SOCIOLOGICAL ASPECTS OF NATUROPATHY

Diane Margaret WIESNER

B.Pharm (Hons.), B.A. (Hons.) (Sydney University).

Submitted for the Degree of Master of Arts with the
Department of Anthropology
The University of Adelaide

Date of submission: October 1981

TABLE OF CONTENTS

FOREWORD

While a personal description of my interest in alternative medical systems may appear somewhat irrelevant to the reader, it may add another dimension to my thesis to give a brief outline of my background.

Practice in pharmacy and specialisation in pharmacology provoked interest in me to study ethnomedicine and medical sociology. During work for an undergraduate degree specialising in Anthropology, I established contacts with researchers and practitioners of Indian and Asian medicines and arranged a study-tour to see traditional, herbal and modern medicine in use in China. In Australia, natural therapy and naturopathy are related systems of health care. They represent the area of study where I have presently directed my attention. My approach is sociological although its context is medical.

To the best of my knowledge this thesis contains no research which has been accepted for the award of any other degree or diploma in any university. Nor does it use any material previously published or written by any other person without due reference having been made within the text.

Signed:

D.M. WIESNER

DATED: October 1981

SUMMARY

For many years, natural therapies, natural remedies and unconventional healing services have been regarded as alternative to, and on the fringe of orthodox, western and scientific medical practice in Australia. By 1974, sufficient interest and comment had been generated in the community for the Federal Government to set up a special Senate Committee to investigate and report to it. The Committee was to be chaired by Professor E.C. Webb and was charged with examining the scientific bases for the practice of chiropracty, osteopathy, homeopathy and naturopathy.

The Webb Committee called for submissions from all interested parties, interviewed witnesses, and considered a number of surveys and questionnaires conducted in different Australian cities. Its findings suggested that many individuals had significant doubts about the nature of conventional medical care and that alternative services could play an important role in community health if given the opportunity.

While making a number of guarded statements about naturopathy, the Webb Committee admitted that it had not interviewed or critically discussed with naturopathic patients, the nature of naturopathic care and the role of the practitioner in their treatment. Nor was it able to come to any conclusions about why normally conservative individuals who are accustomed to consulting a family medical doctor, express satisfaction with naturopathic care and claim that treatments have been successful.

My research aimed to describe the process of naturopathic care. It was conducted using a micro-sociological approach drawing from phenomenology and on the work of the social interactionists in medical sociology. I used both quantitative and qualitative procedures in my investigation.

For naturopathy I found it possible to describe many features which are prominent, though less obvious aspects of conventional medical care. The relationship between the naturopathic practitioner and the patient is vital to that individual's understanding of his therapy and his treatment. The holistic nature of naturopathy and the design of therapy specifically tailored to the personality and needs of the patient permit, and indeed, demand that there be a close relationship between the participants. Rapport is built between the naturopath and his patient at each consultation as every facet of treatment is discussed and worked out.

My observations suggest that there are certain instances or situations in which an individual defines himself as 'being sick so as to require naturopathic care' as distinct from 'being sick so as to require conventional medical care'. This concept develops around impressions about naturopathy, expressions of dissatisfaction with other forms of healing care, and perceptions of what medical care should provide for the patient. During naturopathic consultations with the practitioner, the patient is also forced to come to terms with the naturopath's ideas about health and which may, initially seem unusual and unsustainable to him. Ideally, the growth of the relationship between the naturopath and his patient as a programme of treatment progresses permits the patient to rationalise and incorporate these beliefs into his existing knowledge and experience.

As a result of this study, I regard and approach which naturopaths adopt to their profession and to their patients is contributing to making naturopathy an increasingly popular and beneficial form of health care. Thence, the position which it occupies as an alternative rather than an accepted part of the total health system, is called into question.

ACKNOWLEDGEMENTS

My major debt is to the Department of Anthropology, The University of Adelaide, for having made it possible for me to undertake this study and to my academic supervisors, Kingsley Garbett, Susan Barham and Jeff Collmann. Their assistance, encouragement and thoughts have been invaluable. Other members of staff, fellow post-graduate students and visitors have also helped mould my ideas into a cogent whole.

I would also like to thank those naturopathic practitioners such as Mark Robinson, Julie Lorton and Greg Gill who have been so generous with their time and their co-operation. I am grateful to their patients especially who allowed me to join them in the naturopathic care programmes. The staff and students of the N.S.W. College of Osteopathic and Natural Therapies were also very kind and helpful and allowed me to use their facilities, attend their classes and visit their clinics.

The representatives and spokesman of the more conventional health and medical services are also owed my thanks as they were frank with their opinions and their insights provided a good balance. To Ray Mulvihill who typed my efforts I also express my gratitude.

On a more personal level, I thank my family who provided me with distant, loving support and in South Australia, my special friends also, who put up with me when my morale flagged and my initiative faltered as seems to be all too common in research projects.

To everyone who gave me their time I can only conclude by saying that I hope that their confidence in me is repaid on reading the following pages.

INTRODUCTION

SOCIOLOGICAL ASPECTS OF ALTERNATIVE MEDICAL SYSTEMS:

Since its inception, medical anthropology has shown interest in ethno-medicine, in medical practices which are traditional and indigenous to simple societies, and in sociological aspects of scientific medical care in the more complex, industrialised societies. However, little attention appears to have been paid to medical systems alternative to those which predominate or are the 'accepted' or 'conventional' choice of the individual requiring care, and of the society of which he is a member.

The concept of an alternative is a relative one and public and medical opinions are constantly changing. In the light of the present pattern of medical care available in western industrialised societies, alternative medical care embraces those forms of medical servicing and therapy which are available and accessible to individuals who choose to use them rather than, or as well as orthodox, scientific medicine. Implicit within the definition of these forms of medicine as alternative is the nominal acceptance of the modern scientifically-based discipline as the dominant and conventional form of care. As such, any system of medical treatment and care which is not of this tradition represents an alternative and is deemed to be unconventional or unorthodox within this dissertation.

Another way of looking at the same issue would be to see the situation as does Carl Withers (1946), who, in speaking about a small, mid-western U.S.A. rural town where a traditional viewpoint persists and co-exists with a rudimental concept of modernisation, says:

> "There are five historical layers of medical and pseudo-medical lore, all of which co-exist and have co-existed in varying ratios for a long time. They are in a kind of rough-and-ready historical order of appearance: (1) early medical practice, including both

> "witchcraft" and divine healing; (2) an enormous body of "home remedies"; (3) rational or pseudo-rational medicine connected with the recognised medical profession; (4) patent medicines; and (5) a new and recent wave of curing by prayer and other religious techniques."
>
> (Withers, 1946:243)

All these health-related practices could be classed as alternative medical systems.

Nonetheless, for present definitional purposes, alternative medical care will be restricted to those philosophical systems of medicine and their associated techniques, whose practitioners, were they solely trained in these disciplines, would not be eligible for registration as qualified medical practitioners under Australian Government legislation. Encompassed within this definition are comprehensive medical systems such as homeopathy and anthroposophical medicine, plant-based medical therapies such as naturopathy or herbal medicine and mind and spirit, meditative and exercise programmes such as jogging together with yoga and biofeedback. Physical and manipulative techniques of chiropracty and osteopathy are also considered alternative.

Many of these systems appear to adopt a holistic approach to medicine in which illness phenomena are considered in relation to the individual's total physical, social and emotional environment and in which belief centres on the existence of life energy forces. They show a common-sense attitude to treatment and use mainly diet, mental control, manipulation and remedies based on natural products and life-style re-orientation.

WHY STUDY ALTERNATIVE MEDICAL SYSTEMS:

There is a current demand in Australia for alternative health care services. This appears to be recent and may be transient. Nonetheless, chiropracty, osteopathy, homeopathy and naturopathy have survived and operated relatively continuously for some time outside of, and in spite of,

conventional scientific medicine. Their survival and influence, given their marginal status, has evoked calls from rival health care providers and consumer groups for their registration, for control or for some formal clarification of standards of service and status as practitioners. The nature and cause of any trend remains problematic though a number of State and Federal Government subsidised Committees of Inquiry have been set up at various times over the past 25 years to investigate alternative medical systems.

There are many interesting features of alternative medical systems which present themselves for study from a sociological viewpoint quite apart from their biomedical and philosophical bases. Mary-Ann Beams, in looking at the Social Process of Obstetric Care (Beams, 1977) suggested that there may be a significant personal element connected with having experienced 'satisfaction' as well as clinical proficiency and quality medical servicing during childbirth. She maintained that this influenced the individual's concepts of health, medicine and social encounters in a medical context and relationships with health professionals. Implications can be drawn from her descriptions of the obstetric process about the practice and organisation of medical care and the manner in which it is viewed in certain sections of the community.

To Beams, disappointments are most apparent in the area of personal relationships and conflict with increasingly skilled and competent management by health professionals of the professional component of their work. There is a continual change of personnel attending the woman during her stay in the maternity hospital as a result of the organisation of staff work-shifts: nurses are frequently pressed by hospital routines and can spend little time with individual patients who may be anxious to share new experiences and

worries: the pregnant woman is frequently examined by a number of doctors in the hospital as well as by her own personal physician who may even have limited access to her at this time (Beams, 1977).

It is precisely in this area of 'personal satisfaction with care' to which Beams draws attention, that I believe alternative medical systems have attracted interest in their own right because they claim to make the patient the central focus of care. The apparent orientation of alternative medical systems towards the patient may be a function of the type of care itself or it may be a characteristic of individual practitioners' interests and intensity. The disappointment of Beams' patients with conventional medical servicing may also be important.

Freeman *et al* (1973) suggest that any medical system evolves in order to meet a society's perception of its health needs at that given point in time. Consequently, the increased interest in alternative medicine and the more ready acceptance and popularity of its methods seem to reflect demands within the community. These persist despite the opposition from orthodox scientific medical doctors which ranges from lack of ethical approval and formal sanction to tacit admission of moderate successes in areas such as manipulation.

The basis for the rejection of alternative medicine by orthodox doctors supposedly lies in the past when unqualified 'quacks' were responsible for highly unusual, highly suspect and sometimes dangerous remedies and practices offered in the guise of miraculous cures. While the majority of practitioners offering natural remedies and therapies have some tertiary training and are experienced and reliable, it would be dishonest to deny that there are still some individuals who claim skills and proclaim cures which are questionable.

FINDING A FOCUS FOR STUDY:

The focus of my dissertation is the relationship between the alternative medical practitioner and the patient undergoing alternative medical care. The aim of my study is to describe the individual's understanding of the nature of illness and medical care. I will concentrate on one area of alternative care - that of naturopathy - to describe the social process and nature of this alternative medical system.

Questions which are relevant to my study include: How does the individual undergoing an alternative form of medical care view illness? What are his expectations of naturopathic care? How are these built up? How does the naturopathic patient view his experience of naturopathy? What is involved in naturopathic care which makes it different from conventional medical servicing? What place does naturopathy - and by implication, other alternative medical systems - occupy in the area of health and medical care in Australian society? How do social pressures and demands mould and determine the form which naturopathy is taking?

Naturopathy is a method of treating illness which works on the principle that healing depends on the action of natural healing forces present in the human body. It is a type of medicine practised widely though in many different forms, throughout the world. The 1977 Webb Report of the Committee of Inquiry into Chiropracty, Osteopathy, Homeopathy and Naturopathy had little enthusiasm for naturopathy and the techniques which it grouped under naturopathy - the provision of dietary advice, of remedies of a herbal, homeopathic or mineral nature, for acupunture, zone therapy or colonic lavage. To quote:

> "We are of the opinion that the naturopath assists many patients who have been dissatisfied with medical advice, who suffer from complaints with a strong psychosomatic component, or who are chronically sick but have not received sufficient support in the orthodox situation."
>
> (Webb Report, 1977:76).

I have organised my material in the order in which I have approached naturopathy. Initially, I familiarised myself with concepts of illness and health and examined as in Chapter 1, what it means to an individual to be ill and how he interprets 'being ill so as to require naturopathic care'. This brought into view the functionalist and symbolic interactionist perceptions of illness phenomena and of social role in a medical context. I came to the conclusion that the most meaningful and productive analysis of the sociological aspects of naturopathic care would require me to subsequently adopt a phenomenological and ethnomethodological perspective.

Chapter 2 describes naturopathy, its basic beliefs and treatments and seeks an ideological basis for its persistence. Stanway (1979) criticises medical doctors and prominent members of society for being unwilling to acquaint themselves with facts about natural and alternative therapies so that they might at least be in a position to make intelligent and informed comments on their deficiencies. The efforts of recognised and registered conventional medical doctors to thwart or otherwise hamper efforts by alternative practitioners to obtain legitimation for their activities and to achieve professional status is traced in Chapter 3. The health and medical care system and naturopathy's place within it are further elaborated in Chapter 8.

Chapter 4 concentrates on the patient: his age, sex, marital status, socio-economic parameters and the nature of his complaint(s) for which he sought naturopathic care. The image of the ideal-typical patient and his social world, and the impact which a course of naturopathic care will have upon him can thence be followed. Chapter 5 described what occurs during a treatment programme. From acting as a participant-observer to naturopathic consultations and from interviews and discussions with the participants I describe how the naturopath's and the patient's knowledge of medical care and

perceptions of naturopathy emerge in the treatment process. While in many instances, individuals would be expected to incorporate, into their base-world knowledge, elements of modifying sub-world experience of natural therapies, in some cases naturopathic care could be presumed to be internalized to the degree that previous concepts and beliefs are fundamentally changed. Building especially from Chapters 1, 2 and 4, Chapter 7 looks at the relationship between a naturopath and the naturopathic patient.

Chapter 8 returns to looking at naturopathy as an organised system of alternative medical care and at the politics and rivalry that exists for the provision of health care services to the community. Illich (1975) and Taylor (1979) and many other authors report the confidence, dominance and power of the conventional lobby of medical doctors - vocal and articulate, financially secure and enjoying a high status and prestige by virtue of their knowledge and monopoly as healers. Naturopaths and alternative medical practitioners represent a threat to their acknowledged authority in health matters and their control of medical servicing and organisation.

In my Conclusion, I draw together the threads of my arguments and summarise what I then see to be the sociological process of naturopathic care. I make some predictions which amount to hypotheses which I believe are suggested by my data. Even at this initial stage, I believe that my subject is large and challenging: each avenue of naturopathy which I describe within this dissertation would be a suitable area for further expanded analysis in its own right.

CHAPTER 1:

CONCEPTS OF ILLNESS: BEING SICK SO AS TO REQUIRE NATUROPATHIC CARE

All social groups explain, understand and interpret illness in many different ways. Tied to these beliefs are ways of treating and dealing with illness phenomena. They constitute part of any society's learned and heritable cultural tradition. The focus of most studies of illness and medical care has consequently centred on the level and distribution of disease and illness states in a community.

> "The sum total of a group's way of defining illness, of explaining its sources and occurrences, and of dealing with its burdens may be termed the group's system of medical care."
> (Fabrega & Silver, 1973:1).

Until the adoption of controlled observation as a scientific standard and the concomitant rapid development of medical techniques, European ideas about illness and health were steeped in religion, magic and folk medicine. Explanations of why people became ill were complex and based on culture-specific constructs and epistemology. Yet, there was an inherent appreciation of the importance of social and emotional facts - a method of viewing illness as a temporally bounded phenomenon experienced by the body as an entity, not just by its component parts, and as a process with environmental and psychological as well as physiological implications for the individual and his interaction and participation with other individuals.

In the East, many of these notions still persist in slightly modified form but without a European-styled scientific rationale. Western medicine aims to dissect thereby to understand the functioning of any working part as an element of the mechanical whole. Systematised Eastern medicine is a

product of careful monitoring, meticulous documentation and observation of the body and the mind interacting together. Treatment is directed at maintaining the integrity of the whole individual as a mind-body entity (Stanway, 1979).

Western medicine therefore shows a bio-medical orientation which sees and identifies illness in causal terms derived from scientific knowledge and which aims to use insights gained thereby to improve community standards of health.[1] The recognition of the existence and merits of different systems of medicine results in Fabrega and Silver concluding that:

> "The way in which disease is experienced, defined, and handled by members of the community as well as by medical practitioners is felt to offer a more dynamic if not more dramatic picture of medical problems."
>
> (Fabrega & Silver, 1973:2)

THE MEDICAL WORLD:

It is self-evident that many people seeking medical care are not clinically sick. They are plagued by vague feelings of being generally unwell, of suffering mild depression, lethargy and being 'out of sorts'. They are labelled psychosomatic, neurotic or hypochondriac individuals. The use of such labels conveys little other than that we, as a whole, are unable to deal with these problems effectively (Mechanic, 1968). Once clinical causes are ruled out, Western medical practitioners generally provide a quick "pep" talk, a medication and the individual is sent on his way to deal as best he can with the tensions and anxieties which daily confront him.

---

[1] This sentence emphasises the distinction between health and medicine. Health is a state of well-being experienced by the human body. The World Health Organisation defines it as 'the absence of disease'. On the other hand, medicine is the science and the administration of healing care to the sick (Fabrega & Silver, 1973).

Profound advances in scientific medical technology, the institutionalisation of medical care in large hospitals, the growth of chemotherapy and the sheer diversity of medical specialities and bio-physiological knowledge have contributed to making conventional medicine what it is today. Medical consumer advocates and members of medical and peer professional groups have commented in the news media on how these developments have affected the basic principles and priorities of medical practice. Sociologists have pointed to the relative downgrading of a number of key elements in the healing process especially in the practitioner-patient relationship (Bloom, 1963: Freidson, 1974: Illich, 1975). Costs, complexities in treatment and a lack of time on the part of the physician are named as contributing to dissatisfaction. Complaints are characterised by a particularist approach. Organs are attacked and diseases are diagnosed in isolation. Little attention is paid to social and psychological components in illness and to treating the patient himself, as well as his problem.

Added to the general disquiet about many aspects of health care in many industrialised nations (Dreitzel, 1971: Taylor, 1979: Hetzel, 1974) has been its financial significance in the national economy. Medical and health related matters have become politically sensitive and the focus of increased and not always rational media attention. Informed individuals would seem to be questioning previously readily accepted explanations for increased costs by medical doctors and pharmaceutical manufacturers. They are also interested in the accessibility of all beneficial types of medical service, in their distribution and in the quality of care.

More particularly, Ivan Illich in Limits to Medicine (1975) argues that the massive expansion of modern medicine has had a damaging effect on people's health prospects. He criticises it for 'expropriating' the individual's

health by creating a dependency on medical intervention and removing the essential coping capacities of the individual. He links health to self-respect and independence in dealing with illness without calling for artificial aids. Illich suggests that the growth of the medical industry be limited and calls for greater autonomy for the individual so that he himself and his body can adapt to the varying conditions of human life in modern society.

It is against this background that the interest in unconventional forms of medical care must be viewed. Naturopathy, more than chiropractic and osteopathic manipulative techniques, remains an area of scant public knowledge and awareness. From personal experience and observation, and from two small surveys[2] carried out in suburban Adelaide, I consider that there is general ignorance about naturopathy in the community. This extends to a lack of understanding about what is meant by natural therapy as well as fundamental misconceptions of what is involved in naturopathic care. Table 1 describes the results of these observations.

In addition to the ignorance and confusion which surrounds naturopathy - and indeed seems common to alternative medical care - is a certain confusion and misunderstanding. This is sometimes accentuated rather than dispelled by a visit to a medical doctor. The individual who knows he feels unwell but cannot name specific signs and symptoms and the 'regular' visitor to the doctor, often qualified any expressions of confidence in conventional care by conflict in their own minds between their own perceptions of "being sick" and those of these practitioners. Those individuals who knew about and visited naturopaths and alternative practitioners may have come some way to resolving this problem. On the other hand, they may have a different understanding of what it means "to be sick so as to require naturopathy."

---

[2] These were casual rather than statistically random samples.

TABLE I: KNOWLEDGE AND USE OF NATURAL THERAPIES

(a) GLENELG. Casual Survey of Shoppers along Jetty Road, Glenelg, March 1981.

(N = 115)

		MALES %	FEMALES %	
DO YOU KNOW WHAT NATURAL THERAPIES ARE?	yes	16	8	
	no	3	13	
	non-commital	28	32	total 100%
WOULD YOU USE A NATURAL THERAPIST?	yes	8	6	
	no	5	7	
	if my doctor says yes	34	40	total 100%

(b) MARDEN. Casual Survey of Shoppers at Marden Centre, Payneham Road, March 1981.

(N = 82)

		MALES %	FEMALES %	
DO YOU KNOW WHAT NATURAL THERAPIES ARE?	yes	3	7	
	no	22	38	
	non-commital	14	16	total 100%
WOULD YOU USE A NATURAL THERAPIST?	yes	2	15	
	no	4	16	
	if my doctor says yes	33	30	total 100%

Both of these casual surveys were conducted in areas where there are a large number of conventional medical and natural therapy services available within walking distance of the shopping area itself. It was interesting to note, particularly among the shoppers from Marden, that many had not even noticed the naturopathic and chiropractic practitioners nearby nor knew anything about the sort of treatment they gave. A more comprehensive survey of both areas would reveal that Marden shopping centre was patronised by a slightly higher percentage of the elderly and retired age group than was evident in Glenelg. There was a conscious attempt, on my part, to try and select the persons approached so that there was a smattering of age groups representative of the population age group shopping there. Hence those individuals within Marden shopping centre and approached by me, were of an older age group, in general than the group approached in Glenelg.

SOCIAL ROLE IN A MEDICAL CONTEXT:

Physical and social changes in the environment affect all members of the society and interfere with their ability to competently carry out their normal tasks of daily living. On occasions, individuals may be observed to be unable to complete productive work and organised activities successfully and to seek rest and comfort: to be failing in their "functional competence in enacting social roles." (Wilson, 1970:12). They may be said to be "unwell" or in a state of "ill-health". These terms describe how others in the immediate social world of the "sick" individual perceive and account for his behaviour. The subjective nature of illness is emphasised by Kosa and Robertson (1975:43) who say that: "whoever feels ill should be regarded as sick." The linguistic labels denoted by terms such as 'normal' and 'sick' are used to refer to aspects of an individual's continued adaptation to his natural and social environment. Such an 'identity' constitutes the basis for a set of expectations within the context of a given situation which corresponds to the pattern of behaviour and person-to-person interactions of a social role.

By taking an objective stance, an individual can visualise his personal performance and behaviour from the standpoint of others and see how it reflects back on his own conception of his 'self' and his relations with 'others'.

> "normal and sick can be seen as designations of a person's behaviour by himself (a self concept), or as designations by others, that is, as an imputed identity."
>
> (Manning & Fabrega, 1973:259).

Rosenstock & Kirscht (1979) take a slightly different approach and point out that it is important to keep in mind that the concept of health is probably just vague abstraction to the man-in-the-street. They ask whether

> "the concept of health *per se* constitutes a cognitive structure (such as hunger) or whether it is without phenomenological meaning for most people, constituting rather a construct invented by analysts."

so that

> "whether behaviour can be better explained by invoking the concept of health and attributing some organising and motivating characteristics to it or whether behaviour is better explained by considering particular kinds of health-related matter that may be poorly related or unrelated to each other."
> (Rosenstock & Kirscht, 1979:166)

To the individual, the fact that he considers himself to be ill and how that understanding of being ill affects himself and his actions with others is what matters.

The majority of sociologists discussing concepts of illness and health focus on non-biomedical meanings and the implications of illness, disease and medical care in society. They base definitions of a community's system of belief on the various practices which have been established to deal with illness phenomena. The benefit of this approach lies in its broad, synthetic and comparative nature as it "rests on a framework that emphasizes holism, process and change". (ibid, p3-4). The pragmatic approach of phenomenology and social and symbolic interaction permits a focus on particular situations of a social nature, such as a medical relationship and takes into account their subjective rationalisation by the interactants. It recognises the importance, integrity and meaningfulness of individual social action. In other words, by seeking to maintain the integrity of the phenomenon under investigation, phenomenologists can construct the meanings of actions from the standpoint of the individual performing the action, and its relevance to and interpretation by others. This is particularly relevant in studying the social process of medical care and in looking at illness as a category of behaviour labelled deviant in certain situations (Parsons, 1958: Scheff, 1966).

PARSONS' APPROACH TO 'BEING SICK':

Talcott Parsons devised an analytical construct based on the notion that the sick individual is suffering from a 'disturbance of capacity' which, once recognised, transfers him into a 'sick' role. He described illness as"

> "a state of disturbance of the 'normal' functioning of the total human individual, including both the state of the organism as a biological system and of his personal and social adjustments."
> (Parsons, 1951:428-9)

Within this frame of reference, Parsons extended the care of health and the treatment of illness to a social role relationship in which an element of predictability in an individual's behaviour is balanced by interactional dynamics. Each individual's role could be defined only in terms of its anti-thesis or rather, neither is defined independently of the other.

'Sick' role behaviour describes rights, duties and obligations of the 'sick' individual in an advanced industrialised social context - the American city. The 'sick' individual is exempt from normal social role obligations and from responsibility for the incapacity provided that he accepts the behavioural criteria of the 'sick' role. The occupant of the 'sick' role must recognise that to be 'sick' or ill is inherently undesirable and there is the responsibility, contigent on being accepted as 'being sick', of trying to get well, of seeking competent help and of co-operating in the process of getting well. Norms, values and attitudes and expectations associated with a 'sick' role become culture-specific parameters (Parsons, 1951, 1958).

Looking at the medical doctor and his patient as players of social roles in a unique interactive context, each participant can be seen to bring his own concepts and experiences to the occasion where the relationship is played out (Bloom & Wilson, 1975). These concepts and experiences are a product of his own position as a member of the medical profession, in the case of the doctor, and as a family and community member on the part of the patient.

Both are, of course, members of the larger society as a whole and are located in their own social networks. Bloom summarises and locates the doctor and his patient within this socio-cultural matrix:

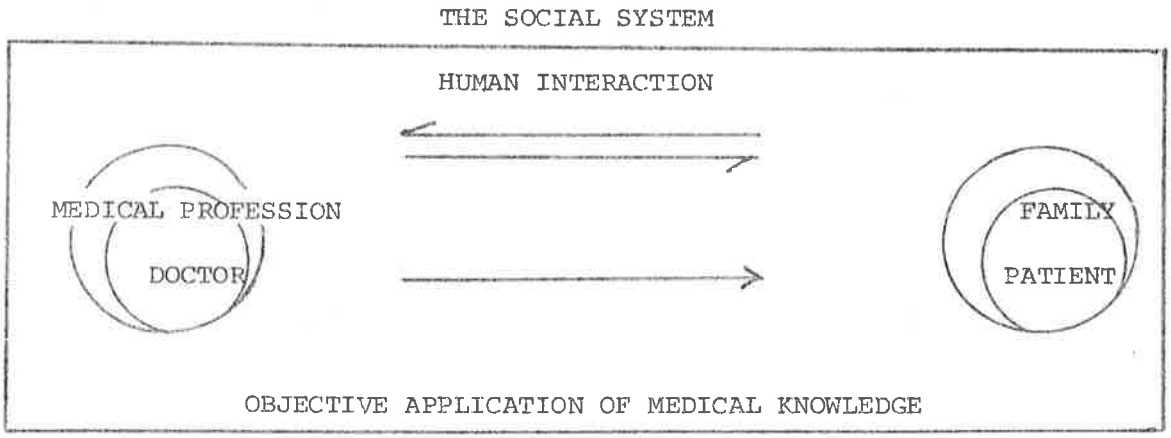


Figure 1: The DOCTOR-PATIENT RELATIONSHIP as a SOCIAL SYSTEM (Bloom, 1963:63).

Figure 1 describes the interaction which occurs between the doctor and the patient in a medical situation. It is centred on the doctor and the patient. To both doctor and patient the medical situation is but one facet of their broader lives. However in his relations with the patient at this time, the doctor acts as a member of the medical profession. At the same time the patient, in his 'sick' role is the focus of the doctor's professional medical knowledge. His own relationship with the doctor is determined by his own immediate social sphere of influence. This is centred on the family.

While Parsons' early analyses, and the work of Bloom and others which stemmed from them, had much to recommend them, they did make a number of fundamental assumptions. Primarily their construction of a formal model in which to conceptualise the doctor-patient relationship was very restrictive. Understandings of what was involved in 'sick' role behaviour and the responses of other individuals and of the doctor in their reciprocal roles conformed to expectations in the majority of situations in the American context. When

transposed to specialised institutions such as mental hospitals (Goffman, 1961: Strauss *et al*, 1964) and non-western societies (Leiban, 1972), the description of what constitutes 'being sick' and the 'sick role' becomes problematic. Parsons is aware of socio-economic factors, personal status and cultural variables within the western medical setting yet his framework fails to successfully incorporate variability from rigid definition and is stolidly functionalist and static in orientation.

Freidson also criticises a deficiency in sensitivity in the Parsonian model to "salient features of reality" (Freidson, 1961:29) and lays stress on the importance of the patient and the doctor's immediate sources of reference for social action. Freidson emphasises the immediate situation itself and the interpersonal networks which play a significant part in the everyday lives of the participants. He argues that:

> "medicine creates the social possibilities for acting sick"
> (Freidson, 1970:37)

By this he implies that medicine is a monopoly with the right to construct illness, defined as a social role. He also raises the possibility of looking at illness as a form of social deviance - an area of study which other researchers pursue with some success.

THE 'IMPAIRED' SICK ROLE:

Despite its deficiencies, Gordon (1966) built on Parsons' work and identified an intermediary category - an 'impaired sick' role - which seems particularly relevant when considering statements such as that of Dr. Bassal of Sydney in the National Times (August 31-September 6, 1980):

> "So many people are not sick, they are unwell - there's something not right. If you go to an orthodox doctor and tell him you are unwell, he will most likely say there's no such thing - there's only being sick. He will probably end up diagnosing you as a neurotic. But actually you could be unwell for many different

> reasons: psychological, nutrition, attitudes, the way you live."[3]

The occupant of the 'impaired sick' role has damaged or 'impaired' health although the prognosis is not immediately life-threatening or serious. Gordon was able to describe this category and apply it to the chronically ill, the permanently partially incapacitated and the aging. These individuals are limited in their ability to discharge personal and social responsibilities but are expected to seek or have sought medical assistance at some stage in their illness.

Gordon also describes an inverse relationship between social status and physical incapacity and compares the concepts of illness of upper and lower socio-economic groups. He is able to conclude that it is in their perception of illness and their reaction to symptoms, in their criteria and the limits of defining the individual as being 'sick' or 'not well' rather than in their approach to dealing with a condition once diagnosed, that differences may be found.

Yet a category of the chronically ill or the incapacitated does not really include many of those individuals referred to by Dr. Bassal. In fact, the 'impaired sick' are often recognised as being to some extent 'sick' by conventional doctors (Gordon, 1966). Vague, non-specific symptoms and reports of being generally unwell characterise some 80% of patients reported to visit conventional medical doctors (Australian Health Survey, 1977-78). . The presence or identification of a causal agent or disease is what scientific medicine requires to define that individual as a medical patient and as warranting care. Hence, these individuals would form a nucleus of potential

---

[3] Dr. Bassal made this statement during an interview for an article about different types of alternative medicine available and what they could offer the community over and above care available from conventional medical doctors.

clients or patients for an area of medical servicing which recognises 'being generally unwell' as a diagnostic category sufficient to require care. Of those individuals who report for naturopathic care, 24.0% describe a non-specific illness as their primary reason for seeking attention. A larger 30.1% will list 'being generally unwell' as a secondary reason behind initiating a visit to the naturopath.[4]

'BEING SICK' so as TO REQUIRE NATUROPATHIC CARE:

"Being sick' so as to require naturopathic care seems to have different implications and to be related to different 'states of being sick' than those which are perceived as requiring conventional medical care. A hypothetical example is the case of Mr. Jones. By undergoing naturopathy, Mr. Jones must be considered to have accepted a designation of 'sick so as to require naturopathic care', prior to making his first appointment with the naturopath. He would be labelled as 'sick' or requiring care by the practitioner providing naturopathy. Mr. Jones may not necessarily also be regarded as 'sick' by his general medical doctor or by his work-mates in the non-medical sphere or by his wife in the domestic sphere. By accepting naturopathic care, Mr. Jones is saying that the way he understands or conceives his illness coincides with that of the naturopath - at least to a certain extent - and that his conception of his illness probably is not the same as that of his general medical doctor, his work-mates or his wife. Furthermore, these people need not necessarily view illness or their own 'being sick' in the same way as each other when they themselves are similarly afflicted. After all, they may differ from Mr. Jones in sex, socio-economic background, present status

---

[4] These figures are compiled from 405 preliminary information sheets where 30.6% report to the naturopath for a chiropractic or manipulative-type problem.

and interests in at least some dimensions and undoubtedly will also tend to view Mr. Jones' illness in terms of how it will affect themselves. Mrs. Jones will possibly need to be more tolerant of Mr. Jones "laziness" and "fussy eating habits", and perhaps have to delay asking him to cut the lawns this week, while Mr. Jones' work-mates will probably have to share among themselves a large proportion of Mr. Jones' normal work which he does not seem to be completing in the required time. Mr. Jones' general medical doctor may not find that Mr. Jones visits him as regularly or that he has a different approach to what he tells him about his health. However the adjustments and concessions which Mrs. Jones and Mr. Jones' work-mates and doctor make for him while he is undergoing naturopathic care will not be as far-reaching as those which they would tend to make were he to regard himself as 'sick so as to require conventional medical care', if they themselves do not consider that he is 'sick' so as to require such dispensations and such special treatment and consideration.

Since degrees of 'being unwell' and of 'being sick so as to require therapeutic care' of one sort or another are so very subjective in nature, I will describe the cases of two 'real' patients to see how they interpret 'being sick so as to require naturopathic care'.

Mr. and Mrs. Botham[5] enrolled in a course of naturopathic care since they both felt 'out of condition' and that they needed to revitalise their diet and their lifestyle. They complained of not 'being well' though they did not see themselves as 'sick' or possessing any specific complaint other than lethargy and irritability which they had themselves identified as a product of their present way of life. They had heard of the benefits of

---

[5] Mr. and Mrs. Botham were both in their early 40's and did not have a family. Both worked as high school teachers.

natural therapy and that diets and exercise programmes organised and designed by naturopaths on a personal basis were very successful in meeting problems such as their own. Mrs. Cozens,[6] on the other hand, named migraine headaches and daily tensions as specific complaints which contributed to her feeling generally 'unwell' and was thereby able to link a cause to her state of 'being'. She did not regard herself as being 'medically sick' and went about her daily household chores and part-time job, but admitted that she found both rather a burden lately. These patients describe problems and define illness in terms which to them suggest that the naturopath can meet their needs: they are 'sick so as to require naturopathic care'. Their problems are also of a general and non-specific nature.

By his act of visiting the naturopathic clinic, the patient accepts that he requires care. Many of those who enrol in naturopathy and attend consultations describe a medical problem and mention a specific complaint. However, the naturopaths whom I interviewed were almost unanimous in agreeing that very few of their patients would accept that they are what they themselves call 'medically sick'. 'Being sick so as to require medical care' seems to embrace those conditions which require immediate alleviation because they are thought to be life endangering by the patient or to be linked with severe pain or injury. Questions answered by volunteers in the Webb Report (1977:504-510) confirm the opinion of naturopaths and the impressions which I also gained in my observations and discussions with other naturopathic patients. The individual who is undergoing naturopathic care seems to consider that he is not sufficiently sick to take extended time off work, or to totally abnegate his social and family responsibilities. He usually

---

[6] Mrs. Cozens, aged 37 years, was a conscientious mother of two teenagers, and worked casually at the local real estate agent as a receptionist.

expects, however, that others will only require him to perform his usual duties with less enthusiasm and lower efficiency. Naturopathic patients who continue to work throughout their treatments and many women who list their occupations as 'home duties' or 'housewife', said that they did what had to be done and certainly did not feel bad enough to 'go to bed' - the expression 'feeling below par' seemed to cover most of their complaints. The phrase 'being sick enough to go to bed' seemed to be associated with full acceptance of the 'sick role'.

Another distinction between 'being sick so as to require naturopathic care' and 'being medically sick' could be linked with the location of the consultation and is associated with 'being sick enough to go to bed'. Individuals who desire naturopathic care are required to go to the clinic for their consultations and to undergo treatment either there or at a natural therapy centre. Naturopaths do not normally make calls to patients' homes as do medical doctors. From a technical viewpoint, this could be partially due to the nature of the care which they offer.

Additionally, natural therapists themselves will accept that medical doctors are those who are trained to minister in acute illness. They do not see themselves as particularly effective in life-threatening episodes. They feel their patients also appreciate the difference between the care which they can offer and the need for immediacy as required where there is evidence or symptoms of acute infection or distress, injury or a crisis such as a coronary infarction. Nonetheless, some natural therapists do claim proficiency in treating infection as well as relieving symptoms which are of a general or bronchial nature. This may be particularly the case where the patient is notationally 'sick' but not bed-ridden such as occurs with a cold or in mild influenza.

It is not surprising that a large proportion of naturopathic patients show similarities to those described by Gordon (1966) as being in 'impaired health'. Prospective members of the category include individuals suffering chronic ill-health such as arthritic omplaints and depressive illnesses, or undergoing psychiatric or physio-therapy or other forms of rehabilitation.

Naturopathic patients who, for purposes of analysis could be classed as 'impaired sick' often will not accept even a definition of being partially sick perhaps because of the realisation of the tacit obligations contingent on their so doing. Many arthritic and rheumatic patients who sought naturopathic care stubbornly maintained their independence. They desire to try and achieve relief, if not cure, without drugs prescribed by medical doctors. On the other hand, many others with little comparative evidence of major discomfort, sought to use a wide variety of treatments. This latter group could be informally identified by their previous experience with prescribed medical drugs, their desire to try any remedy ranging from hydrotherapy to acupunture and manipulation and by their interest in 'taking something'.

I was tempted to group these individuals with those who might be regarded as hypochondriac: as suffering from neurotic or depressive illness of the 'bored housewife' nature[7] and other rather vague types of 'being unwell'.[8]

---

[7] Naturopaths talk about and identify some women as 'bored housewives'. This is a woman who is restless, and has very little interest outside her home. She may have given up or never fully pursued a career prior to marriage or she may have young children who prevent her either going to work or engaging in many activities far from the home. She tends to be easily irritated. In addition, she may be a heavy smoker; may watch a lot of T.V. during the day; may be an irregular and picky eater, and may have been a frequent visitor to her doctor and may complain of headaches or "nerves".

[8] I discuss 'hypochondriacs' as a medical and sociological grouping in a later Chapter. Since this Chapter is concerned with the patient and his social world and ideological perspective, I shall not pursue such categorization further at this stage.

Interpretations of 'being sick' and their relatedness raise semantic problems which can be viewed from another perspective. The medical and health promotional emphasis of naturopathy immediately confront the observer as he walks into a naturopathic clinic: the appearance of the reception room and the display of posters, qualifications, diagrams and literature and, in many instances, of bottles and rows of herbal and tissue remedies. Asked their first impressions, patients will say it was what they expected. Pressed for further details they will invariably reply that they expected it to be "just like the doctor's room; but not as 'professional'". A typical answer would be that given by Mrs. Elba, who went to the Plympton Naturopathic Clinic on Marion Road after a series of unsuccessful visits to her local medical doctor seeking relief from her rheumatism and being told she simply must 'put up with it'.

> "It was just like Dr. Gray's rooms. I immediately felt that it was the right sort of place to be going after finding that my doctor couldn't help me. I felt confident to be a patient there - not like some places you read about and what I had feared it might look like - you know, untidy and not completely clean and not the sort of place where you would get 'proper' medical care?"

Mrs. Elba at once feels confident to become 'a naturopathic patient'. She was not regarded by her local medical doctor as 'being medically sick' - at least as reported by herself: she was pleased that her condition was requiring naturopathic care. She seemed satisfied that she was 'sick so as to require naturopathic care'.

Mrs. Elba's case points out that the acceptance by an individual attending naturopathy, of the label of 'patient' and the categorisation of 'sick so as to require naturopathic care' confirms to the individual the 'medical', the 'health' and therapeutic care designation which their visit to the clinic had been designed to verify. The use itself of the term 'patient' rather than any other such as 'client' or 'customer' or some other professionally accept-

able designation used by other ancilliary health personnel such as social workers, further eases any doubts which the patient may have brought to his initial visit through ignorance or uncertainty.

CONCLUSIONS:

With the aid of a few examples, I have drawn attention to the different perspectives which individuals have of illness, of 'being sick' so as to require conventional medical care and of 'being sick' so as to need naturopathic care.[9] These impressions are gained by and harken back to my discussions of concepts of illness and health. The W.H.O. definition of health as

> "a state of complete physical, mental and social well-being and not merely the absence of disease"

reinforces its perception of health as a general body 'state' and of the relationship between 'well-being' for the individual and of illness with disease processes. At this stage I believe that illness, to the naturopath is more a lack of total body well-being and his interest is directed at management of and improvement to this state of being.

My material on naturopaths and naturopathic patients appears to indicate that their own classifications and designations of 'being sick' so as to requir naturopathic care differs from that which conventional medical doctors and individuals reporting for conventional care see as conditions or degrees of 'being sick' so as to require their care. This distinction appears to be somehow linked to the differing orientations of both forms of medical servicing body health care or medical treatment of a specific condition/complaint. A

---

[9] More examples - especially of patients' understandings of 'being sick so as to require naturopathic care' appear in later pages.

need for conventional care is more linked to an identifiable physiological, psychological or biological causal agent and the treatment of the offender. Naturopathic care is more concerned with the 'state of being' of the individual and hence would seem to be oriented towards treating the persons themselves rather than being directed at the complaint. This is supposed to be borne out by naturopathic practice, theory and description and in most forms of natural therapy (Stanway, 1979: Eagle, 1964). I will follow the naturopathic process to ascertain the validity of my initial impressions and the degree of correlation between theory and practice.

CHAPTER 2:

THE SOCIAL WORLD AND SOCIAL IDEALS OF THE NATUROPATH

In this Chapter, initially I examine the beliefs which are used to explain, and the practices which are used for, naturopathic and natural therapy treatment regimes.

There is an ideology which underpins naturopathy. It constitutes a basis to therapy beyond the purely consistent, logical argument used by one form of healing practitioner to validate his actions to society and to other rival practitioners. With this in mind, I describe the social world of the naturopath beginning with a typical career profile and pass on to place the naturopath in the world in which he practises and relates to his patient and to his profession.

My approach to my data is interactional. At this stage, however, I will be seeking simply to identify the components of, and participants in, naturopathic care. By viewing naturopathy as a cultural process, I hope to bring it within a sociological frame of reference without necessarily inferring that it can be identified as a whole either with specific 'goals' or with special 'functions'.

THE HISTORICAL BACKGROUND TO NATUROPATHY IN AUSTRALIA:

The earliest human records describe man's interest in summoning unknown but suspected powers which he believed to be resident within the human body and which he associated with the possession of 'breath' or 'life energy'. General health and well-being were throught to ensue when breath was present, function was evident and these forces were in a balanced quilibrium.

Periodic episodes of ill-health, body dysfunction and the resultant imbalance would therefore imply a corresponding disturbance to the life energy balance. The stimulation of natural and inherent healing powers would be necessary for health to be restored.

In Europe, these ideas developed into a coherent theory of medicine by Grecian times. Treatment for ill-health was based on using simple, physical techniques supplemented by the use of herbal plants and substantiated by beliefs about causation which were often rooted in religion and magic. Hippocrates, reputed to be the founder of modern medicine, believed that disease was not simply a malady but an effort of the human body to re-establish its disturbed equilibrium and to re-build its life-energy forces. Recovery was the result of stimulating natural healing with the assistance of medical care.

Natural therapy has enjoyed periodic booms and slumps in its subsequent growth but it has persisted to the modern day. During the Middle Ages, when the Church fostered the healing arts and in particular, those using natural therapy methods, such as water and hot and cold compresses and herbal remedies, faith healing became very popular and gradually replaced some of the primitive practices and beliefs. Pilgrims visited popular shrines where miraculous cures were said to have been witnessed and partook of natural waters and therapies associated with these cures. In 1512, a herbalist charter was granted in England by King Henry VIII. This amounted to recognition of the use of some of the traditional botanical and herbal remedies in a formal document (Inglis, 1964).

On the other side of the world, Chinese philosophy and medicine were accustomed to thinking of the body in terms of energy fields and to the use of indigenous plants and herbs for medical remedies. They reasoned on the

need to approach health and ill-health in terms of the balance between hot and cold, wet and dry, fire and water, and other natural elements as represented by and in the body organs and systems. Chinese medicine encouraged the individual to pay attention to the balance of these elements within his own body and to take advantage of its inherent healing powers before recourse to outside agents. Herbal remedies, acupunture and various methods of suction capping and hydrotherapy could be used to stimulate the body to heal itself.

During the eighteenth and nineteenth centuries, many people treating the sick in Europe and those being treated, were repelled by the vicious nature of many of the remedies which involved enemas, emetics, purgatives and the application of leeches based on the theory of ridding the body of its bad or evil contaminants.[1] They sought milder methods using heat and herbal remedies. A therapeutic system called homeopathy and based on the simple dictum 'let likes be treated by likes' (*similis similibus curentur*) was suggested by Robert Hahnemann. Claiming also that he aimed to treat the patient rather than the disease, Hahnemann successfully used micro-doses of simple, specific and natural, uncompounded substances obtained from herbs, minerals and even snake venom. More recently, biochemics or body tissue salts, naturally occurring minerals and compounds have attracted attention. Tissue salts are believed to add to the diet minerals lacking as a result of eating food produced commercially or grown on soil deficient

---

[1] This type of therapy is called allopathy. Allopathic therapy is simply stated (Inglis, 1964:15) as:
"that where the body's workings deviated from the normal, a counteracting procedure should be applied."
Allopathic treatments included application of leeches, blood letting, oral ingestion of harsh chemicals and minerals in solid form.

in essential trace elements. Acupunture and other Chinese medical techniques have also gained in popularity and are employed by many natural therapists as modalities of 'natural healing' treatment.

In Australia, naturopathy is seldom practised solely in terms of diet, mild exercise, meditation and life style changes deemed necessary to stimulate natural healing forces within the human body. Most naturopaths will employ a variety of natural remedies such as herbals, homeopathy, hydrotherapy, acupunture or manipulation to assist natural healing processes.

Although the history, philosophy, theory, principles and practical application of these modalities vary widely, they tend to be supplementary and complementary to one another. Nonetheless, many naturopaths use chiropractic and osteopathic specialities to widen the scope of their practices and augment their incomes. Many believe that if they remained committed to pure naturopathic practice, they would be unable to make a living. This tends to cloud the individual's perception of what the naturopath holds basic to his beliefs.

NATUROPATHIC BELIEFS:

The basis of naturopathy is belief in the existence of life energy forces which, if impaired, result in an individual becoming more susceptible to illness and disease. The concept of a vitality or life energy is neither tangible nor rationally definable to the scientifically trained western mind so that any theory of health based on its philosophy is often difficult for the individual to grasp.

Apart from the gross physical body, there are thought to be several more subtle states of 'being' which interpenetrate the physical. The first is the etheric double which exists in and extends beyond the physical body for

some centimetres and itself is divided into the double proper which consists of a replica of every organ or tissue in the body, and the so-called health aura which extends about 5 cms, from the body, roughly following the shape of the body. Naturopaths have used Kirlian photography and experiments by Russian scientists have confirmed the existence of energy fields radiating from living bodies (Jacka, 1979). The etheric body is considered to be formed by many streams of force which intersect at some points in such a manner as to form whirlpools of force. There are traditionally seven major centres of force placed at different intervals along the spine and relating to the main endocrine glands in the body. These centres are referred to as Chakras.

Naturopaths believe that an imbalance in energy at one or two centres produces identifiable symptoms from which they can identify specific problems and diagnose ill-health. For example, they hold that an imbalance between the sacral and throat chakra or centres is often shown by individuals who are over-weight. Judy Jacka describes this problem more fully:

> "Their thyroid glands are not sluggish enough to be classed as under-active from a medical viewpoint, and yet their throat centre is very sluggish in comparison with an overactive sacral centre. Instead of the psychic forces moving upwards towards the throat, the sacral centre has become overstimulated so that excessive eating or sexual desires are present. If these are not fulfilled the person may become very depressed and introverted."
> (Jacka, 1979:21)

This description itself points to the sub-clinical nature of many conditions identified and treated by naturopaths while most scientifically trained medical doctors are unable to explain or treat the cause of a condition, simply the symptoms which are manifest - in this instance, being over-weight. With this example it also becomes apparent that the naturopath links mind, body and emotion by the transmission of life energy around these centres.

Naturopaths believe that distorted thoughts and emotions directly affect

the body's energy field which, combined with a lack of rest and sunlight and the consumption of devitalised processed food, may result in a condition of 'impoverishment' in the etheric body. This renders it more liable to promote a feeling of being 'generally not well', infection and lack of energy. Diet is the cornerstone of all naturopathic care. Nonetheless, Jacka (1979:24) maintains:

> "One of the reasons for antipathy towards the naturopathic profession results from the crankiness of many exponents in the past, with an excessive preoccupation with diet and the need for reform in this direction. It is true that there have been a number of practitioners who placed too much emphasis on this aspect, and not nearly enough on the other, psychological aspects of nervous exhaustion, and on such factors as heredity."

In this respect she echoes the feelings of Hetzel (1974) who, in discussing health in the Australian population, from the standpoint of a conventionally tralined medical doctor, sees the dietary habits of modern man as one of the major factors contributing to his general malaise and the level of sub-clinical ill-health.

THE NATUROPATH'S 'WORLD-VIEW': TOWARDS AN IDEOLOGY OF NATURPATHY

The naturopath's world-view is based on his ideals of professional commitment and naturopathic beliefs. The basic premise of naturopathy is that if the body is fed only with the ingredients which it needs, inessential and harmful products being excluded, it is possible for it not only to avoid disease, but to be able to throw off most challenges to its well-being without recourse to drugs and surgery.

While the practising naturopath expresses his commitment to a system of medical care which is unique in its orientation, it is not quite so simple to identify an underlying 'ideology' or 'common corpus of belief' which motivates the individual beyond ethical and dedicated professional commitment.

Normally, the concept of 'ideology' is raised in the discussion of political ideas and in association with future utopian ideals and systems. The meaning of the term has been frequently debated. Whether ideas presuppose or at a subsequent date, become formalised into concepts or whether basic beliefs give rise to ideals is the key issue. To Marx and Engels, ideology was a 'fabrication' used by groups of individuals to justify their actions (Marx & Engels, 1967). The concepts in ideology were not only incorrect but were often worked out for the benefit of the dominant group. In effect, therefore, ideology functioned and was organised by the '*status quo*' to ensure its persistence. On the other hand, Mannheim's understanding of ideology - also couched in historical terms - pre-supposed a previous knowledge and comprehension of past and present beliefs relevant to a particular culture (Mannheim, 1948). The concept of ideology has since been more specifically used in an anthropological context wherein interpretations, definition and manipulations of social situations are made possible to permit an appearance of order, simplicity or harmony. My usage of the term would be similar to that of Grimes (1980:31) and it will refer

> "to a set of beliefs and symbolisation only imperfectly and partially related to social practice. Ideology, as defined here, operates to mask inconsistencies between social practice and cognitive phenomena, and functions to perpetuate an existing socio-economic or power structure."

Such a definition permits the wide spectrum of belief and diverse practice espoused by the many claiming 'naturally' based therapies to be subsumed or united by a common theme: that of the existence of an inherent healing force and a sustaining life energy.

Hence we can see that the beliefs of naturopaths appear as ideals of healthy living and preventive medicine. If practices stemming from these concepts are followed and a sensible approach adopted to the problems of daily

life, the individual can expect to maintain a healthy body which is able to ward off the threat of disease or episodes of illness, without outside intervention.

Yet while the expression of such an 'ideology' associated with naturopathy and naturopathic practice may tell us something about it as a philosophy and about its use in a medical sense, it fails to answer questions about naturopathy as a process or a forum for social interaction. In other words - what can we say about those individuals who sustain these beliefs?

Is there some means of identifying them in their common ideals, other than by their interest and use in naturopathic therapies? How do they differ from other individuals who perhaps prefer, or simply use, conventional medical care and maintain its associated beliefs? The answers to these questions should emerge as my analysis of naturopathic care progresses.

THE CAREER OF THE NATUROPATH:

The typical naturopathic practitioner is male, is drawn from a middle to upper socio-economic and educational strata of society and enjoys a ranking in the status hierarchy which is on a par with other health-related personnel such as physiotherapists, but below that of medical doctors and graduates of acknowledged tertiary institutions, such as pharmacists and nurses (Webb Report, 1977).

Many of the older naturopaths who own their own clinics or are established in partnership with a chiropractor or acupuncturist, were self-trained or had an interest in diet and iridology which they continued with part-time diplomas obtained in Australia or from the U.S.A. They are often drawn from other disciplines or were disillusioned with conventional medicine and have since been successful as natural therapists.

Since the establishment of formal courses of training in natural therapies and of full-time courses at recognised colleges where experienced and practising authorities lecture in their special disciplines, there has been a change in the type of student seeking entry. The Director of Education at the College of Osteopathic and Natural Therapies (St. Leonards) in New South Wales, said that presently enrolled students were considerably younger than in previous years, were often choosing to undergo training in natural therapy with a view to making it a career and were not necessarily committed to or initially convinced of, the beliefs and the benefits. He admitted to reservations about the suitability of some applicants whom he believed were simply seeking a tertiary qualification after being refused university admission and were pressured by the high unemployment situation. As a result, the College was introducing screening procedures and interviews prior to admitting students for courses. He was concerned, as were the other members of the staff, that the high standard of graduates and the ideological commitment and sincerity of natural therapists be maintained.

Prospective students are required to have obtained a full secondary school education and compete for entry into courses at a Diploma or at Certificate level after three or four years' attendance at a wide range of classes and practical clinics. Certain courses are mandatory, particularly in the early years of study, and a wide general knowledge and familiarity with all known forms of beneficial natural therapy is required. Specialisation in one or more modality is obtained in the final years, and additional courses may be completed in Australia and overseas leading to further post-graduate diplomas and qualifications. Until the last fifteen years, all certificated or diploma-qualified natural therapists displayed skills acquired in American or European colleges in their practices in Australia. The

remainder were self-trained or experienced therapists whose individual talents had created a demand great enough to generate a regular income. Today, graduates with qualifications obtained and recognised in Australia are moving into practice alone or in partnership with similarly committed or experienced therapists. They are theoretically as well as practically competent in general treatment and/or their chosen modalities.

Once qualifications have been obtained, experience is usually acquired in a joint practice. In time, the individual naturopath establishes his own core of patients and a reputation among them for therapy which may justify setting himself up in his own practice. In my observations and in discussions with patients, I was of the impression that most individuals sought a particular practitioner usually on the recommendation of friends, family or another practitioner: seldom was a therapist selected at random or simply because he "had a practice in the area where I live". This would suggest that fewer individuals approach naturopathy out of curiosity or as a result of media coverage of natural treatments as has occurred at quite regular intervals over the past couple of years, than seek out a particular naturopath for his reputation, his success and his personality.

Despite being required to conform to uniform, minimal standards of education and practice,[2] individual naturopaths differ in their understanding of the essentials of naturopathic practice and of what constitutes the core or "characteristic professional act" (Bucher & Strauss, 1961:328). Individuals also differ in what they aim to achieve as practitioner in terms

---

[2] Uniform standards of education and practice and minimum standards of premises were recently introduced (late 1980 in South Australia) following the recommendations of the Webb Report (1977).

of improvement in their patient's welfare and health.

To illustrate this point, I will take two cases drawn from my fieldwork. They concern consultations between naturopaths and their patients and include my subsequent discussions with the practitioners themselves.

In his consultations with his patients, Mr. G.G., a bio-therapist, issued no medication other than some oral vitamin supplement drops. He sought to establish rapport with his patients. He used a special form of foot massage - metamorphic massage - designed for relaxation. He encouraged patients to discuss personal as well as medical problems. As he massaged he slowly introduced into the conversation, information and queries about diet, health and exercise and their importance to general well-being.

The bio-therapist maintained that, in most instances, no medication at all was required. He aimed for the individual to come to terms with his condition and any minor problems associated with it. He treated the 'whole patient' and not just their symptoms. What medication he did provide was simply to meet patients' expectations. Of particular interest was his manner of approach to, and treatment of, a Down's syndrome child. He endeavoured to assist the child in accepting that she was different from other children thereby alleviating her tension which was evident in her inability to sleep without nightmares, her tantrums and attention demanding behaviour. Often patients came to him after all other courses of care and medication had proved unsuccessful. He had many patients with arthritis and with emotional problems. His interest in them as individuals and as people seemed to provide a satisfaction or meet a need which they said they had missed.

Mr. G.G. advocated diet and exercise as key treatments. He saw an important part of his responsibility as being someone who could refer patients

to other health professionals when he could not assist them further himself. Mr. G.G.'s lack of formal qualifications did not deter patients from seeking his advice and for payment for services as a natural therapist. Nonetheless, other practitioners with more acknowledged and accepted qualifications, did not consider that Mr. G.G. was in a position to offer to treat medical problems for fee or reward or was not providing more than tender loving care. He was seen by them to represent a threat to the integrity, reputation and professionalism of all practitioners who employed natural therapy and to their identity as an occupational group aspiring to high status.

Mr. M.N. is a natural therapist and chiropractor who practices in a natural therapies clinic in south-western suburban Adelaide. He sees naturopathy as a profession in which the therapist, acting as a consultant, uses diet, combined with, or in conjunction with, natural therapeutic supplements such as vitamins and some specific treatment modalities, like acupunture and/or manipulation. The core element of any of his treatment programmes, however, is centred on nutrition and diet. Mr. M.N. considers that, in seeking total body health for his patients, it is his responsibility, as a trained practitioner providing a service for a fee, to use whatever means comes within the ambit of his knowledge (or that of associates practising like therapies) to remedy a patient's problems.

However, these two practioners simply serve to illustrate slight differences in approach adopted to practice and to therapy. A large element in determining the direction in which a naturopath orients himself, is, of course, determined by his own personality and the needs of his patients.

A COURSE OF NATUROPATHIC CARE:

The Australian Natural Therapies Association (A.N.T.A.) states that in naturopathy each treatment is tailored to an individual patient's needs and personality as diagnosed and assessed by the practitioner. A combination of dietary advice, mild exercise, herbal medication, possibly manipulation or acupunture, and even meditation may be recommended. The course of therapy may continue for up to about six months. In most instances, it involves a complete change in diet and in the regular routines and life style of the patient. If successful, the treatment regime will not only remove the present cause of the complaint or complaints which brought the patient to the naturopath, and its symptoms, but improve his general health and well-being so that further episodes of ill-health are unlikely to occur.

It is a feature of naturopathy that initial and early consultations are frequently long. A thorough medical history and a description of normal habits is usually taken and various diagnostic techniques, including iridology and tongue and pulse diagnosis used by Chinese medicine, may be employed. Initial consultations also serve to introduce natural therapy to the patient and provide the opportunity for practitioner and staff to explain theory, methodology and techniques. The patient is encouraged to 'involve' his family and others with whom he lives and works in his treatment programme so that they might also gain and be able to ward off potential ill-health themselves.

To quote from Inglis (1964:64):

> "Naturopathy has...been handicapped in its efforts to establish itself because it is so far from being a single acceptable scientific discipline. Yet this may eventually be turned to advantage. Apart from being the oldest medical system, naturopathy is also the simplest; and it represents, in a sense, the aim of all branches of medicine - or at least what should be the aim: the prevention of unnecessary disease. Nobody disputes that if all citizens were to lead less unnatural lives, eat more sensibly, drink

> less, smoke less, and cultivate more serene dispositions, they would fall ill less often, and recover more rapidly from any illness they catch...The entire community...can be regarded as potential recruits to naturopathy, by aspiration if not by conviction."

Not surprisingly, naturopaths vary in the rigour with which they promote their concepts and advocate their treatments and in the extent of their own personal commitment to naturopathic beliefs in their own lives. The strict believers of 'natural cure' and some macrobiotic and vegan dietary followers insist that only a food found in nature should be eaten and it must always be raw so as to preserve its integrity. In their practices, however, the majority realise the necessity to compromise and are willing to use naturally constituted remedies such as herbals and biochemics and vitamin supplements to promote a quicker return to health for the patient. They even employ acupunture and hydrotherapy - and in this I quote from one of the naturopaths with whom I spoke:

> "to assist the patient's mental adjustment to the change in his accustomed habits: to relieve the stress."

Naturopathic consultations may also involved manipulative therapy where this is indicated, as in a persistent, low-grade pain in the mid-region which was traced in oen patient to a mis-alignment in the spinal column. Considerable latitude is therefore possible in naturopathic care and is involved in any consideration of practices and beliefs.

COMPONENTS OF THE NATUROPATH'S WORLD:

FOOD AND DIET:

Naturopaths generally recommend diets based on wholesome, natural or 'health' foods and balanced in regard to carbohydrates, protein and fats. While they may sometimes explain the benefits or disadvantages of a particular dietary item in terms of being a 'hot' or 'cold' food, or as one which

stimulates certain organs or functions, dietary programmes are detailed for patients in terms of calories, carbohydrate balance and nutritional terminology.

Food is regarded as an important source of *Prana* or health-giving life energies to the etheric constitution of man (Jacka, 1979). Processed food is held to be completely denuded of these vital forces which permeate all living matter and acts as waste in the system. Hence it adds nothing to the energy supply and requires the body to give of its depleted energy to remove the waste. This waste is also increased by the chemicals present in processed food as preservatives and colouring agents.

As Sinclair (1972:12-13) states

> "A health food is difficult to define. Some persons would maintain that it has no separate existence, others that the adjective is important. If one defines a health food as a food that is sold in a health food shop and then one defines a health food shop as one that sells health food, no progress is made."

Others equate health foods with organically grown food in contrast to mass-produced or manufactured and processed foods, chemically fertilized fruit and vegetables or foodstuffs treated with any chemical agent, be it to minimise decomposition, contamination or prevent loss of colour or even 'ordinary' food. Further possibilities - contribution to diet, nutritional potential - present themselves. A compromise suggests itself in the definition of a health food as

> "any food that retains all its nutritionally desirable constituents and has not had added any substance that is harmful."
> (Sinclair, 1972:14)

The origins of the modern health food movement and the desire for pure, unadulturated food seem to lie in scandalous practices used by the food trade at the beginning of the nineteenth century in Britain. The adulteration of cereals to give a pleasing appearance, to prolong their storage life or to increase their bulk to maximise profit for the merchant, often regardless of

the efficacy or potential danger of the additive, was quite common practice. The fashionable desire for white bread led to the grain being mixed with alum and the milling of flour attracted the attention of a new branch of scientists with an interest in mineral nutrients and who pointed to its lower nutritional value. Description of the main vitamin deficiencies in the 1920's and 1930's increased interest in natural foods in which vitamins had not been destroyed and fostered the belief that in such foods, these nutrients were correctly balanced. Their partial removal in manufacture, such as in the processing of flour had already caused alarm. This was brought into focus again comparatively recently in relation to yet another component of the natural grain which is removed in processing - the fibre. The nutritionist John Yudkin (1964) points out that:

> "refining of food products achieves a separation of the palatability of food from its nutritional value."

Hence food processing increases the pallatability of food products by removing bulky and tasteless cellulose components and by increasing flavour by the addition of sugar and by artificial preservatives and colouring agents. This usually involves a decrease in nutritional value and the removal of natural vitamin, mineral and fibre content from food and commensurate benefits which the 'raw' food provides in dietary roughage and products that the body is naturally capable of utilising in metabolism.

Naturopaths maintain that their systems are usually based on the scientifically supportable biochemical fact, that all the natural fluids of the body, with the exception of gastric juice, are alkaline and all wastes eliminated from the body are acid. A diet which is basically alkaline containing fresh vegetables, milk, cottage cheese, fruits will assist in the elimination of waste products whereas cereals, meat, fish, nuts and hard cheese increase the acidity of the system and are ideally balanced by the

individual's intake of alkaline foods. Fresh fruit and vegetables which contain natural fibre and minerals usually comprise 60-80% of a recommended diet. Naturopaths also suggest that foods be only lightly cooked or eaten raw since heat destroys many vitamins and cooking in water which is subsequently discarded, dissolves most of the soluble minerals in the food. They maintain that vegetables and fruit selected should preferably by grown on rich, composted soil since artificial fertilizers do not provide minerals in the form which can be most easily assimilated by the plant so that produce grown in such soils is deficient. Organically grown fruit and vegetables are claimed to be free of residual pesticides which accumulate in the human body and upset the body's normal balance. Food and nutrition are central concepts and principles to naturopathic care. Other 'natural' remedies - those derived from whole plant or naturally occurring products and those which do not involve damaging the integrity of the body - supplement and assist healing begun by diet and using 'proper' foods.

OSTEOPATHY AND CHIROPRACTY:

Both osteopathy and chiropracty are thought to have developed from bone-setting practices which archeological studies indicate were regularly used by early man in conjunction with herbals and other natural remedies. Today, osteopathy is regarded as a system of therapeutics which lays emphasis upon the diagnosis and treatment of structural and mechanical derangements within the framework of the human body. The techniques employed are directed towards eliminating or assisting to relieve these displacements and their associated postural errors (Inglis, 1964:101). Osteopaths maintain that the presence of spinal lesions in the body exerts an influence upon it through the nerves and blood circulation and it is possible to relieve physical disabilities

and ill-health by repair of these lesions.

Chiropracty, which is also believed to have arisen from bone-setting, is fundamentally similar in theory to osteopathy. The main difference hinges on technique. Whereas the chiropractor employs what are known as specific thrusts or direct techniques, the osteopath relies upon indirect articulation. The actual chiropractic thrust is of short amplitude, high velocity and of minimal force and demands great precision in timing, placement and direction of the hands (Stoddard, 1959).

In so far as there is an underlying philosophy to both osteopathy and chiropracty, it could be said to lie in the claims of Daniel David Palmer, the founder of chiropracty. He stated that illness was essentially functional: it becomes organic only as an end process, if the life force is not stirred to action in time (Inglis, 1964:109).

IRIDOLOGY OR IRIS DIAGNOSIS:

Dorothy Hall, a well known author of books on diet and natural therapy writes about iridology:

> "In my own practice as a naturopath and herbalist I listen to symptoms and case histories and make a general assessment of the patient. The eyes then provide me with a 'fine-tuning' analysis of biochemistry and of emotional and circumstantial factors hard to determine by any other method. Illnesses past and present can still be visible, recorded in the iris; and measures can be taken to prevent recurrence."
>
> (Hall, 1980:3)

The scientific study of the eye and what it reveals about the individual was used by Chinese doctors of antiquity. It owes its reintroduction to Europe to a German doctor late last century. It is maintained that personality, health and psychological state can be learned from the eye (Hall, 1980). A comparison of the irises of the eyes of a normal, healthy individual will show substantial differences from those of another suffering some physical

or physiological ill-health. Therapeutic analysis from the eye is, however, held to be a delicate art which requires years of training. Skills must be acquired to discern function through colour and clarity, health and nutrition through structure and the patterning of fibres and occlusions and to locate and diagnose ill-health in the absence of clinically manifest symptoms.

ACUPUNTURE:

Acupunture is a therapy used for the prevention of disease and for the maintenance of health. The practice consists of either stimulating or dispersing the flow of energy within the body by the insertion of needles into specific points on the surface of the skin, by applying heat (thermal therapy), by pressing, by massage or by a combination of these.

Acupunture was developed by the Chinese and its origins date back almost 6000 years. There has been an increased interest in acupunture in recent years, particularly in western societies and techniques have been greatly improved so that there is less trauma and greater efficiency in the application of needles.

The principal acupuncture points correspond to the chakras or energy centres in the body which are identified as focal areas for any imbalances that result in ill-health. Relief of stress from one particular locus corresponds with diagnoses which has traced the problem to a malfunction or underfunction in one or another organ or system of the body.

Acupunture is commonly used to relieve rheumatic and arthritic complaints and for colds, muscular problems, asthma and a variety of chronic conditions not satisfactorily resolved by conventional scientific medical means. It is practised by naturopathic practitioners, practitioners trained in Chinese

medicine and some western doctors trained in conventional scientific medicine. It is argued that its proper use is possible only following years of training and discipline. Its current popularity has led to failure and even injury in some cases where practitioners have attempted acupunture without sufficient knowledge or skill.

HERBALISM:

Many naturally occurring herbs have long been considered to have therapeutic and even nutritional value, and to have medical properties. The details of many herbal medicines are recorded in the Chinese Pen Tsao dating from 3000 BC. By the time of Pliny, herbalism had become so standardised in Europe that there was believed to be a specific herbal remedy to many common complaints (Inglis, 1964:66). Nicholas Culpepper's English Physician and Complete Herbal published in the mid-seventeenth century became a classic text on the subject.

Despite the fact that herbalism was often practised in association with astrology and magic tending to place it in suspect repute, it served as the source of studies into the pharmacological and medicinal properties of plants which could be refuted, purified and presented in an acceptable modern form such as tablets or mixtures. Today, herbal remedies or combinations of plant and herbal extracts are available and still used by natural therapists. Herbal treatment is designed to suit the personality and mood of the individual not simply to treat his disease. Remedies are claimed to work, by virtue of their

> "power to elevate our vibrations, and thus draw down spiritual power, which cleanses mind and body, and heals."
> (Stanway, 1979:63).

One of the herbal based therapies which is used by many naturopaths and

natural therapy practitioners is the Bach Flower Remedies. Thirty-eight flowers were selected and remedies developed from them by a Harley Street physician, Edward Bach, who gave up a flourishing practice to search for medications which he believed would be more suited to the needs of his patients than those in current use at the turn of the century. The flower was picked at a particular time and an infusion given to the patient in drop form over a period of weeks or months according to need (Chancellor, 1971).

HOMEOPATHY:

Related to and developed from herbalism, homeopathy is based on three principles - like cures like, the high potency microdose and the treatment of the patient rather than a disease. While its origin lay in providing an alternative to allopathic remedies, homeopathy has basically remained outside of mainstream medicine which later came to acknowledge the deficiencies and failures of its allopathic practices.

To what extent homeopathic remedies in themselves and the use of micro-doses are successful over and above biased optimism and placebo effects is open to doubt. Nonetheless, homeopathy's simple biological products, its non-toxic chemical and mineral tissue salts are used as adjuncts in some naturopathy treatment programmes.

VITAMIN AND MINERAL SUPPLEMENTS:

Natural therapists and naturopaths have always recommended a balanced diet based on wholesome 'natural' foods. In addition, they suggest that certain minerals and vitamins may be lacking and responsible for the general malaise or contributing to the specific condition which brought the patient to them. They often point to the existing diet, the vitamin-depleting effects of stress in modern life, and to the conditions under which fresh

produce is grown and picked for re-sale. Presently there are a large number of manufacturers supplying the health food and pharmaceutical market with dietary supplements and vitamin and mineral supplements. They actively promote their products by advertising in the media and visits to medical and natural therapy practitioners. It is a large and expanding area of the Australian pharmaceutical market currently worth some $50 million annually (Pharmacy Trade, Jan. 1981).

Naturopaths either directly supply their patients with vitamin or mineral supplements commercially available or with their own specially formulated and packaged products. During a course of therapy, the individual's requirements for supplements alter as his general condition improve. At the conclusion of treatment, a maintenance does of a balance of vitamins and minerals is suggested to suit the individual's own needs and requirements. On occasions, normal retail brands or remedies are suggested and are obtainable through health food stores and chemists. However, the majority of therapists concentrate on devising special programmes of a personal nature.

DISTINCTIVE BELIEFS:

Amidst the web of associated beliefs and theories, naturopathy makes one fundamental claim: to be non-interventionist. It opposes surgery and the use of chemical drugs. The theoretical tenets from which its practices emerged rely on the healing power of nature. This property exists in all whole, integrated living bodies and is dependent on the balance of internal life energies.

Medicine similarly has faith in the healing power of the human body. However, it is not averse to aiding the body directly in meeting challenges to its well-being. Modern medicine believes that it can speed up and improve

the efficiency of the natural repair process by locating and identifying a cause for the break-down and specifically directing its treatments. Hence it intervenes by surgery and the use of drugs.

Table II (over) depicts the explicit and distinctive beliefs of naturopathy and modern medicine aligned as implicit and implied dichotomous pairs. When these pairs are grouped loosely, in the numbered categories of the Table, it is possible to see underlying differences in approach and reasoning emerging in the 'links' between 'like' categories and in semantic nuances (Levi-Strauss, 1968).

Medical beliefs ultimately come to be rooted in the prevalence of a scientific objectivity. They are accepted and they are deemed rational and sustainable because they can be shown to be based in tangible and reproducible physiological fact. Medical treatment stems from these proven beliefs and is itself able to provide objective evidence of its effective use in the particular context.

Naturopathic patients and practitioners approach therapy and describe treatments as degrees of 'satisfaction' or 'success'. Assessments of naturopathy are expressed at a personal and subjective level by those who experience and participate in them. Naturopathic beliefs from which such treatments stem and in which explanations lie are based in philosophical concepts and hypotheses of energy fields and auras. Herein lies the problem for naturopathy. While the existence and omnipresence of life energy forces has been claimed in many societies, and by many philosophies, no irrefutable scientific and objective proof has as yet been tendered to support these claims. The recent research by infra-red and Kirlian photography may be what is required if sufficient evidence accumulates in enough different laboratories.

TABLE II: BASIC BELIEFS OF NATUROPATHY AND MEDICINE.

NATUROPATHY	CONVENTIONAL MEDICINE
1. maintenance of the integrity of the human body.	repair of the human body and return to health regardless of method.
2. imbalance in life energy responsible for being ill or unwell.	disease or organ malfunction is cause of ill-health.
3. healing is the result of inherent natural process preferably acting from a return of life energy or a restoration of equilibrium to body.	healing is the result of inherent body capabilities together with medical agents.
4. healing can be stimulated by natural agents not intervention which damages integrity of whole.	healing can be brought about by intervention - (i) drugs (ii) surgery
5. healing occurs as result of a repair process within the whole body.	healing is due to elimination of disease or removal of affected or malfunctioning organ.
6. healing is often slow as it is indirect.	healing may be slow due to repair but treatment itself often rapid (in case of surgery with removal of offending organ etc) or quite quick (use of antibiotics in infection).
7. treatment successful in impaired health and chronic ill-health and life endangering conditions (long term).	treatment successful in acute illness and in infection and life endangering conditions (of short time span).

I consider Table II helps to draw out these problems. They can be more clearly depicted by re-arranging the categories in a summary form (Table III). Naturopathic medicine is described in relation to modern or conventional medicine in terms of two criteria: causation and treatment.

Hence,

(natural):(conventional medicine) ::(natural remedy):(drugs, surgery)
::(natural, whole):(artificial, compounded).

Then,

(natural):(artificial)::(whole, unprocessed, unimpaired) :(refined, manufactured, processed, reconstituted)

So that,

(unprocessed):(processed)::(unimpaired, undeveloped):(developed, exploited).

The implications in the extension of the logical and semantic categories are towards areas and concepts embraced by the conservationist movement and individuals concerned with social issues associated with the development and exploitation of natural resources.[3]

Table III (below) relates these summary terms. Medicine, as the product of science and modern technology is grouped within cognitive categories associated with notions of progress and growth and expansion. On the other hand, naturopathic and natural therapy beliefs are based on life energy forces and dependent on the cyclic processes of nature. Continual renewal and reconstitution occur within a more-or-less unlimited time frame. The process is accepted as being slow and gradual as opposed to immediate and obvious. Hence, suggestions of another important dimension to be considered - that of time - creep into the analysis.

TABLE III: SUMMARY OF ASSOCIATIONS BETWEEN BELIEFS OF NATUROPATHY AND MEDICINE

NATUROPATHIC BELIEFS	CONVENTIONAL MEDICAL BELIEFS
(natural, whole, cyclic, unimpaired, unprocessed, undeveloped, unexploited,)	(scientific beliefs, rationality, development, manufacture, improve synthetic chemicals, surgery)
equals	equals
(conserving integrity of the whole)	(improvement by improvisation or intervention)

In an industrialised nation like Australia, oriented towards expansion and growth and with a capitalist economy, priorities are allocated in practical and materialist directions rather than towards those which are more demanding

---

[3] The associations between naturopathy and individuals concerned with these issues or pursuing alternative 'counter-culture' life-styles are raised more fully in the Conclusion to this thesis.

of time. The desire to 'maintain the integrity of the whole' is the term used by Table III to summarise naturopathic cognitive belief. Conventional medicine is not as committed to maintaining 'the integrity of the whole'. Its basis in modern society assigns the same priority to time and intentions. Its summary beliefs of 'improvement by improvisation or intervention' stand thus opposed to those of naturopathy.

In western cognitive categories, it is therefore possible to perceive naturopathy in relation to conventional medicine as

(naturopathy) : (conventional medicine) : (non-scientific, irrational) : (scientific, rational)

In other words, beliefs about naturopathy are deemed 'irrational' on the basis of scientific criteria predominating in modern society. The status and significance of naturopathy are closely tied to this judgement. Scientific proof becomes crucial for naturopathy to become more highly regarded.

CONCLUSIONS:

The ordinary everyday world of the naturopath involves his participation in health promotion and the administration of medical care. He meets his patients in his practice and interacts with them with these aims and to provide these services. While he operates largely in a therapeutic context, the naturopath's world also impinges on the worlds of commerce and business. These challenge his professional ideals and his personal commitments. They also pose their own constraints in time. Although considerations of 'time' do not theoretically affect the naturopath's beliefs and practice, they set practical and determining constraints for his prospective patients. They also intervene in other ways.

The image of financial success and consequent, related de-personalisation of medical care has already been cited as a cause of dissatisfaction with

conventional medical servicing. The doubts which appearances may raise of the sincerity and commitment of the naturopathic practitioner are balanced by the existence of a core of ideologically dedicated believers and educationalists. Of necessity, the educational processes whereby new recruits are socialized into the basic belief system and inculcated with the fundamental ideology of naturopathy substantiate the integrity of practices and remedies advocated to naturopaths themselves and to the wider society in which they are employed.

Under the guidance of colleges and training clinics, naturopathy sustains belief in the existence of natural healing forces which are a balance of life energies permeating all living organisms. The social world of the naturopath centres about his application of these beliefs to the practice of natural therapy for medical care and the promotion of health. His "function" in society - in so far as one can be identified - remains defined in terms of his relationships with his patients. His "goals" are directed at justifying his beliefs and his form of therapy and care of these and other members of the community. Naturopathic care is therefore very much a social process in which the naturopath, with his patient, is the interactive focus.

Most naturopaths are aware that they themselves and the manner in which they handle their patients are crucial. In my experience, very few of them conformed to a regular consultation schedule though they usually permitted their reception staff to "bully" them when some of their patients were waiting for extended periods due to prolonged appointments earlier in the day. There was implicit recognition therefore, by naturopaths of the 'time' dimension which pertains to the type of healing process they manage. It corresponds and blends with the 'time' dimension which emerged in my consideration of the associations between the different and distinctive beliefs of

naturopathy and modern medicine. The relaxed and casual attitude of most naturopathic practitioners and the relaxed and casual attitude which they gently convey to their patients encourage them to try to let nature and the human body 'heal itself'. The 'need' for logic and rationale only appears in the formulation of explanations and arguments to account for procedures. The subjective experience of naturopathy is reflected in the personal contribution by the naturopath.

CHAPTER 3:

THE PROCESS OF 'BECOMING PROFESSIONAL'

Within this Chapter, it is my intention to examine the processes by which an occupation such as naturpathy becomes defined, socially as a profession. I explore the characteristics associated with occupations regarded as worthy of this status and what it means for an occupation and to its practitioners, to be labelled 'professional'.

Naturopathy is a healing profession which is undergoing changes which in themselves are contributing to their 'becoming professional'. The processual model which I create describes an amorphous assortment of individuals asserting degrees of conformity with the belief that the forces of nature are ideally in balanced equilibrium. The acceptance of this principle is shown by their pursuit of an occupation which provides natural remedies and uses specific treatments to maintain balance and to stimulate similar natural forces in the body, should ill-health occur.

I use Berger & Luckmann's approach to knowledge as a theoretical basis from which to compare the different models adopted by researchers in talking about the professionalisation process. I examine the suitability of the application of these models to naturopathy.

THE EMERGENCE OF NATUROPATHY:

The early history of the growth of scientific medicine in England and Europe shows remarkable similarity to that of naturopathy and herbalism and, despite differences in political and social conditions, the latter may develop in the future into an institutionalized form similar to that which medicine

has now assumed. Until the last decade, naturopathy was variously and vaguely regarded as a 'counter-culture' type of medicine and as an alternative to conventional medical care. It was seen to be practised by an amorphous assortment of 'quacks', skilled and experienced, together with some very knowledgeable, though unusual practitioners who used no drugs and resisted surgery.

Naturopaths throughout the world accept as their basic concept that the body can be maintained in a state of health by wholesome 'natural' foods, the extensive use of water, fresh air and sunlight, together with adequate exercise and rest, and periods of fasting. In this way, the body is thought more able to resist disease and other types of environmental challenge without recourse to artificial interventions like drugs or surgery. Hence the naturopath ideally endeavours to bring about a state of health or well-being and to prevent ill-health.

Until the late 1940's, there were in Britain very few doctors who were interested in natural therapy and there was very little respect for those who were practising it as the greater proportion were not medically qualified and were often regarded as dubious characters (Inglis, 1964; 1980). On the Continent and in the U.S.A., periodic waves of interest and enthusiasm for naturopathy had resulted in its acceptance in formal, though different forms; on the one hand, as spas and mineral water and dietary control clinics, and on the other, as expensive health and beauty resorts. A College of Naturopathy was established in Britain in 1948 and examinations were held with the aim of compiling a register of naturopaths. Wide and variable boundaries of belief and practice were accepted in an attempt to regulate and organise naturopathy as a healing occupation.

In Australia, naturopathy was practised in a somewhat desultory manner

into the 1960's. In 1975, inquiries by the Government of N.S.W. and of Victoria sought to investigate the standards of alternative medical practice and care with a view to obtaining some control over practitioners and their education. The need for individuals offering natural therapy and associated services to adopt a common stance and to unite became apparent as challenges to their abilities and capability for practising mounted from corporate, community and rival health-care professionals.

NATUROPATHY IN AUSTRALIA:

Naturopathy has come to embrace degrees of acceptance of a compromise between severe or 'pure' regimens of 'hygienic living' and more practical approaches in which several techniques and agents are used within a therapeutic regime.

> "In modern naturopathy, controversy still centres around the extent to which the naturopathic method should be adopting the methods of other related systems, such as herbalism and homeopathy."
> (Webb Report, 1977:72).

As previously noted, I have accepted that 'naturopath' and 'natural therapy' are terms used to describe treatment regimes other than spinal manipulation and that, regardless of any justification by therapists themselves of their use of the word 'natural' or by conventional medical practitioners of the terms 'alternative', 'unconventional' or 'unorthodox' for such therapists, these are socially accepted classificatory categories for the purposes of my study. Selected committees formed and sponsored by different levels of government and administration continue to find it very difficult to make any clear statements which adequately describe the activities of naturopathic practitioners, in such a way that any expectation of their behaviour as consultants or providers of medical care could be predicted for the patient or in relation to other occupational groupings or specific social classes (Webb Report, 1977).

NATUROPATHY AND THE WEBB REPORT:

In 1974, the Federal Government of Australia set up a formal Senate Committee of Inquiry into Chiropracty, Osteopathy, Homeopathy and Naturopathy. The members of the Committee were drawn from politics, business, community organisations and the related health professions. It was chaired by Professor E.C. Webb[1] of Macquarie University, New South Wales. Its brief was to investigate the nature and type of chiropractic, osteopathic, homeopathy and naturopathic services used and available to Australians with a view to their control and to the registration of practitioners so that formal standards and requirements of practice could be set and their activities in the medical field legitimized.

In its early meetings, the Committee sought to interpret its terms of reference more closely and to draw up a series of questions which its final report should attempt to answer. These were of a medical, technological and sociological nature and provided the basis for a wide-ranging and extensive study of these aspects of health care (Webb Report, 1977:15-18).

A number of surveys were undertaken and questionnaires were drawn up to gauge community opinions and feelings regarding the nature and quality of conventional and alternative medical servicing that patients had experienced. Respondents to the questionnaires were selected from lists of patients supplied by co-operating practitioners. Of all the treatments that patients in the surveys received, over 85% were manipulative in one form or another while herbal and naturopathic remedies accounted for a further 12%. All types of alternative healing practitioners were prepared to refer their patients else-

---

[1] Emeritus Professor E.C. Webb was Deputy Vice-Chancellor of the University of Queensland, prior to his appointment as Vice-Chancellor to Macquarie University.

where when required, usually to a medical practitioner: however, many of these patients had already thoroughly investigated diagnostic and therapeutic possibilities of orthodox medicine for a specific complaint. Many patients frequently presented to an alternative practitioner with a specific complaint in the appropriate field of care in which he specialised, such as chiropracty. They commonly recognised the need for medical treatment for conditions they knew to respond well to antibiotics or drugs but resorted to the naturopath for less specific illnesses.

Submissions from interested parties were also requested and witnesses called. The final Report was published in April 1977. It highlighted the diversity which exists in alternative medical practice in Australia and the similarities and differences between the practitioner group as a whole and workers in established and orthodox health care services. The extent of knowledge and skill shown by naturopaths was not considered in detail though the Committee recognised their importance as components of any occupational role and as factors in determining the degree of professionalization which they could be said to have attained. Nonetheless, many people seem to be prepared to pay for services of this kind and derive real and continued value from them.

The final conclusion of the Webb Report stated:

> "(patients) followed the advice of naturopaths in maintaining their health but resorted to orthodox medicine for conditions which they recognised as clearly responsive to conventional therapy. The value of medical treatment for infectious diseases and trauma was accepted but not for less clearly defined disorders."
> (Webb Report, 1977:71)

The following summary recommendations for naturopathy are presented in the Report (1977:99-100):

> "1. The Committee does not recommend the licensing of naturopaths as a vocational group as it considers that such licensing may give a form of official imprimatur to practices which the Committee

> considers to be unscientific and, at the best, of marginal efficacy. It appreciates that some control is desirable over persons practising naturopathy for fee or reward to protect the general public and it considers that vigilance should be exercised over this group by competent authorities to define the standards of the premises from which practice is carried out, to control advertising, to police existing legislation prohibiting the treatment of certain diseases other than medical practitioners and to restrict the prescribing of dietary advice.
>
> 2. The Committee recommends that action should be taken to license acupuncturists, since this modality is reported to be on the increase, is a clearly defined technique for which standards of assessment can be laid down and presents a potential health hazard to the public."

The Webb Report points out that there are many individuals who have in the past and who wish to continue in the future, to use natural therapy and the services of naturopaths. There are others who accept the ideals of natural therapy or wish society simply to offer alternatives in healing services to those already provided under official imprimatur.

There are others again who see within the natural therapies, part of an increased interest among particular segments of society, in the awareness of nature, a concern for pollution by man-made products and other popular, 'counter-culture' and 'anti-establishment' groups and movements.

A large and reaonsably organised and articulate lobby opposing natural therapies can be identified. It includes rival providers of health care services such as medical doctors and their associations and marginal health care workers such as pharmaceutical professions and nutritional advisers. Some identified dangers within the practices of naturopathy while other simply claim not to accept the ideals of natural therapy for a variety of reasons. Productive groups such as drug manufacturers who presented submissions to the Webb Committee seemed to have a vested interest in promoting their own image of naturopathy. This could be described as a perceived threat to their own persistence and survival in the marketplace and to their status and prestige.

Following the Webb Report, all States have established more formal requirements and procedures for the registration of naturopaths and naturopathy practitioners. The benefits of maintaining flexibility in approaches to beliefs to meet the requirements of the many different modalities and the needs of all patients is balanced by the necessity of obtaining authorisation.

Legislators and government regulative officers have found that their task in preparing guidelines for registration has not been made easier by the continued existence of the smaller and ancilliary natural therapies associations in each state. Legitimation of any activity is also usually accompanied by the existence or the threat of imposition of sanctions against individuals who infringe or otherwise fail to conform to procedures which have been formalised. The ultimate sanction remains the withdrawal or cancellation of a practitioner's registration should he fail to conform with standards. Informal censure, in the form of peer group disciplinary action in an organised sense does not appear to be used to register disapproval by association or societies for individuals who fail to accept new policies once they are members: provided they continue to pay their subscriptions, and to formally abide by government requirements, they remain members. They are nonetheless, expected at all times to abide by the ideals of practice and ethics of their association. Such criticisms as are levelled at individual members by the 'general public' or the 'media' are referred by association functionaries to the individuals concerned. Each practitioner must protect his own financial and legal liabilities as there is no formally recognised and organised body to represent the interests of society members facing challenge.

OCCUPATIONAL ASSOCIATIONS:

In the early 1970's, there were a number of independent State-based societies for practising naturopaths. Some of these were associated with the South Pacific Federation of Natural Therapeutics which had its own college, the South Pacific College of Natural Therapeutics at Stanmore, New South Wales. In 1975, the Australian Council for Natural Therapies was founded to act as a central forum for all the separate associations such as the South Pacific Federation, the National Association of Naturopaths and the National Association of Herbalists. The South Pacific Council is an umbrella organisation that includes groups having naturopathy as their main interest but does not include the major organisation of specialized manipulative therapists.

The Australian Council for Natural Therapies and the South Pacific Federation amalgamated their organisations to form the South Pacific Council for Natural Therapies. The National Association of Naturopaths of Australia, the Australian Chiropractors, Osteopaths and Naturopathic Physicians Association, the South Australian Chiropractic Association, the Victorian Chiropractic Association and the Victorian Society of Specialist Osteopaths are now all affiliated with the South Pacific Council. The Acupunture Specialist Practitioners Association has merged with the first two of these associations to form the Australian Natural Therapists Association. Many other smaller associations which have chosen to remain independent have affiliated with the South Pacific Council or the National Association of Naturopaths of Australia (A.N.T.A.).

In the past, each individual association has tended to show and to perpetuate its own approach and attitude and to advocate a specific treatment or practice unless the benefits of a uniform stand on an issue can be pointed out. For example, some of the smaller associations had previously adopted

a more liberal attitude to claims for herbal anti-cancer remedies being successfully used by member therapists while the larger, national and more authoritative societies advocated caution in their use and counselled members to wait until claims of their efficacy and safety could be substantiated (personal communication, 1981).

Many practitioners assert that an appearance of homogeneity is required in the political arena and in negotiations with bureaucratic functionaries and in resisting society's attempts to control and formalise their activities. Naturopaths are seeking to set and maintain minimum standards of education, rules of behaviour and practice similar to those idealised by other occupational groups enjoying high professional status. This apparent unity in interest and ideology, however, appears to contain within it fundamental discordant elements and to lack appreciation of all aspects of the reality of the situation. Among practising natural therapists and naturopaths, there is divergence of commitment to belief in nature as its own healing agent, especially where there is a need to provide, and to be seen to provide a medical service. Patients usually want to see an improvement as soon as possible. Hence time is also a consideration and the practitioner is forced to decide whether or not to use additional treatment to a basic dietary and exercise programme.

Mr. N.A. is a founding member of META (abbreviation of Metamorphosis) an organisation of naturopaths, chiropractors, medical practitioners and specialists and associated health-care workers. He lacks formal qualification which other association members possess and which some members of other societies consider are mandatory for him to practise as a professional natural therapist alongside of themselves as professionals in their specialities.

Mr. B.R. possesses formal and acceptable qualifications for peer group as well as official government recognition as a naturopath and chiropractor.

He is a prominent member of A.N.T.A. and acts as a spokesman to the news media. He co-operates with medical practitioners when and if required by them and is respected by other natural therapists as being skilled and trained as a competent naturopath.

Both gentlemen practise naturopathy for a living: both claim to believe in natural therapy and the existence of life energy and inherent healing forces. As practitioners both are committed and sincere in the conduct of their work. Nonetheless, other practising naturopaths regard them as widely differing in professional terms and ideals. This is most apparent in looking at the associations of which both are members. A.N.T.A. claims a high membership and outlines to and for its members, ideals of practice and standards of behaviour. It has a code of ethics and a formal constitution. It claims to speak for a large proportion of practising naturopaths and natural therapists and to present a reasonably united front on social, political and economic issues in dealings with other related health professionals or with the corporate sector. It seeks to affiliate smaller, subsidiary societies such as South Australian Chiropractors and even META provided that members and associates will accept the validity and policy of A.N.T.A.

TRAINING COLLEGES:

Until the last eight years, most of the colleges and institutions where naturopathy was taught had been established in a somewhat informal manner by an individual who, after some years of practice, had been asked by his friends or patients to share his knowledge and experience. Lacking any State or Federal government subsidy and having only the goodwill, initiative and financial assistance of the founder(s) to keep them in operation, most colleges had limited potential and scope for continuity. The courses they offered,

while sometimes specialising in one particular modality reflecting the predominant interest of the founder, in general sought a blend of the philosophies of science and natural therapy.

Natural therapists and naturopathy associations today are affiliated with or closely associated with many training colleges. The teachers in college appointments often hold official positions in these associations and can agitate for college curriculum and course changes to reflect current association views and interests and any changes in practice. Some of the separate colleges in Sydney and which were also in existence prior to the establishment of the South Pacific Council have merged into the New South Wales College of Osteopathic and Natural Therapies at St. Leonards. In 1981, they are providing a course in natural therapy designed around the proposed government requirements for registration of practising naturopaths.

Recommendations from a series of government reports, culminating in the Webb Report (which I will shortly describe in more detail) and examination of the various naturpathic colleges in operation, have led to the formal moves of government to set minimum levels of education, standards of skill and experience for practitioners for official recognition. There has hence been greater incentive for colleges and training courses for natural therapists to be designed to meet requirement and to more closely make the one conform to the other.

The state and national associations and societies and training colleges linked with them presented submissions to the Webb Committee. They themselves participated in setting the criteria for their own professional recognition and co-operated with rival health care providers in government sponsored meetings. Pharmaceutical companies, religious organisations who perceived some forms of alternative therapy as atheistic and pagan, private and public hospital associations, all joined with medical doctors in arguing against acceptance of all practising naturopaths as suitable and qualified to treat illness.

BECOMING PROFESSIONAL:

One of the crucial questions for studies of occupations and the process of 'becoming professional' is: who or what defines the requirements which result in an occupation being labelled as a profession? Related to this is: what does it mean to an occupation to be regarded as professional?

The traditional functionalist approach to professions tends to assume that a high level of conformity is required within an occupation. Great importance is placed on norms, codes and rules which govern behaviour and standards for the performance of professional work. Individuals practising similar occupations can be seen to constitute a coherent and organised body. Regular procedures serve to socialize new recruits into a common core.

By contrast, Bucher & Strauss (1961) develop a processual model in which professions can be perceived as

> "loose amalgamations of segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular period in history."
> (Bucher & Strauss, 1961:326)

Naturopaths profess a desire and need for flexibility in belief and practice within any assoication or grouping formed with other healers and like-therapists. Many claim expertise in one or more branch of practice or knowledge such as chiropracty, acupuncture or Chinese medicine. In discussing the existence of a professional theos, MacIver (1955) suggests that specialization is the basis of professional work because it promotes superior performance. However, Marshall (1962) argues that competence is a synthesis of general knowledge and skill but with a particular emphasis on the former. He contents that, for political effectiveness within an occupation, unity and consensus is founded on a universally held and commonly acknowledged corpus of belief.

The issue of the professionalism of naturopathy revolves around the

perception and validation of its claim to expertise in non-drug therapy and the assertion of the increased benefits over and above scientific medicine to be gained by following natural methods of health care. Registration procedures and government controls define minimal criteria of general knowledge for practice. Additional requirements are attached to specialised areas of treatment.

DEVELOPING A 'PROFESSIONAL' MODEL FOR NATUROPATHY:

IMPLICATIONS OF THE WEBB REPORT:

In recent years, natural therapy has attracted substantial interest from individuals in the community, from consumer protection organisations, from competing health care providers, from government and bureaucratic functionaries and instititions. This interest culminated in the Webb Report, published in April 1977.

This Report made a number of suggestions on which state governments are invited to act to impose controls to be administered by health department bureaucrats and backed by legal sanctions. From the standpoint of the patient, it makes recommendations concerning minimal standards for therapists and their premises. All those who offer the specified forms of healing services would be required to conform with these specifications and the patient would be able to expect at least this minimal standard of hygiene and cleanliness to be observed at the premises. From the viewpoint of the practitioner, registration would be contingent on personal possession of suitable qualifications and evidence of practice at, or in premises deemed, to conform with the earlier specified standards.

In themselves, however, the imposition of government and legal controls amount to formal and official acknowledgement of the right of naturopaths

and conforming natural therapists, to practise. There is tacit approval, within these limitations by government and acceptance of them, in this position by rival health-care providers. This raises another possibility. Having been forced to assume a unity (of sorts) to meet government requirements and standards, natural therapists and naturopaths are regarded by society as a group and as a constituted professional grouping. They can then use this unity to raise their status as a group in relation to other like practitioners and health care professionals. They have a continued vested interest in amintaining a consistent and uniform stance on principles, beliefs and issues of potential conflict. At the same time, this fragile unity is threatened by internal pressures and factions advocating specific treatments and calling for greater flexibility in approach than such legal limitations as exist permit. The whole issue therefore gravitates about a desire to be regarded as 'professional' and thereby worthy of socio-economic and political rewards commensurate with such status and visibly displayed by other health-care professionals yet maintain faith with natural therapy beliefs and principles regarded by these same conventional health-care professionals as unsubstantiated and non-scientific, and continue to use innovatory techniques well-regarded overseas but suspect in Australia.

In other words, the Webb Report raises two fundamental and related issues in regard to natural therapy. While it recommends a change in the internal organisation of an occupation - naturopathy - it presages a change of an external nature also. The former creates the conditions under which the latter can be achieved. In other words, the Webb Report is advocating change within the existing criteria of what constitutes 'professional' (Webb Report, 1977:99, Recommendation no. 1): a change in the requirements and procedures for recognition of practitioners of natural therapy and control of

standards of permises and types of practice deemed acceptable to health authorities. Official authorisation carries with it social and financial benefits in the form of acceptance of their right to charge a fee for professional service and as being worthy of privileges and prestige associated with other healing professionals. Eligibility for health insurance benefit carries with it the implicit assumption that by being classed by government and by private enterprise as a health service, naturopathy would achieve proof of its social acceptability. The fact of health insurance being extended to this area of medical service would further tend towards a health system in which there is almost free and easy access to all available types of beneficial care. This raises problems for government health policy.

Nor is the Webb Report entirely consistent. Within the same section of this Report (Recommendation no. 2) a change is suggested in the manner in which practitioners using acupunture therapy should perform their duties. This further complicates the situation for natural therapists where pressure from within their association, from individuals and factions advocating specific treatments and new approaches imperil the unity necessary for professional goals to be achieved. Recommendations in regard to acupuncturists would seem to limit this treatment modality to registered medical doctors to the exclusion of possibly more highly qualified Chinese medical acupuncturists not accepted as scientifically-trained medical doctors in Australia (personal communication, 1981).

PROFESSIONAL MODELS:

1. THE APPLICATION OF A SOCIOLOGY OF KNOWLEDGE APPROACH TO THE STUDY OF OCCUPATIONS:

A useful extension of Berger and Luckmann's (1966) contribution to the sociology of knowledge and which I have discussed earlier in relation to naturopahty, is made by James Bishop in his application of the Berger-Luckmann definition of knowledge[3] to the study of occupations.

Initially Bishop distinguishes between institutionalized occupational knowledge involving recognized procedures and ideologies which represent the core of any work, and operational knowledge being that which is applied within the course of the performance of work. In the case of naturopathy, the acceptance that natural forces within the human body can act themselves as healing agents describes the ideology and the ideal means of natural therapeutic care. The application of consultation skills and treatment modalities by naturopaths demonstrates that this knowledge constitutes a phenomenon that is real and has these specific dimensions.

Within any body of institutionalized occupational knowledge, Bishop separates substanive and procedural goals. Substantive goals are

> "those publicly recognised as the *raison d'etre* of the occupation."
> (Bishop, 1979:330)

In this instance, natural therapists would claim that they are regarded as having expertise in natural therapies. By way of contrast, procedural goals

> "are not commonly recognised by those being served as goals, but rather are viewed as techniques used by practitioners towards the achievement of substantive, client-serving ends."
> (ibid:330)

---

[3] Knowledge as

> "the certainty that phenomena are real and that they possess specific characteristics."
> (Berger and Luckmann, 1966:1)

The provision of healing care in the form of services in which treatment modalities follow natural procedures is sought by those individuals approaching natural therapists. Ideology intervenes at two levels: that of a work ideology recognised and accepted by members as a basis for practical performance of work and occupational ideology which serves to explain and justify the existence of an occupation (Bishop, 1979:331). This latter fact is pertinent to the discussion of naturopathy as a profession. It is used by practising naturopaths to validate their existence and to justify their assumption of professional status to patients, government bureaucrats and peer group and rival providers of medical services.

One of the defining criteria of professional work is that it involves mastery of a body of knowledge and a set of techniques (Gross, 1958; Parsons, 1939; Pavalko, 1971). The components of this model appear to be an intensive specialisation in one aspect of the total field in which a broad and general knowledge is held.

In an earlier section, I referred to two different types of natural therapist. Mr. N.A. refers to himself as a natural therapist. He does not claim to specialize in any particular area of manipulation or to possess exclusivity over a natural remedy but he makes use of herbal and homeopathic products and a simple technique of massage. Mr. B.R. says he specializes in dietary advice and chiropracty. He is also an effective osteopath and admits that most patient referrals are of a manipulative nature despite the sign on his rooms: 'Naturopathic Clinic'. Both men agree that they have a broad knowledge of natural therapies but claim that they have some special expertise. They admit to the greater proficiency of others in different areas.

2. CRITERIA OF PROFESSIONALISM:

For clarity, many analyses of professionalism, particularly when they attempt to define its parameters - adopt a Weberian styled approach using ideal-typical distinctions. Elliott (1972) separates the occupational and status dimensions of a profession. He argues that the occupational aspect is concerned with knowledge and task, expertise and completion of the task. On the other hand, status refers to the position of the profession in an overall ranking system. By way of illustration, he mentions English physicians who enjoyed the status of professional by virtue of their being drawn from the upper, cultured classes well before medical science and education could substantiate and support their claims to medical expertise. This contrasts with the situation in U.S.A. as described by Freidson (1970: 113) who links the status physicians to a

> "scientific mystique...consciously reinforced by symbols of success - economic rather than medical in nature".

Natural therapy is enjoying considerable popularity in all areas of the Australian population and particularly among adults in the 25-40 year age group (Webb Report, 1977). Once one acknowledges naturopaths and natural therapists as an occupational grouping, the problem becomes that of their ranking or status within the social system.

Magali Sarfatti-Larson (1977) attempts to cope with these two dimensions of professionalism. She takes a Marxian-cum-economic determinist stance to the problem of increasing tendency towards professionalism. She points to an increasing bureaucratic involvement in the professions and links it to the next stage in the development of capitalism. She also notes that status goals preoccupy most of the newer professions. In this respect, many of the goals expressed by practising naturopaths can be seen to conform with her analysis. Most therapists will express, in interviews that their principal

aim is to be considered

> "equal to doctors and just as specialists in another branch of medicine."
>
> (Mr. J.U., Unley, 1981)

Many dress in formal, starched white coats because they maintain that their patients can equate them more readily with these medical doctors. I heard some patients refer to their practitioners as "doctor" when talking to other patients and staff. Only on one occasion was a special effort made by another individual or a member of staff to correct this impression.

Though Sarfatti-Larson's analysis is not on the whole directly applicable to natural therapists and naturopathic practitioners, sections of her treatment of historico-political processes in the rise of the professions are relevant. She attributes status preoccupation to a need to be seen to conform to the *status quo* and accept the legitimacy of and criteria defined by it. This is combined with a lack of autonomy in determining economic reward.

While the perceptions which patients of natural therapy bring to their consultations do not seem to carry significant or predominant desires simply to use this form of treatment purely because of its informal 'link' with other social alternatives and 'counter-culture' issues, the awareness of the classification of naturopathy as an alternative form of medical, is implicit. Naturopathy is associated with the healing professions. The expectations which patients bring to their consultations and which bureaucrats, legislators and other rival providers of health care services, have of 'medical care' creates an idealised model. Since naturopathy is competing to offer a healing service, and is aspiring to the high professional status and prestige of this role, it must be seen, by institutionalized medicine, by government and by society, to conform with its concepts.

This brings us face to face again with the ambiguity inherent in the

external and internal pressures upon naturopathy. To reiterate: naturopathy is in the dilemma of meeting legal and professional requirements commensurate with privileged social status while seeking to maintain in belief and practice, flexibility and an 'alternative' medical care. The words of Bucher and Stelling (1977:21) come to mind:

> "Professions are never fixed, but must be viewed as continuously in flux, changing in one or another aspect of their internal and external relationships."

3. KLEGON'S 'ACTORS' OR AGENTS OF CHANGE:

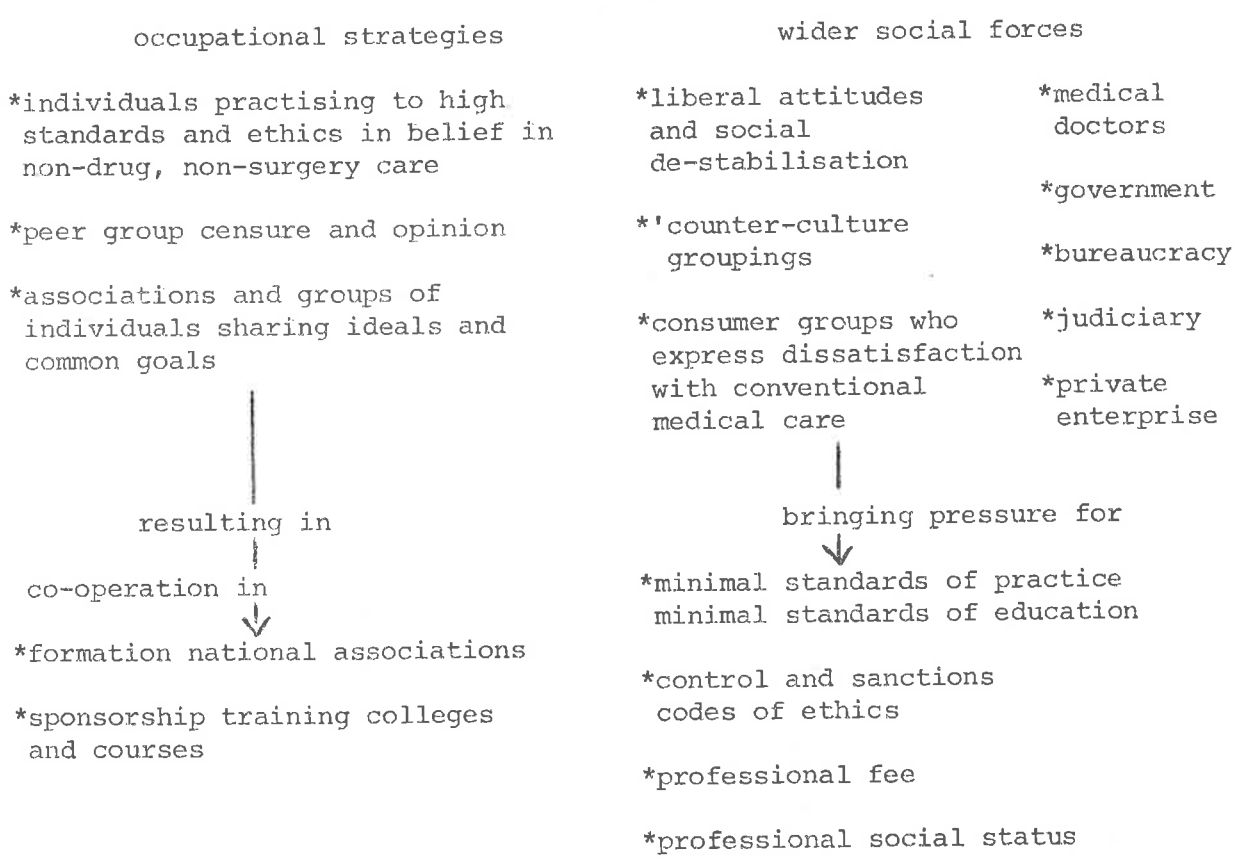
> "Once definitional attempts are de-emphasised and a more critical perspective adopted, it becomes apparent that the ability to obtain and maintain professional status is closely related to both concrete occupational strategies, as well as wider social forces and arrangements of power."
>
> (Klegon 1978:281-282)

Klegon looks at the individuals whose actions seek to or are seen to bring about change. He identifies them as groupings with varying degrees of interest or 'stake' in a particular outcome (Klegon, 1968). Legislators, government officials and bureaucrats with the assistance of occupational functionaries themselves are important in the setting of professional standards Besides state and national natural therapists' associations, interested parties such as the Australian Medical Association, health and medical insurance companies who could be forced to include benefits for natural therapy service within their schemes, and pharmaceutical companies whose markets are threatened by increased interest in non-drug remedies, are involved directly. Even groupings such as the Pharmaceutical Society of Australia, whose members are only indirectly involved, presented submissions to the Webb Committee inquiries.

Using Klegon's "agents of change" definition, it is possible to distinguish two structural categories operating in natural therapy. These

coincide with Klegon's "occupational strategies", namely individuals and groups, and "wider social forces" (see Figure 1).

Figure 1: Actors or "agents of change" in Naturopathy



In Figure 1, it is possible to identify the agents or actors and locate them on the basis of their stance in regard to natural therapy. How they are mobilised or the effects of their association can be traced.

At any one time, the same individuals and the same groups and their actions may be seen to have implications of an occupational nature. They are related to more general social issues and dynamics of power. On the other hand, these groups are attempting to describe appropriate tasks within the occupation while making recommendations on status and reward. These relationships are described more fully in Figures 2 and 3.

Incorporating Klegon into Berger and Luckmann's theoretical frame, the

end product constructs a social reality of the professionalisation process for the occupation of naturopathy. This is very much along the lines developed by Hall (1979) who talks in more general terms, about occupations themselves and those practising them trying to impose their own construction of the value of their contribution to society on 'significant others'. He sees professional groups as manipulating themselves to be a part of a social system in opposition to others who have some 'stake' in the outcome of their struggle for acceptance.

Klegon also raises the possibility of using the employment of lower status and minimally qualified assistants and practitioners who perform mundane tasks and routine procedures. Staff at many of the busier and more popular clinics regularly take iris photographs and explain the basic principles of iridology to waiting patients. Engel and Hall (1973) predicted the expansion of professionalism to embrace those occupying a supervisory role over ancillary staff. They suggested that there would be a trend towards a more consultancy type of role for professionals as increased work and decreased time place additional demand on their services. As increasing numbers are seeking natural therapy care, some practitioners say they are having to call more and more on their experienced staff. This means that they feel they should spend time instructing them and educating and supervising them in basic procedures so that they may be proficient in minimal technical skills and basic nutritional principles. They claim that as long as staff can help them in preparing patients for therapy and manipulation, can answer simple questions and explain the benefits of natural therapy, but will refer difficult queries to themselves, they feel confident to call on their assistance.

While not all naturopathic clinics are able to use their staff in this

capacity, the possibility exists in the future that, if interest in natural therapies continues to grow and additional demands are placed on existing services, the natural therapist will need to think of organising a practice with himself in a more consultative role within the clinic. It is possible to envisage a situation where the naturopath as a professional offers qualified advice on non-drug therapy and non-surgical procedures and makes diagnoses of complaints and draws up treatment regimes. The performance of manipulation, and the administration of treatment procedures and routines would be by less highly qualified personnel who are supervised by the naturopath. In this hypothetical scenario, it would be possible to make comparisons with general medical practice.

A PROFESSIONAL MODEL in which to view NATUROPATHY as an OCCUPATION 'BECOMING PROFESSIONAL':

Using a sociology of knowledge approach, Bishop discussed professionalisation in terms of ideology - he spoke of procedural and substantive goals. Hall also adopted a similar perspective in an attempt to bring Klegon's actors, interested and effective in professionalising strategies, within the process of reality construction by relating them to 'significant others' as individuals and groups. If these same individuals and groups can be shown to co-operate within Bishop's ideals of work and practice, it is possible to incorporate a sociology of knowledge perspective drawing also from Klegon's insights.

Superimposed upon this model and relating it to naturopathy's growth as an occupation and its emergence as a profession we have internal frictions which threaten to disrupt the occupational uniformity and unity which the use of such a model assumes. These tend to retard the professionalisation

process. They cause individuals and factions within the group to question the direction and intention of the goals they claim to pursue. Such tensions provide opportunity for rival and competing health care services to exploit. This in turn reimposes a necessity for adopting a consensus among natural therapists *viz-a-viz* medical doctors, specialists and private enterprise, all endeavouring to maintain the medical '*status quo*'.

In examining methods of treating sociological data and incorporating theory and research, Walter Wallace (1975:13) suggests that it is possible to tabulate the principal phenomena that explain the social against objective and subjective behavioural relations that define the social.

In other words, a summary of the 'dynamics' which operate in the process of professionalisation and the criteria associated with 'being professional' should be suitable for organisation into such tables. In Figure 2, I have taken four areas where occupation and status criteria (as defined by Elliott) intersect occupational strategies and the wider social forces (as described by Klegon) and attempted to identify the relevant actors and their actions. The result of the criteria and performance of professional naturopathy is the existence of those elements comprising Figure 3.

I will discuss the logic underlying these two Figures, commencing with the 'general' characteristics - represented in BOX a and BOX b - and concluding with the features more specifically associated with 'professionalism' - those in BOX A and BOX B.

Together BOX a and BOX b represent a wide range of social forces which create, mould and act upon the individual's perceptions of what a professional person does and how he behaves. Klegon sees them directing the occupational group by their use and demands of the services the group offers. Through government-enacted legislation, the society ensures that the occupational

Figure 2: PROFESSIONAL STRATEGIES AND PROFESSIONAL CRITERIA:

		ELLIOTT'S "CRITERIA OF PROFESSIONALISM"	
		OCCUPATIONAL (knowledge, task definition, expertise, etc.)	STATUS (criteria of social hierarchy)
KLEGON'S ACTORS or 'AGENTS OF CHANGE'	OCCUPATIONAL STRATEGIES	1. tertiary education and minimal general knowledge 2. specialisation 3. practice of naturopathic skills (BOX A)	1. dress, manner, appearance 2. look of premises 3. code of behaviour (BOX B)
		1. participation on committees and involvement in issues associated with occupation 2. interest and involvement in issues related to those of occupation (BOX a)	1. social and educational background 2. high income 3. influence (BOX b)

Depicted as

BOX A	BOX B
BOX a	BOX b

Figure 3: FORMAL REQUIREMENTS OF PROFESSIONAL NATUROPATHY:

(BOX A)	*graduate of recognised naturopathic training college *member of naturopathic professional association	*adherence to 'professional ethics and standards of practice and behaviour (BOX B)
(BOX a)	*membership of committees in community involved in formulating legislation and policy relating to naturopathy *naturopaths as members in committees and in societies in community involved in community issues	(BOX b)

group not only meets its demands but does so with a minimal proficiency. The formulation of these demands which result in legislation occurs by negotiation between members of the community, the occupational group and others with a 'stake' in the outcome. These individuals and groups together set the criteria which comprise BOX a.

In their interaction with the community and with others in like occupations, the occupational group which is the focus of interest at the time - in this instance, naturopathy - becomes 'visible' and identifiable. Those with whom the naturopath comes in contact will, in this wider sense, remember him and his 'image' before they remember naturopathy and its beliefs and ideals.[4] To the wider society, the professional has a high status associated with a high income, influence, and tertiary educational qualifications (BOX b).

The naturopath possesses a minimal level of general knowledge about alternative medicine and has his own special area of practice and proficiency and skill (Elliott's occupation criteria). He has obtained this knowledge through formal education and practical experience. He augments it by contact and discussion with other naturopaths and alternative medical practitioners. These parameters constitute Klegon's occupational strategies.

Elliott's occupation criteria and Klegon's occupational strategy 'come together' within BOX A. The naturopath obtains formal qualifications which are proof of his proficiency to perform his occupational tasks and which are,

---

[4] With this problem in mind and while I was writing this section, I discussed the retention potential of individuals and the selectivity of human memory with two practising psychologists and one psychiatrist with whom I was familiar. Their assistance in my ordering of this data and that of the next page was very much appreciated.

themselves recognised by Klegon's wider social forces. He attends colleges and institutions and joins professional associations where he meets other naturopathic colleagues.

The naturopath achieves status by his personal appearance, his manner and his behaviour in dealing with people. The place where he works either adds to or detracts from, the appearance he himself presents. By the conduct of his practice, the naturopath is likewise able to augment or undermine the personal 'image' he presents. These factors are all relevant to Elliott's status criteria.

In the more dynamic sense of Klegon's occupational strategies, we can perceive that the naturopath's occupation requires him to meet minimal standards in his relations with people. He must prepare himself to be always approachable and amenable. Not only must his premises be clean and attractive to encourage patronage, but they must appear to be occupied and used and busy. He and they must convey the impressions of trustworthiness and reliability. In meeting these visible and not-so-visible requirements, the naturopath conforms with the standards recognised and associated with professionalism (BOX B).

CONCLUDING REMARKS:

Naturopathic training colleges provide general knowledge and permit specialization which is achieved by study at a tertiary educational level. Graduates of recognised colleges are accepted for registration by government as capable of practising natural therapy in conformity with minimal standards and as able to charge a fee for service. Commensurate also with achievement of proficiency is eligibility for membership of professional associations which adhere to codes of ethics and set standards of behaviour. Active

involvement within the community and in professional associations offers the possibility of representation on committees and on corporate boards with individuals who enjoy high social, economic and political status in society. Hence, naturopaths would seem to be worthy, by their participation jointly with them, of the same high status.

Viewed in this light, the process of 'becoming professional' would involve the naturopath adopting occupational strategies which, under the influence of wider social forces, direct him towards the status goals associated with professionalism.

If it wishes to be effective in the political arena, and in its relations with the groupings aligned against it, naturopathy will need to define and to project its ideals more cogently and more consistently. Not only is it opposed directly by those competitors who perceive its threat, but by the news media which seems to adopt a very qualified stance: this falls a deal short of recommendation of naturopathic services while pointing to the inadequacies of conventional health care. So-called 'liberal' elements[5] who oppose medical monopoly and the power of the drug companies as they exist today (Taylor, 1979) point to a 'lack of professionalism' or express doubts about qualifications and standards of knowledge and practice - 'professional competence' - when questioned about their attitude to naturopathy. The tendency towards a maintenance of the '*status quo*' together with the social, economic and political power of the 'medical machine'[6]

---

[5] 'liberal' elements are those arbitrarily identified by their attitude towards development of nuclear energy and towards natural therapy as shown by a casual survey of a middle class shopping population (details Appendix I).

[6] 'medical machine' I define to embrace AMA (organised medical doctor associations), APMA (Australian Pharmaceutical Manufacturers Association), NHMRC (National Health and Medical Research Council), Association of Medical and Health Insurance Companies.

presents a formidable opposition to the relatively small numbers of 'alternative' practitioners who are only just beginning to formulate a coherent ideology and to define ideals and aims.

CHAPTER 4:

THE NATUROPATHIC PATIENT

In an earlier chapter, I referred to two casual surveys of people interviewed in Glenelg and Marden, suburbs of Adelaide. A large number of these respondents neither understood what was meant by the term 'natural therapy' nor knew who a naturopath was and what he did. They were reluctant to use medical services without the knowledge or approval of their medical doctor and were cautious in their acceptance of alternative forms of servicing to those of a conventional nature.

On the other hand, some respondents were familiar with naturopathy and others, to whom a description of natural therapy had been given, said that they would be prepared to consult a naturopath should the necessity arise. Some simply advocated that there be greater accessibility for all to naturopathic and other therapeutic services alternative to conventional scientific medical care. Three European migrants separately called to mind the situation in their former countries where any beneficial form of health and medical servicing was not only available but financially accessible to all members of the community.

The Webb Committee which inquired into chiropractic, osteopathic, naturopathic and homeopathic services in many Australian states during the period 1974-1977 referred to a number of more formally structured and statistically random samples of users of chiropractic and some naturopathic services (Webb Report, 1977:502). Information relating to sex, age, marital status and socio-economic particulars was collected from groups of patients who completed formal questionnaires. Some of the questions probed degrees

of personal 'satisfaction' with conventional, chiropractic or naturopathic servicing and sought to grade patients' responses to each form of care. Ultimately, however, the Webb Committee was forced to realise the limitations posed by the 'write and recall' nature of the questionnaire format.

In drawing these conclusions, the Webb Committee pointed to its failure to interview and critically discuss with naturopathic patients the nature of naturopathic care, the relationship between the patient and the practitioner, and the reasons which many normally conservative individuals who use conventional services, give themselves when embarking on unorthodox programmes of treatment.

It is my intention now to explore these areas identified by the Webb Committee. In this chapter I confirm that individuals seeking care at the naturopathic clinics where I conducted observations showed the responses of normal individuals in the community. As such, their understandings of, actions during and use of naturopathy could be regarded as representative. Initially I use data collected and compiled[1] from Preliminary Information Sheets. Most naturopathic clinics require new patients to complete similar sheets. They provide the naturopath with details of patient age, sex, residential address, present and previous medical history and details of the complaints for which the patient is now seeking care.

Armed with this information, I attempt to identify sets of circumstances, problems and patterns of behaviour which permit me to construct a profile of a 'modal' patient. I describe the different primary and secondary complaints which these individuals present to the naturopath. Bearing in mind the conclusions of the Webb Committee (1977:76) that:

---

[1] The information from Preliminary Information Sheets was analysed by computer using SPSS programme format (Statistical Programming for the Social Sciences).

> "the naturopath assists many patients who have been dissatisfied with medical advice, who suffer from complaints with a strong psychosomatic component, or who are chronically sick but have not received sufficient support in the orthodox situation."

I reintroduce the health belief concepts raised in Chapter 1. Finally, I present the normal daily lives of two patients whose treatments I follow as detailed case histories in the subsequent chapters (Appendix II).

DIAGRAM I: MAP of ADELAIDE METROPOLITAN AREA showing DISTRIBUTION of RESIDENCE of NATUROPATHIC PATIENTS attending CLINIC A (GLENELG)

TABLE I: RESIDENTIAL ADDRESSES of PATIENTS attending NATUROPATHIC CLINIC in GLENELG.

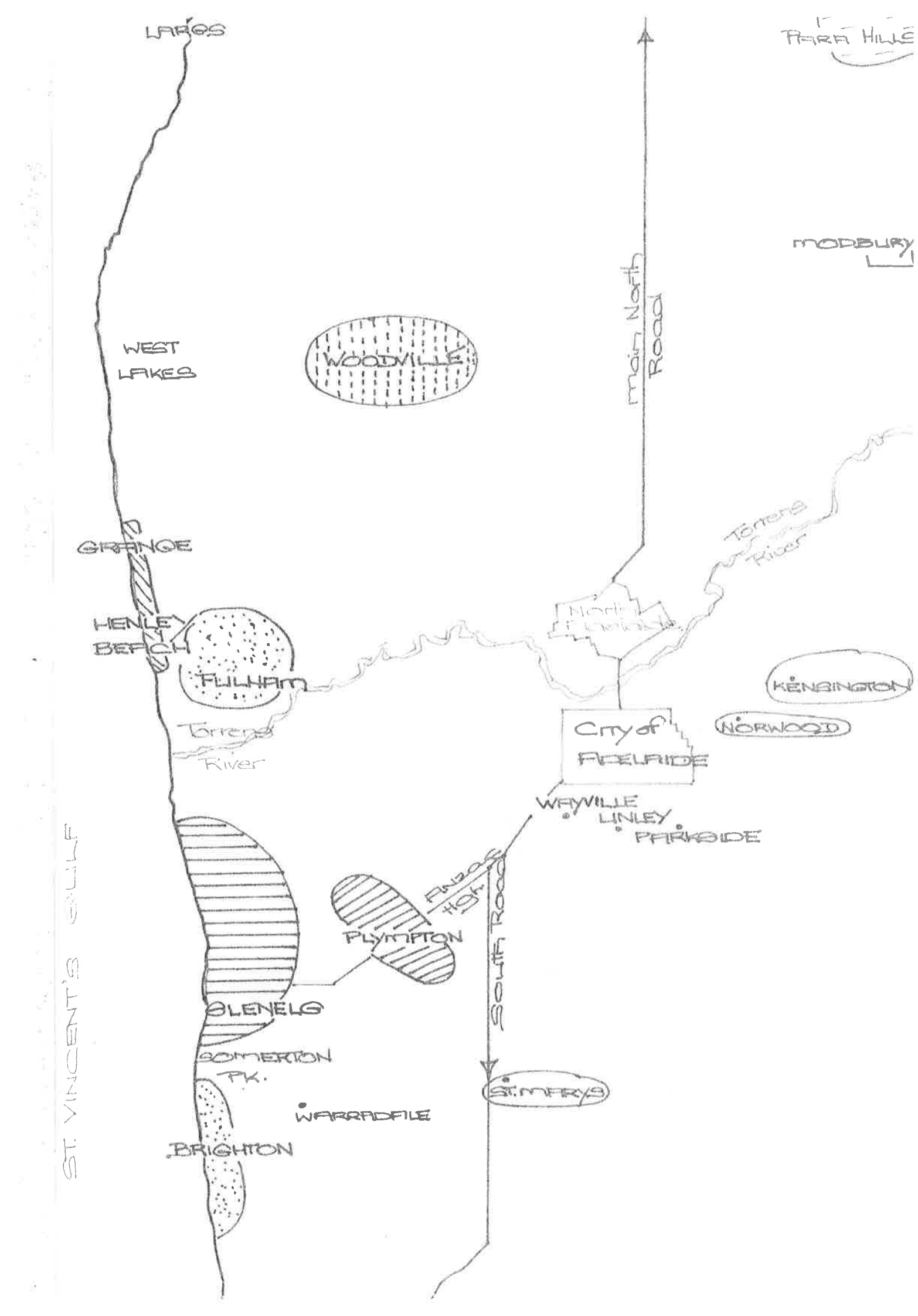
SUBURB	% PERCENTAGE OF PATIENTS (N=405)
GLENELG	10.4
HENLEY BEACH - GRANGE	5.4
BRIGHTON	4.4
FULHAM, PLYMPTON each	4.0
GLENGOWRIE	3.2
WAYVILLE	3.0
PARKSIDE, WARRADALE, WOODVILLE each	2.5
SEACLIFF, EDEN HILLS, MAGILL each	2.0
MODBURY	1.7

These are the major metropolitan suburban divisions from which the naturopathic clinic's patients were drawn.

DESCRIPTIONS OF NATUROPATHIC PATIENTS:

Residential Address:

The most striking feature which emerged from the data on residential addresses of naturopathic patients to the Glenelg Clinic was that only 70.6%


LARGS
PARA HILLS
MODBURY
WEST LAKES
WOODVILLE
Main North Road
GRANGE
Torrens River
HENLEY BEACH
FULHAM
Torrens River
KENSINGTON
NORWOOD
City of ADELAIDE
WAYVILLE
LINLEY
PARKSIDE
ANZAC HWY
PLYMPTON
South Road
GLENELG
BOMERTON PK.
ST. MARYS
WARRADALE
BRIGHTON
ST. VINCENT'S GULF

could be classed as residents within the Adelaide metropolitan area. My suburban boundaries extended as far north as Largs and Para Hills and as far south as Marino with a line drawn through Flagstaff Hill, Upper Sturt and Crafers and then north to Surrey Downs. Outside of the area within this Adelaide metropolis, 1.7% patients were residents from other states. The large number of non-suburban patients could be due to the tourist and holiday nature of Glenelg itself situated as it is on the shores of St. Vincents' Gulf and with a popular beach and associated bathing facilities. Many of these visitors could simply have sought naturopathic advice 'on the spur of the moment' or because they have more than the usual amount of time on their hands and were therefore able to seek advice about previously minor troublesome health problems of a sub-clinical nature. Of those Adelaide metropolitan residents, 15.2% lived within a five kilometre radius of the clinic.

An interesting 5.8% of naturopathic patients live in the Henley Beach - Grange area. This is somewhat higher than might be predicted or expected. Many of these patients seem to be in the younger age groups (under 35 years of age) and their attendance at the clinic might reflect an interest in natural forms of therapy or in alternative medicine. This would be despite the fact that treatment at the clinic would not normally qualify for either government or pensioner health benefit subsidy nor come within those offered by private health insurance schemes.

Users of Naturopathy on the Basis of Sex:

Information supplied for the Australian Health Surveys (1977-78) on the utilisation of therapeutic services of a conventional nature suggests that women are significantly higher consumers than men of all services

(except those specifically associated with male therapy).

There seem to be only a slightly higher proportion of female patients than male at the Glenelg clinic (58% : 42%). I can offer no reason for this unexpectedly high proportion of male patients nor can the clinic staff or the practitioner.

Users of Naturopathy on the Basis of Marital Status:

Within Australian metropolitan, suburban areas, statistics suggest that there is a significantly higher proportion of married than unmarried users of health services. It has to be borne in mind, however, that a considerable number of unmarried patients would be children suffering colds and infections.

TABLE II: 'Users of NATUROPATHY' BY MARITAL STATUS:

	%	
NEVER MARRIED	35.3	
MARRIED	55.8	
DIVORCED	2.7	
WIDOWED	3.5	
SEPARATED	2.7	(N=405)

TABLE III: 'Users of NATUROPATHY' BY AGE AND SEX:

AGE IN YEARS	% MALE	% FEMALE	% BOTH SEXES
0 - 9	10.0	5.1	7.2
10 - 19	7.1	2.6	4.4
20 - 29	24.7	37.0	31.9
30 - 39	22.9	20.9	21.7
40 - 49	12.9	7.7	9.9
50 - 59	12.4	19.1	16.3
60 - 69	8.2	6.4	7.2
70 - 79	1.8 (N=170)	1.3 (N=170)	1.5 (N=405)

Users of Naturopathy on the Basis of Age and Sex: (TABLE III)

It is possible to see that naturopathic care is more commonly sought by certain age groups which differ by sex. Women in the age categories 20-29 and 50-59 comprise 37.0% and 19.1% of the total female patients respectively. In the former category, this high figure is reflected in the 31.9% for total users of naturopathy in the entire 20-29 year age group. The highest usage of naturopathic services by males occurs in the 20-29 year and 30-39 year age groups.

Closer examination, sheet-by-sheet, of information from these patients grouped by age and sex, and consideration of the conditions for which they sought attention did not reveal any significant trend towards one general complaint more than any other. It did, however, suggest that many of the females aged 20-29 lived in the Henley Beach-Grange or Glenelg area in relation to the naturopathic clinic concerned. I made a point of driving past a number of the addresses in this area. By far the majority of those visited would be regarded as lower-cost rental accommodation often in older-styled houses, not particularly well-maintained and outside of which a number of vehicles were often parked. Other young people shared the premises.

It is interesting to compare the figures for utilisation of naturopathic services with data on age and sex morbidity data supplied by Hetzel (1964) who discussed health in Australian society and with official statistics from the Australian General Practice Morbidity and Prescribing Survey (1969-1974) and the Australian Health Surveys (1977-1978). In their early years males are higher consumers of conventional medical services than females. After the age of 30 years women are increasingly more prone to seek medical advice and to show a multiple symptomatology.

Users of Naturopathy on the Basis of Occupation:

TABLE IV: USERS OF NATUROPATHY ON THE BASIS OF OCCUPATION.

OCCUPATION	% PERCENTAGE (N=405)
HOME DUTIES	21.0
STUDENT	12.1
RETIRED/PENSIONER	7.2
SKILLED	12.8
SEMI-SKILLED	17.7
PROFESSIONAL/MANAGERIAL	12.9
UNEMPLOYED	4.2

The occupations specified by respondents to surveys of users of naturopathic services were grouped into the categories of: home duties, student, retired/pensioner, skilled, semi-skilled, professional/managerial and unemployed. The individual occupations subsumed under similar categories in the surveys of conventional medical servicing are not specifically defined. Government surveys of usage of medical care suggest that home duties and retired/pensioner-type categories consume a higher percentage of such services than any other group. While these individuals do also seem to constitute a high proportion of naturopathic patients described in Table IV there is no occupational category with a significantly higher usage of naturopathy than any other.

Reasons for the comparatively lower use of these alternative therapies by 'retired/pensioner' or those categorised as engaged in 'home duties' could be related to the conservative nature of individuals within them. Normally the elderly would be retired/pensioners and constitute also a significant proportion of the home duties category. Such individuals would probably carry pensioner health benefit cards entitling them to free conventional medical services. They would have to meet the cost of naturo-

pathy from a limited income. Hence they would be less able to undergo programmes of naturopathic care because of cost.

Users of Naturopathy: Source of Referral to Naturopathy:

Most individuals who begin a course of naturopathic care give more than one reason for deciding to do so. However, most will admit when questioned more closely that the final decision to visit the naturopath resulted from talking either with a friend or after a friend had taken a similar step.

TABLE V: USERS OF NATUROPATHY: SOURCE OF PRIMARY REFERRAL

REFERENT	% PERCENTAGE
no information	5.2
immediate family	15.6
friend	48.6
relative	4.4
news media, T.V.	14.3
previous alternative medical experience	7.7
health shop	3.0
chemist	1.2
doctor	0

Interest created in the news media and on television, and in women's magazines particularly, is mentioned by most people. There is usually some discussion at the time within the family but only 14.8% and 15.6% respectively, on beginning naturopathy, consider that these factors directly contribute to their final decision. Suggestions by a friend or endorsement by colleagues of naturopathy are named as precipitating factors. This underlies the importance of peer group opinion and the individual's need to be seen to conform with behaviour and standards acceptable to the group over and above all other sources of referral.

Users of Naturopathy: Other Medical Habits:

TABLE VI: USERS OF NATUROPATHY - SMOKING AND MEDICATION HABITS

QUESTION	PERCENTAGE (%) RESPONSE (N=405)		
	YES	NO	NO INFORMATION
DO YOU SMOKE?	29.6	70.1	0.3
DO YOU TAKE ANY MEDICATION?	48.9	50.4	0.7

70.1% of individuals who completed Preliminary Information Sheets indicated that they did not smoke. Those who took medication for any problem at all on a regular basis were approximately equal in numbers to those who did not regularly take medication.

The manner in which the patients completed some of the questions about their smoking and medication habits precluded a more direct comparison of their answers with those of respondents to the 1977-1978 Australian Health Survey or comparison with morbidity data, given by Hetzel (1974:12). My figures suggest that a lower proportion of smokers is likely to seek naturopathic care than non-smokers: they would thence be presumed to be more inclined to seek conventional medical care. Most individuals, however, completing their preliminary information sheets in the reception area of the clinic were possibly subject to the influences of the location itself. The organisation of the reception area creates the impression that smoking and the use of drugs or tablets as being 'unacceptable'. The display of natural therapy booklets, pamphlets, pictures about natural therapy, and the dispenser machine for 'Ecco' rather than coffee or tea, accentuate the message of the posters advocating abstention from smoking and outlining suggestions for exercise and "free air" activities. The individual within the reception area immediately becomes aware that smoking and medication

are not habits condoned or encouraged. His answers to questions of these matters could hence be unconsciously modified. Indeed, the naturopath remarked to me in commenting about the questions on the Preliminary Information Sheet that he had once included a question relating to alcohol consumption but had found that the replies given by such a high proportion of patients were so blatantly untrue that he had ceased to include them.

There is no doubt that individuals themselves differ in their personal assessments of 'degree' of conformity. Definitions of patterns of 'regular' behaviour and of drug use may also vary. The naturopath commented that many individuals considered that two Disprin per day taken each morning as a deterent for headache was not worthy of comment: it was simply considered to be 'normal behaviour'.

There are also more deliberate attempts made by many patients to conceal that they have received other treatments or that they are self-prescribing medication to ease a complaint such as arthritic symptoms of pain. Many of the sheets for arthritic/rheumatic patients requiring naturopathy indicate small doses of medication in the patient's handwriting but are followed by practitioners' remarks about additional therapy or a number of supplementary tablets that the patient had not regarded as worth mentioning at the earlier time. When this was pointed out, the practitioner simply replied that many more pretend that they are not even taking any prescribed medication despite the admission of frequent visits to a medical doctor and in the face of contradictory evidence, such as a half-empty bottle of tablets in a handbag. Such behaviour may be due to a fear that the naturopath will suggest that such medication or self-prescribing be stopped immediately. On the one hand, many are reluctant to consciously flaunt a doctor's advice, though they are more tolerant of unintentional ommission of the occasional tablet. On the other hand, they are apprehensive of any anticipated pain possibly associated with complete renunciation of a doctor's schedule of treatment.

COMPLAINTS FOR WHICH NATUROPATHIC CLINICS ARE VISITED:

Following the purely quantitative section of the Preliminary Information Sheets is a section where patients are asked to give descriptions of the complaints for which they have sought naturopathic care. This is followed by a section asking for details of any associated or related problems of a health nature which have been troubling the patient and which may be a product of or a contributing factor towards, the primary presenting complaint. The following tables indicate that approximately one third of patients who visited clinic A required chiropractic or manipulative therapy. The naturopath expressed some surprise with this figure as he had personally expected that there was a much higher number of cases requiring simple manipulation and who were purely chiropractic one-session appointments. When I returned the results of this survey to him he said that he had drawn the attention of his receptionists to this low chiropractic component of the August-September-October servicing for 1980. They had replied that chiropractic services had indeed been low during that period but that a new girl who had not stayed long on the staff had not given Preliminary Information Sheets to all of these obviously one-session patients.

TABLE VII: COMPLAINTS FOR WHICH NATUROPATHIC CARE IS SOUGHT. (N=405)

	FREQUENCY OF PRIMARY COMPLAINTS (%)	FREQUENCY OF SECONDARY COMPLAINTS (%)
CHIROPRACTIC	30.6	25.4
GI TRACT/INDIGESTION/CONSTIPATION	7.4	6.4
ARTHRITIC/MUSCULAR	1.7	3.0
GENERALLY UNWELL/DEPRESSION	24.0	30.1
HEADACHE/TENSION/NERVES	8.6	6.9
DIET/WANT TO GIVE UP SMOKING	8.6	13.3
SKIN/ALLERGIES	6.4	3.2
RESPIRATION/BRONCHIAL	7.7	6.4
BLOOD PRESSURE	2.2	2.7
MENSTRUAL/HORMONAL	2.7	2.5

The practitioner apologised but indicated that he did not feel that the girl in question had had a significant affect on the results because she had only been employed on a part-time basis for a two-week period.

The material from these responses indicates that there appears to be a relatively low percentage of patients who complain of blood pressure (2.2%), arthritic (1.7%), and menstrual (2.7%) problems to naturopathic practitioners. These conditions would appear to be tacitly accepted as being those requiring conventional treatment by a medical doctor. Diagnosis of high blood pressure is normally made by the medical doctor during a routine check-up. An arthritic or menstrual problem will initially be sufficiently pressing and vague for the patient to seek conventional care with which he or she is familiar rather than naturopathic services whose potential in this regard is seldom appreciated. Those who do report with such diagnosed conditions to the naturopath usually express dissatisfaction with previous medical servicing. The Preliminary Information Sheets of diagnosed arthritic and hypertensive patients list histories of conventional medical treatment and prescription medications.

Conventional medicine also seems to be the first recourse for individuals suffering respiratory and bronchial problems. Only a low 7.7% list this as a primary presenting complaint and only 6.4% indicate it as a secondary problem. The possibility of infection in association with respiratory complaints and the consequent need for antibiotic prescription indicates that a medical doctor is required. Those users of naturopathy with respiratory problems, with the exception of one individual (a young child whose mother was also visiting the naturopath), had had a long history of such troubles. Many considered themselves to have chronic bronchitis or chronic asthma. Others indicated on their questionnaires that they were

not happy with prescription medication and had sought naturopathic therapy to see if improvement could be achieved without the need for sprays and tablets with potentially harmful side-effects.

The Preliminary Information Sheets for those individuals reporting skin complaints and allergies indicate only partial satisfaction with conventional care. This is particularly the case in situations which the patient themselves recognise are recurrent conditions such as dermatitis and psoriasis. Commonly, the type of medication used in the past and quite frequently just casually prescribed by the doctor on subsequent visits, without proper examination or investigation for a cause or precipitating incident, is no longer satisfactory. Many of these individuals report considerable and continued success following naturopathic care.

These tables suggest and discussions with patients substantiate the impression that naturopathic services are most commonly sought for many conditions which patients themselves recognise as requiring conventional care. Neither at this or a later time had they been satisfactorily treated. When those conditions which are suggestive of previous medical diagnosis themselves are totalled, we find that arthritic/muscular, skin/allergies, respiratory/bronchial, blood pressure and menstrual/hormonal complaints cover only 20.7% of presenting problems. Substracting this figure and that of chiropractic/manipulative complaints (51.3%) leaves some 48.7% which both the naturopath and myself considered to be more 'purely naturopathic servicing' type complaints.[2] These complaints were usually of a sub-clinical

---

[2] In summating this data and making such a generalisation about the nature of complaints for which individuals seek naturopathic care, I am aware of the errors inherent in generalisations. Since patients' descriptions of problems and diagnoses themselves are somewhat vague at the best of times, I believe that this is a logical manner in which the data can be more routinely 'ordered' and meaningful conclusions drawn.

nature in that no specific and identifiable symptom was always available. Patients with gastric intestinal and lower bowel problems, for example, very regularly also complained of general malaise and gave vague statements about wanting to lose weight or about irregular eating habits.

The high percentage of patients simply stating that they were 'generally unwell' (24.0%) often had difficulty articulating their problems. The naturopath pointed out that their Preliminary Information Sheets were often only partially completed. He indicated that this was not due to a lack of interest or an inability to communicate but more to an inability to define what was wrong with themselves. Often diet, and wanting to give up smoking, were linked, as primary and secondary complaints, with being generally unwell. Headache and "nerves" also tended to be informally associated with diet or wanting to give up smoking particularly in the sheets completed by middle aged women and those listing home duties as their occupation.

To see if further light could be shed on the occurrence of particular categories of complaints within types of occupational groups, TABLE VIII was compiled by cross-tabulation. Unfortunately the results do not indicate any significant association of a presenting complaint with a particular type of occupational category. Women employed in home duties reported being generally unwell in 24.7% of all visits to the clinic while only 2.4% went to naturopathy for skin and allergy problems. On the other hand, 14.3% of those in professional/managerial duties complained of respiratory problems and a surprisingly low 8.6% figure for tension and headaches.

DESCRIBING 'USERS OF NATUROPATHY':

Approximately five categories of 'users of naturopathy' can be identified First and foremost, in numerical terms, are individuals using naturopathy

TABLE VIII: PERCENTAGES OF NATUROPATHIC PATIENTS in a particular OCCUPATIONAL CATEGORY who are reporting designated PRIMARY COMPLAINTS

(N=405)

OCCUPATION	HOME DUTIES %	PROFESSIONAL %	SKILLED %	SEMI-SKILLED %	STUDENT %	UNEMPLOYED %
PRIMARY COMPLAINT						
G.I. TRACT	9.4	13.4	6.7	11.6	8.2	11.8
ARTHRITIC	3.5	2.8	-	6.9	-	-
GENERALLY UNWELL	24.7	25.7	33.3	24.8	30.6	35.3***
TENSION, HEADACHES	12.9	8.6	16.7	4.6	4.1	5.9
DIET, SMOKING	8.2	7.1	3.3	11.6	14.3	17.6
SKIN, ALLERGY	2.4	7.1	3.3	1.6	8.2	-
RESPIRATORY	3.5	14.3	6.7	6.3	8.4	5.9
BLOOD PRESSURE	7.1	-	6.7	2.3	-	-
MENSTRUAL, HORMONAL	3.5	2.8	3.3	9.3	- **	5.9
* APPROXIMATE TOTALS	100.0	100.0	100.0	100.0	100.0	100.0

COMMENTS: * not all totals sum to 100 due to 'rounding'.

** % students report menstrual, hormonal problems which seems to contradict expected problems for the age group normally regarded as students (adolescents) who are normally subject to menstrual and hormonal irregularities.

*** high percentage of 'generally unwell' for unemployed persons who would be expected to be at least mildly depressed and bored: no specific complaint since problem not so much with health but with personal issues.

for the first time after having experienced dissatisfaction or simply limited satisfaction, with conventional medical treatment. By far the majority of patients seeking care indicate that naturopathy is not their first choice. Nonetheless, there are a number of users of naturopathy who do so for reasons of personal commitment to alternative life styles and beliefs they deem to be associated with these life styles. Naturopathy comes within the definitional dimension of unorthodox and 'unaccepted' ideas held in conventional society and which these individuals have claimed to have disgarded. Others of more liberal ideas than many, but not ideologically committed to 'counter-culture' simply advocate are are prepared to use, naturopathic services because they believe that the individual should have a choice of more than one form of 'acceptable' therapy should he so desire. Users of naturopathy are also individuals who have previously, and successfully, used naturopathy or some other alternative medical service. The fifth and final category contains those individuals designated as 'hypochondriacs' by conventional medicine and whose use of naturopathy comes close to that of those expressing dissatisfaction with the treatment they have obtained from conventional doctors.

Individuals regarded as chronically ill or suffering from illnesses diagnosed as terminal or life-debilitating are frequently grouped in the first and largest category. They tend to express feelings of uneasiness about their treatment by medical doctors or express a dislike for some, or any, drug medication. The suggestion of surgery to treat a persistent problem which has failed to respond to other therapy will often be mentioned as an option given the patient by his medical doctor. Fear of such intervention could precipitate a visit to the naturopath in the hope that a less drastic solution might be possible. As long as there is improvement in

their presenting condition, or simply a change in the type of treatment, there does not appear to be any dispute about the form or design of a programme of naturopathic treatment.

A close study of the information supplied on Preliminary Information Sheets and discussion with patients suggests that they consider that there are conditions perceived to be amenable to naturopathic care as distinct from those considered to need conventional medical care. These patients seem to present non-specific, sub-clinical or sub-pathological signs of 'being unwell' and do not see themselves as being sufficiently unwell that they require a conventional doctor to make a house call: they are well enough to visit the naturopath in his clinic.

In other words, patients often recognise states as well as symptoms of being unwell and seek assistance. Diagnoses and treatment by a conventional doctor is based on a history of the complaint, its physical or psychological manifestations and examination to obtain evidence to justify the individual's perceptions of 'being'. However, some individuals have been identified as having

> "a persistent preoccupation with bodily health, out of proportion to any existing justification and with a conviction of disease."
> (Gillespie, 1972:1132)

The label 'hypochondriac' is often attached to such chronically complaining patients and the situation and nature of their complaints. Individuals conferring this label include the attending doctor and/or the individual's family and others with whom he interacts. Mechanic (1968:117) sees such a designation as accusatory in the sense of constituting a moral judgement or condemnation of the patient and his plea for help and as carrying assumptions that

> "the difficulty resides with the patient rather than with the physician's frame of reference or the nature of the interaction that occurs between physician and patient."

Verification of a complaint or proof of authenticity is important to the doctor and to his process of treatment. It is related to the specific orientation which conventional medicine takes.

For individuals undergoing naturopathic care, considerable time is spent in collecting extensive medical histories and descriptions of normal, daily routine activities. Practitioners and staff concede that the nature and intensity of complaints reported by many patients and their previous histories of medical attendance indicate that they could come within Gillespie's definitional frame. However, as distinct from medicine, which seeks a focus for specific treatments, naturopathy is able to offer care without the necessity of categorizing patients as being wholly genuine or otherwise. "Authenticity" or otherwise appears to be a value judgement entered into by conventional but not by most alternative practitioners.

THE USE OF PRELIMINARY INFORMATION SHEETS:

From the analysis of the quantitative data it is possible to construct a 'modal' type of patient seeking naturopathic care. The 'modal' naturopathic patient would be likely to be female. She would probably choose a therapist recommended by a friend who had herself previously visited the naturopath. She would not necessarily live within the clinic residential area though it is most likely that she would live within five kilometres of it. She is likely to be employed in home duties during the day, claim to be a non-smoker and equally likely to assert that she did not take any other medication. Normally she is likely to be a user of conventional medical services but to hold only qualified satisfaction with the care she has received. Her complaint would probably be non-specific.

While such a summary description is misleading in many respects because

it only indicates trends and probabilities, it may give insight into the more qualitative and personal feelings which contribute to and are finally instrumental in the individual deciding to try naturopathy. However, it remains of a limited and statistical nature. Only by holding discussions with patients themselves is it possible that we can come closer to the reasons underlying statements by naturopathic patients about the type of care they seek, why they seek it and see how these many different influences impinge on, and influence, decision-making processes.

Nonetheless, there is undisputably a large psychological element in many of the treatments and supplements advocated by naturopaths. Almost all naturopaths with whom I talked admitted that great importance lies in the patient being happy and 'satisfied' with the type of care he is receiving. It is highly likely that many patients even realise that remedies such as the biochemic tissue salts may be considered to be pharmacologically ineffective, but will report that a treatment programme has been successful for them. One male patient who was a pharmaceutical chemist reported that his treatments had - much to his very great surprise - proved extremely effective for a persistent muscular problem which manipulation alone has failed to repair.

The naturopath at clinic A mentioned that some of his more casual patients who only turned up for the first two appointments were only interested in finding out something about naturopathy. The interest of many young people in particular was cited by him. He suggested that the high figure for users of naturopathy in the Henley Beach-Grange area was the result of curiosity provoked by friends and the media. He showed me Preliminary Information Sheets from a number of young people listing 'diet' and 'iridology' as their presenting complaints.

THE NORMAL DAILY LIFE OF A NATUROPATHIC PATIENT:

In attempting to see how naturopathic care affects individuals who experience it and how it impinges on their existing ideas, ideals and attitudes, I visited two of the patients described in Appendix II as case histories no. V and VI, in their homes and observed them as they went about their daily lives. Initially my visits were purely social as I had become friendly with both Mr. Roberts and Mr. and Mrs. Quin following discussions with them at the naturopathic clinics where they were being treated. It was at a later stage that I realised that a description of two 'normal' patients going about their daily lives would add greater depth to my analysis of the effects which undergoing naturopathy had on them. Since they do not become 'naturopathic case histories' until the subsequent chapter, and it is my present intention to describe their lives before beginning naturopathy, I will refer to them by the pseudonyms rather than by case numbers.

John Roberts lives in a townhouse at Tennyson. It is a two bedroom exposed brick apartment in a small block. One bedroom he uses as a study. During the week he works as the electrical engineering partner of a small firm. His hours are reasonably regular (9am to 5pm) and the pace is rarely pressed. The firm has three large rooms in an old building in the city. Various electrical bits and pieces are strewn around the floors of all the rooms and tools and partially repaired appliances lie on the benches. The secretary is friendly, casual and 'homely'. John's other partners are similarly normal, friendly and family-oriented men content to earn a living and educate their children. John is the only one who has pursued further study and is anxious to improve the business.

After work on two evenings per week, John attends lectures in electrical subjects as units towards an engineering degree. He is very keen to succeed

in his study and is conscientious in his work without being excessively zealous. He realises his intellectual limitations and admits that he finds new ideas difficult to deal with. He claims that he needs patience and tolerance from his lecturers and tutors. He accounts for this by his upbringing in a small country town. He claims he had a happy family life and is still close to his mother who is his only remaining relative. He has a regular girlfriend who is also working and studying part-time. She is a relaxed and friendly girl who is very patient with what many girls would regard as John's neglectful treatment of her. She explained to me that she did not always feel quite as she might appear in her attitude towards John but I had met her in the context of his health problem for which he sought naturopathic care, and she herself had been extremely concerned about him. Hence she was anxious that his worries in that direction be solved.

Before his visits to the naturopath, John ate regular family-styled 'meat and three vegetable' meals with dessert. He was particularly fond of chocolate and yeast buns made by his mother. Her German coffee cake was also mentioned as a top favourite. He was very proud of his Cornish background and claimed that he could eat pasties any time of the day. He had been a regular player of tennis some years ago but with the increasing demands of study he had found that his weekends were often taken up with assignments. Since he lived in his own townhouse, he found that washing and cleaning occupied the remainder of his spare time so that sport had become a forgotten leisure.

Jennie and Neil Quin had recently moved into a modest timber home with a large rambling garden. They had married with the threat of Neil's early death from cancer in their minds. He had undergone extensive therapy and

consulted many conventional doctors. Jennie had been very supportive of him and they had decided that they wished to marry. She was aware that Neil might not live long and that the therapy he had received could possibly preclude their having children. Both had lived normal lives within their families before marriage. Jennie's father had been a storeman and Neil's father had been in the police force like his son now was. They had met at a church function while in their early twenties and had only started going out together some time later.

The purchase of their house had been a considerable expense for Jennie and Neil coming as it did on top of the cost of his medical treatments. It was very simply and modestly furnished mainly with second-hand items, some of which Jennie had repainted. They were in the process of re-papering the loungeroom when I first visited. They planned to eventually paint the house outside, and each room, one at a time, as funds permitted. Seven cats shared the house with Jennie and Neil. Jennie was particularly fond of all animals and Neil admitted that he had a very hard time convincing her to part with strays and hurt animals. He said that the local vet. saw them at least once a week with some damaged animal Jennie had rescued. He was quite correct: during my visits there, a new 'patient' was always being minded until a home was found.

Neil's illness had caused him to transfer from active police duties to the prosecutions section where he was involved in desk office work at a lower rate of pay. He was normally rostered to work on two evenings per week. Jennie worked in a local pharmacy as a shop assistant. She had been there seven years and was trusted and relied upon by the proprietor. She was never particularly busy at work and had very little to do during the day as the pharmacy was very small. In the evenings she would watch television

alone or with Neil. Soon after the start of his course of naturopathy, Neil commenced lectures one additional evening per week in an attempt to gain a senior constable's stripe.

At the weekends both worked around the house or in the garden. Neither had ever played any sport. They did not have very many friends. Those whom they did visit had either been to school with Jennie and lived in the same residential area, or worked with Neil. They called on one or the other set of parents at least once during the weekend. They said that they did not go out very often for financial reasons. Nonetheless, I was of the impression that should the money be available they would not be likely to use it on outside entertainment anyway. Their conversation was simple and mundane: it covered the regular television programmes, the recent Women's Weekly stories, funny episodes which happened at work, and police jokes. It seldom ventured into politics, religion or questioned social problems. It often included discussion of the local neighbourhood gossip.

Both Jennie and Neil admitted that their decision to consult a naturopath about Neil's illness was 'out of character'. Neil indicated that he had reached his limitations with conventional therapy and had not been happy with all the medication he was receiving. They thought that they might have to change some existing habits because it was a substantial departure for them but they had decided that they must try anything for Neil's health.

John Roberts and Neil and Jennie Quin were what I would consider normal young people living in suburban Adelaide and working in stable circumstances. They were cautious, careful and conservative in making judgements about people and ideas. They were not prone to making rash decisions or acting on impulse. Their decisions to approach naturopathy as a course of care were made for medical reasons. While John was more hopeful of

solution to his problems, Neil and Jennie said that they would be satisfied with any improvement in Neil's comfort and well-being.

With their first visits to the naturopaths, John Roberts and Neil and Jennie Quin become naturopathic patients and are henceforth identifiable with this particular world and its kind of organized "arena" (Strauss, 1978: 119). They themselves choose this forum and are putting into motion the sequence of events which will describe naturopathic care. Yet this is not to forget that Strauss's social world, the naturopathic world and John and Neil's presence as patients in the naturopathic social world, are constructed of universes of discourse. They are peculiar to the context in which they occur and are continually changing within this frame. John's and Neil's (and Jennie's) presence within the naturopathic world of itself describe both it and them.

The very 'normality' of their daily lives, their approaches to life and its problems to me so much mirror those of the majority of middle-class suburban Adelaide people that their decisions to use and their experiences with naturopathy must also be similar to those of other 'normal' Adelaide people. Hence the relationship between John Roberts and his naturopath and Neil Quin and his practitioner will be created and will be constructed out of this 'normality' and the intersecting social worlds of naturopathy and their daily lives.

CHAPTER 5:

THE SOCIAL REALITY OF NATUROPATHIC CARE

In the Social Construction of Reality, Berger and Luckmann (1966) provide an analytical framework for examining how an individual builds up his understandings of the world and his place in it and of his social construction of this, his social world and his reality. They construct a model in which it is possible to look detachedly at our 'selves', 'significant others' and reality as processual whole, evolving or emerging more or less under their own impetus from the occasion of the social encounter. The individual uses compromises, trade-offs and negotiations to create the image of a consistently logical being: one which is acceptable to himself so that he is 'able to live with himself' and one which enables him to 'get along with others'. A rather delicate process of continual interpretation of oneself and of one's relations with others and of the expectations that others will have of oneself, is involved.

When the sociological observer looks at deed as well as talk in the context of any encounter, behaviour in a particular situation will take on a special significance and will be either consistent or at disjuncture with proclaimed goals and therapeutic motives of the participants or interactants. Blumer and Rose (1971) looked at the way individuals use symbols, verbal and physical and at the situation, context and content of social encounters to see how individuals interpret the meaning of phenomena so that they may act accordingly. They believe that individuals act on the basis of the meaning that objects, others and situations have for them and that these meanings are the product of social interaction and are arrived at by a process of

interpretation (Rose, 1971). Such an analytical approach tackles questions which include what it means to both practitioner and patient to be involved in naturopathy and how each views his role and evaluates services and what each endeavours to achieve or gain from embarking on the programme of naturopathic care. Explicit verbal statements, actual events and unspoken gestures and perceived impressions that occur or transpire during the encounter take on a new and different importance: they become symbolic of this type of social interaction.

The present Chapter introduces the relationship between the naturopath and his patient in the clinical context.

I describe naturopathic care as a social reality which involves healing care and medical knowledge but during which health ideals emerge.

Within this Chapter I build the theoretical frame in which the interaction between practitioner and patient can be viewed. Initially I concentrate on the interactional setting of the consultation and describe its spatial and temporal components. I then look for a model which encompasses the reality of naturopathic care.

These descriptions of naturopathy are necessary for understanding the processes by which participants construct their realities and set the context for their relations. Associated with, and relevant to it, are the perceptions and understandings which each participant brings to the social encounter. These wider implications are discussed in the Chapter on the practitioner-patient relationship.

INTRODUCTION:

Following Goffman's use of the concept of 'social encounters' (1956; 1967), medical consultations have been viewed as spatially and temporally

bounded events resembling dramatistic performances in which the players perform and their roles emerge as the drama unfolds (Strauss, 1959; Lindesmith, Strauss and Denzin, 1975). This perspective also incorporates verbal and non-verbal gestures and actions as symbols indicative of social relations and behavioural nuances. Since interaction is essentially an ongoing process, the meaning is not fixed but is constantly being constructed during the encounters of the individuals with each other in the different situations. Blumer (1971:3) puts it another way

> "the actor selects, checks, suspends, regroups and transforms the meanings in the light of the situation in which (he) is placed and the direction of his action."

Gynaecological consultations (Emerson, 1971) and phenomena such as obstetric care (Beams, 1977) are situations in which this approach has been successfully used. Since the naturopathic patient and the practitioner come together in a therapeutic situation and context, a similar phenomenological construction in which temporal and spatial boundaries are established and where the participants undergo a series of face-to-face contacts, should be valuable. The consultation thus becomes the 'stage' for the enactment of the encounter in a therapeutic context and the participants or 'actors' assume, on 'stage' the roles of patient or practitioner and come to terms with what it means to themselves, as they 'produce' and 'direct' themselves through the 'performance'.

In other words, I am drawing on the studies of Goffman, Strauss, Emerson and Beams where there is a similarity to the naturopathic situation. The analytical model of Berger and Luckman I later attempt to apply to the construction by the naturopath and his patients of the social process of naturopathic care. Their working out of the meaningful elements of their relationship, their roles in this context and their understandings built up

during it should emerge from the framework.

CONSTRUCTING A 'REAL' MODEL OF NATUROPATHIC CARE:

My approach to naturopathic care involves study at a microsociological level and an analysis of modes and procedures by which participant individuals define social situations (Dreitzel, 1971). Analysis redefines the interactive situation into social space and social time. The naturopathic clinic is the context in which social interaction occurs in this instance and it is where the actors play out their roles. The usual procedure of a consultation or the normal pattern of naturopathic care, becomes a mutual typification or interpretation of and by the participants as they are involved in the given situation. The relevant, meaningful elements of the situation are continually defined and re-defined so that:

> "under the interpretive paradigm, all social reality is seen as the outcome of ongoing negotiation processes."
> (Dreitzel, 1971:xiii)

The initial impressions of a patient presenting for naturopathic care seem to undergo change from those he will give after one, two or more consultations with the practitioner. Understandably, most patients trying an unconventional form of therapy will have had previous experience with conventional medical care and may or may not have an accurate idea of natural methods of treatment. Their pre-conceptions will have been moulded by the news media, notably the tabloid dailies and radio, by the experiences or impressions of friends and relatives, and by their own attitude to current social issues.

Nonetheless, what constitutes normal behaviour in medical situations and what are the expectations of patient or practitioner about naturopathy may be inappropriate to the reality of a naturopathic consultation. The

patient is likely to approach the consultation with expectations phased in terms of past medical experiences with conventional and perhaps, chiropractic or osteopathic practitioners. This is quite logical since the patient accounts for his visit by a requirement for medical care. If all the rules or guidelines for social behaviour in medical situations do not necessarily apply to situations which pertain in naturopathy, there is likely to be some reinterpretation of behaviour and action. Hence, the image of naturopathy which emerges within the consultation, with the experiences and concepts that the participants bring to their relationship, should indicate how closely naturopathy conforms either to the medical model or describes its own unique reality.

THE CONTEXT OF NATUROPATHIC CARE:

The encounter between a naturopathic practitioner and his patient begins with the act of visiting the clinic or consulting rooms. During my fieldwork I visited a number of naturopaths practising in private consulting clinics alone, or in partnership with another naturopath or an allied professional, such as a chiropractor. Others I called on simply rented rooms where they met patients on certain days of the week and pursued other interests for the remainder of the time and some even made appointments to see patients in small rooms attached to private practice. The majority, however, were established as private entrepreneurs in professional rooms or clinics. The description which follows is that of a typical naturopathic clinic associated with a popular and dedicated practitioner who provided advice about naturopathic, chiropractic and related therapies in a middle-class suburb of Adelaide, South Australia. The clinic was well patronised and, while always being accessible to his patients, the naturopath was

was forced by demands on his time, to require patients to make non-urgent appointments some days in advance.

CLINIC A:

Clinic A is conveniently located on a main road near public transport and local shopping centres. It is a converted shop front with curtained windows and a central entrance which leads into a small, cool and quietly decorated reception area. Some four to six chairs fill most of the room and a stand displaying books on diet, natural foods and exercise, together with a magazine table providing reading material are situated in one corner. The remainder of the reception area is occupied by a large, high counter behind which is a continuous desk on which appointment books, a till, pamphlets and cards and general writing materials are kept. A shelf under the counter rim houses bottles of tablets made from tissue salts, and natural vitamin products and bottles of oral drops occupy adjacent shelves. Degrees and diplomas testifying to the practitioner's qualifications and recognition of his acceptance within his profession and in South Australia as a registered naturopath and chiropractor decorate the walls. Soft, taped music creates a quiet and relaxing atmos phere.

The reception area is staffed by two young nurses[1] who are familiar with natural therapies and practices. They wear neat green and white uniforms and no make-up. Their appearance is tidy, their skins healthy and their manner efficient and friendly. Neither girl smokes cigarettes: both believe that natural health foods are responsible for their own good health and well-being. Both believe that the practitioner is 'one of the

---

[1] The term 'nurse' is used by naturopathic practitioners and by patients. Most of these ladies do not possess formal and conventional nursing qualifications.

best naturopaths in South Australia'.

On entering the reception area from the street, the patient is greeted with a smile, even at busy times or when one girl is left alone at the desk while perhaps the other is assisting the naturopath, occupied with another patient or on the telephone. Whether the reason for the visit be simply an enquiry or for making an appointment for a consultation, the individual is received in a friendly manner. The weather or some other general topic may be discussed and if the patient is familiar to the nurses, his health or that of his family are enquired about. I noted that only on rare occasions - even when an appointment is made by telephone - do the nurses fail to express some personal interest in the patient and his activities. This is usually when the patient himself indicates by a brisk manner or impatience that he is in a hurry. The staff may speed up their queries if they are busy and others are waiting but generally those requiring attention are invited to sit down for a short while. The nurses are friendly relaxed and relaxing girls. They say that the practitioner himself is very well liked by his patients and always has time to listen to their problems. They have themselves been instructed by him to always be friendly and approachable and interested in the patients and their welfare no matter how they may feel or how much paper work they have to get through.

General enquiries about naturopathy and chiropracty from individuals walking past the clinic while shopping were said to have increased over the past year. The nurses said that despite the fact that many of these enquiries are simply made from curiosity or because somewhere the person had read an article about natural therapy, they always take time to talk with the person. They said that it was surprising how many of these general queries did at some later date result in an appointment being made with the

naturopath. On only one occasion did I notice the nurse being asked a series of rather ridiculous questions about 'quacks' and the ethics of people setting themselves up to cure cancer and other diseases without 'proper qualifications'. The nurse handled the query quietly and calmly. Fortunately there were no other people at the time requiring her attention. Eventually the man left.

THE INITIAL CONSULTATION:

Initial appointments are usually made with a very brief account of the patient's reason given on the appointment book. A time is set for the initial consultation and the nurses then explain briefly about natural therapy, may offer the patient some pamphlets to read to familiarise himself with naturopathic care prior to the first visit or ask if he has any questions he wants to ask now.

When the patient arrives for his first consultation, the reception nurses, following their usual pleasantries, will give the patient a form called a Preliminary Information Sheet to be completed by him prior to the visit. This generally takes about ten minutes to complete and for the nurse to check. Approximately five minutes later, the nurse will usher him past the curtained area at the back of the reception room into one of five small rooms leading off a long passage. The practitioner arrives shortly after carrying the patient's Preliminary Information Sheet attached to his pin-board.

The consulting rooms are all about 4 metres long by 3 metres wide and painted an off-white. In most there is a padded couch covered by a sheet with a folded cover-sheet at the base of the couch and a pillow at the head. A chair is usually somewhere at the other end of the room and a small table

where there are simple medical and chiropractic tools such as a hammer, a stethoscope and a blood pressure cuff (sphymanometer), and writing materials. Charts showing acupuncture points, chiropractic pressure areas and others with diagrams of health foods, nutritional values and vitamin requirements detailed, line the walls. Fresh air comes into most rooms via small high windows.

The naturopath usually dresses in casual sports trousers and wears a starched white coat over an informal patterned shirt. He greets all patients with a handshake and/or a friendly smile and sits down with them. After exchanging a few trivalities, he starts asking questions about the details which the patient has supplied on his Preliminary Information Sheet. He asks for clarification and elaboration of different points and makes notations on the sheet. He usually asks additional questions regarding the patient's diet, life-style and habits such as whether he takes regular exercise, how well he sleeps, and how does he find his job in terms of physical and mental stress and strain. A conversational manner is adopted throughout this exchange which at this stage is usually limited due to natural reserve between two individuals who have not been long acquainted. The practitioner seems to be careful not to probe and aware of possible sensitive areas of discussion: I noticed him make notations on his sheets on a number of occasions. Some patients were very willing and able to discuss their ailments and medical history in full and with detail.

When the practitioner has completed his questioning and discussion of the Preliminary Information Sheet, he normally asks the patient what he knows about naturopathy and alternative medicine. He then outlines the basic beliefs and theory of natural therapy and gives a brief introduction to the therapies which he feels are going to be relevant to the patient's programme

of treatment. Depending on the degree of interest which he uncovers, he will recommend publications which further explain his methods and naturopathy and will provide some written evidence of the principles and theories he has just outlined. At all times he speaks in a calm, relaxed manner which invites patients to interrupt and question him further should they wish for clarification of any point. It seemed to encourage patients to ask more about therapies than they were inclined to do at some of the other clinics I visited where the practitioners were not quite as informal and approachable. The enthusiasm and sincerity of the practitioner together with his evident good health were mentioned by patients to me privately, as being evidence to them of the effectiveness of his recommendation.

At this point, some patients required obvious chiropractic or osteopathic manipulation in addition to later naturopathic regimes and they were prepared for them. I shall not discuss this area of the practice, as my general interest is in naturopathy. Except for those individuals suffering sports injuries, diagnosed muscular problems or who have visited the practitioner for principally chiropractic manipulation on the recommendation of a medical practitioner, the normal procedure is as I have so far described.

When the patient is satisfied that all his questions have been answered satisfactorily for the present, the practitioner calls the nurse by pushing a bell. She returns with an elaborate camera device which will be used to take an iris photo for each of the patient's eyes. While she is readying the instrument, the naturopath explains about iridology and its role in diagnosis. He emphasises that this is a reliable method to determine an underlying cause for the patient's problems and that it may also reveal other 'weaknesses' in his body constitution. He describes how he uses iris photos together with the Preliminary Information Sheets and his own assess-

ment and questioning of the patient, to come to a diagnosis and design a programme of treatment which will be peculiarly the patient's own: specifically designed about his problems and adapted, if need be as time progresses to meet his needs and suit him. At this stage, some patients are feeling sufficiently confident to ask some 'testy' questions about iris diagnosis and its role in diagnosis as distinct from medical pathology with which they are acquainted or have had experience. Comments I noted included:

> "That's pretty difficult to believe: what actual scientific proof have you for saying what you claim?"
>
> (Male patient, aged 44 years with problem of haemorrhoids, varicose veins and tiredness and lethargy in general.)

> "If that's true and iris diagnosis is so good why don't the regular doctors like my G.P. use it?"
>
> (Female, aged 28 years, complaining of menstrual irregularity and dysmenorrhoea.)

Others show doubt by their facial expressions and restless gestures. The majority, however, are genuinely interested in what the practitioner is telling them and do not seem to be troubled by the two issues I have just raised in the questions quoted above. No-one refused permission for iris diagnosis to be made during the six months that I was associated with the Clinic.

After the photos have been taken and the nurse leaves, the practitioner explains that he has these photos developed and either assesses them himself or if they prove particularly problematic, he asks an associate for his opinion. He will then draw up a preliminary programme of treatment and a diet which he will discuss with the patient on his next consultation, together with details of his present diet. He then gives the patient a sheet on which he is instructed to faithfully record everything which he eats

over the next seven days and how much sleep he gets during the period. The practitioner normally suggests that the patient returns the completed diet sheet to the clinic prior to the next appointment so that he or she can have an opportunity for considering it in conjunction with his other information prior to the visit.

The consultation is now almost over and has usually taken approximately 45-60 minutes depending on the extent of the patient's interest and queries. The practitioner accompanies the patient back to the reception area and suggests that he makes his next appointment in about ten days time.

CONSULTATION 2:

Almost all patients make an appointment for the second consultation immediately after the first and report for these visits at the due date and time. Almost as many complete the diet and sleep information sheet and return it to the clinic before the consultation. Many additionally ask at this time if their iris photos came out well.

During consultation 2, the practitioner presents and discusses with the patient a comprehensive diet schedule specifically designed to suit his personal needs and to conform with his personal work and leisure commitments. Most patients are very impressed by these individual diets and are enthusiastic to talk about and to implement them. Some immediately recognise that there will be problems in catering for their dietary changes within the family - usually men comment on how their wives will react to having to prepare special food: the practitioner usually suggests that the whole family will benefit from the diet as it is designed for general health and to promote natural healing within the patient's body. Others will point out potential problem areas. The comprehensive and quite substantial

nature of some of the dietary changes is not often fully appreciated by the patient at this stage. However, the days following the consultation normally bring a series of queries and telephoned questions concerning items on the sheet specifically or the need to adhere strictly to the suggested regime in general.

Most patients are impressed by their iris photos. They are usually shown their own photo together with a normal iris photo and the problem areas in their own are pointed out and contrasted. The medical complaints which brought the patient to naturopathy is linked in to the causal problems described in the iris photos.

The majority of patients leave Consultation 2 enthusiastic about natural therapy and anxious to commence their treatment programme. In most instances this involves a combination of diet, natural therapies such as hot and cold baths or compresses, meditation or relaxation, regular routine exercises and dietary supplements in the form of biochemic tissue salts, vitamin or mineral supplements. The staff may provide tissue salts where they are suggested by the practitioner or recommend chemists or health food stores where the particular product or a reliable brand is available. Sometimes the naturopath prescribes or supplies oral drops to be taken in conjunction with other tissue salts or to assist the patient with his diet. These are usually of a herbal or homeopathic nature. Subsequent supplies of these products can be obtained at any time should the patient run out of them before or between consultations.

CONSULTATION 3 AND HENCEFORTH:

Most consultations after the initial two are usually concerned with answering questions about diet and making small changes to the patient's

treatment regime or supplements and with administering ancilliary therapies be they manipulative, in the nature of acupunture or simply to deal with another, newer problem.

Consultation time generally averaged around fifteen minutes unless manipulation was required. The practitioner was always most careful and conscientious in his enquiries about the individual's health and his diet. He asked patients if they wanted to know more about any aspect of their treatment or had some more queries about naturopathy. I noticed that, after the initial enthusiasm for something 'new' seemed to have passed and some improvements in health had occurred, many patients became more casual about attendance and cancelled or postponed visits. It was probably because the patient feels better in himself, and he or she is more confident about and has directly experienced naturopathy. The practitioner's answers have become more predictable as the patient's knowledge has increased. There is also a desire to now complete the treatment programme once improvement had been noted. Towards the latter stages of a programme, some patients were observed tapping fingers on the reception counter or otherwise showing signs of impatience if kept waiting. The staff for their part were possibly a bit less attentive to some of the 'regulars' but I noticed that where patients were reasonably forthcoming and friendly themselves, they became quite 'chatty' with the nurses - particularly the older women.

At about the half-way stage in programmes of natural therapy (approximately six consultations will constitute a course), there appears to arise a possible element of precariousness in what has hitherto been a mutually shared 'performance' and a carefully maintained balance of patient and practitioner realities. Once the necessity for sustaining this medical reality no longer exists either due to the complaint being eased or cured,

or the reality itself takes on a different emphasis in the eyes of one of the participants, the reason for their encounter ceases to exist to these participants. This may be due to a number of factors. The patient may be beginning to feel he has learnt all he wants about naturopathy, he has now experienced natural therapies or that he is not being 'cured' as he interprets or understands 'being cured' or 'being treated'. Many patients, initially prepared to try the practitioner's suggestions about diet and natural foods, find it very difficult and inconvenient for their families to continue to observe even minor alterations in food habits. This seems to be particularly the case where the whole family has not adopted the 'new diet'.

Despite the interest and enthusiasm of friends, relatives or close kin who were tolerant to changes early in the patient's treatment programme, and were interested in his new experiences with natural therapy, there seems to be indications of impatience and intolerance which slip into casual conversation or are revealed in attitudes and stances. Patients reported remarks from friends such as:

> "Oh, Ron: don't ask him! He's still on that crack-pot diet for his 'health'."

or

> "She's an exercise fanatic these days: I thought it would be O.K. again once the novelty wore off, but she seems to have changed totally."

These derogatory remarks and the behaviour and stigmatizing by work and leisure associates, the shaking of heads and the rolling of eyes which I myself noticed among friends discussing others who had 'changed their habits' under natural therapy, contribute to weakening patients' resolve to continue and complete treatment programmes. This is particularly the case in those instances where no notable change or improvement has occurred despite best

effots being made by the patient.

The patient in the later stages of therapy seemed to need added encouragement from the practitioner and staff. A couple of practitioners with whom I discussed this problem said that they were aware of a loss of initial interest and enthusiasm in patients. They felt relatively powerless to do other than they normally did in patient management though it was often helpful to slightly alter a treatment programme in the later stages even where not required, simply to maintain interest. They admitted that they themselves are more likely to show a casual and less enthusiastic approach to a patient's problems particularly where the patient himself does not seem to really be trying to 'help himself'.

In later consultations also, patients often mentioned remarks that others have made concerning their diet or some new habit, and which they had not initially worried about. Some complain that natural foods or those without sugar supplements have 'no flavour'. Unprocessed bran, frequently recommended to patients to add fibre to their diets, is called 'chook food' by a significant number.

However, the majority of patients are happy and content with naturopathic treatments and continue a programme to completion. Most report that they are not only free or relieved of their presenting complaint but are improved in general health. Nonetheless, it is towards the later stages of a programme that any doubts and misgivings which the patient may have, or have had all the time in accepting and adjusting the naturopath's concepts of health care to his own life and in reconciling them with his own appreciation of medical care, may begin to crystallise. The ambiguity and conflict between what are new concepts and his own knowledge and experiences of conventional medicines do appear and expectations associated with therapies and internalised early in life seem to emerge.

For other patients there may be no indication of doubt or conflict. The individual may simply keep his own counsel. If he fails to complete a course of therapy, dissatisfaction is the obvious conclusion of all. If he does complete his treatments, satisfaction is a possibility. Unless he actually undergoes natural therapy or visits the naturopath for his next medical problem, or confidently recommends the naturopath to others, the observer continues to remain uninformed.

THE NATUROPATHIC MODEL:

THE EXISTENCE OF MULTIPLE REALITIES:

Naturopathy is a reality which is not expressed purely as a medical process operating in a healing context. Subsidiary or ancillary perceptions of naturopathy are held by participants. By their existence, these differing themes challenge the ordinary reality and even though the probability of incidence of discomforting events is low, they inherently and continually threaten the state of balance of the reality these same participants are constructing.

Clearly there exists different understandings between the participants about the reality of naturopathic care. Berger and Luckmann (1966) do not raise the possibility of any disjuncture or disagreement - covert as it may be - between two or more interacting individuals about the nature, purpose or likely outcome of their encounter and reality of the situation. Goffman's essays Encounters and Asylums (1959) provide apt illustration of these possibilities. Yet Emerson's description of gynaecological examinations (Emerson, 1971) points out that there can be multiple and contradictory definitions of reality and that it is even possible for them to be maintained by series of balancing strategies by the participants. In addition,

> "the ordinary reality may contain not only a dominant definition, but in addition counterthemes opposing or qualifying the dominant definition."
>
> (Emerson, 1971:76)

It is the co-existence of multiple themes - of dominant and subsidiary rather than contradictory definitions - which seems to pertain in naturopathy. The working out of their relatedness to the given situation and over a period of time is continuous.

NATUROPATHIC CARE AND THE MEDICAL MODEL:

Throughout the programme of naturopathic treatment, the practitioner and his staff, familiar with the nature and reality of naturopathic care, as they understand it, control the encounters between themselves and the patient and take the initiative in any procedures of a routine programme. The sincerity and conviction with which the staff perform their duties conveys their belief in the truth of the reality in which they are participating. This does not seem to coincide completely with what the patient may expect.

As he sees it, the patient has surrendered his body and his self to the naturopath for care. His reasons for doing so are medical. His intention is to seek therapy for some degree of ill-health or some specific complaint existing or persisting at that time. This voluntary act on the part of the patient grants the practitioner and his staff the right to carry out what are their normal and routine procedures with the aim - as the patient understands - of attacking his problem.

The individual tacitly accepts these activities as necessary if he wishes to enjoy the benefits of naturopathic care. In other words, there is an obligation, contingent on his placing his self and his body under this type of care, that the patient, in accepting the status patient, surrenders

to the practitioner, the 'management' of his health and the subsequent, related encounters between them. Since the naturopath complies with this reality by accepting the reciprocal obligation to render care to the patient, he recognises and affirms it. As such, naturopathy comes within the definition of medical care and the healing relationship discussed elsewhere in conventional western medical practice (Glaser and Strauss, 1965; Lindesmith, Strauss and Denzin, 1975; Freidson, 1963).

The reality of this medical model is sustained in a similar manner to that which pertains to these more familiar health care systems. The staff, aware of the patient's vulnerability in having granted them access to his personal experience and his body for treatment, maintain the situation by deference and demeanor in the manner. They listen carefully and fully to any patient's expressions of doubt and their questions regarding natural therapy. They are mindful of the need to show respect by gesture, manner and speech (Goffman, 1967). At the same time, friendly verbal exchanges and gestures continue to acknowledge the individual as a person as well as a patient and to maintain personal rapport. An associated attitude of 'affective neutrality' (Parsons, 1951) is required of the naturopath.

NATUROPATHIC CARE AND A HEALTH PROMOTIONAL MODEL:

At the Naturopathic Clinic which I have described, there is within the context of medical care, a very genuine and expressed interest in the individual attending the clinic as a person as well as a patient. As Emerson (1971:75) is aware:

> "Definitions of reality are continuously validated by apparently trivial features of the social scene such as details of the setting, persons' appearance and demeanor, and inconsequential talk."

The friendly, relaxed atmosphere is sustained by the staff who are encouraged

to use a 'vocabulary of gestures' extending from greetings and farewells to enquiries after a patient and his family and interest in his favourite sport or leisure past-time. To quote Emerson again:

> "Many situations where the...definition is occupational or technical have a secondary theme of sociality which must be implicitly acknowledged (as in buttering up the secretary, small talk with sales clerks, or the undertaker's show of concern for the bereaved family)."
>
> (Emerson, 1971:91)

This serves to reinforce the usefulness and necessity for such activity.

At the same time there is an aura of health, happiness and well-being surrounding the practitioner and his staff. They themselves claim to eat as well as to recommend a diet of natural foods, to only drink alcohol in moderation or socially, and not to smoke.

They express interest in the normal diets and routines of patients before and during treatment. They do not concentrate specifically on the presenting medical complaints and problems of the patient but on more general health topics.

The practitioner, while he endeavours to meet the patients' requirements of medical care will do so within his own understanding of what it means to him, a practising naturopath. He introduces natural therapy to the patient together with a special diet and he explains that this will help cleanse the body of waste so that it can heal itself. Since the treatment is not specifically directed at the patient's complaints, the naturopath can justify his therapy by saying that he wants to make the patient healthy so that his body can cure itself of the medical problem. His emphasis is therefore only indirectly medical in nature. He would appear to conceive of naturopathy and its associated therapies as directed at improving, and subsequently preventing, relapses in health. His role is more to promote health rather than to engage in medical care.

THE MULTIPLE REALITY OF NATUROPATHY:

In naturopathy, the subsidiary realities which exist do so not so much as contradictory or counter-themes to the dominant theme (Ball, 1967)[2] but are more of a qualifying nature. The rendering of medical care is the reason for the encounter between a naturopathic patient and a practitioner. Both acknowledge that this is the purpose of their coming together and they collaborate in maintaining it as the dominant theme of their meetings. Throughout their continued encounters, it is sustained in the patient's eyes by his attendance regularly, his compliance with prescribed treatments and his co-operation and attentiveness. The practitioner, for his part, seeks to meet the patient's expectations of medical service within the terms of the reality of naturopathy as understood by him. In this way, he is seen to provide a medical service and is justifying his role as one who may charge for this service.

In the early consultations, the medical theme appears relatively unchallenged. In the initial consultation, the practitioner finds out all about the complaints which brought the patient to him. He takes a thorough medical history and explains how natural therapy is used to stimulate the body's defences to fight medical problems and improve general health. He explains the pseudo-medical technique of iridology and any other related therapeutic regime he may be likely to suggest to the patient. In the second consultation, the patient's medical symptoms are discussed in relation to his iris photographs and a diet is worked out in conjunction

---

[2] Ball describes the situation in an abortion clinic where the medical definition is the dominant theme and yet where it is under continual challenge from the counter-theme - the socially deviant nature of abortion itself. In other words, we have a situation where illicitness is seen to be operating under the guise of respectability.

with the patient's records of his dietary intake and further explanations are given concerning the theory and practice of natural methods of treatment. With subsequent consultations, and as the patient's medical problem(s) show improvement, there is less emphasis on them and significantly less time is spent discussing how they may be remedied. In these later consultations, the centrality of the medical theme diminishes. There is more attention given to enforcing the need for balanced diet, adequate rest and exercise and a calm approach to general living and leisure pursuit.

It is possible thereby to watch the subsidiary preventive health theme develop. However, despite the shift in emphasis as consultations progress within a patient's treatment programme from a dominant medical orientation, the practitioner endeavours to conjointly sustain this reality for the patient throughout his attendance at the clinic. The naturopath usually asks about the patient's original presenting complaint as well as his general health at the start of each consultation. The amount of time spent in discussing the particular complaint can usually be seen to decrease. As the patient's knowledge of natural therapies and treatment improves with reading and following his practitioner's instructions, the naturopath spends more time in answering questions and explaining concepts to the patient than in simply giving instructions and accounting for them in rational language so that the patient will abide by them. A number of individuals said that, at first they were prepared to go along with natural therapy either out of curiosity or because, having decided to embark on this course of treatment, they felt they should give it a fair try, or simply because they had tried everything else without success. Now that they understood what it involved and some of the theory behind its practice, they felt more able to make a rational decision about it.

The subsidiary or ancilliary perception of naturopathy as a method of achieving and maintaining health defines natural therapy as understood by the practitioner and his staff. It is only slowly and gradually introduced to the patient as he provides information to the practitioner and answers his questions. Allowance must also be made, within the context of naturopathic care for the perception by the practitioner and patient, not only of different interpretations or perceptions of this reality, but of differences in their priorities or emphases which appear where multiple themes do co-exist. The relationship between participants, their expectations and what they perceive as their role can be seen to gravitate about these definitions of reality. While the practitioner complies with the patient's understandings by providing the medical service he seeks, his own perception of what naturopathy is about are built up throughout the course of consultations so that they come to present a coherent whole to the patient. What seems to be involved is a re-education process whereby the patient is persuaded to adopt a new lifestyle which, in the long term, will actually eliminate his need for medical care and maintain him in health. The nature and the manner by which this process occurs is the subject of Chapter 6.

There is no indication, at least initially, that the patient is worried that his medical problem - his reason for initiating the visit - may not be specifically the centre of the naturopath's attention, as may be proven by the conventional medical example in which the doctor prescribes a drug designed to attack the patient's particular problem. Most patients seem quite content in consultations 2, 3 and 4 to accept that naturopathy offers advice and suggestions, not drugs and surgery, and to comply with treatments by word and gesture. Almost all are visibly improved in general health and many enthusiastically claim that they have "never felt better". Others do

admit that they find the change in diet difficult to conform to, particularly when in a family or social situation: exercise may be regularly and joyfully pursued at the start of a programme but often interest fails to be maintained. Some individuals frankly admit to having slipped up on the diet or had a series of days where they missed the morning jog. Nonetheless, they still continue to arrive for appointments and to make more. Clearly, at this stage they are satisfied with the service they are receiving[3]. There is acquiescence by the patient and compliance with the treatment regime for the present because the patient seems to agree that, while it may not be quite what he is used to, in terms of conventional medical care, the naturopath's explanations and rationalizations of his methods and procedures are acceptable.

Hence, the reality of the naturopath's encounter with his patient, while medical in theme, is actively sustained by the practitioner's explanations and his design of a treatment regime to stimulate the patient's body to cure the medical problem. Yet, the practitioner's own understanding or perception of naturopathy are phrased in slightly different terms or with different emphasis from those of the patient. These imply that he holds a perception of naturopathy which is at variance in certain respects with that of the patient.

Throughout the consultation sessions, the naturopath has gently introduced and substantiated ideas about preventive medicine and health promotional ideals. He has articulated them as a congruent and cogent theme which underlies and complements but is also subsidiary to the dominant

---

[3] In the series of essays on "Face-to-Face Work", and on service-client relationships, Goffman (1967) raises the issue of satisfaction with service concept. This is further discussed in the later Chapter on professionalism in naturopathy.

medical reality. At this point, this underlying reality augments but does not challenge the medical reality being constructed and maintained by both parties to the consultation. As the treatment programme progresses however, the subsidiary, health promotional theme increases in significance and the two can be seen to be traded off, the one with the other during the consultation.

To use an illustration for clarity: Facial expressions may often convey doubts which a patient may have about the benefits of a therapy that a naturopath may be recommending. One particular patient, a 47 year old man with a constipation and haemorrhoidal problem, agreed that his diet needed added bulk and fibre after the naturopath pointed it out and went through his diet sheet with him. However, when the naturopath suggested that a bran cereal and wholemeal bread would remedy the problem, the patient showed signs of doubt and at the same time as agreeing to add these items to his diet, asked for an aperient so that he would get immediate relief for his constipation. He had seemed to understand the practitoner's reasoning behind the dietary proposals and the fact that these would not only solve his problem but prevent its recurrence while harsher remedies would be only immediately successful and recurrence inevitable, yet wished for a quick medical solution and evidence of cure. The naturopath supplied a mild aperient based on herbal extracts and vegetable products for use "in emergency". He commented after the patient departed, that this gentleman was simply representative of most patients with similar problems: eventually, if they did take his advice and stick to a diet with more fibre and roughage they would find that they did not need to use laxatives anyway.

> "It's simply a matter of telling them and giving them a start: But I guess it's like everything - people only believe you once they've proved it to themselves. What I generally do is to say the same things over and over again in one form or another at each consultation and with some luck, the message comes through."
>
> (Practitioner, Holistic Health Care Centre, Flinders Park.)

CONCLUSION:

I began this Chapter with reference to Berger and Luckmann's thesis of the Social Construction of Reality as an emergent process. They suggest but do not develop the concept of multiple realities which is most relevant to naturopathy. The participants in naturopathic care bring to it different concepts and understandings about it. These are expressed in terms of their 'goals'. In the interactive context of the consultations, I was able to appreciate the existence and interplay of these themes.

Strauss (1978), in discussing 'negotiations' in a number of different situations, comments on the many overt and covert tactics by which individuals in any social encounter, engage in a series of bargainings and compromises which can be seen as more or less routinized within that social world and as implicitly understood by those within it. He concludes that, while these processes express individual and group interplays of power working themselves out, it is the manner by which they do so which repays close study - not just the products or the purpose of their negotiations. This has been done by following the naturopathic patients through a course of therapy (Appendix II).

In the early consultations, a medical reality dominates the encounter between practitioner and patient. In later stages of treatment this reality becomes increasingly threatened by the promotion of health concept. There is a shift in focus from a therapeutic to a health care theme and from a sustaining and caring approach. Just as the interactive locus - the consultation - is where the balance in participants' concepts of reality are negotiated, it is also where their own identifies work themselves out. As the medical theme of the encounter retreats somewhat, practitioner and patient come to confront one another on more equal terms. Their relationship is structured around their perceptions of these multiple realities.

It develops as dominant and subsidiary themes interplay alongside of, and together with, the ideals and identities of these participants: this dimension of naturopathic care is the subject of another Chapter.

CHAPTER 6:

SOCIALIZATION INTO NATUROPATHY

In this chapter I refer to a number of cases I followed from initiation to completion and which are detailed in Appendix II. I intend to use case histories for my analysis of the naturopathic care as a process of continuing socialization (Berger and Luckmann, 1966). I consider strategies of a patient embarking on naturopathy for the first time and that of the naturopath. I explore how practitioners use their knowledge and beliefs to present arguments which are logical and consistent to the patients. They use these to substantiate their therapy and their treatments in terms which the patients understand and can relate to their previous medical experiences. At the same time, reiteration of these beliefs serves to reaffirm their value, *per se* and to naturopaths themselves as they practise.

THE 'GOALS' OF CONTINUING SOCIALIZATION:

Berger and Luckmann (1966) point to the importance of rationality, consistency and logic in arguments to support beliefs which are different from those acquired early in life. They mention the necessity for time and a persistence of contact with these new ideas and new experiences for them to be successfully and lastingly incorporated into the developed psyche of the adult. Of therapists whom I visited and talked with, all record extensive medical histories in one form or another and spend considerable time explaining beliefs and therapies - more so than medical doctors admit that they are inclined to do.[1]

---

[1] My statements about time given by medical doctors to providing explanations of treatments is simply meant to point out that familiarity of patients with medical concepts and conditions described and diagnosed by them, preclude the amount of time being spent in explanation so that a medical consultation would be either of shorter duration or use this time in physical examination, a procedure not followed by naturopaths.

Considering the intimate and very personal nature of illness to the individual experiencing it, any encounter in a medical context will be likely to be deeply and permanently felt. Berger and Luckmann argue that knowledge gained subjectively and experience felt personally is more enduring and persistent than any other. Hence the intensity of a naturopathic experience is important and motivation would seem highly significant. Considerable emphasis also lies in the manner in which new knowledge is imparted. The naturopath is therefore crucial to his own success as a professional healer. This is supported by following Mr. Quin and Mr. Roberts and Miss Bateman through their therapy with their practitioner. The enthusiasm of all was matched by that of their practitioners.

This brings another point to mind. It is interesting to note that in conversation and in questioning, individuals tend to refer to specific practitioners rather than a naturopathic clinic or naturopathy itself. Referrals for care are usually of a personal nature where they do exist and are drawn from experiences of friends and relatives. Individuals seeking naturopathic care implicitly recognise the central role of the naturopath in managing the consultation, the patient and his treatment programme.

Looking at socialization objectively, adult or secondary socialization could be said to resemble a more or less second level process being built onto and into the underlying structural reality instilled by primary socialization and in which profound emotional experience has assisted imprinting and identification. Unless internalization is progressive and thorough, the contents of secondary socialization would be likely to

> "have a brittle and unreliable subjective reality."
> (Berger and Luckmann, 1966:164)

Case histories indicate how therapists continually return to explanations of methods and therapies. Practitioners recognise this need to reiterate and

reinforce the 'natural' message of therapy at any opportunity and in conversation, by booklet or pamphlet or testimonial of other patients. This takes further time in the consultation encounter.

I was interested to notice that staff reinforce this process by answering informal queries about diets and treatments where patients seem to have been reluctant to bother the naturopath. In many instances, staff initiate an exchange - perhaps by simply friendly remarks about diets, the weather or health in general. Often a gentle banter characterises these exchanges...

"How many cigarettes did you crib last week, Mr. Jarrett?"

or

"I thought you said you weren't going to the pub on Friday nights any more?"

A patient may volunteer the information that he actually likes the taste of a natural, unrefined food - he may admit that when he first started his diet he thought that these foods were totally lacking in taste and had no natural sweetness. He may even have referred to unprocessed bran or to wheatgerm as 'chook-food'.

The rapport established between staff and patients from initial visits to the naturopathic clinic prompts the casual remarks and free exchange of confidences. Patients comment on the obvious health and vitality of the clinic staff and their apparent belief in what they claim is proof to them of the effectiveness of naturopathic recommendations for health.

If one views the staff as 'significant others' and as being 'of the world' relating to the specific social situation created by naturopathic consultative context, it is possible to classify them as institutional functionaries making up part of the naturopathic 'social world'. They will be recognised as elements of this experience, and of the institutionalized context in which the adult perceives reality. They are the 'reality-

defining personnel' referred to by Brim and Wheeler[2]: they augment the naturopath's efforts.

It was also interesting to observe that as treatment programmes progressed and the medical reasons for the patients' visits retreated, greater attention was paid to preventive health measures and the merits of continuing with the same regular schedule of diet and exercise after the programme finished. As practitioners talked about their recommendations they seemed to put greater emphasis on how initial treatment was designed to 'cleanse the body' and remove toxic waste so that it could heal itself naturally. They showed how the same basic regime could be modified and thus form a fundamentally healthy way of living and so prevent further episodes of ill-health. This I have referred to as an ideal which is sought as a long-term goal.

By the half-way stage of treatments, patients were sufficiently interested to have read something about natural therapy, to have talked to their friends about their experiences in treatments and to be feeling sufficiently confident to voice doubts to their practitioner. Most continued programmes of treatment until their conclusion. The most definite indication of the impression which naturopathy had on a patient and of the degree to which concepts and ideas had been internalized could be gauged firstly, by the adherence to a specific treatment regime and secondly by the patient's desire to continue with similar or related approaches to their health after the formal completion of treatments. I was able to gain some impression of patient commitment or 'sincerity' by the varying degrees of

---

[2] Brim and Wheeler (1966) identify 'reality defining personnel' of various institutions as being responsible for imparting and enforcing material in such a manner as to ensure it is successfully and permanently incorporated into previously internalized experience.

acceptance of dietary recommendations and of adoption of suggested changes to life style and exercise patterns. Positive statements and agreement with the practitioner during the consultation did not always indicate that a regime was being followed closely, if at all. Many practitioners did not ask their patients directly if they had complied with the diet, for example. Indirect questioning where casual remarks are 'thrown into conversation' seemed to be more successful at reaching a truer assessment of patients' compliance. The manner of the patient was also indicative of likely adherence to a treatment or of commitment to the programme. Mrs. Hall's casual and distracted attitude could be contrasted with Mr. Roberts' interest and desire to learn more about natural therapies than his practitioner had told him in consultation sessions.

A 'trade-off' seemed to be going on in the minds of many patients between, on the one hand, future benefits anticipated by following the health measures suggested and, on the other, consideration of the inconvenience and problems of undergoing such changes. Whether new knowledge and ideas of naturopathy could be incorporated easily and successfully into the existing spectrum of experience of medical phenomena was less obviously being worked out and probably at a different level of consciousness. I could 'feel' patients who were genuinely interested in the logic of their treatments and naturopathic beliefs attempting to come to terms with them and to reassess their reliance on conventional medicine. Their judgements were also influenced by an awareness which many mentioned, of the labelling of naturopathy as 'quackery'. Many still carried reservations about its validity despite practitioners' and friends' statements to the contrary. To them, naturopathy was, at best, just an 'alternative' or secondary sort of care to that which they would choose to use or would give priority should

a crisis arise. Hesitancy, reservation, a lack of complete trust and of wanting to have faith in naturopathy seemed to be generally present in most patients' minds initially and to persist in many patients' thoughts at completion. These constituted intangible barriers to internalization of naturopathic concepts and were only partially dispelled by explanations and rationalizations. Nonetheless, some patients did prove to be amenable and susceptible to naturopathic ideas and to fulfil their practitioners' long-term 'goals'.

Mr. Roberts' case (Case no. V) together with that of Mr. and Mrs. Quin (Case no. VI) who visited a different practitioner, could be regarded as both 'successful' and 'satisfying' experiences for practitioners and patients. Mr. Roberts' practitioner was enthuasiastic in his praise for his patient and his approach to naturopathy. He conceded that such receptive individuals were not the norm and also qualified his praise by stating that he would be interested to see if Mr. Roberts maintained his new approach to living if a new and different type of woman replaced his present girlfriend.

Mr. Quin's practitioner was more qualified in his assessment because of Mr. Quin's long-term prognosis. He admitted that he had been very gratified to see an improvement in his patient and mentioned that Mrs. Quin, in his opinion, had been vital to maintaining Mr. Quin's new diet. He had felt that this was so at the time when she had been brought into the exercise - quite early (Consultation 2) when he had guessed that Mr. Quin needed additional support because his initial enthusiasm was flagging and he had not been particularly well at one stage. He pointed to Mrs. Quin's role, firstly, in joining him completely but not only in his diet but in following meditation classes and some gentle exercises. She had persisted in making

his special fruit juices[3] and with cooking and sharing his special vegetarian and white meat dishes. The practitioner mentioned that he hoped that Mr. and Mrs. Quin would be able to 'see out' their friends' period of frustration with them. He had reassured them that their friends would soon realise that they were indeed in earnest and not simply experimenting or being 'difficult' and would then return to their earlier tolerance. He said he would keep in contact with them.

The practitioner admitted that they were a successful case. He guarded his statements by remarking about Mr. Quin's motivation to naturopathy and pondered on the unfortunate need for such a strong impetus (in his opinion) to make someone persist with necessary changes.[4]

Certain aspects of Mr. Quin's case which I have here elaborated are relevant to my argument that a continuing adult socialization is occurring in a naturopathic treatment programme. Interest on the part of the patient so that there is perseverance with treatment and continuance with a regime is initially related to treating his medical complaint. After that is under control (in the opinion or eyes of the patient!) his concentration on issues less important, personally, and concerning the 'how' and the 'why' of his treatment can be seen to turn to closer questioning of the practitioner.

---

[3] Mrs. Quin admitted to me that she hated all the washing up dishes that the juice extractor made (his diet required a lot of vegetable juices prepared freshly daily). She was determined to keep it up because he was so much better.

[4] The same practitioner who dealt with Mrs. Paterson dealt with the Quins at Clinic C. However his manner of treating his patients was quite different in each instance. He did not attempt to go into detail in explaining his beliefs and concepts and providing explanations of long term benefits with Mrs. Paterson after giving the amount of simple 'accounting for procedure and medication' that I have described in Appendix II (Case no. VIII) and which seemed to be what she required.

I asked him about this difference later (explaining that I had noticed a difference during writing up my case material). He simply replied that "every case was different and so was every patient".

Mr. Quin's Consultations 3 and 4 contained much discussion about the practices and beliefs of natural therapy. Both Mr. and Mrs. Quin asked for books to read about naturopathy in Consultation 3. Mr. Quin returned next time with questions and he seemed able to deal with the professional terms which the naturopath himself used to describe his beliefs more precisely.

Proper understanding of these ideas and the ability of Mr. Quin to fit them within his own existing beliefs of medical and health phenomena will be crucial in determining whether he would have sufficiently taken note of them and incorporated them into his existing store of knowledge and practice to continue with the naturopath's diet, the meditation and the exercise after his formal treatment regime concludes.

Following on naturopaths' statements about ideology and commitment, 'success' for the practitioner depends on a completion of a treatment regime and on continued adherence to the programme outlined for an individual during this regime, (Chapter 2). At this stage (September 1981) Mr. Quin has completed his defined programme and was sufficiently confident of its merits to be seen to be continuing in it subsequently. Hence, his practitioner could validly claim to have achieved a modicum of 'success'[5] in pursuit of his professional 'goals'. He would also be justified in claiming personal satisfaction from having witnessed Mr. Quin's evident improvement under his new regime and from reaffirming his professional commitment to natural therapies. Such personal satisfaction for him would be linked with his performance in constructing the realities of medicine and health

---

[5] As first mentioned in Chapter 1, in discussing concepts of illness, perceptions of 'being sick' and of 'being well' are very difficult to define and so, understandably are understandings about 'being no longer sick' and 'being well again', from the view of both practitioner and patient. Understandings of 'success' in treatment and therapy need to be similarly qualified.

promotion for himself and his patient during the naturopathic process.

The practitioner is able to discuss how he 'feels' about Mr. Quin's case in these terms and how he regards his chances of continued success by the Quins in keeping to their new patterns. This could be regarded as a departure from conventional medical practice. Once a cold has gone and the patient seems cured, treatment is claimed to be a 'success' by the patient and the doctor. The long-term health issues which could be implied by a patient's having succumbed to a cold in the first place and the implications for his general bodily health, are not usually part of the treatment programme for the cold. For the naturopath, it is important to look at the 'total health' of the patient and adherence to a regime after completion of a defined programme or improvement in a presenting medical complaint, is vital.

Hence it would seem that to the naturopath, the elements of 'success' and 'personal satisfaction' are associated with internalization of his concepts by Mr. Quin. The way that the practitioner goes about trying to achieve this seems to be important and relevant to how successful it is. Rationalization processes and the presentation of consistent and logical explanations to validate a treatment and his own beliefs in it are central to the practitioner's approach. Nonetheless, Mr. Quin's naturopath admits that Mr. Quin's motivation is a valuable element in his continued adherence to, and persistence with, the diet. This would seem to confirm Berger and Luckmann's recognition of the force of emotional impetus in successful socialization (Berger and Luckmann, 1966:164). The naturopath talks about Mrs. Quin's role in sustaining Mr. Quin and joining him on his treatment programme. It was Mrs. Quin (Consultation 3) who copied down the titles of the books on therapy, not Mr. Quin.

This raises another aspect of treatment which may characterise the 'more successful' cases though I have no firm evidence of this statement.

It is the importance of the patient receiving support from another individual. I have mentioned before how important the opinions of friends and the peer group are to the individual's decision to begin naturopathic care. Mrs. Quin wants Mr. Quin to be well: she likes fruit and vegetables and she says that she is not particularly fond of meat. She decides to cook the meal which Mr. Quin requires and as the practitioner instructs: and to try it herself. To Mr. Quin, her continued persistence with these changes would be tantamount to endorsement of his decision to follow the treatment programme and reaffirm his own commitments. When she is convinced that Mr. Quin is a lot better and she also loses weight on her new diet, her commitments to the joint regime are renewed.

It is interesting to see that both Mr. and Mrs. Quin show signs of waivering or uncertainty when the attitude of their peers turns from curiosity and enthusiasm to boredom and frustration. The practitioner is careful to counsel them to bear with these difficulties as they will not persist. This underlies the importance to individuals of obtaining peer group approval and even qualified support.

It is relevant to look again at those cases in Appendix II where reasonable 'success' could be detected. Mr. Roberts was encouraged by his girlfriend who assumed a similar supportive role to that of Mrs. Quin. Miss Grant's mother was prepared to let her daughter "go her own way": the practitioner suggested that Mrs. Grant might like to join her daughter in the consultation room and was aware of her importance in continuing to permit her daughter to follow her regime.

Mr. Ellis excuses his inability to persist with the diet and the inconvenience of preparing the type of meals required by saying that he is a bachelor and doesn't have much spare time (Consultations 1 and 3). Mr. Turner would similarly benefit from the support of another or of his

family but his practitioner appreciates that family stress contributes to rather than relieves his problems with headaches and tension.

The other issue which these cases in general, and Mr. and Mrs. Quin's in particular, bring to light is the importance of the treatment regime to the consultation situation. Ultimate 'success' for the practitioner is linked with his ability to establish a good and useful 'working' relationship with his patient. If he can also go beyond building merely establishing rapport to a closer link - perhaps based on genuine interest in naturopathy on the part of a patient - they both seem to find their encounters more satisfying and to come closer to reaching the 'success' goal of therapy.

Mr. Roberts' personality seemed to be very similar to that of his practitioner. Both individuals were careful and enthusiastic about new ideas and keen to pursue them fully if justified. Mr. Roberts found out all he could about natural therapy then went right ahead with it as the practitioner dispelled his doubts. Mr. Quin was determined he did not want conventional medical intervention and was prepared to try anything else. The practitioner needed to give quiet support and gentle endorsement and explanation to sustain his interest and persistence. He only gradually introduced Mr. Quin to each new avenue of his therapy and was very watchful of his progress. He realised that Mr. Quin needed his wife's support and that her endorsement and personal perseverance were vital. This is more apparent in the later consultations as Mr. Quin knows he has improved considerably but will not ever be totally 'cured'[6]. I believe that Mr. Quin's

---

[6] He says that his prognosis is not good. However, like everyone, Mr. Quin - despite statements to the contrary - would like to continue to hold out hope of a 'cure' or remission. His present health is suggestive of a remission but since it seems to stem from the time when his naturopathic care began, I am regarding it as part of the naturopathic treatment process.

practitioner will continue - as he says - to contact the Quins at periodic intervals to see how they are progressing. To me this was a measure of the commitment of the practitioner (and of those whose case histories are detailed here, with the exception of Case no. X) to his work and ideals.

IMPLICATIONS:

My final remarks following analysis of these cases illustrate the process of naturopathic care and, prior to further discussion of strategies of rationalization and how they are important to continuing socialization, pertinent also to another subsequent chapter (No. 8).

It has become increasingly evident to me that in the minds of patients, naturopathy is continually assessed by them relative to conventional medical care. This is understandable since the 'base-world' knowledge and experience of medicine and its values are learned in an environment and in a culture where scientific medicine is dominant. Naturopathy is compared with what medicine offers in the way of treatments and 'success' and of how its explanations for phenomena coincide or challenge those of medical doctors. The realisation of the prevalence and power of the dominant conventional medical ideology is why practitioners of natural therapies phrase their explanations of phenomena in similar language and why they continually refer to conventional medical values. For example, on the one hand imbalances in body energy are correlated with nervous system discharges and vascular disturbances[7] by medical doctors and, on the other hand, the slower nature

---

[7] Acupunture practitioners' explanations of migraines and headaches will usually be related to energy imbalances (Cases no. II and VII for example). Conventional medical doctors could account for migraines by giving an explanation about constriction or dilitation of the blood vessels of the brain. They might explain a headache in terms of excessive nervous system discharges due to tension or an underlying condition.

of programmes of naturopathic treatment is pointed out in relation to expectations for 'success' in terms of days rather than months.

Considerations of a need for naturopathic care, or 'of being sick so as to require naturopathic care' seem to occur after seeking conventional care and begin with attempts to validate naturopathy *viz-a-viz* conventional medicine. The 'success' of naturopathic practitioners in conveying their beliefs and in explaining treatments relates very much to the attitude of the patient himself when he begins therapy as well as to his previous medical contacts and experiences. This is particularly relevant to Mr. Quin who has had a long history of conventional care. Mrs. Paterson presents another side of the picture. She has her own preconceptions of how her care should be organised and what it should involve. She also wonders whether her medical doctor is going to find out about her visits to the naturopath, and about what he is likely to say. As well as affecting Mrs. Paterson's readiness to accept naturopathic ideas, these worries influence her ability to accept the practitioner's explanations of therapy and to evaluate and incorporate these new ideas into her life. The practitioner's awareness of Mrs. Paterson's feelings and pre-conceptions will affect how his provides his explanations and the extent to which he can make them acceptable to her. The manner of providing these explanations constitutes rationalization strategies. The practitioner's 'success' in rationalizing is important to the internalization process and the degree of 'success' in this respect.

EXPLANATIONS OF NATUROPATHY:

The need for sensible reasons to account for observed phenomena and for explanations in scientific terms is part of our modern cultural tradition.

The medical profession and others closely associated with it, capitalise on this need in presenting their opposition to naturopathy. They criticise natural therapy's failure to provide clinical and pharmacological evidence of its effectiveness. They point to the verbal statements which naturopaths offer as proof of the success of their therapies, and to their inability to substantiate these claims. They draw attention to these deficiencies in the popular press, on television and in regular widely-circulated journals. Impetus is added to their criticisms when these doubts about natural therapies and natural remedies are seen as voiced by such highly respected members of the community as medical doctors have come to be. They are not silenced or even mollified by less committed opponents of alternative medicine pointing to the ways in which naturopathic concepts and approaches coincide, collaborate and even affirm - though in different ideological terms - much of the knowledge of conventional medicine. Descriptions of hot and cold foods, of body and earth elements, of energy imbalances and of 'chi' and 'prana' are not only meaningless initially, to the naturopathic patient who is unaccustomed to such language, but understandably disturbing and potentially threatening to those beliefs and concepts of health he has always held.

There is therefore a responsibility on the naturopath to provide explanations which are simple and phrased in terms with which the patient is familiar, even if they are not entirely accurate or pertinent to naturopathy. They are usually made so as to appear based on common-sense logic and so that they do not undermine the early and precarious confidence which the new patient has in his practitioner. The first explanations given to Mr. Roberts and Mr. Quin were simple and straight-forward until both men indicated that they wished or were able to handle more detailed and more abstract naturopathic concepts. In most cases, however, the naturopath is

only called upon to describe his beliefs and treatments so that they reconcile with the patient's present 'base-world' knowledge of medicine.

Barnes (1974) argues that if one works from a basis of present knowledge to which new facts, new observations or new events are added, inductive processing must inevitably produce convergence towards a particular pattern of belief. Realising the limitations inherent in this simplistic model of natural rationality applied to scientific knowledge, Barnes harkens back to Popper's Logic of Scientific Discovery (1934) before deciding that:

> "it is only irrational to hold to a theory if a clearly recognised falsification of it is ignored. Natural beliefs are irrationally held only if they are closed to correction by awareness of the world."
> (Barnes, 1974:25)

Using this framework, Barnes treats rationality as natural or unproblematic and irrationality as criteria in need of causal explanation. He goes on to explore the sociological possibilities posed by the process of assessing rationally-held against irrationally-held beliefs.

This logic is used in the Webb Report. It concludes that naturopathy is 'irrational' due to a lack of scientific proof (Webb Report, 1977:76), despite the fact that it does 'work' for many people and despite the fact that this cannot be disproved. The Webb Committee maintains that, if naturopathy cannot provide scientific evidence to substantiate its claims that "you will feel better", then it can justifiably be labelled 'irrational'. Since there is no 'recognised' support to the contrary, the Committee conclusions bear out Barnes' arguments.

However, as far as naturopathy is concerned, and the conclusions of the Webb Report are worded, statements about 'irrationality' imply 'irresponsibility'. This is not entirely justified in terms of the submissions presented to the Committee or some of the recent evidence tended by scientists in support of naturopathic theories. It seems to be more

than an issue of whether an explanation given by the naturopath to his patient is sustainable or rational, but whether or not naturopathy is considered a valid form of medical care. That seems to depend to a large extent on 'who' decides that explanations or proof are adequate, sufficient or acceptable. It is conventional medicine which demands that naturopathy give proof in its terms - those of a scientific nature - and reproducible in its own laboratories by its own researchers. Hence, conventional medicine mediates relations between naturopathy and society. Its dominant status carries the multiple dimensions of power which I have earlier touched upon.

RATIONALIZATION STRATEGIES AND PROCESSES:

Rationalization processes are involved in explanations which the naturopath gives for what he says he is doing within the process of naturopathic care, what he is actually doing or is occurring as it progresses, why he is doing it and how he is going about doing it. The successful internalization of 'sub-worlds' into the 'base-world' of the patient is closely linked to strategies of rationalization in this process (Berger and Luckmann, 1966:165).

In Mr. Roberts' case, the naturopath says he is endeavouring to treat his hypertension and his lethargy. During the consultations, he recommends that Mr. Roberts alter his diet and adopt a more relaxed and more balanced life-style which blends leisure and work. Diet is the method by which the naturopath initially treats Mr. Roberts. He explains naturopathy in order to ensure Mr. Roberts' compliance with and adherence to his regime. Necessity demands that the naturopath give explanations for his actions. Rationalization strategies are the means by which he does so.

Initially, in his management of Mr. Roberts and of his other cases, the naturopath provides basic and fundamental explanations for his actions and to account for his therapies. They are based on common-sense and are couched in simple, medical layman's language. If these beliefs and these explanations are accepted by the patient, he may indicate, as did Mr. Roberts, that he would like the practitioner to go into greater depth and detail. The practitioner can gauge whether his patient wants or needs further information by his response to his simplest statements, by his questioning, by the logic of his replies to queries and by his interest in the practitioner's discussion. Many patients seem able to cope with the basic explanations of naturopathic therapy and beliefs but are unable to understand more detailed or abstract ideas. This did not appear to be associated with their intellectual capabilities or their motivation towards naturopathic care, but to be rather more a matter of their being able to handle this information. Where there was some difficulty with the concepts, practitioners generally proceeded slowly and carefully. Some even drew diagrams for their patients where acupunture or manipulation or some other aspect of care could be easily pictured. There was adjustment, therefore, by practitioners of the level of their explanations and alteration to their manner of providing such explanations depending on the patient. It was very much a matter of each case being unique in its own right and it underlined the importance of the relationship between patients and their practitioners.

A more objective assessment of these rationalization processes suggests that it is a requirement of rationalization to justify behaviour on the one hand, and to reconcile beliefs or explanations which may appear challenging or contrary to normal, on the other. In the first instance, then the naturopath gives explanations to the patient to ensure his cooperation. He

has also undertaken to treat the patient for a fee. In addition, he believes that naturopathy can assist the patient. While practical reasons account for the first instance, the second carries connotations of obligations entered into and reciprocity discharged. The last implies a link with concepts subsumed under the rubric of beliefs. In this case, the naturopath attempts to organise, order and present concepts regarded as 'irrational' in some circles so that they will appear 'rational'. He does this by using common-sense logic and pseudo-scientific language. He presents his facts to that they are consistent and reasonable despite their unfamiliar and abstract nature.

Together Mr. Roberts and the naturopath worked with ideas and dietary suggestions in order to design a schedule which would cause minimal disruption, minimal dislocation and be consistent with Mr. Roberts' understanding of a method of treatment whose goal is to reduce hypertension and lethargy. While explanations of this nature are certainly given for practical reasons, and are offered within the interactive frame of social relations, they also carry the unwritten message "these ideas are not what you are used to: consider them carefully because they are really just a different way of looking at more-or-less the same thing". A positive judgement is requested.

Hence these explanations involve rationalization with dual goals in mind - the practical and the related acceptance of the theoretical basis for the practical. A modification of values presently held and methods of assessing medical phenomena used by Mr. Roberts was needed so that he would not dismiss naturopathy as 'irrational' because it posed too much of a contradiction to him.

EXPLANATIONS IN RELATION TO THE EVENT:

Another way of looking at the process of explanation and how it relates to the acceptability of naturopathic care is to consider the general ignorance about and lack of information available on, alternative medical systems. Being classed in the realm of the unknown, naturopathy and herbalism, homeopathy and other natural therapies, are immediately regarded as suspect. Most individuals need to be confident that the practitioner himself is competent and worthy of 'servicing his body' or being entrusted with its care, and that the treatments used are safe and effective.

Miss Grant was initially nervous on visiting the naturopath but having found that there was a logical explanation for her own medical problems, and that naturopathic care was based on a common-sense approach centred on diet, in her case, especially, she was no longer apprehensive. Mr. Ellis was even more tentative in initiating the process of consultation and only decided to make an appointment with the practitioner after reassuring himself that the clinic was presentable, the staff seemed to know what they were doing and that he would be able to obtain the sort of care he required.

Further complicating the problem of how naturopathy is regarded by those who have no knowledge or experience of it, is the question of tangible fact and proof of effectiveness to the individual. The respect with which science and rationality in general, and medical knowledge and conventional medical practice in particular, have come to be regarded in Western societies makes it all the more difficult for the practitioner to establish the validity of his beliefs and the justification for a different sort of treatment. Many therapists indicated to me that it was a very time-consuming and difficult task to try and convince people to

> "turn ideas that they have learned from childhood on their head"
> (Mr. N.C., Camden, 1981)

and take a fresh approach even if they are simply suggesting commonsense treatments and their explanations of therapy are phrased in simple conventional medical language. Of note were Mr. Fellows and Mrs. Paterson who found the ideas and the explanations given by their practitioners difficult to reconcile with their own established concepts of what medical care involved.

In another section of his work, Barnes (1974) observed that rationalization rests on criteria beyond scientific 'fact' and intangible abstractions of 'good' or 'bad' and of 'truth'. He saw it as a logical and consistent sequence of purposive action for which justification and validation could be tended either before or after an event. Explanations in the instance of Mr. Turner and Mrs. Hall to account for their recurrent migraines were intended to justify the procedures used and to reassure them of the integrity and knowledge of their practitioner. While Mr. Turner seemed pleased with his treatment and accepted the practitioner's explanations of the therapy, Mrs. Hall was not greatly improved though she had not been overly enthusiastic in following the ancillary recommendations of the practitioner.

Lindesmith, Strauss and Denzin (1975:282) discuss rationalization strategies and behaviour observed in social encounters. They suggest that:

> "a genuine rationalization is a formulation which the individual himself believes to be true even though it may be labelled self-deception by the outside observer."

Mr. Roberts' explanation of his disinclination to go running regularly in the morning because it was 'too cold' and Mrs. Quin's statement that she was 'not particularly fond of red meat anyway' so that the practitioner's suggestions regarding a non-meat diet did not greatly worry her, both come within the area of forms of self-deceptive logic or distortions of the facts. Both of the individuals are interpreting actions and rationalizing facts in simple subtle ways so that their own 'face' or 'self-esteem' is preserved:

a strategy referred to also by Goffman (1959) in speaking about how the individual comes to terms with himself in encounters with others. These rationalizations themselves are therefore very much to be considered within the context where they occur and in their entirety as a dimension existing before, during and after the event.

Much behaviour calls for explanation after the event: particularly that which is unusual or apart from normal 'accepted' routine. In their social gatherings with friends, Mr. and Mrs. Quin were continually called upon to account for their unusual diet and for practising meditation. Their friends regarded them as problematic and called for explanations for continued adherence firstly to meals which made catering for them difficult and secondly, by implicitly challenging their own approach to life by regularly meditating which to them, was unusual, unknown and hence suspect behaviour. It 'distanced' them and put them into a category normally reserved for 'others' rather than friends. Scott and Lyman (1968) discuss instances where there is a need for persons, such as Mr. and Mrs. Quin to give excuses to justify their actions because they are perceived by others as departing from normal accepted behaviour. Such actions could also be considered to call for more than one interpretation, dependent on the situation and the individuals.

If one approaches naturopathy with these strategies and awareness of these slight differences in meaning, it is possible to see more clearly the practitioner's explanations of therapy, principles and ideals as rationalization of a particular form. Explanations of procedures and attempts to justify and present naturopathic beliefs as based on common-sense, logical and consistent with an all-embracing philosophy of life are made in relation to and so as to appear as able to also embrace already-held, accepted principles and theories of scientific medicine. They are immediately seen

to be Barnes' "valid beliefs", which exist beyond scientific 'fact' and tangible 'truth'. In relation to events, they also occur - as he suggests - either before, during or after, in temporal terms. In other words, these rationalizations - perhaps carrying connotations of a defensive nature, of a need to justify and validate or authenticate different conceptual approach to medical care - are different from those used by individuals to 'excuse' behaviour and to account for actions about to be, or having already been, performed.

CONCLUDING REMARKS:

Naturopaths readily admit that they aim to promote health and that their approach to a medical problem is to adopt a broad and holistic attitude seeing it as evident of some aspect of a general body state of well-being. They gently introduce what they perceive to be a healthier life-style centred on diet, regular exercise, fresh clean air and water, relaxation and balance. The individual who undertakes naturopathic care is - at least as I understand it - undergoing much more than a medical experience and obtaining treatment for his presenting complaint. The naturopath presents him with new ideas and a different way of looking at his health and his life. Hence, I believe the consultation involves a large element of secondary socialization and it can represent a 'learning' experience in a rather unique context. Practitioners will even agree that they endeavour to re-educate. If the patient has had any knowledge or understanding of naturopathy prior to his visits, he is able to reconstruct his original concepts as a result of these experiences and at the conclusion of his treatment regime, he will have a new and different perception of naturopathic care.

If one looks at a naturopathic experience from its initiation one can say that the patient's motives in going to the naturopath are the desire to restore total body well-being. There is at least a partial adoption of the 'sick role' or of an 'impaired sick' role discussed earlier in Chapter 1. The novelty of the forms of bringing about this expressed desire to return to health by the naturopathy, require explanation and justification because the patient is a critical, intelligent and rational individual who needs to be able to accept as well as want to have, reasons for 'doing something'. This is all the more important to him in a medical context because of the subjective feelings which he - just like every other individual in society - has about his own 'body' and his own 'health' and 'giving over for care' this intimate area of his own 'self'. In addition, at one and the same time as the patient is evaluating how he feels about naturopathy, the naturopath and 'giving over his body' into the care of the naturopath, at another level he is being presented with a new and different way of looking at medicine and health from that to which he has been accustomed. Of course, he may not want or even be able to realise that these ideas and this new approach represent a challenge which is open for him to take up and resolve within his own mind and in the light of his own past knowledge and experiences. Mrs. Hall was not interested in more than a different way of trying to give up smoking; Mrs. Paterson was also simply just looking at another way of treating her colds and catarrh as was also Mr. Ellis; Miss Grant realised that more was involved in treating her skin rashes than simply treating them when they occurred and Mr. Roberts wanted to understand how he could live a healthier and fuller life without the need for medical intervention or maintenance.

The elements of a 'learning' experience which cast the patient into the

role of a student and the practitioner into that of a teacher, within the consultation situation are by no means as clearly defined as may be implied by my use of these terms. Suffice to say that the ecuational atmosphere in which the health promotional theme emerges from the consultations is sustained by a playing out of an instructional role by the practitioner in the discussive format facilitated by the consultation setting. The consultation provides the context in which the individual, as a patient, acquires knowledge about and experiences aspects of, alternative and natural therapy. The relationship between practitioner and patient - being decreed by the patient and the practitioner as 'medical' - authorises the practitioner in his 'management' of these consultations. He directs and organises their discussions as well as monitoring and controlling his patient's care. His role as 'teacher' or 'instructor' develop out of this managing and controlling function.

In this Chapter I have concentrated my analysis on only one aspect of the naturopathic process which the case histories I detail seem to suggest: that a secondary socialization process is occurring within the naturopathic treatment programme and that this is occasioned by a need on the practitioner's part to explain naturopathy and his own reasons for adopting a 'natural' approach to 'being sick', and on the patient's part, to be seen to have embarked on a form of care for 'being sick' and having experienced and evaluated that care, to be 'improved', 'well' or not much improved in his bodily state. I have hinted at further implications - the importance of the relationship between the practitioner and the patient, and the spectre of alternative medicine as a threat to scientific medicine which lurks beneath verbal statements and patterns of behaviour followed by both parties to the naturopathic process. These I will pursue in the following Chapters.

CHAPTER 7:

THE RELATIONSHIP BETWEEN THE NATUROPATH AND HIS PATIENT

An important theme of the preceding chapter was the importance to naturopathic care of the relationship between patient and practitioner. The very personal nature of this contact is emphasised by the individual naturopath and is defined by the context in which it occurs: it is apparent in the case histories. In this chapter, I wish to look more closely at the interaction between the key participants and examine the naturopath's and patient's interpretations of and expectations for their encounter and their own part in it.

I begin by examining the concept of role in a medical context and the notion of a 'sick' role for the individual who thus becomes a patient. As I have stated, individuals using naturopathic services are usually not ill as far as a state of physical dependency on others is concerned. Most suffer from limitations to their normal activities ranging from incapacity to a general malaise which is inconvenient to them. If we are to follow the implications and conclusions developed in Chapters 1 and 2, this involves the individual assuming a modified 'sick' role and the practitioner adopting a medical as well as a health educational role in administering his services. Hence, I will be looking at the naturopathic context where the label of 'sick' is applied and is adopted by participants and at how they work out their own relationship.

In any social situation where two or more individuals interact, the very fact of their encounter sets up a relationship between them. It is possible to construct a pattern of behavioural norms and expectations which

are consistent with the world views and understandings held by these individuals and which could be described for a given situation. Yet this inherently implies a tendency towards an institutionalised and functionalist stance in which stress is laid on an individual enacting set, prescribed social roles or being expected to show predictable patterns of behaviour in relation to others.

George Mead (1934), in looking at how the self sought to work out its identity in a context of social interaction, used role to describe the processes of co-operative behaviour between the 'self' and 'others. Some years later, Ralph Turner (1962; 1968) took a similar approach and employed a dramaturgical analogy to draw attention to the fluid nature of interactive processes. He stated that:

> "The idea of role-taking shifts emphasis away from the simple process of enacting a prescribed role to devising a performance on the basis of an imputed other-role. The actor is not the occupant of a position for which there is a neat set of rules - a culture set or set of norms - but a person who must act in the perspective supplied in part by his relationship to others where reactions reflect roles that he must identify. Since the role of alter can only be inferred rather than directly known by ego, testing inferences about the role of alter is a continuing element in interaction."
>
> (Turner, 1962:23)

Role taking in interaction is defined by Garfinkel (1967) as a method of reciprocal identification by an individual of expectations associated with a particular role. He describes it as a process which he calls 'documentary interpretation'. Documentary interpretation means that the actors in a social encounter take each others' actions as the expression or document of an underlying relation and patterns of thought. At any particular time and in any situation, there is likely to be re-definition and re-formulation with the occasion. Hence the difficulty of finding an acceptable and definable 'document' is problematic.

Strauss *et al* (1963) studied the manner in which social relations between individuals worked themselves out. These individuals manoevured themselves around the rules, roles, ideals and realities of a hospital, other hospital staff, the hospital routine and the patients. A process of negotiation was involved. It was characterised by continual review by the individuals of their relations with one another and their role in the hospital setting. Within this institutionally created network of social relations, individuals could be seen to continually pursue and achieve stated and approved goals. This method of analysis gave a broader and more fluid perspective to the concept of role and enabling greater variation in behaviour to be taken into consideration. It was also developed in a therapeutic context.

LABELLING ASSOCIATED WITH A 'SICK' ROLE:

The concept of role as used in a medical or illness context is associated with behaviour, expectations and obligations contingent on acceptance by an individual of the label 'sick'. The act of labelling an individual as 'sick' is performed by 'significant others' (Becker, 1973) who so designate his actions at this time.[1]

Scheff (1966) looked at the labelling process and its sociological implications in the context of mental illness. He traced the process whereby a nameless, residual rule breaker becomes publically labelled as mentally ill and how the stereotypes of mental illness learned in childhood and continuously reinforced since, are applied to that individual. Although Scheff's attempt to clarify the processes of social categorization for mental

---

[1] Becker was in this instance actually talking about applying the label of 'deviant' to individual's actions.

illness by labelling theory may be criticised, it does raise the issue of why certain actions are grouped and labelled in certain ways while seemingly identical actions are not. As Goldstein points out with regard to mental illness:

> "The analyst must take into account the role of complainants, victims, officials, and observers in determining how actions have been defined."
>
> (Goldstein, 1979:388)

I consider that in illness the acceptance of the label 'sick' by an individual is a process which ultimately depends not only on the interpretations of others of their past experiences and understanding of what it means to be ill, but on his own perceptions. It may be a more conscious process of negotiation within himself and balancing of likely benefits as against disadvantages of 'being sick'. A lower work load and sympathy from one's family would be balanced by the restriction of one's freedom of movement and activity and lower levels of expectation in the performance of normal social obligations. In this case, confirmation of a label of 'sick' is not simply a result of the actions of 'significant others' who are normally perceived as those who apply it. In other words, whether the sick individual himself accepts the label, the extent of acceptance by him of such labelling by others and how it differs from normal labelling processes, becomes problematic. Contradictory interpretation or opinion would hold depending on whether the individual confering such a label concurs with the illness beliefs of the individual on whom such label is conferred and *vice-versa*. Willingness by an individual to accept or reject a label would be related to his own assessment of the benefits and advantages to him which would accrue from being designated 'sick'.

THE RELATIONSHIP BETWEEN PRACTITIONER AND PATIENT:

While the interaction of practitioner and patient is the focus of medical knowledge and social action, each of these bring to their encounter experiences and conceptions which are the product of internalization of earlier encounters with and experiences of 'being sick'.

Parsons' model for viewing social interaction and the concept of role invokes the image of mutuality and balance in reciprocal relationships between individuals. However, extensive studies of the patient-doctor relationship in the therapeutic context suggests that there is an inherent asymmetry. If we are to follow Bloom and Wilson (1975:318) this imbalance or 'leverage' on the part of the practitioner is a product of:

> "professional prestige and situational authority of the health agent and the situational dependency of the patient."

Parsons contends that the physician's power is rooted in his having what the patient wants and needs and this suggests a passive dependent role for the patient. Szasz and Hollender (1956) however, construct three basic models of practitoner-patient relationships for particular medical situations. These are seen to be those of firstly, activity-passivity; secondly, guidance-co-operation and thirdly, mutual participation. Although such categorizations may be criticised justifiably as being static and excessively simplistic, relations between naturopathic practitioners and their patients show some similarities which would permit them to be so grouped also.

In a professional sense, a naturopathic patient is 'worked upon' by the practitioner in a similar way to a medical patient. He is the 'object' of treatment: his function in the ministration of care is as a 'passive recipient'. Yet, the practitioner seeks to 'involve' the patient in formulating his diagnosis, working out a diet and a treatment regime and in

thinking about his medical problem in relation to his total body health. When the naturopathic patient actively takes up the suggestions of diet and regular exercise and adheres to a medication schedule under the guidance of the practitioner he is performing within the guidance-co-operation criteria of Szasz and Hollender. Within my detailed case studies, Mr. Roberts and Mr. and Mrs. Quin illustrate the process of discussion and co-operation between patient and practitioner while Mrs. Hall and Mr. Turner assume a more passive role in relation to the active role of the practitioner.[2] They listen to their practitioners and answer questions but do not follow his arguments for discussion or seek to conscientiously implement their suggestions. Since, in my experience I found no ventures in which I could say that the practitioner and patient both underwent a programme of treatment together - my own interpretation of 'mutual participation' - I do not feel that this category is strictly relevant to naturopathy. Nonetheless, to take a position beyond the professional context in which I have been studying naturopathy, it would be possible to see the pursuit within the practitioner's own private life, of the ideals and dietary and life style recommendations which he makes to his patients and to others. This participation in a programme similar to that which he advocates for others and his patients constitutes a category of 'mutual participation'. It also confirms his own ideological commitment to naturopathic beliefs.

Discussion of co-operation and whether or not there is involvement, guidance or participation by both parties to the experience raises the question of whether the consultation serves more as an occasion for patient

---

[2] The nature of Mrs. Hall and Mr. Turner's treatments - acupuncture - facilitates this assumption of role categories. However, it is not this aspect of their programme but that of their attitude to the supporting advice given by the practitioner, which has resulted in my assignment of them to their grouping.

and practitioner to build up their own relationship - and it is this which is an essential ingredient to 'successful' treatment - or whether it is the occasion where treatment is either 'handed out' or 'decided upon' depending on whether the patient being a Mr. Roberts or a Mrs. Hall. In this situation, information-giving by the practitioner, questions tended by the patient, points talked about and natural therapy beliefs explained proceed at a 'visible' and obvious level: the level of discourse. The 'real' purpose of the consultation - the construction of a trusting relationship to which the patient feels inclined to commit his whole body and his whole health, rather than just one facet of it - proceeds unimpaired and on another plane.

The final essay in Goffman's Asylums (1972) discusses the medical model and mental hospitalization. It raises a number of points relevant to the 'giving up' of the body, by an individual for medical 'repair' and describes, in Weberian terms, what he defines as the basic nature of a 'service' relationship where

> "some persons (clients) place themselves in the hands of some persons (servers)."
>
> (Goffman, 1972:326)

The elements of a medical service relationship in institutional psychiatry gravitate firstly about the nature of the practitioner and patient relationship in a repair cycle. The second problem is the concept of a fee for service and its effect on that relationship. Thirdly, Goffman assumes the practitioner's stance by regarding him as a disinterested observer in the interaction of the client and a medical professional (in actuality, the practitioner himself). Aware that there are conceptual assumptions which pertain to all service relationships, Goffman emphasises those which he feels most underlie the medical 'repair'. They include individuals' concepts and thoughts about their own body and its being, together with individual

attitudes to life and death. The individual undergoing naturopathic care will also find that he has to deal with these and other similar issues.

The naturopathic patient does not seem to have any reticence about undergoing his treatment once he has made on appointment and attended his first consultation. The problem seems to be in deciding 'if' and 'when'. Dissatisfaction with medical doctors, is shown, in many of the case histories and is revealed with curiosity in patients' responses to questionnaires. The desire to "do something different" or to "try something which friends have not", all contribute to turning the 'if' into 'when'. In Case no. IV, once initial wariness is dispelled, Mr. Ellis decided to try naturopathy: Miss Grant also showed caution as did Mr. Turner, even Mrs. Paterson and even Mr. Roberts.

Yet these statements carry a need for qualification: a qualification which assumes that nature more of question than answer. This centres on the degree of 'success' of a treatment programme in terms of improvement in the patient's presenting condition or as apparent in the patient's appreciation of the benefits of his own contact with the naturopath. It is related to the patient deciding 'if' he is 'sick so as to require naturopathic care' before he decides 'when' and 'if' the naturopath himself will be able to assist him. Patient motivational problems compound and confound simplistic interpretations based on a concept of 'being sick so as to require naturopathy' rather than or instead of conventional medical care.

These issues apart, the crucial time therefore would seem to be when the individual decides to make an appointment with the practitioner. The visit is the act of commitment of the 'body' or part thereof, to the practitioner so that he becomes effectively, Goffman's 'client' in the medical service context. Contingent upon this act, the patient has accepted both

the need for 'repair' and the obligation of paying for it. In other words, the fact that, of their own volition, individuals attend naturopathic consultations and assign themselves into a naturopath's hands in a manner similar to that which they would do when visiting a medical doctor means that they perceive naturopaths as 'healers' whether they be 'alternative' or conventional.

Parsons (1951) claims that the medical doctor needs to maintain an attitude of affective neutrality in order to protect hsi own status in a therapeutic relationship. This is balanced by a need for flexibility and for friendship and rapport between himself and his patient so that confidences are exchanged and information honestly and freely provided by the other. The doctor controls the interview situation by virtue of his role as provider of care and of medical service. He can be seen to carefully 'manage' his patient, to organise his therapy and at the same time show sensitivity to socio-cultural and inter-personal facets of the patient's problems (Mechanic, 1968; Bloom, 1963; Freidson, 1970).

Blumer (1962) also draws attention to the organisation of professional interviews and medical consultations. On the surface, there would appear to be a similarity between medical doctors and naturopathic practitioners in the initial fact of their performance in similar therapeutic contexts. However, I believe that to accept this situation as it stands would be an unwise assumption. Indeed, Kuhn (1962), in discussing the relationship between social workers and clients as revealed in their interviews, pinpoints differences in the relationship from that of a medical consultation. Despite a claim to operate in a similar therapeutic context, Kuhn attributes to the patient in a medical relationship, a greater degree of co-operation and motivation to alleviate illness than he finds in social work. The

voluntary method by which the physician 'accepts' a 'patient' for care is contrasted with the 'assignment' of a 'client' to a social worker. Kuhn seems to feel that the terms used by social workers to describe persons placed in their care is unique to a therapeutic situation. In addition the manner and structure of the interview with a client, will be organised to draw attention to where authority and control lies. The social worker chooses to modulate or tailor his relationship with the client by such ploys due to the necessarily intimate and personal involvement required of him, in the client's life.

While the individual attending naturopathy becomes a 'patient' for a 'consultation', the practitioner is referred to by the staff at many of the clinics I visited by his personal name rather than any title such as 'doctor' or 'therapist'. At Clinics J and G, christian names were even encouraged. Particularly when he was dealing with children, Mr. N.A. introduced himself by his christian name rather than as Mr. N.A. or some other term. He was at pains to establish friendship on the same level as his patients - he remembered children's favourite games, their 'imaginary' friends and school pals. It seemed more than simply wishing to establish rapport. He did not need to consult his records to remember their names: he asked after their families and about their work. His casual dress permitted him to pass as an individual in the same sense as in a non-medical encounter. At no stage did I see him formally interview a patient by sitting behind a desk in a chair with the patient seated on the other side. Most other practitioners, at some stage during the treatment programme did assume the more formal stances and attitudes of an interview situation whether in a separate room or within the normal consulting area.

When asked about his approach to his patients, Mr. N.A. admitted that

it was deliberate and intended to facilitate an easy exchange on a one-to-one basis, regardless of age, but added,

"I also like people and I want to help them."

Mr. N.A. was obviously less formal than most practitioners engaged in regular consultancy. Those who adopted similar though less marked behaviour to make patients feel at ease tended to be those who did not always have formal qualifications nor practice on a full-time basis.

Another area in which the naturopathic practitioner can be seen to 'manage' his patient lies in his structuring of that individual's expectations of therapy and of its effects. The clinic staff and the practitioner explain the beliefs and aims of natural therapy. Since the medical effect desired by the patient occurs as a result of natural body healing mechanisms being stimulated by following the naturopath's treatments, he (the patient) understands that any improvement or any 'cure' of ill-health will necessarily be relatively gradual. Potential tension in the naturopath-patient relationship associated with anticipation of an immediate improvement in health once therapy begins is dispelled early in the treatment programme. The time for a course of naturopathic care, embracing as it does diet, lifestyle, physical and mental re-orientation, is extended from days (which is often the length of a course of conventional medical treatments, e.g. antibiotics) to months. A more fundamental behavioural change is sought by the practitioner and of necessity this also requires time for it to be effective and long-lasting (Stanway, 1979). Often the patient simply wants therapy to improve the immediate problem or as a palliative. Mr. Ellis and Mrs. Paterson, for example, both sought the type of treatment - tablets, medicines or sprays - to which they were accustomed and which provided a quick and easy solution.

They were not particularly interested in looking at the longer-term

proposals which the naturopath's suggestions presented. To quote from another patient, a Mr. Burrows, a Brighton resident, aged 47 years who attended clinic B:

> "He told me it would take six months to fix my piles properly - that was a whole lot longer than I reckoned on. The surgeon said that I would be O.K. inside of four weeks after an operation."

Miss Graner, living in Norwood and a patient at clinic C realised the need for a longer term approach to solving her acne problem:

> "I knew that my acne would take a while to heal anyway because whenever the doctors gave me some antibiotics and a cream, that took at least a week. But it all came back as soon as the course finished. The local chemist suggested that I try the naturopath because I wasn't keen on taking all those antibiotics and using a cortisone on my face. The naturopath told me my whole system needed a 'clean' out. He put me on a diet (though this wasn't much different from one my doctor had also suggested) and gave me some vitamin and mineral supplements (zinc, I think) and suggested ways to cleanse my skin thoroughly. He told me I shouldn't expect much improvement till about 3 weeks after starting. He also said I should start playing tennis again and get out more in the fresh air."

Hence, it was often possible for me to detect an underlying apprehension and even frustration expressed in unintended gestures or questions about length of a treatment and whether it really is necessary to completely eliminat coffee or sugar from a diet plan. Most individuals want and expect improvements sooner than antural therapy claims is possible. Most practitioners explain that their methods are slower and more gentle than those of conventional medicine. Nonetheless, in talking with patients, I found that they were often disappointed or even impatient for more dramatic results. This was particularly evident once initial enthusiasm had worn and for those individuals who had not fully understood or listened to their practitioner's explanations of naturopathy.

In conventional medical doctor-patient relations, Freidson (1962) detects a variety of tensions and describes them as causing

"a counter-vailing dilemma in the doctor-patient relationship."
(Freidson, 1962:207)

In the case of Mrs. Hall, tension is evident in her approach to her treatment and the naturopath. She did not seem to be undertaking the programme of her own will: she is also apprehensive and uncertain of acupunture. Yet in later consultations tension is also brought to the consultation by Mrs. Hall herself. Eventually it turns to indifference. In Mr. Ellis' case, there is an obvious inability to think in terms of the practitioner's approach to his problem - that of a long-term alleviation of the need for sprays and tablets, and a decreased tendency to be afflicted by respiratory problems. Mr. Ellis continues to think in terms of medication to relieve his problems. The failure of the two to accept or come to a compromise regarding the other's view introduces friction.

Usually, however, in a medical situation, tensions seem to centre on patient's perceptions of the severity of their illnesses and related prospects for 'successful' treatment by the doctor. This is associated with the issue which I raised earlier in relation to the time-scale for 'successful' treatment to be achieved. This potential tension in the relationship is balanced, on the other hand, by the control of a patient and his care, existing, as well as being seen to rest, in the hands of a sole practitioner or physician. This sets naturopathy apart from conventional and specialty medical practice as well as from those institutional situations where the patient is handled by a large number of different individuals (Freidson, 1970; Strauss, 1975).

In illnesses which patients define as critical and potentially life threatening these 'irritations' become tensions rather than simply minor and transiroty inconveniences. Since a larger proportion of patients demanding the care of a medical doctor do perceive their ill-health as being

life-endangering than those who seek naturopathy, there should be potentially less tension therefore in the naturopath-patient relationship and coming from this source.

The extent to which this hypothesis would be borne out is not easy to gauge without comparison of similar situations involving consultations of patients with naturopaths or medical doctors in which the observer could objectively assess actual relationships. The success of such evaluation is, in itself extremely problematic in my opinion and would require considerable substantiating and related research.

Apart from the difficulties inherent in therapeutic relationships and which are applicable in varying degrees to the naturopathic context, there are the obvious tensions due to the different perceptions which patient and practitioner bring to their encounter. The resolution of these tensions in, and the negotiation of, their disparate realities has been discussed in Chapter 5. But it is the interaction of these participatns which has been the central focus of these last two Chapters.

DISCUSSION:

In a similar comparative vein, the naturopath, unlike a medical doctor, does not seem to have the same incentive or need to maintain 'distance' from his patient to the same extent, for his own protection of his 'self' and his own 'involvement' in a professional sense. He benefits from free and easy discussion with his patient of the wider dimensions of his life beyond his medical symptoms. It can be argued that the naturopath is able to establish a closer rapport with his patients because of his need to obtain information about the patient's normal diet and lifestyle and to ensure the patient's co-operation in promoting his total body health.[3]

[3] I am aware that many medical doctors will maintain that they pursue the same objectives in long-term patient care, in particular for individuals who they perceive as being 'their patients'.

By forming a closer relationship as someone who is interested in someone else's life - as well as simply his presenting complaint - the naturopath potentially is able to bring more personal satisfaction than the medical doctor into the therapeutic encounter. Mr. Roberts and Mr. and Mrs. Quin were well satisfied with their care. Mr. Roberts was greatly interested in, and encouraged by, natural therapies and his encounters with the practitioner were characterised by warmth, friendliness and a lack of formality. He himself said that he felt free to discuss any problems. Mr. and Mrs. Quin's visits were slightly more formal.[4] However, they themselves stated that they felt relaxed and confident in the practitoner's consultations after the initial nervousness had passed.

Inevitably such discussion of 'satisfaction' in regard to social relations and individual interactions comes to centre on the individuals themselves and their attitudes and receptivity to one another. While the medical context determines that the encounter will occur, the degree to which ideas are examined, received or internalized will be profoundly affected by those unspoken words, gestures and tacit acknowledgements which ultimately direct human perceptions into actions and this becomes part of the individual's feelings about whether his care is or not satisfying.

By virtue of the sort of conditions which he is able to treat, the naturopath would seem to have greater potential than the medical doctor for also contributing more of his own personal 'self' to the relationship and thereby extending his role beyond that of doing simply healing work. This means that for him there is a conflict between discharging 'caring', as well

---

[4] The slightly more formal appearance of their visits I feel was largely a function of the practitioner himself: he was a less gregarious and 'charismatic' individual. He was quietly confident but cautious in describing his beliefs. His personality suited - in so far as the choice of this word is suitable - those of Mr. and Mrs. Quin.

as the professional, duties and performing 'medical work'. Beams (1977) decides that a similar dilemma exists for staff and patients in obstetric wards and that it detracts from their personal satisfaction in childbirth processes.

In cases where manipulation is indicated to underpin or to supplement a programme of naturopathic treatment, the patient is very obviously 'worked' upon by the practitioner in a more literal sense than Strauss implies in his analysis of the medical relationship (Strauss, 1975). This is in a similar sense to the medical patient. He is a focus for an activity directed primarily towards healing what has gone wrong and only secondarily towards the manipulative treatment and associated programme of natural therapy. This is also the case where hydrotherapy or hot and cold baths or saunas can be said to give the patient the impression that 'something is definitely being done' whereas diet alone and suggestions of ways in which he can re-organise his life - while they may be more fundamental and integral to naturopathic care - fail to create the similar element of satisfaction which the medical patient reports when he leaves his doctor's consultation with a pharmacy prescription in his hand.

These diverse elements of my argument can be drawn together to close this discussion by looking away from and into the naturopathic process and the practitioner-patient relationship. I feel that it becomes a question of deciding about the importance of the practitioner himself to the 'success' of the treatment, to the patient's 'satisfaction' with treatment - here as previously I maintain a distinction - and to the elements or components of a naturopathic programme. These programmes, of themselves, must contribute to 'success' and 'satisfaction' for the patient in some indefinable way.

The naturopath himself, therefore, may not be more genuinely concerned

and more highly motivated towards meeting inner needs of a patient than the medical doctor: he is simply doing his professional duty as he sees it, as he has been taught and as his profession perceives it. By thereby removing the element of personal commitment from the treatment, one can more easily assess naturopathy as a form of care *viz-a-viz* other forms of therapeutic care. I can only suggest that what seems to be a component of greater personal satisfaction for naturopathy is in fact a part of naturopathy and is not necessarily associated with any individual practitioner or with some other subjective aspect of a programme of care.

In the previous Chapter, I paid some attention to rationalization being utilised, during programmes of naturopathic care with varying degrees of internalization being achieved. While I mentioned the importance of the form and the format in which explanations are presented I concluded that the participants to the encounters - the practitioner and the patient - were themselves the determinants in any evaluation which involved elements of 'success' and 'satisfaction' with treatments.

The amount of explanation, rationalization or simply response to question ing can be seen to vary with each patient. The practitioner may need to spend a lot of time - as he does with Mr. Roberts and Mr. and Mrs. Quin - in telling them about naturopathy and its beliefs. Then again, he may need to spend very little - as in the case of Mrs. Hall. Even in the initial stages of her programme, Mrs. Hall seemed slightly distracted and did not concentrate on what the practitioner was saying very intently. She did not question the practitioner so that there was little need for the practitioner to do more than simply explain the mechanical functions of her role: inserting acupunture needles and, as Mrs. Hall reasoned, it was the

needles which would help her give up smoking.[5]

The practitioners in both Mr. Roberts' and Mr. and Mrs. Quin's cases needed to spend considerable time during the consultations in their instructional role as well as in actual administration of therapy (which was, for these patients, largely dietary). Because of the nature of their therapy, these two cases do not give a good guide as to how medical and health promotional roles are played out in the consultative situation.

Mr. Turner and Mrs. Allen both underwent acupunture for a similar complaint. For both patients, insertion and monitoring of the needles - the administration of therapy - was accompanied by reassurance and explanation, and instruction by the practitioner of the patient, in the nature of acupuncture and how the patient could reorganise his life so as to minimise the chance of recurrence of migraines. The relationship between patient and practitioner involved both therapy and learning. While in the early stages of both individual's treatments, it was mainly concerned with instruction about acupuncture and natural therapies, in later consultations, explanations and discussions seemed to be of a less didactic and more of an exchange nature where the knowledgeable tells the learner about something new. However, in many cases, such as Mrs. Hall's, the relationship never reaches this juncture. Mrs. Hall's moderate indifference became disinterest so that the practitioner did not need or was not required to talk about therapy, naturopathy or acupuncture and could not share in any instructional

---

[5] In Mrs. Hall's case, despite the practitioner repeatedly saying that smoking was a habit which must be broken with will-power and effort on the part of the patient, and that the acupuncture was simply to assist in relieving stress and tension imbalances which had and would build up as she was trying to give up smoking. Mrs. Hall seemed to think that the needles alone should take away her desire to smoke. This 'feeling' was gained by both myself and the practitioner.

capacity to augment therapy.

The practitioners themselves commented on which patients requested information and whose visits they found the most rewarding and satisfying, regardless of the final outcome or 'success' of the treatment programme. In Mr. Turner's case, both practitioner and patient agreed that they had done all that could be done with treatment and that further improvement rested on Mr. Turner's home conditions improving. The practitioner indicated that he found this case quite rewarding, if not successful, because both he and the patient seemed to come to common accord about what was wrong and how best it could be dealt with.

A large element of 'satisfaction' for the practitioner, on the one hand, and the patient, on the other rests in that component of their consultations where explanations are provided, instruction given and both parties work together in devising a specific regime. In working out treatment, the practitioner is directing and assessing - he is in 'control'. The patient is responding and co-operating with him by taking on the role of someone learning about "working out a treatment regime". He is also the person for whom the regime is being "worked out". That is, as well as being the patient in the medical situation, he is the student in the educational context. Their relationship seems to have more potential for incorporating facets other than the purely therapeutic which is usually the dominant feature of a conventional medical doctor-patient contact.

CONCLUSIONS:

I consider that the most significant sociological difference between the practice of naturopathy and that of conventional medicine lies in the relationship between the naturopathic practitioner and his patient. This

emerges during their treatment consultations.

A conceptual reality of naturopathic care develops from the interactive process and at the same time, the practitioner and patient can be seen to come to terms with one another. Hence there are two components to any analysis of the practitioner-patient relationship during natural therapy. On the one hand, there is treatment of the relationship itself. On the other, there is to be considered the roles of the interacting parties to the relationship. Both involve subjective and objective assessment of the treatment process.

Largely by virtue of the context in which it is established - an individual seeking care for his body and the intimate associations and implications that this has for him - the relationship between medical patient and his healer is quite unique. The patient usually initiates the visit for medical attention: he expresses his reasons for meeting the doctor for medical attention: he expresses his reasons for meeting the doctor in terms of a specific complaint which he sees as being 'medical' and he is prepared to pay a fee to the doctor for 'servicing' his need. Tension, anxiety and need for reassurance are inherent properties of the encounter.

A naturopathic practitioner is called upon to provide a similar service. While the medical theme dominates early encounters between patient and practitioner, an important element of consultations is educational. Natural therapies are explained and natural therapy-based beliefs and practices described. The 'natural therapy' entity itself is shown to be worthy of a place as a form of therapy and a method of health care in its own right and to be an 'acceptable' alternative to conventional medicine.

Strauss (1978b) underlines the importance of the social worlds of the interactants to the form and trajectory which their relationship describes.

The social worlds of both practitioner and patient impinge on their relationship and influence the perceptions which they bring to their therapy and the way in which they react to it, to each other and to the practitioners' explanations. The increased significance of the educational element of a naturopath's role in providing care and the importance of his own appreciation of natural therapy and its beliefs are factors which contribute to the reality perceived by the patient. The importance of the practitioner's educational background and training and his own professional interests and orientation influences the manner in which he performs and organises patient care.

I have mentioned earlier how the principals and lecturers at N.S.W. College of Osteopathic and Natural Therapies attach great importance to a practitioner being aware of, able to explain and to justify the type of care he is providing. Courses are organised so that students know about all commonly available treatment modalities: counselling lectures and instruction dealing with psychology and patient understanding are provided. This is augmented by mandatory clinical sessions during training so that students are familiar with patient management as well as practising the different modalities. Presenting patients are assigned to students who follow them personally through their entire programme of treatment. The student is assessed on his ability to act in the instructional as well as the therapeutic facets of his role.

There is therefore a formally recognised educational component to the qualified natural therapist's role. As consultations in a treatment programme progress this element transforms from a purely information-giving to a health-promotional emphasis and as the medical nature of the visit recedes, it becomes an increasingly dominant factor of the practitioner's role.

In other words, the medical complaints which originally brought the individual to a naturopathic clinic as a patient seem to provide an excuse for presenting him with a different approach to health care based on prevention. Whether the impact of these new concepts is greatest as innovative stimuli or whether they do form a basis for the internalization of new ideals if they can be made to assume some consistency with existing beliefs, is largely irrelevant to practitioner and patient - if the naturopathic ideals of promoting health are attained. The process whereby the practitioner presents naturopathic care to his patient and how that individual, as a patient and as an individual deals with this experience, has been the subject of another chapter. The relationship between naturopath and patient incorporates these elements and mirrors these inherent tensions. Similarity to the medical relationship becomes a matter of context: the naturopathic context is unique to naturopathy.

CHAPTER 8:

NATUROPATHY IN THE HEALTH CARE SYSTEM

AN EXAMPLE OF THE OPERATION OF POWER IN A MEDICAL CONTEXT

Basil Hetzel (1974:223) sees the health care system as a special instance of a social system. One of the features which characterises relations in any system is resistance to change and to the acceptance of new ideas. There is a tendency to view innovation as a threat to personal prestige and authority and to fear changes in the '*status quo*'.

In a medical and health context, natural therapists are perceived and depicted by doctors and medical bureaucrats, as rivals rather than healer colleagues whose approach to health, and whose contribution to preventive medicine, can augment that of science and technology. I consider that this rivalry is expressed between medical doctors and natural therapists mainly in terms of ideological commitment, professional practice and affiliation between like occupational groups.

I begin this chapter by giving a brief, general outline of the Australian health system and those aspects of it which affect natural therapists and naturopathic care and the nature of medical servicing. My main intention is to locate naturopathy in the health care system as it functions, and to describe how naturopaths are positioned in the dynamics of power relations on particular issues.

Medical doctors, as well as dominating and sustaining a virtual monopoly over health care, enjoy high social status and prestige to which othe rival professional healers aspire. Naturally they seek to manage any potential competitive situation so as to ensure that this continues. They are supported in their visible and vocal opposition to natural therapy, by privat

enterprises such as pharmaceutical manufacturers, private health insurers, suppliers of surgical and sophisticated medical technology with a 'stake' also in maintaining the present health care system. I will describe the situation in the marketing of medical and natural therapy remedies as an example of how pharmaceutical companies seek to ensure supremacy and control in supply and distribution of their own chemotherapy and expand into areas where other rivals are achieving growth which imperils their own monopolies.

The Webb Report of 1977 represented a massive effort by those who perceived within natural therapies and practices of naturopathy, an opportunity to unite in launching an attack at this and other related areas where they themselves felt most threatened. The conclusions by the Webb Committee show the full weight of this powerful and dominant lobby in influencing deliberations.

I also intend to approach the problem of relations between professional healing practitioners from another perspective. At some stage, medical sociologists and many socially conscious health care professionals are forced to come to terms with social, political and economic realities of life. The policies of the Australian government do not guarantee the equal distribution and accessibility of health services to all. Inconsistences are given added irony when actual commitments to available, quality and beneficial care are enshrined in idealistic health policy statements and preambles.

The implementation and organisation of these policies reveal 'subversion' or 'an engineering of failure' due to the careful and deliberate efforts of powerful individuals, groups and corporations. Finally and briefly, I examine the prospects given the present control by scientific medicine and its promoters, for achieving a utopian situation where naturopahic care and natural therapies are freely available and equally accessible to all members of the society.

HEALTH CARE IN AUSTRALIA:

There are three main areas of delivery health care in Australia. The Australian Health Service at present (1980-1981) is concerned with national matters such as quarantine and internal health requirements and the administration of health insurance. It also controls Pensioner Health and social welfare benefits and the Pharmaceutical Benefits Scheme. The State Health Services (1980-1981) are involved in public health and the control of the environment by direct measures such as sanitation and industrial health. They manage hospital services either by direct subsidy or special commission and they oversee the operation of private hospitals. The Community Health Service includes government and voluntary services such as district nursing, agencies involved in the maintenance of health and prevention of disease in the community and certain private medical practitioner and specialist services.

Alistair Campbell (1978) suggests that there are three broad approaches to the provision of health services: these are commercial/competitive, the professional/managerial and the democratic/consultative. He describes health care organisation in the United Kingdom, the United States of America, China and the U.S.S.R. He concludes that any rational approach will tend to show a mixture of all three models although a predominance of one or another will emerge and this will tend to be related to the political context where it is operating.

In the first instance, the recipients of health services are regarded as 'consumers' and health care professionals and other providers of medical care are 'sellers'. Supply and demand determine the balance between them and health becomes a marketable commodity. The health system of the U.S.A. is used to illustrate a context where the medical situation is such that

> "the notion of individual enterprise is stressed and power is allowed to accumulate according to commercial success."
> (Campbell, 1978:10)

The notion of a professional autonomy characterises the second approach. The authority of expertise influences decision making. Similarly, idealistic sentiments are embodied in the democratic/consultative approach which perceives every individual as both a provider of services and a potential recipient of these same services by virtue of his position in society and responsibility to it. Health care professionals are

> "both agents and the advisers of the primary providers"
> (ibid, p.10)

Here, political controls restrict both commercial and professional power.

THE ORGANISATION, PROVISION AND DELIVERY OF HEALTH CARE:

Throughout the twentieth century, the partial realisation by governments of selected humanitarian ideals has meant increasing bureaucratic involvement and financial responsibility for the organisation and administration of health and social welfare services. These are financed and organised in relation to broader policy and are subject to political proclivities and directives.

In recent years, the financing of health has been a balance of state and federal responsibilities. Public hospitals which were originally voluntary, in 1980-1981 are now dependent on the support of government. Pharmaceutical prescriptions and medical doctor consultations receive substantial subsidies. A pensioner medical entitlement care provides for standard medical consultations and home visits by registered medical doctors. Socially disadvantaged and special low income earners also qualify for government assistance for conventional services. Medical doctors are normally compensated directly for the costs incurred in treating recipients of social welfare.

Most health care in Australia is paid from a number of different areas. Financing is a mixture of individual payment by the patient, tax-financed services and subsidies in the form of social welfare medical services, pharmaceutical benefits and medical and hospital subsidies and grants. Voluntary health insurance companies liase with government in relation to costs and servicing and their contribution. Additional revenue is earned from compulsory insurance through workers' compensation and third party motor vehicle accident payments (Hetzel, 1974:270).

Prior to 1970, the individual met the cost of medical care himself but he could receive some rebate from government and voluntary health insurance co-operatives or lodges. Approximately one third of the costs of medical consultations were provided by the patient. One third came from Australian Government subsidy to private insurance companies, approximately 28% from voluntary health insurance contributions and the remainder from compulsory insurances. The gap between hospitalisation costs and subsidy meant that individuals were forced to make up the difference themselves between real medical and hospital expenses and their government's support by the additional assistance and expense of voluntary insurance.

Under Medibank (1973), the Australian Government undertook to pay what amounted to about 95% of the total cost of medical care. The remainder was to be met by nominal patient contributions. The existing compulsory levies were to be maintained but a special health levy which was a surcharge on taxable income was later passed into legislation. Historically, Medibank represented the highest stage of Australian government involvement and commitment to health financing and the acceptance of social welfare ideals. It was based on a compulsory health insurance plan devised by Deeble and Scotton following recommendations of the 1969 Nimmo Report on health insurance.

The major features of this plan were:

1. Universal entitlement to benefits without means testing.
2. Coverage for basic ward hospital care and all medical services.
3. Financing through separate health insurance fund (Medibank) administered by a statutory government commission.
4. The revenue of this health insurance fund to be met from:
   (i) individual contributions equal to 1.35% of taxable income collected as a surcharge on personal income tax.
   (ii) a matching Australian Government subsidy.
   (iii) a levy on workers' compensation and third party motor vehicle insurance equal to the assessed cost of treatment for which they are liable.
5. Withdrawal of income tax concessions on net medical and hospital expenses and contributions to voluntary insurance organisations.

In other words, conventional health and medical care was to be avaible to all individuals at an outlay proportional to their ability to pay and regardless of the extent of the treatment required. It was envisaged that alternative services such as chiropractic, osteopathic, homeopathic and naturopathic services might eventually be incorporated within Medibank benefit entitlements at a later date so that all might equally have access to these services.

The Nimmo recommendations and the Deeble and Scotton plans were never fully implemented and Medibank as it was finally passed into legislation was a much modified and incomplete distortion of an ideal. Opposition continued loud and long from private insurance companies and medical doctors who objected to what they referred to as compulsory nationalisation. They mounted expensive publicity campaigns attacking Medibank and its aims and doctors boycotted government payment proposals. They endeavoured to make the scheme unworkable by bans and restrictions on services. They pointed to the possibility of over-utilisation of services, to inefficiency in

bureaucratic administration which it presented, to a possible decrease in the quality of care and an undermining of professional income and incentive.

A change to a Liberal party national government in 1975 resulted in the progressive dismantling of the Medibank legislation and policy of health and medical welfare and of the existence of a government-financed health insurance entity. Medibank Health Insurance has been completely restructured and now exists as an outonomous private company which competes with other corporations offering health insurance. Despite its ability to provide easily usable health insurance in any state of Australia, and its organisational possibilities, Medibank Private (as this company is designated) fails to attract a proportional number of subscribers.

HEALTH INSURANCE FUNDS AND COMPANIES:

Private organisations and co-operatives offer voluntary health insurance to any Australian to minimise health and medical expenses anticipated and incurred in the course of normal living. The insurance company pays the difference between medical or specialist medical doctor fees charged and that which is recommended and approved by government for subsidy by them to the taxpayer via his voluntary nominated health fund. It also contributes to the difference between hospital costs and government subsidies. Hence, fees charged by doctors and hospitals and the extent of government subsidy determine the proportion of the population who consider it necessary or mandatory to undergo some expense to insure themselves against possible greater outlays. During the era of Medibank, few individuals carried voluntary private insurance as the government met approximately 95% of expected health costs: hence there was a considerable decline in the profitability of many of these private insurance funds.

At present, health insurance funds do not offer benefits for visits to practitioners other than registered medical doctors. Some allowance is made for dental treatment and, in some states, some funds subsidise limited chiropractic manipulation within extended 'extras' tables at additional cost to the insurer. Naturopaths, who also possess medical qualifications, are able to suggest and administer natural therapy within standard consultations if they choose to define them for insurance purposes, as being of a conventional nature. The policy of not providing benefits for consultations other than those by registered medical doctors is directly related to government provision of subsidies for such consultations to the taxpayer via his insurance fund claim.

Many pensioners and socially and economically disadvantages individuals find that they can benefit from chiropractic or naturopathic care (Webb Report, 1977). Nonetheless, they often complain that the cost of insuring in 'extras' tables without guarantees of return of the total expenses outlayed in therapy is not commensurate with paying the practitioner directly when they need it. Consequently, they often do not undergo a full course of care (as is recommended): nor do they feel as inclined to use much therapy even when it is beneficial because it will strain resources often already extended. For example, from clinic B:

> "I know that when I do actually go and see the naturopath for manipulation and a course of hot and cold compresses or his new laser therapy, my arthritis does really improve for a while. I wish I could go every week so that it would be kept under control...but you know how things are when you're on a pension..."
>
> (Mrs. Almond, aged 62 years, living in Glenelg, home duties.)

POST-MEDIBANK ARRANGEMENTS FOR HEALTH CARE:

A change in political conditions in 1975 resulted in a return to a more

commercially oriented approach to health-care organisation (Campbell, 1978). The 'consumers' of health services in the early 1970's had called for a wider range of health care options and a more equitable and equable distribution of services. They had expressed their views in the support that they gave to the political proponents of Medibank. However, those individuals and corporations who supplied their 'services' to these 'consumers' used the economic and political power they had acquired with their earlier commercial success to combine with other sellers of health services, equally affected by the democratic style health policies of Medibank to bring down the Labor party and to undermine the system of health care set up and the threat which it posed to themselves.

There have since been, and there still are, further anticipated decreases in government involvement and subsidising of health and medicine and social welfare financing. Today, practitioners and services more freely compete in the marketplace of health care servicing. Those services which are able to offer the financial incentive of eligibility for voluntary insurance company benefit will therefore offer advantages over those such as natural therapies and naturopathic treatment which present to prospect of refund for expenses incurred. As costs rise, the difference between subsidised and non-subsidised care becomes ever greater. The extent to which State governments are assuming responsibility in areas of health servicing abandoned, or where Federal services are greatly curtailed, is a matter of continuing negotiation. Voluntary private health insurance represents an alternative to minimise these anticipated costs for unexpected illness or chronic ill-health. However, where income limitations preclude such insurance, as is the case with pensioners and low income earners, traditionally the highest users of medical services (Mechanic, 1974), the question of conventional services not covered by government subsidy looms as much a problem as access to naturopathic and natural therapies.

MEDICAL DOCTORS IN THE HEALTH SYSTEM:

In Australia, medical doctors play an important part in the organisation, as well as the provision, of health and medical care. Medical doctors are employed in the Department of Health as advisers and administrators. They define and co-operate in the formulation and constitution of legal and government requirements and sanctions. They are employed by drug companies to research and test new drugs and to identify areas where potential therapeutic markets exist.

More directly, they are involved in staffing, administration and organisation, as well as the day-to-day functioning of government owned hospitals. Many are also additionally concerned with the ownership and organisation of private medical institutions and care. Medical doctors are able to exert their influence in setting standards and determining areas for speciality care in an institution. They direct ordering, purchasing and use of new equipment. They are responsible for designating tasks to ancillary staff within hospital institutions so they can thereby assume a more consultative role (Engel and Hall, 1979).

Manufacturers of new pharmaceuticals and new medical equipment woo medical practitioners with pamphlets, personal visits, samples and access to research personnel for any query to create medical demand and initiate the process of informing the community. They also publicise the benefits of new therapy in the mass media as well as professional journals. By personal demands for new technology, new testing facilities and recent innovations in and advances to surgical management, doctors create and mould social expectations of the form and nature which such care should take.

The considerable power and status enjoyed by doctors is closely associated with the respect which has been accorded them because they control

a body of knowledge and perform in areas considered unknown, unfamiliar or even 'dangerous' and threatening (Leiban, 1972). It is also linked with their possession, as individuals and as a group, of overt symbols of economic and social success - of wealth, property, influence and education. They are able to impose their will on others. Their stance on a wide range of social as well as health related issues is sought and considered. Other healing groups such as naturopaths which admit they are socially and professionally subordinate to medical doctors, aspire to status and rewards similar to those achieved by doctors. Medical doctors thereby conform to Weber's (1968:53) criteria of dominance.

Due to the advances made in medical technology, medicine has diversified and knowledge has become specialised in many areas. The patient has increasingly to see many doctors rather than the one doctor who is 'my doctor'. The doctor is conditioned to fulfill his professional role in a society where more and more is expected of him in terms of knowledge and competence while he is more readily criticised. Today many doctors are said to be:

> "aloof, unsympathetic, even arrogant...with little ability to communicate or respond to their patients' real needs"
> ("New Doctor", 1977, no. 2:38)

The majority of registered and practising doctors belong to the Australian Medical Association (A.M.A.) or to smaller affiliated bodies such as the General Practitioners' Society. The Doctors' Reform Society, a splinter group formed approximately eight years ago in New South Wales to register disapproval among the profession, of health policy and medical delivery in Australia claims membership of 25% of the total registered doctors. Nonetheless, as a professional grouping, medical doctors are dominant in numbers, influence and financial and political power to all other groups of healers. They achieve unity and coherence on medical and health issues *viz-a-viz* others competing or co-operating in providing these services.

The A.M.A. is a formally constituted, highly organised policy making and implementing body. It encourages consesus among members and adherence to policy in practice in order to achieve the social and economic rewards of the system. It arranges meetings, conferences and discussions between members. It is a ready and accessible source of medical and professional doctors' views about medical and community matters. It publishes a monthly bulletin through which its views enjoy wide circulation inside and outside the profession. In the bulletin, the A.M.A. lays down policy guidelines and informs of new advances in therapy and treatment. It also provides leadership and guidance for medical doctors. The structure and organisation is such that there is ready and easy access for the individual to a wide body of respected medical and health-related information.

The bulletin reflects A.M.A. policy in relation to natural therapies, their application and their availability. Letters and editorial comment and the occasional news item will point to deficiencies in training and educational qualifications of naturopaths. The standards of some clinics and the basis of naturopathic beliefs are singled out for criticism. Failures in naturopathic care and reports which imply dangerous or suspect treatment attract the interest of mass circulation daily newspapers. Any breaches or suggestions of infringements of restrictions on treatment limitations imposed on therapists are dramatically portrayed and medical opinion and condemnation sought as it is tacitly accepted by these media sources and by their readers that medical doctors are the final arbiters in defining health care criteria. It is only briefly mentioned - if mentioned at all - that naturopaths themselves and their professional association, A.N.T.A. also dissociate themselves from drastic and innovative and unsubstantiated natural therapy routines and recognise the necessity to comply

with legislative restrictions on treatments.

It is not difficult to see why medical doctors adopt an attitude of suspicion towards natural therapy yet it is inconsistent with the stance many of them maintain in relation to diet and preventive health measures. This is almost identical but recommended by nutritionists of the government health department publications and booklets. They are provided with arguments to substantiate opposition to programmes and remedies which natural therapists and naturopaths offer and to counter patients' queries resulting from newspaper articles, friends' experiences, advertisements and casual conversations.

NATUROPATHY IN THE HEALTH CARE SYSTEM:

The Australian health care system through Federal and State government legislation and controls acknowledges the existence of an approach to health and medical care which is different from that provided by scientific medicine. As long as those who practise alternative medicine conform to defined standards and observe specific criteria, they may offer their services to others for payment. However, those individuals who use them cannot make claims for private health insurance company benefits. Nor will any medication prescribed by a naturopath (who is not also a registered medical doctor) qualify for government subsidy under the Parmaceutical Benefits Scheme. In other words, there is no provision in the organisation and financing of health and medical care in Australia, for recognising the existence of naturopaths and antural therapists as being able to provide beneficial care and as being acceptable alternative healing practitioners to those trained in scientific medicine. They are therefore effectively excluded from use by those recipients of pension and social welfare services

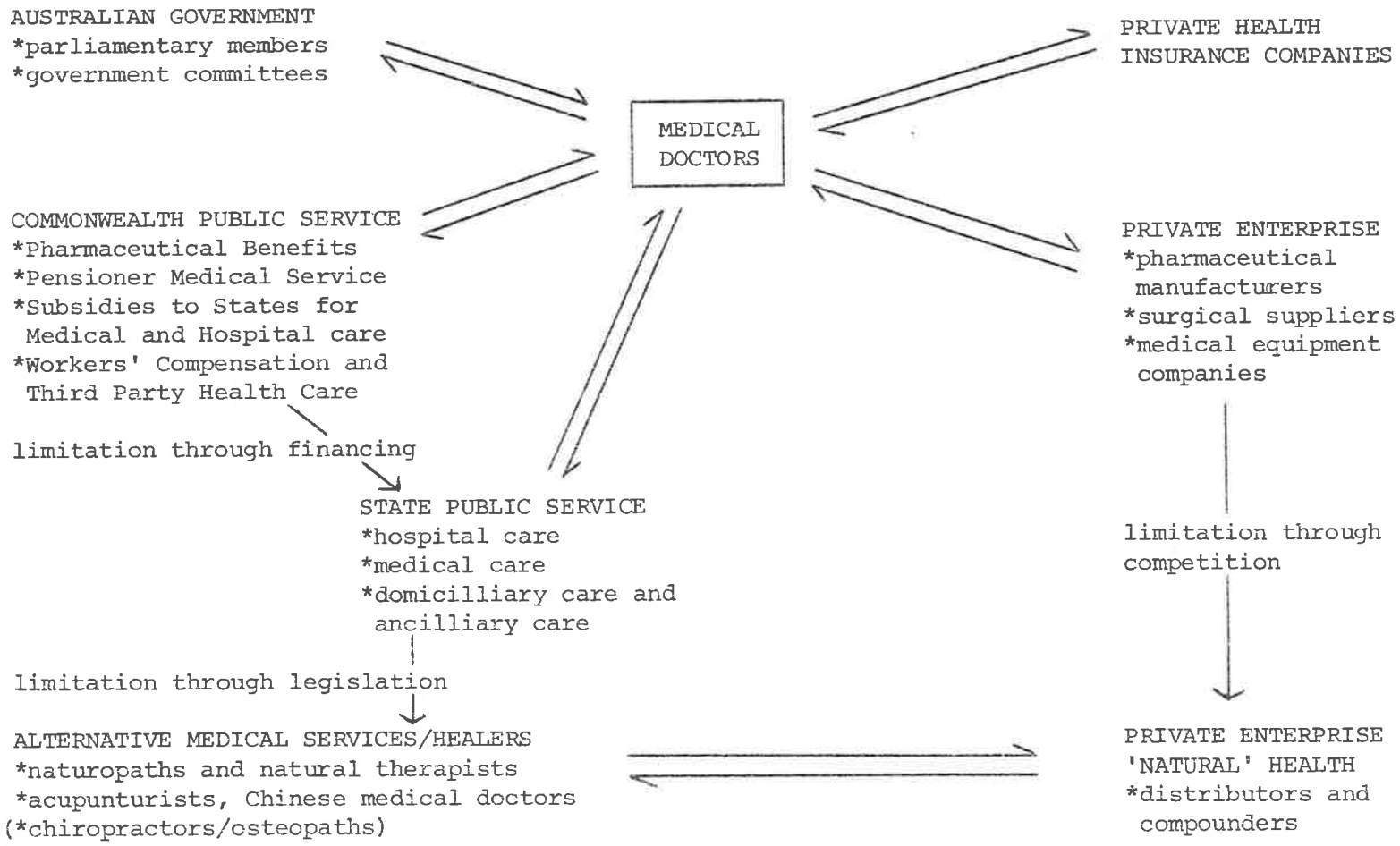
who are unable to meet the cost of consultation and treatment from their income.

This situation contrasts with that in many European countries, e.g. Holland and Germany where alternative health care practitioners and clinics are available and accessible to all individuals under the same conditions as pertain to scientifically based medicine. Naturopaths are formally recognised as being able and skilled to treat certain conditions and as being well-educated and qualified in these areas of care. It is accepted that they can offer benefits and meet social needs which medical doctors do not fully satisfy. They offer non-drug and non-surgical treatments and actively promote preventive health to their patients so that government sponsored incentives to minimise health and medical expenses in the future can be more easily achieved. They therefore also carry a potential threat to private enterprise investment in the use by individuals, of medical services and equipment.

In a structural sense, naturopaths and natural therapists occupy a position which can readily be seen to be on the perimeter of health care servicing in Australia. Figure 1 describes in a diagrammatic form how I see health and medical care organised in relation to naturopathy. Medical doctors occupy a very central and powerful position. They have access to all areas of health servicing: representation is made to them by others and they actively seek to be involved in all organisation, provision and delivery of services.

As Figure 1 shows, medical doctors are subject to federal legislation. They have access to government via their parliamentary representatives as individuals and as a body, the A.M.A. The Commonwealth Public Service, through the Health Department administers pensioner medical services and the Pharmaceutical Benefits Scheme.

FIGURE 1: THE SOCIAL ORGANISATION OF HEALTH AND MEDICAL CARE IN AUSTRALIA



NOTE: (*chiropractors/osteopaths) indeterminate status

It uses its bureaucratic arms to designate hospital and medical subsidies to the States. These allocations carry reciprocal responsibilities for providing ancilliary and supportive care services on which medical doctors may call. The state governments, acting through their own health departments and following the recommendations of the federal government sponsored implementation of the Webb Report (1977)[1] are drafting legislation to enable them to oversee alternative medical systems. Practitioners of naturopathy and natural therapies receive no direct or indirect subsidies for the care they provide but correspondingly have no financial respondibility to either level of government. Nor do they have a direct link to private health insurance benefit funds or to private enterprise interests which cater for medical doctors[2]. The larger pharmaceutical manufacturers and surgical companies lobby parliamentary members on health policy and seek the endorsement of doctors by representation and pamphletting. Representatives of medical doctors' associations are, in their turn, on boards of directors of private health insurance funds and in private enterprise boardrooms.

---

[1] The Webb Committee can be seen to have been constituted from representatives of each of the separate areas with an interest in the health and social organisation of medical care in Australia (Figure 1).

[2] Businesses which supply to health stores, natural therapists and some pharmacies generally have fewer staff, a smaller turnover, and a more limited distribution than the larger medical and pharmaceutical companies. However, the recent boom in health and 'natural' foods has greatly improved business. Blackmores Laboratories, originally a small family company have extended their product range and their distribution throughout Australia. They are now coming to dominate what is a large and increasing commercial area. The traditional medical and pharmaceutical manufacturers are also turning to 'natural' remedies as potential sources of profit. They are now offering large ranges of vitamins, supplements and 'organically grown' fruits and nuts in health food stores, pharmacies and some natural therapy clinics in direct competition to firms such as Blackmores which have in the past controlled this area of commerce.

> "We have maintained a pretty low profile in the eyes of the public and there is no doubt that we must move to capitalise on the adverse publicity which doctors, the pharmaceutical companies with their potent drugs and their side effects, and the issue of pollution, offer for us. It really boils down to a lack of money and people we can pay to help us. We don't have wealthy manufacturers behind us either."
>
> (Mr. A.R. naturopath and chiropractor, personal communication, July, 1980)

While the organisation of these two rival groups of healing practitioners depicts their relative dominance and inferiority in a structural sense, the actualisation of this power relationship is only appreciated in observing its operation: it is possible to view the deliberations and conclusions of the Webb Committee on Chiropracty, Osteopathy, Homeopathy and Natural Therapies in this way.

The Webb Report is an example of how medical and health policy is formulated and the process of its evential implementation by a bureaucracy under government legislation. The Committee included all those individuals and groups considered to warrant a position by virtue of their actual or potential 'stake' in any recommendations. Members also included prominent and independent academics, researchers and community leaders, medical doctors, pharmaceutical industry representatives and politicians. Many submissions made to the Committee were well researched and closely argued (personal communication, 1980). The thrust of submissions from medical doctors as individuals and their national association, and from drug and pharmaceutical industry were aimed at criticising eduational standards, clinical practices, the quality of medicines supplied, a alck of ethical principles and the personal financial interests some alternative therapists have in their own practice. The results of the Webb Report have been a tightening of controls on some forms of natural therapy and a definition of minimal standards of qualifications for practice. This has assisted many of the better clinics

and more qualified practitioners in justifying their presence as a valid alternative to "scientific" medicine. However, in the opinion of two medical doctors who were interviewed in relation to the Webb Report:

"conventional medicine won out!"

The A.M.A. submissions were well worded and doctors lobbyed government parliamentarians and Committee members. They co-operated with the drug industry whose testimonies opposed the submissions of the natural therapists and attacked those individuals who claimed to have been successfully treated by natural therapy. The tone of the preliminary conclusions of the Webb Committee throw some light on the climate under which naturopaths and natural therapists presented their own submissions and defended their own practices and ethics.

> "The Committee recommends that there be no registration of naturopathy, on the grounds that:
> (1) Its education systems are deficient and many of its educational concepts unproven and unscientific...Its philosophy is so broad and vague, and intrudes into so many aspects of medical sciences that a satisfactory educational standard would almost parallel a course of medical education...
> (2) The practice of naturopathy is not widespread in the community. Its adherents represent an extended family with like beliefs and often like attitude of protest. It is a minor cult system, which depends largely upon iridology for its diagnostic capacity, supplemented by a smattering of chiropractic therapy along with other 'modalities' of dubious value.
> (3) There is no satisfactory, well-established system of voluntary registration which would merit upgrading. There are, in fact, schisms and dissensions among the naturopathic practitioners, who are representatives of the output of a number of sub-standard educational institutions or are self-trained and self-styled."
> (Webb Report, 1977:124)

The use of derogatory tones and value-loaded language such as 'dubious', 'vague' and 'smattering' immediately destroys any semblance of objectivity which can be attached to many of the valid and quite sustainable criticisms which the Committee is no doubt justified in making. Statements such as

"its adherents represent an extended family"

and labels such as a "minor cult system" say more about the nature of Committee which passed and formulated these statements than those about whom they were made. There is no doubt that naturopathic advocates and A.N.T.A. were forced into a very defensive position from the onset.

Nonetheless, the Webb Report, in a series of questions directed to a sample of users of natural therapy revealed that significant numbers of these individuals only considered using such therapy if all else was unsatisfactory or if their personal doctor recommended it or gave tacit approval in the face of an admission of his own failure. In other words, awareness of a lack of success in medical treatment is associated with a respect for the professional knowledge of the medical doctor and of his status as an individual able to advise in health matters.

In effect, the Webb Report represents a victory for conservative forces: it has ensured persistence of the '*status quo*'. It has not resulted in natural therapies and naturopathic services being made more widely available to more individuals. It has resulted in a formalisation of controls and requirements for practitioners to conform with standards set by government.

The Webb Report therefore illustrates the operation of powerful interest groups - of pharmaceutical manufacturers, medical insurance companies, and the A.M.A. - co-operating to maintain their monopoly of the area of the healing services focussed on medical consultations. In their turn, medical doctors have managed to sustain their continued dominance in the provision of services and their 'say' in their organisation. The subordination of naturopathic therapies has been formalised within a documented report.

However, by issuing a direct challenge to naturopathy, the Webb Report forced natural therapists to realise that it was important for them to learn

to more cogently express their aims and ideals in practice. It has drawn them into the debate about health care, acceptability, standards, preventive medicine and what are 'acceptable alternatives' to conventional care - even if simply as unskilled players in the hands of larger, more organised professional opponents. It was recorded their 'existence' as a body with a 'stake' as well as an opinion about therapeutic management. It has stressed the need for continued unity among naturopathic and natural therapists and for the projection of a more professional and more ethical image in society if social and economic ends are to be sought and achieved. Whether its effect will be felt beyond the medical circles and parliamentary circles drafting relevant legislation will be seen in the following years.

PHARMACEUTICAL BENEFITS AND MANUFACTURERS IN AUSTRALIA:

Although the Federal Government over the past five years has progressively aimed to decrease its involvement and its responsibility in subsidising the cost of pharmaceuticals supplied under subsidy to private individuals and pensioners, the provision of drugs on medical doctors' presciptions continues to remain high. Hetzel (1974:30) attributes this to

> "a feeling among patients that full value for the visit is not given unless a drug is prescribed."

In about 60% of consultations with general practitioners, some medication is prescribed. He continues:

> "This feeling is readily accommodated and responded to by doctors in both hospital and community and does lead to over-prescribing."

Despite campaigns by A.M.A. and the Pharmaceutical Society of Australia and other concerned bodies and individuals, considerable expectations continue to exist among patients of the benefits of drug therapy and the need for medication.

> "Although many drugs have undesirable side effects and are a major cause of disease, pharmaceuticals are promoted frequently in a promiscuous and irresponsible fashion in respect of both the consumer and the physician. The competitiveness of the industry and the desire to maximise profits result in a vigorous effort to encourage the use of drugs for almost any symptom, and drug advertising is highly prevalent in the media."
> (Mechanic, 1974:282)

More and more people are beginning to realise that many of the manufactured drugs are potent products for the body to deal with and may not necessarily bring either relief or cure. Advertising by pharmaceutical manufacturers in popular journals and in the media enforces these beliefs.

Natural therapy and naturopathic patients will sometimes claim that their reason for initiating a visit is a desire for non-drug therapy or for some form of non-toxic medicinal of a natural rather than a manufactured or synthetic nature (case no. VI, Appendix II). Still more people are interested in nutrition and will complain that they do not know what to believe because some advertisements tell them one thing while their doctor another and the chemist something different again. As one manufacturer and distributor of a range of vitamin and mineral supplements said to me:

> "The layman, faced with articles in the Sunday press, written with comments gleaned from competitors, does not know what to believe."
> (Jan Stevenson, personal communication, January 1981)

In Australia, most pharmaceutical companies import their medications and either package or re-tablet and represent them only so as to conform with local government requirements. Very few firms actively research, develop and manufacture pharmaceuticals. Through their association, the Australian Pharmaceutical Manufacturers' Association, drug companies actively promote their products to medical doctors and the public and lobby government and health service bureaucrats involved in listings of the Pharmaceutical Benefits Scheme. Representatives detail doctors, chemists, hospitals, professionals

in the health care area by personal visit and pamphletting. Advertising is expensive, blatant, strident and demands the attention of the recipient. It points out the advantages of a newly introduced and developed pharmaceutical and substantiates its claims to efficacy with pharmacological and clinical testing information.

Drug manufacturers are represented in most government committees concerned with drug usage in the community and are present at A.M.A. and P.S.A. meetings to ensure that they keep up-to-date with feelings in the supply and distribution areas of their business. They actively discourage interest in 'natural' remedies by indirect personal and pamphlet mention, and statements to the press and individuals.

They claim that they lack standardisation and reliability in response. A typical exchange between a representative of a pharmaceutical company and a chemist interested in what advantages a manufacturing company's range of vitamins offers over and above those being offered by himself at a more attractive price is based on an argument of profitability and the greater acceptability of the pharmaceutical company's lines over that of the 'other' firm, reliability of supply, consistency in standards and formulation and the acceptability of the company's products by the medical profession who write the prescriptions which create much of the chemist's income. Many representatives find it is best to adopt a mixed professional and comradely approach as they 'leave brochures for the chemist to read at his leisure'. One exchange with a Sterling Pharmaceuticals representative following a query about the venefits of his products over and above those of a smaller local manufacturer of 'natural and whole body supplements' included the following:

> "Look - you don't know where the products that the 'other' firm offer come from, regardless of what they say. You don't even know how long they've been in business: maybe they have been supplying the health stores for years but they're not likely to give you preference. Besides, the doctors won't recommend them...they don't have to conform to the standards set for firms like us. That's why they're cheaper too."

Although many herbal and homeopathic remedies are imported from Europe and Asia, natural therapy manufacturing is also undertaken in Australia. The largest manufacturer and supplier to naturpaths and natural therapists is Blackmore's Laboratories of Balgowlah, N.S.W. It began as a commercial venture by the self-trained naturopath, M.C.H. Blackmore. He first produced 'celloids' or biochemic remedies.[3] Today there are a number of natural remedy manufacturers which supply also to practitioners and health food stores and chemists. Blackmores have now expanded their range and the scope of their commercial investments in naturally based medicinals and vitamins and make non-perfumed cosmetics. This has been in response to successful promotion and resultant increased demand for 'natural' and 'ethically' presented products such as the Blackmore's range. Advertising is low keyed and aimed at commonsense logical explanations of the benefits of herbal and wholesome, unadulterated ingredients. It gives simple outlines of principles of nutrition and vitamin supplementation.

Blackmore's manufacturing methods follow conventional pharmaceutical procedures such as granulation and tabulation. The company is required to conform with Health Department standards and pass inspections of premises by Department of Health personnel. It is bound to abide by labelling requirements and principles of good manufacturing practice for presentation of products for sale in the various states. However, the stringent documentation and clinical support which pharmaceutical companies are required

---

[3] Celloids are generally referred to as biochemic remedies. The use of biochemic remedies is based on the concept that many disorders stem from mineral deficiencies in the diet which may arise directly or indirectly as a result of eating vegetables and fruits from plants grown on soil deficient in essential minerals. It is claimed of celloids and other biochemic remedies that they are manufactured in such a way that the absorption of the minerals into the body is facilitated but there is no evidence of this. Most are derived from Schuessler's The Biochemic School of Medicine (Chapman, 1973).

to supply to substantiate claims for their pharmaceuticals is not demanded since the ingredients used in Blackmore's (and most other similarly oriented companies) lines are not regarded as being potent or toxifying and do not come within the poisons listings of such substances set by the states. Nonetheless, the lack of formal controls and limitations is the focus of attack by pharmaceutical manufacturers in response to lower costs to manufacturers not required to conform with these requirements.

In August 1980, I visited the Blackmore's Laboratories and found them to be generally similar to those of many of the smaller pharmaceutical manufacturing companies. Most of the herbal ingredients used are imported and while high quality standards are enforced in identifying and preparing products, the analytical controls of raw materials and finished products is not such as pertains in pharmaceuticals.[4] However, it was pointed out by the product manufacturing chemists, that many of these 'natural' products would decompose if subjected to many of the harsh chemicals and stringent tests which pharmaceuticals undergo and that they are not as concentrated or potent in their effects.

> "It takes many times the very highest dosage of...to even approach the strength, in more pharmacological terms, of one ephedrine tablet."
>
> (personal communication, 1980)

---

[4] Standards of manufacture here refer to the code of good manufacturing practice which pertains in the state where the produce is manufactured. It specifies such things as date of manufacture, ingredients, shelf life, batch number, weight and percentage of additives. It is reasonably uniform in all states. However, uniformity in consistency and adherence to set and regular standard of ingredient and active principle such as that set by the British Pharmacoepia, or the Australian Pharmaceutical Formulary for pharmaceuticals does not presently apply to health foods and vitamin and mineral remedies, providing they do not contain ingredients listed in the Poisons Regulations of any state.

Most of their products are distributed through a variety of outlets. Some preparations are available solely through naturopaths and natural therapists, while others are generally sold in health food stores, specialised selected pharmacies or departmental stores.

Direct confrontation in a commercial sense occurs between larger pharmaceutical companies and suppliers of natural remedies in the vitamin and mineral supplement market. Traditionally, the former have distributed multivitamins through pharmacies while the latter have presented extended ranges of separate vitamins and selected minerals through health food stores. However, there has been a general increase in demand and interest in recent years and health food stores have attracted business by offering complete ranges and information on the benefits which each individual supplement provides. Currently, the vitamin and natural food supplement market in Australia is estimated to be worth $50 million[5] and to be strong and expanding.

Competition is now being focussed on pharmacies which have begun to accept fuller ranges of vitamins and food supplements when they have been approached by companies such as Vitaplex, Blackmore's and Triad Pty. Ltd. Pharmacies also present a more 'ethical' and 'professional' image for their products to manufacturers than health food stores and have the advantage of trained professionals and staff with nutritional knowledge to substantiate claims and add credence to recommendations assumed by the pharmacy customer who sees these items on display in the pharmacy, traditionally the supplier of 'ethical' medicines. The pharmaceutical companies have reacted by expanding their own ranges of vitamins and minerals and actively promoted them in the popular media and press.

---

[5] From Pharmacy Trade, January, 1981:9.

The ability of naturopaths and natural therapists to hold and supply many of the products which they recommend has been attacked by pharmaceutical companies and medical doctors as an unfair advantage and to be a blatant commercialism where the gullible patient is sold expensive unnecessary supplements. By law, pharmaceuticals cannot be supplied by a doctor in sizes larger than special trial or sampler packs (supplied by pharmaceutical companies). Chemists alone are permitted to hold and distribute potent pharmaceuticals which are legally available only on prescription. While naturopaths and natural therapists supply certain products themselves, they usually recommend selected supplements be obtained from specific outlets. They realise the impossibility and expense of carrying a full range of these items. One or two also said that they really did not feel it was 'ethical': their patients would get the idea that they were simply trying to sell their own lines for profit and were not really concerned with the patient's welfare. One other practitioner mentioned that the local doctor had told him that he thought he should only be allowed to supply his recommendations direct to his patients under the same conditions as the doctor regardless of the fact that the remedies offered by the naturopath was not schedule 3 or 4 preparations.[6]

CONCLUSIONS:

In this Chapter I have tackled two issues and handled two problems which are related as illustrations of the operation of power relations in naturopathy. Since politics essentially determines how and to whom social and financial resources are distributed, health care reflects the system of power

---

[6] Schedule 3 and 4 preparations are available only through chemists and are not for general retail sale due to their ingredients and their potency.

and social stratification in society. As David Mechanic (1974:1) suggests:

> "the character of health care is moulded, equally, by the clash of interests at the community level, the organization and promotion of particular structures of professional organization, and the continuing decisions made at the level of operating agencies of all sorts."

Yet characterisations of health care systems and philosophies which arise from prevailing political and economic orientations do not emphasise the need for consistency in health care policy. Disruptive and fundamental changes in major areas of medical servicing due to political events in Australia have undermined community confidence as well as limiting accessibility, and freedom of choice and of permitting equity and equality. Individuals suspect, and surveys confirm (Webb Report, 1977), that they are receiving conventional care which is less satisfying to them and more expensive with each change in policy direction: and expense simply further restricts the distribution and does not necessarily improve the quality of such care and limits utilisation by those individuals most requiring such servicing (Dreitzel, 1973; Hetzel, 1974).

In certain respects the approach taken by C. Wright Mills to power in American society in the 1950's can be useful in an analysis of power relations in medical care in Australia. Although Mills locates power within a social elite representing business/commercial, military and political interests, he identifies and traces their articulations in situations and through issues (Mills, 1956). He sees these individuals as increasingly concentrating power in their own hands by building a coincidence of interests and mutual benefits and establishing networks between themselves and government, private enterprise, the bureaucracy and other 'useful' individuals and groups. They find ways of gaining endorsement and manipulating the plurality of interest groups which constitute the 'middle levels of power' and of 'mass society'

to thereby legitimise their actions. In a medical context, power would seem to lie with the controllers of the economic and social rewards of the system, with government health system bureaucrats, and, at the individual level, with medical doctors.

The attention of medical doctors to issues such as the threat posed by naturopaths and natural therapists appears out of all proportion to their presence or visibility. The continued dominance of medical doctors is assured in simply numerical and socio-economic terms and by virtue of the rational basis of advanced industrial societies. Their authority persists due to technical competence and possession of professional knowledge and expertise in chemotherapy and surgery and management of acute illness. They control areas of therapy and use an approach to health which complements and could combine with that of naturopaths and natural therapists for the benefit of the patient. Nonetheless, Dreitzel (1973) is discussing medical doctors and their attitudes to health care, identifies a resistance to change. He attributes this to their enjoyment of a monopolistic situation in the provision and organization of such care and a desire to maintain the '*status quo*'. Other authors confirm observations that professional perogatives, status and financial issues become focal points of interest rather than patient welfare (Mechanic, 1974; Hetzel, 1974).

While drug manufacturers promote new products by visits to medical doctors, they also establish and maintain relations of mutual benefit with one another, by membership of A.P.M.A., by showing a presence at most A.M.A. functions and by attending P.S.A. meetings. They are represented on the boards of directors of private medical insurance companies and on government committees concerned with health policy initiatives and implementation. Lobbying of individuals and reciprocal endorsement of policy in opposition to

natural therapies who the activation of these underlying relationships. On the surface, they are manifest as co-operation in the presentation of submissions and joint support in the media.

Despite the existence of tentative and potential links with other similarly oriented professionals and groups, and with the manufacturers of natural remedies, with socially and environmentally conscious individuals and with specialised media interests, at present naturopaths could be said to be singularly unable to mobilise and exert power through these links. However, the Webb Report is still referred to by individual naturopaths as 'a starting point for their unity' and is seen as 'an example of how to organize ourselves'. Predictions of the future, of re-alignments and projections of further developments lie beyond the scope of this Chapter and this analysis.

CONCLUSIONS AND IMPLICATIONS

Within this dissertation I have discussed concepts of illness and interpretations and definitions of beliefs perceived as rational or irrational in relation to rationalization processes used to substantiate individual commitments to them.[1]

At the level of action, behaviour is similarly assessed as rational or irrational. It is possible to differentiate in terms of

> "the means by which expectations and values are determined and in the range of alternative actions and environmental possibilities that influence the decision (to act)."
>
> (Stone *et al*, 1979:72)

Here expectancy would be a subjective evaluation of the likelihood that a particular outcome will result from a given situation. Values in a medical context would relate to the perceived benefit of an action whether it be the adoption of a sick role by a patient or the initiation of a specific therapy by the practitioner. Action would hence be a manifestation of belief and experience compounded with expectancy and value.

Since the 1950's, a version of value expectancy theory called a Health Belief Model has been developed. This model was most directly drawn from the theory of Kurt Lewin which drew attention to the perceptions and social worlds of the actor rather than as well as the objective and subjective world of the physician. In essence, this model was constituted of

> "(1) beliefs about the nature of the threat (to health) in terms of its perceived subjective severity if it should happen and the personal susceptibility to that danger;

---

[1] Refer Chapter 6.

(2) beliefs that specific actions had benefits in protecting against the threat; and

(3) beliefs about the barriers or costs associated with taking an action."

In other words, an action - such as initiating a visit to a conventional medical doctor - was seen to be most likely where, in the presence of a threat, the action was seen as sufficiently justifiable in terms of obligations contingent on the individual's acceptance of professional care, of a 'sick' role, and of associated financial and social costs (Rosenstock and Kirscht, 1979:203).

Considering the adherence of patients to medical treatments, Rosenstock and Kirscht (1979) discuss the application of this perceptual-cognitive model to illness, sick role behaviour and perceptions of degrees of 'being sick'. While it does not specifically handle the role of professional encounters and social influences, this model suggests that people only act on what they believe to be the case in a medical situation. This may not correspond with what a medical doctor may himself believe to have made perfectly clear and understandable. Secondly, since medical recommendations by no means encompass all health actions, most people deal with health matters without seeking professional advice so that the sphere of action of the practitioner is limited.

Naturopathy and the decision to seek naturopathic care is usually made by the patient without medical advice but often as a result of experience with conventional medicine. It may extend to a deliberate attempt on the part of the patient to conceal from a medical doctor or even family members that he has sought or is undergoing naturopathic care. The patient suffering non-specific symptoms of being 'generally unwell' or who is chronically ill, or in impaired health or who may be among individuals seeking medical attention, but labelled 'hypochondriac' by conventional practitioners, acts and visits

the naturopathic clinic because he believes that he requires care. He is regarded as 'being sick so as to require naturopathic care".

Inevitably, in any sort of care, there will be contradictions between what patients state and what they actually do - for example, in relation to medication, to attendance at medical consultations and to compliance with treatment regimes. As I described in Chapter 4, asnwers to simple questions raised in a therapeutic context, and concerning smoking habits and medication suggest either a lack of honesty (assumed unintentional), attempts to maintain 'face' or to present a more flattering image of oneself or to be recognised as being 'at harmony' with impressions created by the questioner's setting. These enter into and impinge directly and indirectly on treatment processes, on 'satisfaction' and 'success', on the practitioner-patient relationship and finally on the outcome of naturopathic care for both parties. Rosenstock and Kirscht (1979) correlate such behaviour with socio-economic status, educational level as well as interactional factors arising from patient-practitioner relationships. Discrepancies are also noted to occur between physician's statements about treatments prescribed and their written reports of consultations with patients. A failure to convey and receive instructions, a lack of discussion and clarification of unfamiliar treatments and an inability of both parties to communicate forces the conclusion that the exercise of authority by the practitioner is not, by itself effective, but that both practitioner and patient contribute to the 'success' of therapy.

I have considered naturopathic care at a number of different levels:

(i) that of the conceptualizations of naturopathic patients of 'being sick so as to require naturopathic care' and how this relates to patient understandings about medical care and conventional medical treatments.

(ii) that of naturopathic patient 'satisfaction with care' and 'success' of

treatment regimes. These are both rather abstract and nebulous concepts which I have concluded are centred in the interactional processes between practitioner and patient.

(iii) that of the satisfaction of the naturopath with the naturopathic process and which is necessarily constituted of elements of 'success' and 'satisfaction' to his patients. It is linked with realisation of professional ideals and naturopathic beliefs.

(iv) the emergence of a health promotional model during the treatment regime. This is associated with naturopathic ideology, and is linked to 'success' and 'satisfaction' with care on the part of both participants to the naturopathic process.

Ultimately, and at the conclusion of a course of naturopathic care, the patient would re-define his own understandings of how he now perceives 'being sick as to require naturopathic care'.

I think that the Health Belief Model described earlier helps to bring together these various dimensions and elements of processes of naturopathic care. It has been criticised with some justification (Stone *et al*, 1979) for placing undue emphasis on abstract and conceptual beliefs. Nonetheless, it is the very actions which subjective experience elicits - reticence, coping responses, imagined projected consequences and barriers to undergoing care, which are quite understandable and 'natural'. The 'newness' and difference which naturopathy represents to many individuals approaching this form of treatment for the first time is thus acknowledged.

In Chapters 5, 6 and 7, the abstract and perceptual elements of medical care and health promotion emerged in the processes of reality construction by both parties. Internalization and socialization continued as the consultations progressed. The relationship between practitioner and patient permitted

therapeutic and instructional dimensions to appear in a naturopathic context. Questions of 'success' and 'satisfaction' which were raised initially with approaches made to naturopathy for a therapeutic reason, reappeared for both practitioner and patient. In most instances, no objective and substantial evidence of improvement, 'success' or 'cure' was evident. The patient may simply have been better for no apparent reason; some intangible element of a treatment may be the only explanation. Still, individuals claimed that their symptoms of 'being sick', whether specific or non-specific, were relieved or removed. Therefore to re-phrase an earlier definition of sickness quoted in Chapter 1 (after Kosa and Robertson, 1975) produces the rejoinder:

"whoever feels well again should be regarded as cured".

Plainly it is not simply the existence of reproducible, rational evidence or glowing testimonial that a particular treatment or method therapy is likely to lead to improvement or has inconclusively contributed to the now-improved state of health of the patient.

On this basis, a valid case rested for looking closely at subjective or personal satisfaction in naturopathic treatments and remedies, at the holistic medical approach which naturopathy embraces and at how these meet expectations and values, in terms of the rational and irrational behaviour on which the Health Belief Model is constructed. Those components of 'success', 'satisfaction' and of the relationship built between the participants and described in Chapter 7, now 'fit within and add to' the Health Belief Model. To me, this earns for naturopathy an important place of its own, in the provision of health and medical services in Australia, as a supportive and collaborative dimension of servicing which has not as yet been realised and capitalised upon. The present status of naturopathy was discussed, together with the implications which the existing systems presents, in Chapter 8.

My analysis of naturopathic care also detected a difference[2] in 'goals' sought by the interacting parties. The patient desires medical care and this the naturopath supplies. For this service, he obtains a fee and it constitutes his occupation. With the opportunity provided by the personal contact and the authority which the practitioner has been granted in a medical context, to organise and direct his patient's health, he explains his own personal beliefs about health. At the same time, he justifies to the patient his own approach to treatment as distinct from that which he would have been accustomed to receiving from a conventional medical doctor.

I have described a process which I believe is one of continuing socialization by which the practitioner endeavours to convince the patient of the merits of natural therapy and a naturally based diet and life style over and above conventional medical beliefs, modern diet trends and fashionable life-styles. I have traced the relationship which develops between the practitioner and the patient during naturopathy and how it is crucial in determining the degree to which the concepts presented and the ideas explained are internalised by the patient.

Inevitably the reality which the patient comes to understand as naturopathic care will be structured by his experiences and be affected by the reality which the practitioner has himself about naturopathy and his professional role. It will be different from that which the patient brought to his initial consultation and will emerge during the treatment programme.

Within the treatment programme the individual is induced to adopt a life-style which conforms with that advocated by naturopaths and natural therapists to remedy his ill-health. In the ideal world, he will be motivated

---

[2] The more appropriate word "difference" is deliberately used rather than more emotive terms of 'tension' and more extremely, 'conflict'.

to continue this programme to maintain health and prevent a recurrence of illness. In other words, naturopathy is the therapeutic and remedial aspect of a different approach to living. It is fundamentally dependent on a natural, balanced diet: exercise, leisure and controlled relaxed approach to tensions in daily living complement and complete the individual's well-being.

An underlying theme to naturopathy and the naturopathic live-style is an appreciation of the importance of balanced diet so that the body can pursue a healthy, balanced life. This ties in with the recognition, by anthropologists, that food is of fundamental cultural significance beyond its nutritional merits and its intimate association with customs, traditions, ritual and all aspects of the social system. Conventional medicine and government sponsored programmes of health and hygiene aim to instill the necessity of adequate nutrition and balanced diet to maintain health.[3] Generally, however, the message will be improperly learnt or is over-powered by the predominant trend towards quick, snack-type meals - ready prepared and processed so as to facilitate storage and refrigerator-to-table preparation. The advocates of dietary and food programmes which come closest to those advocated by naturopaths and natural therapists are rarely visible as health care practitioners and do not normally participate in private practice. Only within the last few years as the costs of medical servicing and specialist medical care has increased at alarming rates have preventive medical schemes been implemented and sponsored by governments and supported by medical doctors. Such programmes in health promotion rely on nutritionists

---

[3] Information sheets on diet, hygiene and vitamins are freely available at all State Health Commission offices and are distributed in government primary schools where health and hygiene classes are given by teachers.

and dieticians as well as other ancilliary health personnel. They include "Life Be In It" and "Heart Attack Prevention Week" efforts which aim to create awareness of diet and life-style parameters and mobilise community members into undertaking preventive medical measures, beginning with diet. In technical terms, there is little difference between the recommendations of naturopaths and natural therapists and those of nutritionists and dieticians.

> "There are certain points on which nearly all nutritionists would agree. One is that the technological revolution has greatly altered the natural quality of the food we eat."
> (Diamond, 1979:16)

These can be linked with beliefs of an omnipresent life energy force such as has been claimed to constitute the basis of many traditional and alternative medical systems such as the Chinese, Indian, Unani and the basis of anthroposophical medicine and Steiner's philosophies. As John Diamond (*op.cit.*) maintains:

> "Our foods today are more refined that ever before. And refining reduces or even destroys all the Life Energy in the food. Just as our bodies contain Life Energy, so do the natural foods we eat. But the more these foods are processed, the less, if any, Life Energy will remain in them."

The difference between nutritionist/dieticians and naturopaths and natural therapists lies in their relative 'acceptablility' as qualified advisers and professionals to society and to related health workers. Nutritionists and dieticians are trained in the scientific tradition in so-called recognised centres of learning. They are employed by government in public hospitals and private institutions and work as colleagues in collaboration and with the co-operation of medical doctors, nurses and ancilliary staff. Hence they define disease and ill-health in the same rational scientific terms: they adopt the same procedures in treatment and patient management: they wear similar uniforms and conform to the same insitutional rules required in medical hospitals.

Not only are naturopaths trained in different colleges in a different tradition, but they are 'seen' to be different from other health-related personnel. They do not practise in public institutions of health care at any stage in their career nor are they required or asked to cooperate or collaborate in treatment organisation. Naturopathy is, and will probably remain, an area of private medical practice and will be performed in a non-institutional context. In personal appearance most naturopaths are well-groomed but informally dressed for consultation. However, some self-designated therapists could be classed as 'scruffy', 'untidy' and even 'hippie'. They do not reflect well on more professional oriented practitioners in the eyes of the community. Unfortunately, the association which is presumed between these and many of the more formal practitioners and individuals who are pursuing life-styles on the fringe of conventional society is also responsible for the continued persistence of aspects of the earlier image of 'quackery' assumed for naturopathy.

The mention of individuals classed as pursuing life-styles on the fringe of conventional society raises an issue of which I have become aware as I have carried out my study. Many naturopaths and alternative practitioners are 'normal' middle-class suburban professionals - they present the appearance of above average intelligence, possess tertiary education qualifications and live in comfortable homes in suburbs regarded as being for those on above-average incomes. Many others are less conservative in appearance, more 'casual' in attitude and live in more informal circumstances. They live in newer areas of housing development, they grow much of their own produce for household use and they point to the social and political problems raised by pollution, resources depletion and drug-induced diseases. My question therefore becomes: Is there a social movement occurring in western

industrialised societies such as Australia, and of which naturopathy is a part, characterised by interest in things alternative and 'natural'?

This hypothetic trend or movement could be typified by a fascination for products, life-styles, situations and behaviour designated 'natural' and as demonstrated in its extreme forms by the existence of nudist colonies, 'counter-culture' communal groups and religious sects and ideologically committed individuals adopting a 'simple' life. It would seem to be associated with those claiming to have a liberal social and political orientation, to be interested in conservation issues, and to be concerned about chemicals and manufacturing industry. The terms under which they justify their pursuit of such ideals - be they similar to the naturopath advocating unprocessed bran and raw vegetables to add fibre to the diet of the patient suffering lower gastric tract difficulties, or simply phrased in terms of opposition to the existing power structure in the social system - have achieved a response which may be related to the increased interest in naturopathy and other alternative forms of medical care. However, this 'trend' may simply represent a nostalgia for the past where things were of necessity, unprocessed, and not manufactured, and a fear of a nuclear future: it may be a realisation of the relative powerlessness of the individual in ordering and structuring his own life in society. Yet within this movement is revealed the operation of the multi-national corporations who have sought to capitalise on things 'natural' by sophisticated media promotion of their products presented as 'natural'.

Another related issue is raised by my research and is linked with the provision and delivery of health care services. Any individual is desirous of obtaining the best and the most beneficial form of medical servicing regardless of his status in society. More strigent controls of naturopathic services were fore-shadowed by, and have resulted from, the Webb Report and

subsequent government legislative processes. Recent moves to restructure the health care system have moved towards making medical care - even of the conventional variety - more expensive and less readily available to those on limited means.

Walsh (1979) in Poor Little Rich Country: The Path to the Eighties, discusses the organisation of health services in Australia as part of a new philosophy of neo-conservatism emerging in industrialised western nations and epitomised by the election of leaders of the political complexion and personal commitments of Margaret Thatcher, Ronald Reagan and Malcolm Fraser. It perceives the growth of government and the expansion of bureaucratic responsibilities as a threat to individual freedom. It seeks national resurgence through a restoration of personal initiative achieved by a curtailment of government sponsored 'responsibility' for welfare and many other social services. Walsh describes the construction of this new ideology and its justification in terms of upward inflationary pressure, greater efficiency of organisation and responsibility in financing of government services. Health and medical care is very much of government and community interest and an area of bureaucratic involvement: it represents some 20% of total Federal government expenditure (1979-1980 figures Australian Bureau of Census and Statistics).

Beyond the micro-sociological level at which the majority of my study has been conducted, the present state and nature of naturopathic practice and the place in the health system of alternative therapies can be viewed as a product of its relations with rival providers of medical care. This is associated with those agents and suppliers to the medical market and those with a vested interest in aligning themselves behind naturopathy's opponents for their own benefit. At the same time, such action serves to assert their

own authority and control over health services and medical care and to confirm their endorsement of the '*status quo*'.

The process of naturopathic care has much to recommend it as a compliment rather than as just an alternative to scientific medicine. To incorporate naturopathy within existing health and medical care organisations would require fundamental changes in professional attitudes, community resistance to change and government and bureaucratic reluctance to implement change. This study suggests to me that a comprehensive and holistic health care system should embrace both conventional and alternative medicines. At present, human failings limit man's potential to exploit his own knowledge and nature's ingenuity.

APPENDIX I

SYNOPSIS OF RESEARCH:

My research for this dissertation was undertaken in two cities and conducted at two levels. The majority of my work was carried out in suburban Adelaide. I endeavoured to encompass a wide area of medical care and encountered a broad spectrum of views from different individuals and groups within the community ranging from patients, to medical doctors, to alternative therapy practitioners, to pharmaceutical company employees and to individuals who had little knowledge and experience of naturopathy.

By way of introduction to my topic, I attended a course in Alternative Medicine organised by the Workers' Educational Association and enrolled for lectures in Iridology. I also visited the New South Wales College of Osteopathic and Natural Therapies at St. Leonards, N.S.W., and participated in classes and practical clinics with students.

Once I had gained a general background to alternative medicine, I visited a number of naturopathic and chiropractic clinics in and around Adelaide and had extensive discussions with staff and practitioners concerning their beliefs, their practices and their organisation of patient care. I compared their statements and collected impressions which other individuals involved in more conventional forms of medical care and servicing expressed about naturopathy. Fortunately, most people who were working in health-related areas had had some experience or understanding of naturopathy and were able to offer useful and critical information.

At this stage, I selected Glenelg and Marden as two areas of suburban Adelaide where alternative and conventional services were readily available and accessible to residents and users of public transport. Both Glenelg

and Marden were also identified by other residents of Adelaide as being middle-class suburbs where there was a wide cross-section of different age and occupational groups. I began by conducting a casual survey and interview of people using the principal shopping areas. I was interested in determining the extent of knowledge and experience which normal suburban people had had of alternative medicine and was keen to see to what extent opinions and attitudes described in the Webb Report (1977) were reflected in the populations and areas where I was researching.

Once this introductory material had been compiled, I began to concentrate my study on the practitioner and patient relationship. Several naturopaths had expressed interest in my work and were prepared to let me interview their patients and even sit in on their consultations should the patients themselves be agreeable. Firstly, I collected completed Preliminary Information Sheets from one clinic and subjected them to computer analysis (Chapter 4). I also began my interviews with patients and my observations of the practitioner and patient during and after consultations. Isolated incidents which appear throughout this thesis have been drawn from these experiences. I then selected ten individuals whose contact with the naturopath and progress through a course of treatment could be followed in detail. The most substantive sections of my work are built about their case histories (Appendix II).

One of the problems with my research has been the necessity for confidentiality to be maintained. Throughout my work I have assigned case histories with numbers and given patients Pseudonyms. The clinics and practitioners whose cooperation I enjoyed similarly wish to remain anonymous and are designated by letters. Originally I had intended to give a brief description of these clinics but since my studies began, three of the

five clinics have found it necessary to either move to larger and more modern premises or have altered the layout of their present location substantially due to increase in their clientele.

APPENDIX II

ABOUT THE PATIENT CASE HISTORIES:

I do not wish the following case histories to give the impression that every naturopathic patient follows his practitioner's advice: that most naturopathic treatment regimes are continued to a mutually agreed conclusion: that patients regularly attend clinic consultations or even telephone practitioners (which they often do rather than come to the consulting rooms and/or pay the consultation fee) in the latter stages of treatment.

By far the majority of patients are just like everyone else who seeks care of a medical nature: they attend for one or two sessions or consultations and when their presenting complaint shows improvement so that they can get back to their normal routine relatively unimpaired they do so, and no longer complete the designated treatments and programme. However, there are instances where practitioners' and patients' ideals may be fully (or almost fully) realised and it is possible to construct an idea of what the naturopathic process is really concerned with accomplishing. And it is these cases - hence drawn from a number of clinics, a range of practitioners and their patients - numbering only ten where I have been able to give what amounts to a full 'start-to-finish' description. This has involved ten months spent informally and formally visiting clinics, practitioners and patients and speaking with them and those involved in naturopathic care.

The most complete case histories are nos. V and VI. This is because I have become personal friends with Mr. Roberts and Mr. and Mrs. Quin - I do not feel that this has clouded but rather clarified my judgement of naturopathy. Miss Grant and Miss Bateman have also been willing to meet me informally and discuss their treatments and their feelings. Individual

naturopaths and natural therapists have also greatly assisted in describing (in retrospect) aspects of the consultations where both they and their patients spoke privately - I believe they have done so objectively and fairly.

DETAILS OF PATIENT CASE HISTORIES:

Case No. I - Miss Grant Clinic A

Personal particulars: aged 23 years, single and living in Glenelg: employed as a secretary.

The preliminary information sheet indicated that the patient approached the clinic complaining of skin rashes which had been occurring more frequently of late. A number of visits to the medical doctors in her area had resulted in a plethora of creams and ointments being prescribed, none of which had been very successful despite initial improvements. She was not overly enthusiastic about taking long courses of antibiotics or antihistamines which some doctors had indicated might be required.

Consultation 1: Miss Grant appeared rather nervous and embarrassed in explaining her problem. The practitioner asked if it was any worse before or after her periods, with worry or after certain foods. An iris photo was taken by the nurse who explained how it would be used to find any underlying medical problem which would aid in diagnosing the casue of her complaint. The nurse also briefly explained about iridology and that it was a branch of natural medical diagnosis. The practitioner talked with Miss Grant about diet, its importance and role in body health. He gave her a diet sheet to complete with details of everything she ate at and between meals over the next seven days. An appointment was arranged for eight days later.

Consultation 2: The practitioner asked Miss Grant if there had been any recurrence of the rash over the last eight days. She replied in the affirmative and indicated the neck area, the forearms and fingers. The practitioner closely questioned her concerning its time of occurrence - after an emotional upset, after a particular food and referred to her diet sheet. They both thoroughly examined the diet sheet and her remarks about how she felt.

Miss Grant's iris photos were shown together with those of a normal iris and the practitioner explained that there were inclusions or markings which were evidence of past and present internal body 'disharmonies'. He said that she had a past history of gastric problems and that the colour and clarity of the iris photos wasn't too bad. There were a few light spots which suggested that she suffered from chronic constipation. Miss Grant seemed quite delighted with his conclusions and her photos. She admitted that she had had a suspect gastric ulcer during her Leaving Certificate days at school. She also admitted chronic constipation. Yes: it did seem to coincide with her rashes - now that she thought about it.

The practitioner explained how he used the diet sheet, the iris photos and his discussion with her to make a diagnosis. He believed that the best way to tackle her problem was to concentrate on her diet and thereby avoid further rashes, relieve the constipation and improve her gastric and general body tone. He declined giving her any creams or ointments for the rash as he believed that would pass in due course and they would simply mask the problem. The complete elimination of toxic waste and the promotion of natural healing by the body would be achieved by the sort of diet he wanted to give Miss Grant. He explained how the different elements/components of the personal diet he would now give Miss Grant would promote cleansing of

the system naturally. At her next consultation, he would re-examine her problem and her diet and possibly slightly restructure it. In the meantime he suggested vitamin B complex tablets (Miss Grant obtained these from the receptionist/nurse after the consultation) and drinking plenty of fresh clean rainwater.

Consultation 3: The next appointment seven days later revealed that the rash had now cleared and no recurrence had been evident. Miss Grant said that she was sticking to the diet and had not been troubled by constipation during the past week. She found the diet interesting but wondered about some of the items in it - were they necessary and why, and did she have to continue with them? The practitioner explained how they contributed to the diet but suggested alternatives which would do the same job. The two of them also worked out some other minor modifications. The practitoner later explained to me that he was convinced that Miss Grant's skin problems were diet-related and that she had an underlying food allergy. He suspected it might be to tomatoes, strawberries, pineapples and acid-type foods. He felt that she would come to that conclusion herself shortly and the manner in which he liked to work with his patients was so that the two of them 'discovered' the underlying problem together.

Consultation 4: Ten days after consultation 3, Miss Grant reported that she was feeling very well and so far had not been troubled by the rashes. Both practitioner and patient talked more about food, allergy problems and how diet connected the two. The practitioner suggested a number of publications to provide further details. Small modifications were provided to the diet sheet and Miss Grant herself indicated that she no longer felt she liked tomatoes - "they were not so good at that time of the year anyway". She said that her mother had found it a little difficult when she started

the diet as the family were not accustomed to eating muesli at breakfast and while prepared and anxious to help her daughter, she found her difficult to cater for. Her mother was now convinced that her daughter was not suffering from not eating a cooked breakfast, nor was she being given any strange remedies in funny bottles by the naturopath. The practitioner suggested that Miss Grant might like to bring her mother to the next consultation to meet him. Miss Grant did not seem keen.

Consultation 5: Six weeks later Miss Grant reported alone for her final consultation. She had not had any recurrence of rashes. She had found the book on food allergies very interesting - as did her mother. She said she now understood why she had never liked pineapple -

"my body knew it wasn't good for it!"

Her mother was impressed with her daughter's health and her diet but was not inclined to change herself because she believed she was too old to change her habits. Miss Grant purchased some more vitamin B complex tablets. Two months later, Miss Grant had not reported back to the clinic either with further problems, recurrence of rashes or for more vitamin B tablets. The nurse said that she probably didn't need the vitamin supplements anymore if she was sticking to her diet. She hoped that Miss Grant had continued her enthusiasm but she felt that most people slipped back into their old ways very easily.

Case no. II - Mrs. Allan: Clinic J

Personal particulars: aged 42 years, married and living in Reynella: working as a laboratory technician.

Presenting complaint: persistent migraine headaches with mild hypertension.

Consultation 1: Friends suggested that Mrs. Allan consult a Chinese medical doctor for her migraine headaches. An extensive medical history was taken

and details of Mrs. Allan's daily activities, her fluid intake and diet, her urinary frequency and other seemingly minor physical and physiological parameters. The practitioner diagnosed high blood pressure and confirmed migraine as an associated problem: she warned that there were definite warning signs of impending cardiovascular problems of which the headaches were the first indication. She gave a detailed explanation of the method by which she arrived at her diagnosis without physical examination of the patient. She explained how the different symptoms - urinary frequency, coffee intake, pattern of bladder action - indicated a heat imbalance and how this was related to energy imbalances in the body. Her explanations were couched in a mixture of scientific terms and Chinese medical terminology so that Mrs. Allan would be able to understand the concepts she was describing. The use of acupuncture to correct energy imbalance in conjunction with dietary and life-style advice were brought into the argument.

Mrs. Allan said that she understood the practitioner and asked a few minor questions about natural therapies and acupuncture as she had only known what she heard on the television and radio.

The practitioner then ushered Mrs. Allan into a separate room where she was told to undress and lie beneath the coverlet until she returned. Acupuncture would be administered as she believed that this was what was indicated in Mrs. Allan's case though she would also give her some special oral drops and some suggestions about her diet.

Consultation 2: Seven days after the first consultation, Mrs. Allan returned. During her second acupuncture session, she told the practitioner that she had been trying to cut down on her sugar and coffee intake as suggested. The practitioner explained slowly and carefully how the ingredients in coffee aggravated her problem and how sugar upset the energy imbalances in

her body. She encouraged her to continue with her efforts and hopefully by next session, she might manage to cut them both out entirely. The next visit was to be held in another week.

Consultation 3: Questions about headaches revealed that Mrs. Allan had suffered a couple of minor ones that week: yes, they had happened to coincide with her periods and had not been what she would call 'persistent and migraine'. She had cut out sugar and was now using saccharin: was tea all right? She said that she herself was feeling much better though she had been a little lethargic the last week. She was still taking her medical doctor's prescribed medication for her mild hypertension.[1] She was due to visit him in three days for her regular check: she wondered whether she should mention her visits to this clinic for migraine - she wasn't quite sure how the doctor would regard it. The practitioner said it was up to her.

Consultation 4: One week later, Mrs. Allan reported that she had told her doctor about her migraine therapy and sessions with acupuncture. He had been guarded in his response and had only said that if the treatment was helping her, and she was continuing to take his medication and abide by what he personally told her, then he had no strong objections. (She confided later to me that she was a lot happier having told her doctor about the migraine treatment and been given at least his tacit approval.)

Consultation 5: This was the last migraine acupuncture session. Mrs. Allan confirmed that she thought she was vastly improved. During the month long treatment programme, she had not been troubled by a severe and persistent migraine. She felt better herself and had actually lost a little weight

---

[1] The practitioner had learned of this medication during her first consultation and (as was her usual practice) had not suggested or wished any changes to be made to prescribed medical usages.

which her doctor had noticed and approved of.[2] The practitioner reiterated her suggestions about diet, particularly in regard to coffee and sugar. She emphasised that Mrs. Allan must try and take her daily problems in her stride and be aware of tension provoking situations: that way she could avoid migraines and may also help keep her blood pressure under control. She suggested that if Mrs. Allan was again troubled by migraines, another series of acupuncture sessions might assist in redressing any energy imbalance which would have built up in the body and brought them on again.

Case no. III - Mrs. Hall Clinic J

Personal particulars: aged 29 years, married and living in Elizabeth Downs: home duties.

Presenting complaint: wants to give up smoking.

Consultation 1: A detailed medical history was taken by the practitioner using a Chinese medical approach. Mrs. Hall claimed that she ate no breakfast and no lunch: she drank up to 20 cups of coffee per day with two sugars in each. She smoked approximately one pack of cigarettes per day. She only drank liquor occasionally with her husband at home in the evenings. She moved her bowels only one every eight to ten days. She had meat and vegetables for the evening meal: she cooked with salt and liked to add it to her food. She was not suffering from any medical problem, nor had in the past. She did, however, have high blood pressure during her two pregnancies. She did not need to get up during the night to open her bowels or to urinate. Her perspiration was never excessive even in hot weather. The practitioner looked at her tongue and asked whether she suffered from a dry mouth. She also asked if Mrs. Hall had always smoked as much. Mrs. Hall replied no, and said that there was no tension in the home. She admitted to boredom but was resigned to it because her children still

---

[2] The doctor seemed to think that the weight loss was more responsible for Mrs. Allan's fewer migraines than any treatment given by the practitioner.

required her presence during the day - and she didn't like work anyway: her husband did.

The practitioner explained in general what her treatments involved: she would use acupuncture and make some suggestions for Mrs. Hall about her diet to assist her giving up smoking.[3] She emphasised that acupuncture would help to relieve the stress and mental strain which trying to give up smoking involved. However, she made it very clear that there was a large element of personal commitment involved as well. She explained how the diet which Mrs. Hall was presently following would accentuate her desire to smoke. She said that it would require at least 21 difficult days of persistence for Mrs. Hall to break the 'habit cycle' involved in smoking.

Mrs. Hall did not seem unduly perturbed by this information. She did not ask questions and on occasions reprimanded her youngest child who was playing on the floor and not being too much trouble. The practitioner explained to Mrs. Hall how her present diet and eating habits actually contributed to an energy imbalance and heat imbalance in the body which contributed to her craving for cigarettes and aggravated her desire for coffee and sugar. She suggested that initially Mrs. Hall reduce her coffee and also her sugar intake: she recommended a sugar substitute and limiting fuild intake. She suggested a light breakfast and a light lunch to replace the fluid and the sugar for energy which Mrs. Hall would no longer get from her regular cups of coffee. She recommended using less salt in cooking and perhaps just putting a light dash on her food prior to tasting it. Since Mrs. Hall still had few questions, she was led into the adjoining room to undress for the acupuncture needles. At this stage, the practitioner told me that she

---

[3] The practitioner said to me afterwards that she was careful to mention that the diet was for smoking because she felt Mrs. Hall was not a very enthusiastic patient anyway.

would be surprised if Mrs. Hall managed to be successful in her anti-smoking endeavours as she thought that she was looking for a quick easy solution - like most people - and the approach which she recommended was more difficult than some others being advertised in the media. She expected little change in her dietary habits despite warnings that if Mrs. Hall continued as she was presently, she was likely to be very rundown and to suffer high blood pressure within ten years.

Consultation 2: Five days later, Mrs. Hall arrived for her second consultation and apologised for being late. She said that she had indeed succeeded in reducing her cups of daily coffee and now simply had a cup with breakfast (she now ate a small breakfast after the family and while she read the paper - the practitioner had suggested this strategy). She ate a bit of lunch in front of T.V. and the usual tea. She had not smoked all week but was beginning to feel the craving for a cigarette. The practitioner tried to encourage her and said she was very pleased with her progress. During insertion of the acupuncture needles she reiterated her advice about diet and energy imbalances. She explained that they were simply to relieve the buildup of tension caused by trying to give up smoking and that determination was essential to trying to break a habit. She suggested that Mrs. Hall alter her daily routine so that she was doing something different and would have another activity to concentrate on: perhaps mid-week ladies tennis or ten pin bowling with some other local girls. Mrs. Hall did not seem very enthusiastic about getting out and about but she said she would ask her neighbour whether she knew of any groups. The third consultation was arranged for five days later. The practitioner warned Mrs. Hall that she was now in the most difficult period and her will-power would be severely tested over the next ten days.

Consultation 3: Mrs. Hall was very agitated on arriving and confessed that she'd had a bad morning: her periods had arrived unexpectedly, everything had gone wrong at home that morning and she had weakened as a result and had two cigarettes. The practitioner said 'never mind' and added renewed encouragement to continue. She had some trouble inserting the acupuncture needles and Mrs. Hall continued to complain about one which she said was irritating her unduly. There was little talk this session and the practitioner simply allowed some soft music to come through on the background cassette system.[4] The practitioner confided to me that there would have been little point in attempting more than the required acupuncture needle insertions today.

Consultation 4: Mrs. Hall had to postpone this consultation as it was "too wet to come all the way into the city". When she arrived she said she had not smoked since the last time and was still using sugar substitute. She said she was still doing as required but did not seem particularly talkative or interested. The practitioner and I both were of the impression that she was not being entirely honest about her smoking and might simply just be abiding by a personal undertaking to complete the sessions of visits.

Consultation 5: Mrs. Hall arrived late at her final visit but without the young children. She did admit to having smoked a couple of cigarettes but said that she intended to continue to try and give up smoking. She said that she had developed a craving for sweets and asked for the practitioner's advice. The practitioner in turn asked whether she had started drinking more coffee again. Mrs. Hall's reply seemed to be indirect and suggested to me that she had again increased her coffee intake. Nonetheless, Mrs. Hall promised to show more diligence with her diet and her smoking in the

---

[4] The background music was not always played at Clinic J.

future. Since this was the last acupuncture session, the practitioner reiterated her earlier advice and added more encouragement. She finished by suggesting that if Mrs. Hall was still having problems then another session in two months time might assist.

Case no. IV - Mr. Ellis Clinic A

Personal particulars: aged 30 years, single and living in Fulham: employed as an accountant in a city bank.

Presenting complaint: respiratory problems and recurrent asthma.

Mr. Ellis called into clinic A making a general enquiry about naturopathy. When he first entered, he seemed rather uncertain and looked about the premises more or less to make sure that it was an 'acceptable' place to come. He asked about consultation times, fees and what naturopathic treatments involved. He remarked on the naturopath's certificates on the wall and the receptionist/nurse explained the practitioner's credentials. Mr. Ellis said that he was rather curious about natural therapy particularly after reading that it was sometimes effective in long-term asthmatics and in others with recurrent respiratory problems. He was keen to try something which was not dependent on drug and cortisone therapy, as a form of treatment. He declined the invitation to make an appointment and said that he would possibly contact the clinic at a later date. Mr. Ellis rang the next day and made an appointment.[5]

---

[5] I was at the above clinic when Mr. Ellis first appeared and had asked the receptionist/nurse to let me know if he decided to make an appointment with the naturopath. He seemed to be reassured when I asked whether he would mind if I followed his treatment programme. My impression was that he remained somewhat dubious about the efficacy of naturopathy throughout his visits.

Consultation 1: The Preliminary Information Sheet completed by Mr. Ellis indicated that he had had a long history of respiratory problems beginning in his adolescent years. He had been treated as an asthmatic by a number of medical doctors and had even been through a programme at a special clinic for chest conditions. He was reasonably free of the condition at present except in cold, damp weather such as winter brought. On close questioning by the naturopath, he agreed that he did have breathing difficulties more during spring months rather than winter. He felt it was possible that these attacks could be precipitated by pollens in the air. He agreed to have an iris photograph and was interested in how the practitioner used iridology in diagnosis. The naturopath explained fully about iridology, naturopathic beliefs (in pseudo-medical, layman's terms) and how pollens could affect his breathing. He suggested some books on the subjects and gave Mr. Ellis a diet sheet to complete and return to the clinic before his next appointment.

Consultation 2: Mr. Ellis brought his diet sheet to the consultation apologising for not having dropped it in earlier. The practitioner excused himself to examine it together with the results of the iris photographs. During this time, the nurse explained how inclusions revealed on an iris photo are compared with those of the normal iris and assist in diagnosis. On returning the practitioner indicated that he did not feel that the asthmatic attacks were as closely linked to pollens in Mr. Ellis' case as many other patients he treated where there was a clear tendency towards allergy. He believed that Mr. Ellis was personally more susceptible than most individuals to colds and minor chest infections. Hence he considered that Mr. Ellis should concentrate on improving his general body health through a balanced diet of wholesome and nutritious foods and gradually introduce

regular exercise and leisure into his daily activities. Mr. Ellis admitted that, being a bachelor, he did tend to eat rather irregularly and often skipped meals, ate take-away foods or snacked on chocolates or cakes. He did not play a regular sport although he was very keen on football and followed his local team during winter. During the summer months he would spend the weekend at the beach with friends. He did not find his job particularly demanding so that he was inclined to go out at night pretty often. The practitioner explained how the vitamins and minerals in a diet helped the body dealing with environmental and physiological stress caused by modern living and how a wholemeal foods diet and drinking plenty of fresh water would assist in ridding the body of bad elements and pollutants built up from 'junk' and processed foods such as those available at rapid service diners. He used simple scientific medical terms to describe the absorption of foods from the intestine and how they were metabolised by the body. He described how the body used the different minerals and vitamins to repair tissues and make new ones and which foods were rich in what vitamins. The practitioner also recommended that Mr. Ellis regularly take a multi-vitamin capsule which could be purchased from the nurse as a course of supplementary vitamins. Initially he should take two supplements (the naturopath would tell the nurse which ones) and following his next visit these might be revised. He suggested that Mr. Ellis use his asthma spray only if required but he suspected that after a short time on the diet, Mr. Ellis would find that he was not as prone to attacks or to colds.

Consultation 3: Mr. Ellis had to go away on business and was forced to postpone his next appointment. Two weeks later, he reported that he was feeling very well but found it was difficult to stick to the diet because it was too awkward with business and coming home late at night to have to fuss about food. He asked if the naturopath could give him some extra

vitamin tablets to provide what the food would give. The practitioner gently explained he realised the difficulties, but the food itself provided the fibre and 'exercise' which his sluggish gastric system required and the need to sit down calmly and leisurely eat a meal was in itself important. Mr. Ellis countered by asking whether the practitioner could make some additional suggestions for a single man who was a lazy cook; the practitioner gave him another diet sheet (the same as the earlier personal programme he had given in the previous consultation) with circles around particular items which were easy to prepare and very nutritious. He also suggested a couple of restaurants which catered along health-food lines. Mr. Ellis thanked the naturopath and said that he intended to continue with the diet especially since he had been free of any asthmatic attacks of late. He wondered did the naturopath also supply herbal or homeopathic tablets to ward against asthma. A fourth consultation was arranged for three months.

Consultation 4: Mr. Ellis did not appear for this appointment: enquiries revealed that he had been transferred interstate by his bank.

Case no. V: Mr. Roberts Clinic A

Personal particulars: aged 35 years, single and living in Tennyson: self-employed as an electrical engineer.

Presenting complaint: sleepiness, lethargy, tendency to high blood pressure and not feeling as well as he should.

The patient indicated that there was a family history of blood pressure and coronaries at an early age. He had visited the family doctor and been informed that he would be quite likely to suffer similarly as his blood pressure was already slightly elevated. The doctor suggested some medication but Mr. Roberts declined saying that he was not interested in drugs. Mr. Roberts had also complained of falling asleep 'at the drop of a hat'

which seemed unusual for him as he normally slept very well. Lately however, he had lacked energy and even did not want to go for his early morning beach run with his companions.

> "I told them that it was too cold in the mornings these days. Matter of fact, it's not only too cold: I just find it almost impossible to get out of bed some mornings."

Consultation 1: The practitioner took Mr. Robert's blood pressure and asked a few more questions especially about his listlessness and sleep patterns. He gave him a diet sheet to complete and took an iris photo. The nurse explained the principles of iris diagnosis and answered many of Mr. Roberts' interested questions. Mr. Roberts also closely questioned the practitioner about natural therapies and asked for some reading material to increase his knowledge.

Consultation 2: Mr. Roberts returned with his diet sheet and after a few queries and a brief discussion about whether or not Mr. Roberts had been able to find the books suggested and what they had revealed to him, the practitioner excused himself to complete his diagnosis. In the meantime Mr. Roberts talked with the nurse about diet, energy forces and some of the other simple naturopathic concepts he had read about. She took a blood pressure reading and asked him about tea and coffee intake. The practitioner appeared shortly and began explaining in detail the results of the iris photos and how they indicated a weakness in the vascular system which would correlate with the elevation in blood pressure. There were no other meaningful inclusions.

Both practitioner and patient then spent considerable time discussing Mr. Roberts' diet and centred on sugar-ed foods, tea, coffee intakes and when and how much cake was eaten. He asked Mr. Roberts if he had even had a glucose tolerance test: Mr. Roberts replied that he had but it had not been suggestive of diabetes, and his medical doctor had simply shrugged his

shoulders and said he had a low blood sugar (about 40mg/ml) but he didn't think that was important.

The practitioner said that he himself considered it was quite important and very relevant to some other patterns which were apparent in Mr. Roberts' diet. He said that he now definitely considered that Mr. Roberts had two related problems: firstly a congenital hypertension which could be managed by weight control, life-style and leisure organised to avoid stress, and secondly, hypoglycaemia, which was a little bit more complex to manage. He believed that it was possible to manage both together though he warned that treatment did not produce instantaneous improvement. He thought that it would be up to a year before Mr. Roberts learnt to master his hypertension without drugs: however, if Mr. Roberts diligently followed the diet plan he was going to suggest, he thought that his lack of energy and interest in life would repair themselves.

The practitioner cautioned that Mr. Roberts must be prepared to stick ridigly to the diet which he would draw up for him, for three months. Perhaps he would then be permitted small indulgences: firstly, he must cleanse the body of its toxic wastes which were causing the problems. He suggested that Mr. Roberts totally eliminate all coffee and all sugar from his diet: sugar substitute was permitted as was tea. He then explained in detail how coffee and sugar affected glucose levels in the body and resulted in a rebound insulin release which became cyclic as energy waned and further sugar was ingested to restore it. He also suggested plenty of leafy fibrous vegetables in the diet, glasses of fresh rainwater and wholemeal bread and unprocessed bran to assist in cleansing the body of the past 35 years of accumulated food waste. Mr. Roberts agreed that he understood and fully appreciated the logic of the diet. He was prepared to give it a try - even though he had to give up chocolate bars which he loved and coffee, which he would sadly miss at work. The practitioner sympathised with Mr. Roberts

and said that he himself had once been very fond of chocolate. He pointed out again how important it was to stick rigidly to the diet.

(After the consultation, the practitioner told me that he was most impressed with Mr. Roberts, his attitude and his questions and he felt that he had the personal conviction to follow the treatment programme.) On departing, Mr. Roberts asked for a recommended book he could read on hypoglycaemia: the practitioner gave him one of his own to read and return. The practitioner suggested that if Mr. Roberts had any problems or felt the need for encouragement, he should ring him at the consultation rooms but otherwise, he would arrange a further appointment for three months time.

Consultation 3: Before the consultation 3, the practitioner had spoken to Mr. Roberts twice on the telephone: the first instance when he had returned the book on hypoglycaemia and on the second occasion, to see how he was going with the diet.

The practitioner was quite pleased with Mr. Roberts and added his encouragement. Mr. Roberts said:

> "I haven't found it easy but I'm sticking to it. My girlfriend is a great help...she's a health food addict anyway. She says I certainly needed to take more interest in life and in her: I can see that the book said that was one of the symptoms..."

The practitioner added encouragement and suggested that Mr. Roberts could now attempt the next part of his programme - that area directed at blood pressure control. He suggested that Mr. Roberts again start regular jogging - not on a cold beach at the break of dawn as that would dampen anyone's enthusiasm - but in the evenings and perhaps he might like to join a gym where he could get regular exercise, or perhaps take up social tennis or cricket, if he had played them at school. He explained the need for a regular schedule of leisure and how gentle exercise was important to the body. He suggested periods of relaxation be set aside at various times

during the day for reading, music, playing cards. Mr. Roberts expressed an interest in music.

A further visit was suggested in a month's time. No vitamin or mineral supplements were considered necessary despite Mr. Roberts' query following purchases by other patients in the reception room.

(The practitioner confided in me after he had left:

> "If Mr. Roberts was one of the usual sort of 35 year old fellows who regularly like to socialize at the pub with their friends and regularly eat out, we would probably have had more of a problem. He's a studious type and is studying to improve his qualifications. But then again, we probably would not have had a patient beyond the first consultation: those sorts of chaps usually only turn up here for chiropractic manipulation. They are usually quite content with a doctor's medications without thinking beyond the need for instant treatment and cure.")

Consultation 4: Mr. Roberts reported that he was sticking to his diet and had joined McNally's Health Studio. He had been assessed by the manager and told them that his problem was high blood pressure. A schedule of exercises designed around this problem and centred on weight lifting and chest expansion had been undertaken. He was pleased to also report that he was no longer falling asleep at lectures. He asked about blood pressure regulation and why medical doctors only suggested tablets rather than a schedule of exercise and relaxation such as the naturopath advocated. When the practitioner took a blook pressure reading, Mr. Roberts said that he had purchased a blood pressure monitoring kit himself for home use. He found it very interesting to take his pressure at different times of the day and following different patterns of exercise. The practitioner explained how blood pressure regulation, relaxation and energy balance in the body could be described in scientific medical and naturopathic belief systems so that they were simply saying the same things about the body using different languages. Mr. Roberts asked how the medical profession regarded such explanations because they seemed logical to him although the concept of a life

energy force seemed a bit 'esoteric' or 'philosophical' to him - was there scientific proof of its existence?

Consultation 5: It was six months before Mr. Roberts was expected to see the practitioner again. This followed a call from the nurse who suggested that the practitioner was interested in seeing Mr. Roberts and that there would be no charge for the visit. Mr. Roberts and the practitioner subsequently agreed that he was not only 100% better, but fully understood how he should organise his life and his diet. The practitioner wished him luck and asked him to call around at any time he had further queries or further problems.

Case no. VI - Mr. Quin Clinic C

Personal particulars: aged 29 years, married and living at Regency Park: police officer in prosecutions.

Presenting complaint: Crohn's disease and long-term medication.

The patient arrived to arrange an appointment with the practitioner after continual prodding and encouragement from his wife. His own family were not particularly enthusiastic about his trying a natural therapist using herbal, homeopathic and nutritional approaches but would not be against it as his health was definitely not improving. He had already been under medical doctors for three years and there had been little change. The drugs he was on were not agreeing with him and one doctor (whom he no longer visited) had even recommended surgery. Being diagnosed with Crohn's disease which affected the lower colon, he was not in continual pain and his life was not immediately threatened. However he understood that Crohn's disease was a condition which would limit his life expectations and would require him to be on medication for the rest of his life: this did not appeal to him at all. He though that he might visit the natural therapist as he had

tried everything else and his wife was quite convinced that it would have something to offer.

Consultation 1: Mr. Quin was closely questioned by the therapist concerning his condition, its prognosis, past and present treatments. Mr. Quin seemed to know a lot about his condition and said that he had read a lot about it as the doctors had not been particularly communicative. The therapist also asked about his present medication.

After considering everything that Mr. Quin told him, the therapist said that he felt sure that he could help him to live with his condition without drugs but, while he would assuredly feel better since his body did not have to deal any longer with toxic products of drugs nor their unpleasant side effects if he followed his advice, he would hold out no promise of cure - and he hoped Mr. Quin understood this.

Mr. Quin replied:

> "It's the tablets which are really getting me down. Psychologically, just the thought of having to take them for the rest of my life is enough - but I can cope with that - It's the fact that I always feel so listless and lacking in energy - surely I shouldn't feel that way all the time. And I seem to have this recurring white coating on my tongue and it tastes ghastly. Otherwise they're keeping me under control most of the time."

The therapist explained that the particular medication which Mr. Quin was taking would possibly contribute to a general lack of energy due to a resultant loss of vitamins which the body was not absorbing. He could give Mr. Quin a diet which should control his side effects but to start with he felt that it was wisest for Mr. Quin to continue with his doctor's medication and then once the two of them had seen how he was going then they would go to the next step. A diet record was to be kept. A second consultation was suggested in one month and in the meantime a very intensive course of vitamin B and vitamin K preparations was provided by the therapist.

Consultation 2: Mr. Quin returned to the clinic looking considerably better than before. He reported that he had more energy and that he was feeling better than he had for years except for the continual mouth problem. The therapist was pleased and spent some time going through the diet record with Mr. Quin. He explained how he felt it might be possible to gradually - and he emphasised gradually - reduce the medication. He did warn that if diarrhoea and cramping occurred, Mr. Quin must immediately increase his dosage back to the acute level until these problems passed. He must also inform the therapist. A careful explanation was given of how the diet worked to help cleanse the body of toxic wastes and promote natural inherent healing. An agent which would more or less substitute, in its action for the medication which Mr. Quin was presently taking, was also pointed out. Mr. Quin was instructed to eat small, regularly spaced meals and to eliminate salt, sugars and red meat from his diet. The therapist suggested that Mr. Quin's wife (who was sitting outside) might like to come in, if that was agreeable to Mr. Quin. He then explained to Mrs. Quin the principles of her husband's diet and how she could best assist him by cooking his meals and if possible, joining him on his diet which was a well balanced and general plan for health. She said that she had never been particularly fond of red meat herself so that she would not miss that item from the diet. She genuinely felt she wanted to help and would also try the diet - she said it would be fun doing to together. A further visit was arranged for six weeks time. The therapist suggested that either of them might contact him at anytime should any problem arise.

Consultation 3: Both Mr. and Mrs. Quin reported to the therapist that everything was going well on the diet. Mrs. Quin was quite enthusiastic as it was apparent that she herself had actually lost some weight which she had

secretly wished to do, while her husband had gained. The therapist then explained that the next step was to cut down on white meats and totally eliminate all red meat from the diet. He used diagrams to explain food metabolism and how different foods and vitamins affect the lower colon. He explained about carbohydrate, fat and fibre contents of foods as they related to Mr. Quin's condition and its care. He suggested a couple of books they might like to read. Mrs. Quin copied down their titles. They both asked questions about vegetarianism and different sorts of diet indicating that they had been reading some articles about the subject over the past two months.

The therapist suggested a health food shop where they would be able to buy most of the food he had recommended and it would be 'organically' grown without pesticides or chemical fertilizers which he explained Mr. Quin could be particularly sensitive to with his disease.

The therapist also recommended that both Mr. and Mrs. Quin set aside a time during the day to meditate, to collect their thoughts and relax. He gave them a little booklet on meditation and some tapes to play about relaxation and concentration.

Consultation 4: Six weeks later, Mr. Quin visited clinic C. He seemed very satisfied with his condition though he reported that in the second week of the diet he had had a slight bout of his disease. It had passed rapidly and he had not needed to recommence on the high dosage of his tablets. He wondered if now he could begin to reduce his maintenance dose and perhaps cut them out. The therapist carefully pointed out that he himself would not tell Mr. Quin to do this but if Mr. Quin himself wished to attempt to gradually cut them down and out, he should be able to do it now. He must continue with the present vitamin supplements and should any recurrence of

dis disease appear, then the tablets should be again used. Mr. Quin thanked the therapist and the two arranged to see each other again in about six months.

Consultation 5: Mr. and Mrs. Quin both arrived to visit the therapist about six months subsequent to the last consultation. Mr. Quin said how well he felt: Mrs. Quin endorsed that statement. The three talked generally and specifically about health. Mrs. Quin mentioned that the only thing she found difficult was when they went out to visit friends. Generally, she said that restaurants were quite all right, as they could select items from a varied menu. However, when they ate at friends' homes problems invariably arose. At first, their friends had been interested in their new eating habits and thought it was quite fun and prepared special vegetarian meals - although Mrs. Quin had said she wished they wouldn't go to any trouble. However, lately, she felt that they all regarded them both as a bit of a nuisance - they realised Mr. Quin needed a special diet because of his Crohn's disease, but were not happy to have to cater for someone 'different'. Mrs. Quin said that she offered these days to bring something for herself and her husband, but usually that made things worse. On one occasion, Mr. Quin had weakened because he had felt he was being such a problem and had had to suffer the consequences (fortunately not severe) for the next three days. Mr. Quin interrupted at this stage and said that he felt that the meditation which their friends had also discovered they practised, had 'branded' them as being a bit strange. "It was almost as if they simply stuck to the diet to be difficult" was how he felt. The therapist agreed with them that many people had this problem but it was simply a matter of persisting and eventually one's friends came to accept one as the situation was without query. The visit finished on a happy and friendly note.

Case no. VII - Mr. Turner Clinic B

Personal particulars: aged 44 years, married and living at Blackwood: businessman and retailer.

Presenting complaint: persistent migraine headaches which a medical doctor and a specialist had been unable to treat successfully. Exhaustive medical tests had revealed no underlying pathology.

Consultation 1: The practitioner suggested that iris diagnosis might shed light on Mr. Turner's complaint. In the face of a lack of trust in its reliability and its theoretical basis due to previous reading on iridology, Mr. Turner declined. His doctor had recommended that the practitioner might be able to treat his headache by biofeedback or acupuncture. There appeared to have been some hesitancy by Mr. Turner before visiting Clinic B but he indicated that he had tried everything else. The practitioner then explained what acupuncture involved and how it could be used to treat headache by the positioning of needles to relieve stress at certain critical points in the nervous system and thereby redress an energy imbalance in the body. It was this state of disequilibrium which was responsible for migraine headache where no pathological state could be detected. Mr. Turner accepted this explanation without quarrel. Acupuncture was performed together with gentle reassurances as the needles pierced the skin. A second session was arranged in ten days. The patient was requested to keep a record of the incidence of his migraine headaches and note whether they occurred after certain meals, following a crisis or some emotional upset.

Consultation 2: Mr. Turner reported that he could find nothing to coincide with the onset of his migraine headaches. He had had one three days ago but it had been a very hot and tiring day which was not unusual in his line of occupation.

Consultation 3: Ten days later more acupuncture was administered. No

headaches were reported between this and the earlier consultation. The practitioner asked about his patient's diet. The details given by Mr. Turner suggested that it was reasonably well balanced and that he did not eat, drink or smoke so as to abuse his body. The practitioner emphasised the need for adequate rest and relaxation between periods of work. Mr. Turner indicated that he did have a rather tense and complex family problem at present. The practitioner indicated to me privately that he believed that Mr. Turner's problems lay in having to deal with business problems during the day and going home to deal with another host of emotional problems in the evenings. He believed that Mr. Turner would only be slightly improved by acupuncture unless he learned how to deal with these pressures.

Consultations 4 and 5: Acupuncture was given for 20 mintues in both sessions. The practitioner talked about 'living with tension' and organising life to cope with problems on the job and at home and yet survive. He recommended that Mr. Turner join a health studio or a bowling club so as to take on a new sport and interest, to meet new friends and even establish more business contacts in the process. Mr. Turner laughed. At the conclusion of consultation 5, the practitioner said that he had done all that he could to help. The two men agreed that no further improvement could be expected and the treatment was now complete. If there was a recurrence of severe migraines, Mr. Turner said he felt he would like to have more acupuncture.

Case no. VIII - Mrs. Paterson Clinic C

Personal particulars: aged 57 years, married and living in Enfield: working as shop assistant part-time.

Initial questioning and patient records indicated that the patient suffered from colds and catarrh rather frequently, particularly in the early winter and was often unable to shake them off. She was not impressed with the

antibiotics which her doctor had given her on these occasions. A friend had suggested that she should try a herbal or homeopathic remedy. Mrs. Paterson was not so sure - however, when she was walking past the clinic she decided that her present bout of sinus and catarrh had gone on too long and she had already had two courses of antibiotics without success. Could the therapist give her anything?

Consultation 1: Mrs. Paterson was immediately shown into the therapist and explained her problem. He closely questioned her about past medical problems, sleeping and waking patterns, mucus, urine and took copious notes. He examined her iris with a special torch and explained what he was doing. He mentioned that the iris was often a mirror of the body's state of health. He explained how he thought her problems were related and gave her some herbal drops to clear the sinus condition. He asked to see her again in three days to see how she was progressing and see if they could work out a long-term solution to her catarrh.

Consultation 2: Mrs. Paterson said:

> "About ten minutes after taking the drops, I felt my ears pop and at the same time my sinus head cleared and I felt less stuffed up. It came back in about three hours so I took another dose: was that OK? What is it? I'd like some more, please?"

The therapist was pleased and answered some of her questions in detail. He explained how the drops stimulated natural forces in the body and helped redress the imbalance in elements which had occurred as a result of her antibiotics and infections. He explained that the antibiotics had killed the organisms but his treatment would not have the side effects which similar chemical agents - antihistamines - would bring, and would be easy for the body to deal with. He suggested that there might be certain chemicals, pollens or sprays in Mrs. Paterson's home which actually precipitated and aggravated her condition as well as any infection. She said

that she used to smoke but had given it up some time ago. However, her husband continued to smoke and she found it irritating. The therapist gave her another bottle of oral drops and a vitamin supplement to improve her respiratory and sinus weaknesses and suggested that she come and see him again in three weeks time.

Consultation 3: Mrs. Paterson returned during the course of her treatment to buy two more bottles of oral drops and said that she was still free of her catarrh. She now complained however, that with the cooler weather she was beginning to feel stiff in her joints and asked if the therapist could help her 'rheumatics'?

> "What the doctor gives me works for a while but I think my body is used to it all now and the rheumatics are getting worse as I get older anyway so maybe you can help with that too?"

The therapist suggested a liquid preparation for her to take regularly during the months she was troubled by rheumatism. He advised her to keep out of draughts and to keep the house warm and not to venture into the cold night air without adequate protection. He suggested that she refrain from doing too much hand washing and using cold water during winter.

Consultation 4: Mrs. Paterson returned at reasonably regular intervals for her rheumatism remedy (total about 3-4 bottles) and when she succumbed to a bout of sinus and a cold, returned for more drops and an inhalation. She did, however, also visit her local doctor for medication for both rheumatism and the cold - "just to make sure". Casually asked by the therapist if she had told her doctor about her natural remedies she laughed and said:

> "He'd say I was mad to even try them! Matter of fact, he may even say he won't treat me any more and I wouldn't want that, would I?"

She said that she thought it was good to have advice from two people because health was very important.

Case no. IX - Mr. Fellows Clinic K

Personal particulars: aged 43 years, married and living in Campbelltown: employed as an insurance agent in large company.

Present complaint: wants to give up smoking as he believes it accentuates his high blood pressure tendencies.

Consultation 1: Mr. Fellows had heard that Mr. R.K. gave advice on natural therapy and medical problems from his home Clinic K. He understood that he had had considerable success in treating people for smoking. His own medical doctor had told him that he had a tendency towards high blood pressure which should be controlled now as it could lead to heart problems in later years. He suggested that Mr. Fellows lose weight and give up smoking. Mr. Fellows was not particularly impressed by his doctor nor his approach but he realised that he should do something about his smoking:

> "He really put a scare into me, he did. I don't overeat - sure, I like my food - and the occasional drink and smoke, but only to be sociable."

Mr. Fellows asked if the therapist could give him a diet which would help him to lose weight and give up smoking too. He thought that the doctor's diet was horrible - he'd never stick to it.

After Mr. R.K. had obtained information about Mr. Fellows' present eating habits, he suggested a number of simple measures which would help but not be too drastic. He also suggested that he halve the smoking but if he wanted to smoke, try some special herbal lozenges which the therapist sold him. He suggested that Mr. Fellows call back in 5 days to collect a special diet designed to suit him personally and that he should cut out the smoking as well. This would cost him $140 but that was it - there would be no further financial outlay and it involved a further two visits to see how Mr. Fellows was progressing. Mr. R.K. said that he held out no promises and no guarantees because the success of his programmes rested on the patient's shoulders.

Consultation 2: Mr. Fellows decided to undergo the treatment programme and dutifully called for his diet. The therapist explained briefly how it worked. Mr. Fellows did not seem particularly interested in how it worked and only if it did. Mr. R.K. reiterated that a lot depended on Mr. Fellows himself and his conviction. He pointed out how the different components of the diet would counteract the urge to smoke and suggested a list of procedures for Mr. Fellows should he feel the desire to smoke.

Consultations 3 and 4: More than five weeks after the start of the diet programme, Mr. Fellows had not reported back to the therapist for his subsequent and pre-paid visits. The observer did contact him privately. Mr. Fellows said that the diet was all right for about two weeks but he had had trouble giving up smoking totally. He had lost about 4 kilos in weight and was moderately pleased with that as he was still not feeling quite as bloated. He had reduced his smoking by about half. He felt that this was due to his own efforts and possibly the herbal lozenges rather than the diet. While he was not dissatisfied with the diet or the consulations that he had had with Mr. R.K., he saw no point in going to the final visits. He had felt that the cost of the therapy was too high but at least he calculated that he had saved that much already in cigarettes so that was all right by him. He did not think he would recommend the programme without reservation to a friend but concluded by saying that all anti-smoking schemes seemed pretty costly anyway.

I told the therapist about this conversation and he replied that people like Mr. Fellows often did not stick to the diet or follow the anti-smoking programme to completion.

> "I'm here to give them encouragement and answer any questions. I can't DO it FOR them."

He admitted that financially his interest in natural diets, in people and in herbal anti-smoking lozenges was profitable but he was genuinely interested in helping them as human beings...not just out for the money. I felt that he was genuinely concerned for the people who visited him and sought treatment.

Case no. X - Miss Bateman Clinic A

Personal particulars: aged 24 years, single and living in Fulham Gardens: employed as a shorthand typist in the city.

Presenting complaint: listlessness, lethargy and not feeling all that well. Miss Bateman decided to consult a naturopath after hearing from her friend that she had been treated for a menstrual problem and the treatment did not involve any drugs. She was interested in natural remedies and had read a little about naturopathy and alternative medicine in the newspaper.

Consultation 1: Miss Bateman told the naturopath that she had been lacking in energy the last few months despite eating well and not having too many late nights. She generally enjoyed good health and played tennis regularly at the weekends. Her job was not particularly demanding and she had been employed by the same firm since leaving secretarial college. The naturopath closely questioned her about her diet and whether she had had any previous medical problems - other than childhood illnesses. He explained what naturopathy was all about and how it was related to life energy balance and dietary considerations in a common sense manner. He used simple physiological and medical layman's language and answered some questions she asked about vitamins and depression: she was also interested in how her diet could bring about an energy imbalance which resulted in her feeling tired. The naturopath explained that he felt that her problem was not entirely of a dietary nature - he couldn't be sure until she had had an iris photo or filled in a week's diet sheets - but it could have something to do with her

life-style. He asked did she have any personal problems and talked to her about her work.

Consultation 2: The iris photos revealed that Miss Bateman had no underlying medical condition and her diet sheet indicated to the naturopath simply that she required a vitamin B_6 and B_1 supplement. Nonetheless, he gave her a diet sheet which was not largely different in organisation from that of her present diet with the addition of the vitamin supplements. He talked to her more about her job and suggested she return in two weeks.

Consultation 3: Miss Bateman returned and reported that she didn't really feel any more energetic than before - despite the vitamins. The naturopath closely questioned her about each area of her diet and they discussed the various foods and their vitamin and mineral contents. He asked her about her tennis: did she have many friends?: her family?: a boy friend? There seemed to be some hesitation on the last question so he talked about her job. Perhaps feeling that she knew him better, Miss Bateman mentioned some problems she had been having with a changeover to a new boss when her firm had been taken over by another larger company about six months ago. She was pleased that she had not been retrenched but was not all that certain of how secure her position was - they did not seem to be particuarly busy. She casually mentioned that her boy friend had lost his job during the take-over and had only just managed to find another one at a considerably lower salary. She expected that this would very much delay any chance they had for getting married in the near future - she was 24 years old already! The naturopath spent a lot of time talking to Miss Bateman during the consultation and extended its time to almost 50 minutes. He gave her a completely new diet sheet to use for one week and suggested that she record the details of her body's reaction to the new foods. He hinted that he

had been interested in finding an enthusiastic and healthy patient to assist him in a couple of new programmes he wished to try and that her case was admirably suitable. He suggested the boy friend help.

Consultation 4: Miss Bateman reported to the naturopath eight days later and brought a notepad full of comments. She launched into a detailed description of what she thought about the diet and how much interest her boy friend had shown because he had not been aware that she was going to a naturopath. She had been delighted with his concern for her. They had tried a couple of recipes at the back of the sheet. The naturopath explained how he thought that the diet worked and how it was balanced in nutritional, conventional medical and naturopathic components. He finally suggested that Miss Bateman return to her earlier diet but incorporate some of the elements of the 'trial' programme for variety. He arranged a consultation in 4 weeks.

Consultation 5: Miss Bateman said that she was feeling a lot better and felt more secure in her job - she admitted that she had been reassured that her position would be secure but now she finally realised that that was the case. Her boy friend seemed happy in his new job and now saw it as a challenge. The naturopath advised her to continue with the present diet programme and only return should her problem recur.

BIBLIOGRAPHY

Aldrich, H.E. and Pfeiffer, J. (1976) "Environments of Organizations" in *Annual Review of Sociology*, 2:79-105.

Australian Bureau of Statistics (1980) *Australian Health Survey 1977-78. Doctor Consultations*. Cat. no. 4310.0. Canberra.

Ball, D.W. (1967) "An Abortion Clinic Ethnography" in *Social Problems*, 4:293-301.

Barnes, B. (1974) *Scientific Knowledge and Sociological Theory*. Routledge and Kegan Paul. London and Boston.

Beams, M.A. (1977) *The Social Process of Obstetric Care*. B.A.(Hons.) Thesis, Flinders University, South Australia.

Becker, H.S. (1967) (ed.) *The Other Side. Perspectives on Deviance*. Free Press, Collier-MacMillan Publ. New York.

———————— (1973) *Outsiders. Studies in the Sociology of Deviance*. Free Press. Glencoe. (first edition, 1963).

Berger, P.L. and Luckmann, T. (1966) *The Social Construction of Reality. A Treatise in the Sociology of Knowledge*. Allen Lane.

Bishop, J.M. (1979) "Institutional and Operational Knowledge in Work. A Sensitizing Framework" in *Sociology of Work and Occupations* 6,3:328-352.

Blackman, S. and Goldstein, K.M. (1968) "Some Aspects of a Theory of Community Mental Health" in *Journal of Community Mental Health*, 4:85.

Bloom, S.W. (1963) *The Doctor and His Patient. A Sociological Interpretation*. Free Press, Collier-MacMillan Publ. London.

Blumer, H. (1962) "Society as Symbolic Interaction" in Rose, A.M. (ed.) *Human Behaviour and Social Processes*. pp. 179-192.

Brim, O. and Wheeler, S. (1966) *Socialization after Childhood*. John Wiley. New York.

Bucher, R. and Stelling, J.G. (1977) *Becoming Professional*. Sage. London.

Campbell, A.V. (1978) *Medicine, Health and Justice. The Problem of Priorities*. Churchill Livingstone.

Clegg, S. (1975) *Power, Rule and Domination*. Oxford. Clarendon.

Diamond, J. (1979) *Your Body Doesn't Lie*. Harper and Row. New York.

Eagle, R. (1979) *Alternative Medicine*. Fontana. London.

Elliott, P. (1972) *The Sociology of the Professions*. Herder and Herder. New York.

Engel, G.N. (1962) *Psychological Development in Health and Disease*. W.B. Saunders. Philadelphia.

Engel, G. and Hall, R. (1973) "The Growing Industrialization of the Professions" in Freidson, E. (ed.) *The Professions and Their Prospects*. pp. 75-88.

Fabrega, H. Jr. and Silver D.B. (1973) *Illness and Shamanastic Curing in Zinacantan. An Ethnomedical Analysis*. Stanford University. California.

Frake, C.O. (1961) "The Diagnosis of Disease among the Subanum of Mindanao" in *American Anthropologist*. 63:113-132.

Freeman, H.E., Levine, S. and Reeder, J.G. (1973) (eds.) *Handbook of Medical Sociology*. Prentice-Hall Inc. New Jersey (second edition).

Freeman, H.E. and Simmons, O.G. (1963) *The Mental Patient Comes Home*. John Wiley & Sons. New York.

Freidson, E. (1962) "Dilemmas in the Doctor-Patient Relationship" in Rose, A.M. (ed.) *Human Behaviour and Social Processes*. pp.207-224.

———————— (1961) *Patients' Views of Medical Practice*. Russell Sage Foundation. New York.

———————— (1970a) *Profession of Medicine*. Dodd, Mead & Co. New York.

———————— (1970b) *Professional Dominance: The Social Structure of Medical Care*. Atherton Press. New York.

———————— (1973) (ed.) *The Professions and Their Prospects*. Sage Publications. Beverley Hills.

Garfinkel, H. (1967) *Studies in Ethnomethodology*. Englewood Cliffs. New Jersey. Prentice-Hall Inc.

Glaser, B.G. and Strauss, A.L. (1965) *Awareness of Dying*. Aldine. Chicago.

———————————————— (1967) *The Discovery of Grounded Theory*. Aldine. Chicago.

Gluckman, M. (1971) *Analysis of a Social Situation in Modern Zululand*. Manchester University Press.

Goffman, E. (1959) *The Presentation of Self in Everyday Life*. Penguin. London.

———————— (1961) *Asylums*. DoubleDay-Anchor. Garden City. New York.

———————— (1963) *Stigma*. Eaglewood Cliffs. New Jersey. Prentice-Hall.

———————— (1967) *Interaction Ritual*. Penguin. London.

Goldstein, M.S. (1979) "The Sociology of Mental Health and Illness" in *Annual Review of Sociology*. 5:381-409.

Gordon, G. (1966) *Role Theory and Illness*. New Haven, Conn.. College and University Press.

Goslin, D. (1969) (ed.) *Handbook of Socialization Theory and Research*. Rand McNally. Chicago.

Gouldner, A.Q. (1971) *The Coming Crisis of Western Sociology*. Heinemann. London.

Grimes, S.J.U. (1980) *An Anthropological Perspective on Gender in the Workplace: A Case Study of Women Working in Hotel Bars*. Ph.D. Thesis, Adelaide University.

Gross, E. (1958) *Work and Society*. Thomas Y. Cromwell. New York.

Hall, R.H. (1968) "Professionalization and Bureaucratization" in *American Sociological Review*, 3:92-103.

———————— (1979) "The Social Construction of the Professions" in *Sociology of Work and Occupations*, 6, 1:124-126.

Hetzel, B.S. (1974) *Health and Australian Society*. Penguin. Melbourne.

Honigmann, J.J. (1979) (ed.) *Handbook of Social and Cultural Anthropology*. Rand McNally & Co. Chicago.

Hughes, E.C. (1945) "Dilemmas and Contradictions in Status" in *American Journal of Sociology*, 50, 5:353-359 (March).

Illich, I.D. (1975) *Limits to Medicine. Medical Nemesis: The Expropriation of Health*. Martin Boyars. London.

Inglis, B. (1964) *Fringe Medicine*. Collins. London.

———————— (1980) *Natural Medicine*. Fontana. Glasgow.

Jacka, J. (1979) *A Philosophy of Healing*. Ithaca Press. Melbourne.

Johnson, T.J. (1972) *Professions and Power*. MacMillan. London.

Kaplan, D. and Manners, R.A. (1972) *Culture Theory*. Prentice-Hall. New Jersey.

Karl, S.V. and Cobb, S. (1966) "Health Behaviour, Illness Behaviour and Sick Role Behaviour" in *Archives of Environmental Health*, 12:246-266 and 531-541.

Klegon, D. (1978) "The Sociology of the Professions: An Emerging Perspective" in *Sociology of Work and Occupations*, 5:259-283.

Kosa, J. and Robertson, L. (1975) "The Social Aspects of Health and Illness" in Kosa, J. and Zola, I. (ed.) *Poverty and Health. A Sociological Analysis*. Cambridge, Mass. Harvard University Press.

Kuhn, M.H. (1962) "The Interview and the Professional Relationship", in Rose, A.M. (ed.) *Human Behaviour and Social Processes*. pp. 193-206.

Levi-Strauss C. (1963) Structural Anthropology Basic Books New York

Lieban, R.W. (1973) "Medical Anthropology" in *Annual Reviews in Anthropology* pp. 1031-72.

Lindesmith, A.R., Strauss, A.L. and Denzin, N.K. (1975) *Social Psychology*. Dryden Press. Hinsdale. Ill.

Lorber, J. (1975) "Deviance as Performance: The Case of Illness" in Scarpatti, F.R. and MacFarlane, P.T. *Deviance: Action, Reaction, Interaction. Studies in Positive and Negative Deviance*. Addison-Wesley Publications.

MacIver, R.M. (1955) "The Social Significance of Professional Ethos" in *Annals of the American Academy of Political and Social Sciences*, 297 (January), pp. 118-124.

Manning, P.K. and Fabrega, H. Jr. (1973) "The Experience of Self and Body: Health and Illness in the Chiapas Highlands" in G. Psathas (ed.) *Phenomenological Sociology: Issues and Applications*. Wiley. New York.

Marshall, T.H. (1962) "Professionalism and Social Policy" in S. Nosow and Form, W.H. (ed.) *Man, Work and Society*. pp.225-235.

Mead, G.H. (1934) *Mind, Self and Society: From the Standpoint of a Social Behaviorist*. Edited by C.W. Morris. University of Chicago Press. Chicago.

Mechanic, D. (1968) *Medical Sociology: A Selective View*. Free Press. New York.

———————— (1974) *Politics, Medicine and Social Science*. John Wiley and Sons. New York.

Merton, R.K. (1948) *Social Theory and Social Structure*. Free Press. New York.

Mills, C.W. (1956) *The Power Elite*. Oxford University Press. New York.

Moss, G.E. (1973) *Illness, Immunity, and Social Interaction. The Dynamics of Biosocial Resonance*. Wiley-Interscience Publ. New York.

Mouzelis, N.P. (1968) *Organization and Bureaucracy*. Aldine. Chicago.

Nosow, S. and Form, W.H. (1962) (ed.) *Man, Work and Society*. Basic Books. New York.

Parsons, T. (1939) "The Professions and Social Structure" in *Social Forces*, 17 (May). pp. 457-467.

———— (1951) *The Social System*. Free Press. New York.

———— (1958) "Definitions of Health and Illness in the Light of American Values and Social Structure" in Jago, E.G. (ed.) *Patients, Physicians and Illness*. Free Press. New York, pp. 165-187.

Pavalko, R.M. (1971) *Sociology of Occupations and Professions*. Itasca, Ill. F.E. Peacock.

Popper, M. (1934) *The Logic of Scientific Discovery*. Pelican. London.

Riesman, D. (1953) *The Lonely Crowd*. DoubleDay Anchor. New York.

Riley, M., Foner, A., Hess, B. and Toby, M. (1969) "Socialization for the Middle and Later Years" in Goslin, D. (ed.) *Handbook of Socialization Theory and Research*.

Rose, A.M. (ed.) (1962) *Human Behaviour and Social Processes. An Interactionist Approach*. Routledge and Kegan Paul. London.

Rosenstock, I.M. and Kirscht, J.P. (1979) "Why People Seek Health Care" in Stone, G.C. *et al* (ed.) *Health Psychology*. Jossey-Boss. London.

Sarfatti-Larson, M. (1977) *The Rise of Professionalism*. University of California Press. Berkeley.

Scheff, T.F. (1966) *Being Mentally Ill. A Sociological Theory*. Aldine. Chicago.

Smith, M. and Crossley, D. (1975) (ed.) *The Way Out: Radical Alternatives in Australia*. Lansdowne Press. Melbourne.

Strauss, A.L. (1975) *Professions, Work and Careers*. New Brunswick. New Jersey. Transaction Books.

_____ (1978) *Negotiations. Varieties, Contexts, Processes, and Social Order*. Jossey-Boss. London.

———— (1978) "A Social World Perspective" in *Studies in Symbolic Interaction*, 1:119-128.

Strauss, A.L. and Bucher, R. (1961) "Professions in Process" in *American Journal of Sociology*, LXVI:325-334 (January).

Strauss, A.L., Schatzmann, L., Bucher, R., Ehrlich, D. and Sabshin, M. (1964) *Psychiatric Ideologies and Institutions*. Free Press. Glencoe. New York.

Stanway, A. (1979) *Alternative Medicine. A Guide to Natural Therapies* Rigby. London.

Stone, G.C. *et al* (1979) *Health Psychology. A Handbook. Theories, Applications and Challenges of a Psychological Approach to the Health Care System*. Jossey-Boss. San Francisco and London.

Szasz, T.S. and Hollender, M.H. (1956) "A Contribution to the Philosophy of Medicine: The Basic Models of the Doctor-Patient Relationship" in *A.M.A. Archives of Internal Medicine*, 97:585 (May).

Taylor, R. (1979) *Medicine Out of Control. The Anatomy of a Malignant Technology*. Sun Books. Melbourne.

Wallace, W.L. (1975) (ed.) *Sociological Theory: An Introduction*. Heinemann. London.

Walsh, M. (1979) *Poor Little Rich Country: The Path to the Eighties*. Penguin. Melbourne.

Webb Report (1977) Committee of Inquiry into Chiropractic Osteopathy, Homeopathy and Naturopathy. Aust. Govt. Pub. Canberra

Weber, M. (1968 edition) *Economy and Society*. Roth and Wittich. New York.

Wilson, R.N. (1970) *The Sociology of Health. An Introduction*. New York Studies in Sociology. Random House.

Withers, C. (1946) "The Folklore of a Small Town" in *Transactions of New York Academy of Sciences*, 8:234-251 (May).