"You just got to eat healthy": The topic of CAM in the General Practice consultation

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Abstract

New Zealand research suggests that CAM use by GPs has decreased, while referral to CAM practitioners by GPs has increased, and that patients often do not tell their health practitioners when they are using CAM. The New Zealand Medical Council has developed guidelines for GPs who use CAM. However, there is no research in New Zealand that looks at how patients and GPs respond to CAM issues in the consultation. This paper uses data collected for two research projects on doctor patient interaction. For this research consultations between 105 patients and 9 GPs were video-recorded. In this data set, all but one doctor was 'orthodox' and to some degree reserved judgement on to CAM, albeit remaining cautious in how they made this evident. Patients on the other hand demonstrated a variety of strategies to get CAM on the agenda, and GPs were careful to couch any criticism in such a way as to protect the 'face' of patients.

Keywords:
Sociology; complementary and alternative medicine; doctor-patient interaction

Acknowledgements

This research was funded by the New Zealand Health Research Council and the Marsden Fund of New Zealand. The research team would like to thank the participants and also Dr Deborah McLeod for her input.

In New Zealand there has been a trend of increasing referral by GPs to CAM therapy, with nearly 95% of GPs doing so, but a decreasing number of GPs practising some form of CAM, with only 20% doing so (Poynton et al., 2006). New Zealand research suggests that only one-third of patients who use CAM disclose this to their medical practitioner (Nicholson, 2006). The New Zealand Health Practitioners Competency Assurance Act (2003), which covers general practitioners and other medical practitioners, states that a practitioner cannot be found guilty of a disciplinary offence "merely because that person has adopted and practised any theory of medicine or healing if, in doing so, the person has acted honestly and in good faith" (Medical Council of New Zealand, 2005). The Medical Council of New Zealand's guidelines for medical practitioners who use CAM places the onus on the practitioners "to inform the patient not only of the nature of the alternative treatment offered but also the extent to which that is consistent with

conventional theories of medicine…"(Medical Council of New Zealand, 2005). Underpinning this and indeed all practice of doctors is the Hippocratic Oath to 'prescribe regimens for the good of my patients ...and never do harm to anyone'. This can be applied to CAM as to all aspects of medicine.

Although there is research looking at CAM use by practitioners and patients using interview data (Dew, 2001) (Tovey & Broom, 2007) and a great deal of research using data from naturally-occurring physician-patient consultations that looks at a range of other issues (see (Heritage & Maynard, 2006) for recent examples) there are no examples in the extant literature of studies that explore CAM issues using interactional data. This paper explores interactional issues in relation to two issues: GP responses to patient-initiated CAM talk; and explicatory work undertaken by CAM GPs and orthodox GPs in relation to causation. A thread throughout these domains is the interactional work that CAM issues provoke in the general practice consultation.

The data analysed for this paper was originally collected as part of two related projects exploring clinical decision-making and tracking the interactions of individual patients with health professionals as they move through the primary and secondary care systems in New Zealand. Video recordings were made of 105 consultations with 9 GPs. The GPs were recruited from a mix of central city and suburban practices. All nine consultations where CAM issues were identified have been used for this paper. The paper is divided into two sections, the first looks at interactions involving orthodox GPs and the second looks at interactions involving a CAM GP.

The transcription conventions used in this paper are a simplified version of the one developed by Gail Jefferson (ten Have, 1999) and are appended.

Orthodox GP CAM talk

In this data set there are seven cases where patients raise issues that are CAM related and GPs respond to these in a variety of ways, in practice 'reserving judgement' on CAM to the extent necessary to protect the 'face' of their patients.

In Extract 1 the patient requests information on his blood type, which at first the GP responds to in a positive light before she appreciates that it is wanted as a move to CAM practice by the patient.

Extract 1:
GP06-03

1. GP: and um (.) now you had blood tests (.) they were all last year
2. PT: do you know wha- what my blood type is
3. GP: no [I haven't] done a test for your blood type
4. PT: [( ) no]
5. PT: oh okay
6. GP: if you want me to do a test I will but there'll be small charge for that
7. PT: yeah yep okay (.) it's just I was thinking maybe doing a diet that um- and they

8. need you know it's good to know what your blood type is and they tell you
9. what type of food to eat
((GP turns from computer and faces patient))
10. GP: oh yeah ((inhales))
11. PT: yeah (.) or [not]
12. GP: [well] if you want to it I. mean it there's [none of these diets]
13. PT: [nah (i don't think so)]
14. GP: have any great basis I have to say
15. PT: nah oh you just got to eat healthy [that's all]
16. GP: [I think] you've just got to [eat] a varied
17. PT: [yep]
18. GP: [die-] actually the mediterranean diet's the one we're [all] supposed to be eating
19. PT: [yep] [yep]
20. PT: yep
21. GP: and doing a bit of exercise
22. PT: yeah yeah yeah I know
23. GP: so if you're doing [that] alan [you're fine]is that okay
24. PT: [yeah] [nah no problem]
25. PT: yep yep

The turning point in this interaction is at line 10, after the patient has explained what he wants the blood test for, the GP turns from facing the computer to facing the patient directly and says "oh yeah". The patient responds to this by making a 'retracting' statement as soon as some disapproval might be read by the GP's sudden body movement and he says "(.) or not". The GP then aligns strongly with this retraction, by launching talk as soon as the patient says 'or' which presages a retraction. She agrees, at line 12, that the patient can get the blood test "if you want to". This is prefaced by the word "well". "Well" in this instance is a contrast marker that suggests "impending disaffiliation from or disagreement with" the patient's line of talk (Maynard, 2003). In the following turns of talk the GP elaborates on this disaffiliation and offers an alternative to the patient's position. In line 14 the GP suggests that the blood-type based diet does not have any "great basis" tacitly citing the evidence base on the matter. The patient immediately aligns with the GP and himself offers "nah you just got to eat healthy". The GP then elaborates upon the inappropriateness of CAM since it is now in effect the shared perspective between them, and the patient strongly affiliates with a series of "yep-" and "yeah"s. In line 23 the GP asks "is that okay" to which the patient strongly affiliates with a "nah no problem" to show that he is convinced. The GP offers only vague alternatives, "the Mediterranean diet's the one" and "doing a bit of exercise" without any elaboration on exactly what these might mean. The unspoken reference to 'the evidence' has been the basis of her condemnation.

This next interaction occurs with the same GP and a different patient. In this instance the patient has discussed some suspicious moles with the GP. After the completion of a physical examination the GP says "what else can I do for you", thus creating a felicitous environment for the patient to table further issues. The patient complains of a sore back

after going on a tramp and says she is considering seeing a chiropractor (Chiropractors are primary care providers in New Zealand and referral from a GP is not required).

Extract 2:
GP06-08

1. PT: and since coming back my [back's] been a bit biased and it sort of yoyo's
2. GP: [mm]
3. PT: I feel its getting better but then it (.) um like last night it's horrible finding
4. positions to sleep [cos] the pain's going [down this leg]
5. GP: [mm] [the pain's going down there]
6. GP: yeah
7. GP: and ((exhales))
8. GP: what can you do
9. PT: what can I do any (.) I don't
10. GP: mm
11. PT: yeah (.) I'm tempted to go and see my chiropractor and ( ) just get a checkup
12. GP: well you could (.) what you can do though the usual things (.) we tell you now
13. anti-inflammatory tablets and or (.) panadol or paracetamol
14. PT: right
15. GP: and some exercises I mean you know some of the exercises to do don't you (.)
16. and just watching your posture especially with the kids cos you'll be (.) bending
17. down (pulling up like that)

The patient provides quite a preface providing a narrative about the cause of the injury before suggesting that she might see the chiropractor. Although this might at first appear to be a tentative raising of the topic since she says she is "tempted", it then develops as almost an already-made determination', signalled in line 11 with "my chiropractor and just get a checkup". The word "my" means she has already regularly used a particular chiropractor, and her "just get a checkup" suggest that for the patient this is a routine activity. The GP is careful not to belittle the suggestion since that would also belittle the patient. But in line 12 she says "well", the use of a contrast marker again, followed by "you could" and then goes on to outline an alternative plan of action or a contrast proposal (Maynard, 2003) with "what you can do". The contrasting use of the epistemic modals "could" and "can" are very significant here – "could" is stating a possible course of action – but it is only a possibility – while "can" implies a much greater degree of certainty.

Later in this same consultation the patient persistently resists the GP's advice to do exercises and take medication:

Extract 3:

1. GP: yeah [how wo-] how would you feel about just doing your exercise
2. PT: [um]
3. GP: and taking some anti inflammatory tablets jenny
4. PT: (.) I don't like the thought of taking (.) anti inflammatories for the (.) it's not
5. getting rid of the (.) problem it's getting rid of the discomfort but not-

6. GP: well it may be that you've got some spasms near the ligament especially when
7. you loaded your back up
8. PT: yeah
9. GP: after tramping and it may be that your ligaments have just had some undue
10. pressure on them and there's a wee bit of strain there and it will eventually ease
11. and what you're doing is just making it (.) a bit easier for yourself
12. PT: ( )
13. GP: its comfortable ease and allow you to do some exercises to strengthen your
14. back and to strengthen your tummy muscles again (.) and things like walking
15. going for a [swim you know go for]
16. PT: [yeah so all] the things I do naturally
17. GP: yeah
18. PT: so it's (.) [yeah]
19. GP: [so you can] do that if you want to go and see your chiropractor
20. PT: yeah
21. GP: you know I'll leave that to you (.) yep
22. PT: okay I'll see how I go it's yeah

In lines 4-5 the patient expresses strong disagreement with the GP with "I don't like the thought of taking anti inflammatories" and provides a rationale for not taking the drugs with "it's not getting rid of the problem". The GP provides an extended counter-rationale in lines 6-15, again starting with the "well" contrast marker on line 6 and suggesting that "it will eventually ease" and "allow you to do some exercises". The patient's negative response has been received by the GP in a way that leads her to explicate the cause of the problem and provide a contrast proposal to strengthen the muscles. Peräkylä (Peräkylä, 2006) argues that where there is a discrepancy or controversy in relation to a diagnosis doctors tend to "resort to the explication of the evidence" (Peräkylä, 2006)(p.233). That is "when delivering a diagnosis in a context of discrepant views, they [consider] themselves as accountable for the grounds of their diagnostic statements. They [justify] their diagnostic conclusions by giving explicitly reasons for their conclusions" (Peräkylä, 2006) (233). The GP's efforts here are explicitly rejected by the patient in line 16 when she states that the proposal is "all the things I do naturally", prefaced by an overtly contestive "yeah so", thus implying that the GP's proposal does not help solve her problem.

The GP goes on to explicitly allow CAM in line 19 by stating 'so you can do that if you want to go and see your chiropractor". She has thus not abandoned her 'orthodox' advice since the permission for the chiropractor is in addition ("and") not instead of exercise. The GP then reserves judgement and hands it back to the patient in line 21 with "I'll leave that to you yep" and the patient accepts this by saying "I'll see how I go" thus no longer overtly challenging the GP and not continuing the elaboration of the disagreement.

The following interaction with a different GP occurs well into a consultation and where the GP knows the patient well. In this first extract the patient provides a narrative about a chiropractor which is complex: it depicts a man paying for yet also criticising chiropractic:

Extract 4:
GP03-02

1. PT: and I went back and she says oh where you been and I said well (.) it hasn't been
2. helping to be honest (.) so I was actually thinking about you know (.) leaving it
3. GP: yeah
4. PT: and of course she was going oh no no you need to be doing this regularly for
5. many many months et cetera
6. [because it's posture (and they like) to make their money too so I don't know]
7. GP: [yeah yeah yeah i know i know]
8. I know:
9. PT: [and they] all think they're the best [but um] she (.) did it again however
10. GP: [ah] [yeah]
11. PT: and (.) I had the worst day in a very very long time so [I'm not going] back
12. GP: [yeah well I think]
13. GP: no fair enough bob I think one of the things with chiropracty is that (.) some
14. people do find some relief from it (.) but there is a philosophy that's inherent with
15. it is that you need chiropracty for good health (.) which is a fantastic way to print
16. money [isn't it you] convince your customers that you
17. PT: [ha ha ha]
18. GP: [need to them for good health] which I find it's kind of making well people
19. PT: [mm mm mm mm]
20. GP: unwell

The GP strongly but selectively affiliates with the patient endorsing any negative statements. He does this in line 7 with repeated affirmations “yeah yeah I know I know”. In line 13 the GP further reinforces the patient’s story, positioning “chiropracty” as using a system that is “a fantastic way to print money”. However, he is careful not to be completely dismissive of the possible efficacy of chiropractic since that would also criticise the patient who has been patronising that service. The GP makes a heavily qualified statement that “some people do find some relief”. The generic reference to “some people” makes this an indirect, depersonalised construction as opposed to a direct formulation that might look like “you have not found relief so why have you been wasting your time”. Because “[t]he experiencing subject is not indicated [this] offers a slot for the co-participant to recognize or to identify with the experience talked about” (Ruusovuori, 2007) (606). The GP is also hedging his bets, he avoids signalling disapproval of the patient going to a chiropractor in this instance, but at the same time is discouraging the patient from continuing treatment as this makes “well people unwell”. Thus the technique or practice of chiropractic is deemed acceptable, at least for some, but the practice of chiropractors as a professional group is criticised. The patient’s own critical narrative makes it safe for the GP to discourage the patient from attending the chiropractor in that such a move reduces the face threat to both doctor and patient..

Later in the consultation after a long period where the GP is typing into the computer the following exchange occurs in which again the patient condemns what he simultaneously patronises :

Extract 5:

1. PT: I heard some (.) health shop freak (.) telling me that somac (.) could cause a lot
2. of the butt problems I was getting
3. GP: oh [no just] (.) tell him to naff off
4. PT: [ha ha]
5. PT: and he was saying that because it- it (.) er nullifies the acid or whatever um
6. GP: it does nullify acid (.) and that's-
8. PT: doesn't allow your food to be broken down properly and
9. [if you eat a lot of meat like me]
10. GP: [well it's er actually it's a] it's a very interesting it's a very interesting thing 11.I mean (.) I must admit I've kind of wondered the same

The GP then talks about acid production in the body, continuing with

Extract 6:

1. GP: so the acid is only a very small part (.) of of the whole digestive [process]
2. PT: [okay]
3. GP: but it is a part nonetheless [I mean I I listen I]
4. PT: [(oh so I've) not taken for a while now] anyway
5. [(and um)]
6. GP: [yeah well I'd be] very happy to have you off I mean it was only er it was only for
7. a symptomatic (.) problem (um) I'd be very happy to have you off the somac

The immediate response of the GP (Extract 5 line 3) is a very derogatory one towards the claims of someone whom the patient has characterised as a "health shop freak". This choice of words and the patient's laughter tokens immediately following his report of what the "health shop freak" had said can be heard as the patient inviting a negative appraisal from the GP – and the GP is quick to align with this, suggesting humorously that the patient "tell him to naff off".

The patient's talk is complex. He distances himself from a strong association with the person in the health shop by his use of the non-specifying indefinite determiner "some" in conjunction with the negative characterisation of him as a "freak". The passive positioning implied by his statement "I heard" adds to this distancing effect by suggesting that the information was overheard, not actively sought after. The patient nevertheless demonstrates subsequently that he in fact had a much closer association with the "health shop freak" than this initial positioning would imply. This is clear from the fact that he has told this person about his personal "butt problems" and has taken on board the responses from this person. After the patient provides the "health shop freak's" rationale the GP talks aloud about the issue of acid and digestion and appears to be aligning with the "health shop freak" when he says in line 1-3, extract 6 that "the acid is only a very small part of the whole digestive process but it is a part nonetheless". The patient then discloses that he has not been taking the medication anyway at the point where the GP appears to be about to make a suggestion, possibly to stop taking the medication. The GP

then affirms the patient's decision in line 7, extract 6 by stating that he would "be very happy to have you off the somac".

There are other examples of CAM talk where the GP explicitly reserves judgement of CAM by withholding any response. In extract 7 a woman is consulting her GP about possible sores on her body:

Extract 7
TS GP08-14
1. GP: and did they appear over the weekend those lesions or
2. [was the pain there first]
3. PT: [they've only appeared (then)]
4. yeah (.) I've been just applying some calendula cream and [trying] to tea tree
5. GP: [mmm]
6. PT: and trying to kind of
7. GP: mm
8. PT: calm it down [because I] just thought it was fissures but (.) but then I yeah um
9. GP: [mm]
10. PT: they seem to be have got quite bad over the last couple of days [so] that hasn't
11. GP: [right]
12. PT: been doing anything
13. GP: okay
14: PT: yeah
15. GP: okay (.) look well I'll just get you to pop to the loo
16. PT: okay
17. GP: and do a urine sample for me

In this extract the patient notes that she has used calendula cream and tea tree oil. These are not conventional medical approaches, but neither are they in any sense challenging to orthodox medicine. These could be seen as complementary or even folk medicine approaches. In the disclosure of this use of CAM the patient uses the mitigator "just" to downplay the statements "I've just been applying…", "because I just thought". In this way the patient's self diagnosis of fissures and self-treatment are both downgraded. The GP provides affiliative feedback tokens - "mmm" - to encourage the patient to continue her story and throughout the patient's talk nods and maintains eye contact, thus showing active affiliation with the patient. At line 11 the GP says "right", which in this instance is a news receipt (Maynard, 2003) marking the completion of the affiliative sequence of talk for the GP (Ruusovuori, 2007). The GP has heard the patient's problem, heard that the self-medication has not worked, and is now ready to change the topic and move back to her own medical agenda, which occurs at line 15 when instructing the patient to go and collect a urine sample.

In this example the GP's response is neutral. She neither praises the patient for self-medicating using CAM approaches nor provides a negative response to the patient's story.

The following extract is with a different GP and in this instance the patient is consulting in relation to bowel problems.

Extract 8
TS – GP03-7a
1. PT: I (am) taking homeopathic or a natural um (.) thing for (.) um just keeping your
2. bowel healthy adding um is it the bacteria you are [supposed to have]
3. GP: [mmhmm] yeah
4. [acidophilus and bifidus and that kind of (thing)]
5. PT: [I've just been doing (.) yep yeah doing that] by pills

The GP aligns with the patient by providing a name to the bacteria but again, neither dissuades nor encourages the patient in her self-medication with CAM.

Finally, in this data set there is only one consultation where a GP suggests to a patient that she could use some alternative form of treatment although she hedges it by saying that there is little proven about its efficacy, but the patient might feel better taking it. The following occurs seven minutes into a consultation on premenstrual problems.

Extract 9
TS GP08-18
1. GP: by all means go to the chemist and try (.) there are some vitamin B things that
2. you might be useful evening primrose oil do you want me to jot those two
3. down
4. PT: that would be cool yep
5. GP: and you may well find that there is a sort of premenstrual preparation that they
6. sell that you could try and take [a few days] beforehand as well
7. PT: [oh okay]
8. PT: sure
9. GP: there's not a vast amount of research that shows that [they help] but certainly
10. PT: [that it works]
11. GP: in some people they do and in some people they don't and we can prescribe
12. something for you on an ongoing basis if you feel like its helpful
13. PT: okay
14. GP: but try them and see (.) but I wouldn't be surprised if things just settle down

Of note in this extract is the GP's cautious positioning. The GP presents this option as a 'trial' that may or may not work. There is "not a vast amount of research" although, by contrast "certainly in some people they do" work. Again the generic reference to "some people" helps to depersonalise the GP's advice, and the ambivalence signalled by the modifier "certainly' and the parallel construction "in some people they do and in some people they don't" also helps to distance the GP from any inference that she is actively endorsing this remedy. The presentation of the option appears to be well in line with the directives from the Medical Council in that the doctor has signalled the lack of an evidence base for the option and in addition has qualified the chances of success of the treatment. The option works sometimes for some people, but will not necessarily work

this time or for this patient. Moreover, in line 14 the GP offers the further possibility that it may not even be necessary to try this option by stating that "I wouldn't be surprised if things just settle down".

A contrasting example can be seen in the following extract drawn from a consultation with a patient for whom English appears to be a second language, and who has substituted a prescribed medication with a CAM medication:

Extract 10
TS GP08-16
1. PT: I had two (.) cholesterol tests (I've) actually
2. GP: mm hm
3. PT: but (.) still the same (.) six but um the Lipex that (.) that the that the doctor
4. prescribed um (.) I couldn't sleep [( )]
5. GP: [right]
6. PT: so um I took for one week but um I stop (.) so I went to chemist for for another
7. al alternative (.) um th the thing is (with medicine) (.) mm they er (.) they they
8. call they call it cholesterol manager ((laughs)) (and it's) ((inhales)) but um (.)
9. that's what I'm taking now (.) but er I'm just (.) but I've taken (.) since a month
10. but I only take took (.) two a day (.) but I found you can take actually to enhance
11. (.) [two each]
12. GP: [mm]
13. PT: like that but um (.) but (.) if you know if it's not working until I finish (the jar) I
14. go back to Lipex (.) what do you think
15. GP: ((tut)) well what er what so just tell me what happened with the Lipex you you
16. started it
17. PT: yeah
18. GP: and then how long after that did the sleep problems start
19. PT: um (.) well when I'm taking it
20. GP: mm hmm
21. PT:(I started having) insomnia I can't I can't sleep
22. GP: right
23. PT: yeah
24. GP: and as soon as you stopped it did that c- become normal again
25. PT: yeah
26. GP: yeah

The GP makes further inquiries about the strength of the Lipex and when she was taking it. This is followed by:

Extract 11
1. GP: I'd I just feel I'd I don't know anything [about this medication] because it is not
2. PT: [yeah right]
3. GP: a prescribed one and it may well be that it works perfectly well
4. PT: mm
5. GP: but I can't guarantee you that it c- wouldn't interact with your blood pressure

6. medication
7. PT: mm
8. GP: so (.) from my point of view I would probably be a little bit happier with you on
9. the Lipex
10. PT: okay

The GP then suggests taking the Lipex at a different time to counteract the insomnia.

In this extract the GP has to respond to the patient not only self-medicating but non-complying and in addition to this, non-complying in a situation where the patient is on other medication. The GP does not question the possible efficacy of the CAM medication – "it may well be that it works perfectly well" - but in this instance raises a concern about interactions with blood pressure medication. Since she is being presented with a fait accompli in the patient's substitution of medication, the GP cautiously formulates her countermand to express it as "I'd I just feel". However, the GP offers a contrasting proposal (Maynard, 2003) where she states that "I can't guarantee" that the CAM medication will not interact with the prescribed blood pressure medication. She is implicitly making recourse to scientific evidence here in the implication that she can guarantee that the prescribed Lipex will not interact – although the GP has not explicitly stated that. It is clear that the GP is countermanding the patient's decision to substitute the prescribed medication with an over-the-counter medication. Instead of issuing a direct instruction or advice formulation, this countermand is expressed as a heavily mitigated suggestion. The doctor goes to great lengths to preserve the patient's autonomy by framing the countermand as a tentative proposal by using the first-person formulations "from my point of view and "I" followed by a dense cluster of hedging devices including the modal construction "would be", the modifiers "probably" and "a little bit" and the use of the comparative construction in "happier".

From the data analysis so far we can note that patients initiate talk about CAM in diverse contexts that raise different issues for GPs. In this data set, when individual CAM practitioners are mentioned by the patients the GP responses are not positive and in some instances have been overtly negative. However, while the orthodox GPs' responses to CAM are cautious and while they might criticise individual CAM practitioners, they are nevertheless careful in when and how they are dismissive of CAM itself. If possible they align with any negative appraisal of CAM by the patient, but in a sense give permission to adopt CAM if it does not compromise an orthodox approach. For this reason, supplementation per se elicits neutral responses from the GPs but substitution elicits a negative response. It may be the case that a boundary issue between acceptable and unacceptable CAM practices can be discerned here – where substitution by patients intrudes overtly on the medical domain and therefore is rejected. In addition, CAM practitioners themselves who provide alternative advice and diagnoses are liable to intrude on the GP's domain. However, any rejection of CAM is carefully crafted by the GP so as not to challenge or threaten patients in relation to their choices.

CAM GP CAM talk

This section looks at interactions with the one GP who clearly supported CAM approaches, describing himself as a naturopath. In this next extract the patient references CAM approaches as a reason for consulting this GP. This is a new patient who is consulting in relation to unwanted side effects from Voltaren.

Extract 12
GP04-05

1. PT: all these side effect I hate er having tablet but you know what can you do (.)
2. GP: yeah
3. PT: in- in (husband's name) you know 'you th you have to go to my doctor
   ((lines omitted))
4. PT: this of course you know (.) [eating and]
5. GP: [well]
6. PT: dieting and
7. GP: yeah
8. PT: [vitamins and things]
9. GP: [yeah yeah] yeah yeah

The patient here reveals that she wants to be doctored in a specific way: through alternative medicine strategies: "eating, diet, vitamins and things". Accordingly she has come to this GP because he is the doctor of her new husband, whose sympathy with alternative medical approaches she shares. This is the only GP in the dataset who explicitly aligns strongly with CAM.

Another consultation with the same GP is exceptional for the elaborate detail on the cause and treatment of the condition that is provided, but this is only after the GP has determined that the patient is open to the possibility of, in this instance, dietary change. The professional disciplinary environment in which this GP is working means it is important that he is not seen as imposing an approach on a patient that the patient might not want. For example, in a well publicised case a practitioner has been de-registered in part as a result of being seen to impose his ideas on an unwilling patient (New Zealand Medical Journal, 2004).

This is also a notable consultation in that the GP offers the patient a range of alternatives to the condition. In our data it is not common for GPs to go into a detailed discussion of causation and physiological mechanisms but rather GPs proffer a diagnosis or possible diagnosis, and on occasion a brief explanation about causation. As such GPs could be seen to draw on a common stock of knowledge that requires little in the way of elaboration. When the CAM GP suggests dietary change his explanation is very elaborate. Again we can contrast this with excerpts above where diet talk is short and circumscribed and not seen as requiring explanation or justification. Extracts 13 to 19 relate to a consultation where a test has identified that the patient's cholesterol levels have risen. The GP has established that the patient does not know what the implications of this are and briefly outlines the risk for heart disease. The GP then provides an account of cholesterol and its functions, in far more detail than any other consultation about any other condition. There is no comparable discussion of physiology in the entire data set.

The GP then moves on to discuss what can be done, suggesting that the patients has to "weigh up the (.) for yourself (.) the pros and cons of every (.) um (.) management (.) option (.) that we do because of course it's all long term stuff".

The GP continues.

Extract 13

GP04-08

GP: so (.) it's really important that you r- remember that you know there's all- there's
a lot of (.) options (.) usually in here and if I say to you well (.) you know you
got to [pronounced gotta] do blah blah blah and that doesn't appeal to you you
need to tell me (.) right?

In the above excerpt the GP has made it clear to the patient that he does not have to follow any suggested course of action – thus fulfilling the Medical Council requirements on this matter. The GP then outlines the options available to the patient.

Extract 14:

PT: right
GP: so (.) um (.) very quickly the three options that (.) are (.) um (.) four options (.)
they just- they're- staring at you at the moment are (.) do nothing (.) um (.)
[increased] exercise modified diet perhaps which i will
PT: [yep]
GP: quickly run through your diet (.) in a moment if that's something that you
(.) would want to look at (.) um (.) medication (.) prescription medication
pharmaceutical medication (.) or natural supplement medi- type medication (3)
your initial thoughts are?

To this the patient responds that he will "get back" to exercise, and follows with "and yeah I'm more than happy to modify my diet". The GP then goes through a series of questions about current dietary practices with suggestions for change.

At 14 minutes into the consultation the GP starts on an elaborate narrative outlining his theory of diet. He opens this with a preamble arguing that the modern diet has much lower protein consumption than the "hunter gatherer" diet. This is followed by:

Extract 15:

GP: analyse the nutritional profile of a modern diet (.) it's still the same percentage of
fat but it's now the protein's dropped down to fifteen per cent now the question is
(.) is that significant [inhales] well obviously the answer is it ( ) otherwise I
wouldn't be talking about it but (.) I mean this in fact this- th- these ratios
here is what the government (.) and the ministry of health tells people to eat this
is (.) supposedly the- you know the ideal food (.) pyramid [right]
PT: [yeah] th- this is- this
is [what] I've been doing for

9. GP: [yeah]
10. PT: [twenty years cos um yep]
11. GP: [that's right that's right and it's bunkum you can chuck] all that out the window that they don't know what they're talking about

Following this very strong statement about the inadequacies of orthodox dietary advice the narrative element is embarked upon where the GP relates contemporary dietary practices to the diet of paleolithic times, concluding that.

Extract 16:
1. GP: you've got to demonstrate to your body that there is plenty of protein around and
2. you've got to do that every time you eat

The consultation goes on for a further five minutes with the GP elaborating on his dietary theory in relation to specific eating practices. The patient strongly affiliates with the GP in relation to the narrative and advice:

Extract 17:
1. GP: does that make sense?
2. PT: yes
3. GP: cool
4. PT: that does make sense

And later in the same interaction

Extract 18
1. PT: well that is a fantastic new (.) picture for me
2. GP: good
3. PT: thank you
4. GP: that's all right

Just before concluding the consultation the GP finishes with:

Extract 19
1. GP: remind me to talk to you about milk (.) sometime (.) not today
2. PT: not today
3. GP: no (.) totally over time (.) (been) half an hour already and I've got people waiting
4. (.) hahaha

The GP has spent the equivalent of two appointment sessions describing to the patient the physiology of the 'problem' and his theory of causation and treatment, and addressing specific dietary changes that the patient can make. It is likely that this relates to the GP's particular consultation style, although his other consultations where orthodox treatments are discussed are nothing like as elaborate as this one. It does raise the possibility that for some GPs CAM issues are more time consuming. Ruusovuori (Ruusovuori, 2007) makes a somewhat similar observation in her analysis of Finnish homeopathic consultations where extended affiliative sequences were more often integrated into treatment

discussions than was the case for GP consultations). The GP here not only suggests an alternative but explains what is wrong with conventional approaches. The success of the GP's strategy, in an immediate sense, is seen in the strong affiliation by the patient – "well that is a fantastic picture for me".

Conclusion

The data presented here suggest a number of interesting issues that could be further explored in bigger and more diverse data sets. The data provides a rare glimpse of the working world of medical practitioners in relation to CAM. A number of issues can be drawn out from this type of interactional analysis that sheds light on the place of CAM in contemporary general practice.

From the data it can be seen that orthodox GPs typically reserve judgement or provide neutral responses to CAM issues raised by patients. However, there are situations where countermands are made. One clear transgression is where a patient has substituted a CAM option for a prescribed medication. Another potential transgression issue is where patients take advice from CAM practitioners or advocates. In other words, CAM practices are not negatively judged in themselves by GPs unless they transgress on their medical prescribing or where the role of GPs as advisors is directly challenged.

It is not surprising that GPs would affiliate with patients' negative formulations of CAM when they occur. However, it should not be assumed that this demonstrates that GPs have negative views of CAM as the GPs may be involved in relational work when they do this. That is, GPs commonly have continuity of care with patients and they would be unlikely to unnecessarily challenge a patient on views unless they were of clinical importance. However it is noticeable in this data that where chiropractic is mentioned the two GPs both respond negatively. This resonates with the stance that the medical profession as a whole has historically taken in relation to chiropractic, one of attempting to marginalise chiropractic in the health care system (Dew, 2000). The themes of chiropractic creating an unnecessary market for itself and the availability of orthodox alternatives are repeated in these interactions more than 30 years after the same rhetoric was employed before a New Zealand Commission of Inquiry into Chiropractic (Dew, 2000). This suggests the durability of such critiques but it is not possible to make claims about how widely felt this is amongst the community of general practitioners.

The variety of responses seen in this data set are in line with other research looking at patients and practitioners in relation to CAM. Tovey and Broom note that oncology patients report three types of approach to CAM from oncologists – explicit or implicit negativity, supportive ambivalence and pragmatic acceptance (Tovey & Broom, 2007). Supportive ambivalence is where the oncologists were not supportive of CAM but were supportive of patient choice, and pragmatic acceptance describes situations where oncologists would actively support patients' use of CAM and even refer patients to CAM practitioners. A similar intra-professional differentiation can be seen in this data set, although in this set we have the addition of a CAM prescriber and advocate. Different GP

relationships to CAM can be delineated, including (1) CAM approaches as ones to be rejected even if the only other offering is 'commonsense', (2) CAM as indeed complementary, something that can be added to orthodox approaches that might work, and (3) CAM as a radical alternative based on a different understanding to conventional medical theories.

The data also provides some insight into how practitioners respond to Medical Council guidelines. In this data set, in the two instances where CAM approaches are suggested, the GP either clearly outlines to the patient that what he chooses to do is up to him Extract 13) or clearly states that the use of CAM is a trial with no certain outcome (Extract 9). The demand of the Medical Council to explain the extent to which the CAM practice is consistent with conventional theories of medicine is clearly undertaken by the one GP who provides an account that explicitly debunks conventional theories (Extract 15). In the one other instance there is no discussion of theory whatsoever (Extract 9). By looking at these two interactions it can be seen that it would not always be easy for a practitioner to conform to the Medical Council's guidelines as it would appear to require the practitioner to understand the mechanisms by which CAM treatments work. For supplementation – such as Evening Primrose Oil or a specific "premenstrual preparation" – the GP might not know how the supplement works. However, some GPs take a 'trial'-like approach to CAM, with notable instance in the data sets where GPs suggest that CAM works sometimes on some people.

The examples presented here allow us to see the finely tuned interactional work that occurs in these consultations. The instances of patient-initiated CAM talk show the tentative nature of the patients' presentations of CAM issues, while GPs commonly align with patients, and where they do not align, present countermands or contrast proposals in ways that do not threaten the patient. Even in the example where a patient has substituted a CAM treatment for a prescribed medication the GP is very circumspect in her response to the patient. In conclusion, the data shows how, in consultations with orthodox GPs,. patients make use of a variety of strategies to get CAM on the agenda, while doctors will typically reserve judgement on CAM to some degree and are careful to couch any criticism in such a way as to protect the 'face' of patients. The data is also suggestive of the lengths to which CAM GPs can go to present an alternative explanation of disease and its treatment. This points to an extra burden that GPs who uses CAM may have to carry, that is, more interactional work and potentially longer consultations.

Appendix

Transcription conventions:

(.) denotes a micro-pause

(2) denotes a pause of the specified number of seconds
(and) words in single parentheses denote candidate hearings
( ) parentheses without words denote indecipherable talk
((laughs)) double parentheses denote descriptions of action
[ ] square brackets denote overlapping talk.

References

Dew, K. (2000), 'Apostasy to orthodoxy: debates before a Commission of Inquiry into chiropractic.' *Sociology of Health and Illness*, 22, 3, 1310-330.

Dew, K. (2001), 'Modes of practice and models of science in medicine', *Health: An Interdisciplinary Journal for the Study of Health, Illness and Medicine*, 5, 1, 93-111.

Heritage, J. and Maynard, D.W. (eds.) (2006), *Communication in medical care: interaction between primary care physicians and patients*, Cambridge University Press, Cambridge.

Maynard, D.W. (2003), *Bad news, good news: conversational order in everyday talk and clinical settings*, Chicago, University of Chicago Press.

Medical Council of New Zealand (2005), 'Statement on complementary and alternative medicine', Wellington, Medical Council of New Zealand.

New Zealand Medical Journal (2004), 'Medical discipline - alternative medicine', *New Zealand Medical Journal*, 117, 1191.

Nicholson, T. (2006), 'Complementary and alternative medicines (including traditional Maori treatments) used by presenters to an emergency department in New Zealand: a survey of prevalence and toxicity.' *New Zealand Medical Journal*, 119, 1233.

Peräkylä, A. (2006), 'Communicating and responding to diagnosis', *in* Heritage, J. and Maynard, D.W. (eds.), *Communication in medical care: interaction between primary care physicians and patients*, Cambridge, Cambridge University Press.

Poynton, L., Dowell, A., Dew, K. and Egan, T. (2006), 'General Practitioners' attitudes toward (and use of) complementary and alternative medicine: a New Zealand nationwide survey.' *New Zealand Medical Journal*, 119, 1247.

Ruusovuori, J. (2007), 'Managing affect: the integration of empathy and problem-solving in health care encounters', *Discourse Studies*, 9, 5, 597-622.

ten Have, P. (1999), 'Doing Conversation Analysis: A Practical Guide', London, Sage.

Tovey, P. and Broom, A. (2007), 'Oncologists' and specialist cancer nurses' approaches to complementary and alternative medicine and their impact on patient action', *Social Science & Medicine*, 64, 12, 2550-2564.