Alternative Health Care Utilisation Among Seniors

by

Nuala Katherine Wolfe
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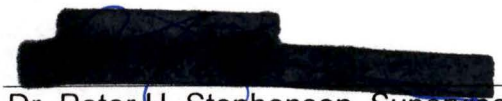
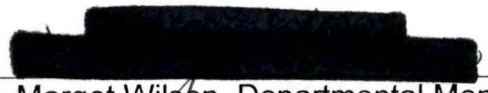


Dr. Peter H. Stephenson, Supervisor (Department of Anthropology)



Dr. Margot Wilson, Departmental Member (Department of Anthropology)

Dr. Margaret Penning, Outside Member (Department of Sociology)

Dr. Rita Schreiber, External Examiner (School of Nursing)



University of Victoria

Supervisor: Dr. Peter H. Stephenson

## ABSTRACT

The increasing use of alternative health care practices in the senior population has gone largely unnoticed in the current literature. For the general population, use of alternative therapies has been reported to occur as a result of physician dissatisfaction or as a concomitant of a changing ideology toward the body, mind and health care. In this qualitative study, fifteen seniors over the age of 65 were interviewed in Victoria, British Columbia to gain an understanding of why seniors use alternative therapies. This study focusses on five alternative health care practices including chiropractic, acupuncture, traditional Chinese medicine, naturopathy and herbology. The results indicate negative experiences with the medical system rather than with the family physician and a belief in responsibility for one's own health as factors for older adults turning to alternative therapies. It is concluded that seniors perceive the use of alternative therapies as a positive event both physically and mentally.

Examiners:

[redacted]

Dr. Peter H. Stephenson, Supervisor (Department of Anthropology)

[redacted]

Dr. Margot Wilson, Departmental Member (Department of Anthropology)

[redacted]

Dr. Margaret Penning, Outside Member (Department of Sociology)

[redacted]

Dr. Rita Schreiber, External Member (School of Nursing)

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# INTRODUCTION

While the rate of population growth in Canada is slowing down, it is slowing more for the total population than for the elderly population. Canada's elderly population (as a proportion of the total population) has grown steadily over the past 30 years (Norland, 1994; Ulysse, 1997). It is currently estimated that by the year 2021 older adults in Canada will make up 18.2 percent of the total population (Norland, 1994).

In 1991, those persons 80 years and older, often referred to as the oldest old, represented 20.6 percent of British Columbia's senior population. It is estimated that by 2011, seniors, that is those 65 years and older, will make up 14.4 percent of the Provinces population[1]. In addition to this, as the elderly population increases in proportion and total numbers, it is also getting older. We are therefore seeing two demographic trends in Canada's aging population. First there is an increasing proportion and total numbers of the elderly and secondly, the increasing life expectancy of the elderly is realised in the increasing numbers of the oldest old.

While living longer is something for which we generally strive, old age often is associated with declines in health and quality of life (Scrutton, 1992). The process of aging involves changes in health and the experience of illness (Hickey and Stilwell, 1992;

[1] For the purposes of this paper, seniors will defined as those older adults 65 years of age and older.

Scrutton, 1992). There is a strong positive correlation between life expectancy and chronic illness: as the life expectancy of our population increases, so does the prevalence of chronic illness and long-term disabilities (Gruenberg, 1977; Scrutton, 1992). As a result, functional status is often compromised and the number of health problems increase in the population, as does the hospitalisation rate for serious diseases (Roos, Havens and Black, 1993). Chronic illness and disabilities are the leading health problems in North America and for many older persons the onset of chronic conditions represents a potential threat to independence (Fries, 1983; Hickey and Stilwell, 1992; Lindsey, 1995).

It has been argued that the conventional Western illness care model is inadequate and inappropriate to meet the needs of seniors who experience chronic illnesses (Duggan and Bates, 1994; Lindsey, 1995, 1997; Scrutton, 1992; Verhoeff et al., 1995; Vincent and Furnham, 1996). Treatment is usually administered by physicians and nurses who are trained primarily in acute care and "institutions designed for emergency and highly technological care" (Lindsey, 1997:229). Similarly, this type of care discourages clients from taking an active, participatory and controlling role in their health.

In the following chapters I will report the findings of a qualitative study in which I sought to explore the reasons older

adults who experience one or more chronic conditions seek alternative health care. The thesis begins with a review of the literature, followed by a methodology section in which I introduce the participants and outline the methods used in the study. In the third chapter I will report the findings in two interrelated areas: (1) attitudes toward conventional medicine; and (2) attitudes toward good health. Three broad areas of discussion emerge under attitudes toward conventional medicine: (1) health care professionals and treatment; (2) medication or "pills"; and (3) "the system". Responsibility for health emerges as a theme under attitudes toward good health, particularly as it relates to the perception of choice, diet and exercise. Also under attitudes toward good health, are personal beliefs and philosophies and a sense of "independence".

# CHAPTER I LITERATURE REVIEW

Alternative methods of health care have long gone unacknowledged and under-researched in countries where conventional medicine is the dominant system of health care (Lindsey, 1995; Scrutton, 1992; Tovey, 1997; Verhoef and Sutherland, 1995). Alternative therapies are labeled as deviant, unsafe, superstitious, and unscientific by the conventional medical establishment (Gort and Coburn, 1988; O'Neill, 1994; Scrutton, 1992). The efficacy of alternative treatment is under constant scrutiny and lack of reliable empirical proof of its effectiveness and safety are at the root of its often discredited reputation. The differences between healing traditions, however, go beyond measurement and proof. The differences lie in opposing world views and approaches to health. Conventional medicine and alternative therapies share a common goal - to restore health. Their approaches differ in that conventional medicine aims to treat disease with a focus to cure, while alternative solutions employ a preventative and holistic approach to healing that involves treating the social, psychological as well as physical aspects of health (Christie, 1991; Furnham and Beard, 1995; Furnham, 1996; Scrutton, 1992; Vincent and Furnham, 1996; Weil, 1983). As such, it is believed that an important component to healing is to allow

clients more control to exercise choice in their health decisions and take responsibility for their health and healing (Gottlieb et al., 1995; Weil, 1983, 1985).

Some conceptual difficulties surround research involving ideas such as independence. The concept of independence is culture-bound, making specific definitions difficult and problematic as they will vary from culture to culture as well as from person to person. For North Americans, independence rates highly as a cultural ideal and, according to Kaufman (1994), is largely associated with achievement, productivity, individualism, progress and social usefulness. As it relates to seniors, independence is considered to be an important component of healthy aging (Anderson, 1981; Scrutton, 1992). In a study looking at independence among older adults, Penning et al. (1998) concluded that choice and functional status are integral factors toward a working definition.

According to Blais (1995), independence does not refer exclusively to self-reliance, social usefulness or the ability to perform physical tasks without assistance. Having reviewed the literature, Blais concludes that there are five elements associated with independence: (1) self-determination, including the ability to make choices and control decisions in one's life; (2) social relations and having access to resources; (3) barriers other than physical

disabilities that restrict one's sense of independence; (4) living in the community; and (5) subjective meanings of independence, as the meaning varies from person to person (Blais, 1995).

Perception of choice, or the actual ability to make meaningful choices and to control decisions is an important feature of maintaining an independent identity in old age. This is significant for elderly people who may already feel a decline in independence as they experience one or more chronic illnesses. As health problems among the elderly become more prolonged and serious, their sense of control over health diminishes as functional abilities become more compromised (Hickey and Stilwell, 1992). This situation may result in feeling, and perhaps becoming, less independent. Simply stated, effectively treating chronic illnesses would not only restore or maintain diminishing health and functional status, it may also contribute to a continuing sense of independence in one's life.

From the preceding discussion, one can infer that alternative solutions to treating chronic illnesses that include choice and control in addition to maintaining or restoring functional ability may contribute positively to a sense of independence and, in turn, to overall health in an aging population.

The strength of conventional medicine lies in treating acute

infections and medical and surgical emergencies (Scrutton, 1992; Vincent and Furnham, 1996; Weil, 1983). Approaches to curing chronic conditions by modern health care methods can be intrusive and wasteful and often result in over-medication (Furnham, 1996). Alternative therapies have been successful in treating irreversible, long term and complex disabilities and chronic illnesses (Furnham, 1996; Lindsey, 1992; Scrutton, 1992). However, care by physicians is still the primary choice for those experiencing chronic illnesses.

The association of chronic disease with use of alternative therapies and the demographic characteristics of its users, was recently described in a study conducted by Statistics Canada (see Millar, 1997). The study revealed that 15 percent of the Canadian population over 15 years of age have sought alternative therapies. Although this research is useful in revealing a positive correlation between the number of chronic illnesses and consultations with an alternative health practitioner (as chronic illnesses increase in number, so do consultations), it does not provide any insight into the reasons the alternative practitioners were consulted in the first place.

Other research to date reveals that alternative therapies are sought primarily because patients feel there has been a failure by conventional medical practitioners to effectively treat their

condition; health care consumers reject conventional medicines' reliance on the use of pharmaceuticals and surgical procedures in favor of alternative therapies, which allow patients to take a more active role in the maintenance of their own health (Furnham and Beard, 1996).

Alternative health care practices have enjoyed a rise in popularity over the past ten years in Canada. Medical doctors, while still our primary health care resource, are looked on less frequently as the sole providers of care, as alternative therapies have become regulated and to a lesser extent professionalised (Furnham and Beard, 1996; Vincent and Furnham, 1996). As a result of the growth in the number of alternative health care users, there is now an increased interest in research into the many dimensions of alternative health care utilization. In the literature, the term "alternative" is synonymous with terms such as "non-orthodox", "holistic", "complementary" and "preventative" medicines[2]. While none of these terms has been assigned a strict definition, the terms have come to refer to anything that is not conventional (allopathic) medicine as we know it. Wardwell (1992) argues that this is not a

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2 Therapies that fall under these headings include anything not included under the conventional medical umbrella such as chiropractic, traditional Chinese medicine, acupuncture, herbology, iridology, naturopathy, massage therapy, rolfing, yoga, therapeutic touch, homeopathy and chelation. This is not an exhaustive list, however and some cleansing diets and methods such as colon hydrotherapy can also be included.

useful category in itself, and called for further specification to facilitate research of the many varied types of health practices. As it is, "alternative" lumps faith healing with chiropractic, undermining the vast differences between the two therapies.

The literature to date falls into two broad areas of research: 1) differences between conventional and alternative therapies (Aakster, 1986; Aakster, 1989; Goldstein et al., 1988, Gursoy, 1996; McKee, 1988), and 2) health care and consumer choice (Furnham and Smith, 1988; McGregor and Peay, 1996; Strain, 1991; Vincent and Furnham, 1996).

There are fundamental ideological differences between alternative therapies and conventional medicine that may influence an individual's health care choices (Furnham and Beard, 1995; Furnham and Smith, 1988; McGregor and Peay, 1996; Strain, 1991; Vincent and Furnham, 1996). The literature identifies five areas in which alternative health ideologies differ from those of conventional medicine: (1) health, (2)disease, (3) diagnosis, (4) therapy, (5) patient. In Table 1, I provided a summary of the different facets of health care (see Aakster, 1986; Aakster, 1989; Furnham, 1996; Furnham and Beard, 1995; Furnham and Smith, 1988; Goldstein et al., 1988, Gursoy, 1996; McKee, 1988; Shneirov and Geczik, 1996).

The five areas outlined above form the basis of what many

authors feel contributes to an individual's choice in health care. That is, individuals choose their health care based on specific ideologies practiced by both consumer and therapist, or they may also choose based on their views of what constitutes practical reasoning.

The results of the research focussing on consumer choice and health care can be broadly categorised into two areas. First, it is reported that people consult alternative practitioners for practical or pragmatic reasons, and secondly for ideological reasons (Furnham and Smith, 1988; Furnham and Beard, 1996; Kelner and Wellman, 1997; McGregor and Peay, 1996; Schneirov and Geczik, 1996; Strain, 1991; Vincent and Furnham, 1996). Pragmatic reasoning refers to practical reasons relating directly to mental and/or physical health that influence health care behaviour. In the literature, pragmatic reasons often refer to dissatisfaction with some specific area of the medical establishment. This could include dissatisfaction with a medical doctor or specialist, or dissatisfaction with, or lack of confidence in, the efficacy of treatment offered by medical doctors or specialists (Furnham and Smith, 1988; Kelner and Wellman, 1997).

Ideological rationales refer to different health and illness beliefs held by patients that will influence their health care

behaviour. These include factors such as beliefs about disease etiology, perceptions of the body's functions, and beliefs about proper treatment and efficacy (Furnham and Smith, 1988; Furnham and Beard, 1996).

Furnham and Smith (1988) support the pragmatic school of thought, arguing that people seek alternative therapies because of past negative experiences with some area of conventional medicine. In 1988, they conducted a quantitative study in the United States of 87 people, 18 men and 69 women, aged 40 to 50. Roughly half sought homeopathic services while the other half consulted a general practitioner. Based on participants' responses to a questionnaire designed to determine perceived susceptibility to disease and illness, beliefs concerning their own control over their health and the perceived efficacy of conventional versus alternative therapies, these authors concluded that people are pushed away from conventional medicine rather that pulled toward alternative therapies. They suggest that people become disenchanted with conventional medical practitioners because of negative experiences, rather than because they believe that conventional medical treatment is ineffective. In addition, they found that the patients in both groups did not hold any fundamentally different health beliefs, nor was there any evidence to suggest that either group was

**Table 1: Biomedical versus Alternative Health Views**

| | Biomedical View | Alternative View |
|---|---|---|
| **Health** | Absence of Disease. | Positive state arrived at through balance of opposing forces. |
| **Disease** | Deviation in specific areas or organs of the body. | disruptive force; "restorative" practices emphasized (Aakster, 1986). |
| **Diagnosis** | Relies less on personal histories as it does on physical diagnosis using technological instruments check listing from a standard list. | "non-intrusive", low-technology with an emphasis on social, psychological, and spiritual dimensions. |
| **Therapy** | Strives to combat destructive forces relying heavily on pharmaceuticals. | Focus on strengthening to restore balance. Rely less on medications and emphasise indivual's responsibility for education and self care. |
| **Patient** | Adopts the role of passive compliance. | Adopts active role participation. |

healthier or lead a healthier lifestyle.

In a study conducted in the United States seven years later, Vincent and Furnham (1996) found that people are likely to choose alternative therapies for four main reasons. These are: 1) belief in

the value of alternative care, 2) previous experience of conventional medicine as ineffective, 3) concern about the adverse side effects of medical care and 4) poor doctor-patient communication. This study supports Furnham and Smith's (1988) earlier study citing pragmatic reasons as the primary catalyst behind consulting an alternative practitioner.

McGregor and Peay (1996) examined some of the the more popular factors that have arisen in current research explaining why people choose alternative therapies. In their study, patients of the Touch for Health clinic and a comparable community sample in south Australia were interviewed by telephone[3]. The researchers interviewed 166 people (43 men and 123 women), with a mean age of 41.7 years. They found that those who make the choice to see an alternative practitioner do, in fact, hold a less positive view of conventional medicine. In addition to this, patients were less satisfied with the outcome of conventional treatment for a chronic condition. The authors, however, point out that less satisfied does not necessarily mean dissatisfied.

Strain (1991) conducted a study in Winnipeg, Manitoba collecting data from a random sample of 743 people aged 60 or older (mean age 71 years), 59% of whom were women, to examine

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3 While the authors do not say specifically, the Touch for Health (THF) therapy is the Australian equivalent of what we call therapeutic touch therapy.

the influence of health beliefs on the use of various health services. She concluded that skepticism about medicine plays a role in utilisation, especially in regard to physician visits. The more prominent factor however, is health beliefs. In particular, Strain suggests that preventative health beliefs may promote use of the health care system. She based this conclusion on the fact that a stronger belief in the value of health maintenance activities is associated with the use of a greater number of services overall, including alternative health services.

Canadians Kelner and Wellman (1997) disagreed with these previous studies, citing their own research. They concluded that patients do not choose alternative therapies strictly for pragmatic or ideological reasons. Using a socio-behavioural model to help explain why people choose alternative therapies, they suggest that patients choose specific kinds of practitioners for particular problems and often use a variety of practitioners to treat a specific complaint. Kelner and Wellman's study differs from the other studies in that they look at a number of alternative therapies, whereas previously mentioned studies look at just one alternative therapy. In their study, Kelner and Wellman look at conventional medicine, chiropractic, Reiki, traditional Chinese medicine and naturopathy. In addition to this, the study is somewhat larger and is

based on 300 interviews which were later analysed both quantitatively and qualitatively. The authors also consider predisposing factors such as age, gender, educational level and health beliefs. Their findings suggest that, rather than relying on one or the other therapy, individuals shop for health care and choose a therapy that best treats their condition. In addition to this the authors disregard the notion of pragmatic versus ideological reasoning, stating that the choice of practitioner is multidimensional and cannot be clarified by either explanation.

There is no one single factor determining consumer choice in health care, however from the literature dealing with this topic, I suggest pragmatic reasons strongly outweigh ideological reasons as a main factor. This is not to say that ideological reasons are insignificant, however the majority of researchers dealing with this topic cite pragmatic reasons as the primary rationale for turning to alternative therapies. Strain (1991) stands alone in suggesting ideological reasons over pragmatic reasons, citing an individual's belief in preventative health practices. She does agree however, that pragmatic reasons arise but, in her experience, not as significantly as health beliefs or ideologies. While Kelner and Wellman (1997) argue that consumer choice cannot be restricted to pragmatic or ideological reasons, they argue that patients choose a practitioner

based upon a certain health complaint suggesting a more pragmatic approach to health care.

From the literature reviewed here, I suggest that utilisation rates vary based on sex, with women using alternative therapies more than men. In fact, in Canada, utilisation rates vary based on a number of factors including age, sex, education, income, regional differences and the number of chronic conditions experienced by an individual (Blais et al., 1997; Miller 1997). In a national population health survey conducted by Statistics Canada in 1994 and 1995 (Miller, 1997), it was estimated that 3.3 million Canadians over the age of 15 years have sought alternative therapies. Those aged 65 and over make up 20 percent of those users, with women consulting an alternative therapist more often than men. Among those with high school education, 14 percent consulted an alternative practitioner, compared with 16 percent of those with some post secondary education, and 16 percent of those with a college or university degree. Regional differences indicate women in British Columbia have the highest rate of utilisation in the country, at 24 percent, (versus 17 percent for men) compared to the East coast whose utilisation rate, for both men and women, is 5 percent[4].

Not surprisingly, the statistics in the study also indicates an

[4] Utilisation rate is refers to an individual having made one visit in the past year.

association between the use of alternative therapies and the number of diagnosed chronic illness (Millar, 1997). Nine percent of those who consulted an alternative practitioner were free of chronic disease, 16 percent had one chronic complaint, 20 percent had two chronic complaints, and 26 percent had three or more chronic complaints, indicating an increased use of alternative therapies relative to number of chronic complaints.

Blais et al. (1997) conducted a study to determine whether users and non-users of alternative therapies in Quebec differed in terms of demographic characteristics, health profile, or utilisation of medical services. Their data came from two sources. The first was the Quebec Health Survey conducted in 1987 of a representative sample of 11,323 households province-wide. The second source of data was the Quebec Insurance Board claims database, which contains the complete registry of services paid to physicians on a fee-for-service basis. The alternative therapies examined in this study included chiropractic, massage, acupuncture, homeopathy, herbal medicine, hypnosis, spiritual healing, naturopathy and osteopathy. The results of the study indicated that users and non-users of alternative therapies differed in age, activity, education and income. They suggest that the users of alternative therapies represent a select group of people, most likely to be

wealthier, better educated and younger, with women making up a greater percentage (Blais et al. 1997). After adjusting for age, income and education, the two groups had similar health profiles. However, users of alternative therapies also made fewer visits to their family doctor or specialist. These results suggest that there may be a positive impact on health for those using alternative therapies reflected in reduced physician visits. However, as the authors point out, more research, is needed to examine the reasons individuals seek alternative therapies and to determine the actual impact on health of various alternative therapies.

# CHAPTER II METHODOLOGY

The literature reviewed in the previous chapter provides us with an understanding of the differences between alternative therapies and conventional medicine as outlined in Table 1. It provides some insight into the reasons individuals choose a specific health care regime over another and suggests that pragmatic reasons are the predominant deciding factor.

Most research is based largely on quantitative research, with qualitative research being conducted as a secondary source of information (see Kelner and Wellman, 1997). Quantitative research has helped determine the general reasons why people seek alternative therapies, but qualitative research can help us *understand* the specific reasons why people look to particular alternative therapies instead of conventional medicine. As it is based on fine grain description, qualitative research allows in depth meanings and attitudes to emerge from the participants' personal histories and experiences.

Many researchers studying health and illness have relied almost exclusively on biomedical models based on "objective" knowledge about diseases and their treatment and, as a result, have largely ignored the personal attributes and characteristics of the patient (Hickey et al., 1992). I have chosen a qualitative research

methodology to emphasise lived experience and individual beliefs and attitudes toward health. As such, this will allow individual meanings of health to emerge. Secondly, Canadian researchers in the field of alternative health have tended to focus on the demographic profile of alternative health users and the association between chronic illness and the use of alternative therapies (Millar, 1997; Blais et al., 1997). This information has been helpful in establishing which population uses alternative therapies and for which chronic conditions. However, the researchers often neglect to consider the reasons *why* people turn to alternative therapies for chronic conditions instead of using conventional medicines. It has been suggested by Blais et al. (1997), that using a qualitative approach would be helpful to our understanding.

## A. INTERVIEWS

Data for this study were collected using an open-ended, semi-structured qualitative interview protocol based partly on preliminary key subject interviews conducted by myself[5]. Two groups of people were invited for interviews in the research. One group included senior users of alternative therapies and the other consisted of alternative health care practitioners. With the

[5] A key subject interview refers to a test run of the protocol whereby the interviewer and the interviewee can discuss the protocol and make the suitable changes.

exception of one participant who chose not to be recorded, the interviews conducted with seniors were tape recorded and transcribed. In this case, I took extensive notes and later typed them out. In the case of the alternative practitioners, all but one interview was recorded. As with the senior participant, I took extensive notes during the interview with this practitioner who chose not to be tape recorded. I did not transcribe the interviews conducted with the alternative practitioners because they were not the main focus of the project. However, extensive notes were taken from the taped interviews.

I drafted two interview protocols (see appendices A and B) based on the person being interviewed. The interviews were guided by a semi-structured qualitative interview protocol. However, the protocol did not entirely dictate the direction of the interview. I designed the protocol used for the alternative practitioners to get a broader understanding of each therapy. Simply lumping all alternative therapies together has been identified as problematic, and so I wished to understand what kind of differences existed for the clients of these various alternatives. I also designed the protocol for the senior participants with a more specific focus. I wanted to concentrate on the reasons seniors turn to various alternative therapies. As mentioned previously, the existing literature does not

focus on one specific population's reasons for using an alternative therapy. In addition, I constructed questions addressing the concept of independence as it relates to seniors' use of alternative therapies. In this way, I could determine if any patterns emerged linking the participants' use of alternative therapies to their individual sense of independence. As the recruitment and protocol varied for both groups, I address each in turn.

1. Alternative Practitioners

I chose to interview alternative health practitioners to provide some background information allowing for a greater understanding of the therapies used and the range of conditions the practitioners believe they can treat. In addition, I felt it was important to allow the viewpoint of the practitioner to be voiced.

I focused on four groups of practitioners: naturopaths, traditional Chinese medicine (TCM) doctors, acupuncturists/ herbalists and chiropractors. My reasons for choosing these four groups specifically was simply because in the greater Victoria area there are an abundance of alternative practitioners in these fields. This suggested that there might be a larger pool of patients who might be interested in the project.

The recruitment of participants was initiated by a letter to

alternative health practitioners detailing the research objectives and asking for their cooperation with an interview and also with recruiting the research participants. The alternative practitioners were chosen randomly from an alternative health directory. The original number of letters mailed out was 30 but the research criteria for practitioner participants greatly reduced the number of appropriate candidates. In the letter I asked that all practitioners have at least five years of experience in their field and have an elderly clientele who have been making repeat visits for at least two years. Five years of experience for a practitioner was not a difficult hurdle, however finding alternative practitioners with an elderly clientele was difficult. Finding alternative practitioners who have elderly clientele making repeat visits for two years who also agreed to be interviewed proved very challenging. It was most difficult finding a naturopath who could provide me with an elderly clientele, but I finally found one who was willing to participate. I asked for a clientele that made repeat visits because I wanted to maintain as much consistency in the user group as possible. Also, I believed that a participant who used a naturopath once may not have the appropriate experience demanded by the protocol. This kind of qualitative research requires expertise among the subjects.

The letter was followed with a phone call to set up an

interview time. I chose the first four who agreed to participate in the project. I conducted all the interviews assuring consistency in both the interview and the analysis. Three of the four interviews with practitioners were tape recorded with the permission of the practitioners. In the case of the interview I did not record, I took extensive notes which were later typed out and discussed over the telephone with the participant. I listened to the tapes of the remaining three interviews twice over and took extensive notes. The participants were informed of the research objectives and it was made clear that they could withdraw any statement or whole interview if they changed their mind. They were also informed that they could decline any answer asked of them and that anonymity was assured in the final paper by my using a pseudonym in place of their real names. Every participant seemed comfortable and eager to participate.

The location of the interview was determined by the alternative therapists. All of the practitioners chose to be interviewed in their offices. This setting seemed most comfortable for them and it made the most sense since the purpose for interviewing was to acquire a greater understanding of what they do.

With the exception of one senior participant who chose a neutral location, all chose to be interviewed in their homes. I found

all the interviews with seniors very comfortable and they seemed to enjoy the research topic. All the interviews were with individual participants. This strategy was largely determined by the participants in the study, who, with the exception of two couples who were interviewed together, chose to be interviewed alone. This is by no means a weakness in the methodology. Rather, it allowed for a more intimate and personal experience for both the participant and myself. Focus groups often yield information from dominant individuals, and would be problematic in this kind of research project by reducing the variety of expressed meaning.

The protocol for practitioners was designed mainly to provide some background information. It should be noted that while the interviews were tape recorded and notes were taken, they were not used extensively in the body of the thesis as the practitioners were not the focus of the research. Having said that, I do think it was important for me to interview them as it gave me a better understanding of the area of alternative health in general and of client experiences in particular.

2. Seniors

Recruitment of the senior participants was conducted by their practitioners. The practitioner asked their clients if they were

willing to participate and the practitioner then contacted me with the phone number of the senior whom I would then call to set up an interview. It made sense that the senior participant be asked to participate by their practitioners whom they know and trust. I provided the practitioner with an information sheet detailing the research objectives to give to the potential participant, as well as my phone number if there were any questions or if they felt more comfortable to contact me directly. In all but one case, in which the senior contacted me directly, the practitioner contacted me with the telephone numbers of seniors willing to be contacted. It should be noted that a bias does exist when the practitioner is asked to recruit the clients her\himself. It is likely that practitioners will *choose* clients they like and have treated successfully, that is, it will not be random. For purposes of this research, however, this may not be crucially important, or even relevant. Mays and Pope (1996) claim that systematic, nonprobabilistic sampling is often used in qualitative research. They state, "the purpose is not to establish a random or representative sample drawn from a population but rather to identify specific groups of people who either possess characteristics or live in circumstances relevant to the research" (Mays and Pope, 1996:12). In other words, the sample is intentionally structured to yield relevant information from a specific

group. I made clear to the practitioners that I would like them to ask all their clients over the age of 65 to participate to minimise what bias exists. The practitioners agreed and the names they provided me with are the clients who wished to participate.

As with the practitioners, I conducted all the interviews myself to ensure consistency. I began each interview with a summary of the research objectives and made it clear that they could withdraw any statement at any time they wished. They were also reminded that they could decline to answer any question asked of them and to assure anonymity, they were informed that a pseudonym would be used in the final paper.

Although I refer to all the interviews as being individual subjects, in three cases, more than one person was in the room at the time of the interview. In the first of these cases, I was interviewing a woman and her husband, both of whom were participants. The second case was a woman and a man who lived together as roommates, again both of whom were participants. In both cases, the interview took on a conversational flow that required far less prompting, allowing the couples to trigger each others' memories and add to each others' experiences. This in no way resulted in incomplete data; rather it prompted a more natural flow of information, allowing me to develop a sense for how one

experience relates to another. In the third case, I was interviewing a participant, Teresa, in a very small motel room, while her husband, Larry, remained in the room for lack of another space to occupy. Although he had his back turned to us throughout the interview so as not to disturb us, Larry often chipped in to remind Teresa of certain events and she often relied on his input to back up her attitudes or stories. Having been treated by an alternative therapist, Larry relayed his experiences, but finished off by saying "but I should just keep quiet". I had to wonder how Larry's presence possibly influenced the interview. I do not feel that Teresa censored her answers because Larry was supportive of Teresa doing the interview and because he consulted an alternative therapist himself. Finally, despite his attempt at being an unobtrusive bystander, he was an active part of the interview.

As mentioned above, when interviewing couples, I needed to use prompts less often as the interview took on a more conversational flow and addressed themes that were of interest to the researcher. Often, I would find myself the object of questions and I rarely discouraged this, suspecting that for some participants asking questions put them more at ease in sharing their experiences in their own terms, if I was willing to share some of my own. In most cases this occurred as an ice breaker and provided a format

for participants to discuss their experiences. Once it became obvious that I was there to learn from them and hear about their experiences with alternative medicine, questions directed at me usually subsided.

I transcribed and analysed the interviews using the qualitative analysis computer program, QSR NUD*IST. NUD*IST is useful in this case for two reasons. First, it serves as an excellent organisational tool, and second, it enabled me to determine the frequency with which certain topical areas became part of the conversations.

# CHAPTER III FINDINGS

In this chapter I detail the findings of the study. I begin with an introduction of the participants, followed by the results of the interviews. The patterns that emerge from the interviews indicate that attitudes towards conventional medicine and attitudes toward good health are significant factors determining why the seniors in this study consulted an alternative therapist. These patterns are examined in detail later in this chapter.

## A. The Participants

### 1. Alternative Practitioners

The practitioners in this research consisted of a traditional Chinese medicine practitioner, a naturopath, a chiropractor and an herbalist/acupuncturist. The herbalist/acupuncturist is the only woman in this group, the others are men. With the exception of the naturopath, all the practitioners are English speaking Euro-Canadians and have been practicing in Victoria between 6 and 14 years. The naturopath was originally from a South American country but has been in Canada for several years. Kevin, the acupuncturist, was able to provide me with the most participants (5), while Javier, the naturopath, had only one senior client seeing him for the minimum two years time. A few of the senior participants were consulting two

alternative therapists at the same time, so for example, while I may have been interviewing someone about his or her experience with acupuncture, he or she may also have discussed his or her naturopath as well.

My objective in interviewing the practitioners was to gain a better understanding of their respective approaches to health and illness. It was important to me to understand how an alternative practitioner successfully combines theory and practice in an environment where one medical system and ideology dominates. It became apparent to me after much reading and then talking with the practitioners that each of these therapies varies drastically and that placing all alternative therapies under one umbrella can be misleading. Taken literally, the term alternative therapy makes sense, as it connotes an alternative to conventional medicine, but in lumping them all together there is an inference that these diverse therapies are "all the same". Chiropractic and naturopathy are no more the same than acupuncture and conventional medicine, and yet both chiropractic and naturopathy are frequently lumped together as alternative therapies. It also implies that a bond exists among alternative therapies as a fringe group working against mainstream medicine. While there is an element of truth to this, there is also as much intra-therapy dissension as there is between

alternative and conventional medicine paradigms. Mike, the traditional Chinese doctor, began training in Victoria after he had consulted a traditional Chinese doctor to treat his arthritis years ago. He traveled to China to continue his studies and, upon completion, has made annual trips back to learn and teach. While he recognises the positive aspects generated by the recent trend in alternative and "natural" therapies, he is frustrated by the fact that many people feel they can practice therapies such as acupuncture and herbalism out of the context of traditional Chinese medicine; that one can become an acupuncturist without being a traditional Chinese doctor. He understands that the training may be adequate, however in his opinion, it is incomplete. He is similarly frustrated by the rising interest in acupuncture by medical doctors because he feels that they are not well trained and are simply using it to obtain control over alternative forms of healing. Mike summed it up by saying, "*acupuncture and herbalism are tools of Chinese medicine that cannot simply be removed from the tool kit and practiced by people who have a six month or even one year certificate*". Little standardisation and lack of professional status means that anyone can practice parts of this tradition which raises concern for Mike and results in a very protective and sometimes defensive attitude toward other health professions.

All practitioners with whom I spoke agreed that working together with the medical establishment and referring clients to each other would be ideal. Other than Mike's concern with the perceived dissolution within his profession, all practitioners were very supportive of other healing traditions and, significantly, also of the doctors with whom they work in Victoria.

2. Seniors

Fifteen senior participants were interviewed and ranged in age from 64 to 87 years old. Six of the interviewees were men and nine were women. According to the practitioners, this gender difference is representative of the user population in general. With the exception of two seniors, the participants were without life-threatening health problems.

In Figure 2 I summarise the health conditions of participants organised by the therapy they use. Four of the participants are using more than one therapy for one or more of their ailments. For example, Ruth has rheumatoid arthritis and is currently seeing both an acupuncturist and a naturopath for her condition. Tina, on the other hand, had experienced gynecological problems as well as having chronic leg pain. For her leg pain, she consults a chiropractor but for her gynecological concerns, she sees a

**Figure 2: Patient Treatment Summaries**

| Therapy | Condition | Meds | Participant |
|---|---|---|---|
| AC | Arthritis, "sore foot"<br>Abscess in ear | None | Sally<br>,, |
| AC | Arthritis | Herbs (AP)<br>Meds from GP | Paul<br>,, |
| AC | Arthritis, Hodgkins,<br>Fibromyalgia | None | Sandra<br>,, |
| AC | Black liver disease,<br>soft tissue damage from<br>car accident | None | Bridgitte<br>,,<br>,, |
| AC | Irritable Bowel<br>Syndrome and<br>pancreas problems | None | Elsa<br>,,<br>,, |
| AC | Peripheral Neuropathy | Meds from GP | Gerry |
| TCM | "Bad back" | Tylenol 3 | Andrew |
| Chiro | Broken hip ('70's) | Vitamins (self) | William |
| Chiro | "Bad" hips | None | Jenny |
| Chiro | Uneven legs, hip problem | None | Teresa |
| NP | Chronic Obstructive Lung<br>Disorder (COPD)<br>Diabetes (adult onset) | Prednazone (GP)<br>Medforman (GP)<br>Tincture (NP) | Donald<br>,,<br>,, |
| AC/<br>TCM | Irritable Bowel Syndrome | Herbs (TCM) | Frank<br>,, |
| AC/<br>TCM/Chiro | Gynaecological problems,<br>Chronic leg pain | Herbs (TCM) | Tina<br>,, |
| AC/NP | Rheumatoid arthritis | None | Ruth<br>,, |
| AC/NP | "Bad" knees | Herbs (NP) | Dotty |

traditional Chinese doctor who performs acupuncture and prescribes herbs. There is no definitive pattern that links a specific condition to a single type of therapy used, however, the table does suggest that chiropractors are seen mostly for mechanical problems such as hip and leg problems. Similarly, those participants who live with arthritis, consult an acupuncturist either solely or, as in Ruth's and Dotty's case, in conjunction with another therapy. Interestingly, with the exception of arthritis, none of the conditions can be considered a condition typically encountered in old age. Ailments such as "bad knees", "sore foot" or colds could just as easily be experienced in any age group.

With the exception of one participant who lives elsewhere with her husband, all the participants live in Victoria permanently. Two of the women participants are of German ancestry but have spent most of their adult lives in Canada, and one woman is Swiss in origin, also having spent most of her adult life in Canada. Five of the participants live alone, and with the exception of Gerry who has a caregiver, they all manage in their daily lives without outside assistance.

Gerry suffers from peripheral neuropathy, which has restricted him to a wheelchair. He currently lives in a care home but may return home once his caregiver returns from a recent trip.

Gerry's form of peripheral neuropathy is degenerative so he is limited in mobility and needs help with activities of daily living (ADLs)[6]. He sees an acupuncturist who treats him for his peripheral neuropathy. According to Gerry, the acupuncture slows the progress of his condition.

Donald, the second participant, has chronic obstructive lung disorder (COPD) and diabetes. He takes medication for both conditions, however his immediate environment is his greatest concern. His COPD is very sensitive to outside factors such as smoke, exhaust, or perfumes, which limits the amount of time he spends outside. He consults a naturopath mainly for his COPD.

Jenny has two daughters who often come over and help her vacuum, but she says this is just as much a social call as it is to help her out. Jenny told me with a laugh, that if her daughters are willing to do the vacuuming, she is not going to argue. The remaining nine participants are married. Among these, I interviewed two couples together[7]. With the exception of William, who runs his own consulting business, all the participants are retired.

Of the fifteen participants, twelve are not taking any medications prescribed by their family doctors or specialists. Three

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6 Activities of Daily Living (ADLs) include tasks such as bathing, dressing, shopping and household chores such as vacuuming and preparing meals.

7 One of the couples told me they were just friends. Having both been previously married and widowed, they decided to become roommates so they could split the rent.

are taking herbs or tinctures prescribed by their naturopaths and herbalists with some success. All of the participants exhibited a great knowledge and understanding of the conditions for which they were being treated, and all were able to discuss their conditions in alternative and conventional medical lexicons.

B. Attitudes toward Conventional Medicine

In the industrial world, the biomedical profession ranks among the top in social status, prestige and financial power (Gursoy, 1996). Today, medicine has attained a position of almost universal social control (Gursoy, 1996). When we fall ill, medical doctors are our primary resource, and it is therefore likely that when discussing health, and in particular, when discussing chronic health conditions, one would reflect on experiences and encounters with conventional medicine.

When I asked participants why they chose to consult an alternative practitioner, the initial response provided insight into the attitudes the participants held towards conventional medicine. The overall feeling is that alternative therapies are part of a whole health care regime employed by the participant. This is to say that health care is not seen as an either/or situation but rather, that alternatives have been adopted in addition to regular visits to the

family doctor, often because the alternatives fill a niche in health care that conventional medicine simply does not. In other words, the predominant issue is one of complementarity.

Andrew has had back problems for years and consults both medical doctors and alternative therapists. He explains his use of health care below:

> *So while Mike's acupuncture and massage therapy helps in tissue repair and massage does and so on, nothing would have cured it except for the surgery, ummm so that's the position I'm in right now.*

It is a similar situation for Ruth. Ruth suffers from rheumatoid arthritis and consults an acupuncturist for her condition. When asked if she sees a medical doctor, she explains that she sees an acupuncturist, a naturopath, and family doctor but each for different reasons:

> *Well yes I must see my family doctor fairly regularly umm, but he can't help my arthritis, he's tried and so have the specialists...I see my family doctor for other things.*

In what follows, I outline three interdependent aspects of health care that influence participants' health care behaviour.

1. Health care professionals and treatment

In a study examining compliance with medical treatment programs among middle-aged and elderly persons living with chronic conditions, Belgrave et al. (1997) reported that physicians' "interactional styles" influenced patient compliance. This suggests that the relationship one has with a practitioner influences health care behaviour. This was also the case with the participants I interviewed. The relationship between patient and practitioner proved to be of importance to the participants. Interestingly however, and contrary to much of the literature, the relationships the patients had with their G.P.s were of little importance to the decision to consult an alternative therapist. The relationships with alternative therapists, however, seemed to be an important aspect of their overall health care choices. With the exception of one, all of the participants liked their G.P.s and some were praised as "marvelous", "excellent" and "very progressive". The exception here is Elsa.

Elsa moved through the details of her Jewish youth in Nazi Germany delicately yet thoroughly, stopping only momentarily to make sure I was making the proper connections between her past experiences and her present physical condition. She suffers from mild depression, which she attributes to her years in Germany and to a recent car accident that resulted in "extreme problems with the

bowel and pancreas", leaving her limited in mobility and unable to sing. She feels now her only choice is to consult an alternative practitioner because of her previous disturbing visit to her doctor: "*I had a check up and he spent a minute and a half because he was too busy to see me and I find this appalling after four years*". This visit, Elsa confided to me, brought her to tears and she told her friends she never again wanted to see a doctor or "use the system".

At present Elsa is seeing an acupuncturist and has been doing so for two years. For Elsa, treatment does not simply mean the right medications, but rather the whole encounter with the health care provider:

> *he (acupuncturist) is very thorough and very kind and I don't know what it is about him being a bush pilot and I met lots of them in my travel in the woods working in Alaska and remote areas and I must say he is an amazing person that healed himself and he came out of it with flying colours and I think he found a sort of a niche in his life to give something back to society the way he is and I found that by having these treatments I have violent reactions, like the other day I came home and I almost absolutely passed out.*

Despite the "violent reactions", Elsa has found someone to whom she can relate, but perhaps more importantly, someone she feels can relate to her, someone whom perhaps she feels has shared

experiences and takes the time to validate her condition and experience. For Elsa, it seemed that the relationship with her health care provider is a factor influencing her health care behaviour. This is not just Elsa's experience. Bridgitte, a vibrant 71-year-old discussed her acupuncturist: "*she is a wonderful person and has a great empathy for people...and I like the way she knows exactly where it hurts and where to put the needles in*".

Diagnosis and treatment vary within the alternative therapies. Yet all share one characteristic that is virtually absent from the annual check up with a family doctor: close physical contact or touching. Many of the participants, especially the women, enjoyed the physical aspect of the treatment. Literally speaking, the 'hands on' approach may be equated with a greater intimacy and therefore a more personal encounter, and perhaps perceived greater level of caring. Sally explained that she was tired of being "poked and prodded" by her family doctor and much preferred the gentle massage and "soothing" touch of her acupuncturist. She explains:

> *He (acupuncturist) spends an hour and a half, he is very good, he would massage my feet and had a special liniment and it was good. Then he gave me what they call a neck release and I'm telling you my shoulders are tight and sore and he just puts pressure on those spots and it relaxes it. Then he puts pressure on two spots here and not hard but firmly and after a while he relaxes it and it is*

> *wonderful, I'd just come out floating, I'd limp in and I'd float out.*

For Sally, the hands-on approach makes her feel good, or relaxes her. For Joanne, who sees a chiropractor for her uneven legs, the physical aspect of the treatment not only helps her condition, but it allows for a more personal interaction. She explains:

> *From day one a chiropractor has to touch his patient...so for me, well I think that I'm more personal with Ian than I am with my doctor. He's (chiropractor) very gentle with me and even if I'm not umm if I'm not in bad shape, he'll give me a little massage and this is what I like because it does help my legs and umm well it feels quite relaxing.*

In addition to enjoying the physical aspect of treatment, many of the participants feel the personal relationship with their alternative practitioner transcends the boundaries of a traditional doctor/patient relationship. Sally's story exemplifies this wonderfully. Sally developed an interest in acupuncture through a series of mishaps with her specialist concerning an ear problem. Her ear ache developed into an abscess that "popped" while hiking in the mountains. The fact that her abscess went undetected was not a problem for Sally, although it made her angry because it ruined her hiking trip. Sally was more upset because her specialist:

> *...wasn't a communicative man actually, there would be a chart on the wall (and I would ask), 'show me on this chart what was wrong with me' and he never would...he was a Scot, he wasn't talking....and I felt so angry you know uhh and I know he's a good doctor but uh psychologically he wasn't there.*

Sally also suffers from arthritis, and later that winter, her arthritis became so bad that she could barely make it to the bathroom without help. She became lethargic and lost interest in doing the things she used to love. Her family doctor suggested a physician who also practices acupuncture out of a local hospital. Having had success with the treatment of the abscess in her ear by a traditional Chinese doctor in the past, she decided to go to the physician/acupuncturist. After one treatment she stopped going claiming:

> *Oh he was a very taciturn person he uh his whole conversation was 'good morning' we got to the needles and he uh (said) 'are you all right, are you comfortable' and 'goodbye' and that was the end of it so you know I wasn't very much encouraged to continue with it...I'm sure he was competent but there was no interchange and no interest so I wasn't going.*

Like Elsa, Sally makes it clear, that for her a more personal, communicative and interactive relationship with her health care

practitioner is an integral component of good health care and in helping her return to her own good health. She is quick to point out that both the specialist and physician/acupuncturist were "competent" and "good" but simply not helpful for her. Bridgitte has a similar story to Sally's. Having gone through a number of "invasive" tests to determine the source of chronic pain, Bridgitte was referred to a specialist. This is her experience:

> *oh and he was so rude to me and the nurses were absolutely disgusted with him because he was so rude. He didn't have any bedside manner whatsoever and he was continuously, he, uh he maintained I was putting this on and that there was nothing wrong with me, and it wasn't the gall bladder and the x-rays didn't show anything and there was nothing in the kidneys, there was nothing in my intestines. I had all these invasive tests done and umm he only did the liver biopsy because our family doctor insisted on it, you know because he said there had to be something. He had known me and my husband and I had been going to this doctor for a long time so he knew really well I wasn't putting this on. It was frustrating, he needed education in interpersonal relationships, that's the problem, they don't get taught in personal relationships.*

Although Bridgitte makes it clear that she was not satisfied with the treatment from her specialist, she does infer that her relationship with her family doctor was good based on the fact that

she had built up a relationship with him.

With the exception of William, who sees a chiropractor, all of the participants said their alternative practitioners spent more time with them and showed a keener interest in their thoughts about their conditions than did their family doctors. This, of course, can be partly attributed to the fact that therapies such as acupuncture by their very nature take more time.

For two participants, the personal relationship with their doctors or practitioners was not as important. William impressed me with an overwhelmingly detailed chart he creates daily and follows religiously, that outlines what minerals and vitamins he needs and in what foods they can be found. This is just a part of an overall health care regime for William. For William, a complete picture of health includes exercise, mental stimulation, socialising and a meaningful relationship with a partner. William explained this to me as we discussed his daily routine which includes reading and exercise. He says:

> *That's one of the reasons why here I am at 87 still with an active business and the reason is that I uh, by keeping up, it's good for me. Incidentally I think having a partner is important if you want to live a long and happy life.*

For William, trips to the chiropractor are more preventative

and play a small but vital role in maintaining overall health. The same goes for Jenny, a lively 81-year-old who lives alone. Jenny decided to consult a chiropractor at the recommendation of her daughter for her "mechanical problems". She prides herself on her good shape, given she's "*eighty-one and a half*", and does not need to go to the doctor claiming, "*there's nothing wrong...I don't have any inside, like anything to do with blood like sickness you know*". When probed about her relationship with her family doctor and the fact that she consults a chiropractor, she said, "*it's got nothing to do with them, you see, I mean I know some doctors hate chiropractors, why I think they'd rather shove pills*". So for Jenny, the relationship with her doctor and her alternative practitioner were of less significance than the fact that she simply needed help with her mechanical problems.

In sum, for many, the participants' relationships with health care professionals are key factors in determining health care behaviours. The participants place a great deal of emphasis on specific characteristics of treatment such as touching and talking, which some feel is absent from treatment they receive from conventional medical practitioners. While many participants express frustration with an impersonal doctor/patient relationship, short visits or too much medication with ineffective results, most

participants do not assign blame to their family doctors, who for the most part are well liked.

2. Medication or 'pills'

Medication or 'pills' came up frequently as the reason people consult an alternative to their doctor or specialist. Several participants experienced stomach troubles as a result of medication prescribed for their arthritis. Ruth, who suffers from rheumatoid arthritis, turned to acupuncture out of desperation because her medication upset her stomach:

> *well the thing is that one reaches the point of trying anything and uh, I certainly believe that we're living in a time for modern medicine but there's also a time for alternatives.*

While many of the participants experienced side effects to the treatment their family doctors or specialists recommended, they assigned no direct blame to their doctors or specialists. Andrew is a very active and youthful 66-year-old who became tired of the side effects of the medications prescribed by his doctor. In summing his experience with conventional medicine Andrew claimed:

> *well, if you're getting allergic reactions well, (the doctor says) we'll put you on some antihistamines and I go 'ok' and the antihistamines are going to make you drowsy*

> *and we're going to have to get you on something else to keep you awake and then you won't be able to sleep at night so so we'll get something to help you sleep and on and on and on it goes and even though I come from a fairly strong medical background, this didn't make an awful lot of sense to me....but the pressures on doctors are so great that they really don't have time to sit and rationalise the medical condition with their patients to my mind at least.*

Only three of the participants were taking medications from their family doctors at the time of the interview. Donald who has "*everything wrong with my lungs except cancer*" was taking medications from both his family doctor and his naturopath. Donald recounts his experiences with incredible accuracy, detailing events down to the very day. Being ill, he tells me, has been a significant part of his life. He tells me this more with a sense of pride, rather than with a feeling of resentment having felt that he has overcome many obstacles .

In 1994 and 1995, Donald had been to the hospital several times as a result of side effects from certain medications he was taking. When he discovered he had adult onset diabetes, he had yet another "confrontation" with the hospital because one of his medications was elevating his blood sugar, resulting in a weekend in

the hospital. Donald expressed frustration with this and drew, in his opinion, a clear distinction between the medications he was prescribed by his family doctor and the medication given to him by his naturopath. Upon hearing that he only had to make a trip to the doctor every two years rather than every year because of an improved condition, Donald says:

> *I know where it comes from, you see it's the uh it's the medication that I get from the naturopath, it's what the medication does for me so I can do my exercises to make my lungs work. In other words, Dr. Jones or Dr. Craig have never given me any medication that will help my lungs expand, they give me antibiotics and prednazone which kill the infection but they do nothing for the lungs.*

Tina explained that she became frustrated years ago because her doctor treated her only for her gynecological problems. She was experiencing post-menopausal symptoms, which she was told not to worry about because at her age it was normal. Tina was prescribed some medication, which she felt did not help and in fact she claims made her feel worse - "*Pills, pills, pills*" she said exasperated. After consulting a traditional Chinese doctor, Tina's symptoms subsided and she explains this was the result of the TCM doctor's ability to treat more than her immediate symptoms. According to her TCM doctor, her gynecological problems were not

all physical but a manifestation of other ailments. What Tina was suggesting was a holistic approach to health care, the cornerstone of alternative therapies.

In sum, medication or "pills" can be a catalyst in determining why one chooses to seek an alternative provider. Many of the participants placed emphasis on this aspect of treatment and showcased it in a rather negative light, maintaining that medications prescribed to them had negative side effects or caused other health problems requiring further medications. For Donald and Tina, some medications had their limits as to what they could do for overall health. As we saw in the previous section however, few of the participants held doctors personally accountable for this aspect of treatment. Rather, most saw it as shortfall in the whole "system" in general.

3. The "System"

Frank was an engineer. His life was engineering and everything he learned as an engineer is translated into his retired life; his identity is rooted in his previous work and it is his work that defines who he is. This is not unique to Frank of course. For many older people have spent a lifetime with the same career, and a large part of their identity stems from their career. When I talked with Frank

and his wife Tina about alternative therapies, Frank drew from his experiences as an engineer to exemplify his attitudes towards health care:

> *...one of the things that I learned in public relations, and public relations is a big part of what you do in fact umm as one of my profs very early in my career told me that 75% of what you do is people related, 25% is engineering and that is so true. And a clue to dealing with people issues in public relations is that you have to give 80% of your attention to 20% of the people, you know it's a squeaky wheel but some people need more attention and the health care system doesn't do that.*

Both Frank and Tina arrived at the realisation that "the system" was not working well for them. Frank's quote exemplifies what other participants were saying about wanting and needing a more personal approach to health care. Here Frank claims it is "the system" that is to blame and Elsa agrees. Claiming that doctors are under too much pressure from the government or drug companies, she says, "*I do think there is something wrong in our system uh people (health professionals) need to be listening more.*"

The "system" can be viewed as both the medical system in place in Canada and/or the government controlling the medical system. The term "the system" is ubiquitous throughout the

interviews. Though never defined, it is assumed we all know what is being referenced to and that it is the same "system" we're talking about. It is this very system that has turned people away from conventional medicine toward an alternative. It has negative connotations such as "pill pushing system", "symptom rather than cause focussed system" and "controlling system". It is a "system" whose philosophy is under attack by the participants. Those who practice under this "system", while not to blame, are regarded as unfortunate accomplices.

The "system" is also the government and is sometimes held accountable for the financial cost of consulting an alternative practitioner[8]. All of the participants are willing to spend money on the services provided by their alternative practitioners, but many of them discussed how unfortunate it is that they have to. For many participants, there was a correlation between "the system" and the fact that one had to pay for an alternative. As Jenny said:

> *That's why they (people) don't go so much because people have to pay for it, why they (government) don't pay for it I don't know. Jealousy, that's all it is cause they don't like the fact that a chiropractor can do what they can't do. They want to give you pills that just eases the pain it doesn't uh cure the situation.*

8 With the exception of chiropractic, none of the alternative therapies were covered by British Columbia's medical services plan at the time of these interviews.

Donald agrees that if the government recognised how effective his naturopath was, they might cover the costs. Donald developed asbestosis or chronic obstructive lung disorder, an occupational hazard his doctors told him, as a result of engineering for over 20 years. Like many seniors, he lives on a fixed income, so cost is an issue for him. For some time it deterred him from regularly seeking medication from his naturopath despite the health benefits it afforded him[9]. After a lengthy letter writing campaign to the Workmans Compensation Board detailing the benefits he experienced from his naturopath, WCB decided to cover part of his costs. When we discussed the medication prescribed to him by his doctor, Donald told me:

> *...the only reason I'm taking it (medication) is cause I'm covered by medical. If I had the option of going to Shoppers Drug Mart and getting my medication at the naturopath, I would go to the naturopath, that's how convinced I am.*

Donald felt it was his duty to make naturopathy recognised and felt a small but significant victory in having WCB cover part of his naturopathic costs.

All but one participant said they would see their practitioners more often if it was covered. Most of the participants made it clear

9 Many of the alternative practitioners charged a reduced rate or did not charge at all. In Donald's case, his naturopath covered some of the costs.

that we need the existing medical system and that it has served them well at some point in their lives. Andrew, for example, feels that without surgery on his back, he would not be able to walk, and he is grateful for the services provided by the medical system. Interestingly, this is the same system that Andrew criticises for over-prescribing drugs and not allowing doctors the time to "rationalise the medical condition" with their patients.

In sum, participants feel the system, which can be translated, depending on the context, as our medical system or the government controlling the medical system, has not met their expectations in some way. Many of the participants feel the medical system controls more than its practitioners; the system also controls patients and alternative health care providers. In maintaining its position as gatekeepers of health care, the medical establishment imposes user fees on anyone who ventures beyond the limits of medical care. For many seniors living with a chronic condition on a fixed income, this control over health care can be extremely limiting. For the seniors with whom I spoke, the response was to take their health into their own hands within the limits of what they could afford. It is an open question, however, whether the control they experience (as independence) would be compromised in some fashion if it was a service provided by "the system" itself.

## C. ATTITUDES TOWARDS MAINTAINING GOOD HEALTH

The attitude one takes toward health can be a factor in determining health care behaviour. Indeed, the attitudes participants held about their health appeared to be a contributing factor in their decision to seek an alternative to conventional medicine. There are three overlapping themes that reflect the attitude participants take toward health. These are: 1) health as personal responsibility, 2) personal beliefs and philosophies, and 3) sense of independence.

### 1. Health as a Personal Responsibility

The route one takes to maintain or restore good health may involve one or many health professionals, but according to participants in this study, restoring or maintaining good health is ultimately up to the individual. Every participant shared the attitude that maintaining health is a personal responsibility and as such, rather than rely entirely on a health care provider, it is up to the individual to do what can be done to maintain or improve health. This attitude is reflected in the interviews in several ways including becoming knowledgeable about one's condition by reading and researching. Two areas in which this is most prevalent: i) perception of choice in health care; and ii) diet and exercise.

i) Perception of choice in health care

As reported in the previous section, many of the participants turned to alternative therapies because they were not getting the results they wanted from conventional medicine. All participants agreed that having a choice in health care is important because it may improve health and because it gives the client control in decision-making over health care.

Ruth has battled with rheumatoid arthritis for years and was tired of seeing no improvement in her condition. For a time Ruth was bound to a wheelchair, leaving her unable to participate in many of activities. Upon hearing from her GP that her condition was not going to get any better, Ruth finally decided to seek other options and try other remedies stating, "*well, uh the conclusion that I came to, well it's my body and if my doctor didn't approve well I'd find someone who did*". Ruth, preferring a neutral location to be interviewed, met me at the public library. As we walked up three flights of stairs in search of a quiet spot to conduct the interview, she recounted a time when she was unable to walk at all. Ruth considers herself very fortunate as she has always received "excellent treatment" from both her GP and the rheumatologist. However, she feels that conventional medicine is "limited" when it comes to treating her chronic condition. The medication upset her

stomach so much she had to stop taking it. Feeling she had exhausted her options with her family doctor and specialist, she consulted a naturopath. With the help of a naturopath, and later an acupuncturist, Ruth feels her condition has improved considerably. Throughout the interview, Ruth referred to herself as being "lucky" or "fortunate" several times. In closing she repeated herself again saying she was "very fortunate" but added:

> *well, it's really a case of help yourself isn't it?....a lot of it is up to the individual. You can't just sit down and wait for people to, to cater to us, we're not going to get very far.*

If a choice did not exist for Ruth, she feels she would not be in the improved condition she experiences today.

Ruth's quote reminds us of one of the defining features of alternative health care: individual responsibility. According to Gursoy (1996), alternative therapies emphasise the importance of individual commitment to health care and individual's power to heal themselves. It can be postulated that the alternative paradigms match the attitude of many of the participants, facilitating the incorporation of alternative health care into their lives.

Frank and Tina also express the importance of having a choice in health care. For them though, having a choice is about having more control over decision making about health. Frank feels that

there is a positive correlation between age and loss of control, that as the older one becomes, the less control one is allowed over one's health. He has given this a great deal of thought and feels that control in decision-making is essential to good health, especially in old age. Frank explains:

> *the crux of the matter is control. And what I'm talkin' about here, uh that I am responsible for my health, not my doctor, not the government, I am responsible and I uh, if we work from that premise uh, the government provides a service to people but leave the individual in charge, give him the information and let him decide because I think people have a much greater knowledge than the system is giving them credit for.*

Tina is a retired nurse. She is still very active as a volunteer and was, at the time of the interview, a member of the board of a retirement home. She and Frank expressed frustration with how seniors' health is dealt with in homes, claiming that their health is secondary to administrative duties. Frank says:

> "*I have seen in some of our institutions for the elderly, you know, their control is taken away*". Tina added, "*I'm on the board and the providers uh health care providers uh they're doing so much recording of this and that, that the actual providing of health for the client is only a portion of it*".

The answer, according to Frank and Tina, lies in allowing clients more control over their own health, "*letting the client make the choices*" as Frank said. This is part of the attraction to their traditional Chinese doctor. Their traditional Chinese doctor encourages self-care and serves more as a guide for Frank and Tina if they run into difficulties with their health. While he has treated Frank's irritable bowel syndrome and Tina's gynecological problems, the traditional Chinese doctor feels that many minor health concerns can be dealt with by patients with the proper guidance. For example, he changed their diets and discussed with them an exercise program that would work well in their lives. This situation works well for Frank and Tina, as it puts control back into their hands. In this sense, an individual's health becomes more of collaborative effort between practitioner and patient/client, allowing the individual more control and decision-making power.

Andrew agrees with Frank and Tina's assertion that control in decision making about one's health is the key to good health. Having decided to modify his diet drastically both at the recommendation of his traditional Chinese doctor and from doing his own research, Andrew told me:

> *I don't feel in any way uh a loss from giving up these things (meat and wheat). I did it voluntarily, nobody made me so that was my*

> *own choice and maybe that's what made it easier ... it's probably harder when somebody else is, says uh makes your decisions...you do what you can to chart your own course uh uh and I think that's about all you can do.*

ii) Diet and exercise

All of the participants agreed that diet and exercise are important components of good health. Brigitte sees an acupuncturist for a number of health concerns. She was recently in a car accident, which resulted in soft tissue damage from her neck all the way down to her arm and left hip. Her doctor, feeling there was nothing else he could do for her, recommended an acupuncturist. The acupuncturist was able to help Brigitte with the damage resulting from the car accident, which allowed Brigitte to stop taking the cortisone injections she felt were not helping anyway. Also, to Bridgitte's delight, the acupuncturist was able to relieve some of the pain she was feeling from a spinal fusion she had undergone years ago.

Brigitte also suffers from a congenital liver disease called Dobin-Johnson disease. She explained that it was a dormant condition for years until she was diagnosed with what her doctor thought was arthritis, and hence she was incorrectly medicated. According to Brigitte, the arthritis medication triggered the black

liver disease which is now "active" in her body. After a long hospital stay, and numerous tests, including a biopsy, it was finally established, that Brigitte did indeed have black liver disease and not arthritis.

Brigitte explained to me that diet is the way she feels she can control her disease arguing:

> *well I uh, my experience is that you have to, you yourself are responsible for your health right? You know what helped me really a lot after (being) diagnosed with the liver problem? uh for years and years I got the Correction magazine and that really teaches you a lot about diet and what kind of uh vitamins and minerals uh* (you can take).

Brigitte taught herself how to control her liver problem because she said both her GP of fifteen years and her urologist admitted they knew little about nutrition. Brigitte now follows a strict diet based on organic fruit and vegetables, and restricts herself from certain foods like meat and many kinds of cheese. Brigitte read the magazine (Correction) for 20 years, and after much trial and error, finally found a diet that allows her to control the liver disease herself.

Sally also changed her diet, although she did so at the advice of her acupuncturist. Sally was asked to change her diet to include more fish and fruit for energy purposes, and flax seed oil instead of

olive oil for its anti-inflammatory properties. While this was difficult for Sally, she stuck to it and became more interested in the healing properties of certain foods. She proudly displayed a stack of books on her coffee table and eagerly discussed how much she has learned. She credits her recent cessation of using sleeping pills to her hobby of learning about food and diet and their healing properties. Sally still consults her acupuncturist for a sore foot and arthritis but is now able to control both her irritable bowel syndrome and insomnia with her current diet.

Paul and Dotty also follow a diet recommended by their acupuncturist. They refrain from consuming canned foods and feel that "natural" products, such as fresh fruits and vegetables are important for their health, specifically because a diet rich in vegetables and fruit allows them more energy to exercise.

Andrew, William, and Donald all feel similarly about the link between diet and exercise. Since starting his new high protein low carbohydrate diet, Andrew feels he is able to exercise more, and consequently see his alternative therapist and GP less. The combination of a good diet and ample exercise, he argues, is invaluable as a preventative measure. William agrees that prevention is a key factor in maintaining good health in old age. He argues, however, that prevention has to be taught to children in

school, because heart disease, cancer and diabetes are all leading killers in North America. He feels these diseases can be reduced considerably if children are put on a proper diet, watch less T.V. and play outside more often.

Exercise was discussed, usually in connection with diet, although to a lesser extent and with a little less enthusiasm. With the exception of Gerry, who has peripheral neuropathy and is confined to a wheelchair, and Jenny, all the participants took part in some form of regular physical exercise. Recently at her grandson's wedding, Jenny "popped out" her hip doing the "chicken dance". The chiropractor is able to help Jenny with the pain, but she is now unable to bowl, which she previously did three times a week. In addition to this, after surviving three strokes, which have left her with a weakened bladder, she is now unable to walk regularly 5 miles. Jenny, however, still considers herself very healthy and very active. She is part of a quilting group, socialises weekly with a group of friends and, until very recently, taught bowling to children.

Exercise is practiced by the participants with few reminders from their alternative therapists. Andrew, William, Donald, Sandra, and Ruth all told me they have been active throughout most of their lives. Paul and Dotty recently moved into a complex with a small garden and a bike path along the ocean. Though Dotty does not feel

they get their bikes out enough, blaming the weather, she feels satisfied with the amount of walking they do. Later she claims, "*well, I think we could improve*". At 70 years old, Donald exercises daily, exclaiming, "*I can walk with anybody and I'm in better shape now than I was when I was 40*". Donald acknowledges the help of his naturopath for his current ability to walk as much as he does claiming, "*his* (naturopath) *medications did not cure the problem, they aided the problem so I could cure the problem myself.*" Recall Donald's earlier assertion that the medication from his naturopath allows him to exercise his lungs.

To summarize, health is viewed as a personal responsibility by all the participants. Although they all consult both a GP and an alternative therapist, all think that when professional health care is needed, they want to have a choice in decision-making. As the participants in this study have attested, having a choice in health care allows seniors to exercise control over their health and may be helpful in treating their condition. Diet and exercise emerged as avenues to recover and maintain control over health in addition to being vital contributors to overall good health.

2. Personal beliefs and philosophies

Suggesting a change of diet to someone who has modified their

diet very little in fifty years is a tall order. As Sally said, "*it takes a l lot of self discipline. Meat and potatoes for fifty years is hard to change*." Andrew agrees with Sally, saying it is difficult, but he feels fortunate that he became interested in his health at an early enough age not to require him to make major changes.

All of the participants have changed some aspect of their diet in recent years, either as a recommendation from their alternative practitioners, or from educating themselves about the link between diet and good health. Although for some, like Sally, a change in diet proved to be a challenge, it was not as difficult as embracing a new philosophy toward health and healing.

For four of the participants, the alternative therapies discussed here were not considered "alternative". Three of them, Sandra, Brigitte and Elsa had spent a considerable amount of their adult lives in Germany and Switzerland. There, use of herbs, tinctures, and massage is considered mainstream and they are usually employed first, while physicians are consulted as a last resort or for more acute problems. The fourth, William, is an enthusiastic and positive 87-year-old who, since retiring, has started his own hair analysis business operating out of his home. He greeted me at the door of his apartment with a reddened face and a bottle of water, having just finished his morning workout on his rebounder (mini

trampoline). After suffering a broken hip in 1970, and at the recommendation of his wife, he saw a chiropractor. William has been seeing chiropractors for 28 years and does not consider them "fringe". He has been going ever since and claims "*now I go and I don't have any aches and pains but it is strictly preventative, it keeps everything in line.*" For William, as for many of the participants, alternative health care choices are made to supplement an already existing health care regime.

Having observed remarkable developments in science and medicine, beginning to embrace a new approach to illness and a new philosophy of health requires a shift in the way many participants think about their bodies and their physical condition.

Many of the participants did not initially believe in the effects of alternative therapies. In fact, few made the decision alone to consult an alternative practitioner[10]. Personal philosophies, faith, and personal beliefs came up frequently in conversations, especially when referring to health. This is not surprising, as many alternative therapies subscribe, by definition, to a different philosophy with regard to health, wellness, and the body. Philosophy and personal health beliefs were most commonly discussed among participants who consulted traditional Chinese doctors and acupuncturists. For

10 For three participants, their family doctor recommended an alternative. For others it was through the advice of a friend, a child or their wife/husband.

example, the concept of Qi (pronounced Ch'i) was discussed often at length by users of TCM and acupuncture. Qi, which can be loosely translated as the energy/life force of the body, is the conceptual foundation of TCM. Several of the participants found they had to shift the way in which they thought about their bodies in order to fully understand and benefit from the therapy they were receiving, and all were quite happy to embrace a new ideology.

Several participants claimed that if does not believe in the actual treatment, one will not benefit from it, although they were quick to point out that this attitude applies to many areas of life, not only to health and well being. Sally is a strong advocate of this philosophy, claiming that, "*you have to believe no matter what medication you're taking or vitamins or anything else, if you believe in it, it's going to be much better, and I believe*." This belief in the therapy is echoed throughout the interviews. Sandra agrees explaining:

> *It helps with pain and it helps with mobility and uh well because I believe in it, I read about and understand how it works and that helps a lot. You know with the body and soul uh have to work together and this is what they try to teach.*

Tina explained that being trained as a nurse, she was indoctrinated into one way of thinking about illness and health. She

and Frank were very skeptical at first about trying alternative therapies. Even after a friend had great results with Chinese medicine, Tina says they still "poo pooed" the idea. Finally Frank decided he would try traditional Chinese medicine as he was suffering with irritable bowel syndrome and was getting no relief with conventional medicine. Frank explained to me that he was diagnosed with a weak liver, but confessed that he had difficulty fully understanding what this meant:

> *you know they talk about Qi, and uh it's a very old way of looking at how our body functions. It's, it's hard for me to understand, he (TCM practitioner) tried to explain it to me but I'm afraid my thinking isn't quite that way but I accepted what he said and believe it or not I was starting to improve. Now whether this is psychosomatic or not I don't know but it doesn't matter because I was feeling better and I was able to sleep.*

For others, understanding what was happening was not as important as believing in the treatment. Sally told me she is well read on many topics including acupuncture, tai Ch'i, reflexology and nutrition, but she says:

> *I have read a great deal, I have read a stack of books this high but I do not understand, it's still a mystery to me. It's not part of our culture, it's very hard accepting something you can't quite grasp and it's hard work to try to assimilate all these new ideas, it's study*

> *and effort and you uh it's really quite demanding.*

As for causes of ill health, personal beliefs play a part. Both Andrew and Jenny feel that stress carries with it many health problems. Interestingly, one of the ways they see reducing the problems that come along with stress is thinking positively. "*Well it's a positive attitude you know*", Jenny told me when I asked how she maintains her current condition. Likewise, Andrew and William feel that a positive attitude in life allows for greater healing and better health in general.

In conclusion, personal beliefs and philosophies are factors determining health care behaviour. However, in this study it seems that for many, a change in health beliefs occurred <u>after</u> an alternative therapist had been consulted. That is to say, health beliefs did not contribute to the initial consultation, but rather it seems were adopted after the fact. Believing and accepting the philosophy of alternative health may be difficult, but it is an important component of healing. Believing in treatment, be it alternative or conventional, is also an important component to healing. As well, having a positive attitude towards all things in life is regarded as important to well being.

3. SENSE OF INDEPENDENCE

The final theme emerging from the interviews is a sense of independence. Independence is a cultural construction, and as such will mean different things to different people depending on factors such as age, gender, ethnicity or culture. In this population, as well as in many Anglo North American populations, independence is highly valued, and to maintain independence throughout one's life is an ideal.

The final section of the interview protocol addressed the issue of independence. The participants were asked if they felt alternative therapies have contributed to their sense of independence. All the participants responded positively to this question with the exception of Gerry. Gerry, who lives in long term care and is confined to a wheelchair, said he does not feel any more independent than he did before he started acupuncture. His acupuncture treatments do not improve his condition, but he feels they slow the process of degeneration, and perhaps allow more movement for him. However, as he has concluded, acupuncture is not going to get him out of his wheelchair. William was sure to point out that it was not only because he consulted a chiropractor that he feels so independent. Rather, it is the whole health care regime that he has maintained for over 25 years in addition to being part of a

meaningful relationship, which have yielded a strong sense of independence.

Since the protocol was designed to explore meanings surrounding health, chronic conditions, and alternative therapies, it is not surprising that most of the participants associated independence with increased mobility and pain management. It should be noted that this does not reflect the only way in which the participants may feel independent, but it is more likely a response to the topic.

Andrew and Susan confirm that mobility is an important aspect of independence. Andrew said he *hoped* that acupuncture was contributing to his independence stating, "*I certainly don't want to be in a semi vegetarian* (sic) *state in some place thank you very much*." Andrew implies both mobility and mental awareness are important aspects of independence. Sandra credits her current health condition to her acupuncturist and to the fact that she walks a lot and eats well. She said if she were unable to go out for her daily walk and socialize, she would not feel independent, suggesting that if one is not independent, one is not living: "*If I didn't do that* (see her acupuncturist) *I would be dead beat yeah, at home and uh to me this is not living*."

Brigitte, Donald, and Jenny associated independence with their

ability to continue living in, and maintaining, their own homes. Brigitte adds that her career has influenced her desire to remain independent, claiming:

> *I do still everything by myself and I want to keep it like that because I can't really imagine being dependent because having been a professional person umm I'm I'm used to a certain amount of independence. My exercises in uh in combination with the acupuncture really helps me to uhh I mean I was not really able to walk, I was not able to knit or embroider or do anything...this arm was completely useless.*

Donald credits his naturopath for his healthy condition and his ability to stay in his home, stating:

> *As I said, if I hadn't taken the medication (from naturopath) I would not have improved from my condition back in 1993 and '94. I would have the DVA* (Department of Veterans Affairs) *looking after me, coming in and putting me in the bathtub cause I was unable to do anything.*

Jenny agrees with Donald and Brigitte, but adds another dimension contributing to her sense of independence. Jenny attributes the fact that she has been on her feet for 18 years to her chiropractor, because he is able to control the pain in her hip. The pain she experiences is debilitating and therefore Jenny feels that,

without the pain management provided by her chiropractor, she would not feel as independent as she does.

Sally and Ruth discuss independence in the context of their overall health and fitness. When I asked Sally if she felt her health care choices have contributed to her sense of independence she said, "*Yes, it let's me do the things I want to do and uh I do a lot of things and I can continue with tai chi.*" When I asked Ruth the same question, she simply said "*well lets face it, when one feels well then one is independent, very independent.*"

Paul and Dotty were the only two that did not associate independence directly with health and mobility. Paul discussed independence within the context of his life with Dotty saying,

> *"Well I think what's helped us is, uh I lost a wife and then we got to know one another and we decided as friends lets get together and she pays her half and I pay my half*", to which Dotty replies, "*so that's independence.*"

Paul later explained that he always has been independent. He feels that most people of his generation have always been independent because many were brought up that way, and the social safety nets we take for granted today did not exist in his day. To exemplify this belief, Paul told a story that reflects his attitude, and influences the choices he makes:

> *When I moved first to 100 Mile House, it was five or six years that we didn't have a hospital, uh we didn't have a place for a doctor 'till the bank manager and I got together and he said, "Paul, why don't you build a couple of houses and we can have a dentist and we could bring a doctor in, he could come in from Williams Lake or Quesnel. We can take charge here". So that's what I did...there's nothing like helping yourself. It's a great experience when you're brought up that way you know, them days you had to get your bread and butter, if you didn't work, you didn't get welfare and that's it. They'd give you a shovel and say 'Here, you want welfare, here take a shot, and you'd work 10 hours not 8'.*

Paul's story reflects the sentiment expressed by so many participants when they discussed their reasons for seeing an alternative therapist. Although the context may be different, the message is the same: taking responsibility for yourself. Paul's attitude is not limited to his health care behaviour; it transcends all aspects of his life and implies that taking responsibility is a large part of feeling independent.

In conclusion, the participants felt that their use of alternative therapies has influenced their sense of independence in a very positive way. For most participants, alternative therapies have helped them increase or maintain their level of mobility, whether it be for exercise and hobbies, daily tasks or maintaining social ties

outside the home. Pain management is also an important aspect of alternative therapies for some participants. Chronic pain is debilitating, and so is an important feature of "independence".

# CHAPTER IV DISCUSSION

The present findings support the existing literature which states that those who make the choice to seek alternative therapies in fact do hold a less positive view of conventional medicine. This is not as straight forward as it may seem however. The participants in this study indicated that they hold a less positive view of certain *aspects* of conventional medicine, but not necessarily of conventional medicine as a whole. This supports McGregor and Peay's (1996) contention that dissatisfaction with one facet of conventional medicine, such as treatment of a chronic condition, may not be reflected in the evaluation of another facet, such as the participants' relationships with their family doctors. Participants in this study demonstrated less satisfaction with their relationships with medical practitioners compared to their relationships with alternative therapists. With the exception of one participant however, they agreed that they were generally satisfied with their family doctors. Relationships with medical specialists proved to be least satisfying, indicating perhaps continuity of care is an important aspect determining health care behaviour. That is to say both family doctors and alternative therapists have more continuous relationships with their patients, allowing for more personal

relationships.

The nature of alternative therapies such as acupuncture, traditional Chinese medicine, and chiropractic, involve touching or massaging. Naturopathy and herbalism also rely on a holistic approach, treating the mental as well as the physical aspects of the body. In this sense, alternative methods of diagnosing and treating illnesses allows for a more personal encounter with the patient.

Despite the more personal relationships established with alternative practitioners, all the participants still see their family doctors, either for an annual check up, or more frequently. It cannot be concluded that the participants in this study turned to alternative therapies because they were not satisfied with their family doctors. It can however be said that they were not satisfied with the treatment performed or prescribed to them for their specific conditions, often by specialists to whom they were referred. Dissatisfied with the treatment offered by their family doctors or specialists, the participants then turned to alternative therapies.

For many participants, the use of medications put them off conventional treatment, either because it did not work, yielded unpleasant side-effects, or created an iatrogenic response requiring still more medications. These results support Furnham and Smith's (1988) contention that it is the presence of troublesome chronic

conditions that motivates individuals to look to alternative therapies for relief.

In this study, however, there is another determinant besides the presence of one or more chronic conditions. All participants voiced the need for control over their health and in health-related decisions. Coupled with their view that health is ultimately the responsibility of the individual, we begin to see a clearer picture of the factors that contribute to consulting an alternative therapist. Since self-reliance is a major part of the early experiences of many older Canadians prior to the development of the welfare state, seniors may be predisposed to this perspective.

Many of the participants felt that the "the system", that is the medical establishment or its governing body, has too much control over health-related decisions, and does not put enough control in the hands of the client. What these findings indicate is that older adults in this group have turned to alternative therapies not simply out of some level of dissatisfaction with an area of conventional medicine, but also because they feel they have little control over their health and want to regain control where they can. All participants felt that one's health is a personal responsibility, and as such, felt that if one is not getting good results with one therapy, then it is up to the individual to find another that works.

Alternative therapies become an attractive solution to many who feel this way because they speak directly to many of the concerns the participants have with conventional medicine.

While the alternative therapies I examined differ from one another in diagnosis and treatment, the philosophies of each embrace a holistic approach to health care. One aspect of a holistic approach is making the patient an active participant in his or her health care, placing more control in the hands of the patient (see Table 1). As previously mentioned, most alternative therapies employ a more personal approach including touching and attention to mental as well as physical health. These aspects of alternative therapies directly address the issues raised by the participants regarding conventional medicine.

Ideological reasons for seeking an alternative therapist emerge in the data. However, the findings suggest that participants in this study adopted an alternative view towards health or health beliefs some time after they contacted an alternative therapist. This further supports the literature suggesting that people seek alternatives for pragmatic reasons. Having had successes with alternative therapies, many participants adopted a more holistic approach to health. The Western medical model of health care has to make room for the traditional Chinese model and the holistic

model employed by naturopaths and other alternative therapists. The present study provides evidence that pragmatic reasons contribute to participants' adoption of alternative therapies. However, it should be noted that alternative therapies are used with conventional medicine, depending on the condition.

The significance of this particular study, and the distinctive feature that separates it from other studies, is that it is a qualitative study in which the researcher listened to members of a specific population: seniors aged 65 years of age and older. By using a qualitative methodology, an in-depth understanding of which lies behind the reasons the participants have sought alternative therapies may be revealed.

What are the implications for an older population? The findings suggest that the meaning of independence for the participants in this study, is largely associated with health and physical mobility. Treatments prescribed or performed by alternative therapists were successful, thus allowing the participants a greater mobility and, enabling them to continue a lifestyle they were used to and wished to continue. In addition, the alternative philosophy promotes personal responsibility and places more control in the hands of the patient, something that seniors who value self-reliance particularly appreciate.

As health problems such as chronic conditions become more serious and prolonged, older adults may feel (and perhaps become) less independent, as their sense of control over health diminishes. If older adults feel they have a choice in health care and take advantage of these choices, not only will they feel they have restored some independence, but the choice of health care itself may improve their physical condition.

Alternative therapies may contribute positively to an older adult's overall health since many alternative treatments have proven effective in treating chronic conditions (Hickey and Stilwell, 1992). In addition, independence is enhanced as alternative therapies provide choice in health care, which in turn, promotes personal control and individual responsibility for health. These are certainly middle class expressions of control cultural values. Whether alternatives hold the same appeal for the poor, who may have less control over their lives, is less clear.

# CONCLUSION

Below I will discuss some implications for policy and practice, and make suggestions for further research based on this project.

The findings indicate that perhaps a more integrative model of health care delivery should be established in which medical doctors and alternative therapists work together in consultation. Many participants did not tell their family doctors or specialists that they were consulting an alternative practitioner. Some felt it was none of their business and others were afraid to offend or betray their family doctors. Whatever the case, there seems to be little communication between medical and alternative practitioners. A "dialogue group" (consisting of medical and alternative practitioners) was developed in Norway, with the hopes of promoting cooperation between practitioners of different therapies (see Moe Christie, 1991). In Norway, as in Canada, many people see both an alternative practitioner and an family doctor. However, members of these professions rarely meet, and the information they receive about each other comes mostly from unhappy patients who have been unsuccessfully treated by the other party. In this sense all the practitioners get a biased, and often incorrect, report of one another's practices. The "dialogue group" was set up to break down any preconceived notions and get a better understanding of what

each practitioner does. This would not only form a bridge between medical and alternative therapies, but between the alternative therapies themselves. This, in turn, would be helpful for those who consult alternative therapists, as they would no longer feel the need to conceal who they are consulting. It would also reduce or eliminate any feelings of betrayal to one or another therapist. Finally, it would be a first step toward an integrative health care practice.

The insights into areas of conventional medicine deemed less satisfactory than the alternative counterpart may also have some application to the education of medical students. Many Canadian medical schools still follow the didactic style curriculum relying heavily on lectures with little student participation. Recently, in British Columbia, however, there has been a switch to problem-based learning consisting of small group discussion and applied work. This setting may be ideal for the introduction of a doctor/patient relationship discussion or even a course.

Finally, there is little readily accessible information on alternative therapies as it relates to older adults. The participants in this study are not representative of the senior population as a whole. With the exception of one, all the participants were living in their homes with no assistance, and although the protocol does not

assess education and income of the participants, they seemed to be a fairly well-educated and well-off group. Essentially they are middle class, middle income Canadians. Those who are not as mobile, or who live in a retirement home or long-term care facility may not have access to adequate information regarding alternative therapies. Alternative therapists can become more public, speaking out to seniors in particular.

Future research focussing on consumer choice should look towards assessing each therapy individually. It became obvious throughout the project that alternative therapies differ considerably and should be taken as individual, unique health care practices. Chiropractic differs significantly from acupuncture in both diagnosis and treatment of the same conditions. At the same time however, both chiropractic and acupuncture are more widely accepted by conventional medicine than herbalism and many other alternative therapies. This may have implications for future research projects that lump all therapies together, because the degree to which an alternative therapy is recognised, both publicly and by conventional medical standards, may influence consumer choice. That is to say, lumping all therapies together when conducting studies on consumer choice may easily result in inconsistent findings.

In addition to this, more specific research with regard to

particular population groups could be conducted. This study has opened a door, as it made a connection between the use of alternative therapies and sense of independence. A more specific study looking at how older adults may feel particular therapies enhance their independence may be useful. This way we could determine if it is, in fact, an alternative treatment itself that is decisive, or perhaps it is more the connection between holding an alternative philosophy and independence that has been found in this project.

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# APPENDIX A

## PROTOCOL FOR ALTERNATIVE HEALTH PRACTITIONERS

BACKGROUND INFO.
Can you give me a brief history of your training and career as a practitioner;
-where did you train
-how long have you been practicing
-reasons for involvement in health field esp. alternative health

EXPERIENCE WITH SENIORS
Can you give me a rough idea of how many seniors use your services, or roughly what percentage of clientele are seniors?

How many are regular clientele of seniors as opposed to one or two time users?
-the answer may depend on the health condition being treated

Can you tell me what brought them to you?
-family
-friend
-referral from physician
-do you advertise at seniors centres etc.

What do you find you treat in seniors?
-chronic vs. acute
-mobility and pain management
-psychological

Do seniors health concerns differ markedly from the health concerns of the rest of you clientele?

Are there conditions that you find you treat more often than not among seniors? (Ie. Is there a commonality in what you are treating in seniors?). IF YES: What are they?

Can you briefly describe to me how you treat the condition?

-does the "prescription" involve behavioural changes such as changes in diet and/or exercise.
-does it involve contact(touching)
-does it involve medication(herbs)
-do you think the treatment has been successful in the seniors you've treated?
-what do you attribute the success to?

*look out for how the practitioner responds to the word "condition". Many alternative practitioners treat a "system" rather than a condition, as one condition is likely related to many other conditions

Can you treat a person who is on multiple medications?
-relationship with physicians/family doctors
-can the two work together?
How much time do you spend with your senior clients? (Likely this will vary depending on the treatment, I want to see if they spend more time with seniors).

DIVERSITY OF CLIENTELE

Do you get a diversity of senior people, with regard to ethnicity, cultural distinctions, and/or wealth? IF NO: ask why they think that is.

Do you think wealth or financial security is a deciding factor in using your services?
-if it was covered partially or fully do you think you would see an increase in senior use?
-how much do you charge?

INDEPENDENCE

Discuss independence study briefly if it hasn't been covered.

Do you think that alternative therapies contribute to feelings or a sense of independence among seniors?
-possible probes are pain management, mobility and psychological factors.

-self care
-IF YES: do your patients relay this to you somehow or is it something you believe to be true?
Do you refer you patients to any other specialists? IF YES: what kind and why?

Do you have anything you would like to add regarding alternative health and seniors?

# APPENDIX B

## PROTOCOL FOR SENIORS USING ALTERNATIVE HEALTH SERVICES

Can you give me a thumbnail sketch of how you view you health in the context of your life?
-has it always been a concern?
-have you been healthy your whole life?
-how important is good health to you?

Can you tell me about your experience with alternative health?
-why did you start?
-when did you start?
-why this kind of alternative therapy?

NOTE: the following questions will likely arise out of the previous questions.

How did you hear about the alternative practitioner you are seeing now?
-family
-friend
-physician
-advertisement

Do you see any other alternative practitioners? IF YES: what kind and why?

What does the alternative practitioner treat you for?
-Chronic vs. acute
-mobility and pain
-psychological

How does s/he treat it?
-medication?
-behavioural changes(meditation, change of diet, exercise)

-touching?

Have the therapies been successful for you?
-again look for WHY and HOW(pain management, mobility etc.)
-control over you own health
-how soon they saw or felt results?

Would you recommend this therapy to others?

How often do you see your alternative therapist?
-how long do you spend with them on each visit?(may depend)

Do you have a family doctor? IF YES: How often do you see your family doctor?

Do you see your family doctor more or less since you've been seeing an alternative health therapist? IF LESS: Why?

Are you on any medication from your family doctor? if YES: WHAT
-is it helpful for you?

Does your family doctor know you see an alternative health therapist? IF NO ask why they don't tell him/her? IF YES: ask if s/he is supportive of this.

Do you see them for different health concerns? IF YES: how do they differ and why do they see two health professionals?

Would you see your alternative health therapist more if it cost less or was covered by MSP?
-IF YES: HOW much more would they see them?
-would you switch over completely if it was covered?

INDEPENDENCE(may come up before the end of the interview)
Have alternative therapies contributed to a sense of independence for you? (May bring up a definition of independence). IF YES: ask how.
-possible probes are pain management, mobility, control over one's

health, self care etc.)
-ie. how does pain management contribute to this feeling etc.

Is there anything you would like to add regarding alternative health care in general?

# VITA

Surname: Wolfe Given Names: Nuala Katherine

Place of Birth: North Battleford, Saskatchewan, Canada

Educational Institutions Attended:

University of Victoria 1993-2000

Degrees Awarded:

B.A. University of Victoria 1997

Honours and Awards:

University of Victoria Fellowship 1997-1999

Publications:

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_____

_____

_____

_____

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Author 

Nuala Katherine Wolfe

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