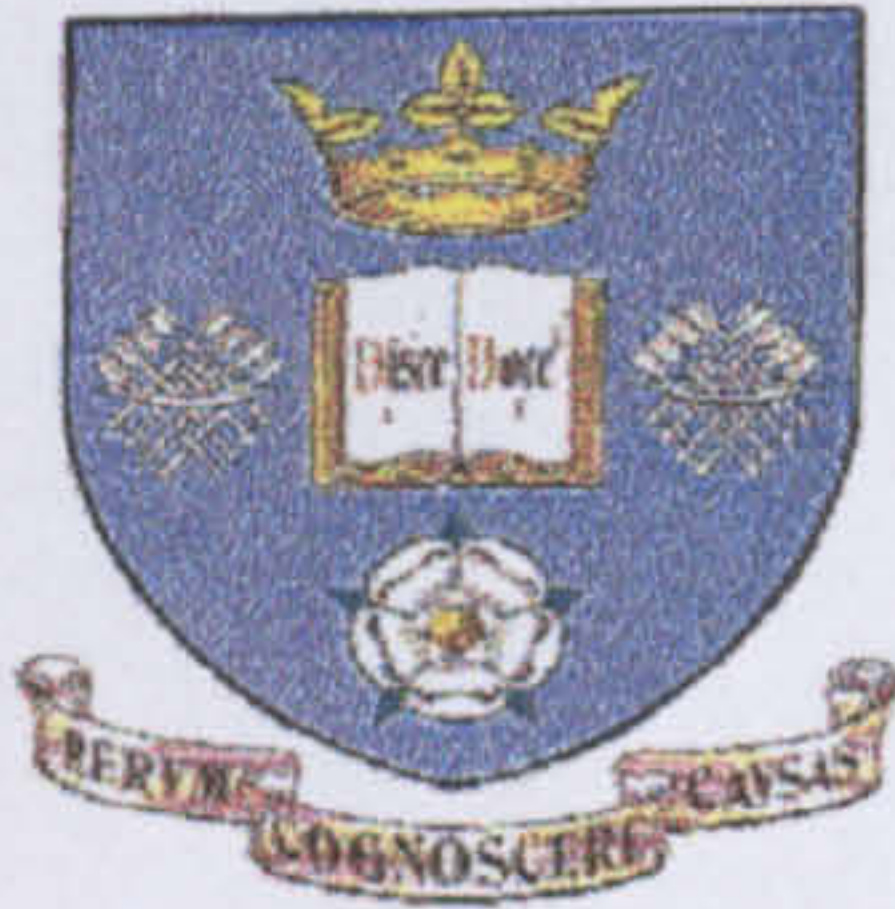


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Institute of
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The impact of delivering shiatsu in general practice

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CONTENTS

	Page number
Chapter I INTRODUCTION	
Personal background to the study	1
The research need to be addressed	2
The scope of the research	2
Chapter guide	3
Thesis style	3
Chapter II LITERATURE REVIEW	5
Orthodox medicine	5
Complementary medicine	7
Wide variety of therapies	7
Range of training opportunities	8
Integrated provision of complementary medicine	9
Characteristics of complementary medicine	10
Holism	11
Traditional Chinese medicine and the concept of chi	13
Meridians of chi	14
The function of tsubos	14
The principle of yin/yang	15
Shiatsu	16
Improvement in health associated with shiatsu	21
Shiatsu and chronic back pain	22
Shiatsu and cerebral palsy	22
Shiatsu for pregnancy and childbirth	23
Shiatsu and palliative care	24
Shiatsu and the cardiovascular system	26
The potential side-effects of shiatsu	27
Symptoms presented to shiatsu practitioners	28
How is complementary medicine delivered?	31
How much complementary medicine is delivered?	31
Who delivers complementary medicine?	32
The integration of complementary medicine into general practice	35
Patient request for integrated services	36
GPs' interest in complementary medicine	37
GPs delivering complementary medicine	37
Nurses and midwives delivering complementary medicine	39
GP referrals to complementary medicine	40
The age of patients GPs refer to complementary medicine	41
The gender of patients GPs refer to complementary medicine	42
The ethnic origin of patients having complementary medicine	43
The types of symptoms that lead to GP referral	44
Chronic symptoms that are hard to diagnose and treat	46
Patient dissatisfaction with orthodox medicine	47
Implications for complementary medicine	48

Guidelines for the integration of complementary medicine with general practice	48
Benefits of integrating complementary medicine with general practice	51
Increased GP efficiency	52
Increased solutions for GPs in patient care	52
Enhanced practice reputation	53
Increased intellectual scope for GPs	54
Saving general practice resources	54
Researching complementary medicine	58
Randomised controlled trial	59
Systematic review	62
The influence of research	62
Conclusions from literature review	64
Chapter III EPISTEMOLOGY AND METHODOLOGY	66
Epistemology	67
Positivism and postpositivism	67
Realist and constructionist post-positivism	68
Methodology	69
Emergent research question	70
Commitment to difference and reflexivity	70
Dialogical data analysis	71
The social and political context of a study	72
Interactive Holistic Research	73
Collaborative research	73
Dialogic research	74
Experiential research	74
Contextual locating	74
Action research	74
Quantitative methodology	77
Qualitative methodology	78
The preferences of qualitative researchers	80
Interpersonal Phenomenological Analysis	83
Limitations of qualitative methodology	84
Assessment of qualitative research	85
Lincoln and Guba's concept of rigour	87
Assessment of current study	91
Assessment of authenticity	92
Assessment of Interpersonal Phenomenological Analysis	94
Application of research	95
Summary of the assessment of the current study	95

Chapter IV	METHOD	96
	The research question	96
	Concepts and indicators	96
	Research aim	96
	Research outcomes	96
	Study design	97
	Referral procedure	98
	Evaluation procedure	99
	Patient evaluation	101
	GP evaluation	101
	Practitioner researcher evaluation	102
	Data collection	102
	Qualitative methods	102
	Semi-structures interviews	102
	Reflective journal for patients	106
	Reflective journal for the practitioner researcher	107
	Yellow cards	107
	Shiatsu forms	107
	Quantitative methods	107
	SF-12	108
	MYMOP-PIRIE	108
	Consultation rates	109
	Data analysis	109
	Interview analysis	109
	IPA in the current study	110
	From epistemology to method	112
	Application of Interactive Holistic Research in the current study	113
	Collaborative research	113
	Dialogic research	113
	Experiential research	113
	Contextual locating	114
	Action research	116
	Application of 'authenticity' in the current study	122
	Fairness	122
	Ontological authenticity	122
	Educative authenticity	123
	Catalytic authenticity	123
	Tactical authenticity	123
	Assessment of Interpretative Phenomenological Analysis	124
	Application of research	124
Chapter V	STUDY SETTING AND PARTICIPANTS	127
	Setting	127
	Participants	129

Chapter VI RESULTS	131
Section one - The impact of the shiatsu clinic on the general practice	133
GP referrals of ten patients	133
Changes in GP consultations	136
Benefits of the shiatsu clinic for the general practice	144
Section two - The impact of the shiatsu clinic on the patients	148
Perceived changes in patients' health	150
Patient expectations of shiatsu	177
Benefits of shiatsu clinic for patients	188
Section three - The impact of the shiatsu clinic on the practitioner researcher	194
Impact on my role as a shiatsu practitioner	195
Working with a new patient group	195
Working in a new setting	196
The challenges I faced as the shiatsu practitioner	197
Receiving feedback on my work	200
Impact on my role as a practitioner researcher	201
Benefits of my dual role	201
The challenges of my dual role	201
Section four - The impact of the shiatsu clinic on methods of evaluating complementary medicine in general practice	203
Referral Forms	203
Interviews	204
Questionnaires	206
Reflective Journals	207
Shiatsu patient notes	210
Consultant rates	211
GPs yellow card	211
Preferred feedback for GPs	212
Section five - The impact of the clinic on the future delivery of shiatsu in general practice	215
Recommendations for improvements to the shiatsu clinic	215
Participant requests for the future delivery of shiatsu	218
GP recommendations for the future delivery of shiatsu	223
Chapter VII DISCUSSION	226
Impact of the shiatsu clinic on the general practice and the GPs	226
Saving practice resources	226
Increased confidence in complementary medicine referrals	228
Greater options of patient care for GPs	229
Changing GPs practical skills and theoretical knowledge	230
Summary of the impact of the shiatsu clinic on the general practice and GPs	231

Impact of the shiatsu clinic on the patients	232
Confirmation of GP comments	232
Perceived changes in patients' health	232
Summary of the perceived changes in patients' health	238
Possible reasons for the perceived changes in health	239
Summary of the impact of the shiatsu clinic on the patients	250
Impact of the shiatsu clinic on the practitioner researcher	251
Working with general practice patients	251
Receiving feedback on my clinical practice	253
The delivery of complementary medicine in general practice	253
Summary of the impact of the shiatsu clinic on the practitioner researcher	254
Impact of the shiatsu clinic on the development of methodology	255
Practitioner research	255
Action research	256
The pilot of evaluation tools	257
Limitations of the study	258
Study setting and sample size	259
Referral procedure	261
Validation of the MYMOP-PIRIE	262
Data analysis	262
Theoretical models	263
Contribution to new knowledge and recommendations for further research	264
Key findings from the GPs	264
Key findings from the patients	267
Key findings from the practitioner researcher	271
Key findings from the methodology	271
CHAPTER VIII CONCLUSION	273
REFERENCES	276
APPENDIX	
Appendix I The history of Chinese medicine	i
Appendix II Data tables	iv
Appendix III Evaluation tools	xi
Appendix IV Patient case studies	xxv
Appendix V Personal objectives in undertaking the study	xxxviii

FIGURES

Page number

Figure 1.	The Japanese symbol for human	15
Figure 2.	A typical back treatment in shiatsu	17
Figure 3.	The touch involved in shiatsu	19
Figure 4.	Epistemology and methodology of the current study	66
Figure 5.	Action research	75
Figure 6.	Evaluation procedure	100
Figure 7.	Patient consultation rates over time	136
Figure 8.	First clinic consultation rates over time	137
Figure 9.	Second clinic consultation rates over time	137
Figure 10.	Patients' mean MYMOP-PIRIE scores	Appendix II.vii
Figure 11.	Patients' SF-12 mental health scores over time	Appendix II.ix
Figure 12.	Patients' SF-12 physical health scores over time	Appendix II.ix
Figure 13.	Cycle of improvement	173
Figure 14.	Patient satisfaction with shiatsu and GP care	181

TABLES	Page number
Table 1. Yin and Yang correspondences	16
Table 2. Shiatsu practitioner diagnosis (n=345) adapted from Pooley and Harris (1996)	Appendix II.iv
Table 3. Patient self-diagnosis (n=345) adapted from Pooley and Harris (1996)	Appendix II.iv
Table 4. Patient self-diagnosis (n=792) adapted from Pooley and Harris (1997)	Appendix II.v
Table 5. Medical diagnosis described by patients (n=382) adapted from Pooley and Harris (1997)	Appendix II.vi
Table 6. Integration of complementary medicine with general practice (Zollman and Vickers, 1999)	49
Table 7. Total costs for subsample of patients 1 year before and 1 year after treatment (Welford, 2000)	57
Table 8. The impact of the shiatsu clinic on the general practice	133
Table 9. The impact of the shiatsu clinic on the patients	149
Table 10. Patients' main two symptoms and duration of experience	156
Table 11. Most commonly cited symptoms	157
Table 12. Comparison of GP and patient choice of symptoms	158
Table 13. GP and patient perceptions of severity of symptoms and satisfying improvement following shiatsu	159
Table 14. The impact of the shiatsu clinic on the practitioner researcher	194

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Chapter I INTRODUCTION

Personal background of the study

This study was undertaken during my post as a researcher at the Institute of General Practice and Primary Care in the University of Sheffield. It was funded by two National Health Service research training awards in 1999 and 2000. The topic of research emerged from my academic experience plus my paid and voluntary employment. This will now be briefly described to present the background to the study and place it in context.

After a degree in Psychology, I was employed as an assistant psychologist for older adults managing a multi-disciplinary training programme on the recognition and management of depression. At the same time I undertook a certificate in counselling and completed a three-year part-time diploma in shiatsu. This enabled me to offer health care to patients as well as developing my research skills. A voluntary position as a co-manager of Sheffield Rape and Sexual Abuse Counselling Service developed my commitment to improving health care services, particularly in deprived inner-city areas. This led me to join the Institute of General Practice and Primary Care in 1997 to co-ordinate a self-directed learning programme to primary health care teams. After a successful European bid, I developed this programme in Belgium, Denmark, Italy and Spain. During this employment I was also involved in writing and delivering a CD-ROM based training package on mood disorders for GPs and psychiatrists.

I decided to amalgamate my interest in complementary medicine and primary care research. After gaining the training awards from the National Health Service Executive (Trent), I conducted the current study on shiatsu in an inner-city general practice. The specific research need that I chose to address consequently emerged from my personal experience as a shiatsu practitioner and my understanding of the current literature of complementary medicine and general practice as a researcher.

The research need to be addressed

The existing literature states that '*...the popularity of complementary therapies is growing rapidly*' (Vincent and Furnham, 1998) with 30% of the British public being treated by complementary practitioners every year (Sharma, 1992) and 75% claiming that it should be made available on the National Health Service (MORI Poll, 1989). Recent governmental policies that introduced primary care groups in 1999 and encouraged the further research of complementary medicine (House of Lords report, 2000) are helping to make this a reality with 40% of general practices now offering access to complementary medicine (Zollman and Vickers, 1990). However, there is little research on how to integrate complementary medicine into general practice (Robinson and Berman, 1984).

Over the last ten years there has been a dramatic increase in interest in complementary medicine from both the general public and the medical profession. It is therefore a matter of concern and importance to both groups that techniques...should be assessed as objectively as possible, and where applicable integrated into general practice (Lewith et al, 1996).

The scope of the research

This study attempted to provide original research on the integration of complementary medicine in general practice. The aim was to assess the impact that a shiatsu clinic may have on an inner-city general practice and the individuals involved. Practitioner research using qualitative methods was used to elicit the experiences of the GPs, patients and shiatsu practitioner. This enabled a detailed exploration of a small sample of participants in their natural healthcare environment. This methodology is consistent with constructionist postpositivism that claims there is not one single and fixed reality that can be captured by research. Instead, this thesis attempts to present a plausible interpretation of the various impacts of delivering shiatsu in a general practice and extrapolate any wider implications this may have on the future delivery and research of shiatsu in general practice.

Chapter guide

Chapter two presents an extensive literature review on the delivery and evaluation of complementary medicine in the National Health Service, particularly in general practice. Chapter three introduces the current study, which attempted to meet the research need that emerged from the literature review. This presents the epistemology and methodology of the study by describing postpositivism, interactive holistic research and practitioner action research. Quantitative and qualitative methodologies are then described, followed by an introduction to interactive phenomenological analysis. This chapter concludes by discussing the assessment of this research approach in terms of its authenticity and potential application of results.

Chapter four describes the specific method of the study by stating the research question and design, and describing how this method is consistent with the epistemology underpinning the research. The study setting and the participants are then described in detail in chapter five to present the context for the results. Chapter six presents the results in five sections to describe the impact of the shiatsu clinic on the general practice, GPs, patients, practitioner researcher and the evaluation and delivery of shiatsu in general practice.

Chapter seven discusses the results in relation to the existing literature in terms of how the study provides new knowledge on the integration of shiatsu in general practice. The limitations of the current study and recommendations for further research are then considered. The last chapter draws these findings together to conclude the study. The appendices are placed at the end of the thesis.

Thesis style

In general, this thesis adheres to the traditional style of academic research. However, since it describes practitioner research, the first person will be used when presenting personal reflections of the study as the shiatsu practitioner and researcher. This provides consistency with the postpositivist epistemology and action research approach that emphasise the involvement of the researcher as a member of the research sample. This sample is described as containing ‘participants’ as opposed to ‘subjects’ or ‘respondents’ to indicate their active involvement in the study.

Receivers of shiatsu are typically known as ‘clients’ but are referred to here as ‘patients’ to provide consistency with the nomenclature used in general practice. Quotations are indicated by quote marks and italics if only one line in length or by indenting text if longer. The hierarchy of headings is as follows:

CHAPTER

Heading one

Heading two

Heading three

Heading four

Chapter II LITERATURE REVIEW

This chapter will define the use of the terms 'orthodox medicine' and 'complementary medicine' within this thesis. It will present the main characteristics of complementary medicine and then describe a form of traditional Chinese medicine known as 'shiatsu'. The increasing popularity of complementary medicine and its gradual integration with general practice will then be discussed before presenting the key issues concerning complementary medicine research.

Orthodox Medicine

Orthodox medicine refers to a type of medicine practised in western health care, also known as conventional or biological medicine. These terms have important connotations, indicating the ability of language to suggest meaning and influence beliefs. 'Orthodox' and 'conventional' suggest a form of medicine that is particularly long-standing, safe and accepted as the status quo. However, each of these claims will now be disputed. Orthodox medicine reputedly emerged at the end of the eighteenth century (Foucault, 1973) but these are other forms of medicine at least as old as this. Homeopathy became particularly popular in Britain at the beginning of the nineteenth century and Sharma (1992) dates it as '*at least as old as orthodox medicine*'. Archaeological evidence claims that oriental medicine such as acupuncture, shiatsu and herbalism is much older than orthodox medicine, emerging as long ago as 3000BC (Duo Gao, 1999).

The safety of orthodox medicine can also be questioned. For example, the main form of treatment in orthodox medicine is the prescription of pharmaceutical drugs. These drugs can have iatrogenic effects when prescribed correctly, and potentially fatal consequences when administered incorrectly. This can be illustrated by the damage caused by Thalidomide and Opren in the 1960s and the continuous number of hospital admissions caused by orthodox medicine (Gould, 1985). The invasive techniques used by orthodox medicine can also pose risks to patients, such as the dangers of anaesthetics and infections from operations. Recently, orthodox medicine has sought to practice an approach based on tried and tested procedures to improve the safety and efficacy of treatments. This is known as 'evidence-based medicine' and it was

developed in Canada in the 1960s. Falshaw et al (1998) claim that '*...evidence-based medicine enables primary care workers to base the decisions that we make about diagnosis, treatment and management of patients on the best evidence available.*' In practice however, much of orthodox medicine is not based on evidence, especially in primary health care, where most patients attend and where most common ailments are presented. Falshaw et al (1988) suggest that '*...evidence-based medicine and its proponents tend to be hospital based...for many of the most common clinical areas there are very few papers on which we can base decisions.*' Furthermore, there is an ongoing debate about how to test efficacy of treatment to deliver evidence-based medicine (Saks, 1994).

Lastly, the acceptance of orthodox medicine could be undermined by the growing acceptance of complementary medicine by the general public. Sharma (1992) argues that the...

...use of non-orthodox medicine is now widespread and popular in the broad sense of that word. This popularity presents a direct challenge to the authority of the orthodox medical profession.

Many orthodox medics are also becoming more interested in complementary medicine. Since the 1980s, many doctors have delivered acupuncture in pain clinics (Camp, 1986), 40% of general practices throughout the UK provide access to complementary medicine (Zollman and Vickers, 1999) and many nurses and physiotherapists offer massage and reflexology alongside their normal clinical duties (Rankin-Box, 1988). Nevertheless, orthodox medicine is clearly still the main form of medicine in the UK. This section has suggested that this may be because of its powerful position in society as opposed to it being the most long-standing or safest approach to healthcare. This is commented upon in Sharma's (1992) definition of orthodox medicine.

What I have called orthodox medicine is orthodox in the sense that it is based on understandings of the body which are widely accepted in western society. The system of medicine practised by doctors asserts its legitimacy with reference to claims of scientificity, claims which are seldom disputed

even if their relevance is challenged. But such 'orthodoxy' is a matter of political authorisation as well as cultural acceptability.

This thesis consequently adopts Sharma's (1992) approach to defining orthodox medicine as '*...the kind of medicine practised under the National Health Service, simply in order to reflect the political reality of its recognition by the state, not in deference to its hegemonic claims.*'

Although the semantics surrounding orthodox medicine have been challenged, this does not reduce the acknowledgement of the need for orthodox medicine. Orthodox medicine has deepened our understanding of the anatomy and physiology of the human body and its treatments have greatly reduced the morbidity and mortality of its patients. It is for this reason that the current study does not place orthodox medicine in opposition to complementary medicine, but considers the possible integration of these two approaches to health. More specifically, this thesis describes the potential for collaboration between a shiatsu practitioner and a team of GPs to deliver a complementary medicine service in a general practice. This requires a definition of complementary medicine.

Complementary medicine

Wide variety of therapies

Complementary medicine is commonly defined as therapies that are 'alternative' to the above concept of orthodox medicine. This definition is based on exclusion, which has consequent problems. Most notably, this definition includes anything from the 'fringe' end of health-care such as auric healing or hair analysis¹ to the more common practices of chiropractic and osteopathy. Depending on the source, complementary medicine can encompass many varied 'unconventional' approaches to health and the British Medical Association lists 116 different complementary therapies (BMA, 1993). The histories and geographical origins of these therapies are widely diverse, ranging from ancient oriental medicine such as acupuncture, already described as

¹ Definitions of therapies taken from Fulder (1996):

Auric Healing - Healing directed towards the subtle or etheric aura of the body to cure its susceptibilities and prevent their manifestation in the body as diseases.

Hair Analysis – The analysis of minerals found in hair, usually by post.

dating from 3000BC (Duo Gao, 1999), to modern western approaches of biodynamics and biofeedback².

Complementary therapies also have many different theories and practices. Homeopathy is based upon the principal of 'like curing like' and treats patients with heavily diluted doses of natural substances, which would cause similar symptoms in 'healthy' people (Fulder, 1996). In contrast, healing is founded on the philosophy that treatment involves the direct transmission of psychic energy through the hands of the healer. No remedies, little diagnosis or formal clinical judgements of symptoms are used, as deemed necessary in homeopathy or orthodox medicine. Consequently, it is difficult to suggest that complementary medicine can be clearly defined from orthodox medicine by a distinct, cohesive theory and practice. An alternative way of distinguishing between complementary and orthodox medicine is to claim that complementary therapies are largely taught and practised outside conventional institutions. This will now be examined in more detail.

Range of training opportunities

The British Medical Association defines complementary medicine as health treatments that are not taught as part of the medical undergraduate curriculum (Integrated Healthcare document, 1997). This definition is again based on exclusion and is not only vague, but inaccurate. There is currently a wide variety of institutions that teach complementary medicine, including many Universities³. Rampes et al's (1997) survey of twenty-four UK medical schools reported that three undergraduate syllabuses offered courses in complementary medicine, and four others claimed that this would soon be the case. They found higher figures in America, concluding that

² Definitions of therapies taken from Fulder (1996):

Biodynamics - Behavioural and psychological encounters with a therapist resulting in an often explosive release of psychological blocks, body tensions, and inhibitions, leading to improved general health and well-being.

Biofeedback - The use of equipment to self-monitor physiological signals from the mind or body and thus bring involuntary processes under voluntary control.

³Current University courses in complementary medicine include a diploma in hypnosis and art therapy at Sheffield University; a BSc Health Sciences for complementary medicine in the University of Central Lancashire; a department of complementary medicine at the University of Exeter and eleven courses including diplomas and both under and post-graduate degrees in the School of Integrated Health at the University of Westminster.

complementary medicine is taught in a third of medical curricula, with a third of these courses being compulsory. Vickers (2000) supports these claims by describing several American universities that offer research and teaching in complementary medicine⁴.

Japan has a varied approach to delivering training in complementary medicine. It seems particularly strict with regard to traditional Japanese medicine as this is predominantly only taught as a postgraduate qualification for trained doctors. Acupuncture and acupressure/shiatsu are taught as non-medical degree courses and osteopathy and chiropractic are not subjected to any state recognised training, (Yamauchi, 1996). Rampes et al's (1997) survey could be replicated to suggest current estimates of institutions that offer training in complementary medicine in a variety of countries.

Integrated provision of complementary medicine

Finally, it is becoming increasingly difficult to distinguish between complementary medicine and orthodox medicine on the basis of where they are delivered.

Complementary medicine and conventional medicine have traditionally been provided in entirely separate settings. Recently, however, there has been a greater integration between the two, with both often provided at the same site (Vickers, 2000).

Complementary medicine is now often delivered in orthodox medical settings. For example, osteopathy and chiropractic are now two of the most commonly provided treatments in primary care, usually for back pain (Koes et al, 1992). In secondary care, physiotherapy and chiropractic clinics are widely found in National Health Service Hospitals (Camp, 1986) alongside acupuncture in pain clinics (Camp, 1986) and rheumatology clinics (Vickers, 2000).

⁴ American Universities teaching complementary medicine include the University of Maryland, Columbia University in New York and Harvard University in Massachusetts.

The integrated provision of services further hinders the clear definition of what makes a therapy 'complementary' as opposed to 'orthodox'.

It will probably become increasingly difficult to define these therapies by their distinction from conventional medicine. For the 1990s are bringing a convergence of medical and non-conventional systems, and a blurring of boundaries (Fulder, 1996).

An alternative definition cites the collaboration as opposed to the distinction between complementary and orthodox medicine. Ernst (1995) claims it is '*...diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual frameworks of medicine.*' The Cochrane Library has since accepted this definition of complementary medicine and it is the preferred description in this thesis of the role of shiatsu in contributing to the services offered in general practice. However, even this refined definition is vague. It seems as if complementary medicine is destined to refer to a wide variety of different therapies, with distinct histories, geographical origins, theories, practices, training and methods of delivery. So, how can this term be clarified to warrant its continued use? One method is to ignore the comparison between complementary and orthodox medicine and instead concentrate on its distinguishing characteristics.

Characteristics of complementary medicine

Pietroni (1992) classifies complementary medicine into the following four categories.

- Complete systems - Homeopathy, osteopathy, herbal medicine, acupuncture
- Diagnostic methods - Iridology, kineseology, hair analysis, aura diagnosis
- Therapeutic modalities - Massage, shiatsu, reflexology
- Self-care approaches - Meditation, yoga, relaxation, dietetics

However, this model only categorises a few of the many therapies subsumed under the term complementary medicine and those that are included could easily be listed under different or multiple headings. It would be more useful to list complementary

medicine's main characteristics in order for any therapy to be classified. An example of this is Sharma's (1992) definition that claims complementary medicine has the following characteristics:

- In addition to promoting general well being it claims to '*cure actual illness*'
- It has '*...some body of knowledge or theory (more or less systematised) about the human person which includes ideas about the causes of illness and health*'
- It involves '*...some kind of technical intervention on the part of the expert practitioner*'

This thesis will define complementary medicine as having the function described by Ernst (1995) and the characteristics reported by Sharma (1992). In addition I suggest that complementary medicine should refer to therapies that adopt a holistic approach to health, which is alluded to in both Ernst's and Sharma's definitions. Since holism is another poorly defined term this will now be described in more detail.

Holism

Pietroni (1992) introduces some of the difficulties surrounding the concept of holistic approaches to medicine.

One of the problems faced in exploring the relations between general practitioners and complementary practitioners is that there is no clear definition of words such as 'alternative', 'complementary,' 'holistic' 'natural', and 'fringe', which are often used to describe vastly dissimilar activities. Much confusion arises from the belief that holistic medicine and alternative medicine are the same thing. There are as many general practitioners who apply the principals of a holistic approach to their patients as there are acupuncturists who do not.

Holistic medicine is not synonymous with complementary medicine. This study will operationalise holism as an *approach* to a patient and their health that any practitioner could adopt. '*It is a way of approaching healing through which a person incorporates several different therapies, including traditional medicine*' (Shealy and Myss, 1988).

Holism views health as a complex interaction of an individual's physical, psychological and emotional wellbeing.

A basic premise in the holistic field is that illness does not happen randomly. Every illness or dysfunction a person develops is an indication of a specific type of emotional, psychological or spiritual stress (Shealy and Myss, 1988).

Aetiology and treatment of illness involves assessment and advice on a patient's whole life-style. This holistic diagnosis assesses the patient's physical and psychological/emotional state plus any coping mechanisms the individual may possess for them. In shiatsu, this is conducted by considering both the 'signs' noted by the clinician such as facial colour or pulse and 'symptoms' described by patient such as pain or depression. Any interconnections between these signs and symptoms would also be addressed. For example, diagnosis may involve assessment of pain (physical symptom) and how the person thinks (psychological reaction) or feels about that pain (emotional response). Alternatively, the psychological/emotional condition could be the focus of investigation with the secondary concern being how this affects the patients' physical health. Traditional Chinese medicine espouses this holistic approach to diagnosis and treatment.

Since 3000BC, the Chinese practitioners have considered the mental, spiritual, and physical aspects of the person before making a diagnosis, thereby treating the cause of the problem, not the symptom. It is unfortunate that Hippocrates' philosophy of treating the whole person has been lost in this era of medical specialisation in the West. On the other hand, the Chinese have consistently treated the whole person during this 5000-year history of medical practice (Bernie in Duo Gao, 1999).

This quote suggests that the holistic approach can potentially be at odds to the conventional perspective of illness being predominantly biologically based. Instead, 'dis-ease', even if mainly expressed in a physical way could have a non-organic cause. Psychological/emotional stress has been found to cause physiological responses in the body, which can lead to ill health if excessive or prolonged (Smith, 1989). For

instance, interpersonal difficulties have been associated with the aetiology of several eating disorders (Strober and Humphrey, 1987) and fear and anxiety can cause an increased heart rate and chest pain during panic attacks (Rowan and Eayrs, 1987). The definition of holism in this thesis does not discount physical aetiology of illness but places it in relation to psychological and emotional states.

Understanding the emotional, psychological and spiritual stresses that underlie the creation of illness is a complex process...People are complicated and their personal histories and emotional patterns are highly individual (Shealy and Myss, 1988).

Holistic approaches acknowledge context, understanding each illness in relation to the individual experiencing it and their wider social world. This is because each patient has their own unique associations and symbols of health and illness that are influenced by their social and interpersonal contexts.

In summary, complementary medicine is notoriously hard to define. This thesis will use the term to refer to those therapies that offer both preventative and curative medicine, have a clear theoretical background, utilise some technical intervention by an expert, and aim to complement orthodox medicine by encouraging a holistic approach to health and illness. A classic example of these main characteristics of complementary medicine can be found in traditional Chinese medicine, described in more detail in appendix I. The main principles of this therapeutic approach will now be described to place the current study's focus on shiatsu in context.

Traditional Chinese medicine and the concept of chi

The Chinese word 'chi' (or 'ki' in Japanese) is similar to 'pneuma' in Greek or 'prana' in Indian philosophy and can be roughly translated in the western world as 'energy' or 'life-force'. Goodman (1990) claims chi is an '*...energy of definite (or definable) quality, energy of a definite direction in space, of a definite arrangement, quality, or structure.*' Chi flows in channels known as 'meridians' throughout the body. The quality of a person's chi is used to diagnose and treat imbalances of their energy that can lead to 'dis-ease'. This is done by stimulating the meridians and

specific points along these channels known as 'tsubos', where the chi is most easily accessed.

Meridians of chi

Traditional Chinese medicine claims there are twelve bilateral meridians that carry chi round the body. Most take the Western name of organs such as 'Liver' or 'Lung' (abbreviated to LV and LU) and are written with a capital initial to distinguish them from the terminology of orthodox medicine. This is because the meridians reflect the holistic nature of an organ's emotional and psychological health in addition to its physical condition. For example, the main emotion connected to Liver is anger and a psychological attribute is the ability to make decisions. Extremes in either direction of these states, such as excessively aggressive outbursts or prolonged repression of anger, could hinder the Liver's physical expression within the body, manifesting in liver organ damage, for example. These signs and symptoms assist the practitioner in understanding the client and making appropriate diagnosis and treatment, particularly by using 'tsubos'.

The function of tsubos

Tsubos are acupuncture and shiatsu points along the meridians where the chi is most easily diagnosed and treated. They are like plug sockets along electrical cables where the energy can be accessed and altered. The tsubos are numbered, such as LU7 for the seventh tsubo on the Lung meridian. They each have several functions and are contacted either by dispersal techniques to move stuck chi or by sedation methods to build weak chi. Tsubos have been described in several different cultures and periods of history. The western explanation is that they are locations of electricity that can be easily located by electronic devices.

Acupuncture points...are places on the skin that are especially sensitive to bioelectrical impulses in the body and conduct those impulses readily...Western scientists have also mapped out and proven the existence of this system of body points by using sensitive electrical devices. Stimulating these points with pressure, needles or heat triggers the release of endorphins, which are the neurochemicals that relieve pain. As a result, pain is blocked and the flow of blood and oxygen to the affected area is

increased. This causes the muscles to relax and promotes healing (Gach, 1990).

Orthodox medicine associates the health benefits of stimulating tsubo points with neurology and the analgesic effects of endogenous opiates and neurotransmitters. One common perception in orthodox medicine is that acupuncture/shiatsu is effective because the tsubos act like a gate to stop pain signals from the spinal cord reaching the brain (Leng et al, 1973). Research could usefully study this further. Traditional Chinese medicine explains the function of tsubos in terms of yin/yang.

The principle of yin/yang

The principle of yin/yang emerged around the fourth century BC (Duo Gao, 1999) and represents opposing but mutually dependent forces such as 'up' and 'down' or 'on' and 'off'. One can not exist without the other and each must be seen in relation to its partner. This is the concept behind the following Japanese symbol for 'human,' as the brushstrokes support each other. It has been used to illustrate the mutual support of givers and receivers of shiatsu as a form of traditional Chinese medicine.

Figure 1. The Japanese symbol for human



Duo Gao (1999) describes that '*Yang represents the functional energetic qualities of the universe, while yin represents the structural and substantive qualities of the universe.*' This can be explained by the following table of associations given to each concept adapted from Goodman (1980) and Masanaga (1977).

Table 1. Yin and Yang correspondences

Yin	Yang
Night	Day
Structural - storage	Active - production
Contractive	Expansive
Responsive	Aggressive
Internal	External
Back	Front

Yin/yang is used to categorise life, to provide order to reality and meaning to the universe. It is therefore a basic tenet of Chinese life being the foundation of politics, art, science and medicine. It is not surprising then that traditional Chinese medicine utilises this concept of yin/yang in the diagnosis and treatment of illness.

Yin/yang are the way of Heaven and Earth, the great principle and outline of everything, the parents of change, the root and source of life and death, the palace of gods. Treatment of disease should be based upon the roots (Yellow Emperor Nei Jing, cited by Duo Gao, 1999).

Yin/yang helps to define the world and all who live in it as constantly changing and moving. Night always changes into day as birth inherently moves towards death. Traditional Chinese medicine uses yin/yang to define humans in terms of their physical organs, psychological personalities and emotional characteristics. The methods by which imbalances in any of these three states are diagnosed and treated, will be illustrated by describing a popular form of traditional Chinese medicine known as shiatsu.

Shiatsu

The term 'shiatsu' did not emerge until the early twentieth century but its origins are found in traditional Chinese medicine (Jarmey and Mojay, 1991). It arose in China around 530 BC and was introduced to Japan during the tenth century AD. It is here that the practice of present day shiatsu developed from a synthesis of massage

practised within families, called Anma, and the formal skills of acupuncturists and physicians.

Shiatsu has gone through several periods of transformation this century, beginning in the 1920s with the work of Tokujiro Namikoshi. He founded the first shiatsu school and clinic in 1925, and published the first books on Shiatsu, placing it within western physiology (Jarmey and Mojay, 1991). The Japanese Ministry of Health and Welfare officially recognised shiatsu as a legitimate form of medicine in the 1950s (Jarmey and Mojay, 1991). A professor of psychology, namely Shizuto Masunaga, instigated the next major change in shiatsu during the 1960s and 70s. Masunaga (1977) reintegrated the traditional, philosophical and physiological elements into shiatsu, creating a detailed theoretical and philosophical basis of shiatsu that drew on Zen Buddhism, western physiology and psychology and traditional Chinese medicine. In particular he established the meridian system of chi in shiatsu previously described. During this time, shiatsu emerged in the United States and Europe (Jarmey and Mojay, 1991) and has since been described as the '*...most well known style of acupressure*' (Gach, 1990). A typical shiatsu treatment lasts one hour with the receiver fully clothed on a comfortable futon mat on the floor.

Figure 2. A typical back treatment in shiatsu



Shiatsu pre-dates the better-known therapy of acupuncture (Duo Gao, 1999) but much more research has been conducted on the latter of these two forms of traditional Chinese medicine. This may be partly due to because the 'hands-on' approach in shiatsu and acupressure became less popular than acupuncture as China began producing a highly advanced technological industry.

There is a massive amount of scientific data that demonstrates why and how acupuncture is effective. But acupressure, the older of the two traditions, was neglected after the Chinese developed more technological methods for stimulating points with needles and electricity. Acupressure, however, continues to be the most effective method of self-treatment of tension-related ailments by using the power and sensitivity of the human hand (Gach, 1999).

Shiatsu is easier to self-administer than acupuncture since this requires that a highly trained practitioner locate exact tsubo points on the body with small steel needles. In comparison, shiatsu can be conducted on much larger areas of the body, which are easier to locate and may only need basic massage techniques. Also, needles are not used in shiatsu so the skin is not punctured during a treatment and subsequent proficiency handling the careful insertion, removal and disposal of needles is not required.

Because acupressure can be practised by anyone, anywhere, at any time, and without tools, it offers superior availability, flexibility and portability. It is a perfect family- and community- medicine. Patients needn't depend entirely on outside institutions for maintaining health if they are able to use acupressure techniques (Duo Gao, 1999).

The flexibility of shiatsu is because instead of needles, the *'technical intervention used by an expert'* (Sharma, 1992) is their own body, and the aim is to stimulate the receiver's own healing processes.

A shiatsu practitioner will utilise their body-weight to exert pressure along the receiver's meridians to balance their energy or 'chi'. 'Shiatsu' is a Japanese word that

literally translates as 'finger pressure' but a practitioner may well use their thumbs, hands, elbows and knees during a treatment. This 'hands-on' approach in shiatsu is probably the main aspect that distinguishes it from acupuncture. They both use the same meridians and tsubos for diagnosis and treatment but in acupuncture there is a steel needle between the therapist and client. The shiatsu practitioner, in contrast, commonly remains in constant physical contact with their receiver. Perhaps it is this essence of touch that is one of the main healing qualities of shiatsu.

Figure 3. The touch involved in shiatsu



A shiatsu treatment involves the use of appropriate touch between practitioner and patient. This includes hands-on contact and the use of the practitioner's own body to support their patient. The use of touch in health seems to be a long-standing tradition based on the instinct to rub away aches and pains.

The origins of acupressure are as ancient as the instinctive impulse to hold your forehead or temples when you have a headache. Everyone at one time or another has used his or her hands spontaneously to hold tense or painful places on the body (Gach, 1990).

Touch is an important aspect of human relationships as it can communicate empathy and support. Fransen (1997) claims that this contact underpins shiatsu as it helps patients feel cared for and activates their body's natural defence system.

Touch is the essence of shiatsu. We all need to be touched in some form, and shiatsu gives you a wonderful opportunity to fulfil this need in a loving and caring way. The nurturing touch of shiatsu helps trigger the self-healing process within (Fransen, 1997).

The healing qualities of touch enable shiatsu to be utilised in cases where more cognitive or strenuous physical therapies are hindered. This may be the case with particularly young or old patients and those with learning difficulties or physical disabilities. However, as already stated, physical contact has to be appropriate and comfortable for both parties for it to be therapeutically effective, especially for these potentially vulnerable patients. Shiatsu achieves this by training practitioners in the issues surrounding physical contact and adhering to the principals of traditional Chinese medicine. It adopts a rigorous approach to using touch based on the formulated maps of the human body that detail the meridians and their tsubos. The present form of shiatsu has evolved from ancient meticulous observation of wounded soldiers who professed to being cured of chronic ailments after being hit by stones and arrows (Chang, 1976).

More than 5,000 years ago, the Chinese discovered that pressing certain points on the body relieved pain where it occurred and also benefited other parts of the body more remote from the pain and the pressure point. Gradually, they found other locations that not only alleviated pain but also influenced the functioning of certain internal organs (Gach, 1990).

In summary, shiatsu aims to assess the quality of a client's chi and balance it to treat specific symptoms whilst promoting relaxation and revitalisation. It works with the client's chi on physical, emotional and psychological levels to encourage long-term healing. In this way shiatsu follows a holistic approach to health, seeing any individual symptom in relation to the body as a whole. Treatment follows a

multifaceted approach of self-help techniques and professional delivery of appropriate touch, dietary and exercise recommendations.

Shiatsu is accepted as one of Pietroni's (1992) classic examples of *'therapeutic'* complementary medicine and also satisfies each of Sharma's (1992) three criteria for complementary medicine. It *'claims to be curative'* (and in addition, preventative); it has a clearly defined *'body of knowledge or theory'* about health and dis-ease; and it requires *'technical intervention'* from a trained practitioner. In addition, shiatsu is holistic and therefore meets this thesis's criteria for complementary medicine. However, research would have to be undertaken to assess if it could complement orthodox medicine by either satisfying a need not met by orthodox approaches or encouraging medics to adopt a more holistic approach (Ernst, 1995). This research would provide essential data for complementary practitioners, the National Health Service and the general public. For example, shiatsu practitioners could use the findings to enhance reflective practice and define areas of expertise and limitations of their therapy. The National Health Service could have further evidence about the efficacy of shiatsu and opportunities for integration; and most importantly, the general public would be more informed about shiatsu and their choices for healthcare. However, the limited research that exists on shiatsu mainly discusses the conditions it treats. During the course of this study I conducted repeated literature searches on shiatsu to ensure the research was conducted with consideration of any existing findings. These will now be presented to provide the background for the current study.

Improvement in health associated with shiatsu

One of the first published accounts of shiatsu was written by the Chief Physical Therapist of a medical centre in America (Vega, 1975). It claims that shiatsu may help alleviate muscle spasms and pain such as shoulder ache, low-back pain, headaches and limitation of movement. Although vignettes are provided to illustrate these claims, this is a personal account of practitioner research that provides anecdotal as opposed to scientific evidence. However, several studies published more recently support the suggestion that shiatsu can help improve a range of physical and psychological/emotional symptoms.

Shiatsu and chronic back pain

Brady (2001) conducted an uncontrolled trial on a convenience sample of sixty-six adults to measure the effects of shiatsu on the pain and anxiety associated with chronic lower back pain. Pain and state and trait anxiety were assessed before and after four shiatsu treatments using self-report measures of known reliability and validity. Pain was also measured two days following each treatment. Reports of pain significantly decreased immediately after each treatment but increased again two days later, suggesting that only short-term relief was found. State anxiety decreased after each treatment, whereas trait anxiety, which was described as a stable construct, did not vary. The use of uncontrolled trials for therapies that are under-researched, such as shiatsu has been advocated by White and Ernst (2001). However, Brady's (2001) study could have been improved by the addition of a control group and data capture of all measures being completed more frequently and over a longer time period.

Shiatsu and cerebral palsy

Vogtle et al (1988) studied an aquatic program involving water shiatsu (WATSU) for adults with cerebral palsy living in group-homes. Six adults were given the therapy two days a week for seven weeks. In addition to approximately thirty-five minutes of WATSU they also received approximately fifteen minutes of a physical activity focused on head, trunk and extremity movement control. Occupational and physical therapy students who were trained in the specific techniques used delivered the new treatment programme. Outcome measures included passive range of motion (PROM) of the shoulder, elbow, hip, and knee joints, resting heart rate, blood pressure, pain rating, social skill measures and caretaker reports. These caretaker reports were used to describe '*ease of care*' in place of functional measures that could not be assessed due to the participants' limited functional ability and potential for improvement.

... the program was effective for improving PROM, decreasing pain, and providing a pleasurable social experience. Benefits were also realised by the students participating in the swim program, including skill development and appreciation of patients with disability with individuals (Vogtle et al, 1988).

This study has usefully provided qualitative information in addition to statistical data from quantitative methods with objective outcome measures. However, the findings cannot be compared to traditional shiatsu as only a water-based form was used and was not delivered by a qualified shiatsu practitioner. The use of a treatment package also means it is impossible to assess how effective the WATSU itself was.

Shiatsu for pregnancy and childbirth

Several studies have claimed that shiatsu can be helpful during pregnancy and childbirth. Jewell and Young (2000) estimate that nausea affects between 70 and 85% of pregnant women in the first trimester and vomiting is experienced by 50%. They reviewed the effects of various therapies on these symptoms by searching the Cochrane pregnancy and childbirth group trials register and the Cochrane controlled trials register. Trial quality was assessed and data were extracted independently by two reviewers resulting in twenty studies meeting the selection criteria. Jewell and Young (2000) concluded that anti-emetic medication was the most effective treatment for nausea but had evidence of adverse side effects and the possible effects of this on foetal outcome had not been researched. Vitamin B6 seemed useful but needed more research, as did the use of the HP6 tsubo⁵ in shiatsu as the results were equivocal. The available evidence for ginger was weak. These findings seem robust due to the rigorous nature of the review, which assessed inter-observer reliability and adhered to strict criteria for the inclusion and exclusion of trials. However, only one tsubo was examined which limits its comparison to traditional shiatsu treatments contacting several tsubos and utilising various additional manipulative techniques.

A more traditional form of shiatsu was described by Yates (1999), a shiatsu practitioner who runs training programmes for midwives and shiatsu students on the use of shiatsu in pregnancy and childbirth. This personal account suggests that optimum foetal positioning can be promoted by shiatsu treatment and by teaching mothers particular positions and movements that will move a baby from breech position (such as being on all fours and crawling). Her comments are supported by other personal accounts of using shiatsu in pregnancy and labour by Stevenson (1997) in an article for nurses and midwives and by Hunter (1999) who was a trained nurse

⁵ HP6 refers to the 6th tsubo on the Heart Protector meridian in the arm.

and shiatsu practitioner. Studies utilising more objective research techniques could be compared with these practitioner research accounts.

Shiatsu and palliative care

Cheesman et al (2001) studied the effect of shiatsu on specific symptoms and general well being of elderly palliative care patients. This involved eleven self-selected patients with a mean age of sixty years who had an advanced progressive disease. Each participant received shiatsu once a week for five consecutive weeks from a qualified shiatsu practitioner and senior hospice nurse. Unstructured interviews were conducted at five time points and subjected to content analysis. Patients' comments were nearly all positive with reported improvements in energy levels, relaxation, confidence, symptom control, clarity of thought, and mobility. They claimed that these improvements lasted between a few hours to beyond the five-week treatment period. This study provides a useful insight into patients' perceptions of palliative care although its qualitative nature restricts generalisation of the findings. The rigour of the research could have been improved by establishing the inter-rater reliability of the two researchers independently categorising the responses into codes. Patients could have been selected using a random sampling method and objective outcome measures could have been compared with the patients' perceptions. Finally, it is not clear what the long-term effects of the shiatsu may be and a longer follow-up than four weeks may have clarified this. Nevertheless, other research does support the use of shiatsu in palliative care.

Bains's (1997) British Medical Journal review of palliative care concluded that '*Non-drug methods are important*' in relieving the nausea and vomiting which affects 50-60% of patients with advanced cancer. She particularly cites the effectiveness of bands that stimulate HP6, supporting the previous finding from Jewell and Young (2000). This review is confirmed by a randomised clinical trial on nausea and vomiting in seventeen women (mean age 49.5 years) undergoing chemotherapy for breast cancer (Dibble et al, 2000). Patients receiving usual care plus shiatsu training and treatment were compared with those receiving only usual care. The research was conducted in the normal treatment setting of an outpatient oncology clinic and a private outpatient oncology practice. As with the previous studies, HP6 was used, but in addition, ST36 was also used on the Stomach meridian in the leg. Baseline and

post study questionnaires plus a daily log were used to collect data. Nausea experience was measured by the Rhodes inventory of nausea, vomiting, retching and nausea intensity.

The results suggested that statistically significant differences existed between the two groups in nausea experience ($p < 0.01$) and nausea intensity ($p < 0.04$) during the first ten days of the chemotherapy cycle, with the shiatsu group reporting less experience and intensity of nausea. The authors concluded that tsubo stimulation may decrease nausea among women undergoing chemotherapy for breast cancer, but a replication of the study was recommended before advice could be given to patients. Nevertheless, this study is one of the few randomised controlled trials conducted on shiatsu, which is considered the 'Gold Standard' of research (Parry, 1999). It would be interesting to replicate this study with a traditional hour-long shiatsu as opposed to treating only two tsubos.

Thwaite (1996) describes a personal account of receiving complementary medicine in her treatment for non-Hodgkin's lymphoma. She describes her visits to the Royal Homeopathic Hospital in London, to receive regular shiatsu, acupuncture, massage and reflexology and describes how these have helped her to cope with the disease and the chemotherapy treatment. There is obviously no way of knowing which therapy, if any actually helped Thwaite's condition. However, this piece of published, anecdotal evidence suggests how ongoing support in complementary medicine can be perceived by patients to be helping them manage their symptoms and comply and recover from invasive orthodox treatments. This positive belief could only be beneficial to such patients.

Stevenson (1995) provides support for Thwaite's claims in her study of shiatsu in palliative care that used practitioner research and patient case studies. As a qualified nurse and shiatsu practitioner, she claimed that *'Feelings of deep relaxation, support and increased vitality are common following a shiatsu treatment.'* She also reported that the shiatsu seemed to help patients with their grief, pain management, insomnia and nausea. The evidence from clinical trials described in this section supports her use of shiatsu for nausea. The shiatsu was tailored to suit each patient's individual need including varying the number of treatments given. Stevenson (1997) concluded that

'Shiatsu should be considered when thinking of complementary methods of support in palliative care.' Again, replication of this study on a larger sample of patients would need to be conducted before conclusions could be generalised. Perhaps a pragmatic randomised controlled trial (Fitter and Thomas, 1997b) could be conducted which would support the use of individual treatments but add rigour to the original case-study methodology.

Shiatsu and the cardiovascular system

Research suggests that the physical effects of stimulating shiatsu meridians and tsubos can aid the cardiovascular system. Felhendler and Lisander (1999) conducted a blind randomised-controlled trial of shiatsu in an experimental setting in a university-affiliated hospital. Twenty-four healthy male volunteers were randomised into three groups, to receive either an active stimulation consisting of pressure on shiatsu points (P), an active stimulation consisting of stroking along the shiatsu meridians (S) or a control stimulation (C). The main outcome measures were skin blood flow, arterial pressure, heart rate and ECG, which were all recorded continuously from twenty minutes before stimulation to thirty minutes after.

The results indicated that in group P there was a decrease in systolic arterial pressure, diastolic arterial pressure, mean arterial pressure, heart rate and skin blood flow. These changes were significantly different from those in C group and, as regards diastolic pressure and mean pressure, also from those in S group. There were no significant differences between S and C groups. It seems that pressure on shiatsu tsubos can significantly influence the cardiovascular system, with implications for the treatment of heart conditions and promotion of relaxation in shiatsu. This trial could be repeated with patients' diagnosed with other complaints to assess the effectiveness of shiatsu. A follow-up could also be included as the long-term effects of the tsubo stimulation are not clear in this study.

A longitudinal study supports the above assertions in a cost-effectiveness assessment of an acupuncture, shiatsu and lifestyle adjustment program (ASLA) conducted in Denmark (Ballegaard et al, 1996). Sixty-nine patients with severe angina pectoris were studied for two years (mean age=62). The follow-up data were based on hospital reports, supplemented by reports from the GP and questionnaires. They were

compared to patients in a prospective randomised trial (n=392) who had either coronary artery bypass grafting (CABG) or percutaneous transluminal coronary angioplasty (PTCA).

The incidence of death and heart attack was 21% among patients undergoing CABG, 15% in the PTCA group and 7% in the ASLA group. Within the ASLA group, 61% of the patients who were candidates for invasive treatment postponed this due to clinical improvement and the annual number of in-hospital days were reduced by 90% compared to the other two groups. There was no statically significant difference in the pain reports between the three groups of patients. However, patients in the ASLA group reported a marked improvement in life quality and degree of disease.

The National Health Service Centre for Reviews and Dissemination estimated the saving in the ASLA group provided a total saving of \$820,000 or \$12,000 for each patient. This was based on savings in the reduction of services required, surgery and sick payments in the ASLA group and the cost of repeated treatments in the CABG and PTCA groups. This suggests that combined treatment with acupuncture, shiatsu and lifestyle adjustments may be cost effective for patients with severe angina pectoris, improving specific symptoms and general health. A replication of this study could be conducted including randomisation of patients to make the design more robust. Furthermore, the shiatsu could be delivered by a professional practitioner, as opposed to the self-stimulation of tsubos by patients with assistance from their carers. Future research could also assess the effectiveness of the separate components of the ASLA treatment package to deepen the evidence base for shiatsu specifically.

In summary, shiatsu has been seen to offer several health benefits to patients. Examples here have included relieving back pain and anxiety, improving mobility in cerebral palsy, reducing nausea and vomiting in cancer and possibly in pregnancy, enhancing palliative care and treating cardiovascular conditions.

The potential side-effects of shiatsu

The literature search found two anecdotal accounts of side effects from shiatsu were described in letters to journal editors. A letter signed by three doctors from US medical schools described a 61-year-old physician who had a '*professional*' shiatsu

treatment and the next day reported *'painless weakness of the left thumb, without sensory symptoms'* (Herskovitz et al, 1992). Medical examination diagnosed *'isolated dysfunction of the recurrent thenar motor branch of the median nerve, apparently the result of focal trauma from the massage.'* The symptoms improved after three weeks and normal functioning returned within a few months. There was no direct evidence that the shiatsu caused the injury but this letter does illustrate the risks of physical therapies.

The second letter links shiatsu to a varicella zoster virus diagnosed in a 64-year old woman seven days after receiving a treatment (Mumm et al, 1993). The authors do acknowledge the possibility of coincidence and also report that the evidence for the existence of the zoster virus is mainly anecdotal, which may account for it being rarely diagnosed. This report is further limited in the lack of information given about the patient, such as her medical history and state of health before having shiatsu. There is also no mention of the qualifications of the person giving the shiatsu or what the treatment entailed. Neither of these letters present a direct causal link between shiatsu and the respective side effects but they do illustrate the need for further research in this area.

Symptoms presented to shiatsu practitioners

The most extensive piece of research on shiatsu describes the symptoms of patients that consult with private shiatsu practitioners (Pooley and Harris in 1996 and 1997). The pilot study in 1996 involved ten shiatsu practitioners recording their consultations over a ten-week period. The maximum number of different patients seen by a shiatsu practitioner was 50, the minimum number was 13 and the mean was 34.5. The ten practitioners claimed to have seen a total of 345 different patients over the ten weeks. They allocated up to three symptoms for each patient, which were grouped using a classification system of symptoms specifically designed for use in primary care (Lambert and Woods, 1987). The patients' self-diagnoses were also elicited, again allowing up to three symptoms each. The full results are presented in tables 2 and 3 in appendix II.

The main difference between the shiatsu practitioners' and the patients' diagnoses is that the therapists cited muscular-skeletal symptoms as the main reason for treatment

compared to stress, depression and anxiety as reported by patients. However, this comparison seems hindered by the different categories used in the two tables. For example, the single muscular-skeletal category in the practitioners' data is separated into three separate categories in the patients' data, namely, neck and shoulder pain, back pain and lower back pain. Neither can these three categories be grouped together to offer a direct comparison with the practitioners' results. This is because patients were allowed to provide up to three reasons for having shiatsu and if some of the categories are then grouped this affects the number of other categories that participants could have cited. It is also unclear whether the patients' category of 'back' refers only to upper or mid-back pain to distinguish it from the 'lower back' category. The different terminology used by GPs and their patients could exacerbate the difficulties in comparing their reports. They could have been describing the same symptoms but with different words.

The methodological concerns illustrate the importance of checking authors' conclusions with raw data. At least Pooley and Harris (1996) present data in detailed tables so the reader can deduce their own conclusions (tables 2 and 3 in appendix II). They also clarified some of these issues in their larger survey (Pooley and Harris, 1997). For example, instead of comparing complementary practitioners' diagnoses with that of patients, the larger study asked patients to describe their own diagnosis (n=792) and that which they had been given by a 'medically qualified practitioner' (n=382). This may have lessened the semantic problems faced when comparing the descriptions of symptoms. The result tables 4 and 5 can again be found in appendix II.

The medical diagnoses reported by the patients were also grouped using Lambert and Woods (1987) classification system of symptoms. The findings show that the patients once again cited psychological/emotional symptoms as their most common condition with over half of the sample (n=411) reporting stress, depression and anxiety.

Just under half of the patients (n=382) were able to report a medical diagnosis by their attending clinician. The main difference between patient and GP diagnosis was that patients cited psychological/emotional symptoms as their main presenting condition as opposed to muscular-skeletal conditions reported by their GPs. This is consistent

with the pilot's findings in 1996. Tables 5 in appendix II includes data on the most frequently cited symptoms under each category heading. This assists comparison with the patients' own diagnoses in table 4. For example, psychological symptoms such as stress, depression and anxiety were described in only 14% of the medical diagnoses compared to 52% of the patients' own diagnoses. This is consistent with literature that claims GPs fail to recognise at least half of the cases of major depression in their patients (Bridges and Goldberg, 1987). Pooley and Harris's tables (1997) also illustrate differences in patient and reported GP diagnoses with regard to lower back pain (clarified in this second survey as separate from the 'other back problems' category) with 31% of patients diagnoses citing this symptom, compared to only 6% of the GPs diagnoses. It should be remembered that it was the patients and not the GPs themselves that provided these medical diagnoses.

Pooley and Harris's work (1996 and 1997) suggests that muscular-skeletal and psychological symptoms were the most common presentation of symptoms for shiatsu. In both studies, the medical diagnosis favoured muscular-skeletal symptoms and patients claimed psychological conditions were their main complaint. The authors claim that the 73% response rate and the 1137 patient questionnaires used in the study means that *'...it is highly likely that the findings are representative of the types of conditions that present for shiatsu treatment in the UK.'* Research suggests that these symptoms are also most commonly presented to complementary practitioners in general. Wadlow and Peringer's (1996) study of acupuncture found that the most common symptom necessitating acupuncture treatment was for muscular-skeletal disorders. These muscular-skeletal symptoms were defined in Pooley and Harris's (1997) shiatsu survey as mainly consisting of neck and shoulder pain, followed by lower back problems and arthritis.

Fulder and Munro (1985) claim that most complementary practitioners treat chronic, muscular-skeletal and stress-related disorders. Emslie et al (1996) add that these symptoms are typically... *'... where conventional treatments may be failing to give people the help they need'*. Interestingly, although complementary practitioners most commonly see chronic symptoms, they tend to have more success treating acute ones (Welford, 2000).

The most common psychological symptom in Pooley and Harris's research (1997) was depression, followed by stress and anxiety. This is again supported by the literature on complementary medicine as a whole, with the 1985 Which survey reporting the second most popular reason for consulting a complementary practitioner was for '*some sort of psychological problem*,' reported by 15 % of the respondents (Which? 1986, cited in Sharma, 1992). It seems that muscular-skeletal and psychological symptoms tend to lead people to try complementary medicine, but how are the treatments delivered?

How is complementary medicine delivered?

This section will examine how much complementary medicine is delivered and by whom.

How much complementary medicine is delivered?

Thomas et al (1991) conducted a national survey on five forms of complementary medicine and estimated that 70,600 individual patients consulted each week with a complementary practitioner providing a total of 4 million consultations in 1987. This was calculated from 1575 practitioners' estimates of their normal workload in acupuncture, chiropractic, homeopathy, naturopathy and osteopathy and confirmed with 2473 matched patient questionnaires. The authors concluded that complementary practitioners conduct one consultation for every fifty-five undertaken by a GP.

It would be interesting to calculate self-treatment of complementary medicine due to the large sales of health foods and herbal remedies (Bakx, 1991). Advances in the Internet and other information and communication technologies have provided the direct marketing of pharmaceuticals to the public (Bynoe, 1999) and no doubt increased sales of complementary medications. The House of Lords report (2001) cites the Royal Pharmaceutical Society figures of £63 million being spent on retail sales of complementary medicine in 1994. This includes herbs, aromatherapy oils and homeopathic medicine. This figure rose to £93 million in 1998 and an estimated £109 million in 2000. The Society's latest prediction is that by 2002, the retail sales of over-the-counter complementary medicine will be £126 million (Roach, 2000). This form of complementary medicine seems very popular, possibly due to being less

costly in time and money and more accessible than formal complementary practitioner consultations.

One of the most recent surveys on complementary medicine was a national, random telephone survey, resulting in 1204 interviews with British adults (Ernst and White, 2000). The survey asked participants if they had used 'complementary medicine or therapies' within the last year, without specifying what this referred to. This meant the results included over-the-counter medication as well as professional consultations with a complementary practitioner. However, the results suggested that only 20% of the sample had used complementary medicine in the previous year.

A more detailed study sent a postal survey to 5010 geographically stratified randomly selected adults in the UK (Thomas et al, 2001). This resulted in a response rate of approximately 60% with 2669 useable replies. Unlike Ernst and White's (2000) survey, Thomas et al (2001) asked participants to state if they had used any of the following six key forms of complementary medicine, namely acupuncture, chiropractic, homeopathy, medical herbalism, hypnotherapy and osteopathy and also the less established therapies of aromatherapy and reflexology. Also in contrast to Ernst and White's (2000) research, they asked respondents to estimate their use of over-the-counter medication, including herbal and homeopathic remedies. The results suggested that 10.6% of the adult population in England had received at least one of the above six key therapies in the preceding year. 13.6% of participants had attended a consultation with a complementary practitioner in one of the eight specified therapies and a total of 28.3% had either visited a practitioner or had over-the-counter medication in the last twelve months or 46.6% over their lifetime. The authors estimate that 22 million consultations were made to one of the six key therapies in 1998. This is a large increase from an earlier estimate of 11.7 to 15.4 million consultations by Fulder and Monro (1985) reiterating that the delivery of complementary medicine is steadily increasing.

Who delivers complementary medicine?

Not surprisingly, complementary practitioners are the largest group of people delivering complementary medicine. Increasing numbers of practitioners further illustrates the growing interest in complementary medicine. The exact figures of the

current number of complementary practitioners is difficult to obtain because of the diversity of complementary medicine as already described, and the various training bodies and practitioner organisations. However, Sharma (1992) cites Fulder and Munro's (1995) finding that the number of complementary practitioners increased nearly six times more than that of GPs in Britain between 1978 and 1981. Their survey in 1981 of professional organisations governing complementary medicine estimated there were at least 30,373 practising complementary practitioners in the UK (Fulder and Monro, 1981). This figure was derived from calculating that 11,184 complementary practitioners and 2209 orthodox practitioners were actively practising complementary medicine, and 16,980 current practitioners who were not known to the relevant professional organisations. Trained practitioners who do not charge for their treatments or were temporarily not working were not included in these figures. In terms of registered practitioners, approximately 13,500 were working in the United Kingdom in 1981 and that this rose to approximately 40,000 in 1997 (Zollman and Vickers, 1999a). A replication of these studies could provide current estimates to suggest how the total number of active providers of complementary medicine has changed in the last twenty years.

Thomas et al (1991) conducted a postal survey on practitioners of acupuncture, chiropractic, homeopathy, naturopathy, and osteopathy. A total of 2152 non-medical practitioners were identified from eleven national professional association registers. From the 1575 replies (73% response rate), the authors estimated that 1909 complementary practitioners and 26 orthodox practitioners were actively practising one of the five specified therapies in Britain in 1987. The difference between this figure and the 30,373 cited by Fulder and Munro (1981) may be due to the earlier study calculating the number of practitioners in a much larger group of therapies including massage, music therapy, healing and hypnotherapy. For example, Fulder and Munro (1981) stated that healing and hypnotherapy provided two of their largest groups of practitioners, neither of which were included by Thomas et al (1991).

Surveys of professional organisations can be hindered by relying on professional registrations that are normally voluntary and demand the satisfaction of entry requirements that can be time consuming and expensive. Some therapies do not have any professional registers and others have more than one, further confusing the

national picture of the number of complementary practitioners. Finally, many practitioners deliver several forms of complementary medicine, as reported by Thomas et al (1991). They may not choose to register in each discipline, partly because of the effort and cost incurred, as described above.

There are two main disadvantages of the delivery of complementary medicine being predominantly conducted by private practitioners. The first is complementary practitioners tend to work from home or rented space in natural health centres, gyms or beauty parlours. This means they are unevenly distributed throughout the country hindering the public's equality of access to services. Treatment fees also vary between different areas, further limiting the population that can utilise this form of medicine. Many people who may benefit from using complementary medicine could be being denied this opportunity. One way of addressing this problem of unequal access is to try and integrate some of the most popular forms of complementary medicine into the National Health Service. This would also help to ease the second main problem of the existing provision of complementary medicine; namely its lack of organisation. There is no single governing body for complementary practitioners. Many therapies have more than one professional organisation and other therapies have none at all. It is not always clear who is responsible for ensuring the validity of practitioners' qualifications and insurance and who a client can turn to if something goes wrong.

Patients also want to be protected from unqualified complementary practitioners and inappropriate treatments. National Health Service provision may go some way to ensuring certain minimum standards such as proper regulation, standardised note keeping, effective channels of communication and participation in research. It would also facilitate ongoing medical assessment, (Zollman and Vickers, 1999).

The integration of some forms of complementary medicine into the National Health Service may provide it with a structure that could raise professional standards and improve patient safety. Existing research suggests that the best place to do this is in general practice.

The integration of complementary medicine into general practice

During the 1990s there has been a significant increase in the delivery of complementary medicine in '*conventional practice*' with orthodox clinicians in 20% of UK general practices currently providing complementary medicine (Zollman and Vickers, 1999). They claim that nearly 4000 orthodox clinicians practice complementary medicine and are members of a relevant register, and many more have basic training in complementary medicine without official registration. A national survey estimated that 40% of general practices offered access to complementary medicine, of which over 70% was paid for by the National Health Service (Thomas et al, 1995).

Although complementary medicine is being increasingly offered in general practice, there is no co-ordination of these various projects or clear strategy for their implementation. More research needs to be conducted on the main forms of complementary medicine, specifically in relation to their effectiveness and possible implementation within general practice. One reason given for concentrating complementary medicine in general practice that is already found in the literature is that they may offer similar kinds of services. For example, Welford (2000) claims that these two forms of medicine are similar in three main ways that can help their integration.

1. Primary care and complementary medicine are more concerned with long-term care of patients rather than cure.
2. 30% of complementary medicine consultations are made by patients before seeing their GP suggesting that complementary medicine is already providing a primary care service.
3. Delegation of care by the GP is much easier within a primary care setting providing opportunities for discussion and sharing of care with complementary practitioners.

GPs and complementary practitioners have the potential to see a patient several times, often over many years, which provides time to assess and treat that person most effectively. A relationship can develop of trust and mutual understanding, as the different layers of a patient's health and wellbeing are unravelled. The GP or

complementary practitioner does not have to diagnose the patient immediately and attempt to eradicate symptoms with the same time limitations as Accident and Emergency staff for example. Instead, the most common form of treatment in both general practice and complementary medicine is the management of chronic symptoms as opposed to curing acute conditions.

Integration of complementary and orthodox medicine may improve services for patients who report complementary medicine as helping specific symptoms and general health and offering an alternative to aspects of orthodox medicine they are dissatisfied and/or non-compliant with. It has been suggested that general practice is ideally suited to incorporate this integration of complementary medicine, partly because its structures may be similar to that of complementary medicine. It may be for some of these reasons that patients have called for the increasing integration of these services.

Patient request for integrated services

Existing research indicates that many patients would like to see complementary medicine and orthodox medicine working together more closely. The Grampian survey in 1992 of 341 adults found '*...considerable support for complementary therapies to be provided on the National Health Service*' (Emslie et al, 1996). For instance, 184 (54%) specified that acupuncture should be provided and 172 (50%) cited osteopathy. Emslie et al (1996) also found that 186 (57%) reported that they would be happy to pay towards the cost of delivering these therapies if they could be available via the National Health Service.

Patients expect GPs to provide them with basic information about complementary medicine and '*...patient expectations of their GP's knowledge about complementary medical techniques are not being met*' (Rampes et al, 1997). Lewith et al (1996) claim that '*GPs need to know enough about these therapies to advise their patients appropriately*' with the potential solution being to train in complementary medicine themselves. They argue that '*One of the areas which has probably been grossly underestimated in relation to the published surveys is the growing use of complementary medicine by conventional doctors as part of their general practice*

commitment.’ This possibility of GPs practising complementary medicine will now be discussed in more detail.

GPs’ interest in complementary medicine

Research on GP and registrar views of complementary medicine suggests that it is becoming increasingly popular with orthodox clinicians. Reilly (1983) found that 86 of 100 GP trainees viewed complementary medicine favourably, particularly acupuncture, osteopathy and homeopathy. This is consistent with Budd et al’s (1990) conclusion that there is ‘...a demand from general practitioners trainees for knowledge of alternative techniques such as acupuncture and homeopathy.’ Wharton and Lewith (1986) also found positive attitudes in GPs, with many reporting a specific desire to train in complementary medicine to deliver additional therapies at their general practices. This study was replicated in 1998 with Wharton’s guidance, providing results that suggested both GPs’ interest in complementary medicine and belief in efficacy had increased (Stopp, 1998).

The types of therapies that are most welcomed by GPs can be suggested from a comprehensive literature review of twenty-five studies between 1982 and 1995 on the views and practices of conventional clinicians with regard to complementary medicine (Astin et al, 1998). Six other studies were excluded due to unreliable methodologies. The team looked specifically at research that pertained to the five of the most popular forms of complementary medicine, namely acupuncture, chiropractic, homeopathy, herbal medicine and massage. In support of Reilly’s (1982) earlier findings, 51% of conventional clinicians believed in the efficacy in acupuncture. In addition, 53% reported the benefits of in chiropractic, and 48% in massage. In contrast to Reilly’s (1982) results, homeopathy seemed less popular with 26% believing it was medically useful and herbal medicine was only deemed efficacious by 13%. It would be useful to discover if acupuncture, chiropractic and massage are the most popular forms of complementary medicine that GPs are training in and delivering in general practice.

GPs delivering complementary medicine

Reilly’s (1982) findings above seem consistent with a literature review of research between 1982 and 1995, that found 19% of conventional clinicians had trained in both

chiropractic and massage and 9% in homeopathy (Astin et al, 1998). Wharton and Lewith (1986) found 38% of 200 GPs in the Avon district had trained in at least one form of complementary medicine. A survey of 341 residents of the Grampian Region in 1992, found that one fifth of respondents who had received complementary medicine, had done so from an orthodox clinician (Emslie et al, 1996). A UK-wide survey in 1995 found almost 40% of all general practices offered some form of access to complementary medicine, half of which did so directly via a member of the primary healthcare team, usually a GP (Thomas et al, 1995). Finally, a more recent survey, focussing on one health authority claims that nearly half the general practices provide access to complementary medicine either directly or by referral (Wearn and Greenfield, 1998).

It seems that GPs have learnt to adapt their work-practices to accommodate this new delivery of complementary medicine. For example, a survey of 1092 GPs (response rate 71%) who delivered acupuncture described how they treated several patients at the same time (Dale, 1996). They also limited the number of acupuncture treatments per week, used the needles for less than the traditional twenty minutes and held evening acupuncture clinics. However, other research suggest that one of the main benefits patients gain from complementary medicine is the longer consultation time, suggesting that if treatments are shortened excessively to accommodate them in a GP timetable, the impact of that therapy could be reduced. Stopp (1999) for example, found that one GP practising acupuncture cited the longer consultation as a main benefit to patients.

I'm aware that a lot of patients have benefited from the extra time and understanding given, whatever the therapy. Just the fact that the therapist is spending time with them will result in an even greater benefit if they had not had that time (Stopp, 1999).

Stopp's (1999) study also suggested financial and practical benefits to the patients, with complementary medicine being offered at a '*subsidised rate*' by GPs with '*a shorter waiting time too*'. However, it is important to see these potential benefits in context, meaning the deciding factor for any treatment must be the health of the patient. As another GP in Stopp's interviews warns '*To get it* (complementary

medicine) *free would benefit the patient, but what really benefits the patient is to get the right treatment.*' An alternative option to the GP delivering complementary medicine is for nurses to adopt this additional role.

Nurses and midwives delivering complementary medicine

Articles on complementary medicine are common in Nursing Magazines and Journals. Armstrong's (1988) review in the 'Nursing Times' of incontinence concluded that *'Complementary therapies can be of great value in the treatment of continence problems'*. Stevenson (1997) recommended that nurses complete the three-year training in shiatsu in 'Complementary Therapies in Nursing and Midwifery.' Wright (1995) postulates that the popularity of complementary medicine in nursing may be because nurses see these therapies as *'...a route back into more caring forms of nursing'*. Nurses could be the main proponents of complementary medicine within orthodox medicine, because of their unique position in the National Health Service.

With over 600,000 nurses in the UK, the potential for wider transmission of the benefits of complementary therapies is enormous. Nurses are everywhere, at all levels of society and health care system. They are in contact with patients twenty-four hours a day and use and influence huge amounts of resources. Patients expect nurses to be the ones to 'humanise' the system for them (Pearson, 1988).

One of the main systems that nurses may be required to help 'humanise' is in maternity care. There currently seems to be a growing recognition of the need for maternity services to help women feel empowered and more in control of their health-care during pregnancy and labour. A report from the Expert Maternity Group from the Department of Health states that *'Each woman should be approached as an individual and given clear and unbiased information on the options that are available to her'* (MHSO, The Expert Maternity Group, 1993). This could include complementary medicine treatment. They also recommended that 30% of women should have a midwife as *'the lead professional'* throughout their pregnancy with antenatal care moved away from hospitals into the community wherever possible. This may again encourage nurses to offer complementary medicine in the growing maternity services offered within general practice. Tiran (1988) argues that the

principles of complementary medicine may be particularly useful for nurses and midwives, and cites shiatsu as one of the therapies most helpful during pregnancy and labour.

Much of the growth of interest in complementary medicine is due to the increased awareness of self-help and being responsible for one's own body, a turning away from the active doctor/passive patient relationship. This is very much in tune with the attitudes of consumers of the maternity services, who want to be more in control of their own labour. Many midwives are exploring a more holistic approach to their patients (Tiran, 1988).

Priya's (1992) cross-cultural research led her to conclude that *'Women experience labour in as many different ways as there are individuals to experience it.'* The addition of a form of complementary medicine to a nurse's repertoire of skills may offer a wider range of approaches to pregnant patients to meet their diverse needs.

In summary, there may be several advantages in general practice staff offering complementary medicine in general practice. In the last ten years there has definitely been a large increase in delivering complementary medicine in general practice for a variety of conditions (Zollman and Vickers, 1990). However, there is little research to suggest how these complementary services can be most effectively integrated into general practice (Robinson and Berman, 1988). An alternative way of offering complementary medicine to patients is for GPs to refer to private practitioners.

GP referrals to complementary medicine

Some GPs fear that complementary practitioners misdiagnose patients and/or give inappropriate treatment (Stalker and Glymour, 1989, cited by Sharma, 1992). However this chapter has established that the majority of users of complementary medicine have not only already been diagnosed by their GP but also had months or years of orthodox treatment for the chronic problems they most commonly present to complementary practitioners. Furthermore, many complementary medicine organisations stipulate that practitioners must encourage patients to see their GPs if they have certain symptoms.

Referrals between orthodox and complementary practitioner practitioners could be seen to improve safety and ensure symptoms are not missed if more than one clinician and medical approach have independently diagnosed a patient. Patients may also feel more comfortable discussing certain symptoms with particular practitioners suggesting that the more people they see, the more chance they have of being correctly diagnosed. Sharma (1992) argues that complementary practitioners do not often conduct home visits so patients who are very ill are more likely to request a visit from their GP or attend an emergency department at a hospital.

Research does show that many GPs refer to complementary practitioners. For instance, the aforementioned literature search of twenty-five studies of GPs' views and use of complementary medicine, claimed that 43% had referred patients for acupuncture, 40% for chiropractic and 21% for massage (Astin et al, 1998). Budd et al (1990) describe this trend as '*...an upsurge of interest, with general practitioners reporting referral of patients to non-medical practitioners.*' Wharton and Lewith (1986) found that 72% of a randomly selected sample of GPs had referred patients to complementary therapists in the previous year.

Although the literature clearly suggests that many referrals are being made to complementary practitioners, there is relatively little research on the actual referrals themselves (Robinson and Berman, 1984). There are no clear guidelines for choosing professional therapists, making appropriate referrals or protocols for closer collaboration between conventional and complementary practitioners. Perhaps some recommendations can be elicited from the research that does exist on the kinds of referrals that GPs make.

The age of patients GPs refer to complementary medicine

The ages of patients in GP referrals for complementary medicine can be compared to those on patients' self-referrals to complementary medicine. For example, Pooley and Harris's (1996) pilot survey of ten shiatsu practitioners concluded that users of complementary medicine ranged from being only a few months old to the over 70s, with the most common age band being between 36 to 40 years. Pooley and Harris (1997) conducted a second, larger survey of shiatsu that confirmed these results as most patients were between 35 and 44 years of age (30% of 571 patients). It is

unfortunate that the same age bands as the pilot study were not used as this hinders direct comparison of the data. It does seem that shiatsu at least, is generally used by adults in their late thirties and early forties. Possible reasons for this are suggested in the discussion chapter.

The shiatsu findings are consistent with literature on other therapies (Wadlow and Peringer, 1996). A survey of 1909 various complementary practitioners and 2473 patients in England, Scotland and Wales found that most patients (24%) were between 35 and 44 (Thomas et al, 1991). Zollman and Vickers (1999a) confirm that the most common users of complementary medicine are generally between 35 and 60 years of age.

The gender of patients GPs refer to complementary medicine

Budd et al (1990) studied GP referrals to acupuncture and osteopathy in a general practice over a fifteen-month period. The acupuncturist (n=90) and osteopath (n=107) treated a total of 197 patients and each worked one-day per week in the general practice. The majority of the patients were female (73% of all osteopath patients and 64% of those receiving acupuncture). This was also found in patients who self-referred for shiatsu (Pooley and Harris, 1996). Of the 345 patients that ten shiatsu practitioners repeatedly treated over a ten-week period, 260 (75%) were female and 84 (24%) were male, with one missing answer. A second, larger survey reported similar findings in 571 patients, with 72% being female and 26% male, with two missing answers (Pooley and Harris 1997). This gender bias is consistent with that found in acupuncture patients (Wadlow and Peringer, 1996).

National surveys only indicate that slightly more women than men utilise complementary medicine. The Research Survey of Great Britain (RSGB) in 1984 found that 73% of the men, compared to 67% of the women reported they had not had any of the specified forms of complementary medicine. The MORI poll in 1989 supported these figures with 71% of men and 67% of females not having experienced any of the complementary therapies listed. As described in the literature review, this was a smaller list of therapies to the RSGB poll, not including herbal medicine for example, and yet the results are remarkably similar.

Thomas et al's (1991) survey of complementary medicine in Britain estimated that 70,600 patients consulted with a complementary practitioner each week for one of five specified therapies. Approximately two thirds of these patients were female (62% as compared to 38% male). Of the 22% of patients who had consulted with their GP in the previous two weeks, roughly two thirds were again female (63% compared to 37% male). This suggests that the predominance of female patients is equally found in both complementary and orthodox medicine. Olesen (2000) claims that these findings should '*...encourage provocative and productive unpacking of taken-for-granted ideas about women in specific material, historical, and cultural contexts...produce new syntheses that in turn become the grounds for further research, praxis, and policy.*'

The over representation of female patients utilising health services could be associated with men experiencing more acute illnesses and dying younger than women (Verbrugge, 1985). Women are reported to suffer more chronic ailments than men do but this could also be affected by stereotypes held about women's health. For example, Jones and Cochrane (1981) asked participants to rate four groups of people on a seven-point scale to categorise the behaviour of '*normal*' and also '*mentally ill*' men and women. The findings were that participants described normal men as being very different to mentally ill men, yet normal women only had to slightly change to be re-labelled as mentally ill. Perhaps GPs have these stereotypes also in terms of what illnesses affect each sex and which treatments, including complementary ones, may be most useful.

The ethnic origin of patients having complementary medicine

MORI (1989) is the only survey of complementary medicine that elicited the ethnic origin of participants and it reported that 29% of black participants compared to 31% of white participants claimed they had used one or more of the six therapies listed (cited in Sharma, 1992). The results suggest little difference between the two groups' use of complementary medicine but more research clearly needs to be done in this area.

An in-depth interview study with patients between eighteen and fifty years of age found different consultation rates with GPs between the patients' ethnic groups (Zola,

1973). The results suggested that white, Anglo-Saxon Protestants (WASPS) were most likely to attend their general practice if they perceived their health to be affecting their work. In contrast, Irish Catholics consulted if it was sanctioned by a 'significant other' such as a relative or friend in their social network. Finally, Italian Catholics sought GP intervention in times of personal crisis or if their health was seen to affect their social relations. Religious practices that could be adopted by different ethnic groups are also associated with mortality and morbidity. Mormons in Utah in the USA have 30% lower incidence of most cancers and Seventh Day Adventists have 25% fewer hospital admissions for malignancies than the general population (Pitts and Philips, 1991). Further research would have to establish if these findings indicate different sick-role behaviours or real differences in experience of illness. In general though, these findings have important implications for epidemiological and demographic data since attendance at general practice and presentation of symptoms seems to be influenced by the characteristics of the population being studied.

The types of symptoms that lead to GP referral

Budd et al's (1990) study looked at referrals for acupuncture and osteopathy in a general practice. The complementary practitioners initially described having inappropriate referrals and feeling limited to mainly offering pain-relief for elderly patients. The GPs reported a tendency to refer patients they deemed were 'difficult', either because of their resistant symptoms or frequent consultations. Continued contact with the complementary practitioners helped to clarify the appropriate kinds of patients and symptoms that could be referred.

By the end of Budd et al's (1990) study, the most common conditions that were referred to the acupuncturist were degenerative or osteoarthritic pain in the back/hip (18 patients); depression/tension/anxiety (14 patients) and neck/shoulder pain (11 patients). This supports the previous findings that patients mainly present muscular-skeletal pain and psychological/emotional symptoms to complementary practitioners. The main symptoms causing referral to the osteopath was joint or muscle strain in the back (28 patients); degenerative or osteoarthritic pain in the neck/shoulder (23 patients), and in equal third place, degenerative or osteoarthritic pain in the back/hip and joint /muscle strain in the neck/shoulder (20 patients each). These results suggest that acupuncturists were referred more chronic, degenerative conditions (as found in

shiatsu by Pooley and Harris, 1996 and 1997) and osteopaths received patients with more acute, recent strains. This is supported by the pre-intervention data that found that 53% of acupuncture patients had experienced their symptoms for more than two years (compared to 25% of osteopathy referrals) and 25% for over eleven years (10% in osteopathy). In contrast, 44% of the osteopathy patients had their condition for three months or less (22% of acupuncture patients).

Acupuncture was seen as more effective than osteopathy in assisting with emotional and psychological illnesses (again supporting Pooley and Harris's findings about shiatsu, 1996 and 1997) with fourteen patients being referred for 'depression/tension/anxiety' compared to only three to the osteopath. The acupuncturist was also referred a much wider range of conditions than the osteopath, including gynaecological and urinary problems and vertigo/dizziness, further suggesting it was seen as applicable to a wider range of conditions than osteopathy. This confirms the previous claim that traditional Chinese medicine (such as acupuncture and shiatsu) is holistic, affecting a patient's emotional and psychological well-being as well as their physical health.

In contrast, osteopathy was used more as a manual therapy easing physical tension and structural imbalances; 92% of all referrals to the osteopath were for muscular-skeletal problems and joint/muscle strain. These rather subtle distinctions between acupuncture and osteopathy seem to have been made by both the clinicians and patients since, after initial problems, the complementary practitioners described they had received appropriate referrals. This supports the earlier suggestions in the literature review that both the medical profession and the public as a whole are becoming more aware of complementary medicine and the conditions the various forms of therapy can treat.

The osteopath also noted a higher proportion of referrals of female patients, reiterating the previous claim that more women than men are referred for complementary medicine by GPs. Perhaps women are more likely to present with muscular-skeletal strains at their practice than to a private clinician or are more willing to have osteopathy than their male counterparts.

Chronic symptoms that are hard to diagnose and treat

Research also suggests that GPs refer patients for complementary medicine specifically because their symptoms were difficult to diagnose. Stopp (1999) for instance, interviewed fourteen GPs about complementary medicine and they described referring patients '*...where no clear reasons why the conditions exists are likely to be the patients who receive the greatest beneficial effect from complementary therapies.*' Another GP in Stopp's (1999) survey described complementary medicine as being useful for chronic recurring symptoms that again, proved hard to diagnose within an orthodox framework,

The real benefit may be for persistent migraine sufferers that keep returning. Also, for patients with conditions that are non specific and recurring but don't fit into any pigeonholes.

A study on complementary medicine in primary care in Liverpool found that 72% of referred patients' symptoms had been experienced for more than a year, with 15% having persisted for over ten years (Hotchkiss, 1995). Welford (2000) claimed that GPs tend to refer patients to complementary medicine if they have chronic symptoms that are resistant to orthodox medicine either due to difficulty in diagnosis or treatment. Over six hundred patients were referred to complementary practitioners during the study (approximately 17% of practice population). Most of them had been referred for chronic conditions, especially muscle and joint problems in support of the previous findings. Furthermore, 34% of patients were referred because their symptoms had not responded to orthodox treatments, reiterating the previous claim that complementary medicine is often used when orthodox medicine fails. This is supported by a GP in Stopp's (1999) survey,

Complementary therapies are especially helpful for the patients that have been resistant to any sort of conventional therapy. A patient for example with soft tissue injury, no break, but sprain to neck and shoulder. The people who have stood the test of time here have been the acupuncturists.

One reason why orthodox medicine for one symptom may be limited is its interactions with other symptoms the patient may be suffering. This can again be illustrated by a

quote from a GP in Stopp's (1999) interviews who claimed that *'Complementary therapies particularly benefit patients who have conditions that are rather ongoing and where perhaps the options that we have in conventional medicine seem limited.'* Unpleasant side effects and/or patient resistance to prescriptions can limit the use of orthodox medication.

Patient dissatisfaction with orthodox medicine

Sharma's (1992) study of complementary medicine users in Stoke-on-Trent in 1986 and 1987 reported their dissatisfaction with orthodox medicine. She described how all but one of the thirty participants attributed their first use of complementary medicine to orthodox approaches either being unable to offer them any treatment or one that was satisfactory. All of the participants had tried orthodox medicine from their GPs and nearly half had either been referred to a consultant or hospitalised for their symptoms before trying complementary approaches. Four of Sharma's interviewees had paid privately for orthodox medicine and still not been satisfied with their treatment, so tried complementary medicine instead. This suggests that GPs do not need to fear that patients having complementary medicine risk having symptoms misdiagnosed as most users seem to consult with their GPs before approaching complementary practitioners.

Sharma (1992) claims that *'Some sufferers had not only been unable to obtain relief from orthodox medicine, but had become sceptical about their GP's diagnosis.'* She cites a participant who disliked her GP's diagnosis of stress and subsequent prescription for anti-depressants. Psychological diagnoses may be particularly hard to accept if they are associated with stigma and embarrassment. This has important implications for patient compliance with recommended treatment in terms of taking medication or complying with referrals. Future research could study this connection further.

The Integrated Healthcare document (1997) claims that this dissatisfaction of orthodox diagnosis and treatment from patients (and clinicians) can influence their use of complementary medicine.

The rapid growth in complementary and alternative medicine in many western countries suggests a degree of public dissatisfaction with what

people see as the limitations of orthodox medicine and concern over the side effects of ever more potent drugs. Biotechnical approaches - pharmaceuticals and surgery - often have a limited amount to offer those with chronic, degenerative or stress-related diseases, mental disorders or addiction.

Implications for complementary medicine

The predominance of chronic and resistant symptoms that complementary practitioners are asked to treat should be considered when developing and evaluating services. Welford (2000) suggests that the smaller improvement found in chronic symptoms may affect how the service is used and result in underestimating the therapies effectiveness.

Those who had had their problems for over a year showed significantly less change in their condition following treatment, compared to those referred with shorter-term problems. This result has implications, both for the way the service is used, and for the level of success indicated by the present evaluation, since it suggests that if it was used for more patients with acute improvement may have been even more marked (Welford, 2000).

Guidelines for the integration of complementary medicine with general practice

The only comments found in the current literature search on delivering complementary medicine in general practice were adapted from the report of The Delivery Mechanisms Working Party of the Foundation for Integrated Medicine by Zollman and Vickers (1999). They claim that this integration can be helped or hindered in the following ways.

Table 6. Integration of complementary medicine with general practice (Zollman and Vickers, 1999)

Successful integration is more likely with;

- Demand from patients
- Commitment from high level staff in the conventional organisation
- Protected time for education and commitment
- Ongoing evaluation of service (may help to defend service in the face of financial threat)
- Links with other conventional establishments integrating complementary medicine
- Realism and good will from all parties
- Jointly agreed guidelines on protocols between complementary and conventional practitioners
- Support from senior management or health authority
- Careful selection and supervision of complementary practitioners
- Funding from charitable or voluntary sector

Problems are likely with;

- Financial insecurity
- Time pressure
- Lack of appropriate premises
- Unrealistic expectations
- Overwhelming demand
- Inappropriate referrals
- Unresolved difficulties in perspective between complementary and conventional practitioners
- Real or perceived lack of evidence of effectiveness
- Lack of resources and time for reflection and evaluation

Hills and Welford (1998) faced some of these obstacles in a complementary medicine clinic in a general practice in Somerset. Patients were given up to three hours of free treatment for each referred condition and could have acupuncture, herbalism, massage, osteopathy and homeopathy. The main obstacles that were encountered in the integrated service were lack of time, research and funding. Limited time was related to inadequate resources to cope with the popularity of the service, as one GP lamented that '*...it is demanding in terms of administrative time and with demand for the service outstripping supply this can easily lead to a build up in waiting lists.*'

The limited amount of research in complementary medicine was also cited as hindering GP referrals (Hills and Welford, 1988). One GP stated that there needed to be more '*...good quality information about these therapies, particularly about the evidence base which is beginning to evolve.*' Another argued that '*...long term National Health Service funding does need to be realised if the service is to be provided on a secure financial basis.*' The issue of funding can hinder the development of initiatives in complementary medicine in the National Health Service. However, studies also exist which suggest the issue of cost can be an advantage rather than disadvantage to delivering complementary medicine. Some projects, for example, have become self-funding and many report that the new services have also been able to save the general practice money (see page 69).

A successful example of an integrated complementary medicine service in a general practice is Budd et al's (1990) study of acupuncture and osteopathy. The authors reported that the GPs found it was easy to accommodate the new service and appreciated the opportunity to discuss patients with other practitioners. This could have improved patient care and on three occasions the complementary therapists actually diagnosed a serious medical condition that had not been detected by the GPs. This suggests that the use of complementary medicine can actually increase patient safety, again challenging the GPs' fears previously described (Stalker and Glymour, 1989, cited by Sharma, 1992).

It would be interesting to study what aspects of complementary medicine consultations help patients notice and disclose symptoms or therapists correctly diagnose them. The on-going relationship between the complementary practitioner

and patient, regular hourly sessions and the generally more holistic approach of complementary medicine to orthodox medicine could all play a role in assisting appropriate diagnosis and treatment. Future research could assess these possible benefits of integrating complementary medicine with general practice further. However, there is already data to suggest that many complementary practitioners would welcome the opportunity to work within the National Health Service.

Some practitioners support National Health Service provision because it would improve equity of access, protect their right to practice (currently vulnerable to changes in European and national legislation), and guarantee a caseload. It would provide opportunities for inter-professional learning, career development, and research. Others fear an inevitable loss of autonomy, poorer working conditions, and domination by the medical model (Zollman and Vickers, 1999).

Perhaps the recommendations of successful integration already described could help reduce these obstacles to the integration of complementary medicine in general practice. Research would have to study this further. The thesis has suggested however that if these obstacles are faced, there are many advantages for general practice staff, patients and complementary practitioners in delivering complementary medicine in general practice.

Benefits of integrating complementary medicine with general practice

Luff and Thomas (2000) conducted a qualitative examination of patients' satisfaction with complementary medicine funded within the National Health Service. They conducted 49 semi-structured interviews using a critical incident approach in 8 sites across England. They claimed the main benefits of these services were that patients claimed they ameliorated or cured their symptoms, including hitherto chronic conditions. Patients saw the complementary practitioners as being caring and they particularly valued their therapeutic relationship, which empowered them to play an active role in their health.

Another study that has looked at the benefits of general practices offering complementary medicine has been the afore-mentioned survey of fourteen GPs

conducted by Stopp (1999). The GPs described four main benefits claiming that complementary medicine provided increased efficiency, enhanced practice reputation, increased solutions for GPs in patient care and intellectual scope for staff. These benefits will now be described in more detail.

Increased GP efficiency

One of the GPs in Stopp's (1999) study claimed that their complementary medicine clinic increased GP efficiency by saving them time '*...it's a speedier service because we don't have to refer.*' This reiterates the earlier benefits of having the clinic in-house. Another GP described a more efficient use of the practices' resources in terms of funding: '*I think it can reduce the drugs budget - I know there is a practice in ...Bristol, where they have managed to fund these therapies by savings on the drugs budget.*' This suggests that in some cases, a practice does not have to find additional funding for an integrated complementary medicine service, but can simply use money to employ complementary practitioners that would otherwise be used for prescriptions.

Increased solutions for GPs in patient care

Stopp's (1999) study refers to complementary medicine offering GPs and patients '*increased solutions.*' A GP remarked '*Well, it's a wider treatment isn't it - GP prescription is OK, but its not the be all and end all of medicine.*' This was also one of the main advantages cited by staff in The Blackthorn Trust who described the benefit to both GPs and patients in having four different complementary therapists in the practice (Logan, 1994).

Hills and Welford (1998) also noted the benefits of increased access after a three-year experiment integrating six forms of complementary medicine into a general practice. They claimed that offering complementary medicine in primary care reduced patient use of orthodox medicine and limited referrals. '*The therapies appeared to have considerable effectiveness in a wide range of health problems, and led to a reduced demand on other aspects of health care provision, particularly referrals to secondary care*' (Hills and Welford, 1998). These findings were replicated by Welford (2000).

The benefits of such a service did appear to be considerable, both for the patients and for other staff at the practice, particularly since it provided

another option of treatment for patients for whom conventional treatment was ineffective (Welford, 2000).

Dempster's (1998) study also described a wider range of choices for GPs and subsequent satisfaction in patients claiming that *'The availability of homeopathy provided GPs with a further therapeutic option, which many patients appreciated.'* Budd et al (1990) list this accessibility as one of the many benefits they found from delivering acupuncture and osteopathy in a general practice.

A major benefit of practising complementary medicine in a primary care setting is that it provides a unique opportunity to offer these therapies to a wider population. Patients can be speedily referred if necessary, either to their GP, or for hospital-based diagnostic tests and there is the opportunity to discuss patients' history and progress with the GP. In addition, access to medical records when permitted by the patient helps to provide a fuller picture of the patient's therapeutic needs (Budd et al, 1990).

Atchison et al (1999) also note these benefits of integrating complementary medicine and orthodox medicine, in their study of back pain with physiatrists (physiotherapists).

CAM (complementary and alternative medicine) has recently drawn a lot of interest from patients and physicians, particularly physiatrists. A physiatrist's knowledge of these techniques is essential to determine when they may fit into a comprehensive rehabilitation program and to encourage patients to participate in an active treatment program along with the passive techniques (Atchison et al, 1999).

Enhanced practice reputation

Patients may prefer a practice that takes a holistic approach to health, providing alternative ways to understand the cause of symptoms. This was reported by a GP in Stopp's (1999) survey,

It has undoubtedly attracted patients to the practice; it has given us a reputation, deserved or otherwise that we are thoughtful and not automatically conventional and therefore like other practices.

Complementary medicine was seen as distinct from orthodox medicine, but in this context, the comparison is positive, suggesting that the practice is modern and open-minded to offer other treatments. Enhanced practice reputation was also reported in a study of homeopathy in general practice (Christie and Ward, 1996).

Increased intellectual scope for GPs

Stopp's (1999) study described a new attitude held by GPs to health and defined it as '*intellectual scope.*' This is the impact that the complementary practitioner seemed to have on widening the intellectual base of existing GP work practices, as one GP claimed that...

...I think there have been considerable benefits. It has made all of us think. The way we are trained as medics, certainly the older ones of us, (and there are three of us who are all very similar ages). And the way we were taught was, that was really the only way of dealing with things, you know, the medical model.

This suggests that complementary medicine was seen by the GPs to widen their '*conceptual framework*' of illness and its treatments as recommended by Ernst (1995) at the start of this chapter.

Saving general practice resources

Stopp's (1999) four main benefits of delivering complementary medicine in general practice together suggest that this may be a clinically and cost effective way of integrating services in the National Health Service. Although further research will have to be conducted for any conclusions to be drawn about these two forms of effectiveness, existing studies do support this claim. Dempster (1998) studied homeopathy in general practice and found that it was deemed both clinically and cost effective. This was partly due to a significant reduction in consultation rates and the

use of medication that was found both during and after receiving complementary treatment...

...the clinical effectiveness of homoeopathy, in relation to the referral criteria, was clearly established from the results obtained. It was also clear that there was a significant saving on GP time. 25 patients (86%) did not need to see the GP again within the time of the study. The reduction in GP visits also combined with specific drug reduction (Dempster, 1998).

Welford (2000) found that the delivery of complementary medicine in general practices was associated with reducing GP consultation rates by approximately a third and also lowering referrals for secondary care services. The largest drop in consultations was found in patients who had previously attended the practice most frequently. Furthermore, the complementary therapies seemed most effective for symptoms that were resistant to orthodox medicine.

Patients are more likely to re-consult with their GPs and nurses if their symptoms persist and they are not referred elsewhere, so the time saved by the any of the practice staff who interact with the patient could also be costed as a benefit of the new service. This could include administration time from the receptionists and practice manager as well as clinical time from the GPs or nurses. Another way in which complementary medicine could save National Health Service resources is via a reduction in referrals to secondary care. In Budd et al's (1990) study, GPs reported a drop in the number of referrals to external sources and lower prescription costs during the time when they could refer to their in-house therapists; *'They have made fewer referrals to hospital physiotherapy departments, fewer referrals to orthopaedic and rheumatology departments, and issued fewer prescriptions for pain-killing drugs.*

The estimated cost of prescriptions in 1990 was over £100,000 for each GP each year, which is double the gross annual National Health Service GP income (Stopp, 1999). Furthermore, two in three consultations result in a prescription (Fry, 1990) so any reduction in medication associated with receiving complementary medicine is clearly of benefit to a general practice. Welford's (2000) previously mentioned study also

found a significant reduction in prescriptions for patients having in-house complementary medicine.

Two thirds of the group had required prescriptions for their problem in the year prior of referral, usually for analgesics. The overall number of prescription nearly halved (Welford, 2000).

The Liverpool primary care referrals centre for complementary medicine reiterates these potential cost and time savings, particularly for muscular-skeletal and psychological/emotional symptoms (Hotchkiss, 1995).

Referring GPs view the service very favourably. In 62% of referrals GPs considered that attendance at the centre could or would affect prescribing, principally reducing the need for analgesia and non-steroidal anti-inflammatory agents. GPs considered that an effect on referrals to specialists and other agencies would also be detected, with a 52% reduction in the number of patients referred to other services. The principal referrals avoided would be to orthopaedics, physiotherapy and psychiatry (Hotchkiss, 1995).

Welford (2000) study also reported a drop in referrals to external sources, reporting that the largest reduction in referrals was for physiotherapy and X-rays. This finding emerged from a cost benefit study of a sub sample of patients with long-term health problems. Other results suggested that savings were made in the overall care of these patients that covered the cost of providing the complementary medicine service. This is illustrated in the following table.

Table 7. Total costs for subsample of patients 1 year before and 1 year after treatment (Welford, 2000).

Number of patients in subsample	41
Total costs before treatment – medication, secondary care, investigations, GP consultations:	£3,773.05
Total costs 1 year after treatment – medication, secondary care, investigations, GP consultations:	£1,523.28
Difference in cost	£2,509.77
Cost of complementary treatment	£2,567.50

Welford (2000) concludes that complementary services can reduce the number and therefore, cost of referrals to secondary care. This may even result in an integrated complementary medicine saving more than it costs. Research calculating the saving made in secondary care in relation to the cost to primary care would have to study this claim further. Other studies have suggested, though, that high cost-savings of these services could make the complementary medicine self-funding.

...there are cost savings available, which will have a recurring beneficial effect on the Health Authority's cash limited budget. Interestingly, the 'per patient' savings equate to the annual cost of employing the homeopath. So this in effect means the project could become self-funding (Christie and Ward, 1996).

Welford (2000) concludes that delivering complementary medicine in general practice may be complex, but could result in saving as opposed to depleting valuable National Health Service funds.

Provision of complementary medicine in general practice is not an easy option; it is very difficult to find a way of funding such a service, although there did appear, from this study, to be evidence that such a service is at

least cost-neutral, on account of savings made elsewhere, and at best, cost-effective (Welford, 2000).

This service in Glastonbury is now being maintained by a charity, with funding from external grants and patients donations. This obviously indicates support from the general public and satisfaction from patients of the service, but it is clear that any complementary medicine service needs to have secure, long-term funding for effective delivery and evaluation. In summary, research suggests that the provision of in-house complementary medicine can save a general practice both time and money.

Researching complementary medicine

This thesis has suggested that there is an increasing interest in complementary medicine from the public, orthodox medics and decision-makers in the National Health Service. In response to this a new research culture has developed within complementary medicine to provide scientific evidence about many of its main therapies. The findings of which can be summarised by Vickers (2000) who claims that the following advances have been made in the field of complementary medicine research, many of which have already been described in this literature review.

Advances in complementary medicine research (Vickers, 2000)

- The quantity of applied research in complementary medicine is growing rapidly and the quality is improving.
- There is good evidence supporting the use of some complementary medicine treatments.
- Guidelines and consensus statements issued by conventional medical organisations have recommended some complementary medicine treatments.
- Complementary medicine is increasingly practised in conventional medical settings, particularly acupuncture for pain, and massage, music therapy, and relaxation techniques for mild anxiety and depression.
- Osteopaths and chiropractors recently became the first complementary medicine practitioners in the United Kingdom to be regulated.

- There is a more open attitude to complementary medicine among conventional health professionals; this is partly explained by the rise of evidence-based medicine.

So, research in complementary medicine is growing in both quality and quantity, partly due to the adoption of research methods that are popular in health service research. The remainder of this section will describe these methods and their role in complementary medicine research.

Randomised controlled trial

The ‘gold standard’ research method for orthodox medicine seems to be the randomised controlled trial (Sackett et al, 1996). The British Medical Journal published its first report of a randomised controlled trial in 1948 that researched the effectiveness of a treatment for tuberculosis (Smith, 1998). Diebschlag (1993) claims that ever since this introduction *‘Most medical studies concern the description and mechanism of disease and utilise controlled studies or randomised trials.’* Many clinical- and cost-effectiveness studies successfully utilise randomised sampling, large sample sizes, control groups, double-blind trials and quantitative outcome measures. This may be influenced by the National Health Service’s concern with the health of populations rather than individuals, which can be effectively addressed by large-scale, quantitative studies. The respect given to the rigour of these methods could also explain their popularity within conventional medical research. *‘The strongest scientific evidence of efficacy is that from high quality meta-analytic reviews of well-conducted randomised controlled trials’* (Parry, 1999).

The details of how to conduct randomised controlled trial’s are still being clarified however (Lewith et al, 2002) and it is still not the standard design for many procedures in conventional medicine (Jadad, 1998). There is some dispute as to how common randomised controlled trials actually are in health research, especially the rigorous, ‘double blind’ variety where neither the researcher nor the participant know who receives the intervention and the placebo. Diebschlag (1993) claims that *‘The “Gold Standard” of the double-blind randomised controlled clinical trial is largely mythical, and it is simply not true that biomedical research rigorously adheres to this model’.* She claims that only 114 from 755 funded trials by the US National Institutes of Health

were double blind. Even following the recent call for evidence based medicine in the UK, the British Medical Journal described '*...dispiritingly large numbers of current treatments for which uncertainty about efficiency and safety remains (due to)...the equivocal results of many small trials*' (Bracken, 1987). Randomised controlled trials require large samples and therefore resources, which could limit their use.

Many of the randomised controlled trials that have been published have been criticised for a '*...a flood of deficiencies. Trials are often too small, too short, of poor quality, and poorly presented, and they address the wrong question*' (Smith, 1998). Smith cites research that describes the methodological inadequacies common in randomised controlled trials (Kunz and Oxman, 1998) and the tendency to ignore both important ethical issues (Edwards et al, 1998) and patients' views (Featherstone and Donovan, 1998). These methodological concerns may partly explain why randomised controlled trials are particularly scarce in research on complementary medicine, even though Vickers (1998) claims that the number of these trials is currently doubling every five years. In the few instances where they have been utilised, it is commonly for experimental research designs such as investigating the mechanisms of acupuncture via its neurological or electro-magnetic effects (Diebschlag, 1993). Quantitative measures may well be appropriate in these studies which can repeatedly 'test' an isolated response in a subject under laboratory conditions. Research with a more interpersonal or institutional focus may require a different approach.

Medicine that is tailored for each individual patient may also not be suited to clinical trials. Saks (1994) claims '*There are also major methodological debates about whether the randomised controlled trial is the most useful method to evaluate holistically based alternative therapies in which treatments are tailored to the individual client rather than given for a standard condition.*' This could further account for the low numbers of randomised controlled trials in complementary medicine and counselling, particularly in primary care. For example, Parry (1999) describes how Rowland et al's (1999) Cochrane review of counselling in primary care was only able to find four studies of primary care counselling to meet their '*stringent eligibility criteria*' for good quality research.

Traditional randomised controlled trials are designed to evaluate specific effects. Walach et al (2002) argue that this hinders their appropriateness in complementary medicine because it relies on questionable assumptions that the therapy has a specific effect, that this is more significant than a non-specific or synergistic effect at measuring the therapy's validity and that specific effects are the most valuable outcome that a therapy can produce. This debate has been partially clarified recently with the development of new 'pragmatic' trials. These retain randomisation and the methodological rigour of traditional trials but enable complementary practitioners to provide individualised treatments and create therapeutic relationships with their patients '*without constraint...under 'normal' service conditions as near as is possible*' (Fitter and Thomas, 1997a and b). These new research designs may increase the use of randomised controlled trials in complementary medicine and improve the rigor of findings. However, it remains clear that randomised controlled trials are clearly not the only way of conducting rigorous research.

...even if we remedied the many gaps in efficacy research, we should still lack evidence to make decisions in the real world. Decisions about how much of which types of therapies to provide for whom, where these cannot be addressed by randomised controlled trial evidence alone. We need practice-based evidence as well as evidence-based practice (Parry, 1999).

Parry (1999) calls for research in four main areas which can all be applied to complementary medicine; firstly, for research on the effect of treatment settings on treatment outcome in general practice. Secondly, analysis of therapy as it is really delivered in its 'tailored' form for each patient, drawing on an eclectic mix of skills and not only on the rarer forms of 'pure' treatment rigidly keeping to a single therapy, '*The most prevalent interventions are paradoxically the least commonly researched*' (Parry, 1999). This could reduce the previously mentioned risk of therapies being distorted so much in the quest for scientific rigour that they no longer represent the therapy being researched. Thirdly, Parry (1999) recommends that research should assess how best to deliver therapies in terms of frequency and equality of access. Lastly, she emphasises the need to address patient choice.

...by their very nature, randomised trials deprive patients of choice. In summary, although well defended against threats to internal validity, the external validity of randomised trials is inevitably compromised (Parry, 1999).

Systematic review

The other method commonly found in health service research that is increasingly found in studies on complementary medicine is the systematic review. The Cochrane Library for example currently holds approximately fifty systematic reviews of complementary interventions. These reviews can pool results from several vetted papers to present easily digestible conclusions on a variety of health care issues. Vickers (2000) claims '*...high quality systematic reviews of complementary medicine have been published recently which provide a reliable basis for making healthcare decisions.*' As an example, he cites a Cochrane systematic review of the St John's Wort herb for mild to moderate depression (Linde and Milrow, 2000). The review included 27 trials and over 2000 participants and concluded that St John's Wort was superior to placebo and equivalent to tricyclic antidepressants, but had fewer adverse effects.

Acupuncture has also been subjected to many high quality systematic reviews. Mayer (2000) for instance, conducted an evidence-based review of the clinical literature on the effects of acupuncture which found it to be *effective* for the treatment of nausea and vomiting in postoperative and chemotherapy patients and *useful* for headache, low back pain, alcohol addiction and paralysis from strokes. Mayer (2000) recommends a quantitative approach for future research in acupuncture claiming it should involve double blind, controlled trials '*...with specific hypotheses, and sample sizes sufficient to allow both positive and negative conclusions.*' I would add that qualitative research also needs to be conducted to deepen our understanding of the therapy's effectiveness and patients' experiences of having treatment.

The influence of research

The increase in high-quality research can motivate influential institutions to accept the use of complementary medicine. For instance, research has prompted the British Medical Association to publish a report commending the use of acupuncture and the

Royal College of General Practitioners in the UK has produced guidelines that recommend physiotherapy, chiropractic treatment, or osteopathy within six weeks of the onset of persistent uncomplicated back pain. *'One consequence of the increase in the availability of high quality data is that guidelines and consensus statements published by conventional medical bodies have supported the value of complementary medicine (Vickers, 2000).*

Increased quality and amount of complementary medicine research can only benefit those who use and deliver complementary medicine. Vickers (2000) suggests that there is...

...an improved awareness among researchers of the importance of complementary medicine and an improved awareness among complementary medicine practitioners of the importance of research. These changes have led to increased funding and the establishment of complementary medicine research units at sites of research excellence.

The creation of national organisations such as the UK Research Council for Complementary Medicine (RCCM) indicates the increasing awareness of the need for high-quality research into complementary medicine. It is unfortunate that they do not have the funding of their European and American counterparts, such as the centre for research into complementary medicine at the National Institutes of Health in America. The American centre's aim is to support a large number of trials and local research centres in a similar way to the RCCM, but with a budget of \$68 million (£45 million). This may be indicative of the support that US academic institutions are now offering complementary medicine researchers.

It is important that universities continue to undertake research into complementary medicine to increase the number of high quality papers that can be widely disseminated. Vickers (2000) claims this can only assist the pursuit of continually improved professional research into complementary medicine. *'These institutions provide the sort of intellectual and practical infrastructure essential for high quality research; this support has long been missing in complementary medicine (Vickers, 2000).* I would add that more encouragement and support is also needed for

complementary practitioner undertaking and participating in studies to develop a research culture within this growing area of medicine.

Conclusions from the literature review

This literature review has suggested that complementary medicine is growing in popularity and research has shown that some therapies have been associated with several health benefits. However, the current method of delivery from private complementary practitioners reduces the equality of access that the public can have to this form of medicine. Unequal distribution of practitioners around the country and charges for treatments greatly hinders the number of people that could potentially benefit from this service. This is exacerbated by the lack of organisation and regulation in many of the therapies. One answer could be the widespread delivery of some forms of complementary medicine within primary care structures of the National Health Service. This would require clear recommendations from high quality research, specifically related to the delivery of complementary medicine in general practice.

The existing research base for complementary medicine has been criticised for lacking in both quantity and quality. The dearth of credible evidence related to complementary therapies could have hindered their acceptance with the general public and orthodox clinicians. Instead, the use of many therapies and the number of both complementary and orthodox practitioners delivering complementary medicine is increasing. For the reasons suggested in this literature review, the increased delivery of complementary medicine within general practice seems likely to continue; but, there is a particular dearth of evidence about how these integrated clinics can be delivered and evaluated.

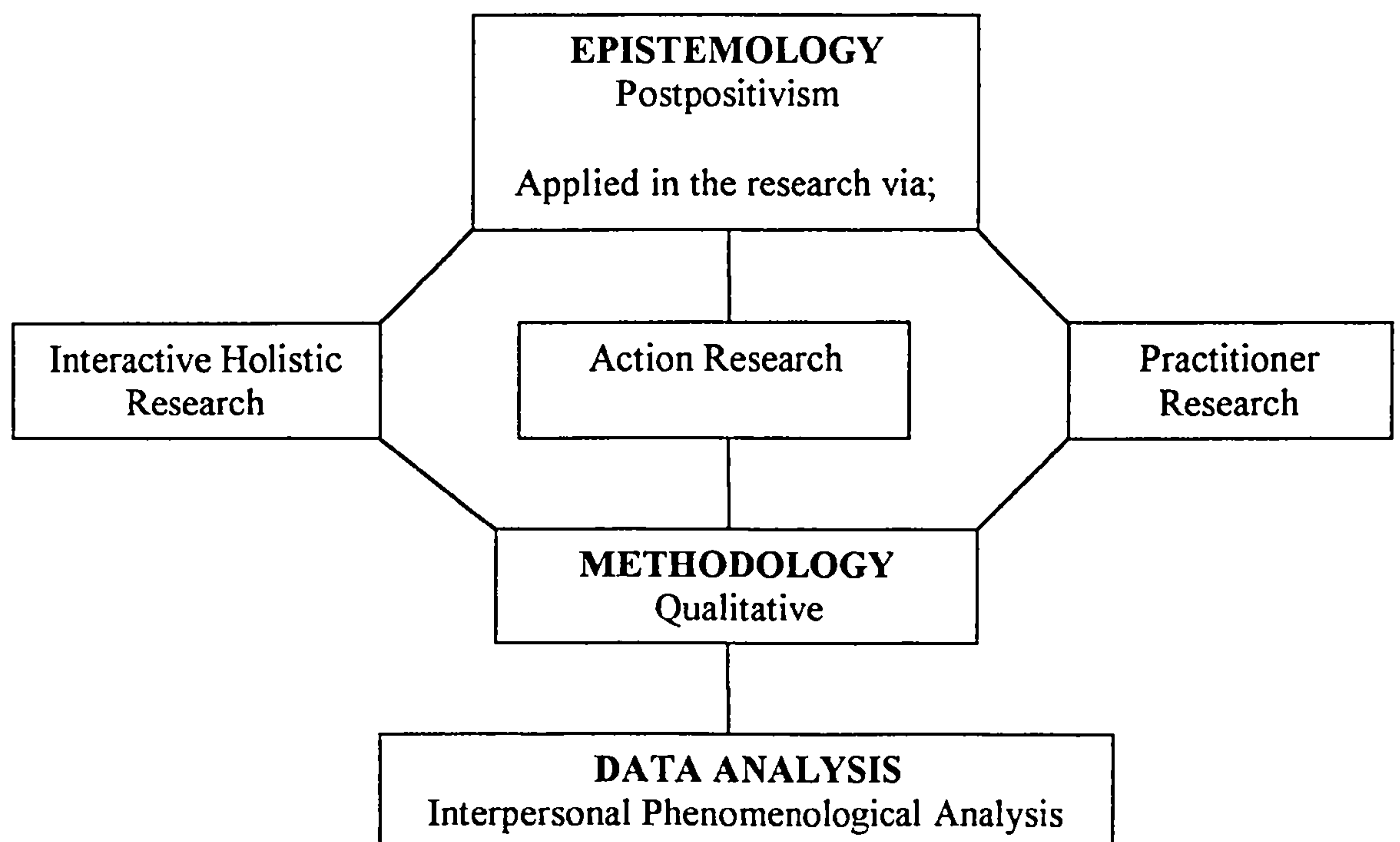
Existing research on localised delivery of complementary medicine in general practice has been shown to offer several benefits to the health of patients and the professional development of staff. However, studies have tended to focus on evaluating services with quantitative outcome measures. The information gleaned from patients is therefore limited to statistical analysis of health questionnaires. Their reflections on the service and potential improvements have largely been ignored. Even if

'satisfaction' has been addressed, this has been via patient satisfaction surveys that have been heavily criticised for not being able to produce useful results (Ryan et al, 1999). It is essential that effective qualitative research is conducted with patients, staff and complementary practitioners to more fully understand their experiences and reflections on the service. This thesis therefore documents the account of a practitioner researcher studying the impact of a shiatsu clinic on a general practice, its GPs, patients and complementary practitioner. This will illustrate the use of practitioner research in developing a reflective evaluative culture in complementary medicine and inform the future delivery and evaluation of shiatsu in general practice.

Chapter III EPISTEMOLOGY AND METHODOLOGY

The preceding literature review concluded that there was a need for qualitative research on the integration of complementary medicine within primary care. This thesis documents an opportunity to conduct practitioner action research on a shiatsu clinic integrated into an inner-city general practice. The aim of the research was to explore the personal and institutional impact of this clinic in an attempt to improve patient care and general practice service delivery. The subsequent research question is set out fully at the start of chapter four. The shiatsu clinic was evaluated in terms of its impact on the general practice and the GPs, patients and complementary practitioner. The chosen methodology of inquiry needed to address the processual issues within the research and to acknowledge the epistemological basis of action and practitioner research. The underpinning epistemology is postpositivist while the methodology is grounded in Interactive Holistic Research (Cunningham, 1988) and qualitative methodology.

Figure 4. Epistemology and methodology of the current study



Epistemology

A justification of method in research rests ultimately upon an epistemology (Silverman, 1994). Hart (1998) comments that this '*...shapes the character of your research study...if we aim to acquire knowledge of the world around us we need to appreciate the implications of what we take as the world, and acknowledge that our approach is not universally shared.*' Research epistemologies lie on a continuum from fixed and structured, pre-conceived designs at one extreme to more fluid, ambiguous and emergent processes at the other. This chapter will therefore clarify the distinction between positivism and postpositivism; the latter being the epistemological stance adopted in the current study.

Positivism and Postpositivism

Positivist epistemologies emphasise the objective reality of the world, and consider that these 'facts' (whether in the natural or social worlds) can be uncovered by research, usually based on empirical investigation. Methodologies derived from positivist epistemology often, though not always, use quantitative approaches, and usually test a pre-conceived hypothesis (Bowling 1997, Denzin and Lincoln 1998). They tend to regard individual differences between researchers as biases to be removed by rigorous methods and strict tests of study and instrument validity.

In the social sciences, postpositivistic methodologies developed as a consequence of acknowledged doubts over positivism's applicability. Postpositivist epistemology argues that only partially objective accounts of the world can be obtained, in part because of methodological flaws in research, but also due to the multiplicity of interpretations of reality that exist in the social world (Denzin and Lincoln, 1998). Reality is partly in the eye of the beholder, and the postpositivist researcher must also acknowledge the influence of their own personal experience and value judgements on the study. In this approach, there is thus a need for methodologies that take into account the impact of the research itself upon the phenomenon under investigation. With the continuing aim of gaining knowledge of the world, postpositivists apply rigorous tests of validity and reliability, while enabling far more flexibility in developing imaginative ways to reduce bias and ensure that a study is adequate.

Thus, for example, Glaser and Strauss (1967) apply postpositivistic theoretical or purposive sampling methods in place of positivist random sampling techniques, while constant comparison and negative cases are also used to help analyse the data. Feminist research has developed approaches that seek knowledge while engaging with the concerns of women and valuing their experiences (Gelsthorpe 1992, Oakley 1998). The method of 'analytic induction' (Mitchell 1983) has sought to introduce rigorous hypothesis-testing to case studies and qualitative analysis. All these are examples of postpositivist efforts to seek truth while critically evaluating 'naïve' assumptions concerning social 'facts' and their discovery.

Realist and constructionist postpositivism

Realist and constructionist perspectives share many of the criticisms of positivism, but have an important philosophical distinction. Realist postpositivists retain a belief that social reality can be discerned, so long as the methodology is adequate and appropriate. Constructionist postpositivists reject this, and argue that no single reality exists and that '*...objective reality can never be captured*' (Denzin 2000). Constructionists have developed post-structuralist commentaries that emphasis the *constructed* nature of the social world, and the part that language plays in this construction (Game 1989, Fox 1999).

Constructivism means that human beings do not find or discover knowledge so much as we construct or make it (Schwandt, 2000)

There is a commitment to difference and an understanding of how contrasting interpretations may co-exist, often influenced by local and contingent factors. Thus, Wynne (1992) found that lay and scientific groups hold very different views about the environment, based on their political and economic positions, and that both positions could be seen as equally legitimate representations of reality. These studies often encourage the use of emergent data that can generate findings that conflict with existing assumptions about the world. For instance, Holmwood (1995) argues that this epistemology for feminist research will help to challenges patriarchal 'knowledge' about gender relations.

There has been a significant development in recent years in the application of a constructionist postpositivist epistemology to research (Game, 1989; Atkinson, 1990; Butler, 1990; Stonach and MacLure, 1997; Fox, 1999). This has led to new and radical ways of addressing methodological issues of sampling and selection concerns (Denzin and Lincoln, 1988; Atkinson, 1990; Hammersley, 1992). For instance, constructionist postpositivism searches for a range of perceived realities from the research participants, to be subjectively studied by an involved researcher. The researcher works with participants to search out their 'authentic' ways of understanding the world (Lincoln and Guba, 1985), in contrast with realist postpositivistic comparisons and negative cases (Denzin and Lincoln, 1988). The search for static social facts is replaced by developing a plausible interpretation of the behaviour and 'knowledges' of social actors in a particular social and political context.

The constructivist paradigm assumes a relativist ontology (there are multiple realities, a subjective epistemology (knower and participant cocreate understandings), and a naturalistic (in the natural world) set of methodological procedures (Denzin and Lincoln, 2000).

Methodology

Within the context of a constructionist epistemology, this thesis emphasises the importance of the following principles:

- the emergence of a research question from the natural study setting and participants (Fox, 1999)
- commitment to a range of different views including those from a reflexive researcher (Denzin and Lincoln, 1998)
- dialogical data analysis (Tyler, 1986)
- acknowledgement of the wider social and political contexts of the study (Reason, 1981)

Emergent research question

This study seeks to acknowledge multiple realities, by starting with a general research topic, as opposed to a limiting, pre-conceived hypothesis. This enables participants to influence the emerging research question, instead of it being restricted by the researcher (who is arguably the one participant who is most ignorant about the context of the research and who will be least affected by its outcomes). The subsequent research question can then be particularly relevant to the context of the study and lead to practical, beneficial outcomes for those involved.

Commitment to difference and reflexivity

The current study is concerned with health, which can be a very individual and subjective experience. As Bury (1997) writes *'Health and illness are intensely personal matters.'* It would be logical, therefore, to expect information about wellbeing to be highly complex and diverse. In contrast to deductive research, which attempts to test a preconceived hypothesis by merging findings into a single outcome, this study actively embraces unexpected data offering variety and difference. Instead of calculating answers by reductionism it adopts the postpositivist interest in posing questions via expansion.

Reason (1981) suggests that the acceptance of a *'heterogenistic viewpoint'* increases our understanding of our experience, other people and the wider outside world. He terms this as encouraging a *'collaborative encounter'*. Participant views are therefore viewed equally as each person has their own valid interpretation of the world. Because of this, one of the views that is respected in postpositivist research is that of the researcher. They are encouraged to reflect upon their own perspective since it is their description of the other participants' views that creates the final representation of the world being studied. Kvale (1992) argues that this approach *'...replaces a conception of a reality independent of the observer with notions of language as actually constituting the structures of a perspectival social reality'*.

The more the researcher can become integrated in the participants' sense of reality, the closer they can come to their experiences and descriptive language. It may

therefore be beneficial if the researcher has personal knowledge of the topic being investigated as in practitioner research. In health research for example, a researcher could also be a therapist. In contrast to the positivist criticism that this could introduce researcher bias, postpositivism argues that practitioner research can increase the strength of its results. It ensures, for example, that the researcher has expert knowledge of the intervention being studied, which could help them develop an appropriate research design to keep the therapy as natural as possible. Reflective practitioner research may also help the researcher be aware of the ways in which their presence has changed the natural environment being scrutinised, as suggested by the Hawthorne effect (Roethlisberger and Dickson, 1939).

Dialogical data analysis

Positivist and postpositivist epistemological approaches suggest different methods of analysing results and presenting conclusions. These differences might be summarised by suggesting that positivist research tends to focus on 'monologues' whereas postpositivist research emphasises the use of 'dialogues'.

Positivism is often associated with a natural science model that prioritises quantitative data. It has also been applied to qualitative research but faces criticism in its methods. For example, the lack of context has been cited as limiting its presentation of data. As Tyler (1986) suggests, positivism seems to have developed a science that has lost the '*...ethnographic context that created and sustained it...agreement among scientists became more important than the nature of nature.*' Positivism is therefore criticised for using rigid, factual discourse that does more to justify its own existence and suggest consensus among researchers than present descriptive, meaningful research.

Postpositivist research tries to keep the topic of investigation as the focal point of research, and claims that agreement between researchers and consensus of opinion is not just unnecessary but often impossible. Each study is unique and must be conducted in relation to its individual context and every 'self' needs to be studied in relation to their 'social processes'. Only then can descriptions, as opposed to representations, evolve from a variety of context-dependent texts

The social and political context of a study

Postpositivist approaches to research argue that '*...the self exists through its relations with others as part of the text of the world*' (Kvale, 1992). Research on '*the self*' cannot be done in isolation but in relationship to other people and the social, political contexts we live in. Constructionism emphasises this by claiming '*We do not construct our interpretations in isolation but against a backdrop of shared understandings, practices, language...*' (Schwandt, 2000). This could seem particularly relevant in this the current study topic of health and medicine.

...any system of medicine is practised within a social and political context and involves interpersonal transactions of a more or less institutionalised nature. These social dimensions are as much a part of medical practice as clinical knowledge (Sharma, 1992).

This research approach clearly contrasts with the positivist tendency to isolate the topic from its normal environment and subject it to controlled studies by an independent, objective observer. Postpositivist researchers claim that isolation from natural contexts undermines the validity of the research.

One cannot understand any psychological state without the capacity to experience it, nor any social situation unless one can get into the '*world-taken-for-granted*' perspective of those involved; yet at the same time as '*getting into*' the experience, the researcher needs to be able to maintain a perspective on it (Reason, 1981).

To summarise, the current study presents a postpositivist epistemology of research from a constructionist approach by enabling a research question to emerge from the natural setting, embracing different views (including those of myself as the practitioner researcher), analysing the data dialogically and considering the social and political contexts of the study. This approach involved utilising a variety of methods which are collectively known as 'Interactive Holistic Research' (IHR), (Cunningham, 1988).

Interactive Holistic Research

Interactive Holistic Research (IHR) was devised by Cunningham (1988) to describe a model of multi-method research. He argues that there is not '*one right way*' to conduct research so IHR depicts '*...a number of methods to provide a holistic framework.*' The working definition of 'holism' in chapter two described it as an approach which takes into account the whole of a subject/object and uses a variety of tools to look at its constituent parts and, most importantly, how they interconnect.

IHR requires the researcher to adhere to five different research principles:

- Collaborative research
- Dialogic research
- Experiential research
- Contextual locating
- Action research

These principles will now be described in brief, prior to their specific application in the current study in the method chapter.

Collaborative research

In collaborative research, the researcher does not dictate the development of the study. Instead, views of all participants are welcomed to embrace diverse, even conflicting evidence. This approach accommodates action-research and qualitative analysis that does not limit the research to the researcher's preconceived hypothesis.

Dialogic research

The main method of gathering data is from the dialogue of the *'two-person interaction.'* (Cunningham, 1988). This complements constructionist post positivism which claims that our world is created (or constructed) by the ways in which we think and talk about it to others. Dialogic research also supports qualitative methodologies that focus on personal meanings and interpretations of events.

Experiential research

Experiential research in IHR recommends that a researcher studies their own experiences in addition to those of others and is therefore also a 'subject' of the research as espoused by the reflexivity of postpositivist research. Experiential research also seems consistent with practitioner research where a health-care researcher may also be a therapist. As Cunningham (1998) states in IHR *'...experiential research is an essential feature of human science activity, and we as persons should learn to be effective researchers of our own experience.'*

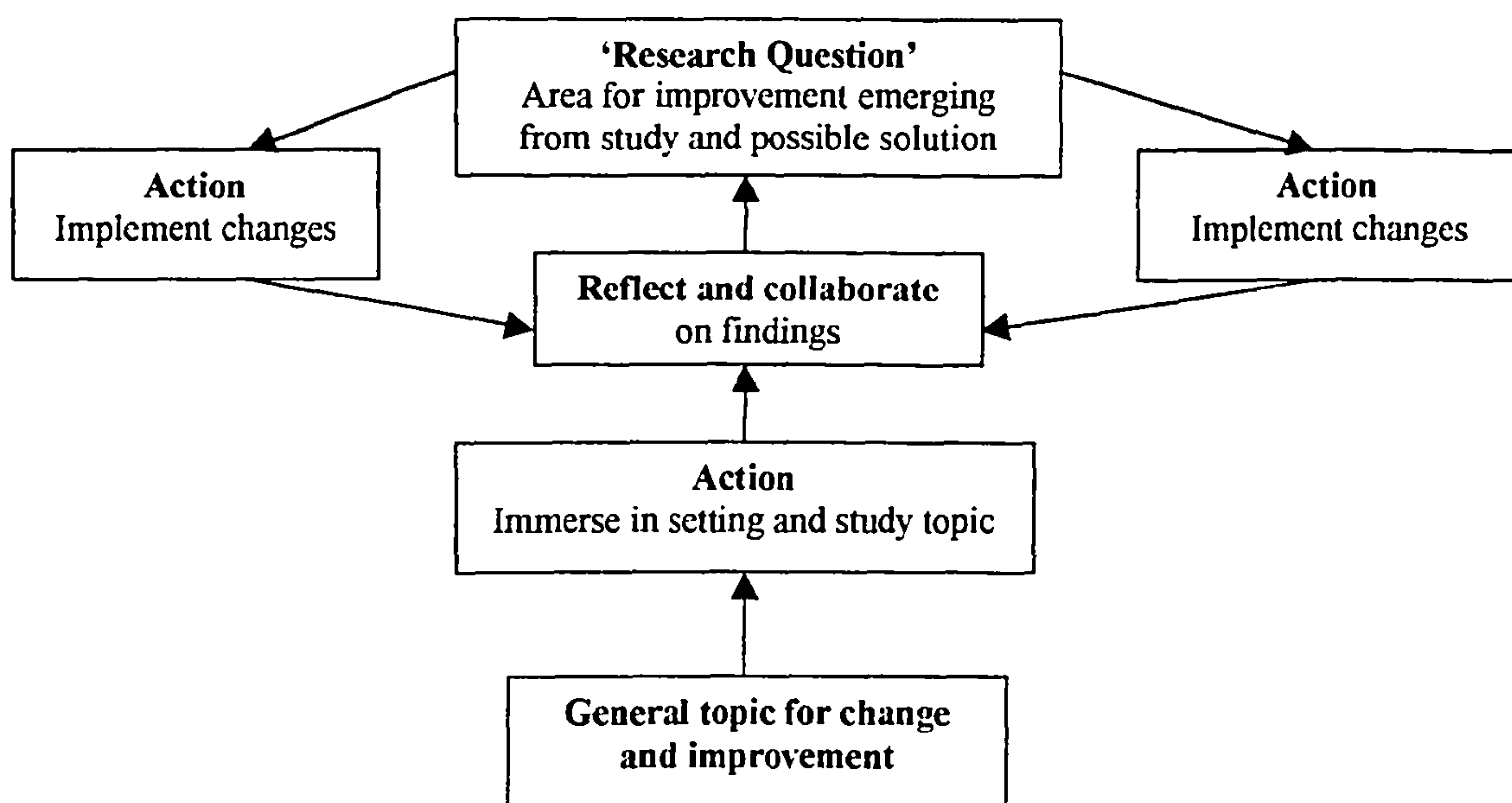
Contextual locating

The information gathered by a variety of methods influence and direct each other in an *'...iterative, to-and-fro process which provides the basis for testing and evolving theory'* (Cunningham, 1988). This provides a fuller picture of the participants, including the researcher's role and the social, political and interpersonal context of the study and can increase the research's 'credibility' (Lincoln and Guba, 1985).

Action research

Lewin (1946) introduced the term 'action research' to describe the study of social systems that aims to change and improve them. It follows a cyclical process of repeated data capture and analysis where the findings generate new stages of data capture and analysis until the data is saturated. This process is commonly depicted as a single circle. The following diagram instead attempts to represent how the findings from more than one action can help produce and refine a research question and study design.

Figure 5. Action research



Malterud (1995) describes the process of action research as focussing on...

...the study of a social situation, intended to improve the quality of action. The two central concerns - improvements in practice and increased knowledge and understanding - are linked together in an integrated and dynamic cycle of activities, in which each phase learns from the previous one and in turn shapes the rest.

The emphasis on the practical application of research supports the postpositivist strategy of bridging the theory-practice gap by conducting studies that may influence political and social structures, such as healthcare systems. For example, action research has been conducted on the care of older people in accident and emergency departments, (Meyer and Bridges, 1998); changing nursing practices (Rolfe, 1998; Titchen, 1993) and implementing clinical supervision in acute health settings (Lyon, 1999). A major benefit of using action research in health studies is its ability to help practitioners to reflect upon their work practices (as previously recommended) to choose areas for improvement and generate practical solutions. Advocates of using action research in health research include Ong (1993) who claims that recent changes

in the National Health Service to health care management and policy need to be assessed by a systematic approach to include users in the decision making process. This approach, known as 'rapid appraisal' is a form of action research that maximises user involvement in making and assessing changes.

An action researcher therefore engages in the world of the study, adopting a wide view of its possible development, allowing it to be influenced by the setting and its participants. The research is not restricted by a set hypothesis to be tested in a pre-defined way, and instead unfolds and adapts as it progresses. It aims to produce practical results which can be applied in a specific setting and involves the researcher as a participant in the study. Action research empowers these participants to ensure that those who may be most affected by the study are involved in its development. The group may then be more likely to feel ownership and acceptance of any suggested alterations, and be committed to their success. Bowling (1997) describes this as a...

...critical, self-reflective, bottom-up and collaborative approach to enquiry that enables people to take action to resolve identified problems. Action research involves a participatory and consensual approach towards investigating problems and developing plans to deal with them.

Action research therefore encourages practitioner research where those involved in social settings conduct the research into them. Bowling (1997) defines action research as very similar to practitioner research which is conducted by '*...participants in social situations to improve their practices and their understanding of them.*' In the context of the current study, I undertook practitioner research as a complementary practitioner. Pope and Mays (2000) suggest that practitioner research is particularly suited to action research in health care because of its ability to empower staff and help them improve their daily practices. Action research also ensures that a practitioner researcher continually reflects on their role via the intensive process of repeated data capture and analysis. Reason (1981) describes how this can strengthen the study's results.

Instead of a single cycle of data collection, there needs to be multiple cycles, where the theory, concepts, and categories are progressively extended and refined, differentiated and integrated, reaching towards a theoretical saturation. This is a rigour of clarity, accuracy and precision (Reason, 1981).

Practitioner action research therefore aims to incorporate process and content, and involve the participants in the changes that are produced. This was assisted in the current study by adopting a qualitative research methodology. This form of methodology will now be discussed by comparing it firstly to quantitative approaches and then by describing the specific form of qualitative analysis chosen for the current study, namely Interpretative Phenomenological Analysis (IPA) developed by Smith (1995b).

Quantitative methodology

Diebschlag (1993) notes that *'quantitative research emphasises the collection of numerical data and the statistical analysis of hypotheses proposed by the researcher.'* Traditional quantitative research tests a pre-conceived, theory-based hypothesis via statistical analysis to produce deductive conclusions. This process is known as the *'hypothetico-deductive method'* (Bryman, 1989) and is based within the natural science model of research. Concepts embedded in theoretical schemes or hypotheses are translated or 'operationalised' into quantitative measures to render them observable, manipulable and testable (Henwood and Pidgeon, 1992). Quantitative analysis is therefore linear and often conducted in an isolated, experimental setting. This is partly to minimise the effects of contamination of the data via 'confounding variables' to maximise the replication and generalisation of results. Quantitative research is also reductionist *'...seeking to look at just one part of a multifactorial situation'* (Diebschlag, 1993). When attempting to assess the impact of one variable upon another, or the relationship between two or more clearly defined variables, the intention is to minimise any other influences. Quantitative research is often intended to achieve replication and generalisation to other settings (external validity). Its aim is

therefore usually predictive, testing a large sample of respondents in exactly the same way and generalising results to similar populations.

The researcher seeks to be objective and detached – a neutral observer whose presence has little impact on the outcome of the research. Research is conducted to minimise contamination from the values or beliefs of the researcher (Ussher, 1992). The application of quantitative research in the social sciences has introduced the concept of ‘experimenter bias’ that may affect judgements in research, and several strategies have developed to reduce such contamination such as double-blind experiments and inter-observer agreements (Robson, 1993). The expectation is that with these strategies in place, objective, factual data can be assured. Whereas proponents of quantitative research claim that its strength lies in its rigorous approach and ability to be objective and make generalisations, critics claim this reifies reality and relies on the notion that a single truth can be established with scientific methods. Lazor (1998) argues that ‘...*the meaningfulness of the social world makes the application of scientific methods such as explanation by laws and causes inappropriate.*’ This suggests that research that utilises qualitative methods is also needed in health care research.

Qualitative Methodology

Schwandt (2000) claims that qualitative methodology describes a ‘*reformist movement*’ of interpretative, critical inquiry that emerged in the 1970s. This research approach was very different to that espoused by quantitative researchers. Qualitative research ‘reformed’ this deductive tradition based on hypotheses for a more inductive approach based on interpretation.

...in the past two decades, a quiet methodological revolution had been occurring in the social sciences; a blurring of disciplinary boundaries was taking place. The social sciences and humanities were drawing closer together in a mutual focus on an interpretive, qualitative approach to research and theory (Denzin, 2000).

Denzin and Lincoln (2000) describe this qualitative revolution as emerging before Schwandt's (2000) reformist movement and developing through seven stages. They suggest qualitative research first emerged in sociology in the 1920s with the Chicago school and in anthropology between 1900-1950. Both disciplines focused on the qualitative research of humans in their natural environment. This initial stage describes a 'traditional' form of positivism (1900-1950) which introduced the ethnographic practice of experienced researcher (usually a white, middle-aged male) conducting fieldwork in a foreign culture. Not surprisingly, this has since been seen as a dubious practice with racist, patronising connotations (Vidich and Lyman, 2000).

A classic example of racist connotations in research is hooks' (1990) criticism of the cover of one of the most famous books on ethnography, 'Writing Culture' (Clifford and Marcus, 1986). He claims that the picture depicts '*...two ideas that are quite fresh in the racist imagination: the notion of the white male as writer/authority...and the idea of the passive brown/black man who is doing nothing, merely looking on*' (hooks, 1990). This does not refer to the black woman and child who are even more obscured by the cover's graphics. Instead, they are ignored by both the original authors and their critic, which may be an interesting issue for feminist research. Silverman's (1997) book on qualitative methodology also seems to represent human research in a stereotypical form, with the cover depicting two male profiles suggesting both the researcher and respondent are white, adult males.

Apart from these changing issues of representation and political correctness, there are several characteristics of 'traditional' qualitative research that have remained as key principles of this approach. Firstly, the claim that research must '*treat social facts as things*' (Durkheim, 1967) by conducting empirical studies and therefore distinguish itself from the more philosophical approaches. This placed sociology and social sciences in general in a distinct, but equal paradigm to the natural sciences, and in opposition to philosophy.

Two other main tenets of qualitative research were established by Durkheim (1967) and classical anthropologists such as Malinowski (1964) and Mead (1923); the

inclusion of emergent data that was not expected and therefore pre-coded and a desire to study human activity in its natural context. This latter requirement is satisfied either by conducting research in the field or by studying events within their historical and cultural context. This is associated with generalisation in ethnographic research or '*...the process of 'totalisation', an operation whereby the ethnographer integrates the different observation sequences into a global referential framework*' (Baszanger and Dodier, 1997).

Denzin and Lincoln (2000) describe seven historical stages of qualitative research but warn that this does not mean that qualitative methodologies have developed via a linear progression of clearly defined categories; '*These seven moments overlap and simultaneously operate in the present.*' However, there are several tenets of qualitative research that seem to have withstood these changes over time. Silverman (2000) describes these characteristics as researcher '*preferences*' in the following list adapted from Hammersley (1992).

The preferences of qualitative researchers

1. A preference for qualitative data – understood simply as the analysis of words and images rather than numbers
2. A preference for naturally occurring data – observation rather than experiment, unstructured rather than structured interviews
3. A preference for meanings rather than behaviour – attempting 'to document the world from the point of view of the people being studied'
4. A rejection of natural science as a model
5. A preference for inductive, hypothesis generating research rather than hypothesis testing

This thesis describes four additional attributes of qualitative research that have been utilised in the current study. These will now be described in more detail.

1. A preference to utilise a variety of methods
2. A preference to conduct holistic research

3. A preference to be a reflective researcher
4. A preference to conduct culturally aware research

1. A preference to use a variety of methods

There are many methods that can be used by qualitative researchers, including case studies, interviews, focus groups, questionnaires, diaries, observation and time sampling. Flick (1998) claims that qualitative research inherently utilises this variety of methods. I would argue, however, that this is not a requirement of qualitative research as studies can use a single method. A benefit of using more than one method is that data can be compared and triangulated to deepen the richness of the findings. Flick (1998) argues that triangulation is not conducted to validate results since a single, objective reality can never be presented by research. Instead, it is utilised, along with multiple observers and perspectives to add depth, breadth and rigor to the representation of that 'reality'.

Richardson (2000) rejects the traditional image of triangulation in favour of a crystal that depicts more than three facets. The flexibility of qualitative research is further portrayed by the crystal's ability to grow and change as well as reflecting both its external and internal world. It can be seen as presenting a more holistic picture of the research topic than the more reductionist practices of positivist, quantitative research.

2. A preference for holism

There are many vibrant images like Richardson's (2000) crystal that are used to suggest the holistic nature of a qualitative researcher. For example, Denzin (2000) describes how the researcher '*...may be seen as a bricoleur, as a maker of quilts, or, as in filmmaking, a person who assembles images into montage.*' The bricoleur and quilt maker images describe qualitative research as the piecing together of varied representations of the reality being studied utilising different tools and methods. The form changes as each technique and associated interpretation is included until a final representation gradually emerges from this holistic process.

My personal analogy represents the qualitative researcher as a chef, rather like the *'bricoleur'* or *'professional do-it-yourself person'* (Levi-Strauss, 1966) who utilises a variety of skills to produce a dish. This *'emergent construct'* changes as new ingredients and cooking methods are used in a practice that is *'pragmatic, strategic and self-reflexive,'* (Nelson et al. 1992). Each flavour can affect and blend into another as with the 'montage' concept, so the final dish is much more than a collection of separate tastes. Again, like the montage, the meal can have a holistic effect, influencing all of the eaters' senses at one time with physical, psychological and emotional consequences.

The food analogy suggests the flexibility of qualitative research, as the final product can be a single dish or a huge banquet. It clarifies the relationship between the chef and the eater; both can be the same person as in practitioner research or postpositivist approaches to qualitative research where the researcher is also a participant. Alternatively, if they are different, both may experience the meal in very different ways. There is no single reality but multiple perceptions and experiences of the dish. In conclusion, the qualitative researcher as chef produces a complex product of simple stages perfecting a recipe to make the method explicit and aid transparency and replication.

3. A preference for a reflective researcher

Qualitative research is largely based upon meanings derived from participants by researchers in the field. It is recommended that the researcher reflects upon how their own beliefs and background may affect their interpretations and presentation of these meanings. Brown (1997) claims that an open declaration of one's interest and motivation, whilst adhering to self-reflection, can enhance the validity of a study.

4. A preference for culturally aware research

Denzin (2000) claims that *'...the interpretative bricoleur understands that research is an interactive process shaped by his or her personal history, biography, gender, social class, race, and ethnicity, and by those of the people in the setting.'* The gender, race, age and background of the participants (including the researcher)

therefore need to be reflected upon to enhance the social awareness of a research project and the practical application of its results. Nelson et al (1992) describes qualitative research as '*...inherently political and shaped by multiple ethical and political positions.*' Denzin (2000) supports this claim by arguing that '*...all research findings have political implications. There is no value-free science.*'

This social, political awareness could account for the popularity of qualitative methods in '*applied*' research; meaning that which produces '*actionable outcomes*' (Ritchie and Spencer, 1994) in areas such as social policy. '*What qualitative research can offer the policy maker is a theory of social action grounded on the experiences - the world view - of those likely to be affected by a policy decision or thought to be part of the problem*' (Walker, 1985). In this way the people most affected by the results of the study, can play an important role in defining the research focus and methods.

This chapter has described the main attributes of the qualitative research adopted in the current study. It will now introduce the specific form of qualitative data analysis that was used.

Interpretative Phenomenological Analysis

Smith (1995b) developed Interpretative Phenomenological Analysis (IPA) to find 'meaning' in the participant's mental and social world. These meanings are obviously not transparent, sometimes even to the participant, so the researcher can only ever have their own interpretation of what the participant meant. Smith (1995b) claims that it is this continual interpretative engagement with the data that led to the term '*interpretative phenomenological analysis.*' IPA therefore embraces both symbolic interactionism and phenomenology as theoretical touchstones in a rigorous approach to analysis. Smith (1995b) writes that symbolic interactionism...

...argues that the meanings individuals ascribe to events should be of central concern to the social scientist but also that those meanings are only obtained through a process of interpretation. It also considers that

meanings occur (and are made sense of) in, and as a result of, social interactions.

IPA therefore attempts to engage with and reflect the real world of the study as in phenomenology, but acknowledges that description must pass through a level of interpretation.

The aim of IPA is to explore the participants view of the world and to adopt, as far as possible, an 'insiders perspective' (Conrad, 1987) of the phenomenon under study. At the same time, IPA also recognises that the research exercise is a dynamic process. While one attempts to get close to the participants personal world, one cannot do this directly or completely. Access is both dependent on, and complicated by, the researchers own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity (Smith, 1996a).

This approach clearly supported the epistemology and methodology of the current study. The practical application of IPA during the data analysis is described in the following method chapter.

Limitations of qualitative methodology

Qualitative research has been criticised for not being as scientific as quantitative research and deemed as only useful in the exploratory stages of a study to assist the more highly regarded statistical analysis.

Qualitative researchers are called journalists, or soft scientists. Their work is termed unscientific, or only exploratory, or subjective (Denzin and Lincoln, 2000).

This reaction to qualitative research could be due to a rivalry between this approach and the positivist perspective (Carey, 1989). Silverman (1997) recommends a more co-operative '*...desire to search for ways of building links between social science*

traditions rather than dwelling in 'armed camps' fighting internal battles.' Until this is possible, qualitative research is seen as rejecting the research methods of the natural sciences and therefore criticised for being based on personal descriptions as opposed to factual statistics. Silverman (2000) claims that these narratives can pose...

...a troubling question: why should we believe what qualitative researchers tell us? How can they demonstrate that their descriptions are accurate and that their explanations hold water?

In other words, how do we know that the researcher and their results are not biased? While acknowledging that all epistemologies have limitations, qualitative research has responded to this argument by accepting that it does not seek objectivity. As already described, qualitative research explicitly calls for the immersion of the researcher's self in the study (Reason, 1996) and this an integral part of Interpretative Phenomenological Analysis (Smith, 1995a). Sword (1997) argues '*...this disclosure of how one is inherently enmeshed in the research enhances the legitimacy of new findings and new insights.*'

Assessment of qualitative research

Diebschlag (1993) claims that,

Quantitative research must be reliable and valid. In qualitative research, the reliability/validity are unknown, and may not be relevant.

The traditional quantitative concepts of reliability and validity are therefore rendered inappropriate in qualitative studies. However, some still try to assess rigour in qualitative research with these positivist constructs '*The logic and procedures of the natural sciences are taken to provide an epistemological yardstick against which empirical research in the social sciences must be appraised before it can be treated as valid knowledge*' (Bryman, 1998). Others claim that this '*yardstick*' simply cannot be the correct measurement for rigour in the social sciences. This is based on the argument that human action needs to be studied in a very different way to topics

analysed in natural science. For example, Westland (1978) describes psychology as requiring more reflective methods of analysis that include the activities of the researcher.

Despite arguments about relativism and subjectivism in the natural sciences there is a clear sense in which the physical scientist stands apart from the phenomena which he (sic) is observing. To treat events in the material world as being strictly determined creates few problems for the scientist himself (sic). A psychologist, however, cannot make explanatory statements about the objects of his investigations, i.e. human beings, which do not also apply to himself (sic) (Westland, 1978).

Ironically, Westland (1978) did not reflect on his own view of inclusion, and failed to write in a way inclusive of female participants and researchers! Sherif (1987) argues that often psychologists adopt natural science parameters for research rigour, as ways to demonstrate their successful achievement of 'knowledge'. Instead they should be developing new methodologies that can appropriately study human activity. Some social scientists have devised new constructs of reliability and validity to be used in the qualitative research of humans and their behaviour. However, I shall argue that these adapted definitions are reductionist and inappropriate bases for the current study's postpositivist approach to qualitative research.

Thus, Pope and Mays (1995) redefine reliability in qualitative research as assessing the researcher's account of the method and data but still as a measure of how much it can stand independently so that another researcher could analyse the data in the same way and come to the same conclusions. They claim validity is how plausible and coherent these conclusions are. These concepts for establishing rigour in qualitative research seem to be based on the earlier work of Lincoln and Guba (1985).

Lincoln and Guba's concepts of rigour

Lincoln and Guba (1985) introduced four new terms in qualitative research, namely credibility, transferability, confirmability and dependability. Credibility and transferability are related to the traditional constructs of internal and external validity, respectively. Confirmability measures how much the research conclusions are based on the researcher as opposed to the research and is the qualitative equivalent of objectivity, (Holloway, 1997). Finally, dependability assesses reliability in terms of how consistent and accurate the study is. Each of these concepts will now be discussed in turn.

1. Credibility

'Internal validity is seen as the most important aspect of validity, and in qualitative research it has priority' (Holloway, 1997). Lincoln and Guba (1985) rename internal validity as 'credibility' claiming it measures the 'truth value' of qualitative research. It therefore assesses how the enquiry was identified, how logical the findings are, and how accurately the study is described. For example, triangulation is recommended to test the trustworthiness of the results, by comparing different sources of data, methods or researchers.

The need for a detailed description of the study is reiterated by Marshall and Rossman (1989) who suggest that if the researcher can *'...adequately state those parameters...of setting, population and theoretical framework, the research will be valid.'* This description of the research process attempts to provide evidence that the participants and their world have been represented truthfully.

Internal validity is achieved when the researcher can demonstrate that there is evidence for the statements and descriptions made. The research is then open to public scrutiny (Holloway, 1997).

However, the concept of credibility assumes that there is a 'truth' to be uncovered by research. Constructionist postpositivism reminds us that reality is constructed and so 'incredulity' over the researcher's choice of data, analysis and subsequent conclusions

should be encouraged. Readers of research should '*...doubt that any method or theory...has a universal and general claim as the 'right' or the privileged form of authoritative knowledge*' (Richardson, 1998). The research is therefore presented in a way that invites its readers to participate in a dialogue concerning the 'truth' of the research.

2. *Transferability*

Lincoln and Guba (1985) define 'transferability' as measuring how much the findings in one setting can be transferred to similar contexts or respondents. Transferability is therefore, associated with the traditional concept of external validity. However, Lincoln and Guba (1985) state that the *new* researcher decides how transferable a study is – as opposed to this being the responsibility of the original researcher to 'prove', as in quantitative analysis. They argue that a 'thick description' is '*...necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility.*' Purposive sampling is also recommended to provide '*rich and specific information*' (Holloway, 1997). However, these decisions about replication of a study have been criticised for depending more on a personal and subjective basis than a '*rational-objective*' basis (Collins, 1985). There seems to be no clear criteria for judging the success of experimental replication, so this method for measuring validity, seems invalid itself.

Transferability may be particularly inappropriate in constructionist postpositivist research because of the assumption that validity can be tested by replication. Regardless of how scientific this replication may be, it is incompatible with the belief that each new researcher is an individual with their own unique world-views and research approach. As previously described, this will affect their handling of data, participants and the research process as a whole. Researchers may well deduce different findings from each other or from themselves with new samples in a different setting and time. Indeed, constructionist postpositivist approaches to research actively encourage diverse findings both between varied researchers and within one researcher's interpretation. A range of results could simply be seen as providing a

fuller picture of the research, and subsequently assisting the reader in developing their own subjective conclusions from the study.

The concept of validity, be it internal or external, is flawed in postpositivist research. *'The essential notion of a valid measure is that it is reaching out for some 'true measure' which is in the end unattainable; validity is always relative, sufficient for some purpose'* (Reason, 1981). This relative validity is also affected by its social and political environment. If a single, constant reality does not exist, research can not provide a unified, fixed representation of it. Reason (1981) claims instead that research is more transient and validity should look at the interpretative skills of the researcher.

...any notion of validity must concern itself both with the knower and what is to be known; valid knowledge is a matter of relationship... Validity in new paradigm research lies in the skills and sensitivities of the researcher, in how he or she uses herself as a knower, as an inquirer. Validity is more personal and interpersonal, rather than methodological (Reason, 1981).

From the researcher's perspective, this involves an awareness of 'counter-transference', referring to the risk of the researcher projecting their personal issues onto the world under study. This is associated with the concept of confirmability.

3. *Confirmability*

Confirmability assesses objectivity, measuring the researcher's influence in the research. Lincoln and Guba (1985) therefore recommend the use of an audit/decision trail to explicitly describe how the data was gathered and analysed. Another way of increasing objectivity is to actively look for data that conflicts with emerging patterns and theories. This is known as 'falsification' in grounded theory (Glaser and Strauss, 1967). Reason (1981) describes this as an *'...attempt actively and consciously to deny, contradict, disprove, the data which are available and the propositions about that data which he has developed.'* He argues that researcher bias underpins not just the concept of validity but methodology as a whole. *'Scientific methodology needs to*

be seen for what it truly is, a way of preventing me from deceiving myself in regard to my creatively formed subjective hunches which have developed out of the relationship between me and my material' (Reason, 1981).

The issue of confirmability causes particular problems with postpositivist approaches to qualitative research. This is because confirmability suggests that the researcher's impact on a study is negative and threatens bias. The opposing view is that this subjectivity is inherent in research and does not necessarily limit rigour. One solution is to view reality as neither subject nor object, but a continually changing process that cannot be divorced from the perceiver. Schwartz and Ogilvy (1980) replace the subject-object split with the concept of perspective. They define this as '*a personal view from some distance... (which) suggests neither the universality of objectivity nor the personal bias of subjectivity.*'

Any concept measuring objectivity is incongruent with the claim that research can only ever offer the researcher's view. It is not just a description of events but an explanation of phenomena, and this explanation is not the phenomenon itself. Instead, it has gone through a process of interpretation and therefore distortion. As previously mentioned, Smith (1995b) claims that qualitative research is concerned with meanings. I would argue that these meanings cannot easily be separated from the individual who presents them, nor are they unitary, fixed concepts that can be repeatedly tested to establish rigour (as suggested by transferability). Riley (1990) claims that '*...meaning is personal and events have different meanings for those present...meanings can also change with time.*' Each researcher can only provide their own timed interpretation of the participant's interpretations of their world and their reactions to it.

4. Dependability

Dependability is associated with reliability, referring to how consistent and adequate the results are. A researcher can suggest dependability via the audit/decision trail, detailing the decision-making process of the research as part of the thick description of the study. Readers can then conduct an inquiry audit and follow this process

(Holloway, 1997). The concept of dependability is consistent with postpositivist research, if seen as a way of making the data capture process transparent, to enable the reader to decide how dependable a study is, as opposed to testing for replication of results. The commitment that constructionist postpositivism has to complexity and difference ensures that each researcher and reader can hold varied conclusions about the results without this suggesting they are unreliable. Richardson (1998) claims that these researchers...

...are off the hook, so to speak. They don't have to play God, writing as disembodied omniscient narrators claiming universal, atemporal general knowledge; they can eschew the questionable metanarrative of scientific objectivity and still have plenty to say as situated speakers, subjectivities engaged in knowing/telling about the world as they perceive it.

The freedom and flexibility of postpositivist research does not mean that its researchers do not have to be concerned with establishing rigour and 'believability', but need adapted or new methods to do so. Richardson (1998) claims that this approach inherently focuses on the validity and reliability of research because it...

...suspects all truth claims of masking and serving particular interests in local, cultural and political struggles... it opens those standard methods to inquiry and introduces new methods, which are also, then, subject to critique.

Assessment of the current study

The quality of the current study will be assessed in the following ways;

1. Lincoln and Guba's (1985) concept of authenticity (further developed by Denzin and Lincoln, 1998).
2. Smith's (1996) specific recommendations for assessing Interpersonal Phenomenological Analysis.

3. The degree to which results are applied to practice and make a change (ideally a notable improvement) to the study setting and its participants, and inform methodology in future research.

The theoretical background of each assessment will now be described. The practical application of these assessments in the current study will be described in the following method chapter.

Assessment of authenticity

This concept refers to how appropriate the research strategies are in providing an 'authentic' account of the participants' world. Authenticity is therefore similar to the previously described concepts of internal validity and credibility but some subtle differences make it more appropriate for postpositivist action research and qualitative methodology. Kvale (1989) for example, defines validity in postpositivism as a process of checking and questioning one's data as opposed to '*...establishing rule-based correspondences between our findings and the real world*' (cited in Miles and Huberman, 1994). In rejection of the traditional measurement-orientated view of validity, Kvale (1989) claims it '*...becomes the issue of choosing among competing and falsifiable explanations.*'

Lincoln and Guba (1985) define authenticity as highlighting five main aspects of a study. Each will now be discussed in relation to their appropriateness to postpositivist action research and qualitative methodology.

1. **Fairness** – the respondents must be treated with respect and have consented to their involvement in the study. This supports a key principal of action research that subjects are treated as participants; respected as equals and empowered to play an active role in the research process. The respect could also extend to seeing the participants in a holistic manner, considering their social and interpersonal contexts as recommended in postpositivist approaches such as feminist research.

2. *Ontological authenticity* – participants are encouraged to reflect upon their human condition via the research, reiterating the aim of qualitative research of focussing on what it means to be human and the motivations and meanings that lie behind actions. This is also consistent with the reflexive nature of postpositivist research where all participants are required to address their own role within the study. This reflexivity has also been used to describe a key principle of action research, Fox (1999).
3. *Educative authenticity* – these participant reflections are aimed at helping them understand others. This again seems supportive of qualitative research, but also the holistic approach espoused in shiatsu of how understanding ourselves helps us to connect with and comprehend others. Action research also requires that study findings are not just used in the academic world but clearly applied in some beneficial way for the group being studied. As already described, action research can focus on raising awareness of social issues and understanding people's responses to them, thus satisfying this educative role of authenticates.
4. *Catalytic authenticity* – participants' reflections and decisions should be supported by the chosen research methodology. The current study enables this by eliciting all of the participants' views, including those of the reflective researcher, in its collaborative approach and eclectic use of methods. Action research encourages this inclusive approach and further uses its methodology to apply the participants' responses into the next stage of the study. In this way, their views and actions shape the continuing development of the research. This seems similar to the '*emancipatory*' action-research described by Carr and Kemmis (1986), that focuses on encouraging all to participate in the research process.
5. *Tactical authenticity* – once these decisions are made, they should inform the participants' actions. Holloway (1997) claims this process '*...should have an impact on their lives. The research should empower them.*' This concept summarises all those above that reiterate the need for the empowerment and

collaboration of all participants and the interpersonal and social application of findings in reflexive action-research.

Authenticity is therefore the yardstick for measuring a study's relevance and accuracy. The current study establishes authenticity by using an open research question that emerges directly from the study setting, involving all participants in the subsequent development of the question and research design and relating findings to practice. This maximises the relevancy of the study since it is conducted in collaboration with those most involved in the setting and affected by the findings.

The researcher's responsibility is to provide a rich account of how the data was gathered, analysed and conclusions drawn, in order for readers to make an informed decision about its authenticity. In this way, a 'thick description' is not provided to aid replication or transferability of the study, but to define the boundaries of the study setting and sample to place the findings in context. The reader can then decide how plausible these findings are, given the circumstances and contexts within which they were collected and analysed. As Adler and Adler (1989) suggest, once a written account of the study contains '*...a high degree of internal coherence, plausibility, and correspondence to what readers recognise from their own experiences and from other realistic and factual texts, they accord the work (and the research on which it is based) a sense of authenticity*'.

To summarise, authenticity relates to the truth-value of research in terms of how coherent, logical and credible the findings are. Regardless of whether other researchers gain similar results in replications, or how transferable/generalisable the study is, authenticity describes the accuracy of the study's depiction. In other words, '*...do we have an authentic portrait of what we were looking at?*' (Miles and Huberman, 1994).

Assessment of Interpretative Phenomenological Analysis

Smith (1996) suggests that '*internal consistence*' and detailed presentation of evidence can assess the quality of how Interpretative Phenomenological Analysis (IPA) has

been conducted. Internal consistence refers to the logical flow of the researcher argument that must be justified with data. In postpositivist action research, the aim is not to prove objectivity or confirmability but to include an appropriate amount of verbatim evidence to enable the reader to assess the final conclusions. As Osborn and Smith (1998) found in their IPA on back pain '*...the aim of validity checks on quantitative work is to ensure that the particular account presented is a sound one warrantable from the data, not to prescribe the singular true account of the material.*'

Assessment of the application of research

One measure of the quality in the current study will be the impact of the findings on the setting (the general practice) and the study participants. The aim is to assist change and encourage improvement in the practice and its systems. This may entail the development of a practical solution to a specific problem, or increasing awareness of an issue or empowerment in study participants. In addition, the study will be assessed in terms of its ability to inform future research methodologies for evaluating shiatsu in primary care.

Summary of the assessment of the current study

This chapter has suggested that both the traditional and revised measures of reliability and validity for qualitative research are inappropriate within the current study's epistemology. Three other assessments of quality have been suggested for use within this approach. However, all research, from all perspectives is subject to the skill of the researcher in identifying a relevant research question, adopting appropriate methodologies to best answer it and appropriate tests of quality to assess it. The reader's assessment of its quality is determined by the researcher's ability in documenting this research process. The next chapter will therefore attempt to assist the reader's interpretation of the study and its findings by presenting the method in detail, describing how it applies the research epistemology and methodology, and assessments of quality.

Chapter IV METHODS

This chapter sets out the current study by describing the research question and study design. It will then illustrate how this method is consistent with the epistemology and methodology described in the preceding chapter. Finally, the research will be assessed in terms of its authenticity, use of qualitative analysis and application of results.

The research question

What is the impact of delivering shiatsu in an inner-city general practice?

Concepts and indicators

- '*impact*' = any changes in the general practice that the patients, GPs and practitioner researcher associate with the shiatsu clinic
- '*delivering shiatsu*' = treating ten patients six times each in a shiatsu clinic one day per week from January to June 2000
- '*inner-city general practice*' = Hanson Medical Centre situated in a deprived council estate in the north of Sheffield, England (a pseudonym has been used to protect confidentiality)

Research aim

To deliver a shiatsu complementary medical clinic in an inner city general practice and research its impact on the organisation, participants (patients and staff) and the practitioner researcher.

Research outcomes

- Description of the *impact* of the shiatsu clinic on the general practice and the GPs, the patients and the practitioner researcher
- Development of *methodology* for researching shiatsu in general practice, including piloting of specific evaluation tools
- Consideration of the *limitations* of the study
- Recommendations for *future research*

Study design

To answer the research question ‘What is the impact of delivering shiatsu in an inner-city general practice?’ a shiatsu clinic was delivered in Hanson Medical Centre (a pseudonym) in an inner-city area of Sheffield. Two clinics were delivered each lasting eight hours a week. The first clinic ran for seven weeks and the second ran for eight weeks between January and May 2000. Ten patients were referred by the four GPs and were treated by myself as the shiatsu practitioner. The patients had six hour-long shiatsu treatments in consecutive weeks and three interviews, one before and after attending the clinic and one at the two-month follow-up.

The data capture involved recording characteristics of patients attending the clinic; any changes in patient health and consultation rates; and the experiences and satisfaction of patients, staff and the shiatsu practitioner involved in the clinic. Since the main focus of the study was to ascertain the personal experiences of all involved in the shiatsu clinic, the appropriate methodology was therefore predominantly qualitative. This involved thirty semi-structured interviews with patients with each patient having three interviews.

Ten interviews were conducted by the practitioner researcher pre-intervention before the patients’ first shiatsu and ten were conducted by the external researcher post-intervention, one week following their last shiatsu treatment. The ten follow-up interviews occurred two months after the last treatment. Six interviews were conducted with the four referring GPs with each GP having one interview each for the first clinic and two having a second interview to discuss the patients they had referred to the second clinic. Qualitative analysis was also conducted on ten patient journals and the complementary practitioner’s reflective diary and clinic notes.

Two previously validated quantitative tools were used in this study design to pilot their use in a general practice setting. The analysis therefore focused on the viability of using the instruments in general practice, which included an assessment of the data gathered. The tools were the SF-12 (Ware et al, 1995) and the MYMOP2 (Paterson, 1996) that was slightly adapted by the original author and myself for use in the

current study. The resulting instrument is referred to as the MYMOP-PIRIE (see page 112). The SF-12 is a shortened version of the validated SF-36 Health Survey, which measures outcomes and is completed by the patient. The SF-12 was completed pre- and post-intervention and at the two-month follow-up. The MYMOP-PIRIE is also self-administered, but the patient decides which symptoms they wish to rate over time. The MYMOP-PIRIE was completed in every consultation and at the follow-up. The two instruments were also used to provide patients with a formal way of assessing any change in their symptoms and perceived quality of life. The findings could be triangulated with the patients' interview comments and the clinical views from the referring GP and shiatsu practitioner.

Quantitative data was also gathered by calculating the number of appointments made by the patients during the eight weeks before, during and after receiving shiatsu. The small numbers of patients in this study obviously means the results of the quantitative data can not be generalised to wider populations. However, it can help to describe more accurately the ten patients who were involved to complement their qualitative data. Much larger numbers of participants would have been required for detailed statistical analysis of the quantitative data and this would have been incompatible with the current research question and consequent research design.

Referral procedure

To encourage multi-disciplinary work, all the clinicians in the practice were invited to make referrals to the shiatsu clinic. This team consisted of four GPs and five nurses (two practice nurses; one health visitor; one midwife and a district nurse). The referral procedure was discussed at the practice meetings to ensure group ownership and maximise compliance. The agreed guidelines (see appendix III) were given to all of the clinical staff at Hanson. These detailed the following inclusion and exclusion criteria for appropriate referrals.

- **Inclusion criteria:** patients who present with non-specific physical symptoms without a diagnosed organic cause. A typical patient could be suffering from chronic (over six months) muscular-skeletal pain such as back/headaches or non-

specific digestive symptoms such as irritable bowel syndrome or pre-menstrual tension.

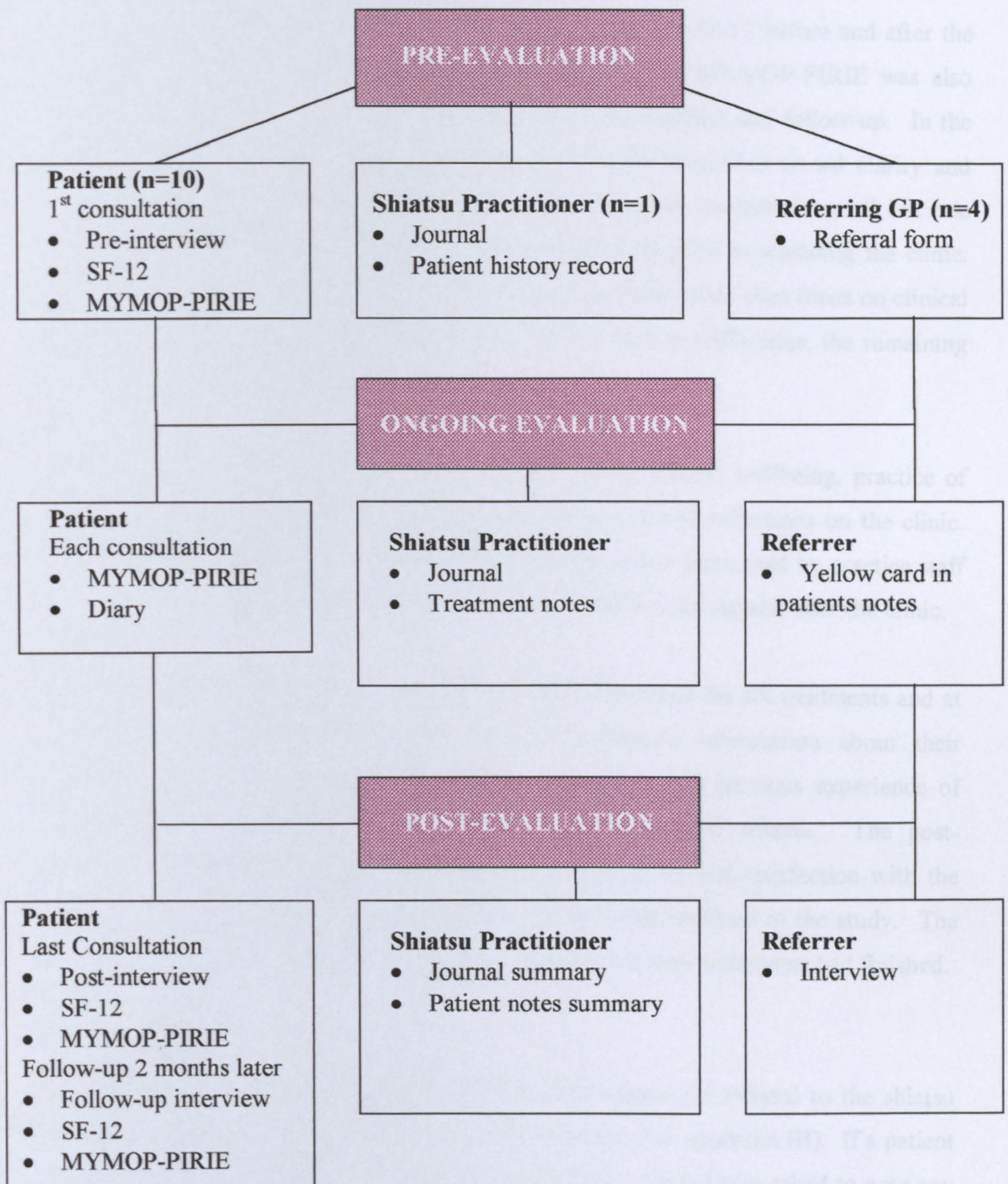
- **Exclusion criteria:** under sixteen, diagnosis of cancer, a terminal illness or severe psychological disorder such as schizophrenia, women wishing to become pregnant or who are in the first trimester of pregnancy, existing involvement with a separate back-pain study in operation in the general practice and exclusion at the discretion of the attending clinician. These criteria also conformed to the Shiatsu Society (UK) guide to professional practice.

The research project was discussed with the patient at the time of referral by the clinician and written consent requested. The patient was given a leaflet describing shiatsu and the research in more detail and was asked to make six, weekly appointments for the clinic at reception. Practice staff telephoned patients prior to starting the clinic to remind them of the appointment time to maximise attendance. A short-notice waiting list was held to fill any unattended appointments.

Evaluation procedure

This section discusses the evaluation procedure of the current study, which is presented in the following diagram.

Figure 6. Evaluation procedure



Patient evaluation

The first ten patients who were referred to the shiatsu clinic were successfully recruited to the research and all completed the study. The impact of the shiatsu clinic on patients was ascertained by the self-completion of the SF-12 before and after the series of treatments and the two-month follow-up. The MYMOP-PIRIE was also completed by the patient, but at the start of each consultation and follow-up. In the first consultation, both forms were filled in with the researcher to aid clarity and provide assistance for future completion. In subsequent consultations, all but one patient filled in the questionnaires in the waiting room prior to attending the clinic. This saved valuable time in the treatment sessions, which could then focus on clinical issues instead of the research evaluation. Due to literacy difficulties, the remaining patient preferred to dictate her responses.

The patients were given a diary to record symptoms, general wellbeing, practice of any exercises recommended by the shiatsu practitioner and reflections on the clinic. The researcher did not have access to patient notes, which were used by practice staff to record consultation rates during the two months before, during and after the clinic.

Semi-structured interviews were conducted before and after the six treatments and at the two-month follow up to gain detailed qualitative information about their experiences. The pre-intervention interview discussed any previous experience of complementary medicine and the patients' expectations of shiatsu. The post-intervention interview ascertained the patients' experience and satisfaction with the clinic and was conducted by a researcher not otherwise involved in the study. The follow-up interviews elicited the patients' progress after their treatments had finished.

GP evaluation

GPs completed a referral form detailing the main reason for referral to the shiatsu clinic and the benefit they hoped to see in their patients (see appendix III). If a patient consulted with a GP while attending the shiatsu clinic, the GP was asked to note any impact they thought the shiatsu had on the patient on a yellow card that was kept in the patient's notes. The card was also used for clinicians to record personal views on

the clinic and help them provide feedback in the semi-structured interviews that took place a few weeks later. The external researcher conducted the interviews after the patients had stopped attending the clinic.

Practitioner researcher evaluation

As the shiatsu practitioner, I completed a reflective diary on the running of the clinic. This was written at intervals during each of the clinic days at Hanson to record the days events and my reactions, as well as reflections in between clinic days. A medical history sheet was completed with each patient during the first consultation and treatment notes were written after each session to record diagnosis and treatment and any changes in signs and symptoms.

Data collection

Qualitative methods

Semi-structured interviews

The current study used semi-structured interviews as the main method of gathering qualitative data. They were chosen instead of structured interviews for the following reasons. Semi-structured interviews are more flexible than structured interviews, allowing the researcher to follow the participant rather than dictate the direction of the interview. This meets the principles of the chosen epistemology and methodology of the research already described. For example, a requirement of Interactive Holistic Research (Cunningham, 1998) is that the participants help to influence the development of the study, and this can be encouraged by them playing a role in directing the interview. Semi-structured interviews enable the participants to give a fuller picture of their experience and this can help the researcher elicit a richness of themes that are not limited to pre-existing, quantitative categories. Smith (1995) claims that semi-structured interviews help the participants suggest their 'ongoing self-story', by describing their own reality and representation of their psychological and social world.

The flexibility in semi-structured interviews can help them feel more like a natural conversation between researcher and participant than a formal question and answer

session. Rapport can be established that promotes honesty and disclosure so the interaction can be less stilted than structured interviews. The order of questions can be more natural and the researcher can follow themes that emerge spontaneously and are of importance to the participant. In this way the interview is led by the participants' concerns and therefore closer to their sense of reality. Again, this can be seen to complement the epistemological and methodological approach described in chapter three.

Finally, the rigidity of structured interviews can cause the researcher to miss important views of the participant, as the interview is limited to pre-determined questions that are given to every participant in the same order. This reflects the researcher's priorities and themes and not the participant's. In contrast, semi-structured interviews try to balance questions that pertain to predetermined topics and also ones that emerge during the interaction, (King, 1994). Structured interviews can be 'colder' and less likely to gain rich data, especially personal and complex information.

The three main disadvantages of semi-structured interviews are that they take more time than structured interviews, the researcher has less control, and they are harder to analyse (Smith 1995). They are criticised for being less rigorous than more structured interviews but as Reason (1981) suggests,

We need to make the first and most open-ended part of the research subject to a rigour and stringency which should apply to the whole project. This is a rigour of softness, of discovery, of turning things over...there needs to be an approach which deliberately opens up the area, and gives explicit permission to explore usually unacknowledged realities.

This approach to research supports that espoused in the current study, as described in the previous epistemology and methodology chapter. Semi-structured interviews were therefore used in the current study to provide a detailed picture of participants' experiences of the shiatsu clinic. Firstly, a schedule for each interview was produced in collaboration with an experienced qualitative researcher to 'brain-storm' what each

interview may include. Smith (1995) claims that this helps anticipate problems in the final draft. The schedule then developed into an interview guide, again with assistance from the expert. Following the study's research approach the questions were designed to facilitate, rather than dictate the interview. The questions were also organised into a logical order with more sensitive topics being discussed towards the end. General questions to 'trigger' the interview were allocated specific prompts to assist the researcher if necessary. This is termed 'funnelling' to encourage participants to discuss the topics with the least intervention as possible from the researcher (Smith, 1995).

There were several revised versions, piloted on private shiatsu clients, as well as research colleagues and supervisors. In this way, the development of the interviews was iterative and not linear (following a principal of action research) with ideas changing as new information emerged. The wording and order of the questions were also finalised via this piloting process to maximise clarity and sensitivity. To allow space for following novel ideas, the order of the questions was not rigid and questions could be omitted altogether if the information had already been provided. Once the final draft was produced, it was memorised so each interview could be as natural as possible (see appendix III). At the end of each interview, participants were asked if there was anything else they wished to discuss. An outline of each type of interview will now be presented.

1. Pre-intervention interview with patients

Pre-intervention interviews were conducted by myself as the practitioner-researcher with each of the ten patients. These interviews took place before the shiatsu treatment began. For the first set of five patients this was conducted at the start of their first treatment session. To minimise time constraints within the consultation, the second set of patients completed the pre-intervention interview in a separate meeting one week prior to their first treatment. This enabled me to deliver a full shiatsu treatment without running over the allocated time because of data collection.

The pre-intervention interview guide covered the following main issues with each patient.

- Existing experience with shiatsu and other forms of complementary medicine
- Initial reaction to being offered shiatsu
- Hopes and expectation about attending the shiatsu clinic
- Concerns about attending the clinic

2. Post-intervention interview with patients

The external researcher conducted the post-intervention interviews with each patient (n=10) in a designated room in the general practice. The interviews took place roughly one week after the patients had ceased attending the clinic. The post-intervention interview for patients discussed the following topics;

- Changes in their health and wellbeing since having shiatsu and attributions of change
- Changes in any appointments they may have had with GPs or nurses in the practice and again, attributions of change
- What they liked and disliked about shiatsu
- Expectations about receiving shiatsu and how far these were met
- Satisfaction with the treatment they received from both the shiatsu practitioner and the other staff at Hanson
- Recommendations they may have made to others about having shiatsu
- Feedback on the evaluation procedure
- Suggestions for improving the clinic
- Possible reasons why people do and do not use complementary medicine

3. Post-intervention interview with GPs

Again, the external researcher conducted these interviews with the four referring GPs once their patients had stopped receiving shiatsu.

The post-intervention interview with GPs discussed the following issues;

- Existing experience with shiatsu or any other kind of complementary medicine
- Reasons and expectations of referral and how far these were satisfied
- Perceived changes in the patients' health since having shiatsu and attributions of change
- Perceived changes in any appointments they may have had with the patients and again, possible causes for any changes
- Reflections on the evaluation procedure including what additional feedback they would have welcomed and from whom
- Views on any impact the clinic may have had on the general practice
- Positive and negative aspects of offering shiatsu in the practice
- Satisfaction with the clinic
- Other patients and symptoms they may recommend shiatsu for
- Beliefs about what shiatsu is
- Suggestions for improving the clinic
- Thoughts as to whether shiatsu should be offered in general practice and if so, how
- Suggestions for the integration of complementary medicine and orthodox medicine in general practice

4. Follow-up interviews with patients

Each patient was contacted by myself two months after their post-intervention interviews to ask about their health and continuation of any recommendations given and complete the final questionnaires.

Reflective journal for patients

The aim of the patients' journal was to encourage them to reflect on the experience of the shiatsu clinic and note any changes they may have occurred in their health and lives in general while they participated in the study. The journal was consequently piloted for use in general practice as a method for gaining patients' on-going self-reports of health and treatment.

Reflective journal for the practitioner researcher

My practitioner researcher's journal was used to log supplementary notes to the shiatsu treatments and the interviews that I conducted with patients. It included my reflections on delivering shiatsu in a general practice and listed action points for me to complete each week. In this way if I had an idea while at the clinic I could record it to act upon later. The journal was also used to pilot the method of reflective practitioner research in complementary medicine.

Yellow Cards

A yellow card was placed in the clinical notes of the ten patients who were attending the shiatsu clinic (see appendix III). The aim was to collect ongoing information about the patient's health and shiatsu treatment during any consultations that they made with GPs during the study. The cards could then be used to help GPs remember any salient issues in their post-intervention interviews with the external researcher.

Shiatsu Forms

These forms included a client history record, completed at the first appointment, and an ongoing treatment record. The treatment form was completed during each appointment with the patients to record their health and a detailed description of the treatment given each week. They helped me as the practitioner make a shiatsu diagnosis of the patient's symptoms and develop an appropriate management plan. Both forms had already been extensively piloted in my private practice and were also used in the study to assess their transferability in general practice. They are included in appendix III.

Quantitative methods

Two brief instruments were used to pilot methodologies in studying complementary medicine in general practice and to assess the possibility of triangulation of data. Because of epistemological stances and sample sizes, the quantitative data is not used to assess the impact of shiatsu.

SF-12

The SF-12 (Ware et al, 1995) is a short version of the SF-36 Health Survey (Ware et al, 1993) and provides an indication of health status and calculates physical and mental health scores over time. It was developed to provide a faster version of the SF-36, based on the finding that physical and mental health factors accounted for 80-85% of the reliable variance in the eight scales of the SF-36. This was found in both patient and general populations in several other countries including America (Ware et al, 1993; McHorney et al, 1993).

The SF-12 was completed three times by each patient. The form involves twelve short multiple-choice questions and only takes approximately four minutes to complete.

MYMOP-PIRIE

The MYMOP-PIRIE is a slightly adapted version of Paterson's (1996) Measure Yourself Medical Outcome Profile (MYMOP2), which is a patient-centred measure of health. As with the SF-12, it can be used to show change over time, but the patient completes it every week. A second difference from the SF-12 is that the MYMOP2 is 'symptom-based' or 'problem-specific' in terms of patients choosing two symptoms they wish to rate each week. They are also asked to rate their general feeling of wellbeing and an activity (physical, social or mental) that their health is hindering. Finally, views on medication are elicited in a multiple-choice question (this addition distinguishes the MYMOP2 from the first MYMOP that did not ask about medication).

All of the original questions in the MYMOP2 were also in the MYMOP-PIRIE version in exactly the same order to aid comparison. Two adaptations of the MYMOP2 were made in consultation with the original author. Firstly, the term 'emotional' was added to the list of possible symptoms that participants could choose to rate (originally described as 'physical or mental'). Secondly, participants were asked to describe how long they had had *both* symptoms (the original form asked just for the duration of symptom one) and rate what improvement they would be satisfied

with for both symptoms at the end of their course of shiatsu. These forms are again included in appendix III.

The MYMOP-PIRIE was used in the current study to pilot its use in general practice and elicit changes in health from the patients' perspective. This tool seemed supportive with the research approach of the current study and the complementary medicine intervention of shiatsu. This is because the MYMOP-PIRIE encourages the participant to lead the data collection by describing symptoms of their choice in their own words, and the MYMOP2 has been successfully piloted in other studies of complementary medicine (Paterson, 1996; Paterson and Britten, 1999). The form takes about five minutes to complete and both of Paterson's studies have found it to be practical, reliable and sensitive to change when used by GPs and complementary practitioners. These claims are based on validation of the MYMOP2 with the SF-36, the EuroQol and the Medical Outcomes 6-item General Health Survey (MOS-6A). An additional benefit of using the questionnaire is that the scores are easy to calculate, in a much simpler and faster way than the SF-12 for example.

Consultation rates

The calculation of consultation rates in the patients attending the clinic enabled the comparison between GP and patients' estimates on the frequency of consultations and also between these estimates and records of consultations actually held. The administration staff at Hanson kindly accessed these patient records and calculated the number of appointments attended for the two months prior to having shiatsu, during the clinic and the two months after it had ended. This quantitative data could then be compared with the qualitative data on changes in consultations from the interviews.

Data analysis

Interview analysis

Each interview was taped with the participant's consent and then transcribed. All of the interviews with the GPs and the pre- and post- interviews with patients took place within their general practice, and two of the follow-up interviews were conducted over the phone for the patient's convenience. There were a total of thirty-six

interviews that were analysed in this study lasting approximately forty minutes each. I transcribed ten interviews to gain an insight into the data being generated and an administrator who was not otherwise involved in the study transcribed the remaining interviews. In addition to a verbatim copy of the interview, the transcripts contained a margin on either side of the text for notes and each line was numbered for reference. The transcripts were then analysed using Interpretative Phenomenological Analysis as recommended by Smith (1995b). This will now be described in more detail.

Interpretative Phenomenological Analysis in the current study

Interpretative Phenomenological Analysis (IPA) (Smith, 1995b) was suited to the current study because it follows a clear process which helped keep the varied sources of data manageable. It also enabled the detailed exploration of the participants' individual experiences as well as identifying any common responses. As already described, IPA focuses on the participants' beliefs and feelings, viewing these accounts as grounded in an experienced reality but affected by the interpretative process of the researcher. The analysis of data was therefore conducted in the following manner.

The first stage of analysis was to elicit themes from the interview transcripts. Smith (1995a) recommends an idiographic approach to this initial analysis, starting with specifics by focussing on one transcript and '*only slowly working up to generalisations*'. This suited my attempt to get closer to each individual's experience and reflection of their healthcare during the study. I therefore began by reading and re-reading one interview whilst making notes in the margin on the transcription. Following Smith's advice, these notes were interesting observations on the text, summaries of passages and preliminary interpretations. The column after the text was then used to note any emerging themes, using key words to describe the possible main meanings in the interview. A highlighter was used to identify extracts in the text that related to each theme. These themes were then written on a separate sheet to be compared and grouped where necessary.

Each time a new theme 'cluster' emerged, it was referred back to the original text to ensure its validity. In this stage, Smith (1995a) writes that *'You are now attempting to create some order from the array of concepts and ideas you have extracted from the participant's responses.'* This order described 'cross-patient' and 'cross-GP' themes that described accounts reflected in each group's responses. My interest was not only with the majority views of groups, but diverse opinions of any individual. This is consistent with the search for difference in postpositivist qualitative research described in chapter three. I therefore also produced individual themes, where a participant presented a unique, but relevant account to be analysed. Commonalities and differences between the responses could then be identified.

Once the final list of themes was produced to reflect the participants' main concerns an 'identifier of instances' was added. This identified where each key theme could be found in the text. I listed the line numbers that included relevant quotes under each theme heading and highlighted the extracts in the original text. This ensured that the themes were repeatedly checked and refined against the original instances of each theme in the participants' own words. As Smith (1995a) describes *'analysis is a cyclical process'* and several themes were adapted as the data was re-assessed. The themes therefore continued to evolve as each transcript was analysed and every new cluster or amended title was checked against the other transcripts to ensure its validity in expressing the participants' main concerns. The resulting themes are presented in a table at the beginning of the three first sections of the results chapter.

This section has attempted to present the process of IPA as a structured form of qualitative analysis that is clearly defined and relatively simple to replicate. It is not, however a purely 'mechanical' or objectively scientific process devoid of any human interpretation. As the name suggests, it is a method of applying these personal, often subjective interpretations in a structured approach to elicit the meanings that may lie behind another person's responses. It enables a rich understanding of the findings by requiring the researcher to repeatedly read transcripts until they are almost learnt by heart and continually refining intelligent guesses at what the participant is saying. Smith (1995a) claims that...

...what will determine the value of the analysis produced is the quality of the interpretative work done by the investigator. So it is important to be systematic but it is also important to be analytical, creative (and hopefully insightful).

From epistemology to method

The current study aimed to assess the impact that delivering a shiatsu clinic would have on a general practice. This involved evaluating the personal experiences of patients and staff, including myself as the practitioner and researcher, and any changes in the organisation. The epistemology described in chapter three and method presented here therefore describe the most appropriate research approach to this topic of investigation. For instance, it encouraged the practitioner researcher to act as both a practitioner and participant in the study and consider the setting's social and political contexts. The use of action research enabled the research question to emerge directly from the study setting and its participants, and maximised the input these participants had in the development of the research and delivery of the shiatsu clinic. Action research also helped apply theoretical research to working practices, to assist the political and social relevance of research.

The aim of the study was not to produce objective data on clinical effectiveness or outcomes, but to gain meanings and experiences of all those involved in the shiatsu clinic. Methodologies other than quantitative ones therefore had to be adopted as *'...there has been a recognition that excessive emphasis on quantitative data and experimental designs place severe limitations on what is researched'* (Diebschlag, 1993). Hence the justification for using qualitative methods in the current study to elicit the personal experiences of the participants. This was done via Cunningham's (1988) model of Interactive Holistic Research (IHR). He recommends that research should be collaborative, dialogic, experiential, contextual and utilise action-research. This will now be examined in more detail.

Application of Interactive Holistic Research in the current study

1. Collaborative research

Collaborative research refers to the 'subjects' in a study being treated as 'participants' who are empowered to play an active role in the research process (Cunningham, 1988). This was promoted in the current study by engaging with the staff and patients in their normal context of the general practice, to access the issues most important to them and develop a relevant research question. This adheres to the principles of inductive and hypothesis-generating research found in both action-research and qualitative methodology (in chapter three). The research proposal was discussed in the monthly practice meetings that were attended by the administrative, management and clinical staff. This ensured that all members of the team discussed how to make appointments and appropriate referrals to the clinic and evaluate their progress. The aim was to maximise the shiatsu clinic's effectiveness for patients and staff and minimise any additional work the project may place on the team. Feedback from the patients and staff also led to adapting the clinic for its second delivery.

2. Dialogic research

The study's epistemology emphasises the use of dialogues in research and qualitative analysis of meanings and interpretations of naturally occurring data (as described in chapter three). This was adhered to by gathering qualitative data in the field to gain an interpretation of the participants' meanings in their own words. Data collection utilised semi-structured interviews with patients and GPs, and documentary analysis from the patients' and researcher's diaries. The interpretations of this data utilised Interpersonal Phenomenological Analysis (Smith, 1995a).

3. Experiential research

Experiential research requires that the researcher consider their role within the study (Cunningham, 1988). This supports the reflexive researcher espoused in practitioner research and postpositivist qualitative research. As a practitioner researcher I reflected upon my role as the shiatsu therapist and the lead researcher, and considered how my beliefs may influence my interpretation and presentation of the results. I listed my preconceptions of the study in chapter six, section three and appendix V and recorded

my ongoing experiences of the research in a reflective journal. This enabled me to undertake Ashworth's (1987) strategy of '*reflecting on fore-understanding*', by reassessing my preconceptions of the research in the light of data gathered in the study. This involved revising the conceptual models until coherence was gained in the final reported findings and describing in detail the interpretative models that were used to derive the data's themes, see chapter three. The continual reflection and alteration of the study aimed to ensure that hypotheses and preconceptions of the study did not limit its progress. This was helped by the collaborative research previously described, ensuring that the study was not directed solely by myself as the practitioner researcher.

4. Contextual locating

This refers to the interconnected analysis of the data gathered by a variety of tools and methods (Cunningham, 1988). As already explained, the research question focussing on the impact of shiatsu and the personal experiences of participants required a predominantly qualitative approach. This allowed the deepening of knowledge of meanings behind the behaviour of the patients and the GPs involved in the clinic. These findings were enriched with simple calculations of quantitative data. Layder (1993) claims that the role of quantitative data in a mixed method study is to complement the qualitative exploration of concepts and theories. For example, in the current study, consultation rates were calculated from the patients' notes. They were compared and contrasted with participants' perceptions of consultations to deepen the resulting interpretation of the findings. In addition, the study utilised existing literature, questionnaires, interviews and reflective journals, and the data gathered from these various methods was seen in relation to each other.

The interconnected analysis of the research methods provides a fuller picture of the participants' experiences (including my own), and the social, political and interpersonal context of the study. These social dimensions were acknowledged in the current study in three main ways. Firstly, the research environment was kept as natural as possible to elicit relevant contexts. Secondly, I reflected upon these contexts by describing in detail the sample and study site (see chapter five). Lastly, I submerged myself, as the practitioner researcher, into this environment so my

experience was as similar as possible to that of the other participants. For example, the shiatsu was offered 'as delivered' in private practice, following Parry's (1999) recommendations for qualitative research. Parry claims that this adherence to reality enables the researcher to study how best to deliver a treatment in terms of its frequency and duration. This methodology also assists equality and does not deprive patients of services and choice as traditional randomised controlled trials might.

Contextual locating also satisfies Parry's (1999) preferences of qualitative research that describe the study of naturally occurring data from the perspective of those being studied. To submerge as much as possible in the natural context of the study, the current research concentrated on one site and chose the normal setting where GPs and patients discussed healthcare. It is common in qualitative research to focus on small sample populations and concentrate on a single case or context. In the current study, the sample size was ten patients, four GPs and one shiatsu practitioner, and a single context was used in terms of analysing one general practice. It therefore utilised a small number of research participants to gain in-depth descriptions, as opposed to large numbers of significant statistics to make generalisations as in quantitative research.

The use of several methods and contextual locating seems similar to triangulation that utilises '*an arsenal of methods*' to '*attack*' a research problem from several different angles (Brewer and Hunter, 1989). Since the methods used in the current study involved more than three approaches, the term 'crystallisation' as opposed to 'triangulation' has been adopted to describe this interconnected analysis (Richardson, 2000). The crystallisation of data involved eliciting data from three different participant groups; the patients, the GPs and the shiatsu practitioner. Crystallisation of methods involved appraising perceived change in patients' health via qualitative analysis of the semi-structured interviews with the patients and their referring GPs, the shiatsu practitioner's clinical notes and the patients' and shiatsu practitioner's journals. Quantitative methods were also used in the analysis of the SF-12 and MYMOP-PIRIE questionnaires and the consultation rates.

5. *Action research*

Action research is the final recommendation of IHR (Cunningham, 1988). It was closely adhered to in the current study by adopting all of the elements that Hart and Bond (1995) claim action research can involve. These elements were described in more detail in chapter three and will be repeated briefly here for clarity. Hart and Bond (1995) claim action research can be,

1. educative
2. concerned with individual as members of social groups
3. problem-focussed, context-specific and future-orientated
4. a change intervention
5. aimed at improving a situation and involving participants
6. a cyclic process in which research, action and evaluation are interlinked
7. founded on a research relationship in which those involved are participants in the change process

The study attempted to be educative by eliciting original findings of how a shiatsu clinic can impact on a general practice and its inhabitants. The participants were seen in their normal social groups as GPs or patients, in their usual health-care setting. This research was problem-focussed on specific symptoms; context-specific being located in one general practice; and both future-orientated and again, educative in informing further delivery and evaluation of complementary medicine in primary care.

The change intervention was delivering shiatsu, which aimed to improve delivery of patient care and involve patients, GPs and the practitioner researcher. The clinic developed through a cyclic process of research, action and evaluation in two separate runs of delivery, utilising feedback from respondents treated as equal participants as opposed to subordinate subjects.

In addition to following Hart and Bond's (1995) criteria for action research, the current study also utilised this methodology by,

1. allowing a research question to emerge directly from the study setting and its participants,
2. developing the evaluation tools from the literature and participant feedback,
3. utilising practitioner research to maintain a practical approach to the research question and encourage reflective practice,
4. grounding results by applying theory to practice which aimed to improve patient care and increase general practice services.

1. Development of the research question

Following an action research model the current study began with the general topic of complementary medicine in general practice, and allowed a relevant research question to develop. This approach enabled the gradual emergence of the salient issues involved in delivering a shiatsu service in primary care. Therefore, instead of testing hypotheses set out prior to embarking on the research, the participants were engaged with in their normal context to access the issues that were most relevant to them. This encouraged all participants to have an active role in the development of the research question. This process will now be described.

The initial research question was focussed purely on the *viability* of delivering a shiatsu clinic in a general practice. The viability obviously had to be ascertained before the project could even hope to glean more specific results. Viability was measured by GPs making the required number of appropriate referrals and patients attending all of their appointments. This could have just provided practical information on the process and structure of the service. This was not the major gap in the existing literature nor the chosen area of interest by myself as the researcher practitioner. It was clear once the research began that this was not an adequate question to gain the more qualitatively meaningful information required.

The epistemology underpinning the research and appropriate methodology called for an attempt to ascertain the experiences of people involved in the clinic. The study therefore aimed at deepening the understanding of the participants' worlds. This required a search for the meanings behind actions and motivations for particular thoughts and feelings related to the shiatsu clinic. In order to elicit an interpretation of these texts from participants, the final research question had to be open and flexible for salient issues to arise and be subsequently analysed. It had to be focussed on the experiences of all those involved to gain the fullest picture.

The study was also conducted to explore issues in running a clinic. Data on referral and attendance was complemented by reflections by both GPs and patients on these events in addition to those from myself as the practitioner researcher. This provided practical information about the viability of delivering shiatsu in general practice and at a more personal level, an insight into what this actually meant for the individuals involved. These personal reflections of the shiatsu clinic enabled it to be assessed by those it affected, and subsequently adapted and improved. Once viability was ascertained and it was clear that the service could be delivered, these experiences of the clinic became the main focus of the research. This enabled a much wider study of the many variable processes involved in the delivery of the clinic, which deepened the richness of the results obtained. The resulting research question therefore investigated any impact the delivery of the shiatsu clinic had on the practice and the participants as a whole.

1. Development of evaluation tools

The Hanson study followed an action research approach to the development of tools used to assess the shiatsu clinic and address the above research question. This involved piloting and adapting the GP and patient interview schedules and the GPs' referral document and yellow cards. Advice on the tools was ascertained from private shiatsu clients, shiatsu practitioners, academic researchers, the Hanson practice team and the referred patients. The final version of these tools that were developed by this group process and repeated piloting can be found in appendix III.

The evaluation of patient satisfaction provides the clearest example of the effect that this vigorous process can have on the development of tools. Initially a questionnaire was created that elicited patient experiences of the shiatsu clinic. This developed from satisfaction questionnaires described in the literature and those used in research that had yet to be published. However, in the final stages of this process, I attended a course on patient satisfaction and decided that questionnaires were an inadequate tool to gain the information I wanted. Further literature searches confirmed several methodological limitations of these questionnaires. For example, there is no clear theoretical or conceptual definition of satisfaction for health care research and this can be further compounded by the common use of this term in other settings (Wilkin et al, 1992).

I therefore reassessed what I was trying to explore with the term 'patient satisfaction.' Since the patients were being asked to describe the impact of the shiatsu clinic on themselves, 'satisfaction' was simply another way of eliciting their experiences of the clinic. I consequently defined 'satisfaction' to refer to how pleased patients were with the treatment they had received. This was not limited to the clinical outcomes of the treatment, but also included their views on the delivery of the shiatsu, remaining consistent with the consideration of context and process in action research. I then found a review paper on the measurement of patient satisfaction in primary care (Pascoe, 1983). The author defined satisfaction as patients' *'...reaction to salient aspects of the context, process and result of their experience'* concluding that it is also inextricably linked to patients expectations and values (Pascoe, 1983).

The final evaluation of satisfaction in the Hanson study asked patients to describe their reactions to the clinic being delivered in the general practice, the process of referrals and treatments and the results of their experience (including any changes in their health). They were asked to rate their satisfaction with their experience on a scale of 1 to 10 to triangulate the descriptions of satisfaction described in the interviews. In this way, a coarse quantitative measure could be tested against the preferred qualitative method of eliciting meanings behind patients' experiences.

In summary, the evaluation procedure in the current study did not simply use pre-validated tools but developed new ones through a repeated cyclical process of ascertaining advice from experts and the literature and piloting the developing tools with patients and complementary and orthodox practitioners. It then compared the findings from different methods to deepen the understanding of the data. Obviously the final versions of these tools would have to be used in several other studies to gain a fuller understanding of any methodological limitations. The assessment of their use in this study can be found in the results chapter in section four.

2. Practitioner research

The current study utilised practitioner research as I was both the main researcher and shiatsu practitioner. As discussed in chapter three, practitioner research has been criticised for causing researcher 'bias', but is accepted as an appropriate method of conducting action research in the current study. This approach does not deny the influence of the researcher in order to claim a factual, objective representation of the participant's world; neither does it adopt the opposing stance claiming that 'bias' is inherent in research and should therefore be accepted and ignored. Instead, the influence of my role both the researcher and practitioner was acknowledged and made as conscious and transparent as possible. As already described, this initially involved an explicit description of my views on shiatsu and preconceptions of the study as presented in the results chapter, section three. As the study progressed, my role as researcher practitioner was continually reflected upon in supervision, field notes and a weekly journal.

Adhering to collaborative research, as espoused in Interactive Holistic Research (IHR) (Cunningham, 1998) my role as the researcher did not attempt to lead the research process. Instead, it was influenced by all participants and assisted by an external researcher, not otherwise involved in the study. This could reduce the risk of my personal influence over-dominating the study. For example, the whole primary health care team was active in designing the referral procedure, appointment system and delivery of the clinic. The patients particularly assisted in the alteration of the clinic and its evaluation.

To further clarify my role as the practitioner researcher, an external researcher was employed to conduct all the post-intervention interviews that asked patients and GPs for their reflections on the shiatsu clinic. This enabled participants to discuss their experiences and satisfaction with the shiatsu clinic with someone who was not otherwise involved in the project. To make this process transparent, during the second run of clinics all transcripts were anonymous to reduce the possibility of the participants being identified by myself in the transcripts. Codes were used for later identification. The patients and GPs were informed of this prior to the interview in attempt to encourage their openness and honesty. This was to help the participants provide both positive and negative feedback for a rich evaluation of the shiatsu service.

The study also triangulated/crystallised data from various sources and different methods to gain the fullest picture of the research. The ways in which these methods interacted were analysed following Cunningham's (1998) 'contextual locating', again described in Interactive Holistic Research (IHR). This satisfied Reason's (1981) suggestion that the move to postpositivist research requires the concept of *contextual validity* '*...which is about how any particular piece of data fits in with the whole picture.*' The emphasis is then on how the representation of the study is based on a diverse data and methods, as opposed to a single 'truth' devoid of researcher interpretation. My experience of conducting practitioner researcher is described further in section three of the results chapter and the discussion chapter.

4. Applying theory to practice

The results of the study were carefully grounded in practical application to bridge the theory/practice gap and produce practical recommendations for the delivery and evaluation of similar initiatives. This was not to generalise findings from one small scale study to produce a rigid protocol, applicable in all other settings but to simply produce a document which attempts to ground interpretative theory in useful, practical advice for similar projects. The detailed description of the research process aimed to enable readers to judge for themselves the applicability of these guidelines in other settings.

The study also could be seen to ground theory into real-life practice via the dual role of practitioner research already described. This was because I utilised my experience as the complementary practitioner in the research to enhance reflective work practices. Again, there are no attempts to convert these limited results into representative data of all shiatsu therapists or complementary practitioners. Instead, the aim was to elicit context-specific data to help develop my own practical, professional skills and reflect upon the possible role of practitioner research in complementary medicine.

Application of ‘authenticity’ in the current study

This concept refers to how appropriate the research strategies are in providing an ‘authentic’ account of the participant’s world. Lincoln and Guba’s (1985) five pre-requisites for authenticity will be listed again to assess the establishment of this concept of quality in the current study.

1. Fairness – the participants in the study were treated with respect and were asked for both verbal and written consent to each stage of their involvement in the research. The consent form clearly stipulated that participation in the study was entirely their decision and they could withdraw at any time, see appendix III. Fairness also pertains to a consideration of the social context that surrounds the participant. The postpositivist approach to action research ensures that this was adhered to, resulting in a theme of ‘interpersonal changes’ depicting participants’ relationships at work and at home (see chapter six).

2. Ontological authenticity – participants were encouraged to reflect upon their ‘*human condition via the research*’ (Lincoln and Guba, 1985) in relation to their health, experience of conventional and any complementary health-care and their attitudes towards this treatment. The qualitative methodology of the study assisted this focus on what it means to be human, experiencing both health and illness, by explicitly asking for the motivations and meanings that lay behind participants’ actions.

3. *Educative authenticity* – this is concerned with how reflection helped participants understand each other. The accounts given in the current study helped my understanding of the other participants and my role as the practitioner researcher. The GPs and myself also agreed that our sharing of health models seemed to enhance our individual understandings of the patients and their experiences. Several patients described how they had taught others some of the self-treatment of symptoms they had learnt from the shiatsu clinic. Educative authenticity supports this humanistic aspect of qualitative research, but also the holistic approach espoused in shiatsu of how understanding ourselves helps us to connect with and comprehend others.

4. *Catalytic authenticity* – participants' reflections and decisions were supported by the chosen qualitative research methodology which explicitly encouraged them to speak freely and reflect upon their views and decisions. For example, it was made clear that their decision to participate in the study or not would be completely supported by myself and the practice team. The use of action research and collaborative research ensured that feedback from those who chose to participate was intrinsic to the development of the study.

5. *Tactical authenticity* – once the participants' decisions were made, they were encouraged to make changes in their actions. This was in support of Holloway's (1997) desire that research should impact upon participants' lives and empower them. The aim of the current study was to encourage patients to play more of an active role in their health and ground their experience of the study in real changes in their wellbeing. For example, participants were asked to keep a record of their reflections and decisions they made in relation to their health and involvement in the project. Any decisions they made were 'action-planned' in their shiatsu sessions, meaning that if a patient stated that they wished to take less medication or do more exercise, we agreed on how this could realistically be achieved by setting weekly goals. Participants explicitly claimed they had felt empowered by their shiatsu treatment and their role in the research, see section two of chapter six.

Assessment of Interpretative Phenomenological Analysis (IPA)

Smith (1996) replaces the concept of validity with 'internal consistence' which refers to a reader being able to follow a transparent, logical flow of analysis. The research approach in the current study was described in terms of its theoretical background (postpositivism), methodology (qualitative research) and specific analysis (IPA). The analytical process, detailing how the themes were derived from the raw data, has already been presented in this chapter. Examples of all data collection tools are included in the appendix for transparency. Smith's (1996) second recommendation is to include plenty of verbatim evidence in the report to assist the reader in these judgements about the appropriateness of the analytic process and research findings. Extensive use of participant quotes are therefore included throughout the results chapter to keep the findings as close as possible to their own choice of words and topics of priorities.

Following Smith's (1996) advice, the current study did attempt to make the research process explicit, which would assist Lincoln and Guba's (1985) concept of transferability. This was not the primary aim however. Instead, the detailed description of the study design, setting and sample was to place the data and its interpretation in its social, political and interpersonal contexts. The contextual description was undertaken to keep the representation of the event as close as possible to the event itself to help the reader assess how plausible the interpretation is, as opposed to how replicable it may be.

Application of research

As suggested in chapter three, the application of the research can be a key indicator of a study's quality. This refers to its ability to cause a change, preferably a clear improvement, in the social system under investigation. I would add that this change needs to be of relevance to those involved in the system to gain most benefit, and not some pre-determined 'improvement' only guessed at by an external researcher. The current study attempted to satisfy this requirement by enabling the research question to emerge from the setting and its participants. This 'question' is a topic for

investigation that aims to develop possible solutions and improvements to the setting and its systems.

In the current study, the setting was the general practice and the system was the delivery of health care to patients. The aimed for improvement was to increase the delivery of services to include a form of complementary medicine, namely shiatsu, and provide information for the future research and integration of services. The current study therefore focussed on assessing the viability of delivering shiatsu in general practice and its impact on this organisation and the people involved. This included consideration of the following:

- The impact of the shiatsu clinic on reports of patients' health (physical and psychological/emotional). This was indicated by patient perceptions in interviews and self-completed questionnaires; GP perceptions in interviews and referral forms; changes in medication suggested by the patients questionnaire and GP prescriptions; and changes in content, frequency and/or duration of consultation with GPs.
- Impact on the practice as perceived by GPs and patients as being due to the integration of the shiatsu clinic.
- Impact on the practitioner researcher as documented in the reflective journal.

The current study focussed on making several changes in the study setting and the experiences of its participants. If successful, the potential improvements of this could be the following:

- Patients could benefit from having additional input into their health and new treatments for their symptoms.
- The general practice would be able to deliver a new service to its patients.
- GPs would have an additional referral route for patients with symptoms that were particularly resistant to treatment as predicted by the literature review.
- As the reflexive practitioner researcher, I would gain valuable experience to enhance my skills and knowledge of both clinical practice and research training.

- The GPs and shiatsu practitioner could benefit from sharing their diagnostic and treatment strategies that could assist the shared-care of patients and possibly, the patients' health.
- The implementation of future shiatsu clinics in the general practice.

The results of the study would be firmly applied in practice and a new wave of action research could begin to assess the new clinic. To summarise, the current study adhered to the commitments of quality in practitioner research and postpositivist action research by conducting a relevant and practical study of the impact of a shiatsu clinic in a general practice. The study setting and its participants will be introduced before these results are described in detail.

Chapter V STUDY SETTING AND PARTICIPANTS

This chapter will set the following results in context by describing the study setting and the characteristics of its participants. This will involve a description of the general practice, re-named as Hanson Medical Centre to protect confidentiality and an introduction to the GPs, patients and shiatsu practitioner involved in the research.

Setting

Hanson Medical Centre is situated in a council estate in the north of Sheffield. It is a four doctor practice (2.5 full time equivalents) with two part time practice nurses (approximately 1 full time equivalent), and a patient list size of approximately 3800. District nurses, midwives and health visitors are attached to the Medical Centre and based in the building.

The local estate that Hanson serves is recognised as an area of urban deprivation by Sheffield City Council, with high unemployment. Figures produced by the Joint Indicators Working Group claim that over 35% of households receive income support and approximately 40% of the children in the area live in houses with no wage earners. This seems reflected in the health problems presented by the patients with substance misuse, for example, being commonly treated at the practice. Consequently Hanson is a methadone prescribing practice and works closely with local drug projects in Sheffield.

The local poverty of the Hanson estate could also account for the prevalence of chronic illnesses such as diabetes, ischaemic heart disease, bronchitis, asthma and epilepsy. A Practice Data Comparison study in 1997 found that these health problems were considerably higher in Hanson than expected in the normal population. Psychiatric morbidity is also high, with 37% of the current total practice population having received antidepressant treatment in the first seven years of the computer records. Of these, 572 patients are currently receiving prescriptions for depression and anxiety. The Standardised Mortality Ratio for the practice is one of the highest in Sheffield at 140 (40% more than the national average) which is associated with increased morbidity.

The practice also provides GP cover for a local 100 bed residential nursing home, and an older-adults day unit at a local Hospital. Despite this, the proportion of children and young adults on the practice list is the highest of the 102 practices in Sheffield. To assist the young people in the area, the practice is involved in two local projects. These provide health education for local teenagers and support to pregnant young women and young mothers. Hanson also supports one of the city's homeless accommodation units. This local unit has a high turnover of patients, often presenting with complex psychosocial as well as medical health issues.

To try to serve these complex needs of the local population, the practice offers the following services in addition to the shiatsu clinic; counselling, occupational health advice, a weekly surgery by the local Citizens' Advice Bureau, physiotherapy, advice from pharmacists, asthma clinic, well baby clinic and an ante natal clinic. The practice also assists a local 'tranquilliser users' self help group and runs smoking cessation support groups. Finally, Hanson is currently in the forefront of efforts to combine local residents' groups, Sheffield City Council, and Sheffield Health to put together a bid for National Lottery funding to set up a Healthy Living Centre for the area.

It is clear that the local deprivation places a strain on the practice resources. Demographic factors, together with a high level of practice activity in preventative work are associated with a particularly high consultation rate (5000/1000 patients/year). The practice manager claims that Hanson has the highest out of hours workload in Sheffield (based on Sheffield GP Co-operative figures), high referral rates and contact with secondary care, high volume prescribing, and heavy use of call and recall systems.

The health needs of the local population and strain on practice services are compounded by high non-attendance at appointments and poor compliance with medication and administrative systems. Non-clinical staff are therefore also in great demand in Hanson. Literacy problems of many patients, for example, can cause patients to require extra time with the administration staff in the completion of forms and understanding of information. Also, the location of the practice in the heart of the estate requires that the reception to be continually staffed during the working day to maximise security.

Hanson Medical Centre was selected as the general practice to pilot the shiatsu clinic. This was because it is an inner-city practice in an impoverished area of Sheffield where chronic illness is rife and complementary medicine is scarce. It is likely that many of the patients would not have had shiatsu before. This could partly be due to the absence of shiatsu being offered privately or publicly in the area and the cost of private complementary medicine elsewhere in Sheffield that adds the extra cost and inconvenience of travelling. The current cost of a shiatsu treatment in Sheffield is between £27.00 and £30.00 per hour and often a series of treatments is necessary to gain most benefit. It was therefore decided that providing a free shiatsu clinic at Hanson, without charging the practice or its patients might improve access to health services and patient care in this inner-city area.

There was also a pragmatic reason for choosing to approach Hanson, in that two of the four GPs already knew me in my employment at the University of Sheffield and seemed interested in the project. The clinic would have to have at least the potential of running for the experiences of those involved to be gained. This thesis is not attempting to claim that Hanson is a representative general practice. Instead, it is following a postmodernist and qualitative tradition of describing a particular setting and its inhabitants in detail.

To conclude, this practice was chosen to maximise the potential benefit a free shiatsu service could offer patients in a deprived, inner-city council estate. The subsequent challenge was to make an impact on these patients who had a higher than average rate of chronic physical, psychological, emotional and social problems that restricted their health and wellbeing.

Participants

GPs

Although all clinical staff were invited to make referrals to the shiatsu clinic, only the four GPs did so. Possible reasons for the nurses not referring patients are given in the discussion chapter. The GPs are represented in the study as GP1 to 4 to protect anonymity. Their ethnic origin was white, two were female and two were male. They each had additional roles to their clinical practice. One of the female GPs was also a

member of a primary care group board and the other managed a weekly hospital-based memory clinic. The two males also worked as academic GPs at the University of Sheffield.

Patients

Ten female patients aged between 27 and 63 attended the shiatsu clinic. All patients were white in ethnic origin. Detailed case studies for each patient can be found in appendix IV.

Practitioner researcher

As described, I was the shiatsu practitioner as well as the researcher. I am a white female and at the time of the study intervention I was twenty-eight years old. My shiatsu training was with the British School of Shiatsu-Do and I graduated from the three-year diploma in 1997. I have since gained professional membership with the Shiatsu Society (UK) by passing the highest national shiatsu examination. This is a voluntary qualification but is an essential requirement for inclusion on the Shiatsu Society's professional register of practitioners. I have been dedicated to continual professional development and have completed several post-graduate courses in shiatsu in addition to working as an assistant teacher on the Diploma course.

I work in a self-employed capacity as a shiatsu practitioner two days per week in addition to my position as a research fellow at the University of Sheffield. I also coordinate three shiatsu exercise classes (called 'Do-in') per week, teaching at least one myself. I thoroughly enjoy working with shiatsu and helping patients improve their health and well being and hope to continue conducting research in this area.

External researcher

This was a female researcher particularly experienced in conducting interviews and qualitative research. Her contribution to the study was to undertake all the interviews with the GPs and the post-intervention interviews with patients.

Chapter VI RESULTS

This chapter will present the results from the research question, ‘What is the impact of delivering shiatsu in an inner-city general practice?’ This will be addressed in five sections to describe the impact of the shiatsu clinic on;

1. the general practice and the GPs
2. the patients
3. the practitioner researcher
4. methods of evaluating complementary medicine in general practice
5. the future delivery of shiatsu in general practice

The impact of the shiatsu clinic will be illustrated with the qualitative analysis of thirty-six semi-structured interviews. As described in chapter four, these interviews were conducted with patients before and after receiving a course of six shiatsu treatments and at the two-month follow-up. The four GPs in the practice who had each referred at least one patient, were also interviewed for their views on the clinic (two of which were interviewed twice as they referred patients to both clinics). Quotes from patient and practitioner-researcher journals and the shiatsu notes will also be used with quantitative data from the patient questionnaires (MYMOP-PIRIE and SF-12) and consultation rates.

Key for quotes

- The ten patients, four GPs and the general practice have been allocated pseudonyms to protect anonymity.
- Quotes from the open-ended questions in the MYMOP-PIRIE questionnaire (see appendix III) are denoted by an ‘MP’. Quotes from the patients’ shiatsu forms are identified by ‘SF’ and those from the shiatsu practitioner’s reflective journal with ‘RJ’.

- Extracts from the interviews with patients are in italics and use the following key;
T2.L58 = Time two, Line 58. The three time points for data collection were,
T1 – pre-intervention interview before the first shiatsu
T2 – post-intervention interview one week after the last shiatsu
T3 – follow-up interview, two months after the last shiatsu
- Referring GPs are distinguished by numbers 1-4 to protect anonymity. When a referrer is discussing a patient the following format will be used; GP1 about Jenny. T2.L58. All GP interviews were conducted post intervention and follow the above key of ‘T2’ for ‘time two’.

Results section one

THE IMPACT OF THE SHIATSU CLINIC ON THE GENERAL PRACTICE

The four GPs claimed the shiatsu clinic impacted upon the practice in three main ways. Firstly, the clinic enabled GPs to refer ten patients to a new therapy. Secondly, GPs' consultations with patients who attended the clinic seemed to change. Thirdly, GPs claimed the clinic offered several wider benefits to the general practice as a whole. This section will present the following evidence to substantiate these claims.

Table 8. The impact of the shiatsu clinic on the general practice

GP referrals of ten patients	Complexity of chronic symptoms
	Limitations of orthodox medicine
Changes in GP consultations	Reduced frequency of consultations
	Variable attendance in consultations
	Legitimate frequent attendance in consultations
	Fewer prescriptions given in consultations
	Consultations described as more positive
Benefits of the shiatsu clinic for the general practice	Greater options for health care
	Reduced patient demand on GPs
	Enhanced practice reputation
	Increased holistic approach to health

GP referrals of ten patients

The main impact of the study on the general practice was the delivery of a new treatment. This enabled the GPs to refer ten of their patients for shiatsu. Individual case studies of the patients are in appendix IV. They were diagnosed with having a complex mix of symptoms that were mainly chronic, had recently worsened and were resistant to orthodox treatment. In this way the GPs seemed to target the impact of the clinic on the long-term care of patients with resistant symptoms.

Complexity of chronic symptoms

The patients that were referred for shiatsu presented with a complex mix of symptoms *'I felt she had a mixture of physical and physiological symptoms which were really hard to disentangle...'* (GP1. T2.L4 about Jenny). Most of the patients' symptoms were chronic, defined as having been present for over six months, with the mean duration being 5.5 years. Several of these symptoms were described as having recently worsened prior to being referred to the shiatsu clinic. One GP suggested that this decline in their patient's health motivated them to make the shiatsu referral as *'...she was feeling a bit - there's nothing can be done - and this is sort of saying that there are things that can be done and yeah it's like giving hope, giving control'* (GP4. T2.L39 about Mary). This seems particularly important in cases where orthodox medicine seems to be making little difference to symptoms and the patients and GPs may begin to feel despondent.

Limitations of orthodox medicine

The patients were reported to have symptoms that were often resistant to orthodox medicine. The complex mix of symptoms experienced also rendered some orthodox treatments inappropriate. GP4 described how several of Mary's symptoms could not be treated because of her heart condition and mentioned the effect this could have on the patient.

GP4. T2.L24 *'Well, she has chronic joint pains and arthritis and anxiety. She has heart problems, she's had a heart attack in the past. She's got diabetes and she's got asthma. She's got lots of medical problems and she's restricted us to how we can treat her physically because of her given heart disease. The things that she needs she can't have because her heart condition's so bad...I think convention medicine has its limits and she's come up against the limits and probably felt quite deserted really...'*

GP1 suggested that orthodox medicine is limited when patients' experience a range of symptoms because it tends to treat each symptom separately. They cited a patient whose physical symptoms had not responded to treatment, possibly because it did not address her psychological/emotional condition.

GP1. T2.L58 about Sara *'She had physical symptoms which were not responding to any of the interventions that we tried, which I thought were bound up with psychological symptoms...She was on two different sorts of anti-depressants, she was having abdominal symptoms, all sorts of treatment for that, and it was probably been going on for some years...'*

The following quote illustrates the difficulties faced by GPs trying to unravel the complexity of a patient's health.

GP1. T2.L123 about Tara *'...she'd had persistent symptoms after a road traffic accident which had been very traumatic. She'd been driving with the little boy in the car and she'd also lost a baby some years previously, so it was pretty grisly and just seemed very, again physical symptoms tied up very much with psychological factors, and the same thing - she'd had all sorts of treatments for her aches and pains. She's seen an osteopath and a physio. and she was also on a bit of anti-depressant and...she really wasn't functioning very well. And I couldn't seem to find a way in, a way to engage with her which I think was really complex, including the children's physical health. Just couldn't seem to tap into a way to approach them.'*

GP2 also reported feeling limited in their care of a patient after orthodox medicine had failed to alleviate her symptoms and had caused a dependency on medication.

GP2. T2.L95 *'I feel much more stuck long term with Lucy...she's had all sorts of different medication. She's had lots of therapy, she's been to see eye-scans, she's been in pain clinic, there's almost no modality of treatment which we haven't tried...I really had no other options...'*

In summary, the first impact of the shiatsu clinic on the general practice was that it enabled GPs to refer ten of their patients for a new treatment. This section suggests that GPs chose to refer patients who had complex and chronic symptoms that were resistant to orthodox medicine. Some of these symptoms had recently worsened.

Changes in GP consultations

Reduced frequency of consultations

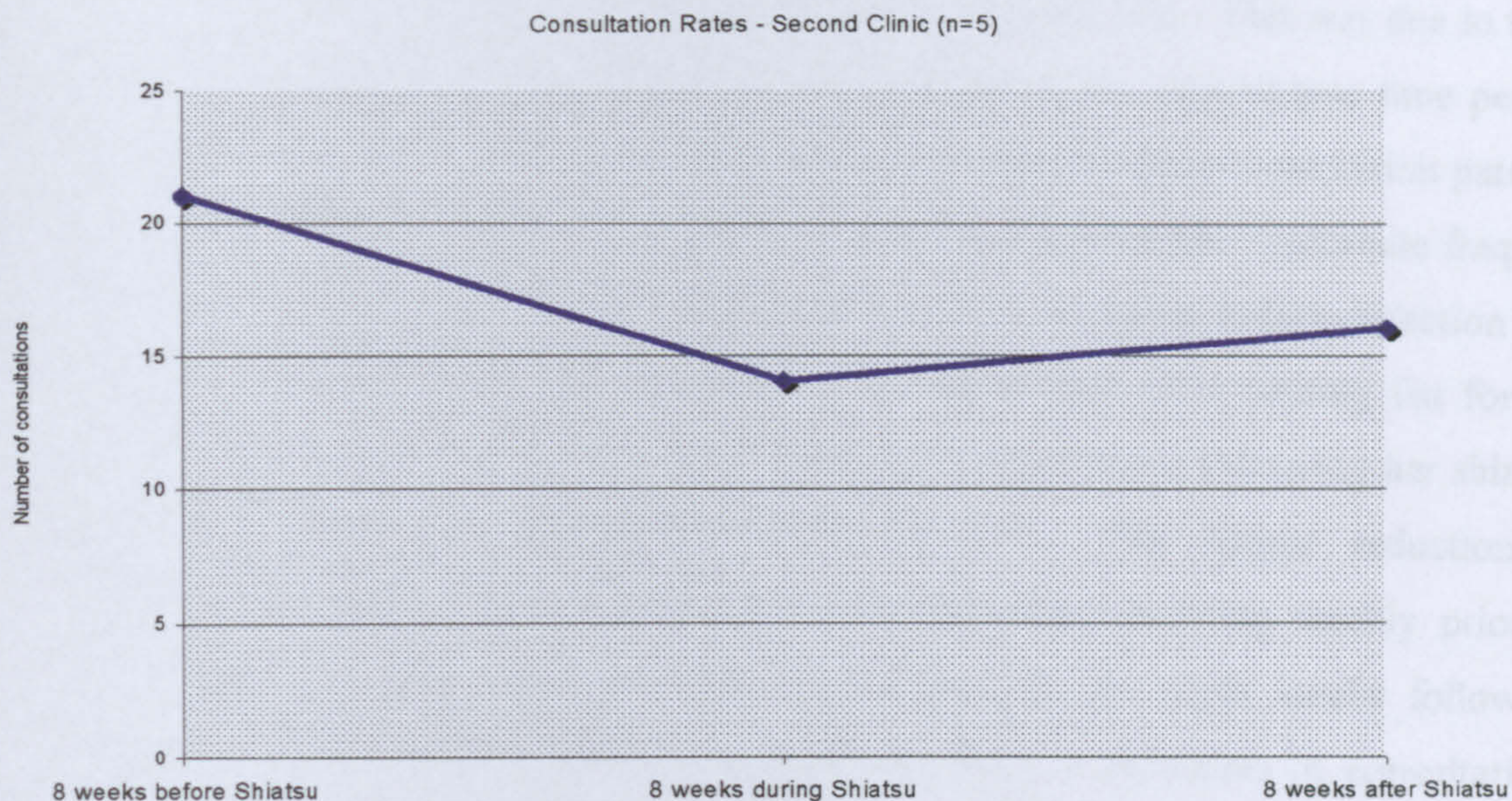
Participants claimed the second main impact of the shiatsu clinic on the general practice was its affect on GP consultations with patients who had received shiatsu. The most notable alteration was that the number of consultations greatly reduced both during and after the shiatsu clinic. This is indicated by the following graph that presents the total number of patients consultation rates two months before receiving shiatsu, two-months during treatment and two months after treatment had ended. This data was calculated from the patient notes by the practice manager and administration staff to protect patient confidentiality.

Figure 7. Patient consultation rates over time



This graph indicates that the patients' total number of consultations in the eight weeks before starting shiatsu, was 40 and this dropped to 24 during clinic one and 21 in the eight weeks after clinic one had ended. The reduction in consultations was more pronounced in patients attending the first clinic, as illustrated in the two following graphs.

Figure 8. Second clinic consultation rates over time



The first clinic dropped from 19 consultations in the eight weeks before shiatsu to 10 during and 5 in the eight weeks after. There were three patients who most reduced these consultation rates; Sara and Tara both came four times in the eight weeks before starting shiatsu and did not attend at all in the eight weeks following. Kate consulted with the GPs seven times before having shiatsu and only once afterwards.

Figure 9. Second clinic consultation rates over time



The second group of patients reduced their pre-shiatsu total of 21 consultations to 14 during treatment and then 16 once shiatsu had ended. This shows that the second clinic did not reduce their consultation rate as much as the first. This was due to three of the five patients requesting frequent consultations in the post-shiatsu time period; two of which will be discussed later in terms of having different consultation patterns than the other eight patients. For example, Mary maintained her 'legitimate frequent attendance' requiring regular appointments due to a recurrent kidney-infection and Kirsty continued her 'variable attendance. Jane had been on a waiting list for the removal of her gallbladder and this occurred in the eight weeks following her shiatsu, again requiring extra appointments with her GP. The largest reduction in consultations in this group was by Clare who had been attending weekly prior to having shiatsu. This reduced to one consultation in the eight weeks following treatment. Although the second clinic did not show a reduction in consultations between the post-intervention and follow-up, both clinics reported a drop in consultations between the pre-and post- time periods.

Patients' comments support the GPs claims that their consultations were less frequent and shorter. For example, Tara's notes indicated that she had fortnightly appointments in the two-months before having shiatsu. She reduced this to having only one consultation in the two months the clinic was running and none at all in the two-months after the shiatsu had ceased. *'I've seen him just the once, maybe after the first or second session (of shiatsu)'* (Tara. T2. L17). Sara had four consultations pre-shiatsu, two during that she described as *'...quicker. Just basically we didn't have any problems to talk about'* (Sara. T2.L19) and no consultations in the two months following shiatsu.

Finally, GP1 illustrates the difference that can occur between perceptions of events and records of them. This GP reported that a patient had been consulting frequently at the practice and was surprised when the notes suggested it was not as often as she had thought.

GP1.T2.L33 about Jenny *'She was attending very frequently...she was coming three times a month really, from September through to January... then I saw her once on the 9th February and I haven't seen her since.'*

The GP mentioned her last consultation with Jenny was on the 9th of February, which was the date of second shiatsu appointment, reporting that the previously frequent consultations dramatically reduced once Jenny began her course of shiatsu treatments.

To encourage a wide range of views in the research, I specifically looked for data that did not fit the perception of consultations being less frequent and shorter. Two new issues emerged, namely the problem of 'variable attendance' hindering assessment of the shiatsu and 'legitimate frequent attendance' continuing throughout the study.

Variable attendance in consultations

One GP noted the difficulty in assessing the effectiveness of an intervention by consultation patterns. They claim that their patient seems to have improved but explains that her reduced attendance at the practice can not necessarily confirm this.

GP4. T2.L106 about Kirsty 'She thought it had been really beneficial, her attendance is very variable anywhere so I don't know whether I'm seeing her less because of the shiatsu...or because it would be a phase where I would see her less anyway because sometimes she comes a lot and sometimes she comes hardly at all, so its quite difficult...'

Legitimate frequent attendance in consultations

Another GP did not perceive a change in her patient's high consultation rate, but seemed to attribute this to her state of health, rather than a deficiency in the treatment.

GP4. T2.L71 about Mary 'I don't think the consultations have been particularly less frequent or shorter particularly, she's a frequent attendee but she doesn't come when there isn't a problem, so she has reason to attend frequently and from that point of view I think she's still behaving completely normally and reasonably.'

The GP seemed to view Mary's high attendance as appropriate, given her state of ill health. However, it remains the case that Mary's shiatsu treatments did not reduce her demand on GPs time.

Fewer prescriptions given in consultations

The second change in the GP consultations was that they involved fewer prescriptions for medication than before the shiatsu began. For example two of the five patients diagnosed with chronic clinical depression (namely Sara and Julie) ceased their anti-depressant medication in the first few weeks of receiving shiatsu. This was maintained until the end of the shiatsu clinic and also at the two-month follow up. A reduction in prescriptions was reported in the GPs' and patients' interviews and supported by the patients' MYMOP-PIRIE forms and journals.

Sara's GP described how she stopped her depression and digestion medication and reiterates the claim that appointments became less frequent.

GP1. T2.L80 about Sara's first two consultations *'She felt she was coping and I put she was quite prosaic so that's you know quite good and we reduced her anti- depressants a bit...I'd put the mood as 'Excellent, exclamation mark' so I was obviously surprised! And the next time I saw her was four weeks later and I'd written, 'Stopped her tablets, exclamation mark!'. Yeah she was one of those people who really seemed to sort of glow, you know exude with health, very impressive.'*

Jenny had been taking several tablets for a range of her physical and psychological/emotional symptoms (described in her case study in appendix IV). After having shiatsu, her GP reduced her medication and the frequency of consultations.

Jenny. T2. L20 *'The doctor didn't give me any medication. She did say that I was looking better and also that I have a monthly appointment and she said 'If your agreeable shall we make it two months?' so you know that's, its obvious I'm feeling better isn't it?'*

Julie's GP also describes her reduction of medication and frequency of appointments reiterating the suggestion that patients reduced their need of GP time and prescriptions during the course of the study.

GP3. T2.L33 about Julie *'She came back and she said 'I must tell you I feel loads better' and in fact looking at her notes here, she seems to have reduced the frequency of her attendance. Certainly, she's not come to see me as often as she usually does. In fact on 12th May she described herself as 'very well'. She stopped her anti-depressant medication and I said there wasn't any need for me to see her again.'*

Tara also reported a reduction in being prescribed medication in her GP consultations. She had been taking daily painkillers for tension headaches that had followed a traumatic road crash several years before. Since starting shiatsu, she described that she had reduced both her prescribed and 'over-the counter' medication and seemed pleased with these changes *'...less frequent headaches...and I've been able to control them, so less medication...It works! It's better than taking proper prescribed medication or Paracetamols, much better'* (Tara. T2.L11). Kate also stopped taking her prescribed medication and tablets she had bought from a health shop. As described later, it seemed as if this was motivated by a desire to test the shiatsu and also her dislike of tablets.

Kate. T2.L45 *'Within two weeks I came off it (the medication), at one stage I was on twenty odd tablets a day and it was just crazy. It was just covering up one underlining problem that I had there so I just come off that while I had the shiatsu.'*

Kate's reduction of medication seemed less successful than Sara's or Julie's, in terms of their reported improvement of symptoms. Kate stopped her medication for physical symptoms, whereas the others had been taking tablets psychological/emotional symptoms (anti-depressants). Perhaps shiatsu was more effective at replacing medication for psychological/emotional symptoms that were perceived as chronic as opposed to being physical conditions that were acute.

The GPs were informed of any changes in medication that were reported in the patients' interviews, either by the patients or myself if their consent was granted. This was to affirm the practice of shiatsu being in addition to normal care to ensure the health and safety of the patients. In addition to changes in the frequency and duration

of consultations and the number of prescriptions required, participants also mentioned how their interactions became more positive during the study.

Consultations described as being more positive

Several of the GPs described a more positive experience in their consultations.

GP3. T2.L56 about Julie *'The consultation I remember was very positive, very brief, she just came back to say that she was going to stop her medication. She felt a lot better, got more confidence and I responded to her by saying that I didn't need to see her regularly anymore, just come when you need to come...this time she had no presenting symptoms other than she felt better, she was very well.'*

The patients' comments support this view, claiming either they or the GP seemed happier in their consultations. Sara thought her GP was being pleased with her progress following shiatsu *'I saw the doctor and she was really quite pleased'* (Sara. T2.L14) and Tara reflected that *'I think I moaned less...it was more positive on my side'* (Tara. T2.L27). This was confirmed by her GP.

GP1. T2.L119 about Tara *'I saw Tara on the 25th January, six days after her first session and I remember her being positive about it. I think things were generally better.'*

The GPs suggested that the positive atmosphere in the consultations had four subsequent impacts on themselves and their patients. Firstly, they suggested that patients' increasingly positive attitude towards their health could actually help them recover from illness and/or manage their symptoms more effectively. This reiterates the claim in holistic approaches to health that improvements in psychological/emotional conditions can help relieve physical symptoms (see chapter two),

GP4. T2.L93 about Kirsty *'...whenever she does take a more positive view, things improve. Her asthma improves, generally she seems to improve and she feels better and I just thought with the whole body and soul treatment she would improve, and I think she has done.'*

Secondly, GPs claimed that the patients' more positive out-look affected the duration of their consultations. This also reiterates the previous suggestion that consultations became shorter.

GP2. T2. L17 about Kate *'She certainly was generally much better. Both in terms of her bowels but also her low mood was a lot better as well. She was more positive. So I guess it was probably a quicker consultation as she was feeling well.'*

Thirdly, GPs claimed that the new positive feeling in consultations made them 'flow' better, partly by helping the GPs engage with the patients.

GP1. T2.L105 about Sara *'Well its just that consultation always flows better with people that are in good spirits. It's not to do with when they are not ill, but when they're feeling good; they're positive and warm. Its harder when you're trying to find a way in.'*

Finally, GP1 reported that the positive atmosphere helped her gain Jenny's trust that her complaints were being taken seriously. This was in response to being asked if she was satisfied with the care that her patient had received in the shiatsu clinic.

GP1. T2.L16 about Jenny *'Yes, very much so. She was delighted and I could really see a change in her and I found her much more positive, much easier to deal with, sort of rested, much better in herself, thinking about the future...I felt before I got the feeling that she always thought that, I think she thought that I wasn't taking her seriously enough.'*

In summary, the number of consultations that GPs conducted with patients attending the shiatsu clinic dramatically reduced and were perceived to be shorter, more positive and involving fewer prescriptions. GP3 described that their expectations of the shiatsu had been '*certainly*' met specifically because their patients had reduced their demand for consultations and prescriptions. The GPs also described several wider benefits that the clinic was said to have on the practice as a whole. These will now be discussed.

Benefits of the shiatsu clinic for the general practice

The GPs cited four main ways in which the shiatsu clinic had impacted on the general practice as a whole. These were that the clinic offered the GPs greater options for health-care, reduced patient demand on GPs, enhanced the practice reputation and encouraged a more holistic approach to symptoms. These claims will each be illustrated in turn.

Greater options for health-care

GPs reported that having the additional treatment of shiatsu in-house provided them with a greater number of options to benefit their patients. *'It's been another thing we can offer and I think this is a positive thing; interesting and different'* (GP2. T2.L58). This GP also noted that it was particularly beneficial for them when dealing with the complex, chronic symptoms previously described *'I think it's been great having another modality of treatment for the people I that I felt stuck with'* (GP2. T2.L161) GP4 described how this could benefit the patients by offering empowerment and hope.

GP4. T2.L132 *'It was nice to have the option of something else really...Yeah I think one of the most important things was just sort of empowering people and giving people hope and enabling them to think conventional medicine isn't 'it', and when there's nothing else that can be done, it doesn't mean that health care stops.'*

GP3 also described psychological/emotional benefits to patients in terms of increasing confidence, which could lead to greater energy and less concern with specific symptoms. This comment was given when describing the kinds of patients they would recommend shiatsu to in the future.

GP3. T2.L246 *'Chronic conditions, conditions when morale is low, confidence is low, when there are multiple aches and pains, where we've reached a sort of plateau in the relationship and there's no new initiatives...the more energetic you feel, the more the symptoms fade into the background, so it's (the shiatsu referral) a way out of medicalising long-term problems.'*

This quote reiterates the need for a holistic approach to symptoms to minimise the risk of medicalising some that may not have organic causes. It also suggests that feeling more energetic can help other symptoms feel less severe. This idea is returned to in section two of this results chapter.

Reduced demand on GPs

It has already been suggested that the shiatsu clinic reduced patient demand for GPs by reducing the frequency and duration of consultations. One GP explained that this created valuable time to reassess the patients' management plans and deepen their therapeutic relationship.

GP3. T2.L191 about Julie and Clare *'Well I think there is often the point with long term patients that you know very well and see regularly within whom you've tried all sorts of different therapeutic manoeuvres...It is hard work when you're dealing with very complex problems to produce a management plan that's stands the test of time because if you're not careful you're just busy treating presenting symptoms not dealing with the underlying problem. So that space for the patients, space for the doctor, enables us both to reassess the long-term chronic problems that they have and then when we meet again we have a fresh approach, so I was treating the patient and I was treating our relationship as well.'*

Enhanced practice reputation

The GPs claimed that the shiatsu clinic benefited the practices' reputation amongst patients and potentially, the National Health Service Executive.

GP3. T2.L176 *'I think it's continued our reputation for innovation...I like to think were at the sharp end, that were always doing new things, that we're introducing innovations...I think this is an innovation that we can put in to our report back to the National Health Service Executive as being a possible pilot study, 'It seems to work fine, can we have somebody please to continue the service'...and there is no doubt that the patients appreciate complementary medicine.'*

GP2 suggested that the shiatsu clinic might help an existing or potential new patient see the practice more positively because of its use of complementary medicine. They claim this could subsequently encourage an open discussion of different therapies.

GP2. T2b.L63 *'...its about saying as a practice we think things like this are beneficial and we are quite happy for you to see complementary therapists and it helps make that more open. Some people suggested that lots of people see complementary therapists but never tell their GPs and I guess perhaps it says it's OK so more people will tell us.'*

The importance of open communication between patients and GPs about their use of complementary medicine is returned to throughout this thesis.

Increased holistic approach to health

GPs suggested that the shiatsu clinic impacted upon the practice by encouraging both patients and staff to think more holistically about symptoms.

GP4. T2.L87 *'It enables people also to take responsibility and to look at themselves in a more holistic way, because people have so many chronic problems, they just get tied in knots by what time of day to take what tablets and when their next appointment is and they forget that underneath they're actually human beings so I hope that will be a positive outcome.'*

GP4 also reported this impact on staff suggesting that the shiatsu clinic challenged their existing view of health and encouraged a more holistic approach. They were cautious as to how long these changes might last.

GP4.T2.L167 *'I think it probably challenged some of the staff to think a bit more broadly about health care and I hope it sort of challenged them to think about illness as well and how they regard that. I'm not sure how long those affects will be, but as clinicians we're probably all sort of quite keen on a sort of holistic view of people and I think we all subscribe to different, not necessarily very alternative, but different sorts of therapy and different ways of dealing with illness. So I think as clinicians we're*

very open to it...Yeah, I hope it's challenged their views on health care and illness really.'

Some GPs suggested that the adoption of this holistic approach had a further impact on increasing the speed of which some patients recovered.

GP1.T2.L110 about referrals *'You know its difficult with all these people because they're all hopefully getting slowly, slowly better, sort of inching their way. But they all seemed to have accelerated forward to move on in a big chunk instead of the kind of millimetre by millimetre that I was accustomed to. Certainly with Sara, over the two years she's made really good progress but it was steady, slow, steady, slow and shiatsu seemed to do really good - moved her forward and off tablets.'*

GP4 summarises several of the above views, claiming that a major impact of delivering shiatsu in general practice is that it can offer hope and greater options for patients in an empowering, holistic treatment.

GP4. T2.L182 *'I think one of the most important things was just sort of empowering people and giving people hope and enabling them to think conventional medicine isn't, 'it!' And when there's nothing else that can be done, it doesn't mean that there's nothing else that can be done. And it doesn't mean that health care stops, and just it enables people also to take responsibility and to look at themselves in a more holistic way.'*

In summary, participants reported several beneficial changes in consultations and the general practice as a whole that they associated with the shiatsu clinic. These benefits were given as reasons for their high level of satisfaction with the clinic, reported in their interviews with the external researcher. When asked to quantify their satisfaction in a score out of ten, three GPs gave ratings of eight and one of nine out of ten; *'I've been really satisfied with it and I've been really pleased that patients were able to have it,'* (GP1.T2.L109).

The next section will present the patients' views on the shiatsu clinic.

Results Section two

THE IMPACT OF THE SHIATSU CLINIC ON THE PATIENTS

The main impact that the shiatsu clinic had on the patients was to affect the way they described their health. Firstly, the patients reported a new understanding of their health. Secondly, patients claimed they had adopted new health-promoting behaviours and thirdly, described their health as having improved. This section will present each these claims in detail. It will also present patients' expectations and satisfaction with the shiatsu clinic and its perceived benefits. An overview of this data is presented in the following table. Individual case studies of the patients are in appendix IV.

Table 9. The impact of the shiatsu clinic on the patients

Perceived changes in patients' health	Increased responsibility				
	New health-promoting behaviour				
	Changes in symptoms	MYMOP- PIRIE results			
		SF-12 results			
		Changes in physical symptoms	Pain		
			Energy		
			Digestion		
			Immune system		
		Changes in psychological / emotional symptoms	Fear of unknown		
			Stress-relief and relaxation		
Depression					
Anger					
	Anxiety				
	Support				
Cycle of improvement in patients health					
Patient expectations of and satisfaction with shiatsu	Cynical expectations				
	Unclear expectations				
	High expectations				
	Expectations met by the shiatsu clinic				
	Avoidance of negative feedback				
	Recommendations to others about shiatsu	Recommended for a mix of symptoms			
		Psychological/ emotional symptoms	Stress		
		Resistant physical symptoms			
Recommendations already made					
Benefits of the shiatsu clinic on the patients	Access to shiatsu in the general practice				
	The opportunity to relieve stress and relax				
	The lack of medication in shiatsu				

Perceived changes in patients' health

The patients described several changes in their health after attending the shiatsu clinic. The apparent clinical impact of the shiatsu on individual patients can be found in the case studies in appendix IV. Whether these views indicate a change in perception or an actual change in health, would require further research on medical outcomes. However, clinical effectiveness is not the focus of this study and it is not possible to estimate how long-term any impact of the shiatsu may be. This section will instead describe the participants' perceptions of the impact of the shiatsu clinic on the health of the patient group as a whole.

Increased responsibility

Patients seemed to reassess their own role in their health during the study and took more responsibility for their wellbeing. GP4 claimed that Mary had become more '*...pro-active about her sort of approach to healthcare*' (GP4.T2.L61). They attributed this to the shiatsu, claiming '*I think it's given her more of a sense of hopefulness*' (T2.L53). Clare described how she gathered information on shiatsu from a video and a book to help her be more involved in her treatment.

Clare. T2.L44 *'I've been out to get a video, well it's a friend's video that I've borrowed, and started doing the exercises and I'm really getting into it. So I've bought books to read about it and everything so that I can start to help myself.'*

Julie also claimed that she wanted to take a more active role in her health and prepare for the shiatsu treatments '*I thought I need to look at this before I start so that I can make sure that I understand it and I can get the best benefit out of it for that six week, so I bought a little "Principals of Shiatsu" book*' (T2.L72). She reported that the shiatsu had helped her see how her health could be affected by her life-style and that she could take more responsibility for how she looked after herself. This manifested in reorganising her time and adopting healthier eating habits.

Julie. T2.L31 *'If I plan to do something with myself and someone else asked me to do something, I went on a back burner and I'd be doing*

something for them. Now, its like...I really surprised myself, somebody came round and I said to them well I've only got three quarters of an hour...I was really proud of myself that I'd actually said this is my time, I've arranged it and I'm gonna do it...I'm looking after myself more...sometimes I'll think I'm too tired to eat, I'll just grab something quick. Now I'm making sure I eat a balanced diet...I'll give myself that time too so its made a general change in everything.'

Julie suggested that her increased responsibility for her health was partly due to feeling empowered by the shiatsu treatments. She claimed it gave her more control over her health than her GP consultations.

Julie. T2.L67 'I like shiatsu cause you've got the control over what you're doing...it's given me some sort of power over what I'm doing...rather than going to the doctors and saying, 'I've got this,' and they tell you to take that or do this and that.'

Kirsty also claimed that the shiatsu encouraged her to take more responsibility in her health than her GP care. She described feeling like a 'lump of flesh' in her GP consultations which suggests an impersonal and passive patient instead of an empowered individual who could be active in her recovery.

Kirsty. T2.L89 'I've not had to see her (the GP) because I feel I'm on the road to healing, rather than just coming in as a lump of flesh and sitting in a chair and saying, 'What can we do about this?' You see, it's different.'

GP4 commented that orthodox approaches to chronic illness can get patients '*...tied in knots by what time of day to take what tablets and when their next appointment is and they forget that underneath they are actually human beings*' (GP4. T2.L188). They claimed that referrals to complementary practitioners could be particularly useful when the patients felt '*undervalued and redundant*' (GP4. T2.L207) and may benefit from a more personal, holistic perspective as described in the previous section. '*I think one of the things that it (shiatsu) would be good for would be encouraging people to value themselves more in that other people are bothered about*

them and just take a sort of step back and look at their lives a bit more as a whole really' (GP4. T2.L203).

Jenny seemed to fit this description of a patient who may benefit from a more holistic approach to her health. In her first interview, she was concerned about her range of symptoms, seeing them as external to her and not fitting her self-image. She described how, even after years of having her symptoms, she did not accept them and was particularly embarrassed about her diagnosis of depression. She also commented that *'I had one or two panic attacks which I felt this is not me and I couldn't understand it and I wasn't accepting things'* (Jenny. T1.L223). In her follow-up interview, she described a similar experience when she *'...really freaked out and there was no reason why I should be. I thought it was my thyroid overacting again...but it was fine so I can't blame it on to that'* (T3.L14). It seemed as if she would be reassured by a clear physical reason for her psychological/emotional conditions. This could have reduced her responsibility in the cause and possibly the treatment of these symptoms. As Jenny received more shiatsu, she began to view her health more holistically and think about how she could help herself.

Jenny. T3.L57 *'I keep hearing this little phrase – 'use it or lose it,' (laugh) so I'm bending my back in the garden and trying to use it. I know that you should make time for yourself. I've got to try and do things to help myself more.'*

The main ways in which patients began to help themselves more will now be discussed.

New health-promoting behaviour

The greater degree of self-responsibility described in the patients may be associated with a range of new health-promoting behaviours they adopted. For instance, many patients reported that they new practised techniques they had learnt in their shiatsu sessions.

Julie. T2.L20 *'I was wanting to sleep at the right time like half past ten. Before that (the shiatsu) it was like two or three o'clock. I'd be exhausted*

and I'd go past sleep by the time it came to bedtime. My mind was awake and couldn't channel it into sleep, and what I liked about the shiatsu was I could do it myself...I could learn to relax myself and practice what we'd done here. Just a total change, absolute total change.'

Lucy described new behaviour in terms of practising relaxation techniques, pressing pressure points and reducing her caffeine intake. She claimed this self-responsibility helped her feel more positive, partly because she was less reliant on the GPs and medication. This again, supports the GPs' claims in section one.

Lucy. T2.L14 *'I've used a lot of the techniques that she showed me to help me relax. I've got a bad back and when the pain gets really bad I get really uptight and what have you and there's pressure points she actually showed me and deep breathing and all that that's really beneficial. Also I was having problems sleeping and she gave me some advice on cutting caffeine out and going on decaffeinated tea to be able to rest - it has helped me. I've managed to cut my medication down a bit which I've been trying to do for ages. I think a lot of it was just sort of making me feel positive about things and knowing what I can do for myself without having to rely on drugs or the GPs.'*

Self-administered pain relief was reported by Tara *'...I had a quite a bad headache, it just wasn't going at all and then I did the arm massage with the channels...so I was really pleased with it'* (T2.L70). She claimed that she maintained her self-treatment in her follow-up interview, two months after her shiatsu had ended. Some of the benefits Tara described included having more options for pain-relief so she was not so reliant on medication and the stigma she associated with this.

Tara. T3.L115 *'I was able to control it so much easier than before. Having all the different techniques to try rather than going straight for the medication...I had a cupboard full to choose from...I haven't even got any paracetamol in the house and that's unbelievable! Before I'd been carrying them in my bag, had them at work, home, in the car and now I've got nothing...whereas at Christmas I was walking around the shops buying*

paracetamol, because you can only buy them sixteen at a time, just to get me over the bank holiday period and I felt like a junkie walking around.'

Sara had continued her dietary and exercise recommendations in the two-months following her shiatsu. Her choice of words at the start of this quote '*I must admit*', could suggest that Sara did not wish to report any negative changes in her health, which may have implications for the validity of patient responses as a measure of therapeutic success.

Sara. T3.L43 *'I must admit that I have had to go back to the doctor's...she's referred me to a plastic surgeon. But, mood wise I'm fine, no problems with that at all. It's definitely better now still from when before I had the shiatsu...the main thing I took away with me were the exercises, the calmness and the stillness – I'm still having that. I think I've changed my eating habits a bit – not completely but I'm getting there. I'm still drinking more water and not caffeine and I've never thought of going back on the anti-depressants.'*

Jenny also described that she continued self-treatment even after her shiatsu had ended, but reported that she used some techniques more than others.

Jenny.T3.L17 *'It did make a difference to me. If I get a headache I use the pressure points and the ones for my ankles less often. The head ache one I do a lot - I did in the bus the other day and I felt it coming so I started squeezing and the next thing I knew it was gone! I do use that.'*

Sara and Julie claimed that their increased involvement in their health reduced their need to consult with the GPs. Sara explained this by commenting '*It just helped me to really recognise my strengths and my weaknesses and how to cope with them so it's just helped me calm down quite a bit*' (Sara, T2.L24). Julie claimed that instead of always visiting a doctor, she would give herself a 'pep-talk' to deal with her symptoms herself.

Julie. T2.L158 *'...the shiatsu made me feel more in control. I thought to myself, 'Right, don't think you're gonna get me down. I'll sort you out,' where as before it would have been, 'I better get to the doctors, I'm feeling this rough.' It was, 'You're not gonna get the better of me. I know how to sort you out.' So, I felt more in power to deal with things.'*

Several patients made quite large changes in their lives during the study, attributing this in some degree to the time for reflection and encouragement of self-care they received in the clinic. Kirsty and Clare both decided to move out of the inner city. Before their treatments had ended, they had both viewed several houses and Clare had begun to sell her home. Lucy and Kirsty claimed that their improved health and attitude motivated them to embark upon regular voluntary work after years of being unemployed. Kate, like Lucy, had been on long-term sick leave when she started having shiatsu. She returned to her job on a part-time after her initial shiatsu sessions and was back full-time by the end of the study.

This section has described how patients were seen to take more responsibility for their health by adopting specific health-promoting behaviours and making wider changes in their lives. This may be associated with reports that patients' symptoms had also changed after having shiatsu.

Changes in symptoms

The table below describes the range and duration of symptoms that patients reported in their first shiatsu appointment. This data was collected by the MYMOP-PIRIE form that asked the ten patients to choose two symptoms (physical/mental or emotional) to rate during their course of shiatsu. The form was completed in the first shiatsu consultation with the practitioner researcher.

Table 10. Patients' main two symptoms and duration of experience

Patient	Presenting symptoms	Duration of symptoms in months
Sara	Bloating	30
	Depression	18
Jenny	Stress	168
	Stomach pain	168
Tara	Shoulder/headaches	11
	Rattyness	11
Kate	Stomach pain	4
	Low mood	1
Lucy	Back Pain	60
	Low mood	36
Jane	Back Pain	108
	Low mood	54
Julie	Difficulty relaxing	36
	Difficulty sleeping	120
Clare	Neck Pain	84
	Dizziness	60
Mary	Knee Pain	120
	Hip Pain	180
Kirsty	Low Mood	60
	Face Infection	24
Mean		67.7

The above table shows the wide range of symptoms that patients perceived to be their main concerns in their first shiatsu consultation. It also describes how the majority of these symptoms were perceived by the patients to have lasted for a long time, with a mean duration of 67.7 months which is approximately 5.5 years. The most commonly cited symptoms are presented in the following table.

Table 11. Most commonly cited symptoms

Symptoms chosen (two per patient)	Number of patients (n=10)
Muscular pain (back-ache, neck, shoulder, knee, hip pain)	6
Depression	5
Stress (including rattytness and difficulty relaxing/sleeping)	4
Digestion (bloating and stomach pain)	3
Skin infection	1
Dizziness	1

The above table shows that most common presenting symptom was muscular pain cited by six of the ten patients as their main concern, shortly followed by depression and stress. Table 12 indicates that the mean duration that the five patients had suffered muscular pain was 94 months (7.8 years). In contrast the mean duration of depression was much shorter at 33.8 months (2.8 years). Stress had the second longest duration with a mean of 83.8 months (7 years) followed by digestive complaints lasting for an average of 67.3 months (5.6 years). In summary, muscular pain was both the most commonly reported symptom and the one with the longest duration. If the depression and stress categories were amalgamated into a new title of psychological/emotional symptoms then this would be the most commonly cited complaint having been reported by nine of the ten patients. The mean duration of this new category would be 56 months (4.7 years). This illustrates the influence that the presentation of quantitative data can have and the use of raw data in clarifying results.

The GPs were asked to prioritise two symptoms that they would rate during the study to record any changes they perceived in their patients' health. The referral forms (in appendix III) were used to collect this information. The GPs chose similar symptoms to the patients as shown in the following table. The ten symptoms that were chosen by both the GP and patient are presented in *Italics*.

Table 12. Comparison of GP and patient choice of symptoms

Patient	GPs chosen symptoms in each patient	Patients chosen symptoms
Sara	<i>Bloating</i>	<i>Bloating</i>
	<i>Depression</i>	<i>Depression</i>
Jenny	Anxiety	Stress
	Varying physical 'polysymptoms associated with anxiety about health'	Stomach pain
Tara	<i>Neck and head pain</i>	Shoulder & <i>neck</i> pain
	'Post Traumatic Stress; <i>irritability</i> , poor concentration, weepiness'	' <i>Rattyness</i> '
Kate	<i>Abdominal pain</i>	<i>Stomach pain</i>
	<i>Low mood</i>	<i>Low mood</i>
Lucy	<i>Back pain</i>	<i>Back pain</i>
	<i>Low mood</i>	<i>Low mood</i>
Jane	Headache/right side facial pain	Back pain
	<i>Low mood</i>	<i>Low mood</i>
Julie	Low energy	Difficulty relaxing
	Generalised aches and pains	Difficulty sleeping
Clare	<i>Neck pain</i>	<i>Neck pain</i>
	Panic/anxiety attacks	Dizziness
Mary	Generalised aches and Pains	Knee pain
	Anxiety re. chest pain	Hip pain
Kirsty	Asthma	Low mood
	<i>Face infection</i>	<i>Face infection</i>

The ten matched symptoms (in italics) were grouped according to the referring GP to learn if particular GPs were more accurate than others at choosing the same symptoms as their patients. All four GPs had at least one patient that listed the same symptom even though they completed the forms separately. This suggests good communication between the referring GPs and their patients about their main health concerns.

However, GPs and patients did provide very different perceptions of the severity of these symptoms, as described in the next table. This data was also gathered by the patients' MYMOP-PIRIE forms and the GPs' referral forms. The table presents a comparison between GPs' and patients' estimations of severity before receiving shiatsu and the improvement they would be each be satisfied with following shiatsu. It also lists the perceived severity of symptoms after receiving shiatsu and illustrates how these perceptions changed.

Table 13. GP and Patient perceptions of severity of symptoms and satisfying improvement following shiatsu.

Perceived severity of symptoms was rated on a scale of 0-6, where 0 was 'as good as it can be' and 6 was 'as bad as it can be.'

Patient symptoms	GP perceived severity before shiatsu	Patient perceived severity before shiatsu	GP satisfying severity after shiatsu	Patients satisfying severity after shiatsu	Patients perceived severity after shiatsu
P1 - Bloating	3	2	2	1	0
- Depression	2	2	1	1	0
P2 - Anxiety/stress	3	2	4	0	2
P3 - Shoulder/head/neck pain	4	3	4	2	1
- Irritability	4	3	2	1	1
P4 - Stomach pain	6	3	6	3	3
P4 - Low mood	4	2	5	2	2
P5 - Back pain	4	2	4	3	3
- Low mood	4	2	5	3	2
P6 - Low mood	3	5	2	2	0
P8 - Neck pain	5	6	2	3	3
P9 - Joint Pain	4	6	2	3	2
P10 - Face Infection	4	6	2	1	2
Median rating	4	3	2	2	2

The above table suggests that GPs perceived patients' experience of symptoms to be slightly more severe than the patients' themselves did, producing a median of 4 from a total of 6 for 'as bad as it can be' compared to 3. GP had higher expectations of improvement following shiatsu reporting they would be satisfied if their median score of 4 was halved to 2 for symptom severity. Patients claimed satisfaction would be gained if their median of 3 also reduced to 2. At the end of their course of shiatsu treatments, the patients' median score for perceived severity of symptoms had reduced to 2. The weekly reduction in the MYMOP-PIRIE scores can be found in appendix II. The SF-12 results also support the patients' assertion that they experienced increased well being during the time they were receiving shiatsu. Both

the physical and mental scores of the SF-12 rose over the three time periods of data collection; pre-, post shiatsu and 2-month follow-up (see appendix II).

This alteration in perceptions of patients' health will now be described in detail by the qualitative data from the patients, their GPs and complementary practitioner. This qualitative data suggests that perceptions of patients' physical and emotional/psychological health changed during the study.

Changes in physical symptoms

Patients claimed there was four main ways that their physical symptoms changed after having shiatsu. They described changes in pain, increased energy, improved digestion and a stronger immune system.

Pain

Clare had been suffering severe, chronic pain in her neck and head for many years prior to having shiatsu. She had been told this was due to degenerative discs and that there was little that could be done. However, she reported a reduction in pain following her shiatsu treatment.

Clare. T2.L58 *'...the pain in my neck and my arms it's helped me with that. Headaches, I was getting terrible headaches I don't get them as much now.'*

Tara also described a notable reduction in pain in her post-shiatsu interview with the external researcher.

Tara. T2.L40 *'The pains through my neck and shoulder just wasn't as it was. I wasn't waking up with it in the morning...I haven't got the headaches, I think it was a dramatic shift because it was always there...and I had some lower back pain and she treated that and that went as well'*

Tara claimed that this pain relief was still apparent in her follow-up interview, two months after the shiatsu had ended.

Tara. T3. L27 *'The main thing I got from shiatsu was the reduction in symptoms, the pains in my head and my neck and shoulders. It's just been excellent – totally different.'*

The maintenance of this pain relief is obviously of great importance when establishing if an intervention has made an impact or not. Lucy also described her pain was less two months after shiatsu than before treatments started, but noted how there had been a relapse in the degree of this relief.

Lucy. T3. L40 *'No, the pain came back but I still felt better in myself. I think there's only so much that it can do and that my pain still going to be there, but I think it was the least painful that it's ever been.'*

Mary, who only attended three shiatsu sessions, described also her pain relief as being only short-term.

Mary. T2.L27 *'As far as my knees and my spine it seemed to help a bit but not for long. It were alright that day I had it and the next day, but then it came back, it relaxed me more than anything, I felt relaxed when I'd had it...It eased my back when I went. It were more or less unbearable. But it took a lot of the pain off, as I say for a short time you see.'*

The presentation of new pain during the study was described by GP1 and discussed more in the Jenny's case study in appendix IV.

GP1. T2.L51 about Jenny *'The things that I referred her for were the abdominal pain and the chest pain, they seem basically to disappear out of the picture. So she didn't mention them. She mentioned four different things when I saw her in February, and none of them was abdominal pain or chest pain.'*

Although only one patient claimed a new pain had arisen after initial discomfort had eased, it is included here as an interesting response to treatment and an example of the variety of reactions patients described. This followed Smith et al's (1999) advice that

it is not simply the frequency of an emerging theme that warrants its inclusion in the analysis, but also the relevance of uncommon ones. It also supports the commitment in the study to uncovering and expressing a variety of views from the participants, especially those that are different from the status quo.

Energy

The second description of physical changes relates to patients reporting an increase in energy after having shiatsu. Sara claimed *'I just felt, the energy I had was just twice as much as normal'* (T2.L56). Kirsty also described this when asked by the external researcher *'Have there been any changes in your health and well being since starting shiatsu?'*

Kirsty. T2.L3 *'Yes, absolutely. Basically, it's restored me from the dead! I feel younger, because on the second one I started feeling much more energetic. I mean at one time I couldn't have got up those stairs.'*

Jenny claimed she became more active during the study because she was able to keep her mind occupied. She had previously attributed her anxiety and depression to having more time to worry since losing her job, see case study in appendix IV *'I have felt more motivated these last few weeks and I've sort of been, looking around the house to see what I can change and what have you and I've been doing little bits of things but I've been thinking, 'I've had my mind on a different thing' and I feel more motivated'* (Jenny. T2.L63).

Lucy reported that she had maintained her increased level of energy in the two months since having shiatsu. In a similar way to Jenny, she associated this with feeling more happy and healthy. Lucy claimed her increased energy helped relieve her pain and depression through being more sociable and undertaking a new voluntary job.

Lucy. T3.L3 *'My back's not as bad as it was, probably in the middle now at three (out of six for severity on the MYMOP-PIRIE form) and my moods also at three, partly because of the voluntary work I'm now doing. It's really good to get out and meet people. I wouldn't have had the energy for that before the shiatsu.'*

Julie also claimed that having more energy dramatically changed her life because she was more able to cope with the demands of work and her four young children and even enjoy a new hobby. It seemed as if her 'sick-role' had been replaced by a sense of normality.

Julie. T2.L135 *'I've just got the energy that I've got. I wake up and I'm not exhausted which I've never had before, having the energy to do things...I'm not up to it. But now nothings too much. I've even bought a caravan...We've got energy to go there. I took six children this weekend, and I've got the energy to do things and that is so nice just to be able to live normally. You feel like you've got quality.'*

She described another occasion when her increased energy helped her enjoy her day. This was assisted by her new attitude of doing more of what she wanted to, as opposed to what she 'should' do.

Julie. T2.L281 *'After the first shiatsu I had energy. We went out. It was with my sister-in-law whose got clinical depression and she'd been really rough and she'd come to stop with me...I'd have never have been that relaxed or energised to go from like half twelve till five o'clock without doing something that I thought should have been done or a task that I'd set for that day. I came back we had tea and I did the house all the way through. I'd got the energy to do it. I felt so relaxed and energised it really made the difference, and that was my first one (shiatsu). I'd changed, I couldn't believe that energy that I'd got.'*

Clare reiterated this possible link between energy and increased well being.

Clare. T2.L54 *'Well, it's helped me relax; it's lifted me spirits. Definitely I'm not as in as much pain and my energy levels are a lot higher. I mean things I couldn't do before, I'm up and I'm doing it. I mean simple things like hoovering up, which I just sit and think, 'Oh! Stuff it!', I just do it now. I don't think about it so my energy levels are a lot higher...because*

if you've got depression, you've got no energy at all you just feel lifeless and weak, it's definitely made a difference.'

Digestion

As table 13 on page 173 illustrates, digestive complaints were cited by three of the ten patients as one of their main symptoms they wished to alleviate via shiatsu. All three patients' digestive disorders were perceived to improve during their course of treatments. For example, Sara was referred for '*bloating and epigastric pain*', and from the second to her last treatment she rated this as '0', indicating it was 'as good as it could be.' This was supported by Sara's comments in her post-interview with the external researcher. Kate's digestion also improved '*I was being sick - vomiting quite a lot, and that ceased during shiatsu*' (Kate. T2.L128). Jane reported that she was '*eating a lot better*' (Jane. T2.L20) though this was not one of her two main complaints she had described on her MYMOP-PIRIE form.

Immune system

The final example of perceived changes in physical health illustrates that several patients claimed their immune system had improved during the study. Kirsty had been suffering from a chronic skin infection that both she and her GP claimed had improved. '*She's had a sort of persistent skin problem since she was in hospital and that is improving*' (GP4. T2.L111).

Summary

Participants have described several ways in which they believe shiatsu is associated with changes in the physical health of patients. If these perceptions were describing a real change in the patients' experience of physical symptoms, it could be expected that their psychological/emotional health might also alter. As already outlined, this study is concerned more with personal views than objective health outcome measures. The participant's perceptions of patient's emotional health will therefore follow to continue the assessment of the impact of shiatsu on the patients.

Changes in psychological/emotional health

The participant's reported several changes in the patients' psychological/emotional health during the study. In some patients' there was a 'fear of the unknown' with regard to having shiatsu and then 'feeling at ease' once the treatments had started. Participants also reported changes in patients' stress-relief and relaxation, depression, stress, anger, anxiety and feeling of support.

Fear of the unknown

A few patients initially reported feeling apprehensive about having shiatsu. This seemed to be associated with having a new treatment that they knew little about. The physical contact involved also may have been unusual or threatening.

Kate. T2.L74 'Obviously, it's a very personal thing and I found that a little uncomfortable at the beginning, but again, once I got to know Zoë and felt bonded with Zoë, then I was fine with that and relaxed more, I think, and got more benefit from it...I did find it quite intrusive being laid on the floor, with your eyes closed and somebody above you working around your body, but that was a personal thing that I'd have just come to terms with, but I soon relaxed and warmed to Zoë, so it was alright.'

Julie described the comfort of being able to remain fully clothed during the shiatsu treatments. This is particularly relevant when working with cultures that have particular beliefs about dress. Julie, for example, is a Muslim.

Julie. T2.L129 'I could come dressed as I am now and I could have the treatment. So people who are a bit coy or don't like being touched. I say to people it's not like a massage - they're not touching you all over. It's like they're just feeling, I mean if it was any more than that I don't think I'd particular enjoy it and I was apprehensive at first. Like how much touching and feeling is there and I was quite happy in the way it was.'

Patients who are uncomfortable with their body image also may find a hands-on therapy challenging. If the patient can cope with this challenge, the physical contact could actually be a particularly beneficial aspect of the shiatsu. Jane, for example,

explained that she was unhappy with her weight and was initially uncomfortable about being touched. This eased once she knew what to expect and she continued to gain confidence during the study.

Jane. T2.L40 *'I don't know I'm a bit funny about being touched with me being, well I'm quite big...and at first I felt a bit strange, but then I was alright...it didn't seem to matter. It's confidence. I think it was knowing what to expect as well...'*

Sara also described feeling uncertain with having a new treatment and not knowing what to expect. She indicates the importance of feeling at ease with the practitioner, and how this can be a beneficial aspect of the treatment.

Sara. T2.L103 *'Zoë was perfect because the kind of personality she's got just makes everybody at ease straight away. It's a new thing and everybody sort of 'God! What's going to happen now?' and telling somebody to relax means that they are going to get more uptight straight away anyway, but I didn't. I just relaxed and that was it...Zoë made me feel relaxed straight away and some of the feelings that she actually gave me from that were great.'*

Patients seemed to be more comfortable with shiatsu once the sessions had started, supporting the suggestion that apprehension could be due to a lack of knowledge about the treatment. This apprehension could hinder the healing process that may be better supported by patients' feeling safe and comfortable. The patients in the current study suggested that this was largely dependent on them feeling comfortable with the shiatsu practitioner. Jenny suggested that her confidence also grew because the shiatsu practitioner seemed comfortable.

Jenny. T2.L127 *'She's a lovely person, she makes you feel at ease and she's comfortable and so I'm very happy with the treatment. Zoë's come up to my expectations because obviously you want to get with somebody who's giving you a treatment.'*

It seems essential that a good therapeutic relationship be developed between the patient and their therapist. This may be particularly relevant when the treatment utilises physical contact and aims to promote relaxation with patients who are suffering psychological/emotional symptoms such as anxiety.

The need for patients to 'feel at ease' was also reported in the external researchers (R2) notes which documented a comment made by a patient experiencing panic attacks and agoraphobia *'Clare smiled and said, 'Zoë always greeted me with a big smile and that really helped me feel comfortable.'* This may have been particularly important for Clare as she claimed she rarely felt relaxed *'...my mind sorts of goes off...well, thankfully Zoë was very professional and she was approachable and made me feel at ease'* (T2.L216). She also described feeling more at ease in the room than she did when she had counselling there *'...it seemed a lot more friendly and warmer...a lot more personal, not so cold'* (T2.L32). Clare is a good example of a patient who suffers chronic and severely debilitating health problems and who may need more reassurance about a new and unusual treatment. These resistant symptoms have been shown in the literature review to be commonly referred for complementary treatment, increasing the need for complementary practitioners (and referring clinicians) to consider patients' fears with unfamiliar therapies.

The issue of fear was also cited in GP/patient interactions. Julie reported that she needed a great deal of encouragement to 'open up' about her health describing how she hid her GP's diagnosis and subsequent medication for depression from her husband for several months. This reiterates the importance of a good patient-practitioner relationship to help the patient feel more comfortable with their diagnosis and management of symptoms.

Julie. T2.L127 *'I bottle everything inside and yet with Zoë I could laugh and we could talk any aspects which was really supportive...It's Zoë's personality as well as the shiatsu. It's like Dr.X, I warmed to him...but like with Zoë I was so glad that she was that sort of person that she supports you like. And I was a bit dithered the first time I walked through the door, you're a bit unsure you don't really know what you're walking*

into. It's like 'Great to see you Julie.' You like to have that acknowledgement that they're glad that you're around...'

This quote is a good example of the difficulty in assessing how much of the feeling of ease comes from the practitioner or the therapy. In addition to discussing the shiatsu practitioner's personality, the patients also cited the shiatsu treatment as helping them feel less stressed and more relaxed.

Stress-relief and relaxation

Sara reported that relaxation was the main benefit she gained from shiatsu, possibly because she described feeling very stressed prior to starting treatments.

Sara. T2.L38 'All of the total relaxation. The calmness, just the peace, the atmosphere, everything about it was so calm. It was just unhurried, the amazing quiet that it gave you was great, it was really wonderful. I mean for the first two weeks I felt like I was permanently smiling from the inside' and L83 'Inner peace and quiet. It's just brilliant.'

Sara and Jenny both claimed that relaxation had been a problem for many years and previous relaxation techniques had been unhelpful. Jenny was also similar to Sara in citing relaxation as the main benefit she received from shiatsu.

Jenny. T2.L48 'I found it very relaxing. Yeah it sort of, it seemed to get me away from things a bit...Just right, you know, stress wise. But I can't clear my mind, like somebody will say like 'relax' and I picture walking round the sea front or watching a waterfall or whatever but then I sort of, my mind's still racing on. But with shiatsu, I'm as relaxed as I can possibly be.'

Jenny attributed this new ability to feel calm to the varied aspects of the treatment package provided in her shiatsu sessions.

Jenny. T2.L69 'I think because it was so soothing. I like the aromatherapy thing which sort of, it felt lovely and it's a nice feeling and then with the

music it did help you to sort of drift off a little...I felt it was very relaxing and it was so different. '

Jenny cites the novelty of the therapy as a positive aspect of shiatsu, as opposed to being frightening as previously described. Later in the interview, she described feeling less stress and pain after having shiatsu *'Although I'm not stress free, I'm definitely...I've definitely got less stress and some of the pains have disappeared'* (T2.L189). These pains could have been associated with physical tension that reduced as she became more relaxed. Stress and pain seem linked in a similar way to patients previously associating more energy with less pain and depression. This reiterates the holistic nature of health and the possible relationship between different symptoms.

Several patients reported their stress relief and relaxation was associated with having 'time-out' from their daily life. It seemed as if the shiatsu treatment enabled them to escape their normal routines and spend some quality time with themselves. Sara, for example, cited the benefit of simply being away from her normally busy life *'... for some reason it takes me away from all the daftness. It was really nice'* (Sara, T1.L42). Kate and Julie also suggested that having time-out was a notable benefit of shiatsu *'I found it very relaxing and for the time I had with Zoë I was just able to switch off from everything and really, I always came out feeling a little bit more lifted as though I'd not got the world on my shoulders'* (Kate. T2.L67). Julie claimed that *'Relaxing was a real problem for me...I just couldn't get a balance where there was time to fit in for myself'* (Julie.T2.L60).

Several patients therefore described themselves as normally feeling very stressed and un-relaxed, and then cited calmness as being one of their main psychological states during the study. Perhaps this relaxation could be associated with the improvements that all three reported in their physical and emotional health, such as pain and chronic depression. This could suggest the importance of relaxation in immunity and reiterates the earlier suggestion of the inter-relationship between physical and psychological/emotional symptoms. Lucy illustrates some of the holistic health benefits that may be derived from having 'time-out.'

Lucy. T2.L5 *'Just taking that little bit of time out to be yourself where nothing else can hassle you. It was like a relief for that short time, well no, because it lasted afterwards. It was just, I think it's hard sometimes when you're trying to do so many things and you're just getting on with life and you don't get time to think about yourself sometimes, and its just nice to not have anything to think about.'*

Depression

Patients described feeling less depressed once they began having shiatsu treatment. This was supported by two of the five patients diagnosed with clinical depression, namely Sara and Julie, ceasing their anti-depressant medication. Participants also reported a reduction in patients' depression in their interviews. Lucy, for instance, reported a change in her mood and remarked on how long she had experienced depression.

Lucy. T2.L27 *'I've been in a really low mood but she really helped with that and made me feel a lot more positive she was really good. I mean its been six years now and I've just got really down with it but she seemed to pick me back up again'*

Kate also reported changes in her low mood and, although she relates this to improving her 'well being', she begins her reply by not connecting this to any change in her 'health.'

Kate. T2.L9 *'I can't notice any change in my health as such, but I have noticed a great change in my low mood, that's was very evident due to the health that I've had, and definitely since shiatsu that has improved immensely...my mood was lifted and its stayed lifted as well...because it was changing my own well being, even the way I looked, my appearance. I just seemed more brighter and even noticed that people commented on it in my eyes. I just seemed to be coping a little bit better.'*

This quote introduces a related theme about how an improvement in mood can help patients access coping mechanisms to assist them with other symptoms they may be

experiencing. GP2 claimed this was the aim with Tara '*...I think that with her mental state I hoped with shiatsu she'd get her well-being back. I think that's a big ambition for her*' (GP2. T2.L136). This reiterates the importance of feeling better psychologically/emotionally and the connection between this and improvements in overall health.

Anger

Sara reported how the anger that normally erupted in stressful situations, disappeared during the course of her shiatsu treatments. Perhaps this is connected to her newfound ability to relax herself, as previously described. She notes how her new reaction to stress helps her slow down and that this actually increases her productivity.

Sara. T2.L88 '*I don't honestly think since the time I've done it (shiatsu) I've lost my temper or my patience once. I get myself really stressed out if things aren't going the way I want them to when I want them to, but now it doesn't matter. It's just sort of, it's a slower pace but there's more things getting done in that pace so I'm actually benefiting from the slower pace more than I was before and its just weird.*'

Lucy also reported a reduction in anger, and related this to her self-treatment in her fifth MYMOP-PIRIE form '*Found relaxation techniques – deep breathing etc – very helpful this week. Exercise is definitely helping with temper.*' Jane cited less aggression when asked why she had recommended shiatsu to others '*I weren't being as nasty to people and I just feel a lot better in myself*' (T2.L72).

Anxiety

Clare often became fearful and suffered panic-attacks in stressful situations. Her GP claimed that this greatly reduced during the study and related this to the shiatsu.

GP3. T2.L81 about Clare '*...Probably about six to nine months she started having panic attacks and there's no doubt that when I saw her the last consultation following her shiatsu, associating the shiatsu with the number of panic attacks she's having, has gone down to about one a fortnight which considering she had about five or six a day when I first saw her is*

pretty good...she has a strategy for dealing with it, so she relaxes and consciously lets go of the panic and then recovers in about fifteen to twenty minutes.'

Support

The patients and the GPs claimed that the shiatsu clinic could offer support through the hour long, weekly treatments. GP4 suggested that this regular input could account for the patients' positive perceptions of shiatsu *'The fact that they were having a caring input regularly for quite an extended appointment was going to be positive,'* (T2. L135). Patients did cite this support as being a beneficial impact of the shiatsu.

Lucy. T2.L32 *'I'm gutted that she's not here to sort me out again. I mean that treatment once a week it gave me something to look forward to and it was just nice to know that I was gonna get a bit of relief.'*

This quote also highlights the problems of discontinuing a service in research, discussed more in the chapter VII. Other comments about support suggests that shiatsu may offer something either in addition to current support structures or in place of them. For example, Clare's GP suggested that the shiatsu reduced the amount of support that she needed from her elderly mother.

GP3. T2.L101 about Clare *'...her mother actually has withdrawn some of her support because six or nine months ago she was almost having to hold Christine's hand all the time but her mother's actually stopped coming to consultations...I think that's a consequence of Christine feeling better that she doesn't need her mum like she did.'*

Patients described the importance of involving other people in their health care and feeling supported by these networks. Many patients claimed they had discussed their treatments to family and friends *'I went home and my husbands one of these if he cant see it, it doesn't happen and I said to him, I swear blind that I honestly felt something's moved in my stomach and something's changed straight away'* (Sara. T2.L118, after her first appointment). Sara's inclusion of others in her health was also reported in my diary entry after her appointment the following week *'Sara said her*

husband told her that he could feel the difference in her stomach – much less tight and knotted. Said he was really impressed.'

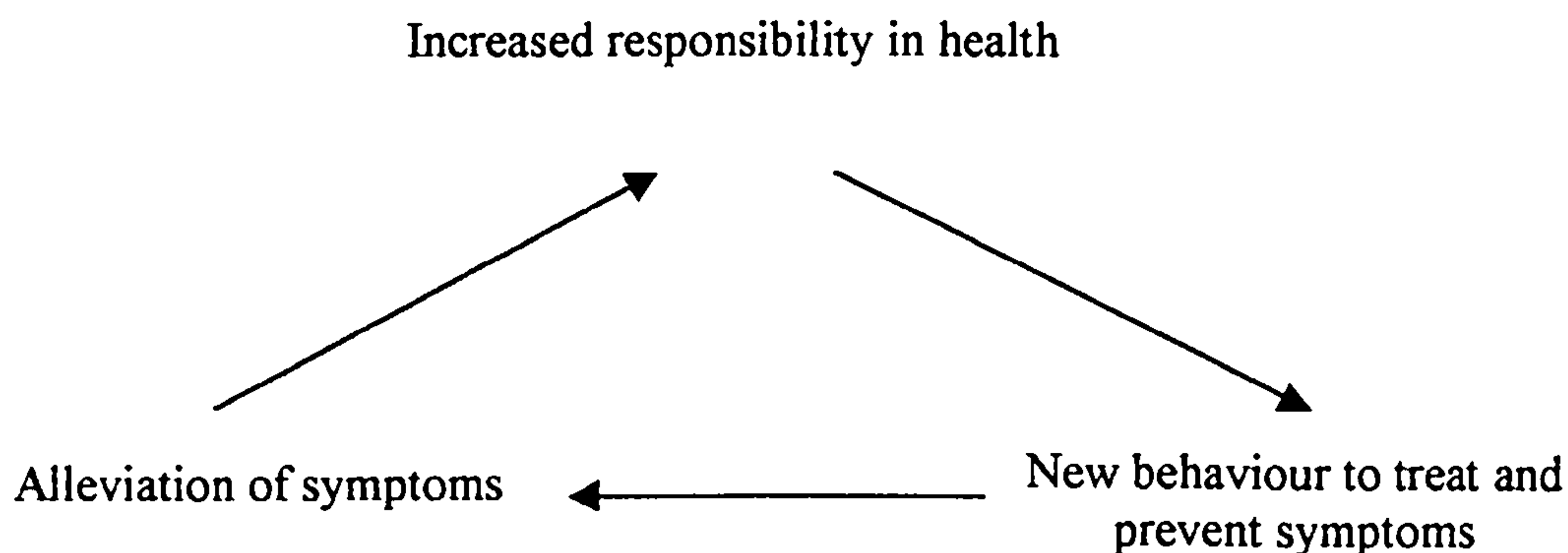
Research suggests that the reaction from 'significant others' to an individual's health can have an important influence on how that person sees their symptoms (see discussion chapter). It was reassuring then that the patients in the shiatsu clinic were not only discussing their experiences with those they cared for but were receiving support and reassurance in return. This was still being reported two months after the shiatsu had ended. Jenny, for example, suggested that she held more credence in the shiatsu when her husband gave his endorsement.

Jenny. T3.L32 'I was telling this friend that Zoë said that this pain is caused by too much energy in one place and it needs to be distributed round the body, and my husband said too that, 'You know, that makes a lot of sense,' and he's always got something bad to say about these things and I was right impressed that he said that. So it really must be good if he agreed with it! (laugh).'

Cycle of improvement in patients' health

The data presented so far suggests that during the study, the patients adopted more responsibility for their health, practised new health-promoting behaviours and experienced an alleviation of symptoms. This is illustrated in the following diagram.

Figure 13. Cycle of improvement



This diagram suggests there is a direct impact of shiatsu on patients' perceived experience of health. When the patients were directly asked what they thought their health changes were due to they all described at least one main improvement in their health that they related in some degree, to having shiatsu. To encourage alternative explanations, patients were asked to think of potential causes other than shiatsu that could have assisted their health. Lucy described several benefits she attributed to having shiatsu, including an improvement in her depression. The external researcher (R2) reflected this back to her (T2.L46).

R2 *'And do you think the changes are due to the shiatsu?'*

Lucy *'Yeah, definitely'*

R2 *'Has there been anything else that could have made you better?'*

Lucy *'No definitely not, things that would make it a lot worse but no, despite that I'm still all right.'*

A similar picture was provided by Kirsty in her post-interview (T2.L219).

Kirsty *'It is the most powerful of all the treatments that I've had because it goes the deepest... the end result has been fantastic.'*

R2 *'The shiatsu has been helpful. Has anything else that's changed in your life that could have brought about the improvements as well as the shiatsu? Has anything else changed for the better that would have helped you in any way?'*

Kirsty *'Oh no! My life is one slog. Gosh no!'*

Sara also attributed all of her health improvement to receiving shiatsu. The external researcher (R2) again attempted to find alternative attributions but Sara reported that the shiatsu had replaced her prescribed medication for her depression and digestion *'No. I don't think so because at the time the shiatsu was the only thing that I was doing - as I say it helped me calm everything down'* (T2.L57). Sara then described how other aspects of her life had actually got more stressful (as Lucy did in the previous quote), but instead of this keeping her symptoms stable or worsening them, they had continued to improve.

Sara. T2.L62 *'If anything work had changed in the sense that I got more responsibilities and things like that. I was having to take more work home so it hadn't changed in calming down in that way. I just acquired more work but I seemed to be getting more done as well, so shiatsu just helped with all of that.'*

To triangulate/crystallise Sara's attributions, her GP was also asked to think of reasons other than shiatsu, that may have contributed to Sara's improvement. The GP was not aware of Sara's comments, but seemed to support them. *'If anything, the anti-depressant treatment dropped dramatically. She stopped it quicker than I would normally have. I would have braced myself for a re-lapse. It really looked like the shiatsu'* (GP1.T2.L9).

Julie has already been shown to associate shiatsu with sleeping much better, having more energy and feeling less depressed; to the extent that after two weeks she, like Sara, stopped taking her anti-depressants. Both ceased this medication in consultation with their respective GPs. Julie's GP made the following comments on her improvement in health (GP3.T2.L45).

R2 *'Could there be any other factors that could be associated with these changes in Julie's case?'*

GP3 *'Well knowing Julie I don't think there is anything else. There's been no other interventions, I mean I've known Julie for ten years and she's had a whole range of interventions and shiatsu initially has made a substantial difference.'*

R2 *'Had anything else changed in her life?'*

S3 *'Not to my knowledge. She still had these difficult children, especially the eldest who suffers from recurring asthma.'*

Like Julie, Jenny has already been described as reassessing her understanding of her health during her course of treatments and although her improvement was less, she also attributed this to shiatsu. *'I'm sort of set in the routine even though I'm not working so nothing else has changed'* (Jenny. T2.L61). Again, this was supported by her GPs views.

GP1.T2.L21 about Jenny *'Seems to be the shiatsu. I don't think anything else really changed to be fair. It surprised Jenny. Yes, in terms of treatment, nothing else changed. I think the positive change was from shiatsu.'*

The comment *'It surprised Jenny'* suggests that she was not expecting shiatsu to help her, which may have hindered her motivation to fully engage with it (see her case study in appendix IV). Following the above quote, the GP was then asked if anything other than the shiatsu could be associated with Jenny's health, the GP reiterated *'No, we didn't change any of the treatment, or do anything different.'* Two patients did change their normal treatment during the study, even though the shiatsu was meant to be additional to existing care. They both stopped an aspect of their health care while having shiatsu.

Tara. T2.L36 *'Nothing else has changed, other than the shiatsu treatment. I've been seeing a chiropractor once or twice a week and I've put that on hold and I've not re-started that, so it wasn't the chiropractic treatment.'*

Kate chose to stop her medication, perhaps to test if shiatsu was working by limiting compounding variables *'So I just come off that (the medication) while I had the shiatsu, to take that decision to let the shiatsu, if it was going to work, work purely on its own merit and not by medication I was getting by the doctor'* (Kate. T2.L48). However, her sudden cessation of prescribed medication could have limited her potential improvement. As already mentioned, the study attempted to look at changes that could be associated with shiatsu plus, not instead of, normal health care. Instead of helping her assess the effectiveness of shiatsu, the alterations Kate made to her health care unfortunately hindered her decision *'Obviously a lot of things have changed, so its hard for me to say that its down to that but it does coincide with shiatsu...I can remember at the time I really believe that it did contribute'* (T2.L12).

There was one alternative attribution that participants provided for the perceived changes in patients' health, suggesting that the weather might have played a role. *'It would be interesting to try a shiatsu clinic which finishes in the Winter, as this one finished when the weather was good, which tends to lead to improvements in patients,*

in moods anyway' (GP4. R2 notes). This is an interesting suggestion since the first clinic started in January and finished in March when the weather was still very bad. A subsequent search through the data did produce a reference to the weather from one of the patients, which supports the GP's view.

Jenny. T2.L58 *'I don't think really there's anything other than the shiatsu. I think the only thing that, I mean it's happened to everybody this but it's getting lighter in a morning and the days are drawing out and which, I feel that must be helping you. That's the good lord isn't it so yeah.'*

Jenny and Kate reported less improvement in their symptoms than the other patients. They reflected that this could be partly due to a lack of commitment or involvement on their part. Kate stated that *'I know I need to like, put in an effort to try and get some benefit from the shiatsu as well'* (T1.L69). Jenny has already described herself as lacking in self-motivation. In her interview she described that *'I think everything you do you've got to put 100% into it as well to make things work and I don't feel that I've been doing enough to help myself after the sessions'* (T2.L94). This supports the claim in the 'cycle of improvement' that greater self-responsibility and practice of healthier behaviours may have resulted in a larger improvement in health. The motivation needed to make these changes may be associated with how much patients expected the treatment to work.

Patient expectations of shiatsu

Cynical expectations

Some patients described feeling rather cynical about shiatsu and being pleasantly surprised by the impact that they felt the treatments had. This has already been mentioned by Jenny's GP for instance. Julie also reported this reaction.

Julie. T2.L130 *'I thought she'll (the shiatsu practitioner) never get me to feeling good...if she could get me to feeling a bit better, that's all I was expecting. I never imagined in my wildest dreams, I think people must be fed up of me talking about it!'*

Jane said she had not expected the shiatsu to be any more successful than her other useless treatments and was, again, surprised by its results.

Jane. T2.L49 *'I expected it not to be any different really. I was all on the down side of it I think. I was really negative.'*

R2 *'And what was the down side do you think?'*

Jane *'Oh well, It can't work. It can't be what they say it's gonna do and everything and it did! I was right surprised.'*

Lucy also suggested that her cynical attitude was partly due to the failure of other treatments she had tried. The number of resistant symptoms experienced by many of the patients did mean that they had tried several treatments before having shiatsu.

Lucy. T2.L70 *I didn't think it would lift my mood as much as it did so that was quite a surprise, and also I think I was a bit pessimistic and cynical about the physical side because I've had that many treatments and that many things done in the past that I just thought, 'Oh I'll just give it a go anyway' but I really did feel refreshed...it just seemed to get my body moving and everything working again. I don't know how.'*

Kate also reported feeling sceptical about shiatsu, attributing this to not fully understanding the treatment and because it was unfamiliar. This may have led her to read about the theory and practice of shiatsu, as already described by other patients, but she remained cynical about the impact it could have. As already suggested, this may have lessened her motivation do what she could to help herself during the study.

Kate. T2.L21 *'I don't really fully understand it myself and still find it hard to understand in my head how it can actually, you know by pressing an area between your finger and thumb can actually have an affect on your stomach, but I know that's how it works...I took a lot of literature actually off Zoë and I've done a lot of reading on it and to be honest with you I was very, very sceptical when I came into it. But I was open-minded and even now (though I don't know how) it can help with your moods, I still do believe that it did contribute to that...I've got no expectations at all, as I*

say very sceptical, yet very open-minded and I actually pointed that out to Zoë from day one, which she said, 'Fine, that's brilliant as long as you're open minded', which I was.'

Unclear expectations

Some patients described quite vague expectations, probably related again to knowing little about shiatsu and its possible benefits or limitations. Tara, for instance, reported that she did not know what to expect but trusted that the shiatsu would not harm her. She also reported how the GP referral influenced her expectations that shiatsu could be beneficial. The confidence instilled by delivering shiatsu in the general practice is discussed in more detail in the discussion chapter.

Tara. T2.L82 'Yeah, I didn't know what to expect. I mean I've had chiropractic and acupuncture to complement the traditional ones, but I really didn't know what to expect with not, apart from the belief that Dr X had given me when I saw her in December, I knew nothing about it...I knew it wouldn't harm me so therefore it could either be only stay the same or be beneficial...'

Tara also mentioned how she was willing to 'have anything' to relieve her symptoms. Other patients also described how the severity of their ill health led them to want any relief, however small from the shiatsu. For example, Kate said *'I was in such a low mood at that time because of everything that was happening, it was all building up for me that I would have been happy just to come sort of half way, which I did do, and that's all I expected and that's all I wanted'* (T2.L116).

High expectations

In contrast to the previous descriptions of expectations being low or unclear, one GP claimed that all the patients had high expectations of shiatsu. It was suggested that this caused patients to view the shiatsu positively, regardless of whether it had actually helped or not. This was the GP who suggested earlier that the weekly input that the shiatsu provided may also cause patients to describe it favourably.

GP4. T2. L13 *'...the patients who were referred to shiatsu were very positive about it. But their expectations were very positive so they felt that they were bound to benefit.'*

However, the patients' own reflections suggested that only one had high expectations of the treatment. This was Jenny who actually described this high expectation as being unrealistic.

Jenny. T2.L8 *'Miracles! (Laugh)...I sort of expected to like jump up and do somersaults or something. I mean it didn't happen but I did feel better, I felt a lot better. I think that my expectations were too high because I expected the lame to walk.'*

She also reported here that these high expectations were not met by the shiatsu *'...it didn't happen,'* contrasting with the GPs suggestion above. Perhaps Jenny's high expectations, coupled with her low self-responsibility as already suggested, made it hard for her to maintain her benefit from shiatsu once the sessions had ended.

Expectations met by the shiatsu clinic

All participants were asked if their expectations had been met. Regardless of how vague, high or low these expectations were, patient responses were very positive.

Sara. T2.L54 *'I think it surpassed them (her expectations) really because, as I say, I didn't expect to feel so good, certainly in the first week...Oh God! You know, where could you begin? I was overwhelmed really with the way it made me feel, the things I could do, the things I hadn't done for years and just the energy it gave me.'*

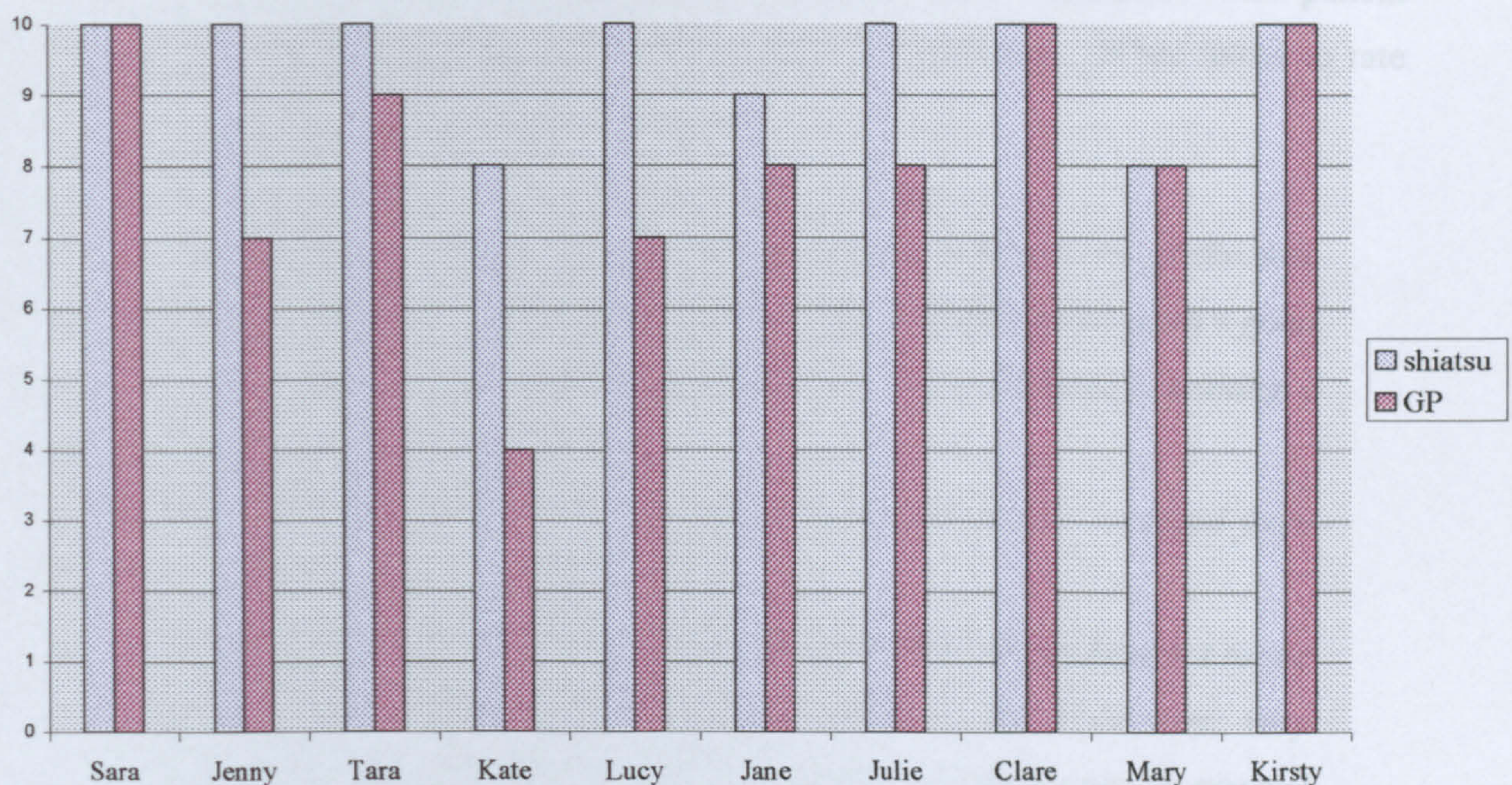
Satisfaction with Sara's general health improvement was also reported by GP who claims she had only hoped that shiatsu could alleviate her digestive condition.

GP1. T2.L68 about Sara *'I thought her abdominal symptoms might settle a bit, but actually she seems as a whole person, she seems better, I have to say...she's the one who's chucked away all her tablets and both her*

stomach tablets and both anti-depressants. But the abdominal symptoms have gone...she was complaining of bloating and distension and all this but yeah, she's really confident. Fantastic!

In support of Sara's case, all of the patients reported satisfaction when asked if the shiatsu had met her expectations. Kirsty, for example replied *'Far in excess of, because there was instant pain relief, a difference in my mobility and in my mood'* (T2.L230). Patient reports of high satisfaction were also found in the quantitative ratings they gave in their interviews. They were each asked to rate their satisfaction with the shiatsu clinic and separately, their GP care on a scale of 1-10, with 10 being highly satisfied. High scores of satisfaction with shiatsu and GP care were reported by all of the patients, the individual ratings of which are illustrated in the table below. It should be noted, however, that these rating of satisfaction are hindered by the methodological issues described in the discussion chapter.

Figure 14. Patient satisfaction with shiatsu and GP care



The responses indicated a high degree of satisfaction with both shiatsu and GP care, the mean difference in scores being 1.4. Patients were asked to explain their high ratings for shiatsu to supplement the quantitative data with qualitative meaning and overcome some of the difficulties of assessing satisfaction. Two patients claimed the

shiatsu had pleased them so much that they were considering training in the therapy themselves. Julie, for instance, claimed this would help her share the benefits she received from the treatment, reporting that *'It's more than met the expectations'* (T2.L148).

It could be suggested that such high satisfaction reports could be because this group of patients was particularly easy to please. However, as already indicated, some of them had very high expectations about the service they would receive from the shiatsu clinic and self-confessed 'unrealistic' hopes for its effects on their health. Others were openly cynical about any benefit they may gain from treatments. Following the action-research methodology, questions were added to the interviews to gain more information about patients' habits of reporting satisfaction. To see if the patients were prone to making positive comments about their health care in general, they were asked to rate the shiatsu and the medical centre separately. Interestingly, this showed that patients did provide different ratings of satisfaction towards different practitioners and this included describing low satisfaction when applicable (see figure 14 on page 201). Qualitative data from the interviews supports this suggestion that patient differentiated between satisfaction of shiatsu and GP treatment. When asked to rate the shiatsu out of ten, Lucy commented:

Lucy. T2.L109 *'I can't see any reason why it wouldn't be at the top, there's nothing that I didn't like about it, there's nothing that wasn't good enough, it was really positive. Probably ten, because there's nothing I didn't like.'*

R2 *'And how satisfied are you with the treatment you've received from Hanson?'*

Lucy *'One of the doctors is very unsympathetic and I do my best not to see that one but the doctor that I see all the time, Dr X is very, very good...he's always got time to talk and he asks how things are in general and he seems interested whereas this other doctor quibbles about every time I want a prescription, or when was the last time you had one and why aren't you trying to cut them down anymore (the pain-killers)...I'm the sort of person that needs encouraging rather than being told off...I have a really bad problem with motivation and I think the shiatsu helped with that*

as well. I felt like doing more when I'd been there I felt like I could go out and get things done.'

This extract from Lucy's interview reiterates the previous claims that the shiatsu helped to empower and motivate patients so they felt more energised. It is interesting that this is cited as an aspect of the shiatsu treatment that was not experienced in Lucy's GP care. It seems that patients' reported satisfaction with their shiatsu treatment seems to have impacted on their view of the GPs and the general practice as a whole. For instance, Lucy and several other patients expressed dissatisfaction with their care at the general practice and suggested that this was partly highlighted by their experience in the shiatsu clinic. Kate lamented the fact that her GPs did not diagnose her symptoms satisfactorily and this led her to seek private orthodox care.

Kate. T2.L153 'I'm not satisfied at all actually, because it's been such a long time. Again, with the medical problems, that's been going on since October and I actually had to end up paying private and they straight away put me in for a biopsy so I was very disappointed that I had to pay private to be told that.'

Clare also compared her high degree of satisfaction with shiatsu with her orthodox medical care, suggesting the need to find appropriate treatment for each individual patient. The following quote illustrates her dissatisfaction with the counselling offered at the general practice and also at a local hospital.

Clare. T2.L47 'It's transformed me, it has (the shiatsu)... to say I've only had six sessions it is really amazing stuff. It's helped me more than tablets. I had counselling and that helped but even more than that, but I went to see the community nurse in a psychiatric hospital and it's a group thing and I felt worse when I came out of there than I did when I came in, so I'm not very sure about that performance. I'd much prefer to have shiatsu actually because it works better for me.'

Other patients suggested that their satisfaction with shiatsu *improved* their view of the GPs and the general practice as a whole. Jenny for example, described being pleased with her GP because they referred her for shiatsu. *'The doctors are so caring...I've*

nothing but praise for them...I think Dr X was wise to let me come and experience it (the shiatsu)' (Jenny. T1.L218). Clare also praised her GP for referring her for a treatment she describes above as being beneficial 'I can't praise him enough...it's down to him that I've had this treatment' (T2.L59). Sara seemed to view the practice more favourably because the integration of the shiatsu clinic suggested that the GPs could put aside their traditional orthodox training and '...close their mind to their thoughts and be open to consideration (of shiatsu) so I think it's a very good medical centre' (T2. L150). This confirms the GPs view in section one that the shiatsu clinic helped raise the practices' reputation as being open-minded and supportive of shiatsu.

Avoidance of negative feedback

The data was reanalysed to find any alternative explanations for the high levels of satisfaction reported by the patients. Two quotes were found that suggested patients might be resistant to give negative feedback. Julie for example had low expectations of the shiatsu and made an equally low rating for how much she thought the treatments could improve her symptoms. It was as if she did not believe that the shiatsu could offer her much improvement and so a higher rating would be unrealistic and would 'let me down' as the shiatsu practitioner.

Julie. T2.L146 '...I put on those forms (I thought she'll never get me feeling good) so if I put 'three' she'll not feel let down. If she could get me to feeling a bit better, that's all I was expecting, I never imagined in my wildest dreams, I think people must be fed up of me talking about it!'

Jenny described feeling uncomfortable when discussing her symptoms. However, she also seemed resolved that it was necessary to tell me, suggesting that she did not refrain from describing 'negative feedback.' Jenny described *'I did feel embarrassed each week when I came and Zoë was saying, 'Now, how've you been?' and I'll say, 'I've got this pain down here and I've got that pain' and I'm thinking 'God! I'm like an old crock!' but I've got to tell her so that was that'* (T2.L192). The data was analysed again to see how Jenny described her behaviour in consultations with the GPs. Jenny described her description of symptoms to GPs as '*moaning*' (RJ), which may indicate more about her self-critical attitude than a reticence to be honest with the

shiatsu practitioner in particular. She also suggested that her doctor did not view her symptoms as seriously as she did.

Jenny. T1.L2 *'Well, I feel I've got aches and pains all over the place, they don't mean a lot. Well, they don't mean a lot to the Doctor, but they do to me.'*

This quote confirms her GP's fears about their relationship that were described in section one.

Patient recommendations to others about shiatsu

One way in which patients suggested their satisfaction with the shiatsu treatment was by recommending it to people they knew. Patients described two kinds of people and symptoms they thought shiatsu could assist; people suffering a mix of psychological/emotional and physical symptoms or experiencing more psychological/emotional symptoms than physical ones.

Shiatsu recommended for a mix of symptoms

Patients described shiatsu as beneficial when a variety of symptoms presented together, supporting the GPs claims in section one. They reported that they recommended shiatsu to people with similar symptoms to their own.

Tara. T2.L156 *'...it had such a beneficial effect to me...It's sort of joint stiffness problems, migraines I think it would work for... Yeah, I think sort of anywhere where there's a lack of control. I had a car crash, so I had problems like that, I had sort of migraines. Using it for anxiety or depression might help, because it's so relaxing and you're sort of given lots of time so it might help things like that, but I just don't know, but I'd just recommend it to anybody.'*

Sara supports Tara's views that shiatsu may be beneficial for a wide range of symptoms and reiterates the GPs claims in section one that it is particularly useful for chronic symptoms.

Sara. T2.L153 *'Anxious. People with panic attacks. Depression, whatever kind of shape or form it takes but certainly the anxiety and the panic attack people. People with chronic illnesses I think with long term pain, things like that.'*

Lucy also suggested that shiatsu could help a mix of symptoms referring to pain and stress as in her own condition. She offers a different view however about the effectiveness of shiatsu for 'deep-rooted' physical pain by suggesting that shiatsu is limited in treating chronic or severe physical symptoms. Perhaps similar beliefs have led others to view shiatsu as being more effective for psychological/emotional symptoms. Lucy, for instance commented that *'Just aches and pains and things, I don't know if it would be beneficial for things like arthritis...people who are stressed out definitely'* (T2.L157).

Shiatsu recommended for psychological/emotional symptoms

Some patients suggested that shiatsu was more effective with psychological/emotional symptoms than physical ones. This was not suggested by any of the GP interviews. Patients claimed that stress was alleviated by shiatsu and physical symptoms were more resistant to the shiatsu treatment.

Stress

Jenny and Lucy recommend shiatsu for stress, again basing this claim upon their own experiences *'Well I think if your stressed up I do think its very good and its good to help you get out of yourself...people like me'* (Jenny. T2.L156). Lucy reiterated the previous suggestion that shiatsu offered anxious or stressed patients time for themselves. She also supported the claim that shiatsu can empower patients so they feel important.

Lucy. T2.L138 *'I think my mum would really benefit from it because she's got liver disease and I don't think she feels physical pain but I know with the worry and everything she just gets really uptight and really stiff and I just think she'd really benefit from it. For the same reasons as me - to clean yourself out really...so that you can concentrate on yourself for just a short time and realise that you are important really.'*

Resistant physical symptoms

Jenny and Kate described that they would recommend shiatsu to people who had physical symptoms that were resistant to orthodox treatment, suggesting that shiatsu is less appropriate for what they deemed as purely physical symptoms that required orthodox 'medical' treatment '*...my brother-in-law he's having some physio. now I thought about him and then I thought no because really you've got to be medical haven't you for that sort thing and I don't know perhaps maybe...So perhaps maybe not every, it would not suit everybody*' (Jenny. T2.164). However, a bit later in her interview, Jenny seemed to contradict this statement, claiming that '*I just think most people would benefit by it, I don't think there's anybody that wouldn't*' (T2.L182). She seems to clarify this by describing that shiatsu can help any-one feel more relaxed and reassured, but may not be the most useful treatment for muscular problems '*As a relaxant but I'm not 100% sure that it'll cure all muscular pain but there's a reassurance about it that makes you feel better*' (T2.L219).

Kate also described that shiatsu may not be effective for physical ailments based on her own experience of poor health. She described that her 'medical problem' required orthodox care but claimed the shiatsu helped to lift her mood and reduce her pain

Kate. T2.L34 '*...the big thing was the mood...which I do believe the shiatsu did contribute to lift me out of that...as for the actual problems I've got that is a medical problem that needed medical procedure. So, again, I think that would be asking too much of something but I think it tries to help with pain, tries to subside that.*'

Recommendations Already Made

Although the questions in the interview only asked participants to describe who they would recommend shiatsu to on a theoretical basis, many responded that they had already suggested shiatsu to others. Sara, for instance, had recommended shiatsu to several friends and relatives as well as colleagues at the general practice she worked in. She also recommended the employment of a shiatsu practitioner within this practice.

Sara. T2.L148 *'I already have! Anybody that listens I think I have! My daughters, my husband, people at work, I have. I've actually said at work that I thought if we could get somebody in at the Rotherham end to do that kind of thing it would benefit some of our patients.'*

Tara has also widely recommended shiatsu and also specific techniques of the treatment even when colleagues find her suggestions rather strange.

Tara. T2.L118 *'...people at work think I'm mad, but I've got them doing it - I've got them using shiatsu when they've got a headache instead of having Paracetamol...and just massage into your little finger, which seems daft but other people at work have promised that they can, just by doing that they can relieve it, they've been transformed as well...Yeah, I'd recommend it...'*

In an attempt to present a full range of views, transcripts were searched to find instances where patients had not recommended shiatsu to other people. Although this was not possible, as all ten had recommended shiatsu to someone, one patient was less enthusiastic about these recommendations than the others. This was Kate, who has already expressed her belief that shiatsu is more effective for psychological/emotional conditions than physical ones.

Kate. T2.L146 *'I did keep Zoë's card and give leaflets to members of my family so at the time I must of really felt as though it was really having an effect. If I was in a low mood, I would definitely try it again...I've mentioned it to somebody who did have problems with their digestive system and I mentioned it to somebody who'd mentioned their back as well.'*

Benefits of the shiatsu clinic for patients

The last impact of the shiatsu clinic on patients describes the benefits that it was perceived to offer them. Participants cited five benefits of the clinic in addition to the changes in patients' health already described. This involved the patients having

access to shiatsu in their local general practice, the opportunity to relieve stress and relax, the lack of medication, the greater time available and the personal touch of the shiatsu practitioner.

Access to shiatsu in the general practice

Patients argued that it was particularly useful to deliver the shiatsu in the general practice. Lucy claimed that general practices were the best place for delivering complementary medicine (see discussion chapter) and others commented upon the benefits of having shiatsu in a convenient and familiar setting. This may be particularly relevant in relation to patients' earlier comments on being apprehensive about new, unknown treatments.

As the practitioner researcher I also noted the practical benefits to patients in delivering shiatsu in the general practice. For example, Hanson had several facilities for patients that may not have been available in a private clinic or practitioner's home. These included a disabled access, a waiting room with a child's play area, a reception for booking appointments and making enquiries, and medical staff in case of serious injury or illness. The in-house clinic also offered regular communication between the GP and myself as the shiatsu practitioner. This was also noted by the GPs as improving care for patients. For example, dangerous interactions between different treatments could be discussed and avoided. The GPs also described the benefits to patients of being referred to a complementary practitioner that the GP knew and respected (see section one in this results chapter).

The provision of a traditionally private and expensive service in the general practice, also meant that there were financial benefits for patients '*...the thing I liked about it is that I was getting this for free as well*' (Jenny. T2.L76). This helps improve the equity of access to complementary medicine, again already cited by GPs in the previous section.

The opportunity to relieve stress and relax

The benefits of relaxation being offered in the clinic have already been described in terms of the impact that shiatsu was seen to have on patients' health. It was also described as one of the aspects of the treatment that they liked the most and deemed to

be a benefit particularly associated with shiatsu as opposed to other kinds of treatment. Tara, for example, described how she enjoyed the relaxation and time for herself in shiatsu and compared this to the less relaxing chiropractic she had received.

Tara. T2.L51 *'I just like everything about it...I enjoy it and the truth is it's like pleasant and relaxing...I've had the chiropractic treatment which is really quite rough and aggressive and compared to that it was just so gentle...I enjoyed the whole experience, it was nice to have time for me...'*

Kirsty also compared her experience of shiatsu to other treatments, namely that provided by orthodox practitioners. She also observed that the relaxed time involved in the shiatsu treatment helped her improve her health and seemed to prefer this to the possibly less-empowering orthodox approach. *'When you said, 'What did you like about shiatsu, if anything?' I reckon that it's a time set aside to heal, not get repaired'* (Kirsty. T2.L228). This supports the previous suggestions that shiatsu offered patients empowerment and 'time out' of their normal busy lives in a way that made them feel like an individual as opposed to a faceless broken patient who needs to be 'repaired'. This confirms Kate's and Lucy's earlier comparison between being treated like a person by the shiatsu practitioner and a patient on a conveyor-belt by the GPs.

The relaxation time available in shiatsu was also cited by Julie as what she most liked about the treatments *'Just being able to relax for an hour undisturbed, it was excellent'* (T2.L131). Kate seemed to relate the relaxation to the hands-on aspect of the treatment *'I did enjoy actually the treatment itself and I found it very relaxing and enjoyed the massage side of it'* (T2.L142). It seems as if this was one of her favourite parts of the treatment though it was cited by other patients as being rather threatening.

The lack of medication in shiatsu

Patients' dislike of medication has already been mentioned in this section. Sara claimed this was a main benefit of shiatsu *'...I didn't want to be permanently on tablets, and I still don't want to be on tablets so I avoid them like the plague'* (T3.L38). Lucy reported that what she most liked about shiatsu was that *'...you don't have to put chemicals and crap in your body – it does worry me how many tablets I'm taking and all the side effects'* (T3.L20). Jenny also cited the empowering nature of

some forms of complementary medicine in comparison to the 'drugs' of orthodox medicine.

Jenny. T3.L101 *'I read about these Chinese medicines where they mix these potions and things and it sounds wonderful. I could be a real convert...I think it because it's because you're contributing as well. The main thing is that its not a drug because people have too many drugs these days and your body becomes immune to it and then, when you're really bad the drugs don't have as good effect on you as they should do... there should be something else, something alternative. It's more natural...'*

The time available in a shiatsu consultation

Lucy claimed that she particularly enjoyed having more time to talk to the shiatsu practitioner and lamented how busy the GPs tended to be. She suggested that the opportunity to relax before having the shiatsu increased the benefit she derived from it.

Lucy. T2.L83 *'I just really looked forward to coming when I did. Not just the treatment but to talk through things and what have you. Because I mean sometimes when you go to the doctors they're so busy and there just waiting to get you out for the next one to get in, and you've only got sort of ten minutes or whatever, but when you come to the (shiatsu) clinic you've got sort of time to have a chat and unwind a little bit. I think you're more open to the treatment then when you've relaxed a bit first, but you can't get that with the doctor, and it's not their fault but they're just so busy and you've got a ten minute appointment, but I just wish they were freer.'*

Perhaps it was this personal approach and extra time that helped Lucy feel different after her shiatsu treatments as compared to her GP consultations. Shiatsu has previously been described as empowering patients which may energise them more than if they feel passive in GP consultations.

Lucy. T2.L148 *'It definitely took that sort of stale feeling because I stay in quite a lot and I just sort of vegetate. I just sort of get really lazy and lethargic and it's just really gave me a boost and made me want to go out*

and get things done; where as normally when I've been to the doctor's I just get in lay down and go back to sleep and I don't feel like doing anything. So it's really a good sort of pick me up but I could do with it every week.'

Sara also compared the amount of time available in complementary medicine appointments to GP ones. Her views seemed based on her own experience as a patient at Hanson and also as a staff member at another busy general practice. She suggests that the limited time offered in GP consultations and also secondary health-care may be particularly problematic for older patients.

Sara. T4. L39 '...I work in a medical centre so I know it, a lot of the thing is the targets to meet and we've got one doctor who has four minute appointments. To be perfectly honest you might have one person coming in who says 'Yes, I need a prescription', 'Fine, here you go, bye,' but you've got other people who need more than four minutes. Even if it's just to talk to the doctor...Its like for older people who come to the doctors to talk and if more complementary medicine was available they might get a real benefit. Being perfectly honest, you know for a fact that if a patient goes into hospital, they're kicked out well before they're ready to go and the GP says give me a ring if there's any problem and they don't have time, so the patients forgets the conversation or doesn't want to bother the doctor because they think they're so busy. That the main problem – we haven't got access to anything else.'

This suggests that patient perceptions of the GPs being so busy may actually stop them asking for necessary treatment. They may be particularly dissuaded from taking the GPs time if their problem is more psychological/emotional than physical. Tara supported this suggestion since she claimed the personal touch and extra time offered by the shiatsu practitioner was especially beneficial near the anniversary of her baby's death *'I got upset over something one day which was actually sort of good as she really listened at that point which was a bad day, an anniversary'* (T2.L55). Tara may not have divulged this important information had there not been time or if she felt less

comfortable with me as her shiatsu practitioner. It seems as if this opportunity to experience and share her feelings was a therapeutic aspect of the treatment.

A personal touch in shiatsu

The GPs and patients have described shiatsu as a holistic treatment, focussing on the patient as a whole and not just their physical ailments. Kate described this as a 'personal touch' when comparing her GP and shiatsu care. She described feeling like an individual during her shiatsu sessions, and particularly appreciated the attention and time the practitioner gave her both during and in-between treatments. This was compared to her feeling like just another patient visiting the busy GPs who forgot about her as soon as the consultation ended.

Kate. T2.L181 'I'd like to say that I found Zoë very professional and I could tell she was motivated by what she was doing. I did very much appreciate the personal touch that she put into it and you felt as though you were her only, if you like, patient. She assisted me and lot and she obtained drinks for me to try and food bars for me to try and that was when I was actually away from her. She just didn't stop, she obviously was thinking 'I wonder what else can assist her', was trying to help me get rid of the pain and so on, and again I can only commend somebody for that, which I never felt that I got from the doctors here. Obviously they are very busy, but it was as soon as you walked out of the surgery it was the next one, which I didn't feel that with Zoë - maybe she did that but I didn't feel that. It really felt as though I was the only person at that time and she wanted to assist and help, which does help when you're feeling really low and you have got problems that nobody else seems to have. Especially when no-one else seemed to have time for you.'

Interestingly, Kate was the patient who wished that the shiatsu room was more clinical, in contrast to Clare's preference of the informal style previously described. Perhaps Kate preferred the formality of the traditional GP consultation room, but the interpersonal skills of the shiatsu practitioner. The impact of the clinic from the perspective of this practitioner researcher will be discussed in the following section.

Results section three

THE IMPACT OF THE SHIATSU CLINIC ON THE PRACTITIONER RESEARCHER

This section will describe how the delivery of the shiatsu clinic within the general practice impacted upon my role as both a shiatsu practitioner and practitioner researcher. As a shiatsu practitioner, it enabled me to work with a new client group in a new setting, which also presented certain challenges. This led me to consider what I was seen to offer as a shiatsu practitioner and to reflect upon the experience of having feedback on my clinical work. This section will then present the main benefits and challenges I faced as the practitioner researcher.

Table 14. The impact of the shiatsu clinic on the practitioner researcher

Impact on my role as a shiatsu practitioner	Working with a new patient group	Professional development
	Working in a new setting	Team member
	The challenges I faced as the shiatsu practitioner	Time constraints
		Room constraints
		The lack of information available about shiatsu
	What I was seen to offer as a shiatsu practitioner	A personal touch
		Time
Receiving feedback on my work		
Impact on my role as practitioner researcher	Benefits of my dual role	
	The challenges of my dual role – the need for clarity	Preconceptions of the study
		Personal objectives in undertaking the study
		Clarity throughout the study
Encouraging participants honesty		

Impact on my role as a shiatsu practitioner

Working with a new patient group

The main impact of the study on my role as a shiatsu practitioner was to enable me to work with patients in the National Health Service. This exposed me to a patient group that seemed to experience poorer health than those in my private practice. For example, the ten patients selected for shiatsu experienced symptoms that seemed to be particularly resistant to change. As described in section two, this was defined as patients experiencing a complex mix of symptoms that were chronic and resistant to orthodox medicine. Furthermore, some of these symptoms were described by GPs and patients as having worsened just before the research started.

Professional development as a shiatsu practitioner

I found that working with this new patient group impacted upon my professional development as a shiatsu practitioner. It helped me increase my knowledge of symptoms and health-care, develop my skills in shiatsu diagnosis and treatment and re-assess my limitations as a practitioner working with resistant symptoms. For example, I spent the evenings after the clinic reading about the various illnesses that patients experienced and the orthodox and oriental approaches to them. Although it was difficult at times to find the motivation or time to do this work, I knew it would be of benefit. I learnt about methods of orthodox diagnosis (including invasive investigations into symptoms such as irritable bowel syndrome) and treatment's involving medication, surgery and referrals. I also developed my knowledge of shiatsu diagnosis and treatment, including dietary and exercise recommendations for certain conditions. This included having supervision from an experienced shiatsu practitioner and teacher to discuss my management plans for the patients. I concluded that the clinic had impacted upon my development as a shiatsu practitioner in terms of increasing my knowledge and skills as a health-care professional.

I also felt that I had developed professionally by learning how to work with people who reported higher level of illness than I was accustomed to. In week four of the first clinic I wrote *'Difficult balance this week wanting to do more for them (the patients) and being hard on myself that I wasn't doing enough, being a 'good enough' practitioner or a 'perfect' one.'* I dealt with these lapses in confidence by accepting

that the degree to which I could help the patients alleviate specific symptoms was sometimes limited by their resistance to treatment, as already discussed. This was again assisted by my clinical supervision. I re-learnt that my role was not to 'cure' patients but to help them improve any aspect of their health and life in general. This had to be done at their pace and within their limitations. For instance, it would be impossible to return full kidney functioning to a patient who had had one of these organs removed. I therefore focussed on the goals of the patient and myself that may be realistically achieved. This sometimes centred on helping patients manage and cope with some of their symptoms instead of trying to cure them.

Working in a new setting

The second major impact of the clinic on my role as the shiatsu practitioner was that I worked for the first time in a general practice. Although this produced certain challenges as described later, the experience was very positive. For example, my private practice has involved working from home or in rented rooms in a gym and more recently, a health and beauty centre. I had not therefore worked in a traditional health-care setting or alongside other clinicians. This resulted in me delivering shiatsu as part of a team for the first time.

Feeling like a team member

My inclusion in the practice team was one of the greatest benefits I received from the shiatsu clinic. Instead of working on my own as had previously been my experience I had assistance from a whole group of health-care workers. For example, I was given assistance by the administration staff who managed the appointments and weekly evaluation forms. The following is an extract from the first day of clinic one.

Really enjoyed the day, was great to feel part of a team and not as isolated as when working from home – others around at lunchtime and to take bookings – feedback from receptionists re. patients' enjoying treatments etc. Felt really professional. Patients expected to wait and be called so I just fitted into the existing systems.

The practice manager also helped me coordinate the clinic by arranging meetings with the team, circulating information about the clinic and its referral and evaluation

procedures and preparing the shiatsu room each week. He also surprised me in the last week of the first clinic by presenting me with five journals for the patients in the second clinic. I recorded in my reflective journal that he said '*...the practice was benefiting a lot from me by having a free practitioner and the least they could do would be organise a few diaries!*' This obviously also helped me as the researcher in the organisation of the evaluation material.

Finally, I received support from the GPs, mainly those who worked at the practice on the shiatsu clinic day. As already mentioned, I enjoyed being able to talk to people at lunchtimes and before or after the clinic. This was noted in week six of the first clinic '*I feel appreciated and increasingly part of a team, even just by having a five-minute chat to GP1 before our days started*'. The lunchtime meetings mainly discussed our mutual care of patients and I felt the GPs were genuinely interested in my opinion and chosen therapy. This again helped me feel part of a team of professionals committed to improving patient care and delivery of services. One illustration of this was a discussion about medication that took place in week five of the first clinic.

...using lunchtime to discuss patients with GPs, informally only but very useful. Spoke to GP1 today about Jenny and her reducing her heartburn tablets slowly. Also reassured her that I recommended to Jenny that she should remain taking Prozac if she felt it helped and should discuss any reduction with GP1 – need a formal feedback (about patients) to referrers? Better to have face-to-face feedback but only tend to see GP1 and GP2.

The challenges I faced as the shiatsu practitioner

Time constraints

The time constraints imposed by the research altered the way I would normally work as a shiatsu practitioner. For example, I noted in my journal on the first day that the time taken in completing the pre-questionnaires with patients sometimes reduced the length of the shiatsu treatment '*Found day really exciting but need more time for hands on treatment and spend less on 'research' part.*' In discussion with the practice team and the patients, I therefore altered the evaluation system to protect this therapy time in two ways. Firstly, I separated the pre-evaluation from the first shiatsu treatment so all

patients in the second clinic had a separate appointment to complete the questionnaires. Secondly, all the on-going questionnaires (weekly MYMOP-PIRIE and monthly SF-12) were given to the patients by the reception staff to be completed in the waiting room and brought to their shiatsu appointment.

The other time constraint was the number of shiatsu treatments offered to patients. In normal practice, they would continue to be treated until they and I thought they no longer required treatment (either because their symptoms had improved or because they had reached their potential benefit from the shiatsu). The research imposed a rather spurious timeframe on the clinic by regulating the number of treatments so all patients received six treatments regardless of whether they needed less or more. My opinion was that some of the patients could have benefited from a longer course of shiatsu and that others' rapid progress meant they could have had fewer treatments. In private practice, the number and frequency of treatments is suited to each individual in discussion with their shiatsu practitioner. They would ideally start with weekly appointments, or even more regularly in extreme cases. This would then be reduced to coming fortnightly, then every three weeks and finally once a month until deemed unnecessary.

In order to minimise any difficulty faced by patients in having to end their treatments, it was made clear in both written and verbal information from their initial invitation that only six sessions would be available. Patients were then reminded of the number of sessions that they had remaining each week. I found that my counselling training helped this preparation of both parties for the end of treatment. Once the evaluation had ended, patients were also able to attend 'Do-In' exercise classes that I ran which are based on the same principles as shiatsu treatments. Finally, they could have further shiatsu treatments with myself at a reduced rate, again once the research was over. Five patients did attend the exercise classes and one still receives a monthly shiatsu (a year after the study) in replacement of the chiropractic she had been paying privately for.

My reflective journal indicates that it was not just some patients who found 'closure' difficult. I felt that we had developed a trusting relationship in the last couple of months and was very grateful for their involvement in the project and enthusiasm for

its research requirements *'As the day's gone on I feel quite sad and almost teary ending the sessions – noting their loss and thanks and also mine.'* I genuinely felt privileged to have been able to work so closely with all ten patients. The high level of contact was partly due to the research aspect of the clinic suggesting that the study also impacted upon my role as a shiatsu practitioner by providing greater contact than normal with patients.

Room constraints

There were two ways in which the shiatsu room in the general practice impacted upon my role as a shiatsu practitioner. Firstly, instead of a designated space for shiatsu I had at home or in rented accommodation, the room in the practice was shared with other staff. It therefore had to be converted into a shiatsu space each morning and back into the counsellors room at the end of each day. The small size of the room meant that this included removing all the furniture to create enough space for the futon mat. This initially posed a few challenges as my very first comment in the journal suggests, *'Arrived to find the room not ready so glad I'd come early! Lesson learnt – organise who will clear the room and ask it to be done Tuesday evening.'*

I subsequently agreed with the practice manager that he would prepare the room for me and I would help convert the space back into the counsellor's room each afternoon. I also arranged to store the larger equipment such as the futon and a shiatsu 'body cushion' at the practice and take smaller items away with me each week. The journal indicates that this system was in place by the second week, after a phone call to remind the practice manager on the Tuesday morning. Unfortunately, the following week's entry described that I was *'...annoyed at the start of the day, arriving to find the room not ready, so clinic started late.'* A further conversation with the manager ensured that the room was always ready in subsequent weeks.

Secondly, the room was located on a busy corridor in the practice, opposite the main staircase. This sometimes caused the room to be quite noisy. I would have preferred a quieter environment to encourage relaxation but I knew that I had to work within the limitations of the space available. I therefore discussed solutions with the practice manager (PM) who agreed to re-set the self-closing door on the stairs. He also suggested that he could put up some notices along the corridor. Both of these

improvements were in place by the following clinic day when I noted in my journal that it re-affirmed to me that the clinic was being run by a team.

The PM has put up the clinic signs so the doors are closed quietly which was nice to see. Not just for practical reasons but also feeling that the clinic is established as part of Hanson and is being looked after and thought of by others here.

Receiving feedback on my work

As suggested above, the shiatsu clinic impacted upon me by providing a great deal of feedback on my work. As already mentioned, GPs and administration staff regularly discussed what they perceived the impact of shiatsu to have been on the patients, as did the patients themselves. I wrote the following in the second week of the clinic.

...really positive feedback from all patients. First one especially, describing coming off Prozac and feeling better than she had done for four years. Said her partner noticed it too.

This pleased me and motivated me to keep focussed on helping the patients, in the same way as a positive reaction from a patient in private practice does. This seems to reiterate the GPs comments in section one about the ease and enjoyment of 'positive consultations'. I was also in regular discussion with the practice manager who often commented on the practical delivery of the clinic. This feedback from the practice was very positive which impacted upon me in terms of me feeling relieved and pleased; relieved that the clinic had been viable and not disrupted the practice and pleased that those involved reported it to have been an enjoyable and beneficial experience. I was also able to use the ongoing information such as the health questionnaire responses to guide my management plans for the patients.

The feedback impacted upon me as a researcher, by suggesting that the clinic had made several impacts on the practice, its staff and patients. The research aim had therefore been met. Further impacts of the study on my role as the practitioner researcher will now be discussed.

Impact on my role as the practitioner researcher

The benefits of my dual role

My experience as a shiatsu practitioner beneficially impacted upon my role as the researcher by ensuring that I had knowledge of the therapy being studied. This helped me develop an appropriate research design that could look at the impact of shiatsu, while keeping the therapy as natural as possible. This enabled me to study the impact of the whole package of shiatsu as delivered in 'normal' private practice, rather than an isolated aspect of shiatsu given under controlled, experimental conditions. My experience as a researcher also beneficially impacted on my role as the shiatsu practitioner by using the research data to inform my clinical decisions. For instance, I had a detailed evaluation of patients pre-shiatsu in taped interviews, a formal report of their progress each week in the questionnaires and valuable feedback about the shiatsu from patients at the end of treatments and even two-months later. The difficulties faced by the interactions between these two roles will now be discussed.

The challenges of my dual role

I had two roles in the study involving both the research and the clinical input and yet I did not wish to dictate its development. I therefore knew that I had to be very clear from the outset about my preconceptions and personal objectives of the research. This was to provide clarity for myself, the other participants and those reading the findings.

Preconceptions of the study

I tried to remain reflective on any expectations I may have during the gathering and analysis of qualitative data, since as already described, the very process of deriving meaning from a transcript involves the researcher's own understanding of the world, biases and pre-conceptions (my personal objectives are listed in appendix V). This is an intrinsic aspect of practitioner action research, which can enhance the quality of a study via researcher reflection. I therefore heeded Smith's (1992) advice by reflecting on how my background, concerns and interests may have affected the research.

My background as a shiatsu practitioner inevitably means I have a positive attitude to some forms of complementary medicine and in particular, believe that shiatsu can be beneficial to health. This belief does not necessarily affect the current study as its

focus is on describing the impact of the clinic in the general practice, not assessing clinical effectiveness. The impact was defined as the experiences of patients, GPs and myself as the shiatsu practitioner. In this way, my own 'background, concerns and interests' as well as my actual experience of the clinic (as the practitioner researcher) are studied as an integral part of the analysis, not as external factors causing bias and invalidating the results.

Clarity throughout the study

The dual role I adopted in the shiatsu clinic also required me to be clear about whether I was interacting with the other participants as a shiatsu practitioner or a researcher. As already mentioned, this was difficult on the first day of the first clinic as the limited time available restricted the adequate completion of dual tasks. I had to complete the pre-intervention data capture as the researcher and also the hands-on treatment as the shiatsu practitioner. Subsequent changes were made to the appointment schedule and it was much easier to feel satisfied with my delivery of each role.

Encouraging participants' honesty

Another challenge faced by my dual role was the risk that it restricted the other participants' honesty when discussing the shiatsu clinic. One way of minimising this was to have an external researcher conduct all post-intervention interviews. However, participants may have known that I would be analysing the data and therefore still wish to give favourable feedback. This risk cannot be eliminated from a study conducted by the practitioner, but can be less problematical depending on the study aim and design. The current study's aim was not to assess clinical effectiveness of shiatsu but present its impact on the organisational setting and the people involved. The chosen epistemology and methodology was therefore the most appropriate way of meeting this aim. It enabled me to apply research to practice by developing my reflective skills and enhancing professionalism as both a researcher and shiatsu practitioner.

Results section four

THE IMPACT OF THE SHIATSU CLINIC ON METHODS OF EVALUATING COMPLEMENTARY MEDICINE IN GENERAL PRACTICE

This section will present the impact of the shiatsu clinic on the piloting of evaluation tools for shiatsu in general practice. Each tool will be described in terms of its viability and participant reflections on its use. This will help inform the future delivery and evaluation of complementary medicine within general practice. Copies of the evaluation tools are in appendix III.

Referral Forms

The referral form was designed with the GPs to be easy and quick to complete and to ascertain useful information about the referred patient for the shiatsu practitioner. They were based on the patients' MYMOP-PIRIE questionnaire which enabled a comparison between the GPs' description of their patient's symptoms with that of the patient themselves (as seen in section two). All four GPs completed the referral form appropriately suggesting that it was a viable tool for use in general practice. When asked about the process of completing the form, GP4 replied *'No it wasn't a problem at all. It was nice to have the option of something else really, and the patients who were referred to shiatsu were very positive about it'* (T2.L132).

The GPs claimed the form took less than five minutes to complete but GP1's comment suggests that she may have taken longer than this on some occasions *'I thought it (the referral process) was fine, its a bit more trouble than we usually take, to fill in the A4 sheets but it's quite nice to think about the referral in more detail'* (GP1.T2.L80). This suggests that although the shiatsu referral form may have requested more information than usual, she found this required her to think about her patient more carefully. This may have been due to the involvement all GPs had in ensuring the form was concise and focussed to maximise clarity and reflection. Future development of referral forms for complementary medicine could also benefit from involving the users to increase their correct completion.

Interviews

All ten patients were asked to participate in three interviews; pre, post and two-month follow-up. They were delivered by myself as the practitioner researcher and the external researcher and two were conducted over the phone for the patient's convenience. The interview guide was sent to the patient prior to each interview to help them prepare their answers and ensure transparency of the evaluation tool.

Patients described the interviews in a positive manner *'It wasn't a problem at all because I had so much to say about it'* (Sara. T3.L65) suggesting she enjoyed the time available in the interview to discuss her views. Jenny claimed she preferred the interviews to the more structured questionnaires *'It was easier to use my own words than use the answers on the forms'* (T3.L43). Tara also preferred being able to describe her answers with her own words as opposed to rating them on a form with number. She cited an additional benefit of interviews was the opportunity to think about her answers beforehand. Tara claimed that this preparation may have enabled her to send her replies by post.

Tara. T3.L72 *'The interviews were easy. I didn't have a problem with that. It's probably easier to describe something rather than just filling in a form and putting a number to it. It's almost like discussing it and then working out the score. The interview with R2, I'd put a lot of effort into preparing for that and she may not have got much more out of me than if I'd just posted the comments back. Perhaps because I'd written so much down and made time to think calmly and logically about it and not feel rushed, I may have written all the information I had.'*

The interview guide therefore encouraged patients to consider their answers before the face-to-face meeting and the interview itself enabled clarification or alteration of any replies. Lucy described this preparation and flexibility of the interview made it feel *'...easy and laid back and nothing to worry about, wasn't scary at all'* (T3.L17). The comments in section two suggested that patients sometimes feared the unknown, suggesting that they may have been less comfortable with the interviews if they had not been made aware of its content and aim. There was one patient who felt uncomfortable during her interview, citing the lack of face-to-face contact as a

possible reason. This was because she had a telephone interview being housebound after an operation.

Jane. T3.L86 *'It was a bit weird actually, probably just because I don't know her, or could see her, but it were ok. We went through everything that needed to be said. There's no other way you could do it I suppose – I was more comfy with the forms and the diary'*

Jenny noted how the questions at the start of the shiatsu session seemed to linger in her mind during the treatment. Although this clinical assessment is an integral part of any shiatsu consultation, she may have not been asked for such detailed answers had the research not been taking place. Jenny seemed to accept that these questions are part of the treatment process but made the valid point that words (written or verbal) can not always express how you feel.

Jenny. T2.L196 *'...I know because this is a trial that you have to ask questions so like the question session was before the actual practice whatever and I found myself, my mind wondering off thinking, 'Oh! I didn't say that to her and I didn't say this,' like I'm going over the questions but then I know that she had to ask the questions so...but then, that was part of the exercise anyway to answer questions and think about my health so it was alright but sometimes you can't always put into words just how you're feeling and what things are doing for you.'*

My views as a practitioner researcher on the patient interviews were noted in my reflective journal. I recorded that I was more comfortable when talking to the patients without the tape recorder. This had been used in the first consultations to record the pre-intervention interviews *'I felt more relaxed without the recorder and noticed patients had looked at it sometimes when it was on, so maybe it affects them too.'* It was useful to compare this with the reports of patients seeing the interviews as relatively easy and comfortable.

In summary, the use of semi-structured interviews in this shiatsu study has shown them to be a useful tool for the future evaluation of complementary medicine. A

recommendation would be to send interview schedules to patients prior to attending interview. Further studies should consider that some patients found the interviews more comfortable and useful than others. A range of methods could therefore be used to offer patients an alternative way of giving their feedback. This would also enable triangulation of the data captured.

Questionnaires

Patients completed twenty-eight of the thirty SF-12 forms (three each at pre, post and follow-up) and seventy-seven of the eighty MYMOP-PIRIE forms. The missing forms were from Mary who was missed her last three treatments due to a recurring kidney infection. The patients did not seem to dislike completing the forms describing them as *'No problem at all'* (Sara. T3.L78). Lucy reported how she *'...was putting more or less the same thing, but I don't know actually, it was fine doing it if it needed doing, it didn't get on my nerves or any-thing'* (T3.L98). This reiterates the limitations of choosing numbers to describe health, which was also commented upon by Jenny *'You know there's an improvement but with the form your thinking-It was very good, better than good but was it exceptional?'* (T3.L65). Tara also comments upon this rather spurious process of rating health with fixed categories, reiterating her earlier comments.

Tara. T3.L43 *'Not a problem. It's difficult to put a number on how you're feeling. And even though it's just a week to think about, it's hard to see the score as the whole week, just get the balance of the average. Like if you had a bad day a few days ago, you have to remember that and actually mark today down a bit'*.

Tara's quote above describes a strategy for calculating her weekly score. Patients may have been calculating these scores in different ways but this should not invalidate the measure of changes over time in individuals if their strategies remain consistent. Jane commented upon this benefit of having a simple comparison each week of her health ratings *'Filling them in were nowt really, it were ok. It didn't make a difference really. It was helpful to see what was going off each week'* (T3.L62).

The patients' comments suggest that the numerical ratings in the questionnaires were helpful in measuring change over time. However, they seemed limited in their ability to describe patients' perceptions of their symptoms. This suggests that future research in patients' descriptions of health should supplement quantitative findings with qualitative data. This could provide more meaningful information on the effectiveness of complementary medicine on improving patient health.

I also made comments on the questionnaires from my perspective as the practitioner researcher. I helped patients to complete their pre-evaluation and this established an appropriate order for the collection of future data. I found that the tools worked best when the patient centred MYMOP-PIRIE was done first, then the generic SF-12, followed by the shiatsu history sheet *'Best to do MYMOP-PIRIE first then SF-12 so patient's main concerns are discussed first and then they can focus on how these symptoms affect their general health – patient can feel 'heard' even during the research bit of the consultation then too hopefully.'*

A further recommendation for future evaluation of complementary medicine would be to pilot the order of questionnaires so their relevance is clear to patients.

Reflective Journals

Patients' reflective journal

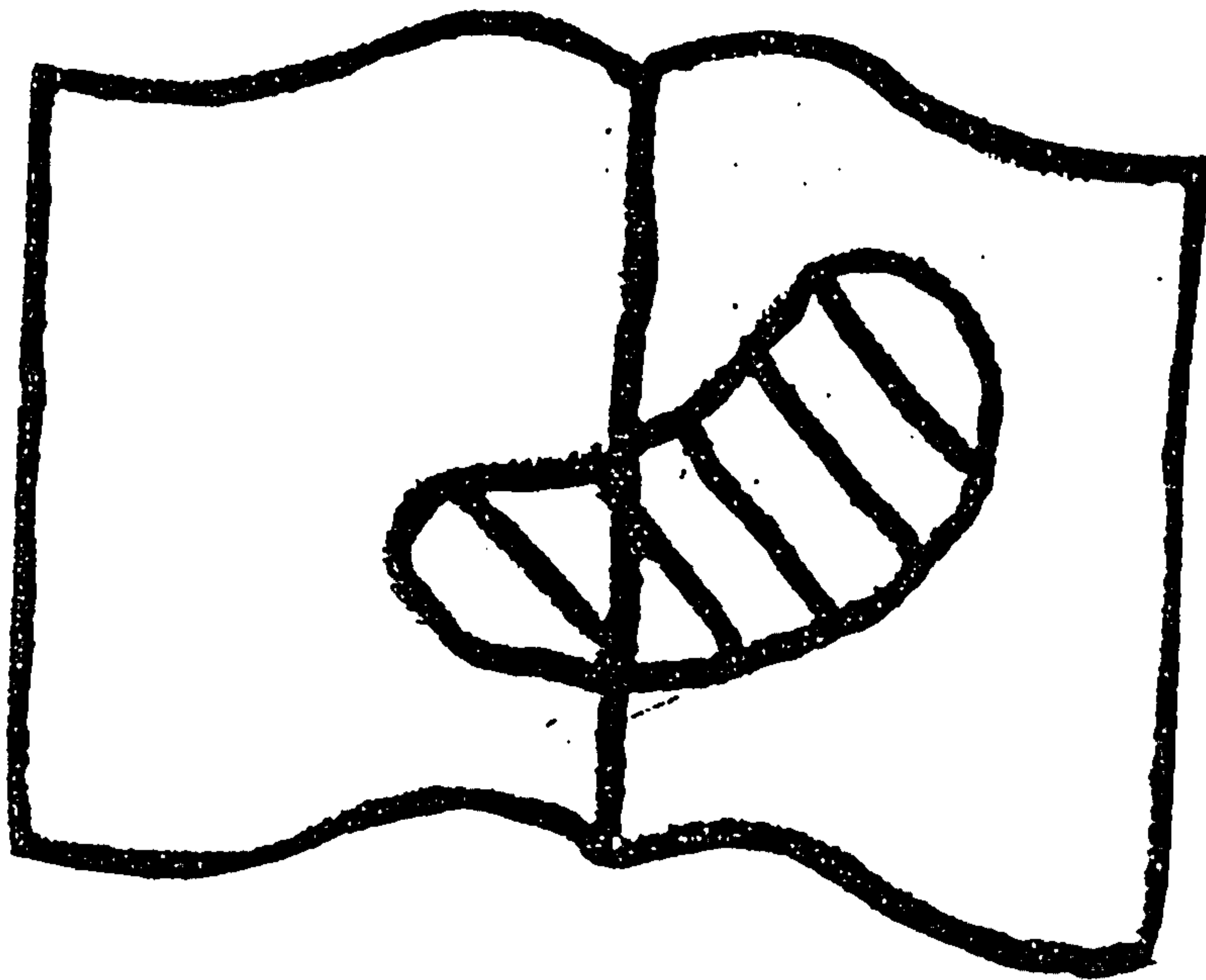
All ten patients were given a journal to record their reactions to the shiatsu. The journals were brought to each shiatsu appointment to assist memory and discussion of the patient's health. Eight were handed in at the end of the study and, once analysed, returned if required. Unfortunately two diaries were lost by the patients and were therefore only seen in the appointments. A recommendation for future research would be to collect or copy diary entries each week.

As with the interviews, the patients provided a range of responses about using the journals. It seems that personal preference will cause one person to prefer written feedback, and another, verbal. This reiterates the use of using a variety of methods to evaluate an intervention so one form of feedback is not favoured. Tara said that she found it hard to write in the journal, and instead produced her own form on the computer.

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Pages 208-211.



Tara. T3.L87 *'Difficult. I'm not into writing things down. Once into the computer I just jotted things down...Maybe because I was used . going to the physio and the chiropracter I'm used to keeping a verbal diary of what I've been like.'*

Lucy described the pros and cons of writing in the journal, claiming she would have preferred to make an entry when she deemed it useful. The weekly system did seem to motivate her to practice her health-promoting behaviours however and assess what was most effective. She also reported that regular entries could demonstrate a change in health between treatments, as suggested with the questionnaires.

Lucy. T3.L92 *'It was nice to keep a record but it played on your mind that I hadn't filled it in yet. It would be better if you just wrote down something when you think it changed or was relevant. It was really good though to write it down and then at least I could see I felt better than the last time, you could look back and see the improvement and work out what was helping or not – I could check on drinking water or not and that made me do my exercises because I knew you were going to ask me the next time.'*

Julie also described the benefit of seeing a positive change in her weekly entries and how it made her reflect on her behaviour and its possible effect on her symptoms.

Julie. T2.L158 *'That was good because it was getting better, and it's good because it makes you reflect. Like the diary, it was good to reflect on what you'd done and how that affected the way you felt.'*

Jenny claimed the benefits on the journal became clearer as the study progressed and suggested that the researcher should have longer to read the entries. This may have been useful in Jenny's case as she tended to write more than the other patients. She also noted how it was hard to remember salient points if she waited too long to write them down. This supports the practice of collecting entries each week.

Jenny. T3.L82 *'The diary was the best. I didn't realise it till half through – I should have handed it in a day before each session and then there was anything that you thought you could have asked me. But things aren't always convenient that way are they? In the beginning I left it for a couple of weeks and then I couldn't remember.'*

Jane's relaxed approach to making an entry helped her see it as less of a problem to complete *'It wasn't a pain 'cos it was just like jotting things down, it were all right,'* (T3.L24). Sara also developed a way of using the journal that made it more enjoyable and supported Jenny's earlier claim that it seemed more useful as the study progressed.

Sara. T3.L65 *'The diary I used to do first thing in the morning – mornings for me are always the best because usually, I'm on my own. I wouldn't say I always enjoyed doing it every day but the first few weeks, I definitely did because there was so much to say about it. As I was getting into it, I must admit, there was less to say because I couldn't have said much more and didn't want to repeat myself.'*

Patients who completed an entry at a regular time each day gave the most detailed information. Future research could recommend this as the standard way of completing brief entries. Alternatively, if studies were looking at a change in a patient's perception of health over time, as opposed to comparing between patients, then a more flexible approach could be adopted. This could allow for the different use of the diaries described by the patients in the current study.

Shiatsu practitioner's reflective journal

The practitioner research journal was initially going to be completed once a week in the shiatsu clinic to record my reflections of the day. However, once the study started I used it to note things of importance in the development of the research and I have since used it to record reflections during the writing-up. It was therefore useful in a practical way to help me remember tasks to do and in a reflective way, to record my views throughout the research. Although I sometimes found it a bind to complete the journal during the clinic, I knew it was much easier to make regular notes on the day

than try and recall them later (as already commented upon by the pa. developed a system whereby I wrote the mornings reflections at the beginning, lunch-break and the afternoon notes at the end of the clinic before leaving Hanson.

I found it useful to refer to my journal during the days after the clinic when I was at the University. It helped me reflect on the clinic and its participants and ensure that any action points had been carried out. It was also very useful in providing supplementary comments in the data analysis. I had recorded some of the patients' non-verbal communication in their interviews and my initial interpretations of their situation and responses. For example, I described an event in a patient consultation that she also commented upon on the interviews, providing both of our interpretations of the situation *'Amazing session with Tara who spoke of a big emotional trauma and cried. I felt really honoured that she felt safe to share this and it seemed like she had let go of some of the pain.'* Tara's description of this event, which supported my reflections, has already been cited in section two.

The use of a reflective journal for a complementary practitioner has not been recorded in the existing literature. This study has therefore piloted a new method for gathering complementary practitioners' experiences of research. The results suggest that this is a useful tool that could be validated in further research.

Shiatsu patient notes

This included the patients' history form and the ongoing treatment notes. The history form was conducted in the first consultation and details the patients' medical history and general life-style including their diet, exercise and stress factors. This document helped me form the initial diagnosis of the patients' symptoms and gain an insight into their life in general. The weekly treatment notes list the patients' presenting symptoms at each consultation and the ensuing treatment. I found it best to complete these notes immediately after the session before the next patient arrived. The appointments were always separated by fifteen minutes to provide enough time for this reflection and also the preparation for the next consultation. I had learnt the need for this from my private shiatsu practice.

The history and treatment notes had been extensively piloted in my private practice, having been the final version of several drafts used over the last few years. They were easy to complete in the general practice and provided valuable information on which the patient could inform their management plans. Other studies of complementary medicine could also include an evaluation of the practitioners' clinical records. This could help practitioners to develop the documents and increase the amount of data held on each patient.

Consultation rates

The practice manager was asked to provide the consultation rates of the ten patients receiving shiatsu. The request was made at a practice meeting for discussion and contact was maintained via e-mail. Patients' notes were accessed by the administration staff who counted the number of appointments attended by the patients for the two months prior to having shiatsu, the eight weeks during and the two months following the end of treatments. This calculation of consultation rates proved to be viable in the general practice. The work involved was minimal and the results proved to be illuminating. Obviously the time spent in accessing patient notes would be far greater in a study with more participants. However, since changes in consultation rates can suggest both the clinical and cost-effectiveness of a complementary medicine service, this method of data capture is recommended for future research. Furthermore, the increasing use of computerised patient notes makes the retrieval of such data much easier.

GPs yellow card

The least successful evaluation tool was the yellow card that aimed to maintain GP involvement in the study. As described in the method chapter they were placed in the patients notes with the intention of reminding GPs to discuss the clinic with them if they consulted during the study. Comments could then be written on the cards and read in the interviews a few weeks later to aid GP recall of any salient issues. Unfortunately I did not put the cards in place myself, as I did not have access to the patient notes. Instead this was done by the reception staff who later suggested that the cards had not been seen by the GPs. This does seem to be one possibility for their lack of use.

GP4. T2.L141 *'I think it's a question of 'What yellow card?' because think especially a lot of the patients who have been referred to shiatsu who are ones who have very thick sets of notes anyway, and you're so busy trying to cram everything back in that you possibly can't actually. I think we knew they were having shiatsu anyway, there were only a small number of people so we all kind of had news about that anyway.'*

This GP quote also suggests that the use of the cards as a reminder for GPs was not necessary as they had only referred a few patients and could easily recall any of their health changes during the study. It is therefore not recommended that this tool be used with small sample sizes. Further research would have to be conducted to assess its use in larger studies.

Preferred feedback for GPs

Once the reflections were gained on the evaluation tools used in the study, GPs were then asked to suggest what their preferred method of feedback would be about the shiatsu clinic.

GP4. T2.L159 *'I would like to know what the patients thought about it and what their expectations had been and whether they thought this had a more long term effect than just you know six weeks or whatever they were coming, because I think it will probably have a longer term effect, but it would be nice to see that happening and what the patients say.'*

GP4 also discussed the difficulties of establishing efficacy of an intervention.

GP4. T2.L253 *'Oh, I was thinking from our point of view if we were evaluating the effects of the patients its actually quite difficult to tease out the effects of shiatsu to all the other things that are happening in our lives. It's very difficult to actually do that, so I think you can only do questionnaires about how people feel about it and how they can see how it's benefited...'*

Another GP suggested having a written report on patients and the complementary medicine, not unlike the yellow card that was piloted in this study which was shown to be unsuccessful.

GP3. T2.L161 *'What would be really nice would be to see a structured report on each patient for the medical records just like the occupational health worker puts on that pink card...information in some ways would be really helpful because it means they're would be a referral option in future that we'd think of because you'd see the pink card like the diabetes and the asthma cards but if there was a unique complimentary therapist card for the records that would be helpful not only to us but to future practitioners should they change practice, so yes that's what I would like.'*

GP3 initially recommended a different research approach from practitioner action research but also described the usefulness of applying results from qualitative research back into the workplace.

GP3. T2.L222 *'Perhaps by an external person rather than the researcher practitioner, rather than sort of this action research methodology. That somebody who would come in and do the interviews quite independently of the practitioner, somebody who knows nothing about shiatsu for example, and then you separate the practitioner from the evaluation and I think pragmatically if this service is to be sold to GPs there needs to be a fairly rigorous evidence base that not only does it work but it is cost effective. Its feasible to introduce into the practice services without causing a lot of disruption, extra work or difficulty i.e. that there is added value and there is a benefit from each service...it could also provide a very valuable opportunity to look at some of the qualitative data when people reflect on the meaning of their illness, because one of the roles of general practice is to interpret meaning of illness back to the patients and I think it could produce some really interesting fundamental research.'*

This study did involve an external researcher to conduct the post interviews and who 'knew nothing about shiatsu.' Finally, GP3 valued the personal feedback from

patients and the shiatsu practitioner that was encouraged in the current study. Patients were asked to discuss their views on their shiatsu with the GPs and the shiatsu practitioner was available each lunchtime for any GP wishing to discuss the patients progress. GP3 claimed that this shared care was not hindered by the different perspectives on health that orthodox medicine and complementary medicine espouse.

GP3. T2.L89 'Well, it's lovely to hear what patients have to say about it. And it's interesting to hear what Zoë has to say about it and there certainly doesn't seem to be any issue about us talking to Zoë about it. It wasn't like we were talking different languages or working in different worlds.'

Future research could assess the use of more a formal regular meeting between complementary practitioners and GPs. One of the disadvantages of the lunchtime meetings in the current study was that they were not attended equally by the four GPs. An advantage of this system was that GPs did not have to find extra time to meet the practitioner researcher. The results do suggest that face-to-face contact is a useful means of gathering information from GPs. Further research would have to confirm how this could be conducted most effectively.

Results section five

THE IMPACT OF THE CLINIC ON THE FUTURE DELIVERY OF SHIATSU IN GENERAL PRACTICE

Recommendations for improvements to the shiatsu clinic

Participants provided three suggestions for improvements to the shiatsu clinic concerning the shiatsu room, access and referral system. These views helped adapt the clinic and produce the recommendations for further research listed in the following discussion chapter.

Recommended changes to the shiatsu room

Two patients described the shiatsu room as being noisy, suggesting it would have been better if a quieter environment could have been found. These comments support the challenges faced by myself as the shiatsu practitioner described in section three. Kate lamented the noise of the doors and stairs (T2.L78) and Tara discussed the room when asked what improvements could be made to the clinic *'The only thing I thought of was the noise because, obviously its very busy in that building and maybe it was the second session, they were constantly walking backwards and forwards and banging the doors...'* (T2.L95). As already mentioned, notices were placed on the shiatsu room door and outside corridor to indicate that a treatment was in progress. An alteration was also made to the self-closing door leading to the stairs, which further improved noise levels.

Secondly, there was a comment on the room not being 'clinical' *'...I think a better environment, a better actual room if you like. I think it would benefit from it being more of a clinical room'* (Kate.T2.98). Perhaps Kate had expected a more traditional, formal environment as in the GP rooms in the practice. Finally, two patients lamented the upstairs location of the room *'She were upstairs as well. I had to go upstairs and you know with me being asthmatic and heart trouble and then my back and that'* (Mary. T2.L24). This was probably what prompted Mary to mention that she would have liked the shiatsu to have been conducted at her house. Mary's age and poor state

of health seems to describes the kind of patient that Jenny describes as having less access to shiatsu.

Jenny. T2.L101 *'I think people who have difficulty getting upstairs would probably benefit by shiatsu...I know its an additional cost and everything but I think it would be nice because if other people had a chance just even if it's a couple of sessions. I can't see how you can improve on it except probably the location of the room.'*

These quotes introduces the issue of 'equity of access' in the shiatsu clinic in terms of having a more accessible location of the room to give more patients 'a chance' at experiencing shiatsu.

Improving equity of access

Sara described equity of access in terms of funding of complementary treatments and patients being motivated by their GPs to try a new therapy.

Sara. T2.L69 *'I don't think the actual clinic itself could be improved but I think it should be made more accessible for other people, and to me the alternative treatments seem to be only there really when you can afford them. If you can't afford them you can't get them...there was no way I could have afforded it myself so it, it needs to be more accessible.'*

Sara also referred to the time constraint imposed on the clinic and supported Lucy's earlier request for the continuation of the shiatsu service *'I wanted to do it again. I really enjoyed it'* (T2.L158). GP4 claimed that the research aspect of the clinic placed restrictions on its equity of access. They noted that only a small number of patients could utilise the service, and future delivery of the clinic could benefit from widening its access to more patients (see section one). This was supported by GP3 who suggested expanding the shiatsu clinic by having several clinics that could receive larger numbers of patients *'I think a larger dedicated group is important and I think far more input. If we had sort of three clinics a week I think they'd be full with people - we've certainly got enough patients'* (T2.L278).

Clarifying the GPs role

GPs' commented that that their role in the study could have been made clearer. GP3 claimed that it was hard to remember some of their tasks involving the clinic and suggested a longer-term clinic that would rectify this as the GPs became more familiar with its working practices.

GP3. T2.L113 *'The difficulty was with as always in general practice the implementation of the system, because the events are relatively infrequent that although the system was all set up people had forgotten by the time the clinic ran or referral was necessary and where all the bits of paper were that needed filling in for referral? They remembered about the shiatsu clinic and they remembered that they had to refer but to actually keep tabs on the process was quite difficult because of the long gap and also it wasn't reinforced often enough for it to become an established system of a practice.'*

This GP suggested that their involvement in the clinic was hindered by the normal pressures of limited time in the practice. They seemed to see the referral as an additional task to complete and so it was not easily prioritised.

GP3. T2.L126 *'It's always the case in general practice; you have a million things to think about and continual problems presented to you every ten minutes all of which are complex, all of which have different referrals, different treatments, different angles that you know it's a very, very complex activity and when you bolt something additional on like shiatsu referral it takes time for that to become part of the body of a normal practice.'*

Improvements to the clinic could therefore include clarification and continuous reinforcement of the referral system (partly by encouraging all GPs to meet briefly with the shiatsu practitioner each week or fortnight) and GPs either receiving or observing a shiatsu treatment.

Participant requests for the future delivery of shiatsu

One clear impact of the shiatsu clinic on the general practice was that participants requested the future delivery of in-house shiatsu. Many of the patients for example, requested continued services as already described. They argued that primary care was the most appropriate place for delivering shiatsu. Lucy for example, almost seemed to want the research to put pressure on the general practice to keep the services in-house *'The best place for it is in the doctors because its local...you'll have to tell them everybody said they should do it at the doctors, that would be perfect'* (T3.L7). GP3 suggested that an on-going shiatsu clinic would increase access to a much wider group of patients. They claimed they already had several patients that could be usefully referred to a future shiatsu service *'Certainly, if we'd had the service that we've had in the last few months I would certainly recommend shiatsu to other patients. I can think of half a dozen now who I think would benefit'* (GP3. T2.L243). GP3's earlier comment also suggested that a longer-term clinic would help them familiarising themselves with its systems.

Finally, Sara argued that patients' dissatisfaction with the traditional National Health Service could motivate them to request new complementary medicine services. This would offer patients suffering chronic illness an alternative to medication, supporting the previously mentioned benefits of complementary medicine offering greater options of care to staff and patients. Sara also claimed such services could offer more time to patients than GPs, reiterating the comments in section three. It seems to have been these views and her positive experience of the shiatsu clinic that led her to request the employment of a shiatsu practitioner in the practice she worked in (see section two).

Participants suggested that if complementary medicine was delivered in general practice, more patients would use it because it could be less expensive and have the GPs' endorsement.

Sara. T3.L27 *'I think some people are afraid to try it – what you don't know, you're wary of it and you don't get a lot of help to actually go and get it and the price puts people off...if you can get most of that kind of*

thing on the National Health Service I'm sure an awful lot of people would benefit.'

The study suggested that the cost of private complementary medicine sometimes hindered access but the main problem was a lack of information such as therapists' qualifications and experience. Participants requested clearer information about complementary medicine and assistance with choosing reputable practitioners from their GP. I therefore considered my profession as a shiatsu practitioner and what reputation this holds. The practice of shiatsu is carefully monitored by the governing Shiatsu Society (UK) and each individual therapist has to pass internal school exams as well as external Society assessments to be included in the national register of qualified practitioners. We are also legally bound to hold annual professional insurance as health practitioners. However, if this information is not made available to other givers and receivers of health care, then the professionalism of shiatsu as a therapy is unknown. One of the patients suggested that this information should be available to orthodox clinicians who could then help the public make informed choices. She recommended developing a National Health Service booklet or internet site for direct access to information and delivering complementary medicine in general practice to ensure safety to patients.

Tara. T3.L51 '...anyone could write letters after their name and you don't know what they mean...one way is to do what you've done, through the medical centre to give it some credibility for people. I've got a pre-school diary for X (her son) and its endorsed by the Health Visitors Association and the College of General Practitioners so you feel the information is not biased, it's sponsored by whoever sponsors the publishing but because its given to you from the GP, you think the stuff in it is going to be good and safe. So, whether the National Health Service could devise a booklet of some kind to say, 'this is what this is' or a site on the internet. And doing it in the practice is best – they wouldn't allow you to do it there if they thought it was going to be dangerous.'

This extract from Tara's interview stresses the benefit of housing complementary medicine in general practice as it gives patients a sense of security that the treatment

has been verified by the GPs. She also reiterates the need for clear information about different therapies, again suggesting that this material is produced or endorsed by established medical bodies. Jenny also cited the need for expert advice on complementary medicine and information about local practitioners to be accessible in general practices. She claims that advice is needed to prevent self-treatment being inaccurate or dangerous and information should be in general practices because that is where people expect to get medical advice.

Jenny. T2.L119 *'You can read but they're all so convincing, these diet books and that. I do think the information should be at the surgery but that would be like doing away with your doctor wouldn't it? People always used to go to libraries but they don't use them now and I think most people visit their doctors for one thing and another so that would be ideal. I always look at the leaflets when I go in, it can be very interesting. There should be more information there on local alternative people.'*

GP1 supported this claim that many patients want information about complementary medicine from their general practice *'...often people ask about it, the patients ask about it'* (GP1. T2.L5). Jane claimed that the apparent divide between complementary medicine and orthodox medicine in the National Health Service was partly the reason for her disbelief in shiatsu.

Jane. T2.L89 *'...why isn't it (shiatsu) more widely spread? GPs aren't telling you about it or you know there's no like media behind it. There's nothing really apart from the specialised magazines and things. You don't really see anything to do with it. Until you've actually tried it you don't believe, I don't think.'*

This supports the earlier view that endorsement from established institutions could increase the use of complementary medicine. She mentions that its limited representation in the media and the National Health Service suggest to patients that it may not be effective. Jenny had read several articles about complementary medicine in magazines and described the problem that being informed can have in consultations with GPs. Her comments illustrate one GP's rather negative reaction to

her being interested in complementary medicine. This is an important consideration for complementary practitioners wishing to co-operate with GPs. The following extract begins with Jenny discussing why more people do not use complementary medicine.

Jenny. T3.L42 *'Perhaps they think it's a bit quackish, but I buy that aloe Vera juice and I read all these things about complementary medicine and to me they do make sense. I don't know, I just feel sometimes that drugs aren't the answer. It's this heartburn. I can't get rid of those tablets but I would really like to. And I said to Dr. X, 'What about Aloe Vera' and she said, 'Jenny, take the tablets'. And another time, when I was reluctant with this Prozac I kept saying, 'I don't want it, I don't want it' and I asked one time, 'What about this St. Johns Wort,' and she said, 'Look Jenny, I'm a doctor, I'm trained to give you medicine and that's my job. I'm not here to comment on things like that'. But I think things are changing more so now. I thought, I felt awful because I thought I was questioning her ability to treat me and I should hate to offend her because she's been so good to me and I've got so much admiration for her that I should hate to think that I was trying to put her down in any way. She obviously thought I needed drug-type medicine.'*

This quote describes the conflict that can arise between GPs and patients over their health-care. The GP clearly viewed her role as not involving any discussion about complementary medicine, whereas that was what Jenny requested. Jenny seems to have felt unsupported by her GP when she was trying to take some responsibility in her health and suggest alternatives to medication. Unfortunately this left her feeling concerned and guilty that she may have offended her GP. This could stop Jenny discussing her use of complementary medicine with her GP, which has already been described as being potentially dangerous. The GPs dismissal of Jenny's interest in complementary medicine (and perhaps, some of her symptoms) was also found later in the interview.

Jenny. T3.L71 *'Funnily enough, I picked up a directory the last time I went to the surgery on alternative medicine and when I went it she said,*

'What's that?' and when I explained she said, 'oh yeah – you'll have a good time with that (laugh) it will last you for ages!'

Tara supported the request for more support and guidance for people wishing to try complementary medicine, reiterating the challenges described in section two on the lack of information about shiatsu. She also claimed that cost is an obstacle and describes how she petitioned her medical insurance company to accept shiatsu in her cover for therapy.

Tara. T3.L52 'Personally I think there's two main things – one is there is so much choice, people hear about something or read it in a magazine and don't know what will actually suit them. As lay person, you don't understand how things can work – like with shiatsu, I thought, 'It can't work, surely!' And the other thing is cost. The reason I've gone for things previously is that physio. and chiropractic I can get on Westfield so it was all paid for. They won't even consider this even though it started off being a referral and through a medical centre. I wrote to them to say I'd stopped the chiropractic and under my GP's recommendation I took this, and the trials finished but I want to continue because I know how much I've benefited, but they won't consider it. If I went back to chiropractic they'd pay.'

Finally, Lucy claimed that these problems of cost and lack of information are exacerbated by some patients' attitude towards complementary approaches to health. She suggested that some patients may not be able to adopt the more active role of self-responsibility and empowerment encouraged in holistic medicine.

Lucy. T3.L31 'Money and ignorance – thinking its just a load of rubbish. Most people think you just go to the doctor's and everything will be all right, they don't believe any-thing else can help them. People don't believe you can help yourself until you're shown how to do it. Once people have tried you see it differently. I did – I didn't have much hope but it definitely made a big difference.'

Lucy reiterates Jane's comments that until shiatsu is personally experienced, patients have no way of knowing how useful it can be. The last improvement to a future clinic would therefore be to offer introductory fifteen-minute treatments to patients and staff to familiarise them with what a shiatsu entails and any effects it may have.

GP recommendations for the future delivery of shiatsu

GP reflections on the clinic were also elicited to suggest recommendations for the future delivery of shiatsu in general practice. Firstly, they recommended that shiatsu should remain in-house due to several benefits that this form of delivery can offer the practice and its patients. GP2 for instance, claimed that it would remove the issue of patient's self-funding complementary treatment and enable the practice team to work closely with the shiatsu practitioner. This would also help staff become familiar with the complementary practitioner and their competence and enable open discussion of what the therapy entails.

GP2. T2.L149 'I guess being able to offer something to people that's free that normally they might think about paying for. So, I think the fact that being able to work quite closely with Zoë and actually talk about the sort of referrals that would be appropriate is very helpful. I think knowing a practitioner to refer to and be confident in their competence feels quite an issue to me. It's difficult to refer people without knowing how competent they are.'

GP2 therefore supports the patients' comments that having a shiatsu clinic in the general practice increases users confidence. Another GP recommended in-house delivery because it enables the orthodox clinicians to remain the 'gatekeepers' of such services. They claimed that this would protect National Health Service resources and keep waiting lists for shiatsu manageable, reiterating the issue of equality of access to limited services.

GP3. T1.L279 'I think it should be a choice that doctors, nurses and their patients could make if it seems appropriate for their condition. I'm not a believer in complete choice as otherwise why bother with having

professionals, you know...if people want to they can see practitioners outside NHS provision, that's fine. I have no problem at all with that I'm just concerned with NHS resources being used inappropriately and I think it would be inappropriate if a shiatsu practitioner was offering a free service independently of the referral process.'

National Health Service resources were also mentioned in terms of funding complementary medicine services in general practice. The following GP relates this to needing research on cost effectiveness and reiterates the benefits of being able to offer a free service in an inner-city area.

GP4. T2.L241 'It depends who would be funding it really, this is one of the problems because there's always this sort of cost effectiveness. If it's so expensive that you can only offer it to a few and you could do a lot more for a lot more people with the same amount of money, then it's difficult to say it should be offered at general practice. It would be nice if it were available for people to take up but I would hesitate to say it should be offered in general practice...For our patients, I think offering complementary medicine, being so expensive and based in the south of the city, would make a difference. There aren't many complementary clinics in X, largely because they're expensive and private and people don't have the money to spend on them.'

This quote suggests that the low-income of many of the patients at Hanson means they could particularly benefit from a free service being delivered at the practice. It also supports the claim that integrated services in general practices assist essential communication and co-operation between the GP, patients and complementary practitioner.

This section has suggested that both the staff and patients involved in the shiatsu clinic discussed the future employment of a shiatsu practitioner. One GP in particular described the possibilities of having an ongoing service in the practice with continued evaluation. They claimed that they would like to implement a shiatsu clinic to help

the patients, support other initiatives in the practice and continue research into this area.

GP3. T2.LI78 ‘...I think this is an innovation that we can put in to our report back to the National Health Service executive as being a possible pilot study; ‘It seems to work fine, can we have somebody please to continue the service?’...if we had the resources, I think we should implement a shiatsu clinic in the practice because it would do us good. It would do the patients good and it would support the new developments that are going on within the practice because we have a whole raft of initiatives that were trying.

At the time of writing, Hanson Medical Centre was considering the future employment of a shiatsu practitioner in a dedicated room once the new premises had been found.

Chapter VII DISCUSSION

This chapter discusses the findings from the study. It will consider how each of the research outcomes listed in the method chapter have been addressed.

- Description of the *impact* of the shiatsu clinic on the general practice and the GPs, the patients and the practitioner researcher
- Development of *methodology* for researching shiatsu in general practice, including piloting specific evaluation tools
- Consideration of the *limitations* in the study
- Recommendations for *future research*

The impact of the shiatsu clinic on the general practice and the GPs

Saving practice resources

The existing literature has suggested that the delivery of complementary medicine in primary care can save general practice resources. A survey of GPs reported they believed the delivery of complementary medicine in primary care provided '*greater efficiency*' in general practice (Stopp, 1999). This is supported by claims that in-house complementary clinics can save time and money by reducing consultations, prescriptions and referrals to secondary care (Hill and Welford, 1998). A study delivering homeopathy in general practice claimed these savings ensured that the service was self-funding (Christie and Ward, 1996). A detailed cost-analysis of a complementary medicine service in general practice concluded that it actually cost less than it saved (Welford 2000). I will now consider how the findings from the current study relate to this literature.

Less frequent consultations

GPs claimed that their consultations with patients who were involved in the shiatsu clinic became less frequent during the study and at the two-month follow up. Consultation rates confirm that patients saw their GPs approximately half as much in the two months during and after the study than before having shiatsu. These results are consistent with the existing literature though caution must be sounded here, because of the small sample size in the current study. Dempster (1998) studied

homeopathy in general practice and found that consultation rates dropped significantly during and after receiving treatment: 86% of the patients receiving homeopathy did not see their GP again during the course of the study. Welford (2000) reported that GP consultations dropped by a third after patients had visited an in-house complementary practitioner. Welford (2000) found that the reduction in consultations was greatest in patients who attended the practice most frequently. This supports the current study's suggestion that complementary medicine may be most useful for patients with chronic and resistant symptoms that require frequent intervention.

The current study has shown that GPs' perceptions of consultation rates are not always accurate (GP1.T2.L33 about Jenny '*She was attending very frequently. Oh! It's not so bad when I look at it*'). This indicates the value of triangulating data from various sources to elicit both the perceptions and records of consultation figures.

Fewer prescriptions

Medication is the main reason why patients attend their general practice, with two in three GP consultations resulting in a prescription (Fry, 1990). However, the current findings have illustrated some of the difficulties related to medication in terms of addiction (see Lucy), side effects and reactions to other treatments. Kirsty's GP claimed that the tablets he would normally prescribe for some of her symptoms could not be used as they could potentially exacerbate her heart condition. He claimed he was unable to treat her effectively and felt restricted by the orthodox approach to health. Sharma (1992) also reported that several of her interviewees argued that some orthodox treatments were '*...too drastic or invasive to be acceptable*' with '*unacceptable*' side effects.

Hanson GPs reported that once patients attended the shiatsu clinic they generally used less of their existing medication and required fewer prescriptions. In particular, they cited the cessation of anti-depressant medication (e.g. Sara and Julie) and reduction in painkillers (e.g. Lucy and Tara). It is unfortunate that there was no objective record of prescription rates during the study as these interpretations are based only on the participant's own assertions. A cost-effectiveness study would have to be done to test such a hypothesis. Nevertheless, the fact that GPs claimed the

shiatsu clinic made this impact indicates a change in perception, if not reality, and this claim is supported by the existing literature.

Welford (2000) reported that prescriptions halved following complementary medicine, especially for analgesics. Hotchkiss (1995) also found that two thirds of their sample of GPs claimed complementary medicine in general practice could reduce prescriptions, particularly for analgesia and non-steroidal anti-inflammatory agents. A study of homeopathy in general practice confirmed that patients' use of medication dropped both during and after having treatment (Dempster, 1998).

Budd et al (1990) also reported that GPs had lower prescription costs while complementary medicine was being delivered in their practices. The total estimated cost of prescriptions in 1990 was over £100,000 for each GP which is double the gross annual National Health Service GP income (Stopp, 1999). If complementary medicine could reduce patients' use of medication, general practices could save a great deal of time and money spent on prescriptions.

The Hanson GPs claims that the shiatsu clinic produced savings in consultations and use of medication are therefore consistent with the existing literature. A replication of this study could measure prescriptions and referrals in addition to the consultation rates to compare GPs perceptions with factual records.

Increased confidence in complementary medicine referrals

Hanson GPs reported that one impact of having the shiatsu clinic in the general practice was that it increased the safety they felt in making the referral. Perhaps this was similar to a fear of the unknown that patients described in relation to shiatsu. The GPs did claim that having the in-house clinic increased their knowledge of shiatsu and what a referral entailed. This may have improved the information about the shiatsu treatment that they gave to patients. Furthermore, GPs claimed that the in-house clinic enabled them to develop a relationship with the shiatsu practitioner and to feel reassured by increased their understanding of the practitioner's professional qualifications.

One of the Hanson GPs suggested their concern about referrals could be because they feared that complementary practitioners may misdiagnose and/or inappropriately treat serious illnesses. Existing research also portrays a fear in some branches of orthodox medicine that complementary practitioners may replace the GP's role in the patients' health care. This was mentioned in the current study as Jenny described that her GP seemed threatened by her interest in complementary medicine.

The GPs also claimed that the referral system ensured that the symptoms presented to the shiatsu practitioner had already been discussed in detail with GPs. One GP described this as their preferred referral procedure as if they wished to remain the gatekeepers of these services and the main protector of patients in their practice. The GPs also tended to refer patients that were middle-aged, had attended the practice for several years and received long-term orthodox treatment for their presenting symptoms. They had also attended the practice frequently (mostly fortnightly or weekly) prior to the shiatsu referral. Finally, the shiatsu was offered in addition as opposed to instead of GP care and did not permit patient's self-referrals, again reducing the chance of patients' having any undiagnosed illnesses. These factors all reduce the risk of shiatsu referrals hindering the GP's input and control of the patients care. In contrast, the study suggested that patients occasionally preferred (or found it easier) to discuss certain aspects of their health with the shiatsu practitioner as opposed to a GP. The involvement of an additional practitioner in the practice could therefore have encouraged patient disclosure, reducing the risks of symptoms being missed or incorrectly diagnosed and increasing the protection of patients' health.

Greater options of patient care for GPs

A survey of GPs claimed that complementary medicine offered them '*greater options of care*' for their practice patients (Stopp, 1999). Welford (2000) argues that the increased options are especially beneficial for patients who have symptoms that are not easily treated by orthodox medicine. This is confirmed by the current study's finding that shiatsu was a welcomed new option for GPs trying to treat patients with chronic and recurrent symptoms. This has also been cited as a benefit of offering homeopathy (Dempster, 1998) acupuncture (Budd et al, 1991) and a range of complementary therapies in general practice (Logan, 1994). The Hanson study

provided new knowledge on this topic by relating greater options of care to increased job satisfaction in GPs. They claimed that they felt more able to help the patients because they could offer an alternative to the orthodox techniques that were failing to improve their health. Instead of repeating the same prescriptions for medication, they could offer the patients hope in a new treatment. They also commented upon how the delivery of shiatsu in the general practice without charge improved the equity of access that the practices' patients had to complementary medicine. This supports findings in the existing literature.

Emslie et al's (1996) survey of 341 people in the Grampian Region in 1992 reported many of the participants were '*...commenting on a desire to see equity of access to complementary therapies for all people.*' The delivery of complementary medicine within general practice and funded by the National Health Service would reduce this inequality. A recent report suggests that quality of access to health services is a current priority of the Labour Government in their aim to reduce social exclusion '*...what patients receive depends too much on where they live,*' stating that access should be '*...based on clinical need, not ability to pay*' (National Health Service Plan, 2000).

GPs claimed that the new access to complementary medicine helped raise the reputation of the practice. They suggested that patients saw the practice as open-minded and contemporary because it was supportive of complementary medicine. This confirms the GP's claims in Stopp's (1999) survey and also those of Christie and Ward's (1996) homeopathic study described in chapter two. Raising the reputation of Hanson would obviously be a positive impact of the shiatsu client since it may encourage existing patients to remain with the practice and new patients to join.

Changing GPs practical skills and theoretical knowledge

Stopp (1999) reported that GPs gained '*increased intellectual scope*' from working with complementary practitioners. This is defined as the influence that complementary medicine can have in changing GPs practical skills and theoretical knowledge. This has been developed by the current study as the Hanson GPs claimed the shiatsu had encouraged a more holistic approach to health in the staff at the general practice. This seemed to include a greater awareness of interpersonal skills in

their consultations. They reported that the shiatsu practitioner helped patients feel like unique individuals as opposed to yet another patient on the conveyor belt of general practice consultations. The GPs claimed that this encouraged them to treat the patients more holistically and help them feel listened to and supported.

The existing literature does suggest that GPs could benefit from further training in consulting and communication skills to ensure the comfort of their patients. Counselling skills could also be of assistance due to the prevalence of psychological/emotional symptoms in patients who attend primary care. For example, Paykel and Priest (1992) call for additional training for GPs in the recognition and management of depression. Approximately 20% of the population suffer from depression, an additional 5% have major depression (Goudie and Richards, 1993) and suicide rates are steadily rising in certain vulnerable groups such as young males (The Health of the Nation document, 1992). However, only 50% of patients presenting with major depression in primary care are recognised by their GPs (Bridges and Goldberg, 1987), suggesting even less may be being appropriately treated. This figure may improve if GPs develop the interpersonal skills necessary to encourage patients to discuss psychological/emotional symptoms and feel listened to and supported in return.

Summary of the impact of the shiatsu clinic on the general practice and the GPs

The Hanson study has developed the existing literature's claims that integrated complementary medicine clinics can save a general practice both time and money. It had provided new knowledge on the ability of an in-house complementary medicine clinic to reassure GPs that referrals of patients will not necessarily reduce their protection of the patients' health and their role as the gatekeeper of services. The study has also deepened the understanding of why such clinics may offer greater options of care in general practice and related this to improving the equality of access to complementary medicine and developing a more holistic attitude towards health. These are key findings for policy makers and funders who may consider integrating complementary medicine into general practices. In particular, the reduction of consultations and prescriptions supports the literature that claims these services can be cost-effective. Clearly, further research is needed in this area, including detailed

evaluation of how complementary medicine may impact upon the most important group involved in health services, namely the patients.

Impact of the shiatsu clinic on the patients

I will now consider the findings of the study concerning the patients' perceptions of the shiatsu clinic.

Confirmation of GPs comments

The patients supported the GP claims that they had fewer consultations and prescriptions during and after receiving shiatsu. The patients' comments about their use of medication will be discussed in detail later in this section. As with the GP comments, the patients' claims describe perceptions as opposed to objective measures of change. However, the similarities between the reports from the two groups support their authenticity. Furthermore the objective measure of consultation rates confirm the reports of their reduction.

Perceived changes in patients' health

The main impact of the shiatsu clinic on the patients was to alter the descriptions of their health. This will be illustrated by discussing the symptoms that were initially presented to the shiatsu practitioner and how they were seen to improve during the study. Again, further research would have to be done to suggest if the reported alleviation of symptoms indicates a real change in patients' health.

Symptoms presented to shiatsu practitioner

The most common symptom that was presented in the current study was muscular pain followed by depression and stress. Though these findings are based on a small sample of patients, they are consistent with results from larger studies of shiatsu. For example, muscular pain was the most common diagnosis given to shiatsu clients in two national surveys, firstly by shiatsu practitioners (Pooley and Harris, 1996) and then GPs (Pooley and Harris, 1997). These musculo-skeletal symptoms are defined in the second survey as mainly consisting of neck and shoulder pain, followed by lower back problems and arthritis. The most common musculo-skeletal symptoms described in the Hanson study were back pain cited by two patients and neck, shoulder, knee and hip pain cited by one patient each. If the separate depression and

stress categories were joined into one, then this would have been the most common presenting symptom in the shiatsu clinic. This supports the two national surveys that found 'psychological symptoms' including stress, depression and anxiety were the most common reasons given by patients for having shiatsu (Pooley and Harris 1996 and 1997).

Both the current study and Pooley and Harris's work (1996 and 1997) suggest that musculo-skeletal and psychological symptoms are most commonly presented to shiatsu practitioners. However, the current study did not replicate Pooley and Harris' (1996 and 1997) finding that patients and complementary or orthodox practitioners differed significantly in these diagnoses (with medical diagnoses citing more musculo-skeletal conditions and patients describing more psychological symptoms). This may be due to the Hanson study having a much smaller sample size of patients who were all from the general practice. These patients had attended the practice for several years, were currently holding frequent consultations and had seen their GP in the week before joining the study. This may have helped them understand each other and merge more of their views on symptom diagnosis whereas the patients in Pooley and Harris' surveys (1996 and 1997) might not have seen their GP recently. Furthermore, Pooley and Harris' surveys (1996 and 1997) only elicited patient recall of GP diagnosis. The current study has developed these findings by comparing actual GP diagnoses in their own words with that of the patients themselves, resulting in a more convergent picture of GP and patient views. This is one advantage of having a small sample size in the current study as all GP and patient diagnoses could be easily matched and compared.

The finding that shiatsu practitioners most commonly treat musculo-skeletal and psychological/emotional symptoms is supported by research on other forms of Oriental medicine such as acupuncture (Wadlow and Peringer, 1996). Research has also found that these two main conditions lead to most of the consultations with complementary practitioners in a range of therapies offered both privately (Fulder and Munro, 1985) and in primary care (Hotchkiss, 1995). Welford (2000) claims they are the main reason for self-referrals for complementary medicine and musculo-skeletal symptoms in particular are cited as causing approximately 75% of visits to complementary practitioners, (Which 1986 and Thomas et al, 1991).

This thesis has suggested that patients who experience both musculo-skeletal and psychological/emotional symptoms are often referred to complementary medicine. This complex mix of symptoms could be due to a relationship between physical and psychological/emotional conditions such as chronic pain leading to distress. This was suggested by several Hanson patients, such as Lucy and Clare and supported by research on chiropractic (Parkers and Tupling (1976) in Sharma, 1992). Conversely, psychological factors could lead to physical symptoms. For instance, the psychological literature claims that an individual's cognitive processes and personality may determine how their body physically reacts to stress (Folkman and Lazarus, 1998 and Smith, 1989). Epidemiological studies have linked psychosocial factors such as unemployment, social mobility and socio-economic status (Brenner, 1987) and psychological diagnoses of Type A Behaviour Patterns (Evans et al, 1998) with coronary heart disease (both cited in and Philips, 1998). Orthodox medicine also suggests that psychological stresses can affect physiology by stimulating the autonomic nervous system and altering hormones and immunity.

In Hotchkiss's (1995) Liverpool study of complementary medicine, psychological problems were defined as patients experiencing stress, violence and addiction, all of which could be seen to lead to physical symptoms. In the current study, Mary described past violence from her ex-husband as still affecting her health and addiction was cited as reducing physical health by Lucy's reliance on pain-killers and Jane's care for her alcoholic brother. Patients presenting with these complex mixes of symptoms may be most effectively be treated by adopting the more holistic approach to health already described by the Hanson GPs. This would adhere to Steptoe's (1989) '*stress diathesis*' model that recommends a '*biopsychosocial*' approach to health considering varied aspects of stresses in a patient's life including non-organic causes of illness and their ability to overcome them.

Perceived changes in physical symptoms

The existing research on shiatsu suggests that it has been associated with several improvements in users' physical health. Pain-relief, for instance, has been related to shiatsu and many other forms of complementary medicine, which may explain why this symptom is so often presented to complementary practitioners. For example, massage, acupuncture and relaxation therapies have been shown to be effective in

pain-management (Stevenson, 1995) as has chiropractic (Parker and Tupling, 1976, cited in Sharma, 1992). The current study has researched this further to ascertain possible reasons for this reported alleviation of pain following shiatsu. The participants suggested that the direct 'hands-on' contact of the shiatsu on the site of the pain was sometimes more effective than their less specific pain-killing medication. They also claimed that they learnt how to prevent and treat their symptoms themselves, as opposed to always having to require GP intervention. The preventative aspect of the shiatsu was cited as helping patients adopt health-promoting behaviours and make their lives less stressful.

The current study also found that it is important to consider the emergence of new painful symptoms when assessing pain relief and complementary medicine. Jenny's GP reported that her chronic pain had been relieved following her shiatsu but a new pain had arisen. This could be interpreted in a variety of ways. Firstly, it could be inferred that the patient might have attended the general practice for reasons that were not purely physical and when one pain was 'cured' another arose so they could maintain frequent contact with the GP. Alternatively it could be that the nature of illness was of pain that arose intermittently in different parts of the body. The nature of symptom alleviation in shiatsu is sometimes that once the main symptom is treated, secondary issues that were hitherto hidden may come to the fore.

In addition to pain-relief, shiatsu has been found to be effective in treating a variety of other physical symptoms. The literature suggests that it can improve the physical and social functioning of adults with cerebral palsy living in group-homes (Vogtle et al, 1988); treat postoperative emesis (Mann, 1999); and treat cardiovascular conditions in a blind randomised-controlled trial (Felhendler and Lisander, 1999). However, a review of thirteen studies in the Cochrane Controlled Trials Register claimed that more research was needed to determine the effectiveness of a specific tsubo in shiatsu for treating nausea and vomiting in pregnancy (Jewell and Young, 2000). This study only assessed the stimulation of a single point on the arm (HP6) and not a typical hour-long shiatsu session or course of treatments.

Welford (2000) found that a complementary medicine package including shiatsu caused a larger improvement in health for patients who rated their symptoms as most

severe before the intervention began. This could explain why the rating of symptoms improved so much in the Hanson study, as most of these symptoms were described as severe and chronic. As already mentioned, Welford (2000) also claimed that complementary medicine was most effective for musculo-skeletal problems and '*psycho-social distress*', again the conditions most prevalent in the current study.

Perceived changes in psychological/emotional symptoms

Existing research claims that shiatsu can also be effective in improving psychological/emotional health. Stevenson's (1997) study of palliative care found that '*...feelings of deep relaxation, support and increased vitality are common following a shiatsu treatment.*' It has been shown to offer welcome support to carers in the community, especially older adults, and help them cope with the demands of looking after others (Formby, 1997). This is supported by the current study as Julie claimed that the support from her treatments helped her look after herself as well as her four children and depressed sister-in-law. Clares' GP suggested that the support given by shiatsu had replaced that previously provided by Clare's mother. Several patients described having support for their shiatsu treatment from friends, relatives and colleagues. The literature on patients' social networks claims that this support can play an important role in their health (Wenger, 1984 and Scambler, 1981). The current findings therefore suggest that treatment programmes could benefit from involving carers and acknowledging the influence of a patient's social network (or lack of one) on their health.

Shiatsu has been described as helping patients with the physical symptoms related to cancer and its orthodox treatment such as nausea and vomiting (Bains, 1997 and Dibble et al, 2000). It has also been seen to offer support for the psychological/emotional demands facing cancer patients. Thwaite (1996) gave a personal account of receiving shiatsu as part of a complementary medicine package for non-Hodgkin's lymphoma, claiming it helped her cope with the disease and the chemotherapy treatment. Ongoing support in complementary medicine may help patients with compliance and recovery from invasive orthodox treatments. In the current study, Jane claimed that her shiatsu treatment had helped her prepare for and recover from her gallbladder operation. Research could investigate how shiatsu may help patients cope with the fear sometimes associated with illness and invasive

orthodox treatments. However, aspects of complementary treatments have also been described as provoking anxiety in patients.

Fear of the unknown in complementary medicine

Emslie et al (1996) found that 81 (25%) of participants in a survey of the Grampian area in Britain had '*some concerns*' about having complementary medicine. They claimed the main cause of this was the unknown qualifications of the practitioners, which was cited by 55 (68%) respondents. The delivery of complementary medicine within general practice may solve this problem, as a practitioner would only be employed if deemed suitably qualified. This has already been suggested as a benefit of delivering complementary medicine in-house by patients and GPs at Hanson. However, some patients still mentioned feeling apprehensive about having shiatsu which conflicts with Emslie et al's (1996) explanation since the therapist's qualifications were made clear to both the patients and the GPs. Instead, the current study suggested that apprehension was due to patients not being familiar with the therapy and it involving physical contact. This 'hands-on' aspect of the treatment raised certain issues for patients with religious beliefs about appropriate clothing and challenged others who had been abused and/or held negative self-images of their bodies.

The findings from the current study have important implications for the design of other shiatsu services. Future patients of shiatsu could be offered a video of a typical treatment to view at the practice or borrow to become more familiar with the treatment. The leaflet given to patients to describe what a shiatsu involves could have photographs added to aid clarification. Patients could also be encouraged to discuss cultural differences and personal preferences in appropriateness of behaviour in medical treatments. This could be applicable for the delivery of other forms of complementary medicine as well as orthodox treatment in general practice.

The ability of the current study to develop these recommendations illustrates the benefit of conducting small-scale in depth research where the participants are empowered to discuss personal issues and provide detailed qualitative responses. Furthermore, the action-research design enabled repeated cycles of data capture to

gather participant views over time. This provided further clarity of this theme of fear, since patients explained that this was only felt before the treatments had begun.

Once the patients had received their first shiatsu, they described feeling at ease with their new treatment, mainly because of their relationship with the practitioner. This was also found in Sharma's (1992) study of complementary medicine, as one of her interviewees partly attributed his improvement to the personality of the practitioner '*... it was the attitude of the practitioner which had given him confidence to make choices and strength of will to carry them through.*' Further research could investigate what aspects of the patient-practitioner relationship helped patients feel at ease.

Summary of the perceived changes in patients' health

The Hanson patients claimed that their shiatsu improved their physical and psychological/emotional wellbeing and left them feeling satisfied and relaxed. This supports the BBC survey of 1204 British adults claimed they had complementary medicine specifically because they deemed it enjoyable, relaxing and effective (Ernst and White, 2000). Studies have suggested that shiatsu has helped patients suffering from pain, joint mobility, cardiovascular conditions, postoperative emesis and nausea from cancer treatments. Further research needs to be conducted to clarify its effectiveness with nausea and vomiting in pregnancy. The current study supports the existing findings that shiatsu helps relieve pain, joint mobility and digestive complaints including nausea and vomiting. It provided new information on the potential involvement of shiatsu in increasing energy and immunity.

In terms of improvements in patients' psychological/emotional wellbeing, the literature claims that shiatsu can offer an enjoyable, sociable and supportive treatment to individuals providing stress-relief and relaxation. It has also been suggested that complementary medicine can cause initial apprehension if it is an unfamiliar therapy and can challenge some patients if it involves physical touch as in shiatsu. Patients also describe their experience of complementary medicine including shiatsu as encouraging relaxation and a feeling of ease. This shows the importance of eliciting patient views both before and after receiving therapy and the need for practitioners to help patients feel comfortable in consultations. Finally, the

Hanson study has provided new information on patients' perceptions of shiatsu and their psychological/emotional health. They claimed that they experienced less depression, anger and anxiety after having shiatsu. Research looking specifically at these symptoms could study this further with obvious implications for inclusion in treatment programmes if deemed effective. A randomised controlled trial could be conducted comparing shiatsu to GP treatment as normal (and possibly counselling or psychological therapies), using validated measures of each of these psychological diagnoses. The previous recommendation from the current study for objective records of medication and consultations could also be used to measure change.

Possible reasons for the perceived changes in health

The cycle of improvement in patients

One explanation for the change in perception of symptoms is that patients experienced a 'cycle of improvement' following shiatsu, as described in the results chapter, section two. This describes patients' health beliefs, health promoting behaviour and experience of symptoms to change over time, causing an improvement in their health. This cycle emerged from the action-research in the study that gathered data at several time points. The detailed reports from both the GPs and patients of symptom alleviation were supported by the statistically significant improvements in health scores on the health questionnaires (SF-12 and MYMOP-PIRIE). Objective outcomes suggest that perceptions of change were at least to some degree, founded on real changes in patients' health, such as the reduction the frequency of consultations shown in the practice records.

Empowerment of patients in shiatsu

A possible explanations for this cycle of improvement is that the shiatsu patients felt empowered to reassess their symptoms and adopt new health promoting behaviours and healthier life-styles. This suggestion is consistent with Sharma's (1992) concept of '*self-reliance*' in complementary medicine and the health psychology literature on the importance of '*personal control*' in ones' health care (Steptoe and Appels (1989). Occupational studies have also suggested that staff who have control to make decisions at work have lower blood pressure than staff who have less authority or autonomy (Theorell, 1989). This reiterates the earlier claim that psychological factors can affect physiological processes.

The cycle of improvement could also be associated with the prevalence of chronic symptoms in the Hanson patients that could have actually encouraged them to feel more involved in their health care. Sharma (1992) claims that chronic ill health provides patients with the time needed to gain information about their conditions and the possible ways of alleviating symptoms. An alternative argument is that chronic illness can reduce a patient's motivation to take responsibility for their health and reduce any feeling of empowerment. Persistent ill health could suggest to a patient that nothing they or medical professionals can do can help them, as in Mary's case at Hanson who was described by her GP as feeling hopeless.

Psychological models of health behaviour

Three models of health behaviour in the psychology literature can help illustrate the cycle of improvement found in the shiatsu clinic. Firstly, the original health belief model (introduced by Rosenstock, 1966 and developed by Becker and Maiman, 1975) can be used to explain the tendency for Hanson patients to adopt behaviours to prevent ill health. It states that preventative action will be taken if a patient has '*perceived susceptibility*' to a symptom; '*perceived severity*' of that symptom; '*perceived benefits*' of preventing or alleviating the symptom; and considers the preventative measures to be worthwhile. All of these conditions seemed to have been met in the current study as participants described the patients as suffering chronic ill health, often with severe symptoms they would welcome relief from and clear benefits if treatment could be effective. The risks of having shiatsu were seen to be low, satisfying the final requirement for the benefits of the action to be worth its possible costs.

The second model of health behaviour is Leventhal and Cameron's (1987) self-regulation model of illness, which portrays a patient as an '*active problem solver*' regulating their health behaviour in three stages (Pitts and Phillips, 1998). As with the previous health belief model, patients must initially have a cognitive representation of a threat to their health, seen in the current study as a continuation of chronic illness or recurrence of acute symptoms. An action plan or '*coping stage*' is then developed, describing the mutual agreement of undertaking shiatsu and recommendations of self-treatment in Hanson patients. Finally, the '*appraisal stage*' illustrates the evaluation conducted by patients in the current study to measure the

success of the coping mechanisms. This model recommends that inadequate measures of success should lead to adaptations of stage two and repeated evaluation until a more satisfactory action plan is created. Again, this was conducted by the action research in the current study, with patients appraising their treatment and state of health each week and shiatsu treatment and recommendations adapting accordingly. This second model illustrates the involvement of the patients at Hanson as active and reflective in their own health-care and allows for individual, cultural and social differences.

Thirdly, the '*theory of reasoned action*' (Fishbein and Ajzen, 1975) can describe the cycle of improvement in Hanson patients in terms of their '*intention*' to get better. Pitts and Phillips (1998) describe that these intentions develop from individually held attitudes towards behaviour such as health prevention or treatment and perceptions of others' view of this behaviour. This was confirmed by the current study as Kate described the embarrassment she felt in buying large amounts of Paracetamol, citing her own dislike of tablets and the social stigma she saw as connected to reliance on medication. Patients also described the influence of their social networks, citing the support they received by significant others to their involvement in the clinic. It seems as if the shiatsu helped patients and their practitioners to focus on their intentions to improve health. The in-house delivery further presented the endorsement of the shiatsu by the general practice that may have helped patients feel they were undertaking a socially acceptable form of treatment.

One disadvantage of this theory of reasoned action, according to Pitts and Phillips (1998) is that it relies upon a direct correlation between intention and behaviour, ignoring the influence that individual habits and situational factors can have upon actions. In the current study, the shiatsu clinic acknowledged these influences by eliciting and modifying patients' habits that might hinder their health improvement. This involved discussing a patient's whole life-style, including eating, drinking, sleeping and relaxation habits. Recommendations for adapting these habits and increasing health-promoting behaviours were then given each week during the shiatsu consultations. The decision to have shiatsu and conduct these preventative behaviours can also be influenced by situational factors such as how possible an action is deemed to be in a particular situation at a given time. The current study

attempted to maximise the ease of delivering shiatsu and its recommendations by using the patients' familiar location for health care and normal consultation times. Dietary and exercise advice only pertained to realistic changes that patients claimed they could make such as drinking more water or conducting a particular stretch each day.

The cycle of improvement suggests that patients were seen to alter their beliefs and behaviour that resulted in better health. Several possible explanations for this change have been postulated including that shiatsu empowers patients to take more control in their healthcare, motivating them to be intent on getting well and offering a treatment that can be perceived to be easy to have, worth the effort in attending the general practice and socially accepted with GP support. The cycle of improvement is mainly based on perception as opposed to objective measures of change. Patients may have expected the treatment to help them and this positive attitude led them to describe the experience favourably once it had ended.

High patient expectations of shiatsu led to high satisfaction

One of the Hanson GPs claimed that patients reported an improvement in symptoms because of a self-fulfilling prophecy in relation to the shiatsu clinic (see results chapter, section two). This suggested that patients expected the shiatsu to be beneficial so described it as such in the evaluation. The patients did claim to be highly satisfied with the changes they perceived in their health following shiatsu, which is congruent with the existing literature on complementary medicine. The Which survey (1986) found 87% of readers claimed their symptoms had either improved or been cured completely and 75% reported they would use complementary medicine again. The MORI poll (1989) also found high satisfaction in 81% of its participants. In addition to the problems surrounding the measurement of patient satisfaction mentioned, these surveys only elicited information about complementary medicine as a whole as opposed to specific therapies. Neither were participants asked to rate their satisfaction with their health following orthodox medicine, which could have been compared to their views on complementary treatment.

The current study used qualitative methods to elicit patient views in context, addressing both their expectations of the experience (as recommended by Pascoe, 1983) and their satisfaction with the specific therapy of shiatsu. These views were then compared with their comments on orthodox care. This challenges the argument that patients expressed high satisfaction because they simply expected the treatment to work. The patients actually had either unclear or very low expectations of their shiatsu treatment. Furthermore, even when the patient could not understand the therapy or was openly cynical towards it, there were still reported improvements in their health. This is supported by a patient in the Glastonbury study of complementary medicine *'It worked well for me and I am a non-believer in this sort of treatment'* (Welford (2000)). The current study has suggested that patient cynicism could partly be due to not understanding or believing in the theory underpinning shiatsu (see Kate). This is consistent with the finding that interviewees described themselves as being *'initially sceptical'* of the clinical effectiveness of complementary medicine before describing satisfaction with the treatment's results (Sharma, 1992).

The comparison of satisfaction described by the patients for their shiatsu and GP treatment suggested that patients were able to provide negative feedback where necessary and did not seem to be a particularly 'easily pleased' sample of patients. Finally, the in-depth qualitative approach to gathering patient views enabled unexpected topics to arise that supported the findings of high satisfaction with the shiatsu. Two patients, Tara and Julie claimed they were so satisfied with their treatment that they wished to become shiatsu practitioners themselves. This has been documented in the literature in relation to clients of acupuncture (Sharma, 1992).

In summary, both the current study and the literature has found that some patients approach complementary medicine with apprehension and scepticism yet are reputedly satisfied with the outcome. The current study attempted to provide an explanation for this, by asking participants to explain their high ratings of satisfaction with their health following shiatsu. Satisfaction with health interventions is influenced by numerous factors in a patient's life in addition to symptom relief and future research would have to untangle this further (Pascoe, 1983). The current study did not limit the interpretation of patients satisfaction to numerical ratings but as

described, also asked them to discuss in detail their expectations and satisfaction with the context, process and experience of the shiatsu clinic. This led to a further explanation for the perceived improvements in patient's health: that the shiatsu clinic offered them things that the GPs could not.

Shiatsu offered what GPs could not

In the current study, patients were not asked to compare or indicate a preference between the shiatsu and GP care that would place them in competitive opposition. Instead, the study attempted to encourage an integrated model of health care where both approaches co-operated for the benefit of the patients. However, patients often compared their experience and satisfaction of the shiatsu clinic with their GP care at the practice. The feedback they gave on the shiatsu clinic was very positive in both the satisfaction ratings and qualitative data. Patients' satisfaction ratings were slightly lower for their GP care but still relatively high. However, their interviews elicited several key criticisms of their GP treatment. This suggests that although the shiatsu was rated highly, aspects of care from others at the medical centre were criticised. This could be interpreted as increasing the validity of the shiatsu ratings as patients did seem to give lower ratings of satisfaction where they deemed it necessary. Three main suggestions emerged for the patients' different descriptions of their orthodox and complementary health-care. They claimed that the shiatsu clinic gave them more time than GPs, a more individual approach and no medication.

Time available in the shiatsu clinic

Patients claimed that the shiatsu practitioner made more time than GPs for patients both during and after the consultations. Kate, for instance, stated her surprise and appreciation towards the shiatsu practitioner for considering her in between treatments and starting consultations with the recommendations I had chosen from books or clinical supervision since our last consultation. The patients suggested that this extra time not only produced useful advice but also helped them feel like individuals that were being cared for. In contrast, the less time offered by GPs was seen to indicate a more perfunctory approach to them as passive patients, only to be considered within the short consultations.

The current study suggests that the different time offered by the shiatsu practitioner and the GPs (and what this was seen to reflect for patients in terms of how they were being treated) influenced their satisfaction with these two modes of health care. The literature review presented conflicting information as to whether the limited time offered by GPs during consultations affects patients' satisfaction and compliance. One study claimed there was not a correlation between the length of consultation and patient satisfaction (Korsch and Negrete, 1972) but another found time restrictions did have a detrimental effect on patients' views of their GP care (Geersten et al, 1973). Future research could also consider patient views on the time given to their health in between face-to-face consultations as in the current study as this might clarify the results.

As the practitioner researcher, it was easier to offer patients greater time than a GP because hour-long shiatsu consultations were offered in the study. I also had a significantly smaller number of patients to focus on than the GPs. The consideration of patients outside of face-to-face consultations is a standard practice in shiatsu where each consultation is prepared for and reflected upon afterwards. This could seem an ideal situation in GP practice but their workload, such as the number of patients they aim to see each day, clearly hinders this possibility. The current study has suggested that time seems to be important to patients, not just in terms of the minutes spent with a clinician but also because it suggests how they are perceived by that professional. This provides new knowledge on how patients may experience and rate satisfaction with their health care and cites the provision of time as a key way in which the shiatsu clinic was seen to improve patient care.

Relationship with the shiatsu practitioner

The patients at Hanson claimed that they had a different relationship with their shiatsu practitioner from that with their GPs. Firstly, they suggested that shiatsu treated them more as individuals, partly because of the interpersonal skills of the shiatsu practitioner. They had only recently met the shiatsu practitioner and had a maximum of six treatments, compared to knowing the GPs for much longer, with some having attended the practice throughout their lives. The perceived difference in the relationships could be due to the differing time available as already discussed and also the distinct approaches to health that each offers. For instance, GPs are

predominantly trained to improve physical health, which may influence the interactions they hold with patients and the relationship that is developed. An example of this is that GPs only tend to see the tip of an iceberg of patients' symptoms (Hannay, 1980). The literature attributes this to patient characteristics restricting their full presentation of symptoms. An additional explanation could be that the GP limits this disclosure, perhaps because of the focus on physical health already mentioned. In contrast, a shiatsu practitioner is trained to consider patients holistically, which would include Hannay's (1980) psychological/emotional components of illness. They also have more time available for these topics to be discussed. This is supported by Hanson patients such as Tara claiming they had described aspects of their health and life in general and shown emotions to the shiatsu practitioner that they had not presented to GPs.

Patients illustrated difficulties in their relationship with GPs in terms of disagreements over diagnosis and treatments of their illnesses. Three patients in the current study reported conflicts with diagnoses, replicating findings in Sharma's study (1992). Jenny, for instance, described how she did not agree with her GPs that she had depression and was embarrassed at describing this diagnosis to other clinicians. Julie also rejected her diagnosis of depression, which encouraged her to stop taking anti-depressants during the study. She had not returned to this medication in the two-month follow-up after her shiatsu had ended and her GP was satisfied that Julie's cessation of treatment had been successful. It could be interpreted that the shiatsu encouraged patients to re-evaluate their diagnoses and symptoms, as reported by Julie. This could not account for the third patient's rejection of her psychological/emotional diagnosis as Kirsty stopped attending her psychiatrist appointments before the shiatsu study had begun.

Patient dissatisfaction with GP treatment of depression is also reported by one of Sharma's (1992) interviewees. He claimed the orthodox approach was ineffective and instead of reaching the cause of his depression it left him suffering '*...a slow death.*' Conversely, he related his experience of acupuncture to a great improvement in his depression and as mentioned earlier, claimed he wanted to train in the therapy himself. This could be researched further to suggest ways in which GPs can improve the way they make and discuss diagnoses and suggested treatment.

This thesis has shown that patient rejection of medical diagnoses may have important consequences for their compliance with treatment. Psychological diagnoses may be particularly hard to accept if they are associated with stigma and embarrassment as suggested by participants in the current study. Further research would need to explore if this was related to poor consulting skills in reaching a mutually acceptable diagnosis and treatment and if there are particular inadequacies in discussing psychological illness.

The existing literature and the current study suggest that problems in GP-patient relationships could partly be due to each having a different agenda for consultations. The Hanson patients have already described wanting more time to discuss a variety of aspects of their life but the GPs may only be able to offer short consultations that tend to focus on the patients' physical health and organically based treatment. The pressure on GPs to conduct so many short consultations per day could further exacerbate patients' dissatisfaction with having to wait days for appointments and suffer delays once at the general practice (Geersten et al, 1973).

Conflict may arise between patients who want to be treated equally in the consultation and be empowered to adopt an active role in their health and GPs who prefer a more dictatorial relationship. In the current study, Jenny lamented the lack of support she gained from her GP to learn more about other modes of treatment, including complementary medicine. This could further discourage patients to talk about some of their concerns and interests in relation to their health. Perhaps Hannay's (1980) analogy of an iceberg could be extended to describe that patients not only present a minority of their symptoms to GPs, but also an abridged version of concerns about their diagnoses or interest in complementary medicine. Even within orthodox treatments there can be disagreements between patient and GPs views, such as the need for prescriptions (Stimson and Webb, 1975). Since problems with medication were a recurrent topic in the current study, this will now be addressed further.

Treatment without medication

One of the main reasons given for patients' high satisfaction with the shiatsu clinic was the lack of medication involved compared to their GP care, confirming the GPs'

earlier comments. Lucy cited the lack of medication in shiatsu as what she enjoyed the most from her treatment and Kate criticised GPs for trying to 'hide' symptoms with tablets, rather than curing them.

Patients seemed to like treatments that do not involve medication because of the risk of unpleasant or dangerous side effects, again confirming the GPs' views, previously described. For example, Jenny described her fear of relying on tablets and Lucy was struggling to become less addicted to her painkillers. Others criticised GPs seeming reliance on medication. This is consistent with Sharma's (1992) interviewees' concern that some GPs dispense many drugs without sufficient consideration of their long-term consequences (Sharma, 1992). It could be these risks that lead between 40 and 50% of patients not to comply with their GP prescriptions (Ley, 1982). Other research has suggested that patients do not admit low or non-compliance with GPs and pretend they take more medication than they really do (Roth, 1987).

The current findings suggest that the problems associated with medication may be more complex than the risk of unpleasant side effects. Forms of complementary medicine can also pose these risks to patients although these may be rare and less severe to the potential complications of orthodox medicine. Side effects can occur with homeopathic and herbal medicine or aromatherapy oils either through inappropriate self-prescribing or inaccurate administering of professional recommendations. The Hanson patients suggested that the lack of reliance on medication in shiatsu might also been seen as favourable because it suggested a focus upon treating the causes of illness as opposed to eradicating or hiding symptoms. This seems particularly important in pain-relief as the participants in the current study and in Stopp's (1999) research suggested that orthodox medication is often limited in providing superficial relief with painkillers. Patients in the current study who disliked medication did describe particularly disagreeing with long-term use of painkillers.

Dissatisfaction with GP care

Some of the perceived improvements in healthcare that were associated with having shiatsu were connected to existing dissatisfaction with aspects of GP care. The suggestion that use of complementary medicine may be partly motivated by

dissatisfaction of orthodox medicine has already been commented upon in chapter two. The Integrated Healthcare document (1997) claims that dissatisfaction with orthodox health-care can influence the use of complementary medicine as suggested by some of the Hanson patients. For example, Sara claimed that the perceived failings of the National Health Service in general motivated patients towards complementary alternatives. This also seems to be one outcome from dissatisfaction with private orthodox medicine since both the current study and Sharma's (1992) survey found some patients who had complementary medicine had previously paid for private orthodox medicine and still not been satisfied with their treatment (e.g. Tara).

This chapter has suggested that some forms of complementary medicine such as shiatsu may be more able than orthodox medicine to meet the current needs of its patients. GPs are more restricted in the time they can offer patients to diagnose and treat complex symptoms effectively (though they may have access to greater frequency of consultations) and focus more on physiological factors in diagnosis and treatment than complementary practitioners. This approach may not be suited to patients wanting a more holistic form of health care as found in the Hanson patients. This may explain the low consultation rates for even severe symptoms in the illness iceberg (Hannay, 1980) and the tendency to not attend appointments with GPs (Sackett and Snow, 1979). Sackett and Snow support the psychological literature on health behaviour models by claiming that higher attendance is found for consultations that the patients deem useful. This suggests the patients' high attendance at the shiatsu clinic could have been partly due to it being perceived to be worthwhile and efficacious. It may also have been influenced by patients' having access to a free treatment in the convenience of their general practice that they would otherwise have to locate and pay for.

Inclination of patients to avoid giving negative feedback

Some caution must be applied in estimating patients' assessment of the shiatsu clinic. While an external researcher conducted the interviews discussing patients' experience and satisfaction with the clinic, the patients knew that I would view this anonymous data at a later stage. This may have influenced some of them to provide positive feedback because they did not wish to seem ungrateful to me as the shiatsu

practitioner or discourage the practice in continuing running the free service. For example, Julie's interviews indicated that her expectation of the shiatsu was very low and she did not want me as the complementary practitioner to feel 'let-down.' This may have motivated her to expect little from her treatments and Jenny described feeling embarrassed when describing her symptoms each week. Both of these patients gave high ratings of satisfaction for the clinic. Lucy also commented on how she wanted her positive feedback to encourage the practice to continue delivering the service. This may have led her to exaggerate her satisfaction with the shiatsu but it seems unlikely that a dissatisfied patient would voluntarily praise the practitioner or encourage the continuation of the service. Continued research into patient expectations and satisfaction could clarify this further. Practitioner research could be exchanged for more traditional methods of gathering patients' views but it could be that patients wish to please interviewers, regardless of their degree of involvement in the project.

Summary of the impact of the shiatsu clinic on the patients

Patients claimed their health care had improved by having shiatsu because it provided greater time (both within consultations and continued care in between treatments); helped them feel cared for as an individual; encouraged an open and honest relationship with the shiatsu practitioner that helped them to disclose varied aspects of their health; and did not involve medication. This could be why patients attended all of their shiatsu appointments (apart from when ill health prevented it) and requested the ongoing delivery of the shiatsu clinic in their general practice. It may also explain why patients in the current study recommended shiatsu to so many friends, colleagues and relatives. These outcomes provide possible explanations for the patients' satisfaction with the shiatsu treatment and their perceived improvements in symptoms and healthcare in the general practice. This does not necessarily mean that patients wanted shiatsu to replace orthodox medicine. Zollman and Vickers (1999) claim that although public surveys indicate an increasing demand for more complementary medicine in the National Health Service, this is usually elicited in isolation to other beliefs and does not indicate that patients prefer complementary to orthodox care. They claim that this refers to two distinct beliefs that should be questioned separately in research. Although the current study did attempt to elicit patients' views on orthodox medicine and shiatsu separately and not place them in

competition with each other, a much larger study would have to be conducted that could focus on this issue before conclusions could be drawn. The Hanson results have provided a valuable insight into the reasons why some patients enjoy shiatsu. These findings could be used by other complementary practitioners and orthodox medics to improve their service delivery and meet the varied needs of their patients.

Impact of the shiatsu clinic on the practitioner researcher

The final impact of the study was on myself. As the researcher and practitioner I was in a favourable position to gain further information on the experiences of therapists in research, either as practitioner researchers or study participants. The main impact that the study had on my role as the practitioner researcher was to expose me to a very different client group that I had hitherto been working with and the challenges that this involved. I also received detailed feedback on my clinical practice for the first time and this led me to reflect upon how best to deliver complementary medicine in primary care.

Working with general practice patients

Budd et al's (1990) reported that complementary practitioners described several differences between GP referred patients in a medical centre and self-referred clients in their private practice. For instance, the referred patients seemed to be less affluent than most private clients and had less knowledge and experience of complementary medicine. This may be due to having less funds for private complementary medicine.

The patients in the current study seemed to suffer more debilitating illnesses than those in private practice, as shown in existing surveys of shiatsu (Pooley and Harris, 1996 and 1997). For example, Mary was obese, had chronic asthma, diabetes, no gallbladder, only one kidney and had suffered two previous heart attacks. This is consistent with Budd et al's (1990) findings that the acupuncturist in the general practice described working with more *'life-threatening illnesses'* than in private practice. A possible reason for this could be that patients would presumably only be attending the practice if they felt unwell and only be referred for complementary medicine if a GP felt it was necessary. This suggestion is supported by the

prevalence of chronic illness that GPs tend to refer for complementary medicine as found in the current study and also in the literature (Welford, 2000). This could increase the severity of symptoms that are presented by GP patients to a complementary practitioner. In comparison, private clients of complementary medicine are generally of a higher socio-economic background, which could give them greater access to a healthy diet and life-style. They also may visit complementary practitioners for relaxation, to 'treat' themselves or simply maintain good health, which would not seem high priorities if funds were limited (as in the practice population of both the current study and Budd et al's research, 1990). These factors could lower the severity of symptoms seen by complementary practitioners in private practice.

The current study considered the effect on the complementary practitioner in working with the different patient group in general practice as compared to private practice. There is only a very limited amount of research on this topic in the existing literature and it mainly presents a negative view from the complementary practitioners. For instance, the acupuncturist working in the general practice in Budd et al's (1990) study claimed that '*...we just get the crumbs off the rich man's table*' and lamented that there were many more conditions that they could treat that were not being referred to them. They felt that the symptoms they were referred were simply those that the GP found '*less interesting or tedious*' as opposed to being particularly appropriate for the therapy. Only one study seemed to mention that patients' presentation of chronic conditions and social problems could be both challenging and rewarding to the complementary practitioner (Hotchkiss, 1995).

I described my experience working with a challenging client group in a more positive way than is often documented in the literature. I enjoyed being faced with a new client group and felt encouraged to develop my knowledge and skills in shiatsu. I was also motivated to deepen my understanding of orthodox medicine and general practice. The study ensured that I was in the optimum place to gain this knowledge by working along-side orthodox clinicians and delivering the shiatsu in a general practice. As the shiatsu practitioner I also noted the benefits of accessing the practice's services such as its wheelchair/pushchair access, the reception, waiting room, toilets and children's play area.

Receiving feedback on my clinical practice

The exposure to regular feedback in the study further impacted positively on my role as the shiatsu practitioner. It focussed my continual professional development on critical incidences during the study and issues raised in the evaluation of the clinic. For example, when a patient described a symptom or treatment that I was not familiar with it would motivate me to learn about it from the literature or other orthodox and complementary practitioners. An issue that emerged in the evaluation was that the extra time offered by the shiatsu practitioner was one of the greatest benefits that patients associated with the therapy. This led me to conclude that a shorter treatment, given by a shiatsu practitioner or an orthodox clinician would have been less well received by the patients, and possibly less effective. Further research would have to study if the duration of a shiatsu could affect clinical efficacy and calculate the optimum length of treatment.

The patients' comments on the personal touch and open relationship offered by the shiatsu also led me to reflect upon the importance of communication and consultation skills in general practice and I was relieved that I had undertaken previous counselling training. This issue has since motivated me to continue my counselling training to further improve my delivery of shiatsu and work in general practice. It could be useful for this to be researched further for the future training of complementary practitioners as studies in orthodox medicine have suggested that training in consultation and communication skills can improve GPs' performance. Howe (1996) found that such training increased GPs' and nurses' ability to diagnose and treat psychological symptoms (already cited as an area for improvement). However, there is great variation in the level of training that GPs tend to have in how to conduct appropriate consultations (Goldberg et al, 1980). Further research could therefore be conducted on the patient and practitioner experiences of consultations before and after training in communication, consultation and/or counselling skills. This could be undertaken by orthodox and complementary practitioners to help encourage reflective practice and enhance existing work practices.

The delivery of complementary medicine in general practice

My work in the general practice also led me to reflect upon the possibility that practice team members may wish to offer shiatsu themselves. This was partly due to

reading the existing literature on the increasing number of orthodox clinicians, such as GPs training in complementary medicine and delivering therapies in general practice (Wharton and Lewis, 1998; Thomas et al, 1991). I therefore reflected upon the delivery of complementary medicine from orthodox clinicians as opposed to complementary practitioners not otherwise trained in orthodox medicine. An advantage of this approach would be that a new member of staff would not have to be inducted into the practice.

The disadvantages in orthodox clinicians delivering complementary medicine are that they may only offer that therapy within a traditional consultation. This would reduce the time available in the treatment (Dale, 1996; Stopp, 1999). It may not be cost effective to ask GPs to deliver traditional hour-long shiatsu treatments if complementary practitioners would be cheaper to employ. Also, orthodox clinicians' training in complementary medicine may only be rudimentary and delivered as an adjunct to their orthodox role, possibly restricting their knowledge and experience of the therapy. Even with full training in a form of complementary medicine, conflict may arise for clinicians trying to work with very different theories of medicine, diagnostic techniques and treatment principles. The resulting therapy may be maybe very different to that provided by an individual who mainly works as a complementary practitioner. This thesis subsequently recommends that complementary medicine is mainly delivered by fully qualified complementary practitioners that are also trained in orthodox medicine either to a basic level (as in shiatsu training) or a professional level (as a physiotherapist or nurse for example). This reflection is based on the debates in the current literature and my own experience of the challenges incurred when delivering complementary medicine in a general practice and the skills required to face them.

Summary of the impact of the shiatsu clinic on the practitioner researcher

The current study has provided new knowledge about the experiences of complementary practitioners in research. It has been novel in describing the positive aspects of delivering complementary medicine in primary care in terms of exposing the practitioner to a new client group in a new setting. This was described as enhancing the practitioners' skills and knowledge of complementary and orthodox medicine and the daily workings of a general practice. The findings have also

developed the existing grievances from complementary practitioners such as being referred a very limited sample of patients and symptoms and the risk of therapies being less effective if delivered in a shortened form by GPs with only rudimentary training. Finally, my experience as the practitioner researcher enabled me to produce original reflections on the piloting of the study methodology.

Impact of the shiatsu clinic on the development of methodology

I will now consider the impact of the shiatsu clinic on the development of methodology for researching shiatsu, including the piloting of evaluation tools.

Practitioner research

The use of practitioner research in this study has provided unique insights into the delivery of a complementary medicine clinic in general practice from the complementary practitioner's perspective. This produced new knowledge on the impact of a shiatsu clinic on the complementary practitioner as discussed above (also see results section, section three). The use of practitioner research also enabled me to develop my skills as both a shiatsu practitioner and a health-care researcher.

The advantages of conducting practitioner research are that the researcher can engage directly with the other participants in the study. I could be involved in both the clinical and evaluative interactions with the other participants. My role as researcher informed my practice as a shiatsu practitioner and visa versa. For example, I could supplement theoretical knowledge of these subjects with experiential involvement, instead of being a therapist ignorant of research issues, or a researcher not practised in shiatsu. I was the main researcher with expert knowledge of the intervention being studied and could develop an appropriate research design for the question, keeping the treatment as natural as possible.

There were two main disadvantages of practitioner research. The first was the challenge of managing two roles within a study. In the first clinic, for example, the research aspect of the consultation restricted the time available for the shiatsu treatment. This was helped by having an extra meeting in the second clinic to conduct the pre-evaluation. I also allocated specific time during the consultations to conduct the delivery and the evaluation of the treatment. Shiatsu consultations

traditionally involve feedback and encourage empowerment in patients and reflective practice in practitioners. I therefore saw the formal evaluation of the study as an extension of the normal feedback that is integral to shiatsu consultations. Having extensive research experience also assisted my use of practitioner research. It may be harder for complementary practitioners of other therapies and with less research experience to assume the role of practitioner researcher.

The second disadvantage of conducting practitioner research is the potential confusion of this dual role from the point of view of the participants. This chapter has already discussed the risk of patients giving positive feedback to me because of my role as the shiatsu practitioner. This was minimised by an external researcher conducting the post and follow-up evaluations, but the patients still knew I would analyse the information and this may have affected their responses. These concerns may lead to practitioner research being criticised for not being rigorous, especially if not seen within the context of postpositivist action research.

Action research

The main benefit of using action research in this study is that it focussed the research on improving the setting of a general practice and its structures of delivering health-services. It therefore assisted the application of this thesis from being an academic exercise to making real changes in a general practice and the experiences of its patients and staff, including the practitioner researcher.

The action research approach to the study supported practitioner research by including all of the users' views in the repeated evaluation of the clinic, including those of the practitioner researcher. This cycle of intervention and evaluation encouraged the development of my practitioner researcher's skills and experience of both shiatsu and research repeated through the repeated feedback on the clinic. The patients' comments also seemed to encourage reflective practice in the GPs, which may have led to the development of a more holistic approach to health in the practice. Finally, action research ensured that the data capture in the current study was conducted at several time points to provide information throughout the duration of the study. This led to the finding that descriptions of patients' health, behaviour and their consultation with GPs changed over time.

In summary, the action research procedure of evaluation was rather complex and required clear organisation to ensure all the various tools were used at the right time. However, it generated a great deal of useful data and allowed the comparison of different tools, crystallisation of data gathered and the assessment of change over time. As Sharma (1992) notes, a single survey would not enable this depth and breadth of analysis as it is not designed to discover how decisions can emerge from groups over time. A survey could involve a much larger number of participants over a wider area but would not be suitable for the current study's aim of gathering in-depth data from a small group of participants in one specific social context. The impact of shiatsu on the organisation, its staff and users was the focus of the study and the use of action research by a practitioner researcher was therefore deemed the most appropriate methodology.

The pilot of evaluation tools

The aim of the study was to ascertain any impact of the shiatsu clinic on the participants such as any changes in their behaviour. Since the motivations behind the behaviour were more the focus of analysis than the frequency of them, a qualitative research approach was most appropriate. As Sharma (1992) argues, qualitative data is more useful than large-scale surveys for answering these kinds of questions. She also recommends the use of longitudinal data to capture decisions and behaviour over time. Semi-structured interviews were piloted in the current study to elicit in-depth qualitative data from the patients and GPs. All of the interviews were successfully conducted with the participants by me as the practitioner researcher or the external interviewer. Holding the interviews in the shiatsu room on the normal clinic day may have assisted this as it provided uninterrupted time and privacy. The practice team was accustomed to not using the room on that day each week and there was no phone that could disturb the interview.

The interviews proved to be a viable tool for gaining detailed information from the participants in relation to the interview schedule and also enabled unexpected topics to emerge. One advantage of using this method in the current study was that they encouraged participants to expand on simple 'yes/no' answers. The participant responses were not always immediately clear, as when GP1 replied 'yes' and also 'no' to the question about changes in her consultations with Jenny (see results

chapter, section one). If the interview had been more structured and based on tick boxes, or if the methods used were closed questions on forms, the interpretation of this GPs answers could have been very different.

Other tools that were successfully piloted for researching shiatsu in general practice were the health questionnaires (SF-12 and MYMOP-PIRIE) which were easy and fast to complete by the patients and the shiatsu notes (client history and ongoing-treatment notes) written by the practitioner. The use of these tools in the current study suggested that future research could also benefit from having planned assistance for patients who are not able to complete the questionnaires themselves, and reception staff willing to distribute forms and pens on patient arrival. The collection of consultation rates was also a useful method for gaining basic statistical data that could be compared with participant views. The one tool that did not seem necessary in the study were the GPs' yellow cards. They were designed to be completed by GPs during the study to help them remember salient issues in their patient's health in the interviews a few weeks later. Although, this was not deemed necessary with only ten patients who were all well known to their GPs, it could still be useful in a larger study with greater numbers of patients. This could be assessed in future studies.

The study has provided new knowledge about the methodology applicable to complementary medicine research. It has shown the use of a mixed-method approach, utilising both qualitative and to a much smaller extent, quantitative analysis. Furthermore, specific tools have been assessed for their future use in assessing complementary medicine in general practice.

Limitations of the current study

The current study has a number of limitations that should be considered when interpreting its findings. These limitations refer to the small sample size, referral procedure, validation of the MYMOP-PIRIE, data analysis and use of theoretical models.

Study setting and sample size

Although the epistemology and methodology of the current study supports the use of a single study setting and a small number of participants, there are several limitations to this research approach. Firstly, the action research approach focussed the study on a single general practice in attempt to improve it. This limits the application of the findings to other settings. As Diebschlag (1993) suggests *'The disadvantage of single-case studies is that they have dubious predictive value for other patients or other practitioners.'* This could be further exacerbated in the Hanson study since two of the four GPs knew me from my work at the University, potentially affecting their involvement in the study. They may have been particularly open to complementary medicine or accepting of me as a practitioner researcher and therefore unrepresentative of typical GPs. Further research could conduct a series of clinics in various general practices where the practitioner researcher is unknown.

The sample size in the current study also deems the findings as unrepresentative of all patients or complementary/general practitioners involved in a complementary medicine clinic in general practice. This is because a qualitative research approach was adopted which involved in-depth analysis of a small number of participants. It would have been inappropriate within the study's research question, epistemology and methodology to have conducted a larger number of interviews *'...it is very difficult to devise methodologies where the details of process and personal experience can be captured without some sacrifice of scale'* (Sharma, 1992). The small-scale of the study was described in detail to enable the reader to assess the transferability of the findings to other general practices and GPs, patients and complementary practitioners. Much larger numbers of participants and a different research approach would have been required to produce findings that could be more easily generalised to wider populations.

The patient group was homogeneous with regard to two demographic characteristics, namely gender and ethnic origin with all of the patients being female and white. It would be interesting to learn if this sample had external validity and would have been more representative of the general population if a larger group of patients could have been accommodated in the study. The literature suggests that most patients of complementary medicine, either by self-referral or GP referral, are female and white.

Although this confirms the current study's findings, the small number of patients involved may have hindered its ability to provide new knowledge about the impact of shiatsu on male patients and those of different ethnic origins.

All of the patients that were offered shiatsu consented to taking part in the study and attended all their appointments in the clinic (apart from two patients who were bed-ridden during their last shiatsu treatments). This could suggest that the sample consisted of patients who held a particularly positive view of complementary medicine or had previous beneficial experiences of complementary therapies. However, this conclusion is not confirmed by the detailed description of the patients and their comments in the thesis. Nevertheless, the high degree of patient consent in the study is unusual compared to non-attendance figures in the literature for orthodox medicine (Sackett and Snow, 1979). This suggests that they may be atypical patients. More research would again have to be done to consider this further, perhaps involving a larger number of patients and a control group to assess how representative the study sample is.

The small patient sample also restricted the equality of access that patients had to the shiatsu clinic. This is an inevitable limitation of conducting in-depth, small-scale qualitative research and was commented upon by the participants.

GP4. T2.L195 'I think one of the difficult things is that you couldn't offer it to more people really. In a way it felt like there was sort of a very select bunch who were allowed to have this special therapy and it was quite restricted so I found that quite difficult. You know obviously you couldn't offer something to everybody...' -

In terms of the staff, the involvement of all of the GPs working within the general practice in the study ensures that the GP sample was representative of the GP team at Hanson. Again, continued research would have to assess the external validity of the findings in terms of how transferable they are to other GP teams in different practices. A limitation of the staff sample was that it only contained GPs. This was because it was only this group that referred to the clinic though all the clinical staff, including attached nurses and health-visitors had been invited to do so. When

questioned as to why this was the case, the nurses and midwives reported that they usually only saw patients after referral from the GP and that if the GP had not considered the patient suitable for shiatsu, they were not confident to refer that patient themselves. Further research would have to investigate these views further and look at issues of empowerment in staff and power dynamics of general practices. This could lead to recommendations to assist disciplines other than GPs to be more involved in complementary medicine clinics in general practice, especially with the current emphasis of multi-disciplinary teamwork in primary care.

Referral procedure

The ten patients that were involved in the current study were selected according to information criteria as opposed to ensuring that they were representative. The aim of this sampling method is '*...to include as much information as possible...to detail the many specifics that give the context its unique flavour*' (Lincoln and Guba, 1985). In this way, the sampling reflected the qualitative research approach that aimed to understand a particular group of participants and their meanings in a given context. This epistemology and methodology of the study again limits the generalisability of results.

The sampling procedure was not pre-determined but emerged from the participants in the study to adhere to action research. The practice team was asked what kinds of patients and illnesses they would particularly like assistance with from the shiatsu clinic. Instead of a single symptom such as asthma being chosen the decision was that sampling would be based on patients presenting with non-specific physical symptoms without diagnosed organic cause. This provided a variety of symptoms for the research and the GPs with clear referral criteria and the opportunity to refer a group of patients they thought may particularly benefit. Patients presenting with these symptoms in the four weeks prior to the start of the clinic were invited to take part in the study. This ensured that the patients were referred according to the emerging criteria from the practice team and not self-selected. The GP referral reduced any bias in the patient group from individuals referring themselves because they were particularly open to complementary medicine or being involved in research for instance.

The study's sampling method provided new knowledge on the kinds of symptoms that GPs refer for shiatsu when given the broad inclusion criteria of non-organic cause. The limitations of this approach are that it restricts the depth and range of findings that can be gleaned about the impact of shiatsu on a particular symptom or condition. Future research concentrating on a single diagnosis would be required before conclusions could be drawn about the impact that shiatsu may offer a particular illness.

Validation of the MYMOP-PIRIE

The MYMOP-PIRIE was slightly different from the original MYMOP2 devised and tested by Patterson (1996) as described in the method chapter. This limits the validity of the new tool and more research would have to be done to test this further. This also applies to the interview schedules and the GPs yellow cards that were devised during the study and have not been subjected to rigorous testing of validity. Finally, the findings on patient satisfaction are hindered by the methodological problems in defining and measuring this concept. Any method of eliciting satisfaction data seems hindered by the tendency for participants to give the response they think is desired by the interviewer (Mays and Pope, 1996). These methodological limitations must be considered when interpreting the study's findings.

Data analysis

Following practitioner-research, I conducted the data analysis in the current study. This approach has been criticised for limiting the reliability of the analysis and subsequent findings (Mays and Pope, 1995). The modernist concept of reliability could have been established more convincingly if a second researcher had also conducted an independent analysis of the transcripts for comparison. This was deemed unnecessary in the current study to allow the more personal practitioner researcher approach to the data analysis and would have also been outside the scope and resources available for a PhD. The reliability of the findings is suggested more by describing the setting and participants (including the researcher) in detail, using verbatim quotes where appropriate. The subsequent interpretations made by me were also placed in context of my preconceptions of the study and my aims in

conducting the work. This attempted to make my role as the analyser of data as transparent as possible.

The small scale of the study particularly limits the usefulness of the quantitative data. Although the quantitative tools were predominantly piloted for their use in evaluating complementary medicine in general practice, the results have been included in the thesis to compare with the qualitative data and describe the sample in more detail. These quantitative results must be viewed with caution because greater numbers of participants would have been required to meet the power calculations for data that can be generalised. The statistical significance found over time in the SF-12 and MYMOP-PIRIE must therefore be interpreted with care. This also applies to patients' consultation rates and the comparison of their satisfaction scores of shiatsu and general practice care. A longer follow-up would also have provided more data about the potential long-term effects of shiatsu. The study was also limited in not gathering quantitative data on prescription rates that could have been compared with the qualitative findings. Finally, there was no control group for comparison.

Theoretical models

The current study postulated that patients reported a cycle of improvement in their health after having shiatsu. This was related to health belief models, in particular the Theory of Planned Behaviour (Ajzen, 1991) to explain patients' behaviour in terms of their perceived control over their health. In retrospect, it would have been useful if the Hanson patients' attitudes to health could have been categorised using a locus of control measure. A brief multiple choice questionnaire could have been added to assess if they had an internal locus of control which led them to take responsibility for their health and benefit from the empowering shiatsu. Alternatively, an external locus of control would cause patients to attribute their health to factors other than themselves such as other people, chance or luck and conduct less preventative health measures or self-healing techniques.

An external locus of control was suggested by some of the patients in the current study. Jenny attributed her health to her GPs, the shiatsu practitioner, the weather and 'the Good Lord' claiming that she knew she needed to do more to help herself. The Hanson patients may be likely to display an external locus of control because

they lived in a deprived inner-city area with few local services such as fresh fruit and vegetable shops or recreational centres that could help them improve their health. Future research could study if there is any association between patients' locus of control and perceived effectiveness of complementary medicine. An objective measure of health improvements could also be compared to patients' health beliefs. The findings could provide valuable information to health service providers in terms of how best to tailor treatments to meet the varying personalities and life experiences of patients.

Contribution to new knowledge and recommendations for future research

This section will discuss the contribution that the key findings have made to the limited research on shiatsu and the existing studies of other complementary therapies in general practice. Taking these findings and the afore-mentioned limitations of the study into consideration, recommendations will be made for further research.

Key findings from the GPs

The GP-patient consultations became less frequent, shorter and involved fewer prescriptions both during the shiatsu study. It has been suggested that this was partly due to the shiatsu offering extra time and an individual approach to patients and empowering them to look after themselves more. The changes in consultations were still reported at the two-month follow-up suggesting that it was not just the added input from the shiatsu practitioner during the study that resulted in patients requiring less time from their GPs. The current study also showed that GPs were not always accurate at estimating the frequency of consultations they had held, -even only recently, with patients.

Recommendation 1 – The effect of shiatsu on GP-patient consultations

Future research could test the current study's claim that patients consulted with their GPs less often and held shorter appointments after having shiatsu. It could study what aspects of the shiatsu seemed to be associated with any changes such as the extra time given, the individual approach or the emphasis on empowerment. A pragmatic randomised controlled trial could look at the impact of the hands-on part of the treatment by comparing two kinds of shiatsu that were the same in every way including the time, support and discussion offered, apart for only one group having the physical contact of the shiatsu. Studies could also elicit GP and patient perceptions of consultations and compare these with each other in addition to the practice data.

The Hanson study suggested that GPs wrote fewer prescriptions and patients took less medication during the shiatsu clinic. Many of these reductions were still reported at the two-month follow-up, such as Sara and Julie having ceased their anti-depression medication. In addition to reducing medication for psychological/emotional symptoms, participants' also described needing less medication for pain relief, sleep and digestive disorders.

Recommendation 2 – The role of shiatsu in reducing GP prescriptions

Additional research could be undertaken on the use of shiatsu in reducing GP prescriptions, especially for depression, pain, sleep and digestive disorders. This could involve objective measures of prescription rates from practice records to enhance the current study's qualitative findings on patients' use of medication.

The key findings addressed above suggest several ways that the shiatsu clinic beneficially impacted upon the patients and their GPs. Due to the small-scale design of the study, these benefits were only available to ten patients. The choice of these patients provides further new knowledge on the kinds of patients and conditions that

GPs refer for shiatsu. Firstly, the selection of only female patients supports the existing finding that complementary medicine in general is most commonly used by females who either self-refer (Thomas et al, 1991 and 2001) or consent to GP referrals (Budd et al, 1990). It also confirms the limited research on shiatsu that reported more females than males use this form of complementary medicine (Pooley and Harris, 1996 and 1997). The literature review in this thesis then added to this knowledge by postulating several reasons why females tend to have shiatsu much more than males from both GP and self-referrals.

The age of shiatsu patients was found to cover a large range in the Hanson study, again confirming the wide age group of patients that self-refer for shiatsu (Pooley and Harris, 1996 and 1997) or are referred by a GP to another form of complementary medicine (Thomas et al, 2001). This would need to be addressed in larger studies before any conclusions could be drawn. Another limitation of the current study is that the small sample group could have limited the ethnic mix of patients involved in the study. The literature search found the ethnicity of complementary medicine users had not been considered in the vast majority of the existing data.

Recommendation 3 – GP referral patterns for complementary medicine

This thesis recommends that further research focus on the over-representation of female patients referred for shiatsu in the current study. The findings could develop the knowledge on male and females' health-seeking behaviour and GPs referral patterns of patients to complementary medicine. Changes in work practices based on these results could help balance the access that males and females seem to have to these complementary health services. Studies using a larger sample could also address the age and ethnic mix of patients referred for shiatsu in general practice.

The reduction in consultations and prescriptions could have saved practice resources in terms of time and money. The GPs also suggested that the in-house aspect of the clinic reassured them about the safety of referring patients to shiatsu and encouraged them to take a more holistic approach to health. These are key findings for fund-

holders considering buying such services and integrating complementary medicine more formally within general practice.

Conventional clinicians and managers want persuasive evidence that complementary medicine can deliver safe, cost effective solutions to problems that are expensive or difficult to manage with conventional treatment. Unfortunately, such evidence is scarce and equivocal (Zollman and Vickers, 1999).

The Hanson study also reported that GPs and patients felt that the shiatsu clinic had beneficially impacted on the general practice by increasing its reputation by supporting complementary medicine, encouraging a more holistic approach to health and illness and providing greater options of care for both the patients and their GPs. These findings deepened the existing data on GPs views of the effect complementary medicine can have in general practice in Stopp's work (1999).

Recommendation 4 – The benefits of delivering shiatsu in the general practice

Further research is needed to assess the current claims that an in-house shiatsu clinic can be cost effective, enhance patient safety, increase a general practice's reputation and assist GPs' working practices by saving valuable resources of money and time, encouraging a more holistic approach to their work and providing them with greater options for their patients care.

Key findings from the patients

Both the GPs and the patients claimed that the patients' health had improved during their attendance at the shiatsu clinic. They specifically referred to the alleviation of chronic musculo-skeletal and psychological/emotional symptoms that were presented to the shiatsu practitioner. This is consistent with the existing literature that claims these symptoms are most commonly presented to acupuncturists (Wadlow and Peringer, 1996) and shiatsu practitioners (Pooley and Harris's surveys, 1996 and 1997). The majority of patients in the large-scale shiatsu surveys were self-referred to private shiatsu practitioners who charged for each treatment. The current study has therefore provided a new finding that chronic musculo-skeletal symptoms, depression and stress also motivate GPs to refer patients to a free in-house shiatsu

clinic. It has also described in detail several changes in these symptoms that participants related to patients' having shiatsu. However, these findings could indicate a change in perception as opposed to an actual change in the patients' health.

Recommendation 5 – Patients' symptom presentation

The current study could be replicated on a larger scale with greater numbers of patients and possibly more than one general practice to represent different attitudes towards complementary medicine. This could address the symptom presentation in shiatsu consultations in more detail and study the association between reports of health and actual experience.

The existing literature defines the musculo-skeletal symptoms that patients most commonly present to shiatsu practitioners as being neck, shoulder and lower back pain (Pooley and Harris, 1996 and 1997). The current study has developed this finding by ascertaining that these are also the three most common musculo-skeletal symptoms that participants present to an in-house shiatsu clinic. They are also the main physical symptoms that the participants claim was improved by having shiatsu. This suggests that shiatsu is at least perceived to be clinically effective for the physical conditions that most often motivate the shiatsu treatment. The study also found that one patient reported an improvement of her original musculo-skeletal symptoms, and described that new symptoms then arose that required further shiatsu treatment.

The Hanson findings provide new information on the perceived clinical effectiveness of shiatsu for increasing energy, immunity and reducing sleeping and digestive disorders such as bloating, nausea and vomiting. This last claim can further the debate on the lack of evidence for shiatsu's alleviation of nausea and vomiting in pregnancy (Jewell and Young, 2000) and its reputed use in relieving these symptoms in patients with cancer (Bains, 1997; Dibble, 2000).

Psychological/emotional symptoms were also reported differently after the patients had received shiatsu. They claimed that the shiatsu had helped to relieve their depression, stress, anxiety and anger. It was described as an enjoyable and supportive

treatment that offered relaxation and revitalisation and empowered them to take more of an active role in their health care. This supports the claims in the existing literature that describes complementary medicine including shiatsu as improving several non-physical aspects of individual's health. Vogel et al (1988) claimed that a complementary medicine package that included water-based shiatsu treatments improved the mood of those involved. They attributed this to the participants expressed enjoyment of a social activity that was fun and also stimulated their minds by developing skills. The Hanson study offered new knowledge on this topic by concentrating on the delivery of shiatsu as opposed to several therapies and still found that patients' health was seen to improve. This was attributed in part to the support that patients received in having shiatsu from their kinship and friend networks, building on the work of Wenger (1984) and Scambler (1981).

Recommendation 6 – Clinical effectiveness of shiatsu

Further research could continue to study changes in perceptions of patients' health when receiving regular shiatsu treatments. As in the current study, these perceptions could be elicited from the patients themselves as well as their referring clinicians and shiatsu practitioner. This thesis recommends that the physical and psychological/emotional symptoms that participants have claimed have been affected by having shiatsu should be studied in clinical effectiveness trials. The affect of patients' social networks on the prognosis of these symptoms could also be researched. If a positive correlation was found, future delivery of complementary medicine could utilise group treatment programmes and consider the role of patients' social networks.

The study delivered shiatsu as a package of care including the hands-on treatment plus dietary and exercise recommendations and suggestions for self-treatment of meridians and tsubos. The findings suggest that the time and individual approach offered in shiatsu are deemed as particularly important by patients. Further suggestions could have implications for complementary practitioners delivering shorter consultations concentrating on the most effective aspects of shiatsu and orthodox clinicians using shiatsu techniques with patients. The Hanson study regulated the number of treatments to six, weekly appointments as opposed to tailoring the shiatsu for each

individual patient as found in private practice as documented in the limited existing literature (Stevenson, 1997).

One of the negative impacts of offering a time-limited package of care is that services are then withdrawn from patients. The issue of stopping treatment in research studies was commented upon by several of the GPs and patients and the practitioner researcher and recommendations were made to minimise the potential difficulties this can cause.

Recommendation 7 – Unravelling the shiatsu package

New studies could look at what aspects of the shiatsu package impact the most on patients. It could question if there is a particular number or frequency of shiatsu treatments that is optimum for helping patients. Again, this would have important implications for the future delivery of shiatsu in general practices. Further research could also assess the impact of ceasing interventions on these groups of people and develop the current study's suggestions for overcoming the limitations of short-term research interventions.

An unexpected psychological/emotional issue that the current study uncovered was described as a fear of the unknown. This refers to several Hanson patients expressing apprehension at having shiatsu suggesting this was partly because it was an unfamiliar therapy and also involved being touched (though they remained fully dressed).

Recommendation 8 - Patients' fear of the unknown in medical treatments

Future research could address patients' concerns in both complementary and orthodox medicine where treatments are unknown and may involve undressing and/or physical contact. This could help health services to consider the need for patients to feel at ease and encourage referrers to explain unfamiliar treatments and discuss patients' fears. It could also consider the role of complementary medicine in supporting patients with invasive orthodox techniques. Research could assess if these changes in practice could increase patients attendance at general practice and reduce non-compliance with medication, referrals and invasive treatments.

Key findings from the practitioner researcher

The shiatsu clinic impacted on me as the practitioner researcher in a positive way, encouraging reflective practice and skill development in both shiatsu and research. The method of practitioner researcher provided new information on the challenges and benefits of working in a new setting of a general practice with a different patient group to that in private shiatsu practice. For example, the severity and duration of illness was much greater in the general practice patients than found in my private practice of shiatsu and that reported in the literature on shiatsu (Pooley and Harris, 1996 and 1997) and other forms of complementary medicine (Budd et al, 1990). However, I felt that the support from working as part of a dedicated team of health professionals was a great improvement to working in isolation in a single-handed private practice. These findings suggest that other complementary practitioner may also benefit from working in a general practice team, sharing skills and knowledge to assist the multi-disciplinary care of the patients. This contrasts with the existing literature that presents mainly negative reflections of complementary practitioner working in general practice.

Recommendation 9 – The practitioner researcher’s perspective

Future research could deepen the current study’s information about the practitioner researcher’s perspective in delivering and evaluating complementary medicine in general practice. It would be useful if the challenges and benefits of this work could be elicited, including reflections on the method of conducting practitioner researcher.

Key findings from the methodology

This study was focussed on the impact of shiatsu in general practice from the perspective of the people involved. It therefore adopted the practitioner-research use of predominantly qualitative methods described in chapter three. This mixed methodology has been presented as the most appropriate for the research question in the current study. However, this question only addressed only one gap in the dearth of literature on shiatsu and also the existing research on complementary medicine in general. This thesis consequently recommends that other questions requiring different methodologies be addressed by future research. In terms of aiding the

integration of shiatsu in general practice, the two main areas to be considered are its potential clinical- and cost-effectiveness that have been alluded to in this study.

Recommendation 10 – Methods for future research on shiatsu

The final recommendation for future research is to continue the development of appropriate qualitative and quantitative and methods to study shiatsu in general practice. This could deepen the current study's findings on the impact of shiatsu on a general practice, its staff, patients and practitioner researcher and provide new information on a shiatsu clinic's potential cost and clinical-effectiveness. This could inform the financial and clinical decisions that need to be made for the future delivery of shiatsu in general practice.

To conclude, this thesis has developed the limited research that exists on shiatsu as a form of complementary medicine and its possible role within general practice. The current study has suggested that it is both viable and beneficial to deliver this form of complementary medicine in general practice. It has also illustrated several benefits of complementary and orthodox practitioners working together to enhance patient care and their own professional development. It has increased the research-base for complementary medicine in primary care via an in-depth qualitative analysis of a single general practice, in particular suggesting how a shiatsu clinic impacted on this location and the people within it. It has also presented recommendations for further research in this area and provided new knowledge of the role of practitioner action research in complementary medicine research. The current study has consequently addressed its objectives in providing new knowledge on the impact of shiatsu in general practice, the remaining research questions that could be addressed and the use of several innovative research methodologies.

Chapter VIII CONCLUSION

This thesis has made a useful contribution to several key debates about the delivery and research of complementary medicine in primary care. It has described the successful integration and detailed evaluation of a shiatsu clinic in an inner-city general practice. The findings suggest that this new service had several beneficial impacts on the general practice, its GPs, patients and complementary practitioner. This included changes in perceptions of patients' health and significant reductions in prescriptions, use of medication and the number and duration of consultations with GPs. GPs claimed the clinic saved valuable practice resources, provided greater options for patient care, changed GPs' practical skills and theoretical knowledge, encouraged them to adopt a more holistic approach to health and improved the reputation of the general practice. The study also raised the issue of nurses not feeling empowered to refer patients to the clinic, which could be addressed in further research.

This thesis has also piloted several innovative methodologies for complementary medicine research in general practice. Most notably, the use of practitioner research has been shown as a viable and appropriate method for the research question and the personal account of this approach's challenges and opportunities can usefully inform future practitioner researchers. For instance, I found that this dual-role required clarity and time but enabled me to find a relevant research topic and appropriate design that would maintain the essence of shiatsu, emerge myself within the study setting and learn more about the participants from the perspective of both the researcher and shiatsu practitioner. These findings may help to develop an evaluative culture within complementary medicine and encourage more practitioners to engage in and conduct research.

The use of action research focussed the study on improving the general practice and its systems of care for its staff and patients. It allowed for an emergent research question and the repeated adaptation of the shiatsu clinic from the recommendations of those involved. This ensured that the study was not simply a piece of academic research but made several beneficial changes as described above to the general

practice, its staff, patients and myself as a practitioner researcher. These insights would not have been possible without the predominance of qualitative methods in the study, which have helped to fill the gap in the existing literature on how complementary medicine can be delivered in the National Health Service.

This thesis has also contributed to wider current debates surrounding the politics of complementary medicine in terms of how it can be funded and regulated. It has cited studies that claim complementary medicine clinics in primary care can be self-funding and even save limited practice resources. This is supported by the current study's finding that patients greatly reduced their appointments with GPs, took less medication and were given fewer prescriptions both during and after having shiatsu. The study has also highlighted the dissatisfaction many patients have about the quality of information available to them on complementary medicine and fears about the regulation and professionalism of complementary practitioners.

This thesis has proposed a model of delivery for complementary medicine within primary care to address the concerns that arose during the study. Integrated services enable orthodox clinicians to remain the gatekeepers for referrals to complementary therapies alleviating fears that these practitioners may misdiagnose and inappropriately treat patients. The qualifications and insurance policies of complementary practitioners can be verified by a practice manager, as with any other staff member, and they can work closely with orthodox professionals within the general practice. This enables patient to benefit from a more holistic approach to their health and practitioners can develop their understanding of and learn from each others discipline. Most importantly, the equality of access to complementary medicine could be greatly improved by ensuring patients use of therapies is due to clinical need as opposed to personal funds.

It is proposed that the current study is replicated on a larger scale, involving greater numbers of general practices, patients, shiatsu practitioners and referrers (including disciplines other than GPs). It is also recommended that continued work is conducted on the use of practitioner action research in shiatsu to supplement pragmatic randomised controlled trials to assess the potential clinical and cost-effectiveness of shiatsu in general practice. This would contribute to the growing research base that is

required for the National Health Service to consider commissioning a wider-spread integration of this complementary therapy in primary care. In conclusion, within the current political debates surrounding the funding and regulation of complementary medicine, this thesis has provided a detailed understanding of the feasibility and impact of delivering and evaluating shiatsu in general practice.

APPENDIX I - The history of traditional Chinese Medicine

As already mentioned in relation to the longevity of orthodox medicine, archaeological evidence dates traditional Chinese medicine as emerging approximately 4,000 years ago (Bernie in Duo Gao, 1999). This appendix describes the history of traditional Chinese medicine to illustrate the key characteristics of complementary medicine, as defined in this thesis.

It is claimed that traditional Chinese medicine began during the Shang Dynasty of China between 1766 and 1100BC in the Huanghe Valley of Ancient China. It became a formal system of medicine during the Zhou period of 1100-221BC with the emergence of agriculture, irrigation and the development of over 1,000 districts (Duo Gao, 1999). Herbal medicine was the first formal type of traditional Chinese medicine, followed by acupressure/shiatsu and then, acupuncture. Archaeological findings of stone needles dates acupuncture back to the Neolithic period, (Duo Gao, 1999). Although traditional Chinese medicine reached Europe approximately 350 years ago, it only became a legal medical practice in the United States in 1975, confirming the resistance orthodox medicine seems to have towards several forms of complementary medicine.

Two main 'Celestial Emperors' are seen as the founders of traditional Chinese medicine; Shen Nong, the Red Emperor, who invented herbal medicine and Huang Di, the Yellow Emperor, who introduced the 'art of medicine', (Duo Gao, 1999). Other important people in the development of traditional Chinese medicine were Confucius (551-479 BC) and the Mohist and Logician philosophers of the 3rd and 4th century BC. Confucius introduced empiricism and early scientific thought via his beliefs on active, conscious humanism, ethics and the quest for spiritual development.

Confucius placed great emphasis on continual learning and thinking and is accredited with founding the first formal education system with the establishment of a private school for young men (Jaspers, 1957). This reiterates that some forms of complementary medicine espouse a holistic approach to health and a commitment to continual professional development. With regard to learning, Confucius claimed 'the old' should be submerged into the new, meaning that ideas can only be refined and

updated and not produced fresh from any single individual (Jaspers, 1957). He also enforced the view that learning had to have a practical application to be useful and quotes Confucius (551-479 BC) *'If a man recite all three hundred pieces in the Book of Odes by heart and, entrusted with the government, is unable to perform or if sent abroad as an ambassador, he is incapable of replying on his own, where is the good of all his learning?'* This illustrates the experiential training given in many forms of complementary medicine.

Confucianism therefore encouraged an educated approach to traditional Chinese medicine with continual learning, refining, checking and discussing of theories, diagnosis and treatment principles. The very names and descriptions of organs and channels of energy in traditional Chinese medicine reflect Confucius's descriptions of intricate social networks and economic power structures. For example, acupuncture/acupressure points often refer to 'palaces' and 'gateways'; functions of organs are described in terms of 'controlling', 'producing,' 'protecting' and 'storing' vital substances; and herbs are separated into 'emperors', 'ministers ' and 'assistants'. All this grew from thousands of years of on-going learning and traditional Chinese medicine developed into a rigorous and detailed form of medicine.

Confucianism was attacked centuries later in an aggressive attempt to stymie the established government and enforce the new Qin dynasty (246-210BC). The climax of this was in 213 BC, when all Confucian books were burned apart from one copy of each that was kept in the Chinese State Library (Loewe, 1991). The perceived threat of Confucius's work was probably due to his encouragement of education and questioning of society in terms of its politics and philosophy. The later Mohists also discussed the influence of society on language, human sensation, perception, first- and second- hand evidence, deductive and inductive logic, levels of causality and in particular they are accredited with *introducing '...an empirical attitude towards investigating phenomena and relied on a community of observers to verify the truth or falsity of a claim'* (Duo Gao, 1999). Again, this scientific reflection can be seen to influence the development and evaluation of the predominant form of medicine at that time, namely traditional Chinese medicine.

Linked to the Mohists, were the Logician philosophers who, as the name suggests, looked at logic in human cognition. They were also known as the 'School of Names' reiterating the emphasis on language and reasoning and continual learning. Reber (1985) defines logic as *'The normative branch of philosophy that deals with the criteria of validity within thought, the canons of correct prediction and the principles of reasoning and demonstration.'* The emergence of this scientific reasoning from the Mohists and Logicians instilled empirical investigation into traditional Chinese medicine that was later supported by the Taoist alchemists. *'The most important contribution of the Taoists to traditional Chinese medicine was its empirical and scientific theories'* (Duo Gao, 1999).

The Taoists also introduced meditation, exercises and breathing techniques into medicine. This reiterated the traditional Chinese medicine focus on treating the whole person and encouraging self-treatment and maintenance of health. This can be related to the afore-mentioned concept of holism within traditional Chinese medicine.

The aim of all Chinese medicine practitioners, particularly in the West, is to change people's thoughts on healthy living and attempt to achieve a positive outlook whereby we realise that what we eat, how we take mental or physical exercise, and how the world around and our environment affect us all have everyday implications on our state of health (Duo Gao, 1999).

Traditional Chinese medicine is therefore a holistic form of complementary medicine that claims to be preventative and curative utilising a complex body of knowledge that has evolved over the last 4000 years. It has a detailed theory of health, illness and the human body and is based on the technical intervention of trained practitioners working with chi.

APPENDIX II – Data Tables

Table 2. Shiatsu Practitioner diagnosis (n=345) adapted from Pooley and Harris (1996).

Category	Number	Percent
Musculoskeletal	191	55.19
Psychological	190	54.91
Neurological	58	16.76
Digestive	35	10.12
Female genital system including menstruation	32	9.25
Respiratory	32	9.25
Skin	21	6.07
Endocrine & metabolic	16	4.62
Circulatory	15	4.34
Pregnancy & family planning	12	3.47
Blood	11	3.18
Urology	6	1.73
Social problems	5	1.45
Ear	5	1.45
Eye	3	0.87
Male genital system	1	0.29
Other	24	6.95

Table 3. Patient Self-Diagnosis (n=345) adapted from Pooley and Harris (1996).

Presenting condition	Number	Percent
Stress / Depression / Anxiety	122	35.29
Back	88	25.43
Neck and Shoulders	84	24.28
Fatigue and feeling unwell	77	22.25
Lower Back	57	16.47
Headache / Migraine	46	13.26
Digestive	39	11.27
Atopic Conditions	28	8.09
Arthritis	17	4.91
Other	91	26.29

Table 4. Patient self-diagnosis (n=792) adapted from Pooley and Harris (1997).

Symptoms / problems	Number	Percent
Feeling stressed/ depressed/anxious	411	52.3
Neck/shoulder problems	380	48.3
Fatigue/ low energy	300	38.2
Lower back problems	245	31.2
Sleep disturbance/ insomnia	176	22.4
Digestive	145	18.4
Headache/ migraine	120	15.3
Menstrual/ menopausal/ hormonal problems	94	12.0
Other back problems	87	11.1
Breathing problems (other than asthma)	85	10.8
Arthritis	73	9.3
Heart/ circulatory problems	71	9.0
Skin problems	62	7.9
Asthma	22	2.8
Blood problems	21	2.7
Pregnancy/infertility problems	12	1.5
Other symptoms/ problems	292	37.2

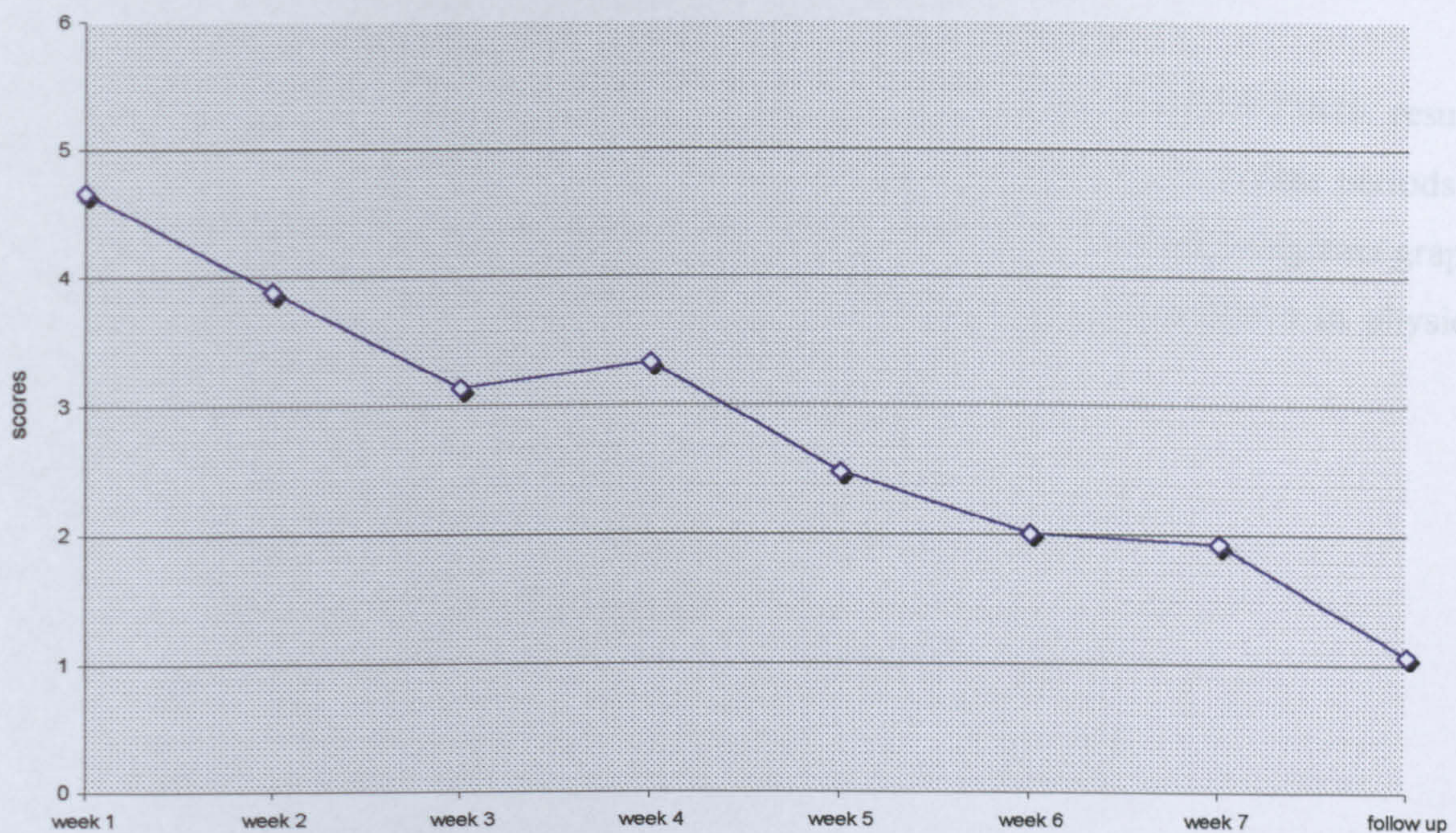
Table 5. Medical diagnosis described by patients (n=382) adapted from Pooley and Harris (1997).

ICPC Category	Number	Percent
Musculoskeletal neck/shoulder (22) lower back (21) arthritis (21)	111	29.1
Psychological depression (23) stress (14) anxiety (6)	52	13.6
Digestive irritable bowel syndrom (15)	32	8.4
Female genital system breast cancer (10) menopausal problems (5) fibroids (4)	31	8.1
Neurological migraine (6) multiple sclerosis (9)	28	7.3
Circulatory hypertension (13)	27	7.1
Respiratory asthma (13)	20	5.2
Blood HIV infection (10)	13	3.4
Endocrine & metabolic diabetes mellitus (4)	7	1.8
Skin	7	1.8
Pregnancy & family planning	5	1.3
<i>Ear</i>	3	0.8
Male genital systems	2	0.5
Urology	2	0.5
Eye	1	0.3
Social problems	1	0.3
General & unspecified myalgic encephalomyelitis (26)	40	10.5

MYMOP-PIRIE results

The MYMOP-PIRIE forms suggested that patient profile scores dropped considerably during the time the patients received shiatsu. Scores are from 1-6 with higher scores indicating ill health. These profile scores are calculated by adding the four main ratings for symptom activity and well-being and dividing by four to produce a mean. By calculating an average of these individual scores, the following table can illustrate the mean scores of all ten patients at eight points in time. Week one is pre-shiatsu, weeks two to six is during the clinic and week seven is post-shiatsu. The follow-up refers to the questionnaire results two months after ceasing shiatsu treatments.

Figure 10. Patients' mean MYMOP-PIRIE scores



The above chart clearly indicates a steady decline in mean profile-scores during and after the six-week long shiatsu clinic. This is suggested by the scores reducing not just during the clinic but at the post-intervention at seven weeks and again at the two-month follow up. Since a rating of '0' meant the chosen symptom was, 'as good as it can be', the decreasing scores indicate an improvement in health, at least as perceived by the patients. Tests of normality were conducted on the data which concluded that the scores were normally distributed (Kolmogorov-Smirnov statistic 0.195, $df = 9$, $sig = 0.200$). Paired-sample t-tests were then conducted to assess if the

difference in means between pre- and post-shiatsu scores was significant. The results indicated that the mean reduction of patients' scores of 2.58 was significant and one can be 95% confident that the true reduction in MYMOP-PIRIE scores was between 1.36 and 3.81 ($t = 4.87$, $df = 8$, $p = 0.001$).

The same statistical tests were conducted on the difference in the means between the pre-shiatsu scores and those at two month follow-up. Again, normality was assured (Kolmogorov-Smirnov statistic 0.147, $df = 9$, $sig = 0.200$) and the t-tests calculated there was a significant difference between the pre mean score of 4.5 and the follow-up mean score of 1.06. The average reduction of patients' scores was 3.45 and one can be 95% confident that the true reduction in MYMOP-PIRIE scores was between 2.10 and 4.79 ($t = 5.92$, $df = 8$, $p < 0.001$).

The SF-12 results support the patients' comments and the MYMOP-PIRIE results. Both the physical and mental scores of the SF-12 rose over the three time periods of data collection; pre-, post shiatsu and 2-month follow-up. The following two graphs (figures 12 and 13) plot this change over time, indicating improvement in physical and psychological health.

Figure 11. Patients' SF-12 mental health scores over time

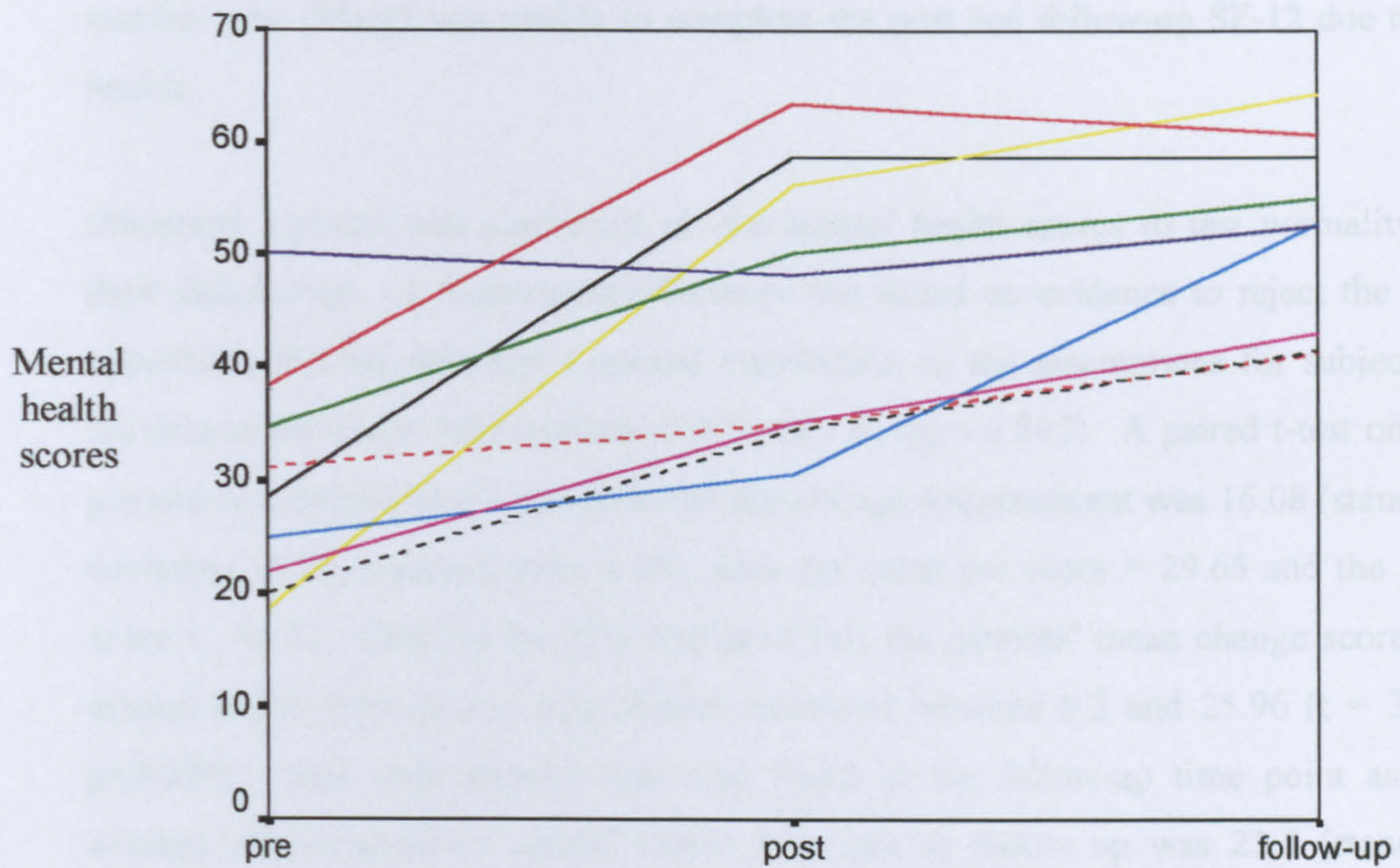


Figure 12. Patients' SF-12 physical health scores over time

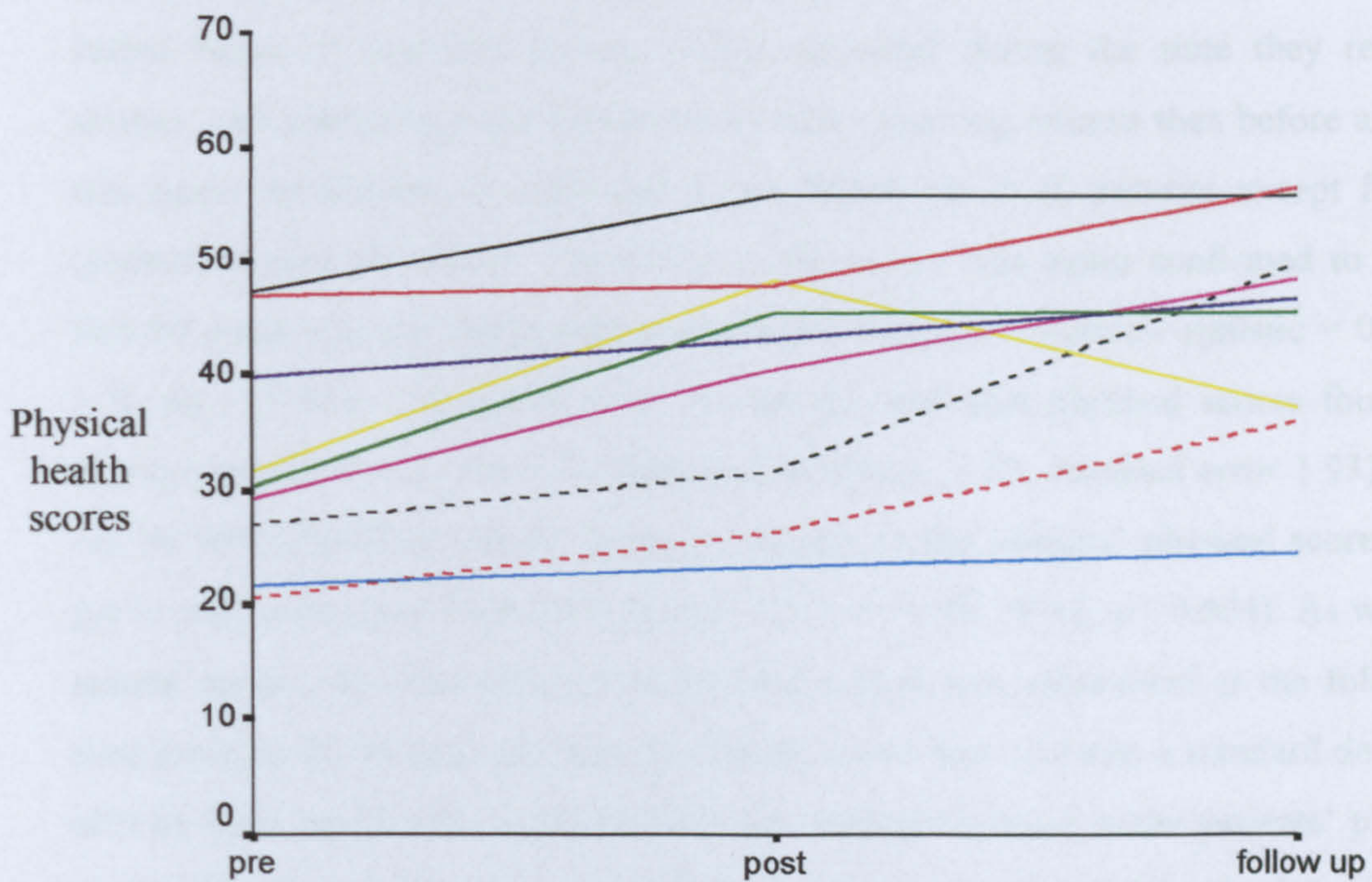


Figure 11 suggests that the patients began their shiatsu treatment with varying base-line mental health scores, but all patients' scores increased during the time they received shiatsu. Only nine patients' scores are described in each graph since patient number nine (Mary) was unable to complete the post and follow-up SF-12 due to ill health.

Statistical analysis was conducted on the *mental* health scores to test normality of their distribution. A Kolmogorov-Smirnov test found no evidence to reject the null hypothesis that the data had a normal distribution so the assumptions for subjecting the data to the t-tests held (statistic 0.200, $df = 9$, $sig = 0.802$). A paired t-test on the pre and post mental health scores found the average improvement was 16.08 (standard deviation 12.86, standard error 4.29), with the mean pre score = 29.65 and the post score = 45.72. One can be 95% confident that the patients' mean change scores in mental health from pre to post shiatsu increased between 6.2 and 25.96 ($t = 3.75$, $p < 0.006$). This improvement was also found at the follow-up time point as the average improvement in mental scores from pre to follow up was 22.6 (standard deviation 12.1). One can be 95% confident that the average increase in the patients' mental scores from pre to follow-up time points lay between 13.3 and 31.2 ($t = 5.6$, $df = 8$, $p = 0.001$).

A similar pattern is found in the patients' *physical* health scores in figure 12 with a varied range of base-line scores, which increased during the time they received shiatsu. All patients gained higher scores after receiving shiatsu than before and this was again maintained, or improved at the follow-up in all patients except for one (patient number six, Jane). Normality of the scores was again confirmed to ensure that the t-test was the appropriate analysis (Kolmogorov-Smirnov statistic = 0.22, $df = 9$, $sig = 0.430$). A paired t-test on the pre and post physical scores found the average improvement was 7.71 (standard deviation, 5.79, standard error 1.93). One can be 95% confident that the average increase in the patients' physical scores from pre to post shiatsu lay between 3.25 and 12.17 ($t = 3.99$, $df = 8$, $p < 0.004$). As with the mental scores, the improvement in physical scores was maintained at the follow-up time point as the average increase in change scores was 12 (with a standard deviation of 6.8). One can be 95% confident that the average increase in the patients' physical scores from pre to follow-up time points lay between 6.8 and 17.1 ($t = 5.4$, $p = 0.01$).

Appendix III – Evaluation tools

Patient Information for the shiatsu clinic

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and feel free to discuss it with friends, relatives and any of the staff at Hanson. Ask us if there is any-thing that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank-you for reading this.

The New Shiatsu Clinic

My name is Zoë Pirie and I am a Researcher at the University of Sheffield and a Shiatsu Practitioner. Shiatsu is a popular form of complementary medicine similar to acupressure massage or acupuncture without the needles! It is pronounced 'she-atsu' and literally means 'finger-pressure' though the practitioner usually uses their thumbs and palms. The treatment takes an hour and involves gentle pressure techniques, massage and stretches. Shiatsu is usually practised as private medicine and is not available on the National Health Service. However, I am currently researching the use of shiatsu in general practice and am offering free treatments to ten patients at Hanson Medical Centre from January to June 2000.

Your Invitation

Your GP/Nurse thinks you may benefit from having shiatsu and has referred you to the clinic, which is every Wednesday. You are invited to have eight appointments – six shiatsu treatments and a brief meeting the week before and also after your series of treatments. If you become pregnant during this time it is best not to continue with the treatments so please tell the shiatsu practitioner as soon as possible. Otherwise you can continue your life as normal and carry on taking your usual medication and seeing the GP or Nurse at the centre. The shiatsu is offered in addition to your normal health care and there are no known negative side effects.

All information that is collected about you during the research will be kept strictly confidential. You will not be identified in any report or publication and will have the opportunity to see the results before the final version is written. The project has been funded by the North Trent Region National Health Service Executive and is housed in the University of Sheffield, Institute of General Practice and Primary Care.

If you wish to be part of this study, please;

- Read the shiatsu leaflet entitled 'Do you want to treat yourself?'
- Sign both Consent Forms, either now with your GP/Nurse or at your first shiatsu appointment. Keep one copy for yourself and return the other to your GP/Nurse or to Zoë directly in your 1st appointment.
- Book 8 appointments for the Wednesday shiatsu clinic with the Receptionist, preferably on consecutive weeks.
- Make sure you can attend all your appointments as this may affect the study – let the practice know as soon as possible if you need to cancel and rearrange.
- Wear loose fitting, comfortable clothes and socks for your treatment (no jeans please - jogging bottoms can be borrowed if required).

What to expect;

- You will be given a telephone call by the practice staff to remind you about your first appointment.
- At the start of your first appointment I will ask you about your symptoms and fill in 2 brief health questionnaires – to save time in the following weeks, one of these questionnaires will be left for you at reception to fill in and bring to each appointment. Alternatively I can help you complete the questionnaire in the clinic room.
- Your 2nd to 7th appointments will then include a hands-on shiatsu treatment. During the treatment you will lie on a comfortable futon mat on the floor and will remain fully clothed.
- I may recommend some gentle exercises that you can do between treatments to help yourself feel better faster - you will be given a diary so you can record your practice if you wish and make notes of any-thing you want to remember to say at the next appointment.
- In your 8th appointment, you will be asked to give your feedback on having shiatsu to a researcher and complete the last 2 health questionnaires.

I look forward to seeing you soon. If you have any questions please feel free to contact me, Zoë Pirie on 0114-271-5442 (Tue, Thurs & Fri) or 07968-013452.

Referrer guidelines for the shiatsu clinic

To help make the shiatsu clinic a success you only need to refer two or three patients each. The criteria for referrals are listed below to help you choose appropriate patients. For the 2nd set we need 5 patients to have booked 8 appointments, preferably on consecutive weeks, starting from Wednesday 29th March 2000. All staff are invited to have a mini shoulder/back treatment if there are any free sessions during the study – just keep your eye on the blue clinic book in reception and book yourself in! I hope you find the shiatsu clinic beneficial.

Inclusion Criteria;

- Presentation of non-specific physical symptoms without diagnosed organic cause

Exclusion Criteria;

- Under 16s
- Involvement in Back Study
- Women in the first 3 months of pregnancy or intending to become pregnant between January and June 2000
- Psychological diagnosis such as major depression or schizophrenia
- Diagnosis of Cancer
- Patients in receipt of palliative care
- At the discretion of the referring clinician

How to make a referral;

- ☺ Please give your patient the **enclosed pack** containing *Patient Information*, the *Shiatsu Leaflet* (entitled, 'Do you want to treat yourself') and the 2 *Consent Forms*.
- ☺ Explain that if they wish to attend the clinic they will need to sign both **consent forms**, either now with your-self or at their first shiatsu. I need one form and the other is for the patient to keep. They can then **book eight appointments** in the Wednesday shiatsu clinic, preferably on consecutive weeks. If they wish I can phone them to introduce myself and answer any queries they may have.
- ☺ Please complete the light blue **referral form** and leave for Zoë in reception.
- ☺ Feel free to call me at work 271-5442, mobile 07968-013452 or home 286-4734. ☺

Study Number:
Patient Identification Number:

Consent form for the shiatsu clinic

Title of Project: Delivering shiatsu in general practice

Name of Researcher: Zoë Pirie, Research Fellow and Shiatsu Practitioner Dip.BSS, MRSS, PRSI

Please initial boxes		
1. I confirm that I have read and understood the Information Sheet dated 08.03.00 (version 3) for the above study and have had the opportunity to ask questions.		<input type="checkbox"/>
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.		<input type="checkbox"/>
3. I agree to take part in the above study and attend 8 appointments in the shiatsu clinic.		<input type="checkbox"/>
<hr/>		
Name of Patient	Date	Signature
<hr/>		
Name of Person taking consent	Date	Signature

Please sign both consent forms; keep one copy and either hand the other to your GP/Nurse now or bring it to your 1st shiatsu appointment, thank-you.

(The 'yellow card')

To be kept in the patient notes;

Shiatsu clinic attendee

This patient is currently attending the shiatsu clinic. Please ask them how it is going and make a note overleaf of any changes in the patient and your interaction that could be associated with this.

These notes will hopefully help you discuss your views on the shiatsu clinic in a short interview with a researcher in a few weeks time so feel free to write any additional feedback here.

The interviews will mainly discuss two topics:

1. **Impact** - Any impact the clinic may have had on the patient and your interaction with them.
2. **Reflections** - Your personal reflections on the shiatsu clinic.

Many thanks – Any queries feel free to call me on 271-5442 (Tue, Thu & Fri days); 286-4734 (eves) or 07968-013452 (mobile).

Shiatsu clinic notes;

Please write your name, the patients name and date. Then any notes on the impact of the clinic (what you think and what the patient says) and any personal reflections.



SHIATSU CLINIC: MYMOP-PIRIE FORM 1



Name.....	Date of Birth.....	Date.....
Telephone Number.....	Sex (please circle)	Female/Male

1. Please choose one or two of your **symptoms** (physical/mental/emotional) that you would like to see improve with shiatsu. Insert the length of time the symptom has lasted, either all the time or on and off. Then circle how **you** think your symptom/s have been in the **last week**, in the first row, and what score you would **realistically be satisfied with** after your series of shiatsu treatments.

SYMPTOM 1.....

Duration	less than 2 weeks <input type="checkbox"/>	2-4 weeks <input type="checkbox"/>	4-12 weeks <input type="checkbox"/>
	3 months-1 year <input type="checkbox"/>	over 1 year <input type="checkbox"/>	

The last week	0	1	2	3	4	5	6
	As good as it can be						As bad as it can be

Satisfying improvement	0	1	2	3	4	5	6
	As good as it can be						As bad as it can be

SYMPTOM 2.....

Duration	less than 2 weeks <input type="checkbox"/>	2-4 weeks <input type="checkbox"/>	4-12 weeks <input type="checkbox"/>
	3 months-1 year <input type="checkbox"/>	over 1 year <input type="checkbox"/>	

The last week	0	1	2	3	4	5	6
	As good as it can be						As bad as it can be

Satisfying improvement	0	1	2	3	4	5	6
	As good as it can be						As bad as it can be

2. Now choose one **activity** (physical, mental or social) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

Activity.....

0 1 2 3 4 5 6
As good As bad as it
as it can be can be

3. How would you rate your general feeling of **wellbeing** during the last week?

0 1 2 3 4 5 6
As good As bad as it
as it can be can be

4. Tick the box which best describes how you feel:

Cutting down on **medication** is;

- not important to me
- a bit important to me
- very important to me

If you have answered that medication **IS** important to you, write down what medication you would like to cut down, or avoid, and how much of it you are taking at the moment.

Medication.....

Dosage and Frequency.....

Pre-Treatment Patient Interview

1. What do you think shiatsu is? What conditions could it help? Why have you come for shiatsu?
2. What treatment you have received so far in Hanson for these symptoms? How effective has it been?
3. Please describe any experience you have with shiatsu or any complementary therapy.
4. How did you react when shiatsu was suggested to you?
5. What are your hopes and expectations in having shiatsu?
6. Do you have any concerns about having shiatsu?



SHIATSU CLINIC: MYMOP-PIRIE FORM 2



Name.....Date.....

1. Please circle the number to show how **you** think your symptom/s have been in the last week.

SYMPTOM 1.....

The last week

0	1	2	3	4	5	6
As good as it can be			As bad as it can be			

SYMPTOM 2.....

The last week

0	1	2	3	4	5	6
As good as it can be			As bad as it can be			

ACTIVITY.....

0	1	2	3	4	5	6
As good as it can be			As bad as it can be			

3. How would you rate your general feeling of wellbeing?

0	1	2	3	4	5	6
As good as it can be			As bad as it can be			

4. If an **important new symptom** has appeared please describe it and rate it below. Otherwise do not use this box.

SYMPTOM 3.....

The last week

0	1	2	3	4	5	6
As good			As bad as it			

5. The treatment you are receiving may not be the only thing affecting your problem. If there is anything else that you think is important, such as changes you have made yourself, or other things happening in your life, please write it down here.

4. If cutting down or avoiding **medication** is important to you, tick the box to show how this has changed since your previous MYMOP form:

Not much change
Taking less medication
Taking more medication

If there has been a change, write down what medication has changed, and how much of it you are taking now:

Medication.....
Dosage and Frequency.....

Please use this space for any other information you wish to give, thank-you.

Thank-you for your time – please hand the completed form to Zoë.
All replies are strictly confidential.

Patient Feedback Meeting

To help evaluate the shiatsu clinic we need to know what you thought & felt about it. This is why you are invited to have a feedback meeting after your six shiatsus. The meeting will be based on the following questions. Please take some time to read them and think about your answers. You may make notes if you wish in your diary and bring it with you to help remember your feedback. The Interviewer is Jane Walker, a Researcher at Sheffield University. Any-thing you say will remain strictly confidential and will only be heard by Zoë. You will not be identified with any quotes in the final report. Thank-you again for your involvement in this project.

- 1
 - a. Please describe any changes you have noticed in your health and well-being since having shiatsu (*If you have not noticed any changes please go to question 2*)
 - b. If you have seen your GP/Nurse since having shiatsu please describe any changes you have noticed in these appointments
 - c. If you think any of these changes may be associated with having shiatsu, please describe how. ie. what specific aspects of shiatsu seem to be linked to changes in your health/appointments with GP/Nurses?
 - d. If you think these changes are associated with other things in your life in the last few weeks, please describe them

- 2
 - a. What did you like about shiatsu, if any-thing?
 - b. What did you not like about shiatsu, if any-thing?

- 3
 - a. What did you expect from having shiatsu?
 - b. Did your treatments meet these expectations? Please explain why

- 4
 - a. Please describe how satisfied you are with the treatment you have received from the shiatsu practitioner to date. Please rate this satisfaction on a scale from 1-10, with 0 being least satisfied and 10 being most satisfied.
 - b. Please describe how satisfied you are with the treatment you have received from the other staff at Hanson to date. Please rate this satisfaction on a scale from 1-10, with 0 being least satisfied and 10 being most satisfied.

- 5
 - a. Would you recommend shiatsu to someone else?
If yes, why and what kinds of conditions do you think it could help?
If no, please explain why
 - b. What do you think shiatsu is?

- 6
 - a. What was is like...
 - I. filling in the forms each week?
 - II. writing the diary
 - III. having the interviews
 - b. What do you think is the best way to evaluate the clinic?

- 7 If you think we could improve the shiatsu clinic, please explain how

- 8 Why do you think more people don't use complementary medicine?

- 9 Is there any other feedback you would like to give?

Staff Feedback Meeting

To help evaluate the shiatsu clinic I need to know what you thought & felt about it. This is why you are being asked to have a brief feedback meeting after your patients have finished having shiatsu. The meeting will be based on the following questions. Please take some time to read them and think of your answers. Feel free to make some notes if that helps. The interviewer will also bring the yellow 'shiatsu clinic attendee' sheet from the patients notes to help. The interviewer is Jane Walker, a Researcher at Sheffield University. All your responses will remain strictly confidential and only be heard by Zoë. You will not be identified with any quotes in the final report. Thank-you again for your involvement in this project.

Aim of this form is to gain staff experiences of;

- **Perceived impact of shiatsu** in terms of a) patient health and quality of life and b) consultation behaviour from the patient and yourself including management of care (medication or advice you may have given etc)
- Reflections on the **delivery of the service** including understanding of and satisfaction with the shiatsu service

Questions

1. Please describe any experience you have had with shiatsu or any other complementary therapy
2. You will be asked questions 2-4 for each patient you have referred.
 - a. Why did you refer patient a/b/c/etc for shiatsu?
 - b. What did you expect from your referral to the shiatsu clinic?
 - c. Did the clinic meet your expectations for this referral? Please explain why.
3.
 - a. If you have seen patient a/b/c since they have been having shiatsu please describe any changes you have noticed in their health and well being.
 - b. If you think any of these changes may be associated with having shiatsu, please explain.
 - c. What factors other than shiatsu could be associated with any of these changes?
4.
 - a. If you have consulted with patient a/b/c since they have been having shiatsu please describe any changes you have noticed in these appointments
If you have noticed any changes;
 - b. If you think any of these changes may be associated with having shiatsu, please explain
 - c. What factors other than shiatsu could be associated with any of these changes?
5. Please give any feedback on the progress of patients you referred to the first clinic

6. a. What are your thoughts on...
 - I the referral process to the shiatsu clinic?
 - II the yellow cards in the patients' notes?
 - III these feedback interviews?
- b. What feedback would you like about the shiatsu and from whom?
7. a. What impact, if any, do you think the shiatsu clinic has had on the practice?
- b. What were the positive things about offering shiatsu at Hanson, if any?
- c. What were the negative things, if any?
- d. How satisfied you are with the shiatsu clinic? Please rate this satisfaction on a scale from 1-10, with 0 being least satisfied and 10 being most satisfied.
- e. Would you recommend shiatsu to other patients? *If yes*, what kinds of patients would you refer? What symptoms do you think could benefit? *If no*, please explain why.
8. What do you think shiatsu is?
9. a. If you think we could improve the shiatsu clinic, please explain how.
- b. Do you think shiatsu should be offered in general practices? *If yes*, how best could this be done? *If no*, please explain why
- c. What would help the integration of complementary medicine and orthodox medicine?
10. Is there anything else you would like to say about the shiatsu clinic?

(This was not used in the study)



SHIATSU CLINIC – PATIENT SATISFACTION FORM

ID No.....

This form asks you about your experience and satisfaction of the shiatsu clinic. Please give your own opinion as be as honest as possible. You do not have to give your name. Please answer the following questions by circling one word on each line. Thank-you for your help in this study.

Access:

1. Convenience of location of shiatsu clinic;	poor	fair	good	very good	excellent
2. Hours when clinic was open;	poor	fair	good	very good	excellent
3. Arrangements for making appointments;	poor	fair	good	very good	excellent
4. Length of time spent waiting at the clinic to see the shiatsu practitioner;	poor	fair	good	very good	excellent

Communication:

5. Explanation of treatment;	poor	fair	good	very good	excellent
6. Attention given to what you have to say;	poor	fair	good	very good	excellent
7. Advice you were given about ways of avoiding illness and staying healthy;	poor	fair	good	very good	excellent

Interpersonal Care:

8. Friendliness and courtesy shown to you by your shiatsu practitioner;	poor	fair	good	very good	excellent
9. Personal interest in you and your problems;	poor	fair	good	very good	excellent
10. Respect shown to you, attention to you privacy;	poor	fair	good	very good	excellent
11. Reassurance and support offered to you by your shiatsu practitioner;	poor	fair	good	very good	excellent
12. Amount of time you had with your practitioner during a visit;	poor	fair	good	very good	excellent
13. The outcomes of your treatment, how much you have been helped?	poor	fair	good	very good	excellent
14. Overall quality of care and service;					

15. What did you like most about attending the shiatsu clinic?

16. What did you like least about attending the shiatsu clinic?

17. Do you have any suggestions for altering anything about the clinic?

18. How many treatments did you have?.....

Was this too few just right too many

19. Would you recommend shiatsu to someone else?

yes no don't know

Please use this space for any other comments you think may be helpful.

Appendix IV - Patient case studies

This section will present ten case studies to describe the group of patient's that were referred to the shiatsu clinic. The development of their shiatsu diagnosis and management of symptoms is then outlined.

Patient 1- Sara

Sara was a forty-six year old administrator at a large general practice. I recorded on her patient history form that she described herself as 'happily married' with two grown-up daughters and a 'busy and demanding' job. Sara mainly presented with digestive problems including nausea after eating and chronic stomach bloating that were collectively diagnosed as Irritable Bowel Syndrome (IBS) by the GPs at Bluebell. Because of this, Sara had undergone several investigations including a laporotomy with appendectomy in the summer of 1997. However, her symptoms were not relieved and she suffered an open wound for five months, which repeatedly caused abscesses. A second and equally ineffective operation to treat an incisional hernia took place in the following autumn in 1998. Ever since, Sara has experienced severe pain both at the site of the operation and also along the left side of her torso. She related some of her stress to her mother's death eighteen months ago. Sara felt very depressed and dated this back to February 1999 when she recalled thinking *'I'm never going to feel that good. I knew I couldn't go on any longer without any kind of help. I just wanted to go into a corner and die.'* This was captured on her first MYMOP-PIRIE form.

Sara's current depression seemed exacerbated by her belief that her lack of physical health rendered her unable to maintain her previously active life-style. For example, she had been a key member of her local Territorial Army group and claimed that ceasing this caused her weight to increase from nine stone to twelve stone in the last three years. Sara also associated her decline in exercise and consequent weight-gain as causing knee-pain in the preceding five months. She described that it was not arthritis but a wasting of her muscles and had been shown some exercises by the physiotherapist to rectify the problem. However, her knee-pain persisted. Finally, Sara also associated her depression to the death of her mother a year ago and the pressure placed on women to be the main caregivers in the family.

Sara.T1.L36 *'...you're a mum and you're supposed to do everything for everybody...you're always under a lot of stress because the family still look at you as the main person to solve all the problems.'*

Sara had a dramatic increase in her health and happiness during her course of shiatsu treatments, as indicated by her scores on the questionnaires and her feedback in each interview. In consultation with her GP she stopped taking her anti-depressant and digestion medication and by the follow-up had stopped her regular check-ups with her GP. She cited reducing her medication as being *'very important'* in her first MYMOP-PIRIE form, describing *'Its so important because if I can cut down on my medication I'll feel happier in myself as well.'* She did not expect such a rapid reduction however, as in her third treatment she wrote *'I'm going to be on at least one tablet for quite a long time I think'* although also noting that *'I have been a lot calmer this week and have definitely felt happier.'*

Sara's improvement was most probably assisted by her determination to get better and take responsibility for her own health. She was keen to practice exercises between treatments, writing that *'The exercises definitely help'* in her last MYMOP-PIRIE form and changed her diet after the first session. She lost weight and rated her two main symptoms, bloating and stomach pain as 0 out of 6 referring to 'as good as it can be' from treatment five onwards and again at the two-month follow-up. To conclude, Sara reported a total recovery of all ill health, physical or otherwise and related this to her shiatsu treatments.

Patient 2 - Jenny

Jenny was a fifty-eight year old, married woman who had no children after having a hysterectomy when she was thirty-one. She seemed quite an anxious person and was clearly worried about the physical cause of her ill health. During her course of shiatsu treatments she related her current state of health to two main life-events; being made redundant and not having found further employment, and her husband undergoing a triple by-pass fourteen years previously in 1986.

Jenny's GP described the reasons for referral as being *'Polysymptoms associated with anxiety about health (chest pain, abdominal pain, headache, cough, dizziness'* and

'anxiety' as the second main symptom, though she was also taking Prozac for depression. Jenny stated that stress was her dominant symptom and listed lower back pain and stomach-ache as secondary complaints. She presented with a wide range of symptoms and fears that also included puffy eyes, a bad cold, heartburn, swollen ankles, frequent night-time urination's, hot body temperature and hot extremities.

Her main psychological/emotional symptoms were concern and embarrassment about her health as if she had no 'right' to be ill (possibly because of her husband's clear medical condition) and fear that her husband would die of a heart attack. Despite his otherwise good health this worry seemed to continually prey on her mind, especially since leaving work and having much more spare time. I recorded Jenny's description of her anxiety, in her first consultation, in my reflective journal '*Some days I think he's not going to pull through. It's worse when I'm on my own to think. It's a bit frightening* (looks tearful and very scared)'.

Jenny had an initial improvement in her health, writing in her second treatment that, '*Since last week I've perked up quite a lot. My cough is easing and I have to say I am feeling much better and livelier!*' (MP). Her MYMOP-PIRIE scores for stress and stomach pain were 0/6 by the third week, falling from 4 and 3 respectively when she began treatment, and general well being jumping to 2/6 from the initial 5/6. However, a new symptom, namely a stiff leg, emerged in week three, and although this did not affect her stomach rating, her stress and wellbeing scored worse by week four. This pattern continued with ratings lowering again in week five and again in week six, when another new symptom arose (dizziness), which lasted just one week.

In general, Jenny seemed to have a bad week with high scores for all symptoms, followed by a good week with relief from these on-going main symptoms but the emergence of new complaint. Overall, however, her health did improve as the severity of the two main symptoms declined, until she only rated stress as 2/6 and all other pains as cured, both in the last session and at the two-month follow-up.

Jenny may have had a more sustained progress if she had been more motivated to help herself, and she often chastised herself for not doing more. However, she did report an improvement in her symptoms and seemed to change her view of her health, seeing it

more affected by what she did herself. A longer course of treatments may have helped to support this view and empower her to take more responsibility in her wellbeing. In the limited time available, I had to accept that my responsibility was to treat Jenny as best as I could and provide recommendations for her self-care, and Jenny's responsibility was to adopt healthy habits if she deemed them useful.

Patient 3 – Tara

Tara was a thirty-five year old mother, wife and part-time 'policy and development' advise nurse at the local council. She had a five-year-old son and was not planning to have any more children after the death of her second son four years ago, who was born prematurely. She and her husband named the boy and she openly grieved for him in one shiatsu treatment near the anniversary of his death. Tara described this uncommon emotional release as testimony to the trust she felt in the shiatsu and myself.

Tara was referred because of chronic neck and head aches post-traumatic stress following a road traffic accident. She seemed particularly upset by this incident because she had her son in the car with her. Tara described her main symptoms as sharp pain in her head and neck, which radiated down her arms, making most of the top half of her body agony to touch. She also described pins and needles and loss of sensation in these painful areas and was very concerned with her 'rattyness.'

Tara made a good improvement in her symptoms, and greatly reduced her pain relieving medication. This was partly by following several recommendations for natural pain relief and decreasing muscular tension with regular exercises and relaxing music tapes (that she would listen to with her son in the car). She described how she enjoyed sharing these recommendations with colleagues and discussing her shiatsu treatment with them. Her mood greatly improved and she claimed she was much less irritable and much happier with being able to manage her symptoms. This maintained two months after ceasing shiatsu as her follow-up interview describes,

Tara. T3.L94 'I've generally been ok. About two or three weeks ago I had a bad few days but I got it under control and have had nothing since. It's totally gone which is great and I've taken no tablets or anything at all for

the last two weeks. Before it would last for days. I worried it was the start of it getting bad again but it went and was just a little 'blip' for some reason. But I've had no bad headaches and I just treat them myself. I've been able to do that.'

This quote shows that she maintained her new positive attitude to her health, even seeing a recurrence of symptoms as a temporary 'blip' rather than a problematic relapse.

Patient 4 – Kate

Kate was twenty-nine, worked full-time and lived with her partner. They had no children and she 'loved' her job, though she also described it as very demanding. She seemed to enjoy the stress and excitement involved in her position as a sales manager and worked long hours. However, her ill health rendered her unable to work at all, and this was distressing her greatly. Kate's GP hoped the shiatsu could help Kate return to work.

GP2. T2a.L40 'I was hoping that her pain would be reduced, and she'd been off work for a while, and she'd be able to get back to work and she'd be able to cope with her symptoms better really.'

GP2 described Kate's pain and reaction to it as the main reason for referring her to shiatsu.

GP2. T2.L29 '...she'd been having a lot of problems with abdominal pain, and she'd had a little blood passed which seemed to be irritable bowel. She's very anxious, and she was very anxious about it being serious, but also about the effect it was having on her day-to-day life. She wasn't terribly amenable to explore her own psychological direction with me, or so it seemed, it certainly that had been the experience, not with myself but with one of my partners when she had a sort of post-viral syndrome. Again she didn't seem very keen on exploring physiological direction to that, particularly with us as doctors, and we tried various medical treatments which hadn't worked terribly well, and I thought well I'm not

really sure what I'm gonna do next...so shiatsu seemed the obvious next step really. I mean both the possible direct benefits that shiatsu, but also I guess was thinking, ' Well, perhaps Zoë with more time and a different approach may enable Kate to open up about psychological aspects than she had done with the doctors, so they were the reasons really. '

Kate presented with chronic constipation and stomach pain which was making her 'double-up' roughly five times a day. She was often constipated for roughly ten days and then suffered severe diarrhoea and was regularly passing blood in her stools. Her digestive problems caused her feel too bloated to eat and she had lost over a stone in weight in the last four months. Kate was very anxious about her health and was recently diagnosed as depressed.

Kate described herself as apprehensive and cynical about having shiatsu. However she was willing to try the treatment and became notably more relaxed during the sessions. She seemed to appreciate the personal relationship with myself as the shiatsu practitioner, but preferred the traditionally clinical atmosphere of the GP consulting rooms. Perhaps she felt more comfortable in a more formal environment that she saw as being appropriate for health care. Kate's progress during her shiatsu can be illustrated by her GPs reply when asked if the clinic had met his expectations,

GP2. T2a.56 'Yes certainly. I haven't actually seen her since, about a month ago and she was much better. She'd come back to work, she was in less pain, her mood seemed a lot better as well. She was back at work full-time without any problems, so she seemed much better about it. '

R2, 'And do you think the changes were associated with having the shiatsu?'

GP2, 'That's right. I can tell. Oh yes. '

Patient 5 - Lucy

Lucy was twenty-six and single. She had stopped working due to her ill health and lived alone. She was involved in a road traffic accident five years previously and was still fighting for compensation. I felt that her health might not improve until the court case was resolved, and she could stop having to prove that she was injured and let go

of the emotions that this caused. This was discussed with the GP who seemed to agree and a few weeks later mentioned the following in his interview.

GP2. T2.L99 *'...she'd still got a compensation claim going on...which doesn't help. I'm not saying that she's in any sense lingering, but I think when people have that sort of stuff hanging over them it's extremely difficult to move on.'*

Lucy was referred to the shiatsu clinic because of a chronic back pain and depression that began after the car crash and resulting whiplash. In addition to these symptoms, Lucy complained of nausea roughly four times a day, pain in her right hip which radiated down her leg and an irritating itch all over her body. She looked very depressed and sleepy and spoke in an almost inaudibly quiet, slow voice. This seemed partly due to a dependence she had on very strong painkillers. Her GP had mentioned this in the 'any other information' section of the referral form, *'Using strong opiate-type painkillers. Would be good to be able to reduce these.'* Lucy also took anti-inflammatory tablets and Prozac.

Lucy did report an improvement in her back pain and low mood, particularly citing the relaxation techniques and exercises as curbing her temper. She reduced her painkillers, which pleased her GP, and became much more animated and vocal in the consultations. She began voluntary work, which she really enjoyed, and this seemed to help lift her depression, but exacerbated her back pain from being so much more active. Lucy could have benefited from a longer course of treatments, and she lamented this not being possible.

Patient 6 – Jane

Jane was twenty-nine and worked part-time as a dressmaker in a local wedding shop. She had three older brothers and lived at home with her mother' partly through *'duty'* since her father died, (SF). She was referred with *'low grade depressive symptoms: underconfidence, irritability, poor sleep and fed up, plus headache/right sided facial pain.'* GP1 also wrote on the referral form that Jane had suffered back pain for the last fourteen years, (Jane later described being 'paralysed' for three days after slipping a disc in her sleep) and had recently stopped taking Prozac due to it having *'no*

benefit. She was also waiting to have an operation to remove her gallbladder. Jane's priorities on her first MYMOP-PIRIE form were her low mood that she estimated had lasted five years and backache. She also presented with daily nausea, vomiting at least once a week and frequent passing of stools (three/four times a day, immediately after eating). Her other concern was not being able to conduct any exercise due to weak knees and was unhappy with her weight.

The relationship between Jane's psychological, emotional and physical health seemed complex as she claimed her depression led to insomnia, which in turn caused restlessness and irritability that exacerbated her back ache (SF). In addition to the hands-on shiatsu, Jane's treatment included discussing the feelings she had towards her father's death and her life with her mother since. She felt '*cheated*' that she had to '*look after*' her mother and resentful of her brothers' lack of support (SF). During her course of treatments one of her brothers admitted his alcoholism and went in to hospital, which caused Jane further worry.

By her second treatment, Jane had stopped having caffeine, had begun to sleep better and had reduced her sleeping medication. Jane said she had '*felt brilliant*' the day after her shiatsu and friends and colleagues had commented on her looking much better, (SF). Her relationship with her mother seemed to improve as she described her Mother supporting her more in her diet and had joined her in replacing caffeine with decaffeinated tea. However, Jane's digestion was still poor and she was very concerned about her brother. In her third session, she reported that she had been able to sleep through a night without any medication, which she had only ever done once before, since starting the tablets. In following treatments, Jane's mood continued to improve, as did her digestion and sleeping (only requiring tablets twice per week by treatment four) but she twice mentioned falling, again blaming her weak knees. In her last session, she mentioned that she had started a diet, which she referred to in her follow-up interview two months later,

Jane. T3.L17 '*I'm getting there (after having her gallbladder operation). I'm finishing my last antibiotics today and the nurse is coming out tomorrow. I'm still feeling better than I was before having the shiatsu,*

definitely. I'm doing things differently, coping better. I'm good now actually, I'm not feeling bad at all.'

R1, 'And how's the mood?'

Jane, 'I'm a lot better, I've not been down at all'

R1, 'Did the operation get you down?'

Jane, 'No. I'm alright. I'm just taking one day at a time and going from there. I've lost a bit of weight and that was one of the things so, 10lb, and my stomach is fine now.'

Patient 7 – Julie

Julie was a thirty-seven year old mother of four young children, aged two, four, seven and nine. She also worked part-time as an NVQ Assessor at a local College. She described herself as *'very happily married,'* but seemed to *'take on'* the problems of her large extended family. In addition to the symptoms described by Julie's GP, she presented to the shiatsu clinic with chronic insomnia,

GP3. T2.L18 'Julie had a number of problems. One of which is recurring depression and the other is generalised aches and pains associated with tension. She's got young children who are very demanding and she also works and she doesn't get a great deal of support from home. She also has gynaecological problems as well and I referred her to the shiatsu practitioner in order to treat some of her more generalised symptoms rather than specific gynaecological symptoms but her more general symptoms of back pain, etc.'

Julie had a strong reaction to her first shiatsu treatment, reporting much more energy and relaxation than normal. Over the next six weeks, her health continued to improve as her pain subsided and depression lifted. She became very self-motivated and described conducting her shiatsu exercises frequently, often with her children. By the end of her treatments, Julie had stopped her anti-depressant medication and started sleeping and she left me a card with the following message: *'Thank-you for bringing shiatsu to me. It has really changed my life and given me such inner strength and power. Words can't express the difference you've made.'*

Patient 8 – Clare

Clare was a forty-seven year old, single mother of two children, a son aged sixteen and a daughter aged twenty-seven. She no longer worked because of her poor health and was undergoing a distressing legal battle with her last employer over losing her job. Her main support was from her seventy-three year old mother who recently had to accompany Clare if she left the house.

Clare presented with chronic neck pain she had suffered for seven years and headaches for the preceding five years. X-rays had found degenerative discs in her cervical spine (neck). She also reported pain in her lumbar spine (lower back) since being twenty/twenty-five years old. Clare had had a hysterectomy four years ago to stop heavy periods that lasted two weeks; an operation on tennis elbow in her right arm that still ached; and a lump removed from her left arm-pit two years ago, again leaving residual pain. Clare brought her mother to her first appointment, to help her feel less anxious, as she had become agoraphobic and was suffering several panic attacks a day. She described having a total '*breakdown*' and seemed very depressed and lethargic, speaking in a quiet, low monotone and was devoid of facial expression. Clare's GP described referring her to shiatsu to try and help her physical and psychological symptoms,

GP3. T2.L70 '...another patient who I know very well who I have seen over a number of years, at least ten years, and has had a very long and complicated medical history. But the main two problems for which she was referred to the shiatsu clinic were the generalised aches and pains that she had which I thought were caused by the stress and tension of the life - she's had a lot of psychological problems and these are causing her all sorts of physical symptoms like asthmatic symptoms. I referred her because I thought that her generalised well being would help her deal with the symptoms if not remove them entirely That's one reason, the other reason was that she has been suffering from panic attacks which were a recent upset, probably about six to nine months she started having panic attacks.'

Clare described her steady progress during her course of shiatsu treatments.

Clare. T2.L4 *'Everything's changed. I mean if you had of seen me when I first started coming, I was so underconfident. I mean I've had all sorts of things and nothings really done a lot, but this session has always great. At the beginning, the relief, it's like slowly. I'd say first two to third and then after that it was just like a gradual improvement as I went along...she helped me a lot, a great deal mentally and physically.'*

In addition to her health improvement, Clare also made several big decisions about her life during her involvement with the shiatsu, such as selling her house and moving to a much less deprived area of the city. This was particularly brave for Clare as it meant moving away from her Mother, whose daily support had been essential before having the shiatsu.

Patient 9 – Mary

Mary was sixty-three years old and had retired from work at fifty. She was a mother of six children, grandmother to fourteen and great-grand mother to six. I assisted her in the completion of the evaluation forms as she did not seem comfortable reading or writing. Mary's GP described her as being 'down-to-earth'.

GP4. T1.L67 about Mary *'We'd never had particularly long consultations, she's a very straight forward Yorkshire woman she says what she thinks, she asks you what she wants to know and you get on with it.'*

Mary had the poorest health in the sample of patients who attended the shiatsu clinic. She was an insulin-dependent diabetic, asthmatic and obese; weighing over sixteen stone at a height of 5'4. She had suffered two heart attacks five years ago and had her gallbladder and right kidney removed. Repeated infections in her left kidney had hospitalised her twice. Mary presented with 'toothache' pains in her back and left leg to her foot and described her left knee as feeling 'dislocated.' This had been checked by the GP and no cause for the pain found. Her orthodox medical treatment was greatly limited due to her heart condition.

Mary reported a reduction of back and leg in the first three shiatsu treatments and greater relaxation. Unfortunately, her kidney became re-infected and she was unable to continue with her course of treatments. She would have needed a longer course of treatments to have the possibility of improving her health more.

P10 – Kirsty

Kirsty was fifty-five and did not work. She had lived alone for the last ten years since divorcing after twenty-six years of marriage. Kirsty seemed to have a difficult relationship with her sister and mother, who was ninety-eight and remarried eight years ago. Kirsty also talked frequently of her x-partner who she described as abusive and related a lot of her health problems to these relationships.

Kirsty's GP referred her to shiatsu for asthma and a skin infection. She also wrote on the referral form that Kirsty is aware of the *'psychological effects of her illness and has a holistic approach to healing. Long, very complex history!'* Kirsty's medical history detailed many physical, emotional and psychological symptoms, including eye and skin infections, cellulitis, pulmonary embolism, thrombosis, celiac disease, claustrophobia, panic attacks (especially while travelling) and tuberculosis, which caused her to be treated in isolation for nearly a year when she was twelve. She also suffered several allergies, including being unable to tolerate many drugs. Kirsty seemed sad and was tearful in her first three treatments. She chose this *'low mood'* and her face infection as the two symptoms she most wanted to be helped by the shiatsu.

Kirsty viewed her current symptoms in terms of a spiritual *'cleansing'* and astrology and has some complex reasons for her health that seemed rather deluded. For example, she thought one of her symptoms was related to her x-partner whose name began with the same letter. This unconventional attitude towards her health was discussed and confirmed by her GPs, who were treating her as normal after a referral to a psychiatrist had proved unhelpful. She was an intelligent, articulate woman who was perfectly competent to live alone and had not been diagnosed with any psychological disorder, so was deemed suitable for treatment in the shiatsu clinic.

My treatment plan for Kirsty was to 'ground' and calm her mental activity and strengthen her lungs to improve her asthma and shortness of breath. Her reaction seemed to reflect this as she reported her main improvement as being a greater sense of relaxation and contentment. By the end of her course of treatments, she felt comfortable driving and had successfully taken several bus journeys without having a panic attack. She had made several changes in her home, selling excess belongings and planning to move house. Her physical symptoms seemed less affected by the shiatsu and continued to be *'up and down'* (SF).

Additional information for the patient case-studies

An example of the shiatsu diagnosis and treatment principals for the patients will now be presented using Sara 's case study.

Sara's shiatsu diagnosis and treatment

Sara's symptoms provided a shiatsu diagnosis of an imbalance in her 'Earth element' that is associated with the stomach (ST) and spleen (SP) meridians (channels of energy). This was chosen because of the following of Sara's symptoms:

- adopting a paternal (especially maternal) role of nurturing and caring for others, often to the detriment of herself
- excessive mental activity, especially worrying
- being over-weight, suffering digestive disorders bloating, nausea, constipation, low appetite, IBS and stomach pain

Her treatment therefore focussed on balancing these meridians directly and also via work on supporting channels. Since shiatsu is a holistic therapy, sessions also included 'hands-off' treatment looking specifically at her understanding of her physical, psychological and emotional health. Discussions therefore took place on issues of concern for Sara, to give her opportunity to clarify and accept or change difficulties in her life. Finally, dietary and exercise recommendations were also given.

APPENDIX V

Personal objectives in undertaking the study

The personal objectives I had in undertaking such research are as follows:

- Improve services to patients and increase access to shiatsu
- Establish the viability of delivering shiatsu in general practice
- Understand what impact a shiatsu clinic could have on a practice and the people involved
- Develop personal reflective practice and enhance professionalism as a shiatsu practitioner and researcher
- Raise the profile of complementary medicine, in particular shiatsu in the orthodox medical and academic communities

REFERENCES

- Anastasi, A. (1988) 'Psychological Testing' (6th Ed) New York: Macmillan.
- Armstrong, F. (1988) 'Natural solutions', *Nursing Times*, Aug 12; 94(32): 67-9.
- Astin, J.A. (1998) 'Why patients use alternative medicine. Results of a national survey', *The Journal of the American Medical Association*, 279:1548-1553.
- Astin, J.A., Marie, A., Pettetier, K.R., Hansen, E., Haskell, W.L. (1998) 'A review of the incorporation of complementary and alternative medicine by mainstream physicians', *Archives of Internal Medicine*. 158:2303-2310.
- Atchison, J.W., Taub, N.S., Cotter, A.C. and Tellis, A. (1999) 'Complementary and alternative medicine treatments for low back pain', *Physical Medical Rehabilitation: State of the Art Reviews* Oct;13(3):561-86.
- Atkinson, P (1990) 'The Ethnographic Imagination,' London: Routledge.
- Bains, M.J. (1997) 'ABC of palliative care: Nausea, vomiting, and intestinal obstruction', *British Medical Journal*: 315: 1148-1150 (1st November).
- Bakx, K. (1991) 'The eclipse of folk medicine in Western society', *Sociology of Health and Illness* 13 (1); 20-38
- Ballegaard, S., Norrelund, S., Smith, D.F. (1996) 'Cost-benefit of combined use of acupuncture, shiatsu and lifestyle adjustment for treatment of patients with severe angina pectoris', *Acupuncture & Electro-Therapeutics Research*. 21 (3-4):187-97
- Barnes, J. (1988) 'Focus on phytotherapy', *Pharmaceutical Journal* Jan 10; 260(6976): 67-8.
- Baszanger, I. and Dodier, N. (1997) 'Ethnography, relating the part to the whole', in Silverman, D (2000) 'Doing Qualitative Research, A Practical Handbook', SAGE Publications Ltd.
- Beal, M.W. (2000) 'Acupuncture and Oriental body work: traditional and biomedical concepts in holistic care: history and basic concepts', *Holistic Nursing Practice* 14(3):69-78, Apr.
- Beals, A (1976) 'Strategies of resort to curers in South India', in C.Leslie (ed.) *Asian Medical Systems*, Berkeley: University of California Press cited in Sharma, U. (1992) 'Complementary Medicine Today; Practitioners and Patients', London, Routledge.
- Bech, P. (1993) 'Rating scales for psychopathology, health status and quality of life', Berlin: Springer-Verlag.
- Becker, M.H. and Maiman, L.A. (1975) 'Sociobehavioral determinants of compliance with health and medical care recommendations', *Medical Care* 13: 12.

- Berkman, P. (1975) 'Survival and a modicum of indulgence in the sick role', *Medical care*, 13, 85-94.
- Bernie, B. in Duo Gao. (1999) 'The Encyclopaedia of Chinese Medicine', Carlton Books Ltd.
- Brady, L.H., Henry, K., Luth, J.F., Casper-Bruett K.K. (2001) 'The effects of shiatsu on lower back pain', *Journal of Holistic Nursing*. 19 (1): 57-70.
- British Medical Association (1993) 'Complementary medicine', Report of the Board of Science and Education. Oxford: Oxford University Press.
- Bowling, A. (1997) 'Research Methods in Health – Investigating health and health services', Open University Press, Buckingham.
- Brabeck, M.M. (1996) 'The moral self, values and circles of belonging', in K.F. Wyche and F.J. Crosby (Eds) 'Women's ethnicities: Journeys through psychology' (pp.145-165), Boulder, CO: Westview.
- Brewer, J. and Hunter, A. (1989) 'Multimethod research', Sage Publications.
- Bridges, K. and Goldberg, D. (1987) 'Somatic presentation of depressive illness in primary care', in Freeling et al. 'The presentation of depression: current approaches', London: Royal College of General Practitioners.
- Brown, J.R. (1997) 'Researcher as Instrument: An Exploration of the Relationship Between Gestalt and Qualitative Methodology', *Gestalt Review* Vol. 1 (1) p.71-83
- Bryman, A. (1988) 'Quantity and quality in social research', Routledge, London.
- Budd, C., Fisher, B., Parrinder, D. and Price, L. (1990) 'A model of cooperation between complementary and allopathic medicine in a primary care setting', *British Journal Of General Practice*, 40 (338); 376-8
- Budd, S. and Mills, S. (2000) 'Regulatory Prospects for Complementary and Alternative Medicine: Information Pack', University of Exeter, on behalf of the Department of Health.
- Burns, T. (1992) 'Erving Goffman', London: Routledge.
- Bury, M. (1997) 'Health and Illness in a changing society', Routledge.
- Butler, J. (1990) 'Gender Trouble', London: Routledge.
- Bynoe, R. (1999) 'M'Learned Web:drugs on the Net – Viagra', ZDNet (UK) News story, April, <http://news.zdnet.co.uk/story/0,,t269-s2071446,00html>.
- Camp, V. (1986) 'Acupuncture in the NHS', *Acupuncture in Medicine*, 3 (1); 4-5.
- Carr, W. and Kemmis, S. (1986) 'Becoming Critical: Knowing through Action Research', Victoria: Deakin University Press.

- Chang, Dr. S.T. (1976) 'The complete book of acupuncture', Berkeley, Celestial Arts, 14.
- Cheesman S. Christian R. Cresswell J. (2001) 'Exploring the value of shiatsu in palliative care day services', *International Journal of Palliative Nursing*. 7 (5): 234-239.
- Christie, E.A. and Ward, A.T., (1996) 'Report on NHS practice-based homeopathy project', St. Margaret's Surgery, Bradford on Avon, Bath.
- Collins Dictionary of the English Language (1984) McLeod (Ed), William Collins Sons and Co. Ltd, Glasgow.
- Cunningham-Burley, S. and Irvien, S. (1987) 'And have you done anything so far? An examination of lay treatment of children's symptoms', *British Medical Journal*, 295, 700-702 in Pitts, M and Phillips, K (1998) 'The psychology of health – an introduction', Routledge, London.
- Cunningham, I. (1988) 'Interactive Holistic Research' in 'Human Inquiry in action', Reason, P (Ed), Sage Publications Ltd.
- Dale, J. (1996) 'Practising Acupuncture Today: A postal questionnaire of Medical Practitioners in Acupuncture', *Medicine*, November, Vol 14, No.22, pp104-108.
- Davies, C. (2000) 'Getting Health Professionals to work together', *British Medical Journal* Vol. 320, 15th April page 1021-1022.
- Davis, P. (1984) 'Trends in complementary medicine', The Institute of Complementary Medicine, London.
- Dempster, A. (1998) 'Homeopathy within the NHS. Evaluation of homeopathic treatment of common mental health problems, 1995-1997', Rydings Hall Surgery, Brighouse, West Yorkshire.
- Dennis, W. (1973) 'Children of the crèche', Englewood Cliffs, N.J: Prentice-Hall.
- Denzin, N. and Lincoln, Y. (Eds) (2000) 'Handbook of Qualitative Research', Second Edition, Sage Publications Inc.
- Denzin, N. and Lincoln, Y. (Eds) (1998) 'Collecting and Interpreting Qualitative Materials', Sage Publications Inc.
- Denzin, N. (1978) 'The Research Act: A Theoretical Introduction to Sociological Methods', McGraw Hill, New York.
- Dibble, S.L., Chapman, J., Mack, K.A. and Shih, A. (2000) 'Acupressure for nausea: results of a pilot study', *Oncology Nursing Forum*, 27(1):41-7, Jan-Feb.
- Diebschlag, F. (1993) 'Types of Research Designs', *The European Journal of Oriental Medicine*, Vol 1. No 3.

Dingwall, R. (1992) 'Don't mind him – he's from Barcelona; qualitative methods in health studies', in Daly J et al (eds.) *Researching Health Care; designs, dilemmas, disciplines*. London: Tavistock/Routledge, pp161-75.

Duo, Gao, Dr. (1999) 'The Encyclopedia of Chinese Medicine', Carlton Books Ltd.

Durkheim, E. (1967) 'The rules of sociological method', Trans S.Solway and J.Mueller. New York: The Free Press.

Edwards, S.J.L., Lilford, R.J. and Hewison, J. (1998) 'The ethics of randomised controlled trials from the perspectives of patients, the public, and healthcare professionals', *British Medical Journal* 317:1209-1212 cited in Smith, R. (1998) 'Fifty years of randomised controlled trials', *British Medical Journal*; 317: Editor's choice.

Eisenberg, D.M., Kessler R.C., Foster C, Norlock F.E., Calkins D.R., Delbanco T.L.. (1993) 'Unconventional medicine in the United States. Prevalence, costs and patterns of use', *The New England Journal of Medicine*; 328:246-52.

Eisenberg, D.M., Davis R.B., Ettner, S.L. et al. 'Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a follow-up national survey', (1998) in *The Journal of the American Medical Association*, 280:1569-1575.

Elder, N.C., Gillcrist, M.D. and Minz, M.D. (1997) 'Use of Alternative Health Care by Family Practice Patients', *Archives of Family Medicine*, Vol. 6, Mar/Apr:181-184.

Emslie, M., Cambell, M. and Walker, K. (1996) 'Complementary therapies in a local healthcare setting. Part One: Is there real public demand?'

England, S.L. and Evans, J. (1992) 'Patients' choices and perceptions after an invitation to participate in treatment decisions', *Social Science in Medicine* 34:1217-1225.

Ernst, E. 'Prevalence of complementary/alternative medicine for children: a systematic review', *European Journal of Paediatrics* (1999) 158: 7-11.

Ernst, E., Resch, K.L., Mills, S., Hill, R., Mitchell, A., Willoughby, M., White, A. (1995) 'Complementary medicine- a definition', *British Journal of General Practice* 45:506.

Ernst, E. and Pittler, M.H. (1998) 'The effectiveness of acupuncture in treating acute dental pain: a systematic review', *British Dentistry Journal*: 184: 443-447.

Ernst E. and White A. (2000) 'The BBC survey of complementary medicine use in the UK', *Complementary Therapies in Medicine*, 8(1):32-6, March.

Eysenk, H.J. (1953) 'The structure of human personality', New York: Wiley.

Falshaw, M., Carter, Y., Livingstone, A. and Booma, K. (1998) 'Introduction to Evidence-based Primary Care and its Application in Commissioning', Radcliffe Medical Press Ltd.

Featherstone, K. and Donovan, J.L. (1998) 'Random allocation or allocation at random? Patients' perspectives of participation in a randomised controlled trial', *British Medical Journal* 317:1177-1180 cited in Smith, R. (1998) 'Fifty years of randomised controlled trials', *British Medical Journal* 317: Editor's choice.

Felhendler D. and Lisander B. (1999) 'Effects of non-invasive stimulation of acupoints on the cardiovascular system', *Complementary Therapies in Medicine*, 7(4):231-4, Dec.

Fitter, M.J. and Thomas, K.J. (1997a) 'Evaluating complementary therapies for use in the National Health Service: 'Horses for courses', Part 1: The design challenge,' *Complementary Therapies in Medicine* 5, 90-93.

Fitter, M.J. and Thomas, K.J. (1997b) 'Evaluating complementary therapies for use in the National Health Service: 'Horses for courses', Part 2: alternative research strategies,' *Complementary Therapies in Medicine* 5, 94-98.

Flick, U. (1988) 'An introduction to qualitative research: Theory, method and applications', London, Sage

Folkman and Lazarus (1998) 'Coping as a mediator of emotion', *Journal of personality and social psychology*, 54, 466-475.

Foucault, M. (1973) 'The birth of the clinic: an archaeology of medical perception', London: Tavistock Publications.

Foundation for Integrated Medicine (1998) 'Integrated healthcare: a way forward for the next five years?' London: FIM.

Fox, N.J. (1999) 'Beyond health, Postmodernism and Embodiment', Free Association Books, London.

Frankenburg, W.K. and Dodds, J.B. (1967) 'The Denver developmental screening test', *Journal of Paediatrics*, 71, 181-191.

Franzen, S. (1997) 'Shiatsu', Anness Publishing Limited, Lorenz Books.

Freidson, E. (1970) 'Profession of medicine: A study of the sociology of applied knowledge', Chicago: University of Chicago Press.

Fry, J. (1984) 'The National Health Service data book', MTP Press, Lancaster.

Fry, J. (1993) 'General Practice, The Facts', Radcliffe Medical Press Ltd. Oxford.

Fulder, S. & Monro, R. (1981) 'The status of complementary medicine in the United Kingdom', London: Threshold Foundation.

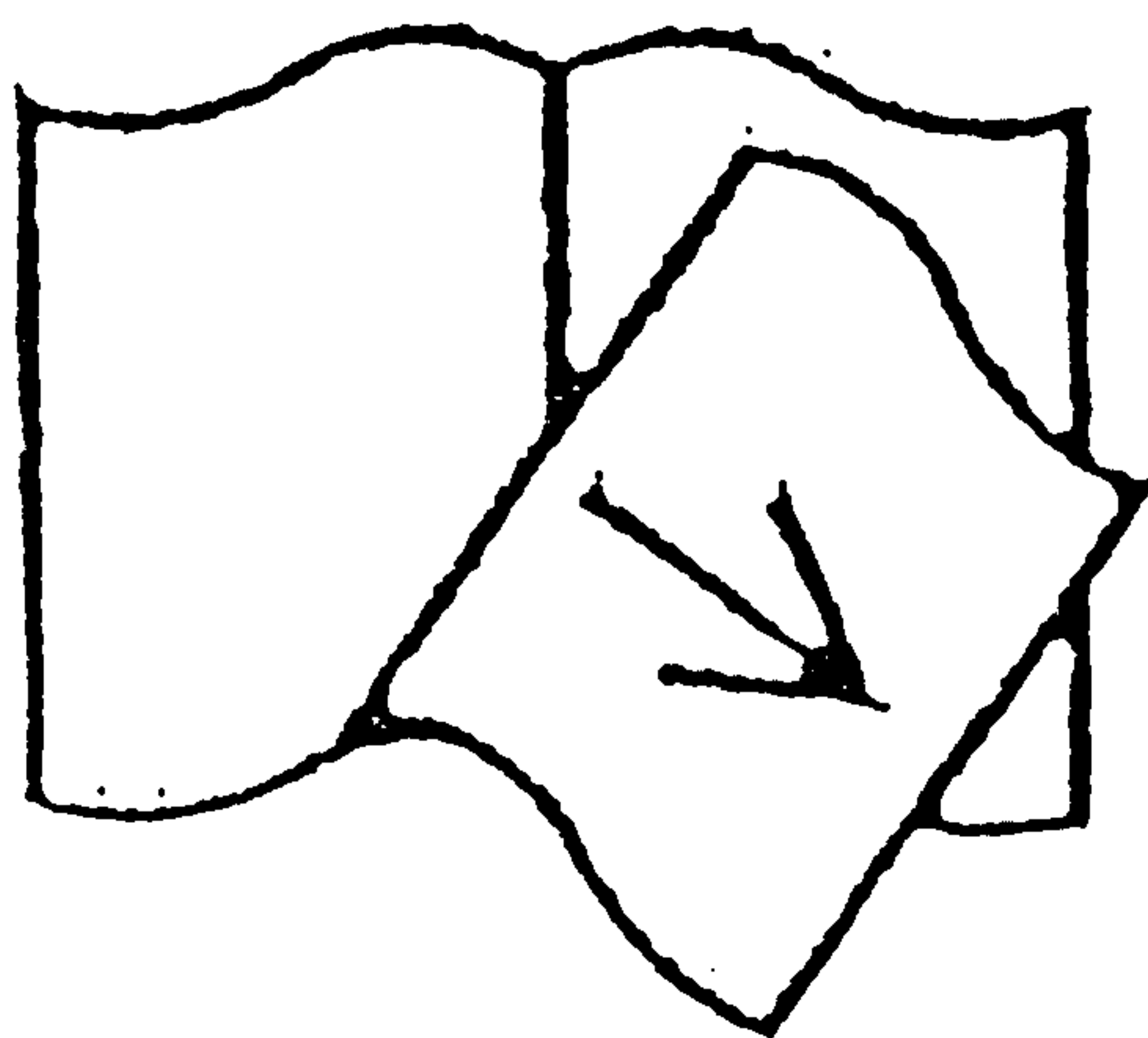
Fulder, S. (1996) 'The handbook of alternative and complementary medicine', Oxford University Press.

- Fulder, S.J. and Munro, R.E. (1985) 'Complementary medicine in the UK: Patients, practitioners and consultations', *Lancet*, 2, 542-5.
- Gach, M.R. (1990) 'Acupressure – How to cure ailments the natural way', Judy Piatkus Publishers Ltd, London.
- Game, A. (1989) 'Undoing the Social', Buckingham: Open University Press
- Geersten, H.R., Grey, R.M. and Ward, J.R. (1973), 'Patient non-compliance within the context of seeking medical care for arthritis', *Journal of Chronic Diseases*, 26, 689-698 in Pitts, M. and Phillips, K. (Eds) (1998) 'The psychology of health – an introduction', Routledge, London.
- Gelsthorpe, L. (1992) 'Response to Martyn Hammersley's paper "On feminist methodology"', *Sociology*, 26: 213-18.
- Gerhardt, U. (1989) 'Ideas about illness: an intellectual and political history of medical sociology', London: Macmillan.
- Glaser, B. and Strauss, A. (1967) 'The Discovery of Grounded Theory', Aldine, Chicago
- Goodman, S. (1990) 'The book of shiatsu – the healing art of finger pressure', Avery publishing group inc. Garden City Park, New York.
- Goldberg, D., Smith, C., Steele, J. and Spivey, L. (1980) 'Training family doctors to recognise psychiatric illness with increased accuracy,' *Lancet* ii: 521-523.
- Goudie F. and Richards, G. (1993) 'The psychological needs of older adults and their carers in primary care'.
- Gould, D. (1985) 'The Medical Mafia', London, Sphere.
- 'GP' Magazine, June 30th, 2000.
- Haber, H. (1994) 'Beyond postmodern politics', Lyotard, Rorty, Foucault. New York: Routledge.
- Hammersley, M. (1992) 'What's wrong with ethnography? Methodological explorations', London, Routledge.
- Hannay, D. (1980) 'The iceberg of illness and trivial consultations', *Journal of the Royal College of General Practitioners*, 30, 551-554.
- Hart, C. (1998) 'Doing a Literature Review', London, Sage.
- Hart, E. and Bond, M. (1995) 'Action research for health and social care: A guide to practice', Buckingham: Open University Press.
- Helman, C.G. (1994) 'Culture, health and illness', (3rd Edition), Butterworth-Heinemann Ltd. London.

- Hemmings, A. (1999) 'A systematic review of brief psychological therapies in primary health care', The Counselling in Primary Care Trust and The Association of counsellors and Psychotherapists in Primary Care, British Library Cataloguing in Publications Data.
- Henwood, K. (1996) 'Qualitative Inquiry; perspectives, methods and psychology' in Richards, J 'A Handbook of Qualitative Research Methods for Psychology and the Social Sciences' Leicester, BPS Books.
- Herskovitz S., Strauch B. and Gordon M.J.V. (1992) 'Shiatsu massage-induced injury of the median recurrent motor branch' (letter) *Muscle & Nerve*. 15 (10): 1215.
- Hicks, J. E. (2000) 'Rehabilitation strategies for patients with rheumatoid arthritis. Part 2: modalities, orthoses, and assistive devices', *Journal of Musculoskeletal Medicine*, 17(7):385-7, 391-3, 397-8, July.
- Hills and Welford (1998) 'Complementary Therapy in General Practice', The Somerset Trust for Integrated Health Care, 1 Wells Road, Glastonbury.
- Holmwood, J. (1995) 'Feminism and epistemology: what kind of successor science?', *Sociology*, 29: 411-28.
- Hooks, B. (1990) 'Yearning: Race, gender, and cultural politics', Boston, South End.
- Howe, A. (1996) 'Detecting psychological distress: Can general practitioners improve their own performance?' *British Journal of General Practice*, July, 407-410.
- Hotchkiss, J. (1995) Liverpool Centre for Health 'The first year of a service offering complementary therapies on the National Health Service', Observatory Report Service No. 25, Department of Public Health, The University of Liverpool.
- House of Lords Select Committee on Science and Technology – sixth report, 'Complementary and Alternative Medicine', 21 November 2000
- Huang, Y. (1996) 'A comparative study of the provision of maternity care, cultural customs and postnatal depression in the UK and Taiwan', Unpublished PhD Thesis, Department of General Practice, The University of Sheffield.
- Hunter C. (1999) 'Shiatsu therapy in labour', *Australian Nursing Journal*. 6 (8): 36
- Jarmey, C. and Mojay, G. (1991) 'Shiatsu - the complete guide', Thorsons, HarperCollins: London.
- Jaspers, K (1957) 'Socrates, Buddha, Confucius, Jesus' from 'The Great Philosophers', Volume 1, R. Piper and Co. Verlag, Munchen.
- Janzen, J. (with the collaboration of W. Arkinstall) (1978) 'The Quest for therapy in lower Zaire', Berkeley, University of California Press cited in Sharma, U. (1992) 'Complementary Medicine Today; Practitioners and Patients', London, Routledge.

Pages
Missing
not
Available

p283 — 289



Taylor, C.R. (1984) 'Alternative medicine and the medical encounter in Britain and the United States', in J. Warren Salmon (ed.) *Alternative Medicines. Popular and Policy perspectives*, London: Tavistock, cited in Sharma, U. (1992) 'Complementary Medicine Today; Practitioners and Patients', London, Routledge.

Taylor, V. (1988) 'Feminist methodology in social movements research,' *Qualitative Sociology*, 21, 357-379.

'The Health of the Nation: A strategy for health in England' (1992) written by the Secretary of State for Health, London, HM Stationary Office

Thomas, K.J., Fall, M., Parry, G., Nicholl, J. (1995) 'National survey of access to complementary health care via general practice', Medical Care Research Unit, University of Sheffield.

Thomas, K.J., Carr, J., Westlake L. and Williams, B.T. (1991) 'Use of non-orthodox health care in Great Britain', *British Medical Journal*; 302: 207-210

Thomas, K.J. (2001) 'Access to complementary medicine via general practice', *British Journal of General Practice*: 51; 25-30

Thomas, K.J., Nicholl, J.P. and Coleman, P. (2001) 'Use of and expenditure on complementary medicine in England – A population-based survey', *Complementary therapies in medicine* Vol 9, pp 2-11.

Tiran, M.D. (1998) 'Complementary medicine and midwifery', *Midwives Chronicle*, May: 101(1204):139-42.

Titchen, A. (1993) 'Changing nursing practice through action research', Oxford: National Institute for Nursing.

Tyler, S. (1986) 'Post-Modern Ethnography' in Clifford, J. and Marcus, G. (Eds) 'Writing Culture, The poetics and Politics of Ethnography', California Press, Berkeley, USA.

United Nations (1990) *Demographic Yearbook 'Special topic: Population Census Statistics'*, New York: Department of International, Economic and Social Affairs, Statistics Office.

Vega, R.H. (1975) 'Shiatsu, a pressure technique', *Physical Therapy*. 55 (4): 381-382.

Verbrugge, L. (1985) 'Gender and health: An update on hypotheses and evidence', *Journal of Health and Social Behaviour*, 26, 156-182.

Vick, S. & Scott, A. (1998) 'Journal of Health Economics', 17, pg 587-605.

Vickers, A.J. (1996) 'Can acupuncture have specific effects on health? A systematic review of acupuncture trials', *Journal of the Royal Society of Medicine*; 89: 303-311.

Vickers, A.J. (1998) 'Bibliometric analysis of randomised controlled trials in complementary medicine', *Complementary Therapies in Medicine* 6: 185-189.

- Vickers, A. (2000) 'Complementary Medicine', *British Medical Journal* 321:683-686.
- Vidich, J. and Lyman, M. (2000) 'Qualitative Methods: Their History in Sociology and anthropology' in Denzin, N. and Lincoln, Y. (Eds.) (2000) 'Handbook of Qualitative Research', Second Edition. Sage Publications Inc.
- Vincent, C. and Furnham, A. (1998) 'Complementary Medicine, A Research Perspective', John Wiley and Sons, West Sussex.
- Vogtle L.K., Morris D.M. and Denton B.G. (1998) 'An aquatic program for adults with cerebral palsy living in group homes', *Physical Therapy Case Reports* Sep: 1(5):250-9.
- Wadlow G. and Peringer E. (1996) 'Retrospective survey of patients of practitioners of traditional Chinese acupuncture in the UK', *Complementary Therapies in Medicine*, 4, 1-7.
- Walach, H., Jonas, W.B and Lewith, G. (2002) 'The role of outcomes research in evaluating complementary and alternative medicine', in Lewith, G., Jonas, W.B. and Walach, H. (2002) 'Clinical research in complementary therapies', Churchill Livingstone
- Ware, J.E., Snow, K.K., Kosinski, M. and Gandek, B. (1993) 'SF-36 Health survey manual and interpretation guide', The Health Institute, New England Medical Centre, Boston, Massachusetts.
- Ware, J.E., Kosinski, M., and Keller, S.D. (1995) 'SF-12: How to score the SF-12 physical and mental health summary scales,' The Health Institute, New England Medical Centre, Boston, Massachusetts.
- Wearn, A.M. and Greenfield, S.M. (1998) 'Access to complementary medicine in general practice: survey in one UK health authority', *Journal of Research in Social Medicine*;91:465-70
- Welford, R. (2000) 'Integrated healthcare in Glastonbury', *Holistic Health*, No 64, Spring.
- Wenger, G.C, (1984) 'The supportive network: coping with old age', London: Allen & Unwin.
- Weston, K. (1996) 'Requiem for a street fighter' in E. Lewin and W. L. Leap (Eds) (1996) 'Out in the field: Reflections of lesbian and gay anthropologists', (pp.274-286). Urbana: University of Illinois Press.
- Wharton, R.W., Lewith, G. (1986) 'Complementary Medicine and the General Practitioner', *British Medical Journal* 292:1498.
- Which? (1992) 'Complementary Medicine and the consumer', November pp.445-47.
- White, A.R, Rampes, H. and Earnst, E. (2000) 'Acupuncture for smoking cessation,' in Cochrane Colaboration (Ed) *Cochrane Library*, issue 2, Oxford: Update Software.
- Wilkin, D., Hallam, L. and Doggett, M. (1992) 'Measures of need and outcome for primary health care', Oxford University Press.

Wright, S.G. (1995) 'Bringing the heart back into nursing', *Complementary Therapies in Nursing and Midwifery*, 1, 15-20.

Wynne, B. (1992) 'Risk and social learning: reification to engagement', in Krinsky, S. and Golding, D. (eds.) *Social Theories of Risk*. Westport, Co: Praeger.

Yates, S. (1997) 'Shiatsu: redefining its role in pregnancy, birth and baby-hood', pp16-19, *Shiatsu Society News*, Winter Edition No.64.

Yamauchi, M. (1996) 'Japan', *British Medical Journal* 313: 132.

Zinn, C. (1996) 'Australia', *British Medical Journal* 313: 133.

Zola, I. (1973) 'Pathways to the doctor - from person to patient', *Social Science and Medicine*, 7, 677-689.

Zollman, C. and Vickers, A. (1999a) 'ABC of complementary medicine: Users and practitioners of complementary medicine', *British Medical Journal* 319:836-838

Zollman, C. and Vickers, A. (1999b) 'ABC of complementary medicine: Complementary medicine in conventional practice', *British Medical Journal* 319:901-904.