evident – particularly in chapter 8 – that depending on their paradigmatical position, this type of homoeopathic practitioner tends to utilise an idiosyncratic mix of communicative routines that are quite distinct from both professional homoeopaths and allopathic doctors. Again, partly due to restrictions on the

amount of data available, I have only been able to make some general points relating to the apparently 'allopathic' bias that some of these practitioners exhibit. Given a larger collection of relevant consultation examples, a more specific comparative analysis of this could be undertaken.

Overall, this study has highlighted the role that communication plays in driving and defining the homoeopathic experience. It has also, I hope, strengthened the argument that research into micro-communication practice can be successfully augmented by broader ethnographic work, and that methodological combinations such as the one I have utilised can be an effective means by which medical perspectives that are currently categorised as complementary or alternative are investigated. The work begun in this study may be one way in which apparently marginalized and under-researched complementary therapeutic traditions can start to be integrated into mainstream methodological investigation.

Appendix I

Homoeopathic training colleges from which course details were obtained.

The Contemporary College of Homeopathy
3 Coldharbour
Bridgetown
Totnes
Devon **TQ9 5BL**

The British Institute of Homeopathy
Cygnet House
Market Square
Stains
Middlesex **TW18 4RH**

The Northern College of Homeopathic Medicine
Swinburne House
Swinburne Street
Gateshead **NE8 1AX**

The School of Homeopathy
Yondercott House
Uffculme
Devon **EX15 3DR**

Alternative Training
Orchard House
Merthyr Road
Llanfoist
Abergavenny **NP7 9LN**

The Lakeland College
5 Sandes Avenue
Kendal
Cumbria **LA9 4LL**

The College of Practical Homeopathy
186 Wolverhampton St
Dudley
W. Midlands **DY1 3AD**

The Allen College of Homeopathy
Jasmine House
65 High Street
Earls Colne
Colchester **CO6 2QX**

The South East College of Homeopathy
41 Terminus Road
Eastbourne
East Sussex **BN21 3QL**

The British School of Homeopathy
Pump cottage
Compton Durville
South Petherton
Somerset **TA13 5 ER**

Appendix II

Homoeopaths who responded to the survey

(Names originally taken from the RSHom June 2000 register)

Ruth Appleby	rutha@iol.ie
Gordon Adam	adam@gjsc.freeserve.co.uk
Grazyna Baran	gbaaram@ndirect.co.uk
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Richard Bocock	ichjb@lineone.net
Ros Broadbent	ros.broadbent@ukgateway.net
Sarah Byfield	sarahbyfield@btconnect.com
Angela Baker	nbaker@netspace.net.au
Robert Bridge	robertbridge@compuserve.com
Christine Conyers	christine@conyers.screaming.net
Sally Carthew	sallyc45@aol.com
Valerie Colley	vcolley@genie.co.uk
John Carpmael	double.happiness@virgin.net
Brigit Crane	bcrane@nildram.co.uk
Alan Crook	alancrook@onet.co.uk
Rowena Doble	health@wellspring.netlineuk.net
Pat Deacon	pdeacon@cnx.net
Fiona D'Alwis	fiona@homeopathy-uk.com
Gail Enever	enever@waitrose.com
Caroline Eyles	caroline@eyles.co.uk
Robert Every	revery@aol.com
James Fitzgerald	jfitzg9078@aol.com
Marianne Fitzgerald-Klein	marianne.f@talk21.com
Heinke Groth-Woodbridge	oak.leaf.co@talk21.com
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Hugh Harrison	Hugh@maryview.freeserve.co.uk
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Anne Isaacson	lesisaacson@aol.com
Susan Josling	sjosling@aol.com
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Lynda Kenyon	l.kenyon@barnsley.ac.uk
Sally Kent	salkent@ndirect.co.uk
Marie Lloyd	marie.Lloyd@urfx-freeserve.co.uk
Kieran Linnane	kieranlinnane@yahoo.com
David Lewis	LewisRSHom@aol.com

Joan Luff	144health@ts.co.nz
Kathy Meader	bewell99@aol.com
Patricia Mayborne	patricia.mayborne@zoom.co.uk
Janice Marshall	janice.marshall@virgin.net
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Russel McNeil	russellmcneil.homeopath@virgin.net
Andrew Meyer	andymeyer@excite.co.uk
Adele Miller	Adele.Miller@care4free.net
Lesely Murray	homeopathy_for_u@hotmail.com
Patricia Moroney	homeopathtrish@yahoo.co.uk
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Richard Napper	Richard.napper@virgin.net
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Vivienne Thompson	v.thompson@homeopathy-soh.org
Rosemary Todd	gregtodd@emirates.net.ae
Thalia Vines	thaliavines@yahoo.com
Charles Wansbrough	chwansbrough@cs.com
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Madeleine van Zwanenberg	madeleine@vanzwanenberg.freeserve.co.uk

Appendix III

CA Transcription Symbols Key

Conversation analysis (CA) is largely concerned with the analysis of the verbal communicative practices that people routinely use when they interact with one another. Talk (and much non verbal behaviour), is regarded as performing various forms of social action (Drew *et al,* 2001), action that in the case of the medical encounter is entwined within the wider context of the activities of the consultation. To be used effectively, CA depends on the analysis of a large number of *naturally occurring* examples of a given phenomena. In the medical encounters used in this study, this has included video and / or audio recordings of complete consultations. These 'raw' data are then transcribed with a detailed system of notation (see below) that attempts to capture, among other things, the relative timing of participants' utterances (the exact points, for example, when one person's speech overlaps another in their ongoing talk), nuances of sound production, word emphasis, and certain aspects of intonation. The approach contrasts with many of the more traditional qualitative research methods, such as interviewing or observational studies, in that it does not rely to any great extent on subjective interpretation. Another useful feature is that it allows for the effective use of comparatively large sets of data, which, as an aim of CA is to detect commonalties of behaviour, helps to reduce any distortions that might be introduced by the idiosyncratic communication styles of individuals.

In CA, punctuation symbols such as full stops, commas and question marks etc., are used to denote the characteristics of ongoing speech and do not necessarily retain a conventional grammatical function:

XX - underlining indicates emphasis on a word.

. - full stops are used to indicating a falling intonation.

, - commas indicate continuing intonation.

? - question marks indicate a rise in intonation.

! -exclamation points indicate an animated tone (not necessarily an exclamation).

.h - indicates an in breath.

h. - indicates an out breath.

↑ or ↓ - indicates speech spoken with a high or low pitch relative to the surrounding talk.

°x° - degree signs indicate speech that is quiet relative to the surrounding talk.

(0.5) - numbers within brackets indicate timings in whole and tenths of a second.

(.) - a full stop within brackets indicates a 'micro pause' of less than two tenths of a second.

(??) - unrecoverable fragments of speech are given within single brackets.

((x)) - descriptions and other information extra to the transcription are given within double brackets, eg: ((door bell rings)).

[- square brackets are used to denote overlapping speech.

<xxx> - words within angular brackets are spoken faster than the surrounding speech.

Appendix IV

Full CA transcripts for chapter 2 case studies

(JS-JP-3-10-00)

Hom: Right Emma?
(1.5)
Pat: °I've been doing° quite well.
(.)
Hom: Have you
Pat: Yes
Hom: Well that's good news
Pat: I know
(1.2)
Hom: So
(2.0)
Hom: saw you what, about
(0.5)
Pat: .h (0.5)erm I'd- this is where I'd been doing even better because
I've been writing it down again
(0.5)
Pat: I['m (back to weight n- ? / waiting)
Hom: [Saw you on the fifth of the ninth wasn't it
(0.5)
Pat: Yes it was (0.8) yes (1.0) and you gave me those tablets (.)
on the fifth as well didn't you
Hom: Yea? I sent you some arnica oil
Pat: Yes.
(0.5)
Hom: So,
(1.1)
Pat: °Tk° .h er[::
Hom: [how was everything
(2.2)
Pat: Yeath-er- I think (.) sort of: erm (0.3) within about (0.4)
five to (0.4) five to eight days (.) I definitely felt an improvement
(.) tk .h y'know with the mood swings and the (0.5) well not mood
swings but y'know-a e-i-<y'know> the slightest if you went boo (0.3)
I'd-a-^h.a-h.a I'd-a burst into tea[rs .h well thankfully=
Hom: [<↑H↓hm>
Pat: =that's:: (0.9) sort've (.) cleared up
(3.0)
Hom: Th-so that's gone comple[tely
Pat: [It has yea (0.5) yea
Hom: °Tk°-so the weepiness (1.2) °has gone°
(2.4)

Hom: °°(n-)the mood swings°° ((sounds of writing / paper rustling))
(3.9)
Hom: <Tht's right↑>, cos ths-the remedy that you had (1.0) I looked back in the notes and you hadn't had it for ages and ages have you=
Pat: =Right at the begin[ning you gave me that
Hom: [Right at the beginning
(.)
Pat: and [it was a higher potency as well [tht I think you said
Hom: [It- [That's right
Hom: That's right n it worked quite well then
(1.0)
Pat: Well it definitely worked again this time
(1.9)
Hom: Good so .h (1.2) erm: (1.0) thr was your shoulder though (.) Your shoulder was beginning to ache.
Pat: Tk-h. e-well it's sortuv- it's moved it's not-cos that was the right shoulder wasn't i[t .h erm: the problem I'm=
Hom: [H-hm
Pat: =having at the moment is sort of my left- it's my left hand, and my left shoulder .h (0.5) which (.) is quite erm (.) I've not had this for quite a long time (0.5) erm y'know it's sort of .h I can't e-do a- prop- I can do a fist but I couldn't grip anything .h really tightly (.) erm and they're quite swollen are my fingers ((hom writing)) (6.5)
Hom: ^Tk so it's sort of moving around again [(a bit / is it)
Pat: [It- it has yea .h and this with-the- it's going to my left shoulder but it's only .h when I wake up in the morning (1.4) erm it's very achy so whether it's a case of it's- .h y'know I've been layed on it through the night
(.)
Hom: But it's not keeping you awake in the night=
Pat: =No (0.4) no
(5.5)
Hom: So when you wake up it's very ach[y
Pat: [It is yea
(3.3)
Pat: It just seems strange that it's gone onto the left side cos I haven't had this side for such a long time
(3.5)
Hom: ^Tk but in spite of all that your sort of moods still bett[er
Pat: [Yea I feel- I feel (.) fine.
Hom: And you feel i-sort of ok in yourself [then
Pat: [I do yea (0.5) °yea°
(6.5)
Hom: Tk-.h (0.2) e:rm (2.2) aGEN I-I (.) I put down that you were always worse first thing in the morning
Pat: ^T well that i-it is the case definitely
Hom: ^Tk so you sort of (.) loosen up as y-we go along=
Pat: =Without doubt, the more I've (.) sort of move about, the more movement i get
(11.7)

97 Hom: ^Tk and what-a- your right shoulder's okay?
98 Pat: Yes (.) yea I'm not having any problem with that since erm:
99 .h well since-a-since I started taking those tablets which y-ga-
100 I mean (.) they weren't for that (.) but erm
101 (3.6)
102 Hom: What about your sleep (.) cos your sleep was awful you
103 were waking at three n four
104 Pat: Erm: (0.8) better I mean I'm- I can go through to till sort of
105 six now which is a lot better
106 (8.5))((Hom consults notes))
107 Hom: ^Tk-h. (0.7) an::d (4.5) yea↓ (0.5) cos last time there'd been a
108 lot going on you'd had that sort of (0.9) awful trip to st
109 - er: to snt ives hadn't [you
110 Pat: [Oh that's it e-it ws just- it was (.) just a
111 really bad time, everything .hhh sort of all bad news hh. what
112 with all the deaths and h. <as I say> the trip down to saint ives
113 and having to come back a lot sooner (0.4) it was just too much
114 t-y'know the length of time I was sat .h [I mean richard helped=
115 Hom: [°H-hm°
116 Pat: =with the drivin[g but it didn't actually matter whether I was=
117 Hom: [Hm::
118
119 Pat: =driving it's-it's the length of time I'm actually in one plac[e
120 Hom: [Hm
121 Pat: .h This is why I think it's worse overnight y'know when I get up
122 in the morning
123 Hom: Yea cos you're=
124 Pat: =Because I'm in .h virtually one pl- cos I don't move about a lot
125 at night
126 (0.4)
127 Hom: Because everything's so stagnat[ing in your joints isn't it
128 Pat: [It just s:eizes up, everything just
129 s:tops n [so when I get up in the morning .h
130 Hom: [Yes
131 Hom: °Ye[s°
132 Pat: [Erm: (.) so I-I found that that's (.) what I had after the long
133 journey to saint ives and back again
134 Hom: ^Tk-.h so what, talking about that then what about (0.3) the
135 dreaded food. (1.3) How are we do[ing
136 Pat: [How am I doing ^hi-he-he-<he-
137 he-he-he> .hhh (.) not to bad
138 Hom: N[ot to bad=
139 Pat: [Erm
140 Pat: =well the thing is I've started back at the: erm (0.9) ^tk-health club
141 (0.5)
142 Hom: Right?
143 (.)
144 Pat: So I've started back there again (.) erm as from yesterday
145 (1.0) e::rm (.) which I think gives me (.) a bit more incentive
146 (0.8) y'know when I've (.) sort of (.) exa- cos I went I got there
147 for about (0.2) half past eleven yesterday morning I came out
148 about quarter past one.
149 Hom: Hm:
150 Pat: And I've been on the tread mill
151 Hom: °H[m°

Pat: [and the bike an I'd ts- done some swimming.
Hom: Right
Pat: Er:m (.) so it does make me feel a bit better about y'know-
i-n instead of coming home and thinkin .h (0.5) I'll tuck in-^h.-to
^the things I shouldn't have (1.2) °it° makes me feel a bit more
sensible – whether that will continue
(0.8)
Hom: So you're feeling more motivated generally
Pat: Well ye[s
Hom: [To eat better
Pat: Yea-.h and the fact that I want to do the exercise
Hom: Yea
(1.9)
Pat: because I mean I- I haven't done this fr (0.5) best part of a year=
Hom: =Hm
(2.0)
Hom: So you're feeling better for exercise.
(0.5)
Pat: Erm yes I think- I mean I'm .h I think m- like my elbow
this morning things were a bit on the stiff side but I th-
that is definitely I think because of what I did yesterday (0.8)
with- y'know with the exercise cos I haven't done any .h
Hom: So you're not sort of binging on chocolate and
things [(are you)
Pat: [No, no I've been doing quite well with that. .h The only
thing I have done (.) erm which-a- I mean I haven't touched crisps
cos I don't buy crisps in
Hom: Hm
Pat: .h An I have had quite a few bags of crisps an I'm wondering if
that could have anything to do with my left hand (0.8).h cos
I kn[ow
Hom: [Pota↑toe[s
Pat: [Yea I kn:ow
Hom: Yea
(0.6)
Pat: I mean if I eat- if I went f- for dinner and had potatoes .h I
(w)- can always tell in my right hand
(0.3)
Hom: Right
Pat: Within sort of a day or two days .h and the- (w)- I've not touched
crisps for such a long time
Hom: H-yea
(0.6)
Pat: An then I've -I've (.) I spoze in a way I've had a bit of a .h a binge
on them (0.7) er:m (0.6) so I'm wondering if that's got
anything to do with this[:
Hom: [Well I'd have thought it would have
Pat: Yea
(0.7)
Hom: °Yea°
(0.5)
Pat: Er: which thankfully they're gone (.) they're all gone (0.9)
it's-it's somebody ^tht brought th-^.h-em ^e-h-h .h[h
Hom: [^.h=
Pat: =I'm just- I'm hopeless I'm just no: go[od at-

207 Hom: [Somebody brought them so
208 you ate them all=
209 Pat: =E-yea
210
211
212 Hom: B-^Ha-f[h.
213 Pat: [↑hi-↑hi-↑hi- I'[know
214 Hom: [^e-kh-f[:
215 Pat: [^(oh)-↑.hh-^ea
216 (0.5)
217 Pat: ^W-heow
218 Hom: So y're going to stop the crisps.
219 Pat: Well yes because I don't buy them (.) it's not something
220 I- ever ever buy and I haven't done so for a long time
221 (1.5)
222 Pat: (tk) but they ended up in the house and I ate them
223 (2.0)
224 Hom: Tk-.hh
225 (0.7)
226 Hom: Right-hh.
227 (0.9)
228 Hom: And the orange juice you'd been drink[ing (°a lot°)
229 Pat: [<I've>-d-I've finished
230 with tha[t
231 Hom: [St-done that=
232 Pat: =Yes I stopped tha-t (.) the last time I came to see you I
233 think I'd finished w- (0.7) had I finished with it then or: (1.5) this
234 is where this comes in handy then now s[tarted writing it
235 Hom: [You'd been drinking it-
236 (0.8)
237 Pat: I had been drinking quite a lot (0.3) .h oh yes i-it was the
238 last time I saw you on the tuesday the fifth I said I'd (.) (tk)
239 I said then I would stop drinking it and I haven't touched any since
240 (1.5)
241 Hom: Tk-.h and what about things like the amica oil does that-
242 is tha[t
243 Pat: [Tk-.h erm (°°I-I°°)[well I've-
244 Hom: [doing anything do you thi[k
245 Pat: [I've tried it on sort
246 of my finger joint I mus[t admit I haven't tried it on=
247 Hom: [Yea
248 Pat: =like my feet or: .h an I've-I've put it on b- just before I've got into
249 bed. (1.3) Er:::m (2.0) No I think <I don't k'now> y-h.-it's hard to tell
250 isn't it-(b)-I-think (.) they've felt better in the morning (1.0) er:m (0.3)
251 but it's-it's- (0.4) I don't know (0.4) I think- I think it has felt a little easier.
252 (1.2)
253 Hom: Well it's certainly gone- (.) not going to harm ([d-so)
254 Pat: [Well that's it=
255 Hom: =so keep sort of rubbing that in
256 Pat: But as I say I've put it- I-p-tend to do it just before I get into bed
257 so I'm not (.) likely to be .h going and washing my hands
258 or [doing anything (1.2) bt so far I've only tried it on my hands
259 Hom: [°Yeah°
260 (0.8)
261 Hom: .h And what about the feet how are they

262 Pat: Tk-.h not too good.
263 Hom: Not good.
264 Pat: No↓, no definitely (.) definitely they're very very tender
265 (4.7)
266 Hom: So tell me about (0.3) how they feel
267 Pat: Well, h-gain it's-it's sort of the-they are worse first thing in
268 the morning when I get out of bed (1.5) erm .h (0.6) an I tend
269 t- it's my right one that's the worst cos I tend to walk on the side
270 a little bit until I get ((thumping sound)) (0.5) into the bathroom
271 where the tiles are and then I put my feet flat on the tiles (.) n
272 it feels wonderful
273 (0.6)
274 Hom: You like the cold ([don't you)
275 Pat: [Oh it feel- yea (0.2) feels really good
276 (10.3)
277 Hom: So that's quite strong isn't it (.) cold on your feet
278 Pat: Hm
279 (3.6)
280 Hom: And like now are they aching.
281 Pat: Tk-.h n-no it's not- it's not the continual ache like they used to
282 be it's just if I put the pressure on them
283 Hom: °Hm°
284 (0.2)
285 Pat: It's if I get up and start to walk about then I can feel it .h but
286 it's not that continual ache that I used to (0.5) have before (1.9) I
287 mean I can't feel them now there's nothing there now but when
288 I stand up
289 (4.5)
290 Hom: They're sore
291 Pat: Hm
292 (20.00) ((Homeopath consulting book))
293 Hom: Did I have my lovely new book last time.
294 Pat: Yes you did (1.5) cos I-I asked you if you'd (layed the other) to
295 rest ^.h-[h.-h-h [h-h-h-h
296 Hom: [↑.Hih [↓.heh
297 (.)
298 Hom: I['ve actually paid for it now so-
299 Pat: [K-.hh
300 Pat: ^Kho ^righ-h-[hi-t
301 Hom: [^Hi-hi
302 (.)
303 Pat: .H does [it work better when i[t's paid for
304 Hom: [<So>- [So it's all mine
305 (0.3)
306 ???: O-a-.hh
307 (4.5)
308 Hom: °Tk-.h°
309 (0.4)
310 Hom: Erm:
311 (0.5)
312 Hom: What about the flax
313 (0.9)
314 Pat: Tk-.h oh yes I've started that again
315 Hom: It's good=
316 Pat: =Yes (.) yes I have, I've started-

317 (10.5)
318 Pat: but that could take a little time cos I-a (.) I only started it on
319 saturday.
320 (35.9) ((Homeopath consults book - sound of pages turning))
321 Hom: Tk-.h so it's ↑m:ore↓ th-w- (.)the left side now ths- that's the
322 problem isn't it
323 Pat: It has been fr <as I say> about five or six days (0.7) but
324 (0.5)do you think it could be the crisps? (1.3) °rather than°
325 (1.5)
326 Hom: Well (1.2) n-yea well [no
327 Pat: [°Cos° it just seems strange I haven't had
328 any problem with the left side for such a long time
329 (15.0) ((Homeopath consults book - sound of pages turning))
330 Hom: And it's not like (1.0) e-I mean you know like before you had it (0.6)
331 lasting n-say a day (.) in a certain joint and then it would flip to
332 another [joint
333 Pat: [No it's not doing tha[t, it's not-
334 Hom: [It's not doing- (.)it's [not flitting is it
335 Pat: [No
336 Pat: No it isn't
337 (0.9)
338 Hom: <<Soa-it-sa->> (.) it's remaining fairly con[stant (in a ??)
339 Pat: [It's: (.) well it's-i-it's
340 been here <as I say> for about five or six days
341 Hom: Yea
342 Pat: Erm: (0.4) sort of in the-in the left side in my left shoulder
343 when I wake up. .h And towards the end of the day it starts to
344 ache again then.
345 Hom: That lump hasn't appeared ag[ain
346 Pat: [No (1.0) °no there's no sign of
347 anything
348 (1.9)
349 Hom: But you're okay sort of during the day [it's sort of=
350 Pat: [Tk-.h
351 Hom: =[when you're tired and first thing in [the morning
352 Pat: =[Ei-well [That's right it's when I first
353 sort of start to get up in the morning when I-wh-when I wake up
354 I can feel it (.) as I mo[ve .h er::m and then (0.5) <I don't=
355 Hom: [°Hm°
356 Pat: =know whether it goes away> or whether perhaps you just (0.6)
357 don't think about it as you n-n- e-e-you know as you carry on
358 and do everything .h I mean it certainly didn't stop me in the
359 gym yesterday.
360 (0.8)
361 Hom: °Didn't it°=
362 Pat: =No (1.2)°no°
363 (1.6)
364 Hom: And what about your hand.
365 Pat: Tk-.h er::m (0.7) I mean that is bad for my left hand (0.3) I
366 mean I've-I've sort of squeezed my rings on this morning which
367 I shouldn't have done (0.3) I should've left them off
368 Hom: [An-a they're very sore
369 Pat: [(?)
370 Pat: Er::m (0.2) no they're not- it's not sore but when I do that (.)
371 I mean you can see it's just all puffy n (1.0) sort of spongified

(0.5)
Hom: °Ek-h.°
(1.0)
Pat: I mean it's (0.5) I- there's no definition
there [which I-I do usually have.
Hom: [E yes it's very- (.) it's much more swollen than the other
one i[sn't it
Pat: [Yea (.) I mean that's the one I usually have the problems
with as you know which you can see (0.9) but this one I mean look
where my rings are as I say I shouldn't have put them on
Hom: °Hm°
(0.5)
Pat: Er:::m (0.4) and it's been like that (0.2) an it's- you know it's stiff
.h it's not ↑achy s:- y'know it doesn't it's:: sort of ache but .h (.)
like when I do that I can feel (0.5) it's like <somebody's> (0.6)
tightening all the tendons down my fingers [and into=
Hom: [Hm
Pat: =the:re (0.6) an I couldn't grip e-I grip any=
Hom: =Hm=
Pat: =thing really hard I wouldn't be able to open a jar or something
(3.0)
Pat: °Tk° but (.) just sat like this no it doesn't it- (.) it's not aching
(1.0)
Hom: Ndt ↑have you noticed any difference e-like before a period again.
(0.8)
Pat: Yes: (0.2) er:m (1.5) .h now (.) actually over (2.2) erm my
period was on the nineteenth s-of september (0.8)and over that
time for about four days I mean I had the most a-h horrendous
hot sweats at night I was ab-so-lutely (.)dripping through the night.
(8.5)
Hom: That was what (.) just b-
Pat: Th[at was e- that ws sort of (0.4) <e-as:> it was tuesday the=
Hom: [just before
Pat: =nineteenth and it sort of started on the .h monday (0.7) and
went over to about the thursday or friday
(4.6)
Hom: So during really
Pat: Yea (0.3) sort of a-actually over the time
(5.8)
Hom: But what about your joints like
(0.7)
Pat: Now that'[s - e-that's when this s:ort of (0.2) kicked in=
Hom: [before
Pat: =really with my left side (2.0) that's when I really notice that
I was having problems with the I- with the left hand (.) n my left
shoulder
(8.2)
Hom: °Hm:°
(41.5) ((homeopath consulting book))
Hom: .h ↑Would you say↓ ((name)) tht (1.2) tht- do you ever (0.7)
notice that if your mood is (1.0) good (0.5) then your joints are
worse (.) an if your mood is (1.0) bad (1.0) °then your joints
are better
(0.8)

426 Pat: The other way round (0.7) if-if I'm-if I'm not feeling good in
427 my self my joints are wors:e
428 (.)
429 Hom: Are they
430 Pat: Mm[:
431 Hom: [So it- does- that doesn't altem[ate sort of mental bit=
432 Pat: [No:
433 Hom: =and the
434 (.)
435 Pat: No:
436 Hom: the physical [bit
437 Pat: [No it definitely-
438 (5.0)
439 Hom: .h (0.7)But you say your moods sort of quite good at the
440 momen[t
441 Pat: [It is, yea
442 (0.8)
443 Hom: But we've still got these sort of niggles going on
444 Pat: °Hm°
445 (7.2)
446 Hom: So how would you say you're sort of (1.0) n-they generally
447 were then (.) compared with how you have been
448 (0.9) [now
449 Pat: [Wh-ch-a the joint[s
450 Hom: [°Ye[s°
451 Pat: [.h Th-well (.) I mean as you know I-
452 I've had k- a really good run. (.) Of- of everything being
453 (0.2)
454 Hom: °<H-hm>°
455 Pat: Sort of: er (0.6) you know this sort of this pain free so [I=
456 Hom: [°Hm°
457 Pat: =spose it just feels like it's: (0.4) erm (.) not starting up again
458 cos it's not that- <it's not (like)> it's not horrendous by any
459 means [.h it's feels like I've over done something
460 Hom: [°Hm°
461 (0.5)
462 Hom: Right
463 (0.5)
464 Pat: It'[s that sort of erm (0.3) like I've just done that .h I mean=
465 Hom: [Right
466 Pat: =when I was sort of picking up before (0.3) an I started to get
467 more into the garden again .h and doing the gardening .h I
468 realised y'know after a day in the garden the next day
469 (0.8) [I suffered for it an it's that sort of- s- feels like=
470 Hom: [°Hm°
471 Pat: =I've over done some[thing but I haven't
472 Hom: [°Hm°
473 (4.5)
474 Hom: Just the crisps.
475 (1.0)
476 Pat: Ah yes (0.2) ^ak-h.-h.-h.- you're not sposed to (.) .hh (°not°)
477 sposed to remember that one
478 (0.6)
479 Hom: ^K-h. .h
480 (11.0)

Hom: Tk-.h Yea: so where do we go here (0.5) erm
(10.5)
Hom: Cos that remedy r^h.eally picked you up a bit
didn't i[t
Pat: [It did definitely
(31.8) ((homeopath consulting book))
Hom: And you have no trouble with your spine do you
Pat: No
(26.0) ((homeopath consulting book))
Hom: Y-joints (.) e-th-th (.) they never sort (.) of change colour
they never go sort of bluish.
Pat: No, they go red
Hom: Red.
(.)
Pat: °Hm°
(19.5) ((homeopath consulting book))
Hom: Oh that's right I got you some- a remedy called foomicaroofa
(1.2) n that- this is the wondering arthritis (1.3) en (.) pains
come with marked swelling redness and heat (0.8) °nd the joint
is inflamed p- pain is worse n the slightest motion° (1.5) n that's
you isn't it
Pat: Yea (0.2) definitely.
(1.5)
Hom: But y'see this is the one tht pain lasts about a day then
disappears n then (.) reappears in an[other joint
Pat: [Which I'm (.) I'm not
getting that now [it's not actually no it's [not wondering
Hom: [K^h. you're not [you're not are you
(.)
Hom: No
(15.5)
Hom: N you wouldn't say you were worse from (.) change of
weather would you
(1.5)
Hom: Damp [cold weather, cold air?
Pat: [Well: hh.
(0.2)
Pat: It- it doesn't help - me - personally but that's: e-as you know
I don't like it when the winter starts to come on. (0.5) I'm not
a winter person so-I-a don't think it helps
(4.5) ((sound of page being turned))
(6.5)
Pat: And as I see less and less days when I can get out in the
garden (1.0) I certainly
Hom: Yea
(0.4)
Pat: Sort of doesn't help
Hom: Go and hibernate a bit
Pat: Oh I could and I've said that to you before I g- I would willingly
hibernate over winter .h and come out again in the spring
(10.0)
Hom: I wonder if it's (.) w-h-orth repeating the (0.2) (now) n-you said
something which reminded me of something (0.3) erm (1.7) ^tk-
ah the hot sweats (8.5) yea↑, do you remember (1.5) I gave
you a reamedy called tberculinum a while ago (1.2) °you

probably don't°
Pat: No↓
Hom: Erm
(0.5) ((sound of pages turning))
Hom: (°Shit° / °it°)
(2.2)
Hom: H-we were talking (.) at the time about
(1.2)
Hom: Erm
(3.8)
Hom: Your b- ah your mood in particular and your sort of erm
(3.0)
Hom: Y'know y-your romantic (.) dreaming (.) sort o[f
Pat: [Hm:
Hom: and I read e-a- (0.4) passage out of this
Pat: Oh that's right
Hom: n it w[as
Pat: [It was: [spot ^h.on↑
Hom: [n you said that's me
Pat: It was absolutely spot on ^k-h.
(3.8)
Hom: Well that's a big hot flush remedy it's also a rumatoid
(0.8) remedy
(1.2)
Hom: Erm
(0.8)
Hom: An it's also a-a good remedy to s^h.ort of (1.5) what we
call an inter-current remedy a remedy just to sort of (0.4) give
you a bit of a boost
(0.6)
Pat: Righ[t
Hom: [An it's a good remedy to take (0.8) in the autumn
(0.8)
Pat: [Yea
Hom: [To prevent people getting things like flues↓ n (.) colds
n [°things like that°
Pat: [Hmm
(1.4)
Hom: So I just wonder whether it's worth (1.8) y'know giving you
a one (.) off (.) of that (0.5) just s[eeing if that settles=
Pat: [(°°seeing°°)
Hom: =things down
(0.4)
Pat: Yea .h cos I'm not- I'm not having the hot flushes any- it
was literally .h a period of-of sort of o-over my period for
about [four days .h but they were bad
Hom: [Yes
Hom: Ye[a
Pat: [they were re[ally
Hom: [And during the night
Pat: Yea
(1.2)
Pat: I mean it wasn't through the day I didn't get them through [the=
Hom: [No

590 Pat: =day it was literally in bed [at night (.) that [I was absolutely=
591 Hom: [Yea [Yea
592 Pat: =dripping
593 Hom: °Yes°
594 (0.5)
595 Pat: Whereas thankfully that's: (.) that's gone
596 (8.2)
597 Hom: .h Well I'm a ↑bit tempted t- to give you (.) a tub (.) now (1.0)
598 and give you some more nat mure (0.7) and just (.) wait three
599 weeks
600 Pat: Yea
601 Hom: Give me a ring (0.8)[and then, depending on (1.4) n how you [are
602 Pat: [°°H-hm°° [Feel
603 Pat: Yea
604 Hom: Is to whether we then repeat (0.2) the nat mure again because
605 That .h (.) the last remedy did- (.) has done quite a [bit
606 Pat: [^Tk-bt-
607 yea deffinitely
608 Hom: But it's jst sort of that it's (.)y'know appeared on the other
609 side (1.0) but I mean y'know it could be that you were
610 aggravating it with things like crisps °n-n°
611 Pat: Yea
612 Hom: Food n-
613 (0.2)
614 Pat: Hmm cos eh-I mean I'm not (??[??)
615 Hom: [(?? ??)
616 (0.5)
617 Pat: .h I'm not the bes:t when-when it comes to the diet (0.2)
618 unfortunately I wish I ^wh.as h-.h e.h but-erm (.) .h but there
619 definitely won't be ay more crisps
620 (0.6)
621 Hom: ^R-h.-ite yeah. (0.2) [^Ak-hhh-ah
622 Pat: [Absolutely .h I mean I always liked them it's
623 something that (0.8) they're very moorish (.) erm or I've found
624 them so .h and this is why I stopped buying them (0.6) plus
625 for the potato side of it
626 Hom: Well exactly (0.7) exactly yea
627 (10.5) ((homeopath consulting notes))
628 Hom: Yea ↑((name)) so I think (.) k-think we'll do that. I'll give
629 you the (.) the-erm (1.0) the teberculinum.
630 (0.5)
631 Pat: Right
632 (0.9)
633 Hom: And then (0.2) some nat mure (0.7) to t[ake
634 Pat: [(°°H-hm°°)
635 (0.8)
636 Hom: If we need t-d-to er
637 (3.2)
638 Hom: give you that later.
639 Pat: Yea
640 (4.2)
641 Hom: But give me a ring in six weeks (1.0) sorry=
642 Pat: =three we[eks
643 Hom: [three weeks
644 (2.0)

645 Hom: °It's this video° (??)
646 Pat: ^Ny-h.a-h-h-.ha (.) h.
647 (31.0)
648 Hom: An if- y'know (0.4) there's no improvement then then
649 I'll just (0.3) I'll have a good look at it
650 (1.5)
651 Pat: Nd see=
652 Hom: =(Have) a bit of (.) peace and quiet and have a (0.2) a <u>think</u>
653 a[nd erm (0.7) ge<u>t</u> °(??) to you°
654 Pat: [Yea
655 (0.8)
656 Hom: Is that ok
657 Pat: It is, yea (0.5) yea that's fine (°yea°) ((ref to tape recorder))
658 (0.4)
659 Hom: Shall I a- (1.5) a- switch this off . . .

(PS-VT-21-06-00)

Nur: If y'd like to come through misses ((patients name))
Doc: Hello? There?
Pat: H'llo
(15.0)
Doc: Right (.) how are you doing
Pat: Fine apart from a bad ear
Doc: Bad ear?
Pat: Y:es hu[h
Doc: [Right wh[at's the problem
Pat: [You asked me last time if I had ear ache or not 'n I said no h-'nd the following week I st-ha:ar:ted
Doc: Right?
Pat: And I went to the doctor and he said it was an ear infection
Doc: Right
Pat: And he put me on antibiotics
Doc: Uhu=
Pat: =It hasn't cleared it
Doc: Right
(.)
Doc: so what's the symptom: th't you've g- pu- you're ge[tting pain=
Pat: [apart f:-
Doc: =are you
Pat: Yeh I[t's n o t (.) as violent as it was
Doc: [whi- which
Doc: Right
Pat: Erm but um (.) very definite
Doc: Right >it's th- right ear< I[s i-
Pat: [yeh- .hh an:d (.) when it didn't clear up I- after these antibiotics I went back again en 'e said (there were) fluid in the lower
(.)
Doc: righ[t
Pat: [ear drum
Doc: yeh
(.)
Pat: But: the pain was not just in ma ear t- w's (0.4) behind
Doc: Right
Pat: un- pa- (.) went along there=
Doc: =Okay r[ight
Pat: [al:l round there
Doc: Okay
Pat: Erm it's not constant like it was t' start with but erm (1.6) >every now un again a get shooti[n-<
Doc: [shooting pain right (.) and the hearing's still down is it
Pat: (...) hh. huh [huh huh .hh
Doc: [°right° and the left side's okay
Pat: Yes

Doc: ↑Swallowing alright?
(.)
Pat: Erm yeh it's ev'ythin's more lack of survivuh saliva th-
Doc: R[ight
Pat: [things get stuck yuh kno[w
DOC: [right nothing
Doc: >th-uh-th-uh-[th-uh-<no feeling of any blockage or a[nything
Pat: [It doesn't hurt or anything [oh no
Pat: .hh But the nigh- (.) before .hh this started (.) erm when a go t- bed a gargle
Doc: Ri:ght
Pat: An:d we'd been out for a meal actually now whether this had
anythin' tuh do (.) with it but I'd had a prawn cocktail
(.)
Pat: It w's a bit strong (.) I had a job getting it down and something-
shot out of (m- mouth)
(.)
Pat: it felt like I was bringing a marble up
Doc: Ri[:gh]t
Pat: [bu-] er:m: (.) un then everything- seemed hollow
Doc: Right
Pat: A:ll uv that side of muh head
(.)
Pat: Y'know [up muh nose un do[wn ma throat
Doc: [mm hmm [oh right mm hmm
Pat: .hhh un ah just thought wel it's better out than in wha-h.-t-
h.-ever h.-it was 'cause it just went zumm down the plug
ho-ho-le=
Doc: =Ri[ght
Pat: [.hh[hh
Doc: [okay=
Pat: =Er:m
Doc: Sounds a bit like the alien. [story.
Pat: [y-huh huh y-hand yeh .hhh=
Pat: =und it just the following day it felt crackly un then that's when me ear ache started
after that so whether it wus any connection a don't know
Doc: Okay
(.)
Doc: Okay b[ut overall you feel you're making [good progress
Pat: [-ts: [oh a lot=
Pat: =better yeah
(4.5)
Doc: Okay (.) w'll let's have a look at the ear first of all
(15.0)
Doc: Yeah (.) certainly looks like you've got some fluid on that side
↑s:- look on the other side (2.8) ↓just have a look in that right ear 'cause it little- it
just looks a bit honey coloured at the bottom of the drum which is fairly typical of
fluid
(7.5)
Doc: I wouldn't a- don't think that's sinister at all it might be in
part related to your treatment with a bit of=
Pat: =pain

100 Doc: (Eustation) tube disfunction on that side but um
101 (3.0)
102 Doc: I certaintly don't think that there's anything sinister about it(1.7) erm
103 (3.4)
104 Pat: That's all a wanted just fer you tuh say that hh. huh huh huh huh .hhh
105 (10.0)
106 Doc: °Tuning fork° (3.8) ((ringing of tuning fork (2.5))) c'n yuh hear that? there.
107 Pat: °Yeh°
108 Doc: C'n y' hear it at the back
109 Pat: °°Yeh°°
110 Doc: Which is the loudest the back one
111 Pat °°The side°°
112 Doc: °That one (.) is it right okay° .hh well let's just check yer hearing first of all
113 Pat: hmm
114 Doc: 'cause that's that doesn't show you t' be too deaf it might be
115 that everything's dispersed but erm let's just check that over and then I'll see you
116 back in here in probably about fifteen twenty minutes time alright?
117 (.)
118 Nur: Right if you'd like t- take a sea[t in the
119 Pat: [right
120 Nur: waiting area misses ((patient's name)) we'll call you through for the hearing test (in
121 a while) thank you
122
123 ((The patient leaves for a hearing test and returns later))
124
125 Doc: Hello again. (.) .hh (.) well that- that confirms that you've got some fluid in that ear
126 Pat: yeh
127 Doc: And I think if it's causing you bother (.) it would be a good idea to get you in °as a
128 day case (.) drain the fluid off
129 (.)
130 Doc: Put a little grommet in the ear which will allow (.) air in and out of the middle ear°
131 .hh and just to be on the absolute safe side we'll also check the back of you're
132 no:se
133 (.)
134 Doc: To make sure that there isn't on that side
135 (0.5)
136 Doc: Uh- that end of the (eustation) tube that might be causing the problem
137 Pat: Ye[h
138 Doc: [-ts extremely unlikely but yuh know I think that er given your past trouble we
139 should do that
140 Pat: y[eah
141 Doc: [so we'll get on with that uhm (4.0) actually if we do go fer the eleventh of july fer
142 tha[t
143 Pat: [eleventh[:
144 Doc: [fine (.) [alright
145 Pat: [(...)
146 Doc: n- that- that can be as a day case (.) right (.) grommets and dee you ay pee un ess
147 Nur: Yeh
148 Doc: ↑Alright?
149 Pat: yep fine

150 Doc: And then what we'll do::. (.) is see you back here (1.0) not in a months time but in
151 six weeks time °wh'ch- w'll (.) give us time to get that underway° .hh alright=
152 Pat: =Right well thank[s ever so much=
153 Doc: [OKAY
154 Doc: ALRIGHT
155 Pat: Bye
156 Doc: By:e
157 (.)
158 Nur: Just give you this fer yer six? (.) uhu (.)↑right you just take that up t- the desk
159 then?
160 Pat: Okay BYE
161 Nur: They'll send you all the details

Bibliography

Adams. J. (2000) General Practitioners, Complementary Therapies and Evidence Based Medicine in England. *Complementary Therapies in Medicine.* 8: 248-252.

Adler. S. R. (1999) Complementary and Alternative Medicine use Among Women with Breast Cancer. *Medical Anthropology Quarterly.* 13 (2): 214-222.

Astin. J. A. (1998) Why Patients use Alternative Medicine: Results of a National Study. *Journal of the American Medical Association.* 279: 1548-1553.

Atkinson. P. (1995) *Medical Talk and Medical Work.* Sage. London.

Atkinson. P, and Heritage. J. (Eds) (1996) *Structures of Social Action: Studies in Conversation Analysis.* Cambridge University Press. Cambridge.

Atkinson. P, Coffey. A, Delamont. S, Lofland. J, and Lofland. L. (Eds) (2002) *Handbook of Ethnogtaphy.* Sage. London.

Ball. D. W. (1967) An Abortion Clinic Ethnography. *Social Problems.* 14 (3), 293-302.

Barry.M. J, Fowler. F.J, Mulley. A. G, Henderson. J. V, and Wennberg. J. E. (1995) Patient Reactions to a Programme Designed to Facilitate Patient Participation in Decisions for Benign Prostatic Hyperplasia. *Medical Care.* 33: 771-782.

Beckman. H. B, and Frankel. R. M. (1984) The Effect of Physician Behaviour on the Collection of Data. *Annals of Internal Medicine.* 101: 692.

Benveniste. J. (1988) Human Basophil Degranulation Triggered by Very Dilute Antiserum Against IgE. *Nature.* 333: 816-18.

Berman. B. M. (2001) Complimentary Medicine and Medical Education. *BMJ.* 322: 121-122.

Boerick. W, Boericke. O, and Bentham Savage. R. (Eds) (1990) *Homoeopathic Materia Medica with Repertory* (Classics in Homoeopathy). Homoeopathic Book Service. London.

Boon. H. (1998) Canadian Naturopathic Practitioners: Holistic and Scientific World Views. *Social Science and Medicine.* 46 (9): 1213-1225.

Bourgeault. I. L. (1996) Physicians' Attitudes Toward Patients' use of Alternative Cancer Therapies. *Canadian Medical Association Journal.* 155 (12): 1679-1685.

Boyd. E. A. (1998) Bureaucratic Authority in the "Company of Equals": The Interactional Management of Medical Peer Review. *American Sociological Review.* 63: 200-224.

Boyd. E. A, and Heritage. J. (Forthcoming) Analyzing History-Taking in Primary Care: Questioning and Answering During the Verbal Examination.

Bradbury. E. T, Kay. S. P. J, Tighe. K. C, and Hewison. J. *Decision* (1994) Making by Parents and Children in Paediatric Hand Surgery. *British Journal of Plastic Surgery.* 47: 324-330.

Briggs. C. L. (1989) *No Bones about Chiropractic? The Quest for Legitimacy by the Ontario Chiropractic Profession, 1895-1985.* PhD Dissertartation in Department of Behavioural Science / Community Health. University of Toronto. Toronto, Ontario, Canada.

Briggs. C. L. (1994) The Silent Partner? The State's Role in the Formation of the Ontario Chiropractic Profession's Identity 1925-52 *Health and Canadian Society.* 2: 35-62.

Bryan. L. (2002) Daily Regimen and Compliance with Treatment: Concordance Respects Beliefs and Wishes of Patients. *BMJ.* 324 (16th Feb): 425.

Button. G, and Casey. N. (1996) Generating Topic: the use of Topic Initial Elicitors. In: Atkinson. M, and Heritage. J. (Eds) *Structures of Social Action: Studies in Conversation Analysis.* Cambridge University Press. Cambridge. pp. 167-190.

Byrne. P. S. and Long. B. E. L. (1989) *Doctors Talking to Patients: A Study of Verbal Behaviour of General Practitioners Consulting in their Surgeries.* Vice and Gorfin Ltd. Exmouth.

Calman. K, and Hine. (1995) D. *A Policy Framework for Commissioning Cancer Services.* Department of Health. London.

Cant. S, and Sharma. U. (1996) Demarcation and Transformation Within Homeopathic Knowledge: A Strategy of Professionalisation. *Social Science and Medicine.* 42 (4): 579-588.

Cant. S, and Sharma. U. (1995) The Reluctant Profession: Homeopathy and the Search for Legitimacy. *Work Employment and Society.* 9 (4): 743-762.

Cassell. E. J. (1997) *Doctoring: The Nature of Primary Care in Medicine.* Oxford University Press. Oxford.

Chapell. P. (1999) *Emotional Healing With Homoeopathy: A practical Guide.* Element. Dorset.

Chatwin. J, and Collins. S. (2002) Communication in the Homoeopathic Consultation. *The Homoeopath.* 84 (winter): 24-27.

Chatwin. J, and Tovey. P. (forthcoming) CAM, Cancer and Group Based Action: A Critical Review of the Literature. *European Journal of Cancer Care.*

Christie. V. M. (1991) A Dialogue Between Practitioners of Alternative (Traditional) Medicine and Modern (Western) Medicine in Norway. *Social Science and Medicine.* 32 (5): 549-552.

Clarke. A. (1990) A Social Worlds Research Adventure. In: Cozzens. S, and Gieryn. T. (Eds) *Theories of Science in Society.* Indiana University Press. Bloomington.

Collins. S, Drew. P, Watt. I, and Entwistle. V. (2002) 'Unilateral' and 'Bilateral' Practitioner Approaches in Decision-making About Treatment and their Consequences for Patient Participation. Paper presentated at the International Conference of Communication in Healthcare. University of Warwick.

Consumer's Association (The) (1992) Alternative Medicine. *Which?* November issue. pp 13-21.

Coombs. R. H, Chopra. S, Schenk. D. R, and Yutan. E. (1993) Medical Slang and its Functions. *Social Science and Medicine.* 36 (8): 987-998.

Coward. R. (1989) *The Whole Truth: The Myth of Alternative Health.* Faber. London.

Coulehan. J. L, and Block. M. (1987) *The Medical Interviewer: A Primer for Students of the Art.* F. A. Davis Company. Philadelphia.

Coulter. H. (1981) *Homoeopathic Science and Modern Medicine.* North Atlantic Books. London.

Dept. of Health. (1999) *The Cancer Plan.* Dept. of Health. London.

Diamond. J. (2001) *Snake Oil and Other Preoccupations.* Vintage. London.

Dickinson. D, Wilkie. P and Harris. M. (1999) Taking Medicine: Concordance is not Compliance. *BMJ* . 319 (18th September): 787.

Drew. P. (1994) Conversation Analysis. In: Asher. R. E, and Simpson. J. M. Y. (Eds). *The Encyclopedia of Language and Linguistics.* Pergamon. Oxford. pp. 479-454.

Drew. P. (Forthcoming) Comparative Analysis of Talk-in-interaction in Different Institutional Settings: A Sketch. In: P. Glenn. C, Le Baron, and Mandelbaum. (Eds.) *Excavating the Taken-for-Granted: Essays in Language and Social Interaction.* Lawrence Erlbaum, Mawah N.J.

Drew. P. (forthcoming) Mis-alignments Between Doctor and Callers in 'After-Hours' Telephone Calls to a British GP's Practice: a Study in Telephone Medicine. In: Heritage. J, and Maynard. D. (Eds), *Practicing Medicine.* Cambridge University Press. Cambridge.

Drew. P, and Heritage. J. (1992) Analyzing Talk at Work: An Introduction. In: Drew. P, and Heritage. J. *Talk at Work: Interaction in Institutional Settings.* Cambridge University Press. Cambridge. pp 3-65.

Drew. P and Holt. E. (1998) Figures of Speech: Figurative Expressions and the Management of Topic Transition in Conversation. *Language in Society.* 27 (4): 495-522.

Drew. P, Chatwin. J, and Collins. S. (2001) Conversation analysis: a method for research in health care professional-patient interaction. *Health Expectations.* 4 (1): 58-71.

Easthope. G, Tranter. B, and Gill. G. (2000) General Practitioners' Attitudes Toward Complementary Therapies. *Social Science and Medicine.* 51: 1555-1561.

Eiesnberg. D. M, Kessler. R. C, Foster. C, Norlock. F. E, Calkins, and Delbanco. T. L. (1993) Unconventional Medicine in the United States –

Prevalence, Costs, and Patterns of use. *The New England Journal of Medicine.* 328 (4): 246-252.

Elwyn. G, and Gwyn. R. (1999) Stories we Hear and Stories we Tell: Analyising Talk in Clinical Practice. *BMJ.* 318 (16th January): 186-188.

Entwistle. V. A, Sowden. J. A, and Watt. I. S. (1988) Evaluating Interventions to Promote Patient Involvement in Decision-making: By What Criteria Should Effectiveness be Judged? *Journal of Health Service Research Policy.* 3 (2): 100-107.

Faculty of Homoeopathy Medicine (FHM) *Overview.* http://www.trusthomoeopathy.org

Featherstone. M. The Body in Consumer Culture. In: Hepworth. M, and Turner. B. S. (Eds) (1991) *The Body, Social Process and Cultural Theory. Sage.* London. pp 1-35.

Fisher. P, and Ward. A. (1994) Complementary Medicine in Europe. *BMJ.* 309 (9th July): 107-111.

Fitzgerald. F. T. (1983) Science and Scam: Alternative Thought Patterns in Alternative Health Care. *New England Journal of Medicine.* 309 (17): 1066-1077.

Foundation for Integrated Health (2000). *Towards a National Strategy for Research and Development in Complementary and Alternative Medicine.* FIMED.

Frank. R. (2002) Homoeopathy and Patient - A Dyad of Harmony? *Social Science and Medicine.* 55 (8): 1285-1296.

Frankel. R. M. (1983) The Laying on of Hands: Aspects of the Organisation of Gaze, Touch, and Talk in a Medical Encounter. In: Fisher. S, and Dundas. T. (Eds.) *The Social Organisation of Doctor-Patient Communication.* The Centre for Applied Linguistics. Washington.

Frankel. R. M. (1983) From Sentence to Sequence: Understanding the Medical Encounter Through Microinteractional Analysis. *Discourse Process.* I (7): 135-170.

Frankel. R.M, and West. C. (1991) Miscommunication in Medicine. In: Coupland. N, Giles. H, and Wiemann. J.M. (Eds.) *"Miscommunication" and Problematic Talk.* Sage. London. 166-184.

Freidson. E. (1960) Client Control and Medical Practice. *American Journal of Sociology*, 65: 374-382.

Fulder. S. (1996) *The Handbook of Alternative and Complimentary Medicine.* Oxford University Press. Oxford.

Fulder. S. (1992) Alternative Therapists in Britain. In: Saks. M. (Ed). *Alternative Medicine in Britain.* Clarendon Press. Oxford. pp. 162-180.

Fulder. S, and Munro. R. E. (1985) Complementary Medicine in the United Kingdom: Patients, Practitioners and Consultations. *The Lancet.* 2 (8454): 542-545.

Furnham. V. C. (1996) Why do Patients Turn to Complementary Medicine? An Empirical Study. *British Journal of Clinical Psychology.* 35 (1): 37-48.

Furnham. A, and Smith. C. (1988) Choosing Alternative Medicine: A Comparison of the Beliefs of Patients Visiting A General Practitioner and a Homoeopath. *Social Science and Medicine* 26 (7): 685-689.

Furnham. A, and Kirkcaldy. B. (1996) The Health Beliefs and Behaviours of Orthodox and Complementary Medicine Clients. *British Journal of Clinical Psychology.* 35 (1): 48-61.

Goffman. E. (1972) *Encounters: Two Studies in the Sociology of Interaction.* Penguin. Harmondsworth.

Greenhalgh. T. (1999) Narrative Based Medicine in an Evidence Based World. *BMJ.* 318 (16th January): 23-325.

Greenhalgh. T, and Hurwitz. B. (1999) Why Study Narrative. *BMJ.* 318 (2nd January): 48-50.

Guyatt. G. (1993) Letter to the Editor. *Journal of the American Medical Association.* 269 (10): 1255.

Hak. T. (1994) The Interactional Form of Professional Dominance. *Sociology of Health and Illness.* 16(4): 558-571.

Haakana. M. (1999) *Laughing Matters: A conversational Analytical Study of Laughter in Doctor-Patient Interaction.* Unpublished PhD thesis. Department of Finnish Language. University of Helsinki.

Haakana. M. (2001) Laughter as a Patient's Resource: Dealing with Delicate Aspects of Medical Interaction. *Text.* 21-(1/2): 187-219.

Hall. J. A, Horgan. T. G, Stein. T. S, and Roter. D. L. (2002) Liking in the Physician-patient Relationship. *Patient Education and Counseling.* 48 (1): 69-77.

Have. P. T. (1991) The Doctor is Silent: Observations on Episodes Without Vocal Receipt During Medical Consultations. *Les Formes de la Conversation.* 2: 55-76.

Have. P. T. (1989) The Consultation as a Genre. From: Torode. B. (Ed.) *Text and Talk as Social Practice: Discourse Difference and Division in Speech and Writing.* Foris. Dordrecht. pp.115-135

Heath. C. (1992) The Delivery and Reception of Diagnosis in the General-Practice Consultation. In: Drew. P, and Heritage. J. (Eds.) *Talk at work: Interaction in Institutional Settings.* Cambridge University Press. Cambridge. pp. 235-267.

Heath. C. (1989) Pain talk: The Expression of Suffering in the Medical Consultation. *Social Psychology Quarterly.* 52 (2): 113-125.

Heath. C. (1986) *Body Movement and Speech in Medical Interaction.* Cambridge University Press. Cambridge.

Heath. C. (1981) The Opening Sequence in Doctor-Patient interaction. In: Atkinson. P, and Heath. C. (Eds) *Medical Work, Realities and Routines.* Gower. Westmead. pp. 71-90.

Heritage. J. (2002) Justifying the Medical Visit: Doctorability Across the Medical Encounter. Paper given at the International Conference on Conversation Analysis (ICCA-02) Copenhagen 17-21 May.

Heritage. J. (2000) *Accounting for the Visit: Giving Reasons for Seeking Medical Care.* (Pre-publication copy).

Heritage. J, and Lindström. A. (1998) Medicine, Motherhood and Morality: Scenes From a Medical Encounter. *Research on Language and Social Interaction.* 31 (3/4): 397-438.

Heritage. J, and Stivers. T. (1999) "Online Commentary in Acute Medical Visits: A Method of Shaping Patient Expectations." *Social Science and Medicine.* 49 (11): 1501-1517.

House of Lords Science and Technology Select Committee (2000) *Sixth Report - Alternative Medicine.* House of Lords. London.

Hudson-Jones. A. (1999) Narrative in Medical Ethics. *BMJ.* 318 (23rd January): 253-256.

Hughes. C. (2003) Health as Individual Responsibility; Possibilities and Personal Struggle. In: Tovey. P, Easthope. G, and Adams. J. (Eds) *The Mainstreaming of CAM: Studies in the Social Context.* Routlege. London. pp. 44-60.

Hughes. D. (1982) Control in the Medical Consultation: Organising Talk in a Situation Where Co-Participants Have Differential Competence. *Sociology.* 16 (3): 359- 376.

Hunter. K. M. (1991) *Doctors' Stories: the Narrative Structure of Medical Knowledge.* Princeton University Press. Princeton.

Hutchby. I, and Wooffit. R. (2001) *Conversation Analysis.* Blackwell. London.

Inglis. B, and West. R. (1983) *The Alternative Health Guide.* Michael Joseph. London.

Internet Health Library 1999-2000. http://www.internethealthlibrary.com/

Jefferson. G. (1996) On Stepwise Transition From Talk About a Trouble to Inappropriately Next-positioned Matters. In: Heritage. J, and Atkinson. J. M. (Eds) *Structures of Social Action.* Cambridge University Press. Cambridge. pp. 346-470.

Jefferson. G. (1980) On "Trouble-Premonitory" Responses to Enquiry. *Sociological Enquiry.* (Language and Social Interaction.) 50: 3-4.

Jefferson. G, Sacks. H, and Schegloff. E. (1987) Notes on Laughter in the Pursuit of Intimacy. In: Button. G, and Lee. J. *Talk and Social Organisation.* Multilingual Matters Ltd. Clevedon. pp. 152-105.

Jump. J, Yarbrough. L, Kilpatrick. S, and Cable. T. (1998) Physicians' Attitudes Toward Complementary and Alternative Medicine. *Integrative Medicine.* 1 (4): 149-153.

Kacperek. L. (1997) Non-verbal Communication: the Importance of Listening. *British Journal of Nursing.* 6 (5): 275-279.

Kaplan. B. (2001) *The Homoeopathic Conversation: The Art of Taking the Case.* Natural Medicine Press. London.

Kaptchuk. T, and Eisenberg. D. M. (2001) Varieties of Healing. 1: Medical Pluralism in the United States. *Annals of Internal Medicine.* 135 (3): 189-195.

Kemper. B.J. (1992) Therapeutic Listening: Developing the Concept. *Journal of Psychosocial Nursing and Mental Health Service.* 30 (7), 21-23.

Korsch. B. M, and Negrete. V. F. (1972) Doctor-Patient Communication. *Scientific American.* 227: 66-74.

Kronenfeld. J. J, and Wasner. C. (1982) The use of Unorthodox Therapies and Marginal Practitioners. *Social Science and Medicine.* 16 (11): 1119-1125.

Langer. B. (1996) The Consuming Self. In: Jureidini. R, and Pole. M. (Eds) *Sociology: Australian Connections* (2nd Edition). pp. 143-162.

Lask. B. (2002) Daily Regimen and Compliance with Treatment: Concordance Respects Beliefs and Wishes of Patients. *BMJ.* 324 (16th February): 425.

Launer. J. (1999) A Narrative Approach to Mental Health in General Practice. *BMJ.* 318 (9th January): 117-119.

Lerner. I. J. (1984) The Whys of Cancer. *Cancer.* 53 (3) (sup): 815-819.

Lindquist. G. (2001) The Culture of Charisma: Wielding Legitimacy in Contemporary Russian Healing. *Anthropology Today.* 17 (2): 3-8.

Little. P, Everitt. H, Williamson. I, Warner. G, Moore. M, Gould. C, Ferrier. K, and Payne. S. (2001) Preferences of Patients for Patient Centred Approach to Consultation in Primary Care: Observational Study. *BMJ.* 322 (24th February): 468.

Macmillan Cancer Relief (2002) *Directory of Complementary Therapy Services in UK Cancer Care: Public and Voluntary Sectors.* Macmillan Cancer Relief. London.

Massey. A. (1998) "The Way We do Things Around Here": The Culture of Ethnography. Paper presented at the Ethnography and Education Conference, Oxford University Department of Educational Studies (OUDES), 7-8 September.
(Accessed from: http://www.geocities.com/Tokyo/2961/waywedo.htm)

May. C, and Sirur. D. (1998) Art, Science and Placebo: Incorporating Homeopathy into General Practice. *Sociology of Health and Illness*. 20 (2): 168-190.

Maynard. D. W. (1991) Interaction and Asymmetry in Clinical Discourse. *American Journal of Sociology*. 97 (2): 448-95.

Maynard. D. (1989) Notes on the Delivery and Reception of Diagnostic News Regarding Mental Disabilities. In: Helm. D, Anderson. T, Meeham. A, and Rawls. A. (eds.) *Interactional Order: New Directions in the Study of Social Order.* Irvington, New York. pp. 54-67.

McLeod. G. (1978) *Treatment of Horses by Homoeopathy.* Health Science Press. Holsworthy.

Mead. N, and Bower. P. (2000) Patient-centredness: a Conceptual Framework and Review of the Empirical Literature. *Social Science and Medicine.* 51 (7): 1087-1110.

Miller. K. (1998) The Evolution of Professional Identity: The Case of Osteopathic Medicine. *Social Science and Medicine*. 47 (11): 1739-1748.

Mills. S, and Budd. S. (2000) Professional Organisation of Complementary and Alternative Medicine in the United Kingdom 2000. *Complementary Health Studies*, Department of Lifelong learning, University of Exeter.

Montbriand. M. (1998) Abandoning Biomedicine for Alternative Therapies: Oncology Patients' Stories. *Cancer Nurse*. 21 (1): 36-45.

Morrell. P. (1998) *A History of Homeopathy in Britain.* Homeopathy Home. (online) Dec.. (http://www.homeoint.org/morrell/articles/pm_brita.htm)

Ngokwey. N. (1989) On the Specificity of Healing Functions: A Study of Diagnosis in Three Faith Healing Institutions in Feira (Bahia, Brazil). *Social Science and Medicine* 29 (4): 515-526.

Nicholls. P. (1988) *Homeopathy and the Medical Profession.* Croom Helm. London.

Novak. K. L, and Chapman. G. E. (2001) Oncologists' and Naturopaths' Nutritional Beliefs and Practices. *Cancer Practice.* 9 (3): 141-146.

Paget. M. A. (1983) On the World of Talk: Studies in Misunderstanding. Fisher. S, and Dundas. T. (Eds.) *The Social Organisation of Doctor-Patient Communication.* The Centre for Applied Linguistics. Washington..

Peace. G, and Manasse. A. (2002) The Cavendish Centre for Integrated Cancer Care: Assessment of Patients' Needs and Responses. *Complementary Therapies in Medicine.* 10 (1): 33-41.

Peräkyla, A. (1998) Authority and Accountability: The Delivery of Diagnosis in Primary Health Care. *Social Psychology Quarterly.* 61(4): 301-320.

Peräkyla. A. (1997) Conversation Analysis: a New Model of Research in Doctor-Patient Communication. *Journal of the Royal Society of Medicine.* 90 (4): 205-208.

Peräkylä. A. (1995) *Aids Counselling. Institutional Interaction and Clinical Practice.* Cambridge University Press. Cambridge.

Pomerantz. A. M, Ende. J, and Erickson. F. (1995) Percepting Conversations in a General Medicine Clinic. In: Horns. G.H, and Chenail R. J. *The Talk of the Clinic.* Erlbaum. New Jersey. pp 75-82.

Porter. R. (1997) *The Greatest Benefit to Mankind: The medical History of Humanity From Antiquity to the Present Time.* Fontana. London.

Rayner. L, and Easthope. G. (2001) Postmodern Consumption and Alternative Medications. *Journal of Sociology.* 37 (2): 157-176.

Rees. L. R, and Weil. A. (2001) Integrated Medicine. *BMJ.* 322 (20th January): 119-120.

Reilly. D. (2001) Enhancing Human Healing. *BMJ.* 322 (20th January) 120-121.

Reilly. D. (1999) *CAM in Europe: Reflections and Trends.* Article prepared for 2nd International Joint Symposium. Seoul. Korea.

Reilly. D. (1999) *The Evidence for Homeopathy.* Unpublished report (version 4.2) presented to the consensus management panel. Grampian. Scotland.

Reilly. D. (1983) Young Doctors' Views on Alternative Medicine. *BMJ.* 287 (30th July): 337-339.

Reilly. D. (date unknown) *Creating Therapeutic Consultations: Some Reflections.* Unpublished lecture transcript.

Research Council for Complementary Medicine (The) (RCCM) (2000) *A Survey of Knowledge and Understanding of Unconventional Medicine in*

Europe. The Research Council for Complementary Medicine (RCCM). London.

Research Council for Complementary Medicine (The) (RCCM) (1994) *A Research Report for Wessex Regional Health Authority.* The Research Council for Complementary Medicine (RCCM). London.

Robinson. J. (1998) Soliciting Patients' Presenting Concerns. In: Heritage. J, and Maynard. D. (eds.) *Practicing Medicine: Structure and Process in Primary Care Encounters.* Cambridge University Press. Cambridge.

Rodgers. C. R. (1961) *On Becoming a Person: A Therapist's View of Psychotherapy.* Houghton Mifflin. Boston.

Rost. K, Carter. W, and Inui. T. (1989) Introduction of Information During the Initial Medical Visit: Consequences for Patient Follow-through with Physician Recommendations for Medication. *Social Science and Medicine.* 28 (4): 315-321.

Rotter. D. L, and Hall. J. A. (1987) Physician Interviewing Styles and Medical Information Obtained from Patients. *Journal of General Internal Medicine.* 2 (5): 325-329.

Rotter. D. L, and Frankel. R. (1992) Quantitative and Qualitative Approaches to the Evaluation of the Medical Dialogue. *Social Science and Medicine.* 34 (10): 1097-1103.

Royal collage of General Practitioners (The)
http://www.rcgp.org.uk/rcgp/

Sacks. H. (1998) *Lectures on Conversation. Vol. II.* (Edited by Jefferson. G). Blackwell. Oxford.

Schofield P.E, Butow P.N, Thompson J.F, Tattersall. M.H.N, Beeney L.J, and Dunn S.M. (2003) Psychological Responses of Patients Receiving a Diagnosis of Cancer. *Annals of Oncology.* 14 (1), 48-56.

Schegloff. E. A. (1996) On Some Questions and Ambiguities in Conversation. In: Heritage. J, and Atkinson. J. M. *Structures of Social Action.* Cambridge University Press. Cambridge. pp 28-52.

Schegloff. E. A, and Sacks. H. (1973) Opening up Closings. *Semiotica.* 7: 289-327.

Sharma. U. (1993) Contextualizing Alternative Medicine: the Exotic, the Marginal and the Perfectly Mundane. *Anthropology Today.* 9 (4):15-18.

Sharma. U. (1992) *Complementary Medicine Today: Practitioners and Patients.* Routledge. London.

Siahpush. M. (1999)(a) Why do People Favour Alternative Health? *Australian and New Zealand Journal of Public Health.* 23 (3): 266-271.

Siahpush. M. (1999)(b) A Critical Review of the Sociology of Alternative Medicine: Research on Users, Practitioners and the Orthodoxy. *Health* 4 (2): 159-178.

Siahpush. M. (1998) Postmodern Values, Dissatisfaction with Conventional Medicine and the Popularity of Alternative Therapies. *Journal of Sociology.* 34: 58-70.

Silverman. D. (1987) *Communication and Medical Practice: Social Relations and the Clinic.* Sage. Bristol.

Society of Homeopaths (2000) *Homoeopathy Simply Explained.* Society of Homeopaths. Northampton.

Stewart. J. (ed) (1995) *Bridges Not Walls.* (6th edition). McGraw-Hill. New York.

Squier. R. (1990) A Model of Empathetic Understanding and Adherence to Treatment Regimens in Practitioner-Patient Relationships. *Social Science and Medicine.* 85(7): 669-673.

Stoeckle JD. Billings JA. (1987) A history of history-taking: the medical interview. *Journal of General Internal Medicine.* 2(2): 119-27.

Sudan B. J. (1993) Abrogation of Facial Seborrhoeic Dermatitis with Homoeopathic High Dilutions of Tobacco: a New Visible Model for Benveniste's Theory of 'Memory of Water'. *Medical Hypotheses.* 41(5): 440-4

Svarstad. B. (1974) The Patient-Physician Encounter: An Observational Study of Communication and Outcome. Doctoral Dissertation. Uni of Wisconsin, Dept. of Sociology.

Taylor. M, and Reilly. D. T. (1986) Is Homoeopathy a Placebo Effect? Hay Fever Trial. The Lancet. 2 (8512): 881-6.

Thomas. K. J, Carr. J, Westlake. L, and Williams. B. T. (1991) Use of Non-orthodox and Conventional Health Care in Great Britain. *BMJ.* 302 (26th January): 207-210.

Thomas. K, Nicholl. J, and Coleman. P. (2001) Use and Expenditure on Complementary Medicine in England. *Complementary Therapies in Medicine.* 9: 2-11.

Tovey. P. (2001) The use and Purpose in the Sociology of CAM. *Complementary Therapies in Medicine.* 9 (3): 134-135.

Tovey. P. (1997) Contingent Legitimacy: UK Alternative Practitioners and Inter-sectoral Acceptance. *Social Science and Medicine.* 45 (7): 1129-1133.

Tovey. P, Easthope. G, and Adams. J. (Eds) (2003) *The Mainstreaming of CAM: Studies in the Social Context.* Routledge. London.

Turner. S. J. (2001) Use of Homoeopathy and Non-antibiotic Treatment for Mastitis in Somerset. *Proceedings of the British Mastitis Conference. Institute for Animal Health/Milk Development Council.* pp. 13-23. Institute for Animal Health/Milk Development Council

Tyler Kent. J. (1993) *Repertory of the Homoeopathic Materia Medica (Classics in Homoeopathy).* Homoeopathic Book Service. London.

Vincent. C, and Furnham. A. (1996) Why do Patients Turn to Complementary Medicine? An Empirical Study. *British Journal of Clinical Psychology.* 35 (1): 37-48.

Waitzkin. H. (1984) Doctor-Patient Communication: Clinical Implications of Social Research. *Journal of the American Medical Association.* 252 (17): 2441-2446.

Wardwell. W. I. (1994) Alternative Medicine in the United States. *Social Science and Medicine.* 38 (8): 1061-1068.

Watts. F. N. (1983) Strategies of Clinical Listening. *British Journal of Medical Psychology.* 56 (2): 13-123.

West. C. (1984) *Routine Complications: Troubles with Talk Between Doctors and Patients.* Indiana University Press. Bloomington. Indiana.

West. C. (1983) "Ask me no Questions..."An Analysis of Queries and Replies in Physician-Patient Dialogues. In: Fisher. S, and Dundas. T. (Eds.) *The Social Organisation of Doctor-Patient Communication.* The Centre for Applied Linguistics. Washington. 127-157.

West. F, and Frankel. R. M. (1991) Miscommunication in Medicine. *"Miscommunication" and Problematic Talk.* Copland. N, Giles. H, and Wieman. J. M. (Eds.) Sage. London.

Wharton. R, and Lenith. G. (1986) Complementary Medicine and the General Practitioner. *BMJ.* 292 (7th June): 1498-1500.

Whelan. T. J, Levine. M. N, Gafni. A, Lukka. H, Mohide. E. A, Patel. M, and Streiner. D. L (1995) Breast Irradiation Postlumpectomy: Development and Evaluation of a Decision Instrument. *Journal of Clinical Oncology.* 13: 847-853.

Whiteford. M. B. (1999) Homeopathic Medicine in the City of Oxaca, Mexico: Patients' Perspectives and Observations. *Medical Anthropology Quarterly.* 13 (1): 69-78.

Willis. E, and White. K. (2003) Evidence Based Medicine and CAM. In: Tovey. P, Easthope. G, and Adams. J. (Eds). *The Mainstreaming of CAM: Studies in the Social Context.* Routledge. London. pp. 151-174.

Wright. O. (2003) GP 'Swung a Crystal to Treat Sick Baby. *The Times.* Jan 4th