

CHAPTER 5: CRITICAL DISCOURSE ANALYSIS

The CAM–EBM interface holds distinct conceptions of philosophically derived acceptability criteria for valid and usable knowledge, which can lead to tension between the respective fields. This is evidenced in instances when CAM advocates criticise the limited ability of reductionist EBM to reflect knowledge and when proponents of EBM condemn CAM for failure to take up scientific research as the primary knowledge source because of an implausible philosophy. These interactions frequently present as an impasse and create ongoing argument or retreat to incommensurability.

The literature recognises these differences and points out that the system with the greater legitimacy is likely to hold authority and therefore more influence. In this respect CAM is seen as having immense public popularity while EBM has support from state-legitimised institutions. The CAM position can be said to be similar to other public movements and their interactions with sanctioned establishments, such as feminism with patriarchal political systems, and HIV/AIDS patients with biomedical research. This leads to the description of CAM as a social movement with civil force (Coulter & Willis, 2004; Goldner, 2004; Nissen, 2011a; Schneirov & Geczik, 2003) politicising therapeutic pluralism and research to create ‘epistemic modernization and liberalization’ (Hess, 2015, p. 157). In contrast, EBM is seen as the fulcrum between state legitimacy and scientific healthcare (Jacob, 2015). Therefore two distinctive legitimisation systems are active in the CAM–EBM interface - one public and one state - with exceedingly active boundaries between these.

From this situation, queries have arisen regarding the use of legitimisation as a tool to demarcate CAM and EBM knowledge. For example, EBM is proposed to endorse certain healthcare practices as a way to halt the public movement away from validated healthcare systems towards CAM and reorient this back to state-sanctioned epistemic authority (Hunter & Grant, 2005; Kuhlmann, 2006; Timmermans & Oh, 2010). Within this strategy, EBM methodologies are said to serve as demarcation tools and selected healthcare journals as

conduits of the legitimisation discourse (Derkatch, 2008, 2012a; Keshet, 2009). At the same time, CAM applies a variety of boundary markers to claim healthcare territory (Derkatch, 2012b; Koteyko, 2009; Oerton, 2004; Owens, 2015). Therefore dynamic interaction between different legitimisation devices are situated within the CAM-EBM interface, and frictions between these occur. This was clearly identified in the literature review and confirmed in the thematic analysis where participant utterances arising in response to these dynamics were noted. Therefore this chapter aims to deepen understanding of participant negotiation of this contested knowledge boundary through a structured critical analysis.

These knowledge debates occur within socio-political and economic contexts that deliver communicative priorities and strategic imperatives for CAM and EBM, and there are common rhetorical features that are found within the argumentation structure of such disputes (Blackledge, 2012; Bloor & Bloor, 2007; Fairclough, 2012, 2013; Forst, 2007; Honneth, 1995b; Toulmin et al., 1984; van Dijk, 2012; Wodak & Meyer, 2009a), as shown in Table 5.1.

Table 5.1: Rhetorical features commonly found in knowledge disputes

Ideology	Power	Marginalisation
Manipulation	Constraint	Inequality
Imposition	Suppression	Oppression
Rejection	Exclusion	Misrecognition
Injustice	Coercion	Distortion

These features tend to originate from the argument holding authority and are directed against the entity regarded as non-compliant, which in this case refers to the discourse of EBM directed to CAM. However, because this authority requires legitimation there are perspectives and counterarguments that emerge in response to such justificatory attempts, and these can exhibit similar characteristics. Therefore this is not a one-sided use of rhetoric, and CAM can respond to the EBM discourse through similar linguistic terms.

To gain understanding of participant position in this linguistic milieu it is necessary to move from a strongly blended fusion of horizons and apply the hermeneutic arc to create distance from the language under analysis. This is particularly important in insider research where there is potential to remain bonded to the inter-subjective relationship and omit the benefit that can be gained by inserting space between the text and its interpretation. Therefore this chapter applies distancing as a prerequisite to the use of critique within analysis.

The analysis applied in this chapter moves away from the previous method and its surface review of linguistic statements, and engages with the ways language is constructed. In line with the methodological requirements, this approach is embedded in critique and formalised within critical discourse analysis. This method describes language existing within ideological struggles that mediate everyday conversations to legitimise representations of the world. Consequently, the analytical focus explores how language is formed and presented within larger contexts and concerns, and the ways individuals and groups reproduce or resist the embedded nature of language-based ideologies (Fairclough, 2013; Wodak, 2001a, 2001b, 2013a).

Dialogue is structured in numerous possible ways within knowledge debates. Specific features within these interactions are the target of the critical discourse analysis method, and to explicate these from statements and to appreciate their content requires precise techniques. Thus Reisigl and Wodak's (2009) discourse-historical approach, which is a sub-discipline of the critical discourse analysis canon, was used as the basis for inquiry in this analytical phase. This interrogates the six discursive elements outlined in Table 5.2, which are explained in more detail below. These elements combine to configure linkages between language, the structuring of this for influence, the linguistic orientation towards the interpreter, and the related knowledge upon which the discourse draws.

Table 5.2: Elements under analysis in the discourse–historical approach

Element	Description	Purpose
Key utterance	Central component of a discursive structure	Focuses the discourse on a specific topic that directs interaction and interpretation
Co-text	Language preceding or following each key utterance	Supports the key utterance and directs interaction and interpretive orientation
Discourse markers	Linguistic structuring components	Influences attitude to the discourse and supports the co-text
Inter-textual links	Links to past or present discourses	Illustrates, evocates, reinforces, or disrupts the key utterance
Context	Socio-political and historical forces informing the discourse	Embeds the genre in the structures and frameworks of history and socio-political agency
Genre	Style of linguistic engagement	Symbolises a specific social activity based on context

Analysis within the discourse–historical approach firstly centres on three of these six elements. Primary attention is on the key utterance, and all successive analysis relates to this. The second focus is the review of co-text, where language surrounding a key utterance is reviewed for its capacity to augment the discourse focus and direct interpretation. The third emphasis is assessment of discourse markers, which are linguistic connectors such as ‘but’, ‘often’, ‘because’, ‘sometimes’, ‘then’, ‘therefore’, ‘so’, and ‘after all’; these serve as boundary mechanisms, topic switchers, filters, confirmation seekers, hedging devices, and discourse connectors (Jucker & Ziv, 1998a; Schiffrin, 1987). These direct attitudinal and relationship balance, intention of speakers towards hearers and implicit instruction as to how to interpret language. Thus they serve specific purposes in discourse.

The key utterance, co-text, and discourse markers are referenced to the remaining three discursive elements to ‘make visible the interconnectedness of things’ (Fairclough, 1985, p. 747). These are (1) review of inter-textual links, where specific keywords, topoi, or themes in the discourse are identified; (2) interrogation for socio-political and historical contexts that serve as the generative sites of the discourse under review; and (3) clarification of genre, where situated norms, values, and ideological interests

produce a style of linguistic engagement that serves as ‘a system for accomplishing social purposes by verbal means’ (Swales, 1990, p. 41). This latter aspect is important as it is common within professional discourse and it reflects specific forms of knowledge production and negotiation of other knowledge types (Berkenkotter & Huckin, 1995; Wodak & Meyer, 2009a).

The reference points that emerge from the use of these discursive elements are then related to general features of the discourse. These include signs of linguistic consistency or inconsistency, self-contradictions, paradoxes, and match or mismatch of context to discourse character. Due to the documented dynamics of the CAM-EBM interface, the weight associated with these particular features lies in identifying and relating these to the discursive reproduction of the legitimisation or delegitimisation of CAM knowledge. Therefore the purpose of this discourse-historical approach, as it is situated within the wider critical discourse analysis discipline, is to examine the ‘ways in which language is used in various expressions and manipulations of power’ (Blackledge, 2012; Reisigl & Wodak, 2009, p. 89). Thus it adequately reflects the theoretical framework and methodological orientation.

The caution related to the use of this type of analysis is management of the potential for placement of external political or socially critical aspects of unrelated topics within the analytical process (Wodak, 2013a). This threat to trustworthiness is addressed through researcher reflexivity and repeated comparison within the transcript, across the literature, and to the principles of Critical Theory to ensure the contextual accuracy of findings.

5.1 Critical discourse analysis techniques

The development of the five themes brought forward into this chapter was previously explained, so the current analysis requires only the application of critique. Figure 5.1 shows this process for each theme, where a quote that underpins, differs from, or contests the themes under discussion is presented as a unit of analysis. The quote elements are mapped, the findings discussed,

theorised to the literature, and assessed against theory. When this is complete each set of findings is collated and condensed within the discussion section and taken forward for analysis and discussion in Chapter 6.

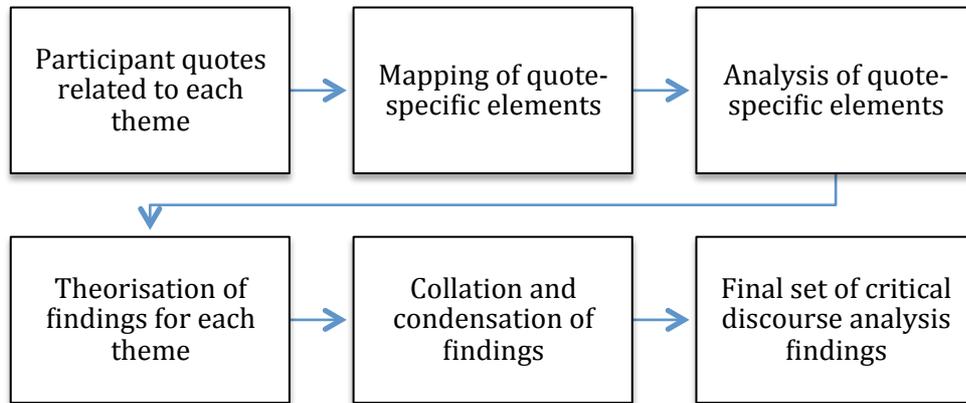


Figure 5.1: Critical discourse analysis data flowchart

In the following pages each theme is presented in sequence and three quotes of significance are shown, along with conflicting cases where present and relevant (Silverman, 2006). These themes are designated and displayed as:

- Practitioner-focused epistemological pluralism
- Negotiating EBM limitations
- Intermingling knowledges
- The perpetual role of beliefs and values
- Responding to ideological critique

These themes are analysed via an iterative and succinct illustration with accompanying text containing parsimonious evaluation. A collated summary of the findings related to each theme completes the individual sections.

5.1.1 Patient-focussed epistemological pluralism

Theme 1: Practitioners use multiple sources of evidence to work with their patients

The first examined quote arose from a question that explored focus group participant experience of using evidence.

It depends again, what we mentioned before, what evidence we talk about. Evidence affects my treatment plan because the more knowledge I have and the more things I can draw on the better. But if I have, sort of, my own clinical evidence from what I have experienced, what works with clients, if I need to use some other techniques to help clients which are maybe not evidence-based then I also use them. So for me it's more of a mixture, and the main thing is what works and what I trust works (Focus group participant SB80).

As per Figure 5.2, the key utterance describes 'other techniques' helping clients within a patient-centred care model. The co-text outlines the necessity for expansive knowledge to enable a broad therapeutic toolkit, referenced to experiential learning where therapeutic outcomes generate evidence. The markers reveal reasoning ('because') explaining the need for a broad knowledge base with conditional requirements ('but if I have' and 'if I need') determining ('which are maybe') applied knowledge as non-EBM, and the referring back ('so for me') of the utterance to the autonomous practitioner.

The inter-textual links illustrate clinical evidence tied to knowledge gained from experience informing treatment planning. This is contextualised to broader discourses of knowledge types ('It depends ... what evidence we talk about'), the application of this for patient benefit ('other techniques to help clients'), clinical legitimacy ('what works'), and belief in the efficacy of the applied therapies ('what I trust works'). The utterance is situated within reasoning about pluralistic knowledge based on the clinically legitimate use of non-EBM evidence.

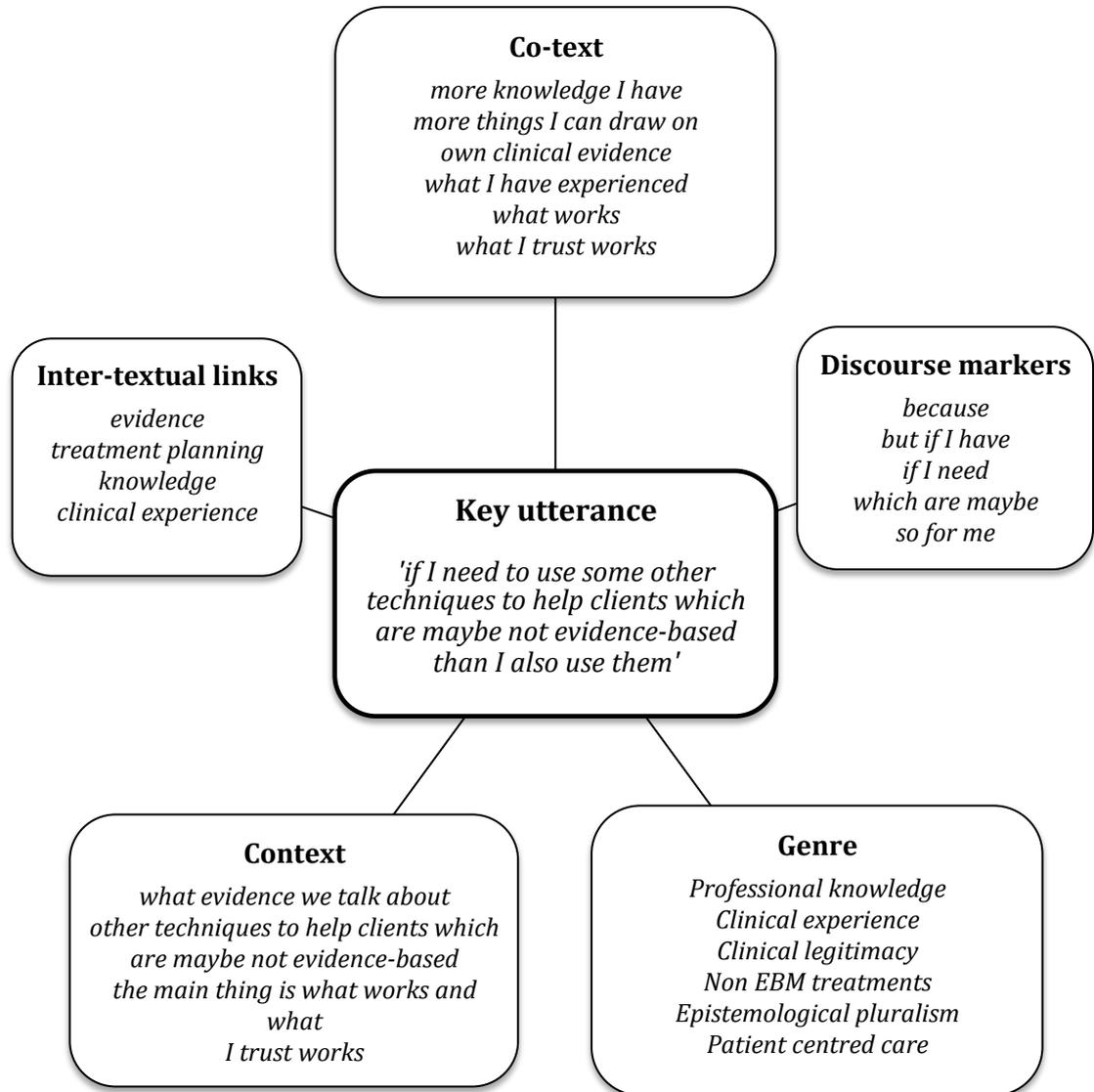


Figure 5.2: Theme 1 quotation 1 mapping

Therefore this quote has internal coherence and relates to the broader CAM discourse where clinical autonomy is emphasised, evidence is broadly interpreted, and clinical legitimacy grounds a discourse without the negative rhetorical features under examination here.

Theme 1: Practitioners use multiple sources of evidence to work with their patients

The second examined quote arose from the same question exploring focus group participant's experience of using evidence.

... anything I regard as evidence strongly influences the way I would practice ... you're always learning new things and if you're not I think that's, you've got to be asking yourself a few questions ... I think evidence, regardless of where it comes from, is perhaps a key to being a good practitioner, is keeping an open mind and continued learning. And if you're not going to take that on board and put it into practice I think it would be counterproductive (Focus group participant AB49).

Figure 5.3 shows this quote focusing on 'anything I regard as evidence' as a strong informant of practice, with the key utterance describing subjective determination of what this may be. The co-text frames evidence use requirements as maintenance of an open mind for practitioner learning, where to not pursue knowledge is counterproductive to good practice and questionable. The discourse markers show how this utterance is directed, with the use of second-person grammar ('if you're not' and 'you've got to be') focussing reasoning to the listener's perspective. The conjunction 'if' introduces conditional clauses related to learning, questioning a lack of learning and not integrating learning; whereas 'is perhaps' and 'I think' reduce the force of these around statements related to evidence and good practice for the individual clinician.

The inter-textual links reinforce the connection between knowledge as evidence and the use of this for ongoing education in practice. This is contextualised to the integration of non-EBM evidence ('regardless of where it comes from') to continuing education ('learning new things') for a variety of knowledge types that influence practice ('keeping an open mind'). As a genre this utterance relates to a professional development discourse emphasising ethical practice applying pluralistic knowledge as continuing education that is individually assessed for clinical relevance.

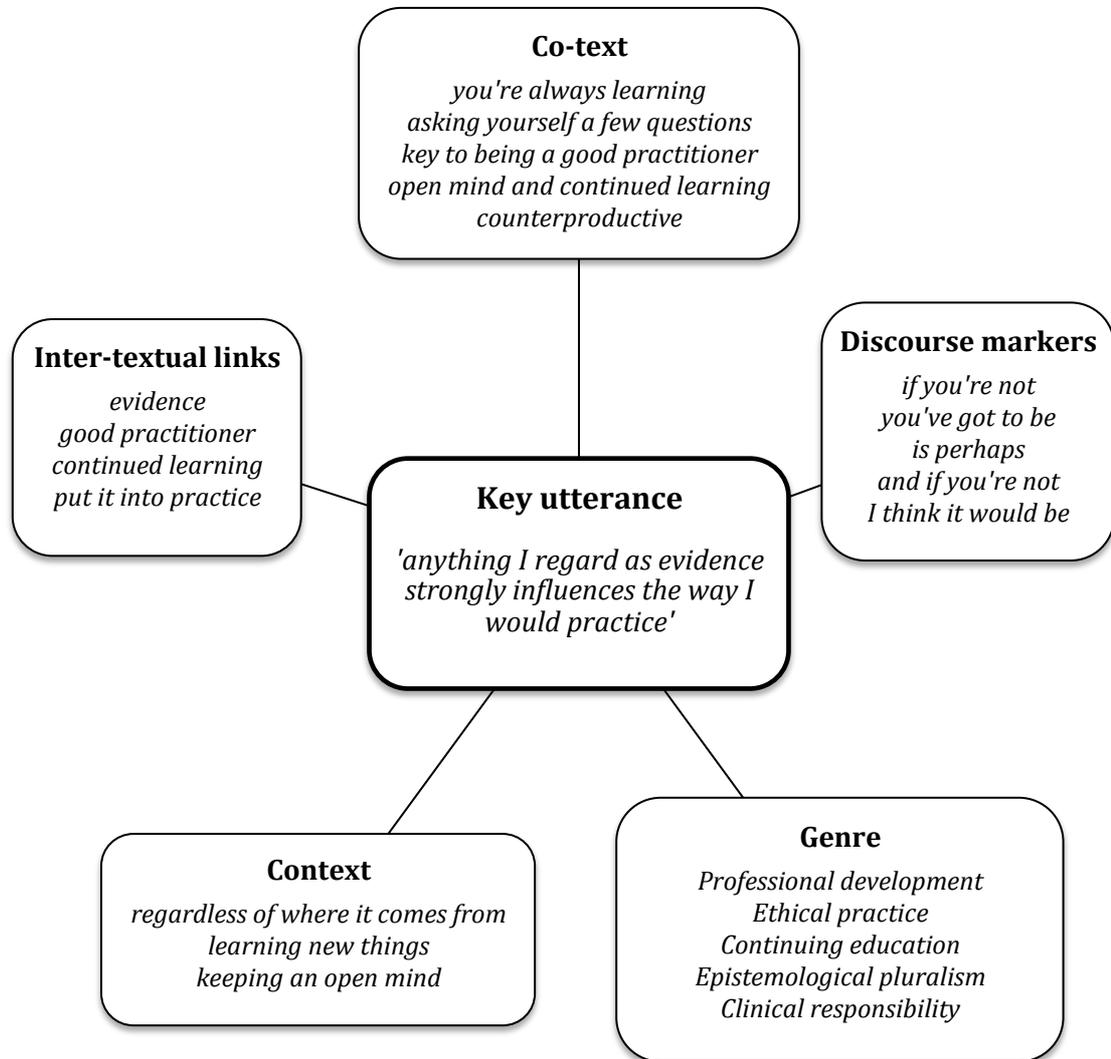


Figure 5.3: Theme 1 quotation 2 mapping

The utterance as a contextual whole emphasises the role of knowledge for learning in practice and is coherent with a professional development narrative where evidence use merges with ethical and responsible practice.

Theme 1: Practitioners use multiple sources of evidence to work with their patients

The third quote arises from a question asked of an interview participant about their use of various types of evidence.

... ideally if there's a randomised controlled trial or a few randomised controlled trials or a meta-analysis or systematic review of trials or whatever, that's ideal. I acknowledge that, especially within complementary medicine, that's not always available. I would then go with ... a semi randomised or pseudo randomised or some kind of trial and then if it's not that, certainly I have no real problem using a case series, I think at least that's better than nothing. And then I would go with ... expert opinion ... and I probably sometimes lean on that quite heavily in certain areas. And then less than that then there's all the kind of theoretical pre-clinical stuff (Interview participant 25B6).

As Figure 5.4 reveals, this utterance reflects reliance on the EBM grading of evidence quality. The co-text frames this in relation to the value of expert opinion in instances where CAM evidence is lacking. There is awareness of evidence use from different hierarchical areas, particularly when moving down the EBM pyramid. Discourse markers show recognition of the difficulties for CAM in this model through reporting ('I acknowledge') and emphasising ('especially') this as an issue of relevance. The remaining markers situate CAM evidence lack ('if it's not that', 'I think at least', and 'less than that') at the different evidence levels.

The inter-textual links locate the utterance in the EBM framework and again contextualise the low level of CAM evidence ('not always available'). As a genre this quote is located in EBM and does not discuss evidence outside this hierarchical model. There is an emphasis on the limited CAM presence in the upper levels of the evidence hierarchy and expert opinion is often used as a knowledge source ('lean on this quite heavily') to negotiate this lack.

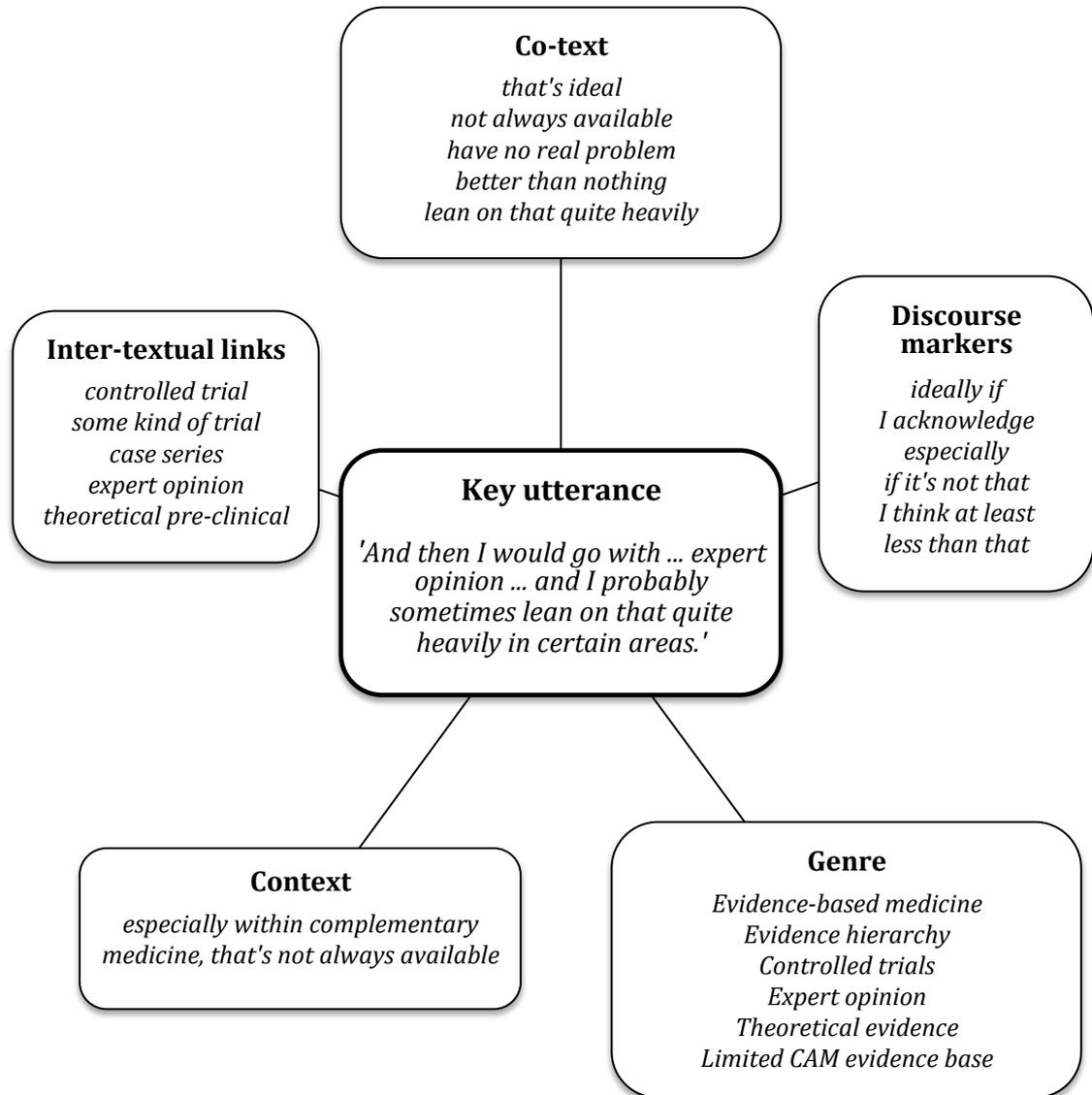


Figure 5.4: Theme 1 quotation 3 mapping

This quote contextualises knowledge within the EBM model and does not look externally to this. There is negotiation of limited CAM evidence in the EBM narrative through recourse to expert opinion. Situating knowledge in this way serves to safely negotiate the requirements of this model when using different knowledge forms. This shows engagement with EBP where the best available evidence is applied within the context of availability.

5.1.1.1 Discussion of discourse analysis of Theme 1

The presented participant quotes show individual negotiations of the CAM–EBM interface through the use of multiple knowledge sources in practice. Identified negotiation strategies include situating the use of pluralistic knowledge with autonomous responsibility, clinical legitimacy and professional development, as well as reasoning the use of CAM expert knowledge for clinical know-how within the EBM hierarchy.

These participants displayed recognition of the primacy of their professional knowledge base for patient-centred care. Acknowledgment of limited EBM evidence was present, suggesting that numerous knowledge types are sourced, differentiated, and applied in a reasoned way that is specific to the practice context. In the first quotation clinical evidence is prioritised as it represents ‘what works with clients’; for the second, professional knowledge growth is cited ‘because you’re always learning’; and for the third, the use of expert opinion is applied as there is the need to ‘lean on that quite heavily in areas’. Each of these relates the available evidence to personalised practice styles and underpins the autonomous nature of community healthcare practice.

The first two utterances imply clinical expertise and ethical practice playing a leading role in knowledge translation. This emphasises clinical legitimacy and professional philosophy playing a key part in ‘human interaction in clinical contexts, clinical judgment and reasoning, and clinical philosophy’ (Malterud, 1995, p. 189). Thus the way knowledge is integrated into N&WHM practice is an individual process between a practitioner and patient and at the same time this application is shared across professional commonalities. So while the discussion of the theme differs between utterances, the underlying motivations for knowledge use in practice are similar. It is the framing of this knowledge use that reflects degrees of differences between participants.

For example, the third utterance shows strong reproduction of EBM principles and reflects the uptake of objective knowledge. In this instance there is no broadening of evidence beyond this model, and CAM is located within the confines of this as opposed to overlapping or separate to it. Thus the possibilities for CAM knowledge are bound to the EBM hierarchy and its philosophical framework, meaning there is a low level of CAM evidence available to apply under this model. Thus referral to expert opinion arises as a strategy that negotiates the demands of a clinical practice based on EBM.

Although appealing to expert opinion can be a resort to authority (Walton, 1997), which Sackett (2000) says is yielding to persuasive power over scientific evidence, when there is a lack of evidence or the need for contextualisation of this, it is a valid and viable option (Tonelli, 1999; Wenger, 2012). Thus the use of expert opinion within an EBM model is recommended where appropriate. In this instance the adopted stance reflects the principles of the EBCAM model (K. Wilson & Mills, 2002b) where objective knowledge is privileged over subjective interpretation; however the value system of CAM providers retains legitimacy in the clinical setting. Thus this utterance remains situated within professional commonalities.

For these participants professional knowledge is pluralistic knowledge use where clinical needs determine the application of contextualised evidence sources. Knowledge is uniquely differentiated to develop and maintain a competent and ethical practice that is focussed on improving patient outcomes through informed treatment planning. Thus the actions described within these utterances signify autonomous reasoning by knowledge holders that are mediative of the EBM model. For these participants the CAM–EBM interface is either non-problematic or successfully negotiated relative to their practice method, and professional knowledge is effectively applied to ensure the best patient care.

5.1.2 Negotiating EBM limitations

Theme 2: Research evidence has limited clinical validity, so practitioners weave traditional and experiential knowledge into outcomes-based patient-centred care

The first quote arose from a focus group question asking what evidence in practice means (this extends content discussed in analysis of Theme FG1).

I had a very heavily evidence-based education ... because that's just, that's how it is now. And I love it; I find it fascinating, I think it can add a layer of knowledge to what we're doing. So if you've got the traditional understanding of a herb and then you have a piece of something that's been developed in a lab or through a trial, that adds a little skin on top of it. To me it adds a depth of understanding to the herb, but I'm not going to be blinded by that kind of evidence because it's still a case of if it doesn't fit the person it's not useful to me (Focus group participant MB6).

Figure 5.5 shows how EBM knowledge is combined with traditional knowledge in circumstances where it can extend clinical validity and increase treatment effectiveness. The co-text states this can occur by increasing understanding of traditional medicinal plant knowledge ('skin on top' and 'depth of understanding'), with the caveat that this is not unquestionably accepted ('not going to be blinded') unless external validity ('fit the person') is present. Discourse markers direct reasoning ('because'), and first- and second-person grammar ('I find it', 'if you've got', and 'to me it adds') creates inclusiveness between the speaker and listener. These are then aligned to emphatically conditional decision making ('But I'm not going to be' and 'it's not useful').

Inter-textual links orient EBM to traditional knowledge where the former is treated as other ('that kind of evidence') in relation to clinical legitimacy, patient-centred care, and clinical autonomy. This is contextualised to the current widespread use of EBM education in CAM, traditional knowledge, and the synergy between these as knowledge systems to create best patient care.

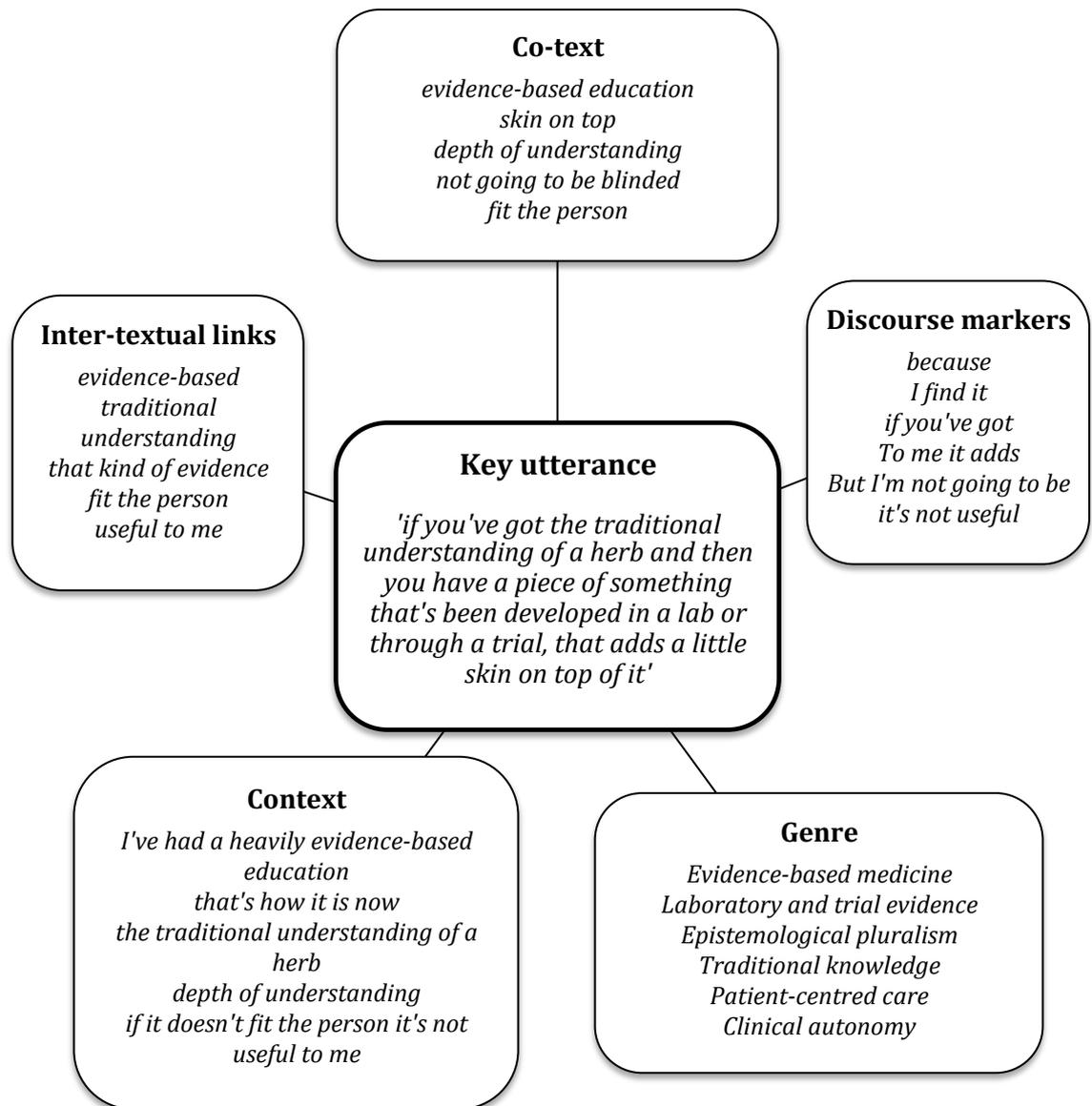


Figure 5.5: Theme 2 quotation 1 mapping

This utterance as a whole incorporates different types of knowledge and recognises their capacity to fulfil external validity requirements for the individual autonomous practitioner managing a unique patient case.

Theme 2: Research evidence has limited clinical validity, so practitioners weave traditional and experiential knowledge into outcomes-based, patient-centred care

The second quote arose from focus group interaction between three participants (P) in response to a question asking whether the EBM research model is suitable for practice.

P1: Does it accurately represent my work? ... ultimately there's not enough research out there to support my work. So I'd say no. It's just not there. It's missing. Hasn't happened yet.

P2: Yeah I agree.

P3: Would you use the current research model to generate more?

P1: I would love the current research model to generate more. But it comes back to marrying that with clinical practice for the best outcome for the client.

The content of Figure 5.6 reveals agreement between orientations towards the EBM model coupled with clear expression of the limited CAM presence within this. This shows why participants refer to traditional and experiential knowledge in practice and underscores their desire for more knowledge per se. The co-text reinforces the lack of EBM-derived evidence as well as the qualification that any evidence must have model and external validity to improve patient outcomes. The discourse markers show 'ultimately' used as a concluding statement where the first person interprets a lack because 'it's just not there'. The key utterance is marked by the contrasting conditional that all evidence is 'for the client'.

The inter-textual links identify the low level of CAM evidence contributing to the inability of EBM to represent work practice, with the current EBM model useful in so far as it is able to inform clinically relevant, patient-centred care. The context reiterates this in simple terms by outlining the low CAM evidence base within EBM and the desire for more evidence to be generated via this mechanism.

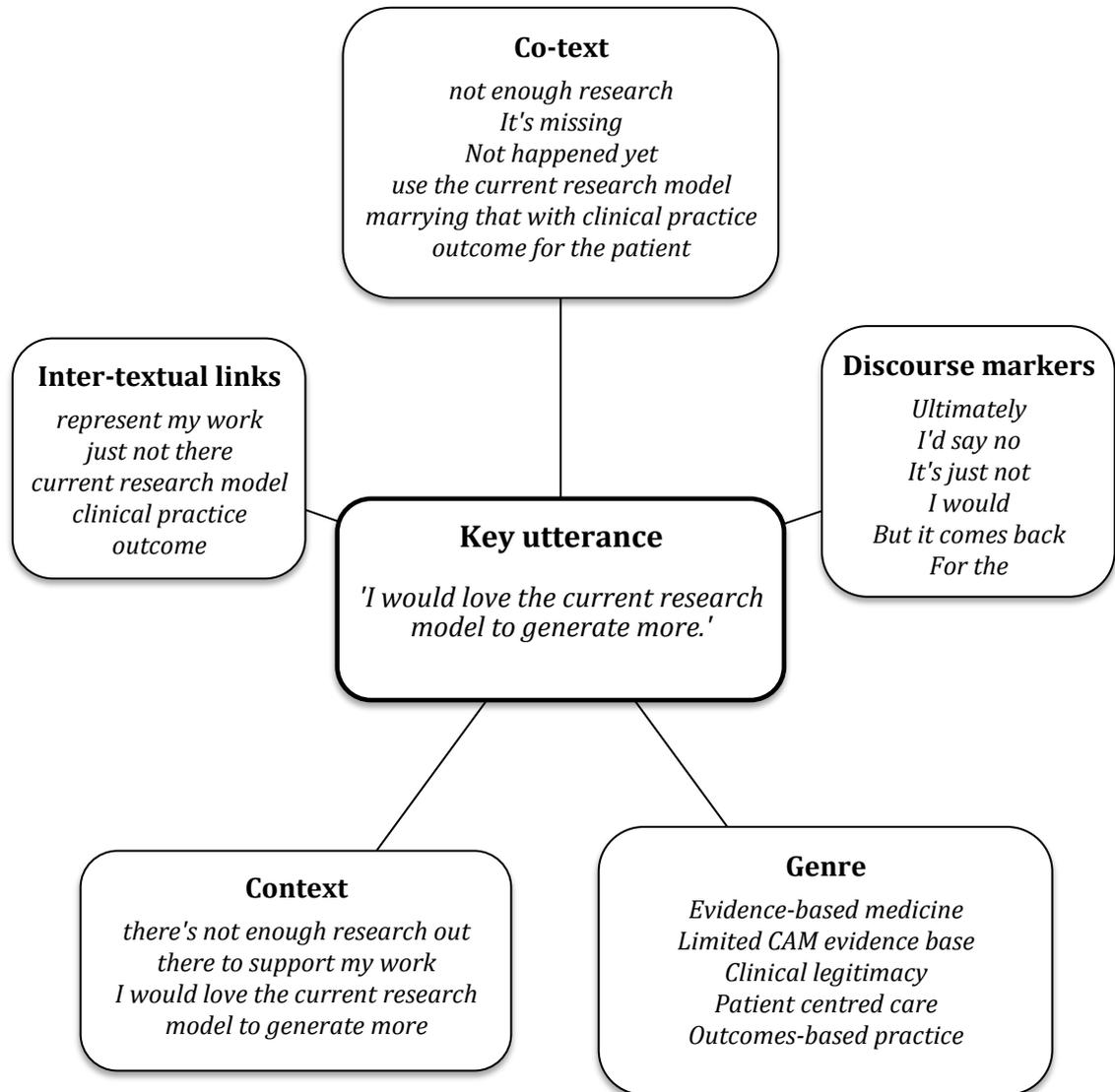


Figure 5.6: Theme 2 quotation 2 mapping

This relates directly to the genre of EBM as an integrated aspect of EBP and stipulates that its use must provide practical benefit for the patient. This reveals understanding of the potential for EBM outputs within the EBP model but shows awareness of the inherent limitations of this for N&WHM EBP.

Theme 2: Research evidence has limited clinical validity, so practitioners weave traditional and experiential knowledge into outcomes-based, patient-centred care

The third quote arose from an interview question asking whether traditional evidence comes into clinical decision-making processes.

... what I have a real problem with and I talk to a lot of my colleagues about, is this omnipotent statement that lots of people use when they say oh yes we have traditional evidence. To me it shuts down all debate, it's like this omnipotent statement that says you can no longer talk to me or question me about this because I've just given you the omnipotent statement and that is we have traditional evidence. I talk to them and say well let's examine traditional evidence then. How valid is it really? We've got herbs that have been used over thousands and thousands of years, but in different cultures in different ways. And there's the paradigm of understanding the human body, it's very different in these cultures so I don't actually think we can extrapolate from one culture to another very easily around the use of a herb for a particular condition ... And so although I acknowledge and I do put some credibility in traditional knowledge I don't see it as the omnipotent almighty statement that a lot of people use it as (Interview participant 25B8).

Figure 5.7 demonstrates reservations regarding the validity of traditional knowledge for preferential application in clinical practice. The co-text identifies a 'real problem' due to the 'omnipotent' nature of statements made that 'shuts down all debate'; making it difficult to 'examine traditional evidence' where cultural practices imply distinct knowledge. The discourse markers guide an argument where the use of first person plural grammar ('We've got') situates this as a profession-wide problem while at the same time personal credibility confines this.

The inter-textual links identify the nexus of this quote and show the presence of hedging where the discussion moves from criticism to question to disclaimer.

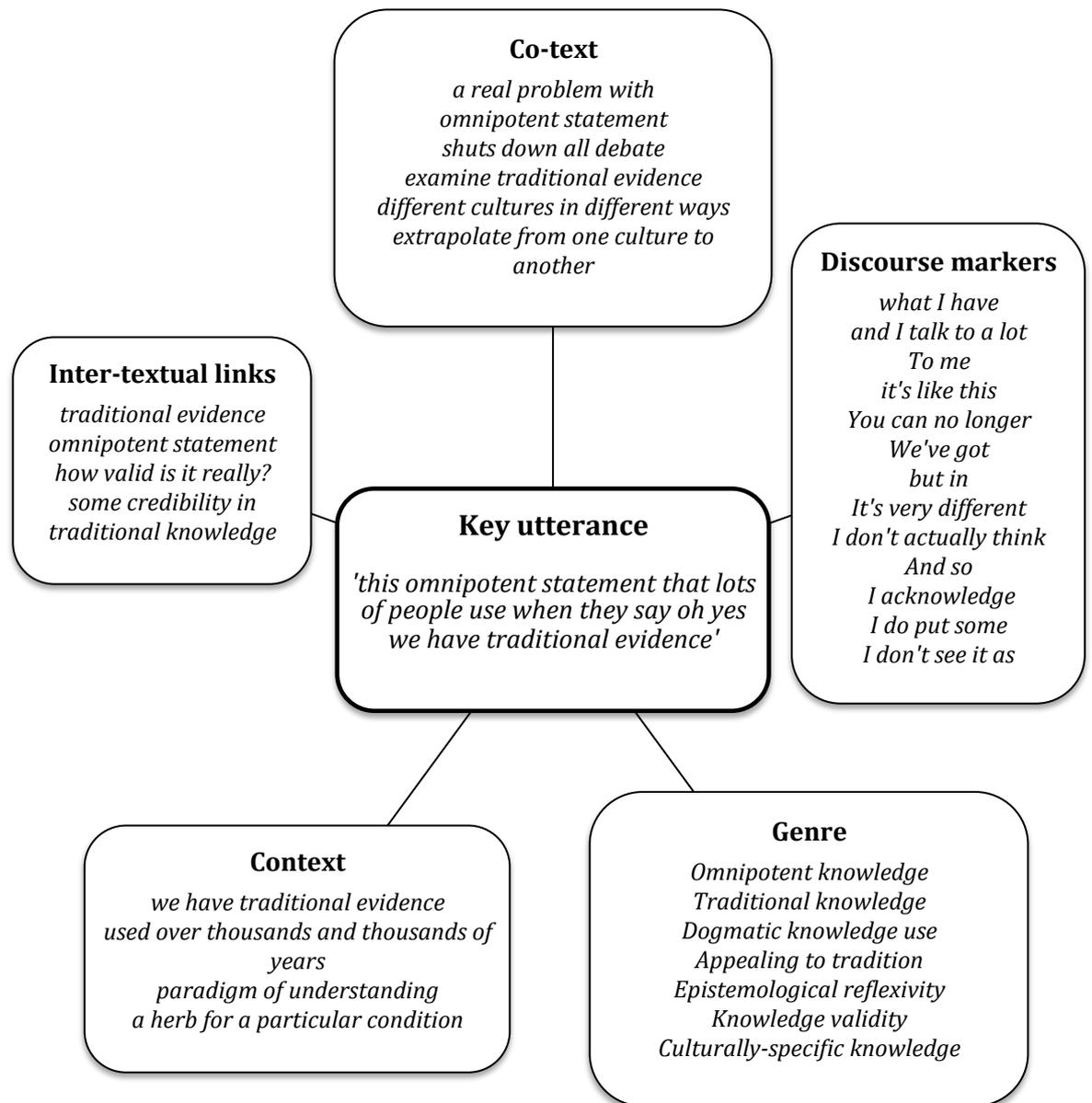


Figure 5.7: Theme 2 quotation 3 mapping

This is contextualised to the rationale for traditional knowledge ('used for thousands and thousands of years') that is located in distinct knowledge paradigms of the body and the appropriateness of therapeutic specificity in such instances. The genre notes fallacies in argumentation and identifies the appeal to tradition.

5.1.2.1 Discussion of discourse analysis of Theme 2

These quotes provide three distinct perspectives on the limitations of evidence for CAM practice and they explore the place of EBM, traditional knowledge, and clinical experience as either sufficient or insufficient knowledge sources for patient care. The defining feature of these quotes is the strong sense of self-understanding in the individual positions towards knowledge sources, and the evident reasoning processes applied to the use of quality assessment measures in each instance. This is particularly clear in the discourse markers where first-person grammar is used to locate the discussion in each participant's experience, and then contrasting conditional terms are applied to orient the discussion to reasons for viewpoints. Each set of inter-textual links also matches to the context and genre and there is a high degree of internal coherence within each quote.

The first of these quotes describes a solid educational training in EBM and discusses this in relation to the use of traditional medicinal plant knowledge for patient care. There is emphasis on the value of this model ('I love it') and the ability of EBM to extend and deepen the knowledge of traditionally endorsed plant medicines. However, this admiration is relative ('I'm not going to be blinded by that kind of evidence') to practical application and patient relevance, meaning EBM is situated against pertinent knowledge in a patient-centred care model. EBM is not prioritised and it serves a role as an add-on to other knowledge types, in this case tradition and clinical experience. This is the use of evidence in context-oriented and problem-sensitive situations (Reed & Lawrence, 2008) with an orientation towards traditional knowledge generating clinical legitimacy where practice-based evidence is preferred.

For the second quote there is clear reasoning as to the limitations of EBM where CAM has a minimal presence in the upper evidence hierarchy (Ernst, 2009c). This creates a shortfall of CAM-specific EBM knowledge in an EBP model and there is the request from two of the three interacting participants for the generation of more evidence to assist in resolving this. However, this

is required to be relevant to improving patient outcomes within the clinical context through 'marrying that with clinical practice'. Thus the experience of assessing clinical evidence is prioritised as a key effectiveness measure for this participant.

The third quote presents the viewpoint that traditional knowledge is an inadequately evaluated and widely used 'omnipotent' evidence source for the N&WHM professions. This discusses the presence of an appeal to tradition and the dogmatic perception of a safe, effective, or better form of knowledge; which in reality is not self-evident and therefore should not be uncritically accepted (Lee-Treweek, 2005). Several points in this argument ('omnipotent statement', 'shuts down all debate', and 'how valid is it really?') are later downgraded to the acknowledgment of some validity for this knowledge. This questioning of inflexible knowledge use is fitting and does not imply discursive oppression, injustice, or ideology; rather it shows epistemological reflexivity (Dowling, 2006) and a balanced argument that corresponds to the literature (e.g. Gilca, Gaman, Panait, Stoian, & Atanasiu, 2010; Helmstädter & Staiger, 2014; Kallea & Soukand, 2012; Pirker, Haselmair, Kuhn, Schunko, & Vogl, 2012; Saslis-Lagoudakis et al., 2011; Saslis-Lagoudakis et al., 2012). This also resembles thematic data citing the need for advanced skills in interpreting traditional knowledge that may be of poor quality.

These quotes show negotiation of limited EBM capacity for CAM through the use of traditional knowledge and clinical experience as determinants of evidential validity. The first two quotes discuss criteria that direct decisions for evidence use, and the third quote shows critical analysis of traditional knowledge. Participants are epistemologically reflexive and self-determine and reason their use of these knowledge forms, thus indicating free agency and empowerment in decision making about non-EBM evidence sources.

5.1.3 Intermingling knowledges

Theme 3: Research evidence is variable; research integrity, quality, relevance, and ideology is questioned; and practitioners are confident in their application of non-EBM knowledges and evidences

This first quote for this third theme arose from a focus group question asking if applied evidence is compatible with practice principles.

I just wanted to say that for me you look at all the evidence ... you look at all the evidence ... and see if it has actually been done properly and is that evidence really saying what it is supposed to be saying ... does it really make sense anyway, and what are the mechanisms of it and does that evidence then reflect what you're trying to achieve for your patient, and then if it's appropriate for that healing philosophy for that patient. And we do that with every patient on a case-by-case basis (Focus group participant MB121).

Figure 5.8 shows the key utterance verbalising a process of analysis focussing on the validity of knowledge. The co-text places the criteria of assessment in 'all the evidence' that must 'make sense' through a correspondence between 'mechanisms' and what the practitioner is 'trying to achieve' for the patient who has a 'healing philosophy' treated on a 'case-by-case basis'. Thus the patient-centred care model provides quality assessment criteria for evidence use. The discourse markers show how reasoning is taking place; the individualised nature of the quote ('I just wanted to say') expands to include the listener ('You look at') followed by statements as questions ('is that', 'does it', and 'what are') that lead into a directive ('what you're trying to achieve').

The inter-textual links reinforce the reasoning process through a pathway from valid evidence and its mechanisms of action that are matched to patient needs. This is contextualised to the need for evidence quality, relevance, and philosophical appropriateness that are applied in an individualised manner.

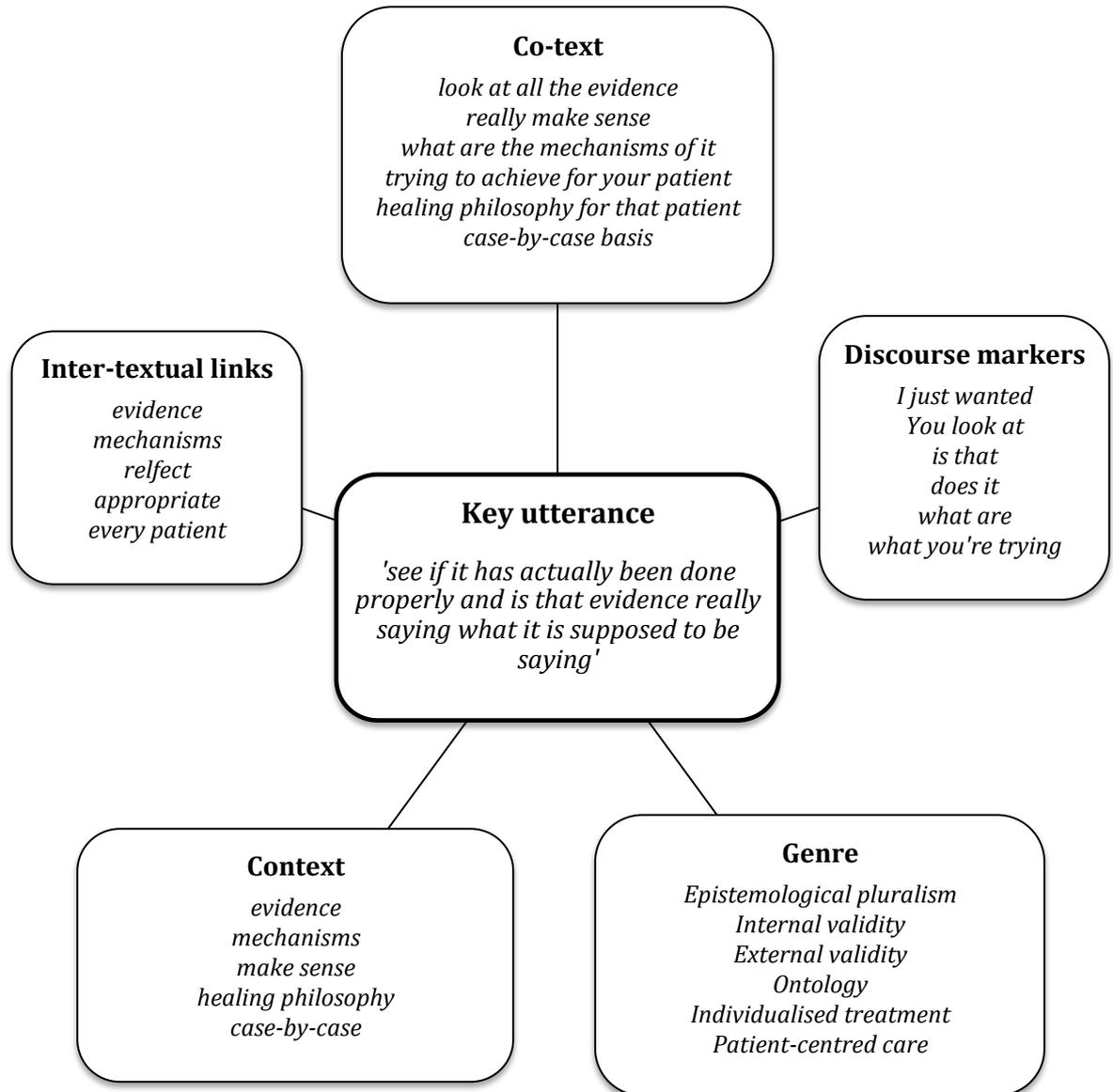


Figure 5.8: Theme 3 quotation 1 mapping

This reiterates the need for epistemological pluralism that provides valid knowledge for a philosophically informed practice that prioritises the patient case and its needs as the arbiter of decisions about evidence use.

Theme 3: Research evidence is variable; research integrity, quality, relevance, and ideology is questioned; and practitioners are confident in their application of non-EBM knowledge's and evidences

This second quote arose from a focus group interaction between participants (P) discussing a question about researching and representing practice.

P1: I'd have to say being reflexive. Like you know reflecting on what's happened and where it has worked, has it worked, how can I change that, what would I do differently next time. And I ask myself that all the time

P2: But then what you don't, what you never know, if it's the age of your extract ...

P1: Yeah, so many variables.

The interaction analysed in Figure 5.9 shows a method of assessment for knowledge use. The key utterance reveals a practice-based evidence approach to understanding effectiveness, where clinical legitimacy has primacy within a multivariate environment. This participant uses discourse markers to personalise their method ('I'd have to say') that includes the knowledge of the listener ('You know') and orients to the types of reflexive questions that are asked in clinic ('How can I', 'What would I') before emphasising this as a perpetual process.

The inter-textual links reference similar discourses where being reflexive leads to understanding in a multivariate environment. This is contextualised to exploring what works, what to change, and how to do things differently, and the recognition of this as a continual activity. There is acknowledgment of clinical uncertainty between participants ('Yeah, so many variables') that is accepted as incorporating the complexity of N&WHM healthcare practice.

The dialogue queries the presence of clinical confounders ('what you never know, if it's the age of your extract ...') and their effects via a reflexive method where to confidently apply knowledge requires markers of quality, relevance, and outcome.

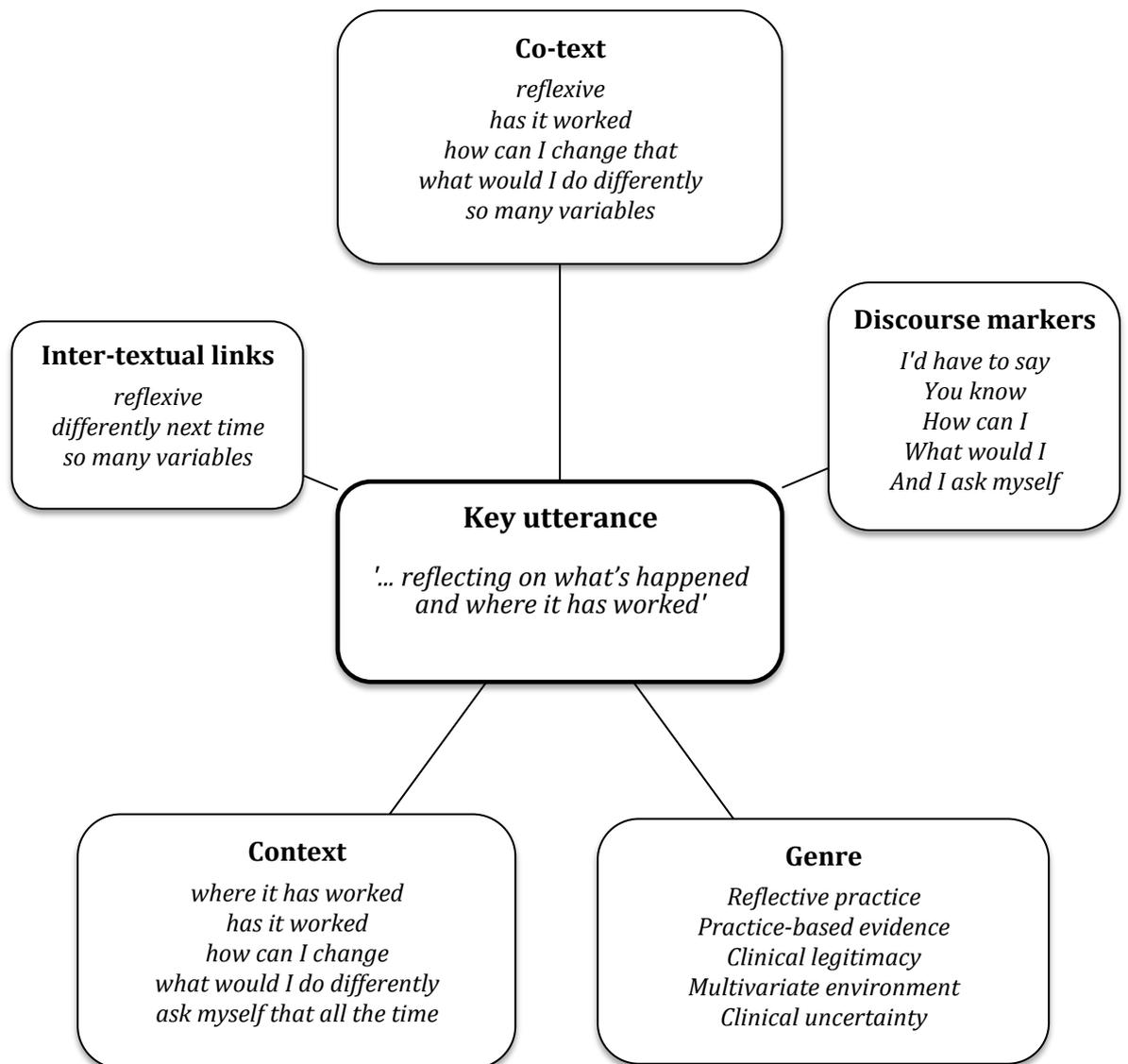


Figure 5.9: Theme 3 quotation 2 mapping

Hence this participant uses these reflexively to understand, improve and have confidence in the reasoning of, and acting on, knowledge, while at the same time incorporating the inherent uncertainty of their multivariate clinical practice. This reveals considerable self-assurance in understanding and meeting patient needs in a situation of complexity.

Theme 3: Research evidence is variable; research integrity, quality, relevance and ideology is questioned; and practitioners are confident in their application of non-EBM knowledge's and evidences

This third quote focusses on an interview participant response to a question asking if there was anything additional to add to the dialogue.

(T)he world seems to be jumping into this, well jumping onto the bandwagon of evidence-based as if that's the solution, as if scientists know everything, and my experience is they don't know anything. It's just people in a little room asking very tiny questions and every so often somebody does a meta-analysis and tries to make something meaningful out of, you know, to connect the dots (Interview participant 19B56).

In Figure 5.10 the key utterance outlines a perception of scientific research as specious; implying ideological preference overtaking useful knowledge generation. This is situated within a co-text that describes widespread ('the world') engagement with a fashionable ('bandwagon') EBM that involves removed ('my experience') and reductionist ('people in a little room' and 'tiny questions') research that is reconfigured ('make something meaningful') as clinically appropriate ('connect the dots'). The discourse markers orient a critical discussion where the implausibility ('as if') of science is juxtaposed to personal ('and my') experience that minimises the capacity of the scientific method (it's just', 'every so often' and 'tries to').

The inter-textual links further situate this discourse of criticism when comparing EBM to a 'solution' where scientists are said to 'know everything' and to gather disparate and reduced information together into meta-analyses as a way to present meaningful knowledge that can represent a complex interconnected reality. This is contextualised to a wider discourse that criticises the reductionist scientific method by proposing an inability to adequately reflect an interconnected holism because of its meaningless and artificial research processes.

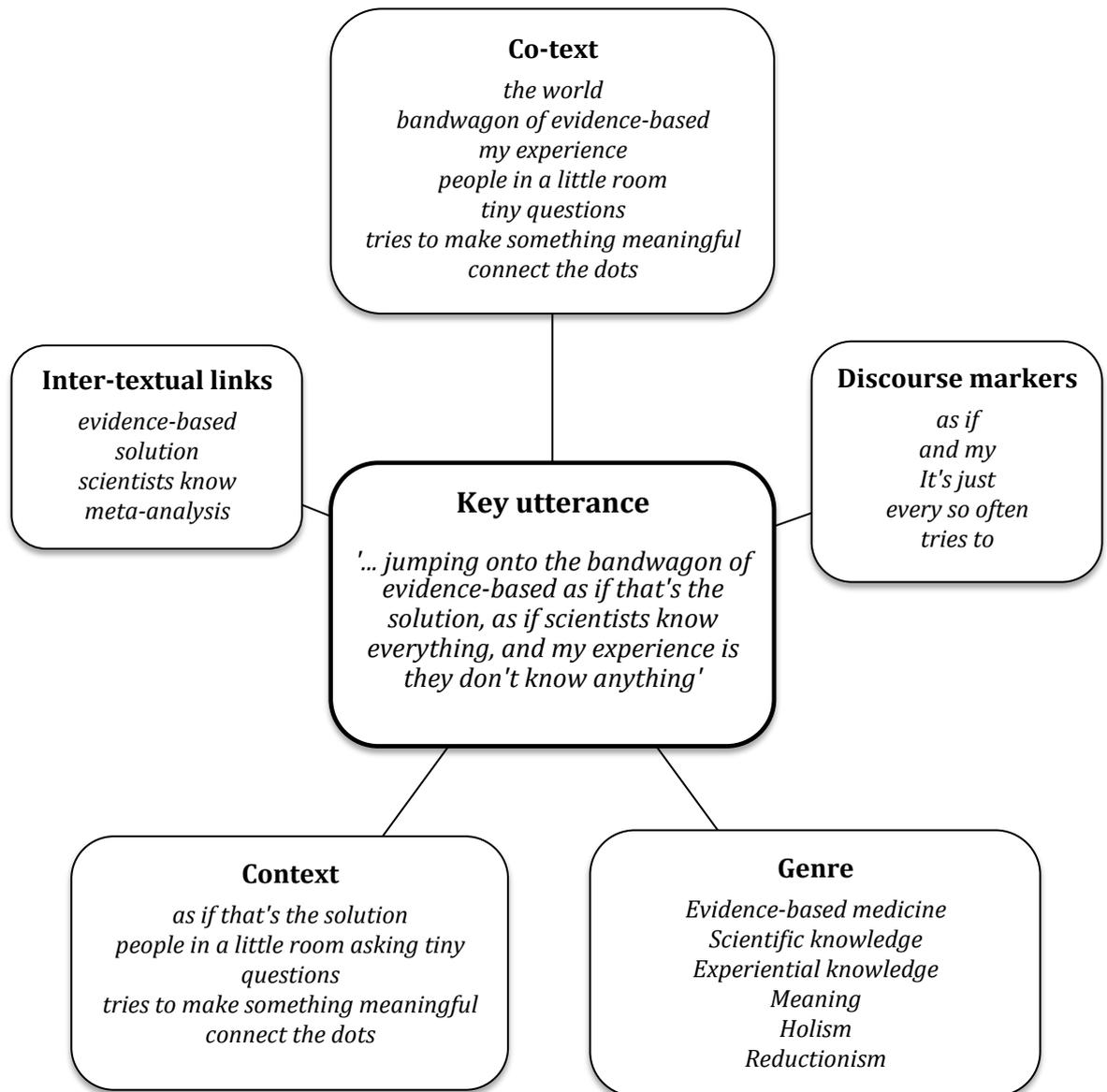


Figure 5.10: Theme 3 quotation 3 mapping

This is related to a wider genre of anti-EBM discourse based on experiential knowledge with opposition to reductionism. In this case such strong criticism is situated in a meaning-based holism that resists the ideological domination of the reductionist scientific method.

5.1.3.1 Discussion of discourse analysis of Theme 3

These quotes show participants perceive, assess, integrate, or dismiss EBM-derived evidence on the basis of its usefulness for their clinical practice situations. The reviewed discourses identify different ways of assessing the quality and validity of knowledge sources, and they expand beyond EBM to discuss the complexity of N&WHM therapies that are inherently multivariate in nature and difficult to accurately clarify within a reductionist model. The common discourse is that knowledge is aligned to patient needs and for some practitioners scientific knowledge is incommensurable with the experience of holistic practice due to its philosophical orientation.

The first quote describes the process of critical analysis of evidential claims, which is a core skill in knowledge translation. This indicates an active pursuit of EBP that involves clinical judgment about the most appropriate, relevant, and valid evidence that successfully meets quality and integrity criteria. These judgments about knowledge have a value-oriented base that directs the analysis and synthesis of evidence in an discretely determined way (Strech & Tilburt, 2008). The individualised values are related to critical thinking capacity and the ontological preferences to which these align in the clinical context (Gambrill, 2005; Shaban, 2005). Thus decision making is contextualised to each patient case that interacts with the practitioner. This participant expresses all of these components.

An emphasis on practice-based evidence is evident in the second quote where reflexive practice is used to assess the effectiveness of clinical knowledge. The accuracy of this approach is queried within participant interaction through an example of confounding factors that can arise when assessing the effectiveness of an intervention in this way. The complexity of the provided example is acknowledged without disagreement, which indicates that the largely unknown multivariate nature of practice is accepted without hesitation. Confidence in managing this complexity emerges from the paucity of EBM evidence that can capably assess multivariate environments

and multicomponent therapies, which leads to the development of independent critical appraisal skills. This research inadequacy is recognised and strategies of inquiry are developing that move towards the effective examination of these (e.g. Bell & Koithan, 2006; Hooker, 2011; Lan, Xie, & Jia, 2013).

Total negation of reductionist science, and by proxy the EBM model, as a useful tool for developing knowledge is evident in the third quote. This stance is based on personal and experiential learning, which is used as the contrasting knowledge source against the scientific method. This reflects a preference for professional knowledge based on an ontology that opposes reductionist philosophy and promotes the primacy of knowledge developed through the 'transformation of experience' (Kolb, 1984, p. 41). Unfortunately this argument is situated in a form of epistemological monism that creates a knowledge silo based on a similar exclusivity that is the target of much of the criticism against EBM.

These quotes show diverse stances towards N&WHM assessment criteria for knowledge sources. The first two participants acknowledge the variability of research evidence and, with the third participant, express knowledge assessment criteria for validity, quality, relevance, and ideological presence. There is an emphasis on clinical experience as the dominant judgment method, with varying degrees of allegiance to this being evident across the three quotes. Concomitant to this are degrees of resistance to EBM as the sole knowledge source within EBP, with the first and second quotes applying epistemological pluralism while the third is situated in emphatic opposition to EBM derived from an experiential viewpoint. Thus the act of decision making about evidence can indicate ideological resistance. The latter perspective can be challenged on grounds of philosophical monism and the unwarranted exclusion of relevant evidence derived from the EBM model.

5.1.4 The perpetual role of beliefs and values

Theme 4: With time in practice, evidence is gathered and applied in an individual hierarchical style reflective of practitioner beliefs and values

This first quote arose in response to an interview question asking if professional values shift as evidence becomes increasingly available.

I guess I was always naturally cautious, I just feel more confident in prescribing when I know that there is evidence to support it. And I feel like I can explain things in greater detail so that people can make an informed decision, whereas even 10 years ago in the research literature there wasn't a great deal of information out there for obviously the wide variety of things that we prescribe. So I guess my morals and ethics haven't changed, it's just the evidence helps me to sit more comfortably with how I would like to prescribe, how I would like to practise (Interview participant 26B46).

The key utterance in Figure 5.11 describes comfort with the ability of evidence to sanction clinical practice in a moral and ethical framework. The co-text expresses how evidence improves self-reliance ('feel more confident' and 'sit more comfortably') and enables improved decision making ('explain things in greater detail' and 'make an informed decision') to create a practice method that is morally and ethically congruent ('how I would like to practise'). The discourse markers show the use of the first person and reveal how the emotional stability of the stated position ('I feel') is yet to become a solid cognitive position ('I guess'), possibly because the past lack of evidence ('there wasn't') is not resolved into the future ('I would like').

The inter-textual links highlight three interlinking themes of evidence in the literature as information that can reflect morals and ethics in prescribing and practice. These are contextualised to evidence creating confidence and improved decision making that leads to a feeling of security in prescribing practices and clinical method. This reflects a mix of values-based practice and EBP where available confirmatory information provides a sense of stability for ethical practice.

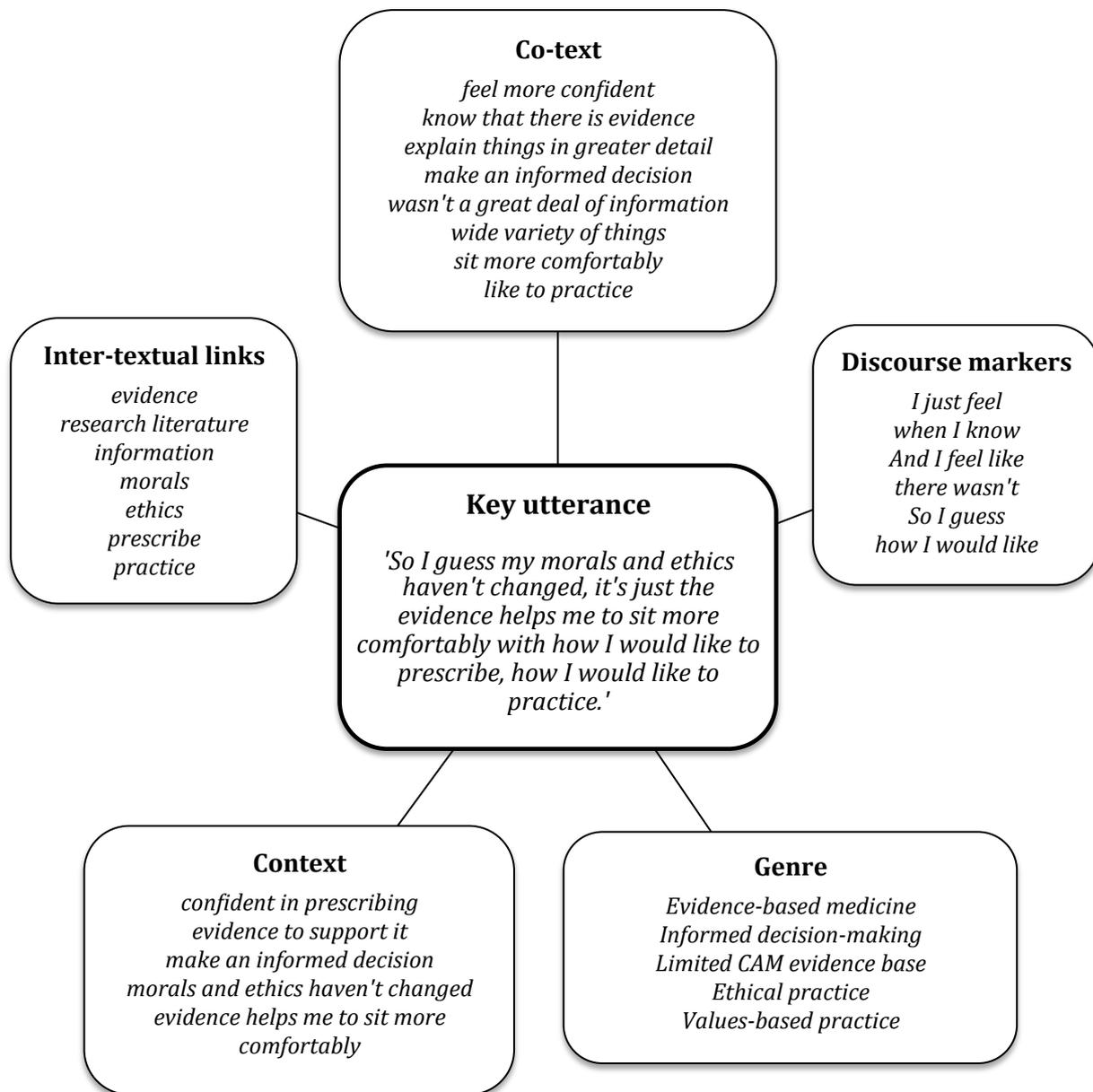


Figure 5.11: Theme 4 quotation 1 mapping

However, this position describes the current CAM evidence base as greatly improved while at the same time showing cognitive instability when describing this as sufficient for the desired practice method. Thus there is internal incongruity within this quote.

Theme 4: With time in practice, evidence is gathered and applied in an individual hierarchical style reflective of practitioner beliefs and values

The second quote emerged from a question exploring difficulties in gathering and applying knowledge.

So, no, I don't find it difficult to sift through knowledge anymore and to understand ... you know like I have quite a strong personal sense of: OK this is clinical knowledge and experience, this bit is traditional herbal knowledge, this bit comes from evidence-based scientific knowledge. But I don't find it hard to find what I want to find when I need to find it, or to kind of mobilise it if you like ... there's a variety of different ways of looking for different kinds of information and you can pursue them very systematically (Interview participant 4B46).

The key utterance in Figure 5.12 outlines a strong personal position revealing epistemological pluralism in action. The co-text shows the accessing of knowledge as a simple and ordered process ('don't find it difficult', 'find what I want', 'variety of ways', and 'pursue them systematically') that is easily translated into practice ('mobilise it'). The discourse markers identify the first-person relationship ('I don't find' and 'I don't have) to knowledge forms ('this is' and 'this bit is') that are intentionally chosen ('what I want' and 'when I need') and described to the listener as a technique that can be applied by practitioners generally ('you can').

The inter-textual links describe how this ease of knowledge access, use, and understanding has become easier over time. Experience has developed a 'variety of different ways' of information access that are associated with a systematic technique of data mining across multiple knowledge types. These are translated in response to each specific clinical situation and are gathered in an ordered process of interpretation and understanding. The necessity to 'sift through knowledge' is described as becoming easier over time, a situation that appears to create a broadened technique of information gathering and an increased amount of captured knowledge.

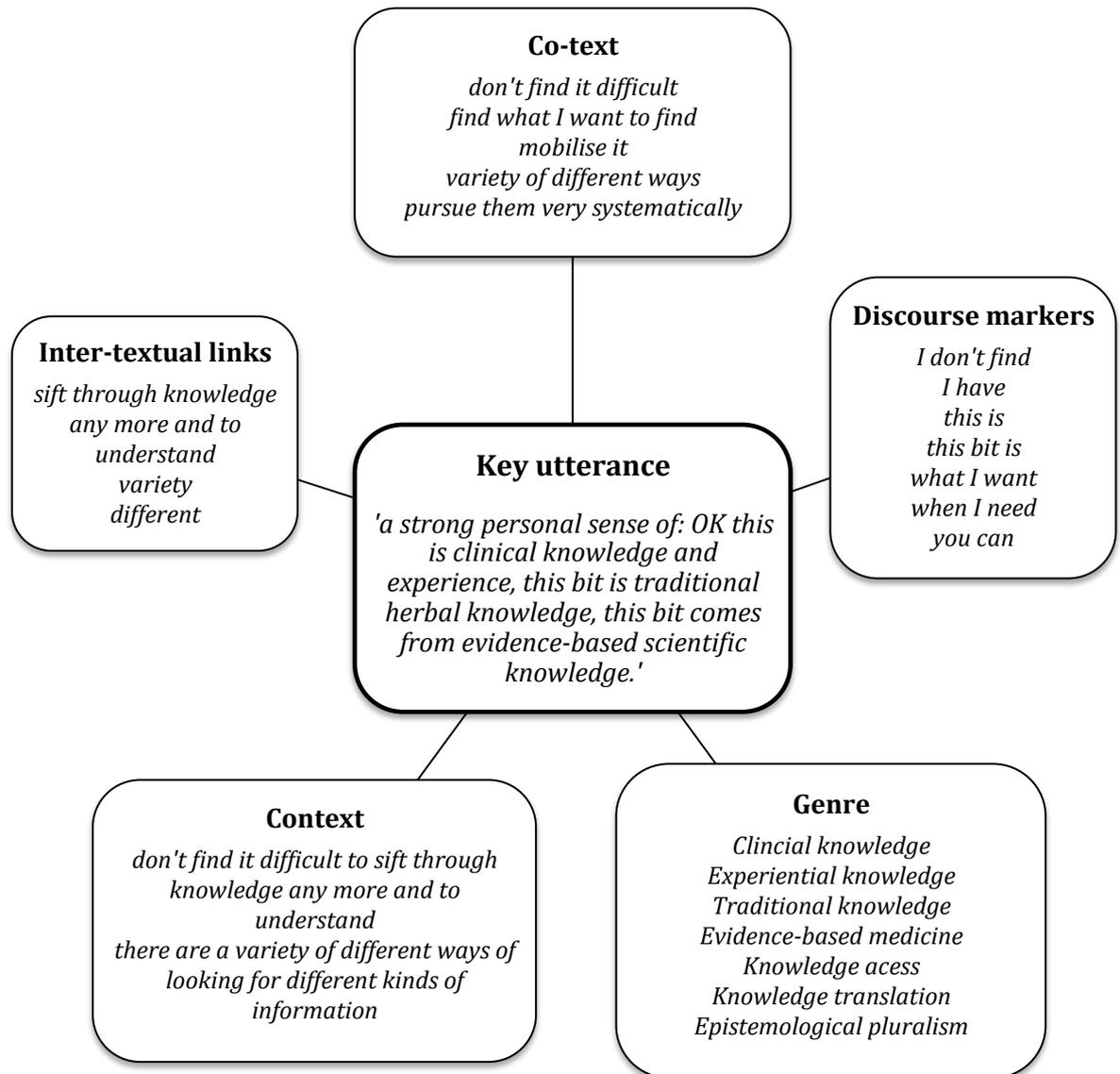


Figure 5.12: Theme 4 quotation 2 mapping

This leads to engagement with clinical, experiential, traditional, and EBM knowledge that can be applied to the presenting case as required. This approach shows considerable sophistication and evident self-determination.

Theme 4: With time in practice, evidence is gathered and applied in an individual hierarchical style reflective of practitioner beliefs and values

The third quote shows an interaction between the interviewer (I) and an interview participant (P) when discussing evidence use.

I: People will be applying a kind of breadth of knowledge types and evidence in their practice to kind of reflect what it is they do in practice. And I guess I'm kind of asking of you does the evidence types you're using, does that fulfil that role for you?

P: No, I don't think so. I think the evidence I use is much more mechanistic than the way I am in practice.

I: Yes. So how do you sit with that?

P: I have lots of inner conflict (Interview participant 6B62).

As per Figure 5.13, the key utterance describes how ongoing evidence use over time does not inevitably lead to the development of philosophically congruent knowledge access and use. The co-text succinctly outlines this as a problem that is located in the interplay between evidence generated from a mechanistic philosophy, a practice that is not conducted in this way and the result of this for the practitioner translating the evidence. The discourse markers show a first-person discussion based on a cognitive ('I think' and 'I don't think') approach to using evidence that is antagonistic to a personal state ('I use', 'I am', and 'I have').

The inter-textual links situate the degree of difference between these cognitive and more personal states by comparing the way practice is conducted to a 'much more mechanistic' evidence that informs this, thereby leading to 'lots of inner conflict' between this evidence and work practice behaviour. This incongruity is contextualised in a way that reinforces these polarities and simplifies a difficult situation for this participant. The broader genre outlines these difficulties within discussion related to the philosophy of EBM, the inadequate external and model validity that arise because of this, and the consequences of acceptance of these inadequacies into the practice setting.

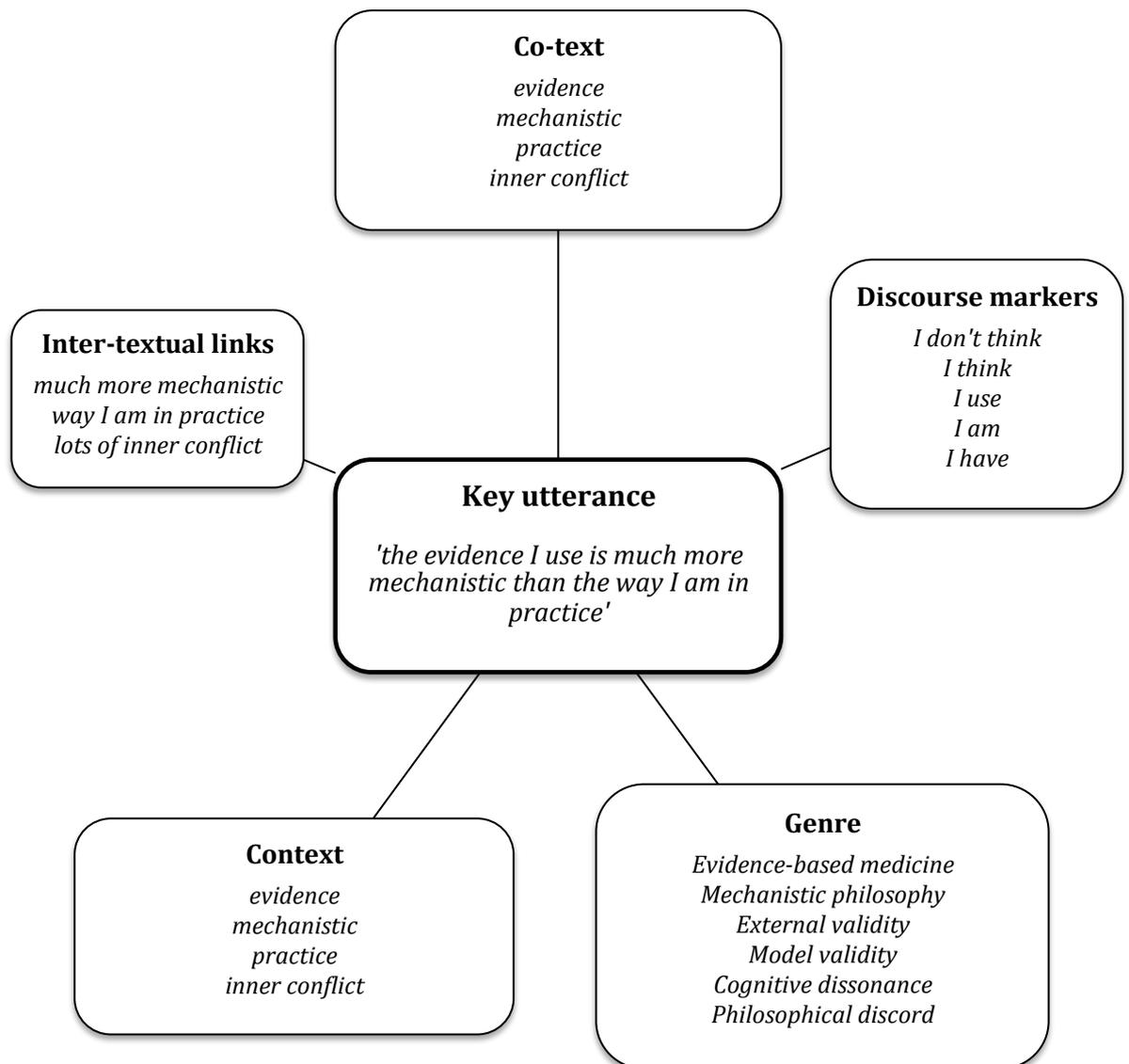


Figure 5.13: Theme 4 quotation 3 mapping

This reveals the outcomes for individuals when constraints created by ideological imposition lead to distortion of the internal coherence of the lifeworld.

5.1.4.1 Discussion of discourse analysis of Theme 4

These quotes describe three different outcomes that arise for each participant due to engagement with knowledge in practice over time. The most striking feature to emerge is the presence of dissonant cognition compared to actual experience for two participants; with the presence of this as either concealed within language or openly expressed. Conversely, there is strong coherence for the remaining participant, and these each contribute to an expanse of discursive positioning for participants in relation to this theme.

Comfort from evidence use is made clear in the first quote, and the key utterance implies a strongly located EBP that reflects morals and ethics for practice while becoming increasingly informative over time. However, the discourse markers reveal disparity between actual and desired eventualities and incoherence between emotion and cognition in the expressed language. This signifies differences between what is felt to be occurring compared to what is thought to be right, which reveals possible cognitive manipulation causing reproduction of an implanted discourse at the expense of coherent interconnection between emotion and cognition. This is, in Habermasian terms, representative of the conflict between communicative and strategic action and uncoupling of the lifeworld and system (Habermas, 1987).

The second quote expresses an interconnection between a strong personal sense of being and participant engagement with knowledge. The negotiation of epistemological pluralism is evident where processes that have matured over time lead to the ability to arrange a wide array of knowledge types in order of preference. This skill is individually developed to enable a specific method of knowledge use in clinic, and it reflects a high level of professional expertise and reflective understanding of inherent capacities. The described action involves non-reductive, decentralised, self-determined thinking that can solve complex problems (Jacobson, 2001) and it presents this action as achievable for others.

The third quote clearly shows cognitive dissonance and awareness of an incongruent situation. For this participant the acceptance of conflict between accessed knowledge and practice method is self-evident, and identifies the point of contention as philosophical incongruity and issues of validity related to mechanistic research methods. These are commonly identified as problem areas in criticism of EBM from those working in practices with philosophical groundings in opposition to this model, notably in the areas of evidence, meaning, and values in practice (Andersen, 2001; Mason et al., 2010; Okasha, 2000). Although the admission of conflict is honestly made it clearly indicates ideological constraints and a breakdown in ease of practice and inner peace as a consequence; which is a more evident symptom than the language conflict identified for the first participant.

These quotes demonstrate particularly interesting approaches to evidence use over time, and expose the sophistication and problems that can emerge for N&WHM practitioners in this area. It is clear that the linkages between beliefs and values in practice are reflected through the way participants situate themselves relative to knowledge types. However, it is also known that conflicted knowledge engagement causes unease and increases the potential for either epistemological bifurcation through domination by other knowledge (Singer & Fisher, 2007), or intellectual maturation as knowledge is successfully located within the internal workings of a particular philosophy (B Hofmann, 2002). The provided quotes show that participants respond to knowledge uniquely and that meaning within work practice is individuated across a shared professional discourse (Buetow, 2002; Dahlberg, 2006). From this analysis it appears that such individuation may also be a point of susceptibility for ideological manipulation leading to internal constraints. Thus beliefs and values can be colonised, which contributes to lifeworld unease.

5.1.5 Responding to ideological rhetoric

Theme 5: Vested interests use EBM as a tool within arguments against CAM practice

The first quote represents a focus group discussion in response to a question asking if EBM is compatible with practice principles.

P1: There's so much pressure on us to go by that model.

P2: There is, isn't there?

P1: Yeah, it's intense. So you can't even almost say your own opinion because you don't want to do the unethical, so-called unethical thing, say the wrong thing to the patient or say your real view I suppose.

P3: Why? I don't understand that.

P1: Well, I feel like the evidence-based approach is ... like the hierarchical model I'm talking about, not the circular type of model.

P2: The NHMRC [National Health and Medical Research Council] model, yeah.

P1: There's so much pressure on us to conform I suppose to the biomedical paradigm that I feel as almost I can't say my own opinion. Does that make sense to anyone?

General agreement

The key utterance of Figure 5.14 reveals perception of pressure, conformity, and oppression from the EBM model. The co-text identifies the reasons for this as 'so much pressure' that is 'intense' in its demands 'on us to conform'. This leads to difficulties in the ability to 'say your own opinion' and 'your real view' for fear of saying 'the wrong thing'. The discourse markers orient this as a significant ('there's so much') issue demanding allegiance ('go by that') in a way that creates apprehension ('You can't even almost say' and 'You don't want to'). This leads into first-person markers that vaguely ('I suppose') direct the argument before reorienting to emotion ('I feel') and then a modal verb that expresses an inability to speak ('I can't) for oneself. The inter-textual links describe EBM as other ('that model') dictating ethical and correct behaviour towards patients that conflicts with clinical freedom.

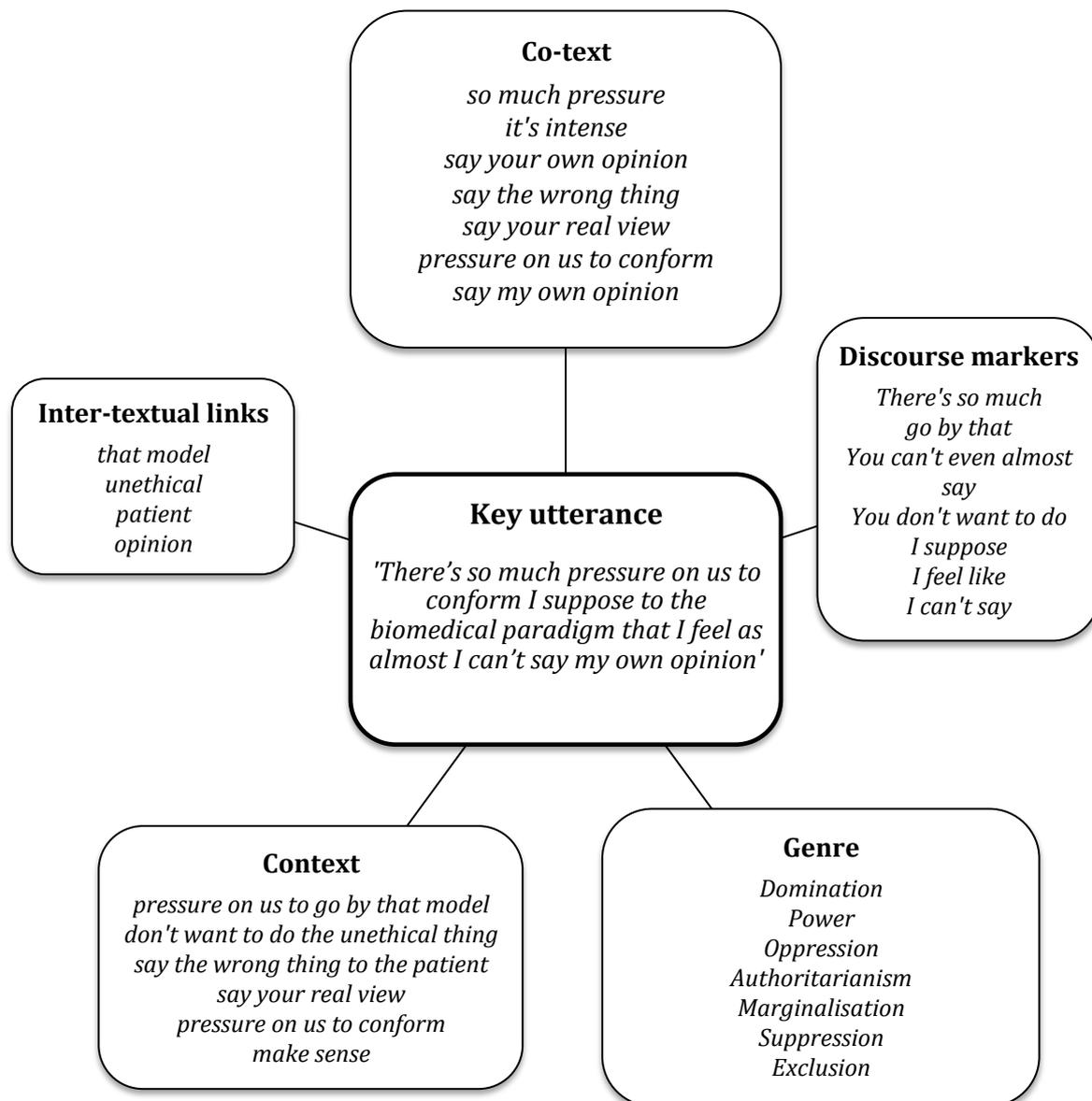


Figure 5.14: Theme 5 quotation 1 mapping

This creates suppression of voice and an inability to express coherence and real views, which is a perspective that makes sense to all participants. This indicates epistemological power operating in an authoritarian manner that opposes, oppresses, marginalises, and excludes any alternative to a knowledge model that demands conformity.

Theme 5: Vested interests use EBM as a tool within arguments against CAM practice

The second quote arose from an interview question enquiring as to whether the negative discourse regarding CAM and EBM affects work practice.

I tend to look at that arm of medicine and its diatribe against complementary medicine, and ... I really think they represent people who have a strong feeling against complementary medicine, most of whom have extraordinarily little understanding of it ... most of it's coming from worst case scenarios they might have seen in practice, looking at the most extreme end of complementary medicine practices, failing to understand what complementary medicine as it is practised and taught looks like. So there's that aspect of it, that's extremely problematic. But it's also kind of boundary wars, there's the entrenched paradigm, you know, holding up its flag and saying this is what medicine should look like (Interview participant 4B42).

In Figure 5.15 the key utterance identifies the fulcrum of the EBM-based arguments against CAM as ideological boundary wars. The co-text locates this within an 'arm of medicine' with 'strong feeling' based on 'extraordinarily little understanding' of the majority of CAM practice. This is a mistaken interpretation that is 'extremely problematic' as it uses the 'extreme end' of practitioner action to construct 'boundary wars' between CAM and those who have a vested interest in 'what medicine should look like'. The discourse markers direct the conversation from the first person identifying those who hold these views to a contrasting subject where the larger genre is identified.

The inter-textual links show three linkages to this discussion, where the argument emerges from those who are situated within the 'entrenched paradigm' of medicine that rallies 'against complementary medicine' as a way to enact 'boundary wars' to protect that paradigm. This is contextualised to the concept of the argument as a 'diatribe' and as a position that fails to 'understand complementary medicine' as it is practised. This is related to the larger genre where strategies of rhetoric based on single cases are used to create a symbolic portrayal of a work practice to demarcate a profession.

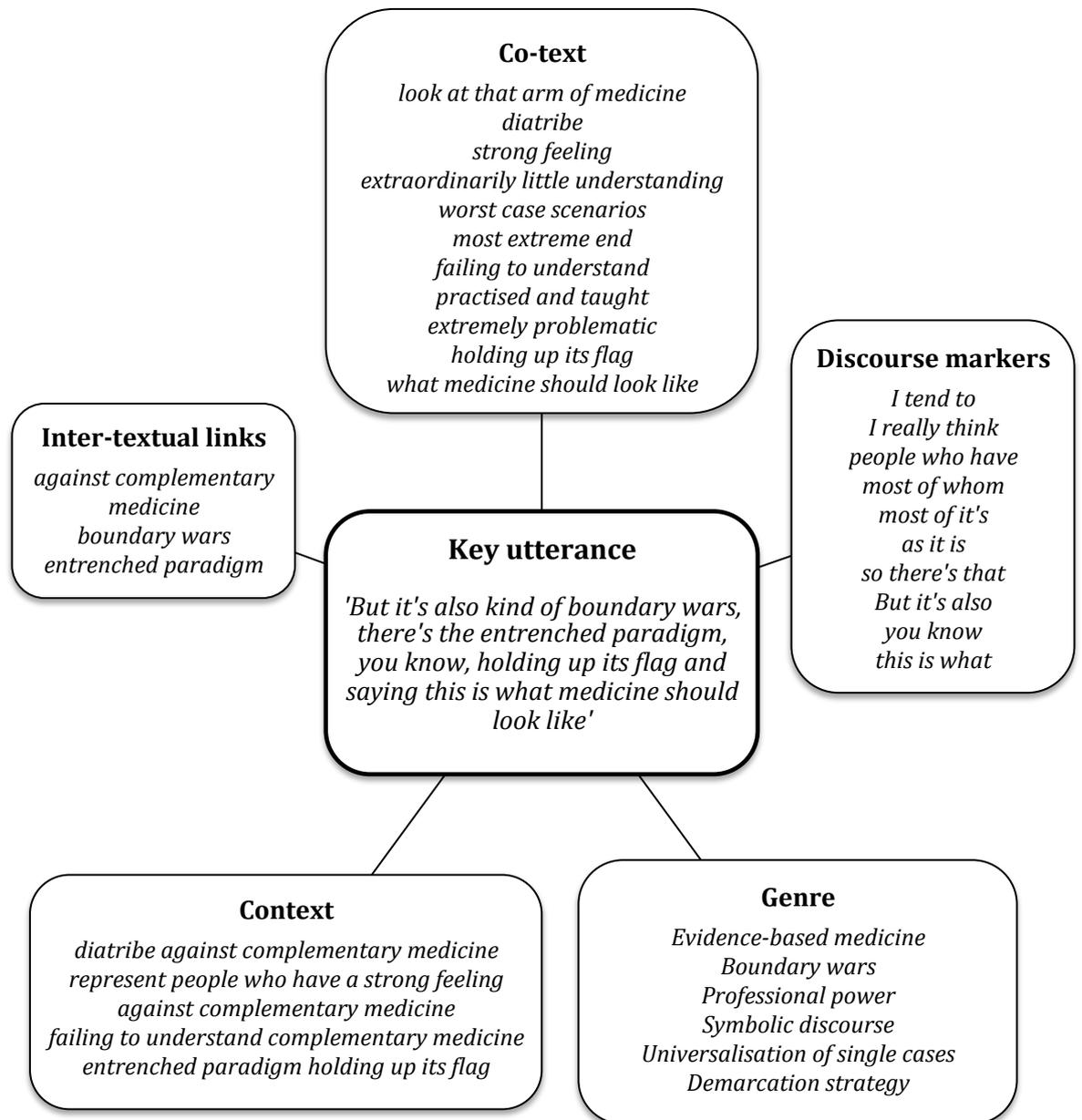


Figure 5.15: Theme 5 quotation 2 mapping

Thus the strategic use of discourse to exert power through knowledge is clearly identified, and the marginalisation of this to a small and ill-informed group presents a developed and resistant counterargument.

Theme 5: Vested interests use EBM as a tool within arguments against CAM practice

The third quote arose from a focus group question on what evidence in practice means.

Chaste tree [Vitex agnus-castus - a medicinal plant]. Great that it's just been found to have all of these additional actions but it's not limited to those actions. And that's where I think it would be quite difficult for someone coming from that biomedical field who's so used to that real specific detailed reductionist perspective to then accept that more wholly worldly view on applications of what could be medicine. Because it's a lot easier to go, OK, well this is the broad component and actions and interactions and cross-functions and activities of chaste tree, and start to narrow it down to fit a patient's profile and biochemical imbalances more than looking and starting from a really pinpointed view upwards (Focus group participant AB39).

The key utterance in Figure 5.16 discusses the argument against CAM from the perspective that a lack of understanding underlies an inability to comprehend the philosophical basis of N&WHM practice. The co-text portrays this through an example of a medicinal plant and recent research identifying a set of specific actions that are seen as part of the activity for this therapeutic substance. The reductionist and holistic perspectives of these actions contrast the discussed argument and its target. The discourse markers direct the listener through this by describing these actions ('it's been found to have all of these') and then outlining how change ('so used to' and 'to then accept') in philosophical thinking is required to understand ('of what could be') the in-practice use of this therapeutic substance.

The inter-textual links locate the discussion in the 'actions' and 'applications' of 'what could be medicine' with respect to the differing philosophical views of the 'patient's profile'. This is contextualised to understanding the medicinal plant and the patient in a manner that is larger than the knowledge offered by reductionism, where the inability to grasp this perspective leads to a narrow view of the practice of medicine.

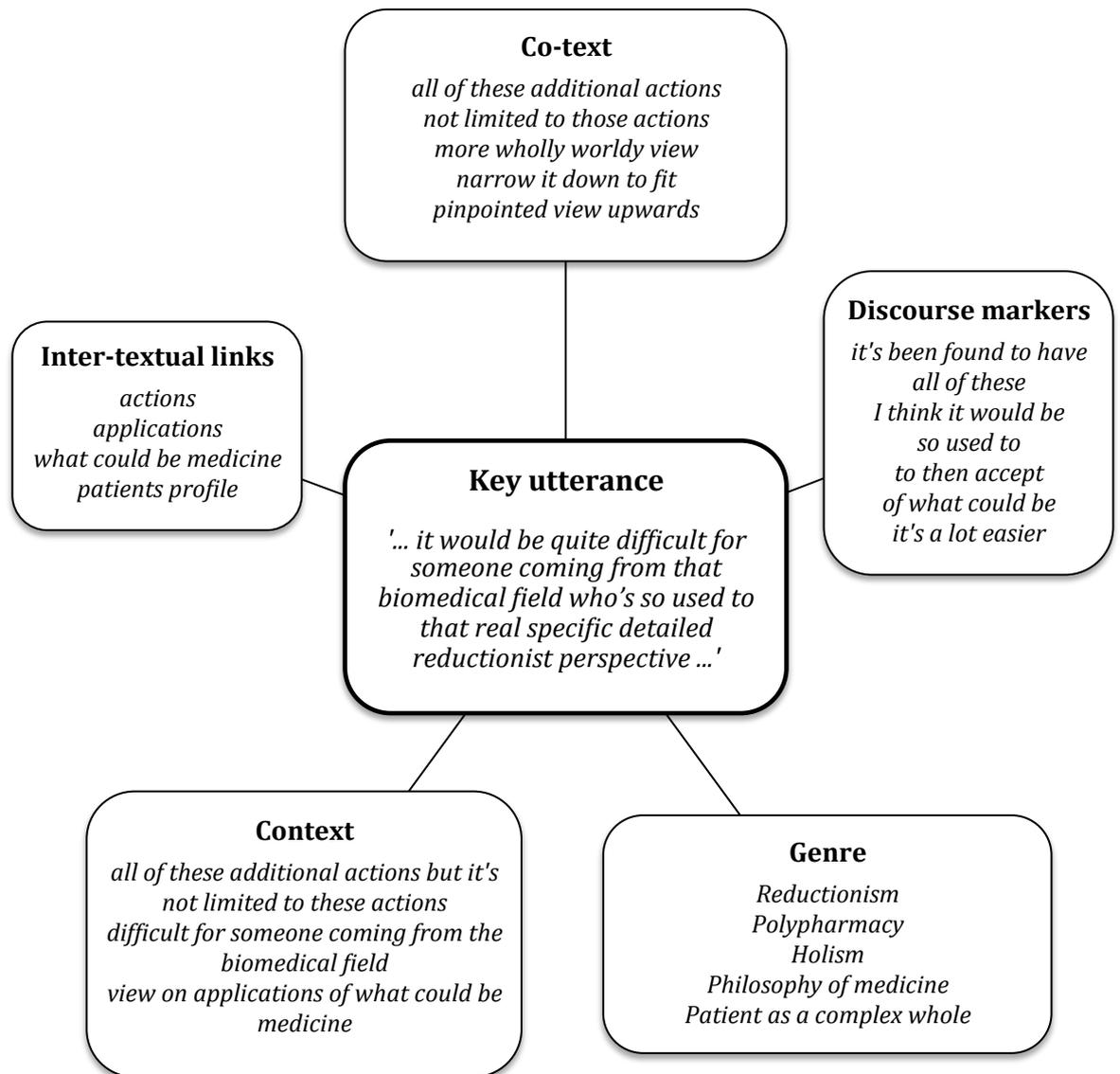


Figure 5.16: Theme 5 quotation 3 mapping

This strongly reflects philosophical distinctions and resistance to the arguments against CAM from a position of developed self-awareness as a holistic practitioner. Thus the proposed argument is turned back to its architects as their problem to solve.

5.1.5.1 Discussion of discourse analysis of Theme 5

These quotes show three responses to arguments against CAM that are based on the rhetoric of EBM as the source of knowledge that can discern valid from invalid healthcare practices. Responses range from the presence of frank oppression and suppression of voice to two counterarguments based on recognition of professional boundary maintenance and philosophical distinctions. The common thread among these three quotes is recognition of attempts to destabilise and marginalise CAM healthcare practices through specific ideological interests promoting a corrupted EBP model. This is used to frame an argument that contains emphasis on EBM as representative of healthcare evidence, which for two participants is a fallacious proposition.

The first quote displays evident oppression, where the consequences are suppression of sense of self in the professional capacity. The position stated by this participant is met with agreement from the focus group members and as such this signifies more than one case of this type of response. Therefore the power that is carried within the argument against CAM has considerable force for these participants, and the marginalisation that arises due to the authoritarian nature of the involved discourse has negative consequences. In discourse analysis parlance this reflects the abuse of power where the will of those in positions of authority suppresses the will of others (Reisigl & Wodak, 2009). Thus the response points to the presence of ideological influence and the suppression of any voice that may emerge against this.

The second quote locates and resists the anti-CAM argument by taking the discourse apart into its constituent parts and identifying its flaws. The underlying motivation of the arguers is then related to wider concerns that are often seen to represent vested interest groups in knowledge arguments. This pinpoints the basis of the argument and forms the foundation of a counterargument that in turn marginalises those involved in arguing against CAM. This reflects similar strategies that exist within the literature (Walach,

2009a) and signifies an active resistance to the misuse of power through the manipulation of knowledge.

The third quote offers a similar strategy to the previous participant but locates the counterargument within philosophical approaches to healthcare therapeutics, practice, and the patient. This focuses on the reductionism of EBM and the subsequent inability of this model to comprehend holistic practice, particularly within the breadth of medicinal plant actions and their associated polypharmacy (Liu, Wang, Zhou, Wang, & Yang, 2013). As in the previous quote there is reference to the control and manipulation of healthcare knowledge by an overbearing ideology that fails to entertain or understand other philosophical possibilities.

Participant responses are in line with literature describing the ideological argument against CAM as limited in its capacity due to its inability to account for a multitude of health-related factors residing outside the EBM model (MacArtney & Wahlberg, 2014); factors situated in areas where CAM has high effectiveness and public appeal. Thus ideological power within a discourse that dominates by negativity, marginalisation and suppression is seen as an exercise in boundary setting by naïve rationalists manipulating evidence in a way that erodes medicine's values of patient care (Derkatch, 2008; Greenhalgh, 2012).

The presence of this type of discourse does not only apply to the argument against CAM as discussed here; such rhetoric exists across the healthcare disciplines (e.g. Greenhalgh et al., 2014; Jadad & Enkin, 2007; Tracy, Dantas, & Upshur, 2003). Misuse of power and ideological intrusion are recognised problems that are attached to the intransigent use of the EBM model, and the issues identified for participants are not specific to the CAM–EBM boundary. Thus the suppression of voice and the resistant positions of participants that are found here are not unusual or infrequent. These important characteristics of the CAM–EBM interface will be theorised in Chapter 6.

5.2 Review of analytical findings

The analysed quotes were condensed into four discourse-based thematic areas by collapsing the dominant themes: (1) the participant-EBM interface; (2) the misuse of EBM as a dominant knowledge form; (3) practitioner negotiation against the misuse of EBM; and (4) participant strategies at the EBM interface.

5.2.1 The participant-EBM interface

The explored quotes reveal a shared understanding of the benefits and limitations of EBM evidence, which is transposed to the recognition of positive and negative knowledge features generally. Participants differentiated these features to presenting cases within an understanding of multivariate practice settings and the necessity for critical appraisal of applied knowledge. EBM is one component of epistemologically pluralistic practices, where its contextualised placement contributes to knowledge translation that often matures in its implementation over time.

Within this pluralism the indiscriminate acceptance of any form of knowledge is discouraged, as is denial of EBM evidence, and the single case of negation of the latter due to incommensurability is a position that is unlikely to be accepted across the professions. Interestingly, participants applied knowledge in a way that was similar to the findings from the focus group and interview thematic analysis. Thus the consequence is EBM forming part of a practice-based evidence model delivered in the individual practice context and across the profession as a whole.

From the critically analysed data it is evident that the EBM interface is generally non-problematic for the majority of participants. However, for some the individualised nature of practice may create a degree of vulnerability to domination by strong knowledge ideologies, and as a

consequence there is evidence of suppression of voice and philosophical conflict for certain participants.

5.2.2 The misuse of EBM as a dominant knowledge form

Various participants identified the use of an imbalanced EBM model as a tool of manipulation via its application as a boundary marker in arguments against CAM. Numerous participants describe this as marginalisation of specific healthcare disciplines that fail to meet a certain style of EBM-based criteria. The perception of the imposition of this EBM was acknowledged and there were some signs of domination and suppression of freedom of thought and feeling as a result. This is noticeable in language displaying incoherent cognition and emotion, comments of conflict between EBM and practice philosophies, and difficulties in expressing the true self in practice due to pressure to abide by a dissonant perception of EBM.

This reveals the reproduction of a knowledge discourse that participants see as constraining upon the coherent expression of other knowledge forms. For several participants the voicing of knowledge differences that exist in their healthcare practice was difficult due to fear of repression from an overbearing evidence discourse. The forces underpinning this are identified as ideologies that represent a misuse of power. This leads to rhetoric of legitimacy as a way to destabilise other knowledge, which serves to maintain and strengthen professional boundaries in the healthcare marketplace. The majority of participants identify this type of strategy and the misuse of the EBM model within this, and they are cognisant of the limitations of the proposed argument. Due to this they resist the misuse of EBM while simultaneously negotiating the EBM interface.

5.2.3 Practitioner resistance against the misuse of EBM

Resistance to the imbalanced EBM model is a common reaction to the demand for the sole use of explicit knowledge. Because participants are

autonomous clinicians with developed intellectual capacity they freely choose to apply or dismiss EBM-derived evidence on the basis of its usefulness for practice context. This action resides within reasoning that informs the use of chosen knowledge to individualised patients, which is assessed against outcomes and an iterative learning and meaning-making cycle of knowledge generation. Concomitantly, participants have significant epistemological reflexivity and reasoning in their use of knowledge, which leads to well-informed agency in evidence decision making. Clinical judgments are critically rationalised and they reflect practice-based evidence in the context of professional philosophy and patient preferences.

This way of being shows resistance to the constraints that are inherent within the EBM model. Thus the use of an imbalanced EBM as an argument for a normative healthcare is simple to contest. This is because normal work practice becomes increasingly oppositional in this context. Thus it is negation of the reliance on manipulated externalised evidence-application criteria and the blending of tacit *and* explicit knowledge to achieve the best possible patient care that shapes a strategy of resistance to the misuse of EBM. However, proponents of the strong form of EBM see the purposeful use of knowledge pluralism within a praxis-based phronesis as a deviant act, thereby leading to ongoing tension at the participant–EBM interface.

5.2.4 Negotiation strategies at the participant–EBM interface

The participants in this study, like every healthcare practitioner working in a complex healthcare setting, are required to negotiate their relationship to EBM. For participants this negotiation lies within professional knowledge expressed through epistemological pluralism based on holistic cognition to solve individual patient problems through the best available knowledge.

The boundary between participant knowledge and EBM is not static, but fluctuates according to practitioner and patient needs. This reflects the core principles of EBP and the use of the best available knowledge contextualised

to the clinical situation, and the patient–practitioner relationship. This EBP contains its own quality assessment criteria, ethical practice guidelines and evidential quality tools that encompass linkages between beliefs, values and philosophy. Thus the negotiation of EBM for these participants lies in N&WHM EBP and its alignment to professional knowledge.

5.3 Conclusion

This chapter has applied the discourse-historical approach of critical discourse analysis to develop understanding of participant quotes. The distillation of these to their discursive elements reveals a professional discourse that is largely resistant to manipulation. Participants express a coherent rationalisation of meaning within their professional genre that generates a positive identity construction. This identity is able to resist attempts at domination by inappropriate ideological forces through the development of meaning that emerges from a philosophically informed phronesis directing coherent action in practice.

These findings are now melded with those of the thematic analysis from Chapter 4 and taken forward to Chapter 6 where they are interpreted through the theoretical framework. These collated findings are discussed with the aim of developing final outcomes.

CHAPTER 6: THEORETICALLY INFORMED DISCUSSION

The research question inquires after practitioner beliefs and work practices, and clarification of these two components based on the information gathered so far is necessary before analysing their relationship to EBM. The literature review provided evidence for the existence of a philosophically informed CAM practice, but determining what this actually looks like for the research participants here requires aggregated appraisal before assessing the literature. This is important, as the academic philosophy information notes the lack of precision around definitions and descriptions of these as a whole for CAM, and the homogeneity across the professions increases the difficulty in proposing any unifying statement. Therefore it is necessary to describe the participant philosophical viewpoint prior to theoretical analysis.

6.1 Condensing main findings

The literature coalesces to propose the N&WHM professions hold an essentialist teleological position with a holism that rationalises knowledge use. This philosophical position is said to lead to an emphasis on either praxis or poiesis in professional practice, and is proposed to locate the practitioner in his or her experiential world. This then contributes towards an emphasis on either the pursuit of practice-based knowledge generation or the primary use of EBM outputs as evidence within reasoned clinical decision making. This interconnects philosophy, knowledge, and reasoning.

Therefore the importance placed on either of the praxis or poiesis positions within clinical practice shapes the relationship between the participant and their use of EBM. This means having an informed understanding of how the three elements of philosophy, knowledge, and reasoning may intersect for participants provides a solid footing for theoretical analysis. Hence these are now discussed in the context of the collation of data analysed to this point, and quotes are used to exemplify the findings.

6.1.1 Participant philosophy

The data show that the majority of participants recognise and understand how their philosophical position influences their use of certain knowledge types. It is generally agreed this manifests through a stance towards the patient as an intrinsic part of the natural world and as a whole entity with innate capacity for healing. Knowledge that can usefully inform decision making based on this perception is applied within a reasoning process that is oriented towards the best patient outcome. Most participants discussed this in the context of holism and referenced this to patient-centred care. This suggests there is an interconnecting thread between philosophies, knowledge, and reasoning that informs action and directs decision making.

6.1.2 Participant knowledge

Participants recognise the primacy of their professional knowledge base, its epistemologically plural nature and its use in situations where clinical needs determine knowledge use. This is seen where a holistic cognition is applied to context-dependent patient problems and knowledge is critically appraised within a decision-making milieu that is oriented to solving a presenting problem. Hierarchies of diverse knowledge use take place in response to the complexity of presenting cases, and EBM is applied as one component within pluralistic knowledge choices. This occurs within an environment where co-production of patient outcomes is prioritised; meaning all knowledge and its use is contingent. Assessment of applied knowledge takes place through reflexivity and practice-based evidence outcomes.

6.1.3 Participant reasoning

A chosen philosophical position underpins individual knowledge preference and the associated execution of reasoning. This means knowledge is sourced, differentiated, and applied in a way that reflects philosophical conceptions that serve presenting patient needs. Thus for the bulk of participants a

philosophically based practical reasoning emerges where decision making reflects practice-based evidence in the context of professional philosophy and patient preferences. In all cases the emergence of patient–practitioner, co-produced meaning guides knowledge use and directs reason-based action.

What arises from this collation of data is the presence of a holistic philosophy interacting with practically reasoned knowledge for a contextualised practice reality. This reveals practice ‘know-how’ that reflects an evident orientation to praxis over poiesis. How this may function is illustrated in Figure 6.1.

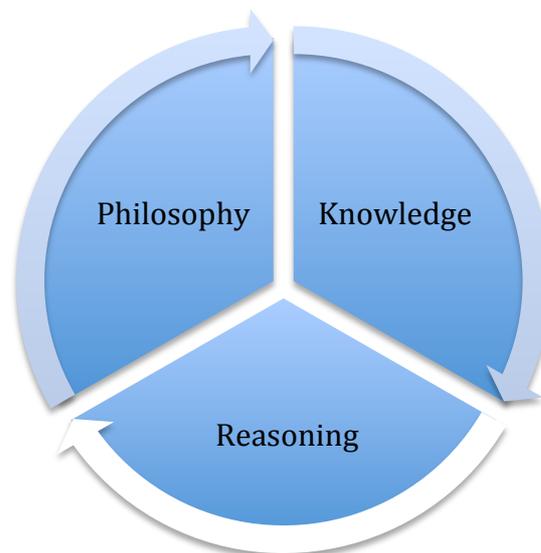


Figure 6.1: Participant praxis

The following participant captures the essence of this model and reveals the placement of philosophy, reasoned assessment of knowledge, and the iterative reintegration of this into the praxis framework:

For me I have a healing philosophy, I look at the evidence, I use it as a tool to select, I use it to select tools, and then I bring the tools into my philosophy once I have looked at the evidence and thought, I think it does this. I think this tool does this. I think it's a screwdriver I've got and not a hammer, I want a screwdriver. And that's what I'm using evidence for, to measure my tools. And then I take the tools and I use them within my philosophy (Focus group participant SB157).

The iterative and spiralling nature of this process is evident and it is clear that philosophy prioritises knowledge application and determines the type of reasoning required to use the chosen knowledge.

Participants identified key features that orient their practices towards praxis, which then act to shape the use of phronesis in a pluralistic knowledge environment. Figure 6.2 presents these within a hub and spoke model, where the areas encased within the solid line represent the shared praxis and poiesis aspects of practice, and those within the dashed line, praxis-based practice only. The former combines tacit and explicit knowledge whereas the latter uses mainly tacit knowing. As this shows there is a greater number of praxis than poiesis components, and therefore by necessity there is the need for a higher level of phronesis to engage with this array of demands.

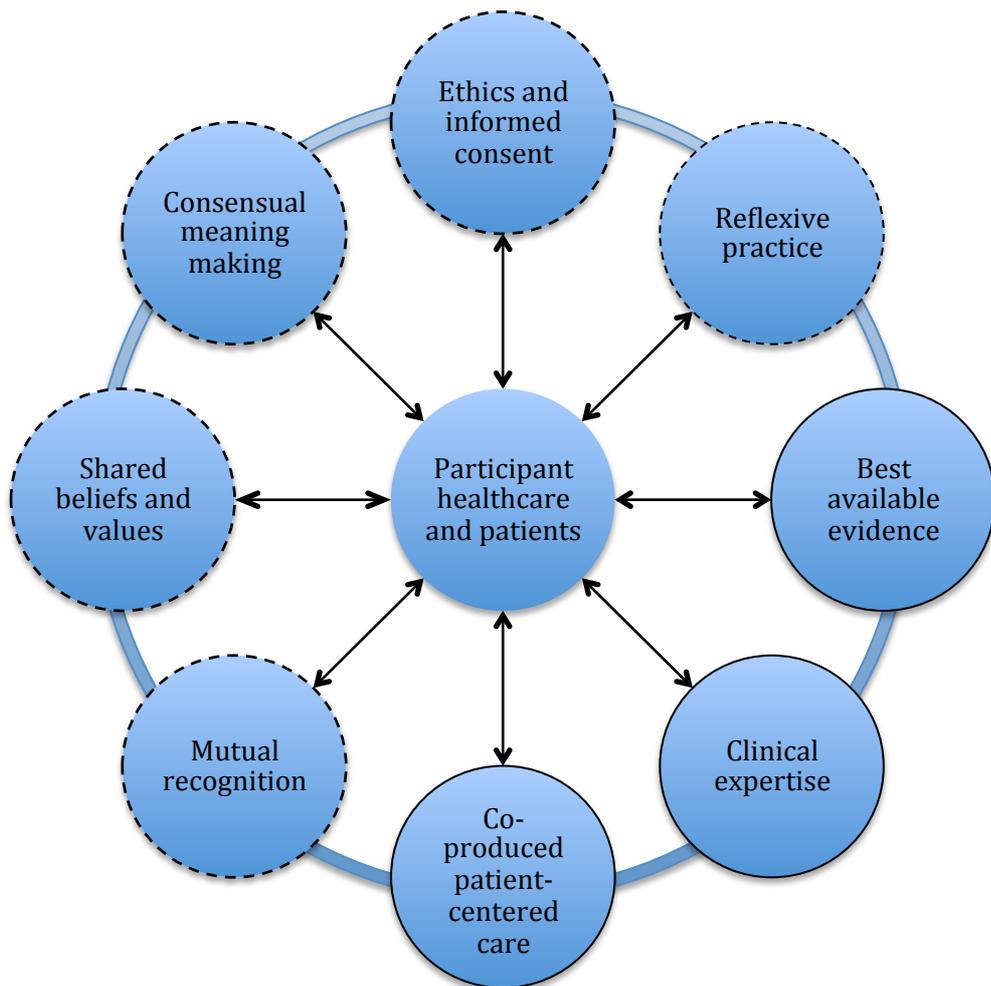


Figure 6.2: Participant practice

The features of this model reveal how EBM may be of practical use in the practice setting. Because this orients to poiesis, it is proposed that EBM can successfully provide information for the shared praxis–poiesis EBP domains of best available evidence, clinical expertise, and patient-centred outcomes. Due to the holistic, pluralistic, communicative, and social nature of the remaining components, EBM cannot deliver knowledge to these areas as a result of its inherent ontological and epistemological constraints. This illustrates its natural limitations and the inappropriateness of its use as the sole practice informant, as described in the literature and by the research participants.

From this point, the integration of data describing participant experience of interaction with EBM adds to the information for theoretical analysis.

6.1.4 The EBM interface

Participants viewed the original EBM model as inherently beneficial and they recognised some interpretations of this as removed from its inception and therefore dubious. Because of this degradation away from its roots, many participants described strong EBM as misaligned to practice and implausible within a patient-focussed EBP model. As this consistently omits multiple practice and patient realities, and therefore offers limited usable knowledge, there is logical necessity to rely on other knowledge forms that competently address multivariate realities. As a result there is integration or dismissal of EBM outputs on the basis of their legitimacy and usefulness for individual clinical practice situations.

Therefore participants blend knowledge for and from a praxis-based phronesis for patient care that applies EBM as required, while at the same time resisting strong EBM. Adherents to the latter perspective regard this as a deviant act and assert non-EBM knowledge is unacceptable, from which they then argue for the delimitation of CAM healthcare. Participants viewed this as a domineering proposition that exposes ideological interests;

nevertheless there were some signs of these demands causing domination, suppression of voice, and internal conflict. Susceptibility to these negative effects appears to be due to individualised community practice, and there are some concerns about the resilience of professional knowledge in the face of this type of authoritarian behaviour.

From these data it is evident there are ubiquitous participant negotiation strategies towards the EBM model, widespread resistance to the intrinsic features of the intransigent use of EBM and pockets of oppression due to the use of such EBM in a dominating manner. The findings discussed to this point are now subject to analysis within the theoretical framework.

6.2 Situating participant data in the theoretical frame

Participants discussed topics within shared communicative forums and one-to-one interactions. The resultant dialogue has coherence between what is meant and what was said, which is a connection of 'cognitions, obligations and expressions' (Habermas, 1987). These encompass the domains of intellect, professional discourse and praxis-based practice with lived experience. Such features form communicative acts that infuse a professional identity and a shared understanding. These serve the role of 'coordinating action and socializing actors ... transmitting culturally stored knowledge (and) fulfilment of norms' (Habermas, 1987) and they collectively shape participant discourse. This reflects the notion of communicative action generated from consensually derived expressions of lived existence in the lifeworld.

6.2.1 Participant knowledge interests

Intrinsic to the content of this communicative action are knowledge interests (Habermas, 1968). From the data it is evident most participants express a historical-hermeneutical position based on a developed body of professional knowledge that applies interpretive understanding in practice. Also apparent

was the capacity for integration of EBM, which is an orientation towards a secondary empirical–analytical interest. This was evident when contextually relevant evidence was applied where appropriate, which means EBM outputs can be useful when they are able to successfully inform a given situation. The caveat with this is the logical necessity of praxis within a holistic practice (i.e. the coalescence of Figures 6.1 and 6.2). Concomitant to these are the critical–emancipatory interest that is alert to the imposition of dominant knowledge. The critique associated with this interest takes place within an environment of poiesis and phronesis, where acceptance or dismissal of knowledge is referenced to praxis-based criteria that determine relevance or irrelevance.

Consequently, each knowledge interest is aligned to philosophically informed practical reasoning and a praxis-based knowledge that derives from communication leading to consensual decision making. Thus participants are primarily located in historical–hermeneutic interests and apply critical–emancipatory and empirical–analytical interests to their relationship with EBM. This is the basis of participant engagement with this model, which will now be analysed within the theoretical framework template.

6.2.2 The balanced and resistant participant lifeworld

From the reviewed content, participant descriptions of practice fulfil the criteria of a lifeworld and EBM meets the description of a strategic imperative. These positively interact when the imperative is productively integrated into a lifeworld that remains stable and normalised throughout the period of contact. Conversely, if the imperative is illegitimate there is resistance and the communicative forum determines action to be taken in response to its presence.

From the participant data it is evident that the practice-based lifeworld assesses the feasibility of the EBM imperative and generally regards this as unsuitable as the primary knowledge form. Although EBM research may hold some features of relevance, this is not commonplace and there is rejection of

the imperative in a lead role and the pursuit of alternatives that reinforce the validity and values of the lifeworld. Thus the imperative is resituated within epistemological pluralism and the practice-based evidence model serves to identify where and when it may be useful. This is the successful integration of EBM into the balanced lifeworld where the system and lifeworld have harmonious relations.

Aligned to this are two main areas of participant resistance towards EBM. The first of these is associated with the integration described above and is a mild form of resistance. This emerges from the EBM lack of recognition for contextual delivery of therapies that results in a plethora of practice realities being omitted from consideration. Participants understand this and they critically appraise EBM outputs for relevance to presenting cases within their practices. They fully realise the practical limitations such research carries, and accept or reject this based on its external and model validity. Therefore invalid knowledge is irrelevant, and resistance to its presence occurs. This is based on the understanding that the imperative fails to recognise ontological and epistemological features outside its own domain and it has limited applicability for multiple areas of practice.

The second and much stronger level of resistance occurs in response to inappropriate demands to abide by the EBM imperative. When ideological interests infiltrate EBM processes they are unable to realise its inherent constraints and they propose EBM-derived demarcation criteria. In terms of recognition and justification theories, this position is one of manipulated instrumental reasoning vindicating misrecognition to enact epistemic injustice (Carel & Kidd, 2014; Fricker, 2007). Most participants recognise and strongly resist the accompanying arguments against their practices, and therefore they reject the resultant strong discourse and its imperative. Thus the position of resistance is grounded in reasoned judgments about the benefits and deficits of the varieties of EBM to the practice-based lifeworld.

From this discussion it is possible to position a cohesive participant view towards EBM in the shared domain of positive use and resistant attitudes. These are unified here as they are most often discussed together within the data collection; that is, EBM is considered as critically applied through the integrated application of knowledge interests that do not separate this from its pluralistic inclusion or its reasoned exclusion.

As per the descriptions in Chapter 2, this modelling holds two axes: the vertical contains the reproduction processes of participant professional culture, the integration of this within society, the socialisation of cultural norms, and the recognition and justification of these; whereas the horizontal holds the structural areas of participant practitioner roles, the societal response to participant practice and the participant in clinical practice. Figure 6.3 shows each of these intersecting areas as they are filled due to analysis within the theoretical framework model.

From the placement of collated participant data it is evident there is a developed professional identity and balanced lifeworld with a firm structure and resilient reproduction capacity. These coalesce to adequately resist attempts to destabilise and colonise communicative action through unwarranted imperatives. The following participant emphasises the sentiment displayed within this model, with their first sentence referencing the notion that EBM provides legitimacy to the lifeworld:

I think to be taken seriously evidence is really important and I don't think it's solely and only the most important. And this is also coming from personal experience. When I will use just a single herb that has had some scientific use, or using it because of scientific data, using it alone versus the results that I found with the same client when I combine that with other herbs, which are more clinical evidence, my experience of using them, nothing scientific at all, and then what changes with that. And the results change. The evidence only takes us so far (Interview participant 17]36).

		<i>Structural components</i>		
		<i>Participant in clinical practice</i>	<i>Society surrounding participant practice</i>	<i>Participant as practitioner</i>
<i>Reproduction processes</i>	<i>Cultural reproduction</i>	Transmission of culturally stored knowledge to sustain a breadth of meaning and action	Legitimation of professional culture and its relevance to a context-dependent society	Reproduction of professional praxis and practice for action
	<i>Social integration</i>	Immunisation of ethics, values, and knowledge for practice. Resolute professional discourse	Consensual understanding contributes to meaning and action for patient-centred care	Reproduction of membership of the professional community
	<i>Socialisation</i>	Legitimate enculturation of philosophy, beliefs, and values meeting praxis and practice needs	Legitimation of practice philosophy, beliefs, and values within and by society	Stable self-identity as a member of a valued, recognised, and justified profession
	<i>Recognition</i>	Self-confidence in the effectiveness of a widely recognised practice and profession	Mutual recognition and respect that permeates patient-practitioner relationships	Self-esteem as a practitioner delivering a recognised form of healthcare
	<i>Justification</i>	Justification for patient care and applied knowledge due to congruent reasoning and action	Able to justify action to society, which justifies and independently confirms practice and patient interactions	Justification of praxis and practice within daily work and lived professional existence

Figure 6.3: Positive and resistant participant lifeworld

What can be extracted from this utterance is the positioning of EBM outputs as contingent to professional and experiential knowledge derived from practice outcomes. EBM evidence is compared and contrasted against these and is found wanting due to its inherent limitations. This quote represents a consensually agreed finding that indicates the participant–EBM interface is successfully managed in the majority of cases via a positive and resistant lifeworld position. However this is not evident for all participants.

6.2.3 The colonised participant lifeworld

If the imperative penetrates the lifeworld in an unwelcome manner there is uncoupling of the lifeworld from the system or, in this instance, the loss of a balanced and resistant participant–EBM relationship. For example, when instrumental reasoning is ideologically manipulated within an imperative, the associated proposition is that this is reasonable and beneficial for the lifeworld. This discursive position occurs when ideological decisions about means-focussed ends are determined from *a priori* stances that are described as rational. However, ‘what is called rationalization at this level is called ideology at the level of collective action’ (Habermas, 1968, p. 311) and unless these decisions are consensually incorporated into communicative action they will be resisted.

If a strategic imperative proposes that it can competently assess participant practice based on instrumental means that neglect appropriate ends, and then declares there is no evidence for this practice, this can be perceived by participants as an ideological and not a reasoned proposition. Because the imperative can only offer knowledge for minimal components of practice, the logical conclusion is to resist the imperative.

It is at this point that ideological influences become most acute. Here the imperative will apply system resources to negotiate resistance and influence the communicative sphere to take up the imperative. Thus it is presented as legitimate, beneficial, coercive, or authoritarian, and if reasoned resistance is underdeveloped or absent, it may then be taken into the lifeworld and be reproduced and become colonising in nature. If this is the case the positive and resistant lifeworld becomes imbalanced and the imperative behaves parasitically by reproducing within a manipulated form of reasoning.

Several participants described such colonisation within comments ranging from suppression of voice to feelings of inner conflict. These reflect distorted communicative action and lifeworld unease. In the former there is a position

of a feeling of being limited in what can be said and what is acceptable to say, and there is inability to disentangle the parasitic imperative from the communicative sphere. In the latter there is imbalance between the EBM imperative and lived experience that leads to the unsettling of the participant philosophical base. When a contradictory philosophy is reproduced it clashes with established ontological perspectives and leads to feelings of disjunction. This contributes to a negative participant–EBM interaction and the possibility of a colonised lifeworld. Figure 6.4 shows the potential outcomes of such an occurrence. This scenario reflects a minority of participant data that appear to arise due to individual interpretation and integration of an imperative.

One participant described how problems arise due to challenges to praxis stability that manifest via assimilation of epistemologically dominant imperatives. This utterance discusses changes to knowledge over time, which creates a crisis in professional epistemological standing due to a shift from experientially based understanding to a prioritised imperative:

... it changes how people understand knowledge, what people understand knowledge to be. You know. I think that until 30 years ago, herbal medicine was taught really in a traditional mould and what you were getting was the words of your predecessors passed down to you as reliable knowledge. That shifted emphatically. You know fundamentally. EBM has brought into play a consideration that there are other forms of knowledge, that scientific knowledge and EBM absolutely are the truths of the age and that they have to be given priority. And I'm not sure that I agree with that, and particularly not in all cases. But I think it does fundamentally change how you view the knowledge of your profession (Interview participant 4B30).

For some participants the presence of an EBM imperative and its associated demands for prioritisation are difficult to differentiate from valid and invalid imperatives, meaning its integration into their communicative forum is due to either coercive epistemological discourse or isolation from communicative assessment of the imperative.

		<i>Structural components</i>		
		<i>Participant in clinical practice</i>	<i>Society surrounding participant practice</i>	<i>Participant as practitioner</i>
<i>Reproduction processes</i>	<i>Cultural reproduction</i>	Reduced transmission of culturally stored knowledge that limits breadth of meaning and action	Negation of professional culture and limitations of permissible knowledge. Irrelevance to a context-dependent society	Corrupted reproduction of professional praxis and practice. Limitations of practice breadth
	<i>Social integration</i>	Restricted ethics, values, and knowledge for practice. Fractured professional discourse	Destabilisation of meaning and action for patient-centred care	Hindered reproduction of membership of the CAM community
	<i>Socialisation</i>	Illegitimate enculturation of EBM philosophy that does not meet patient expectations	Reduced legitimisation of practice values within and by society	Unstable self-identity as a member of a misrecognised and unjustified profession
	<i>Recognition</i>	Reduced confidence in the effectiveness of praxis and practice leading to susceptibility to domination and manipulation	Lack of inter-subjective recognition and respect between parties leading to misrecognition or disrespect of societal role	Low self-esteem within work practice and misrecognition or lack of recognition of identity by others
	<i>Justification</i>	Questionable justification for applied patient care due to ideological constraints on reason and action	Unable to adequately justify actions to society leading to imposed limits on what action can be publicly justified	Difficult to justify praxis and practice to oneself leading to a feeling of an unjustified lifeworld

Figure 6.4: Negative and colonised participant lifeworld

The collected data show that the outcomes of the changes brought about by EBM are generally non-problematic for participants as a whole, and there was consensus that this model serves a warranted ancillary purpose in practice. This is not a ubiquitous position for participants and there are pockets of lifeworld colonisation that signify communicative disruption. From this understanding it is now possible to discuss findings that emerge from the implementation of this theoretical framework to the participant data.

6.3 Theoretically informed findings

From the generation of the lifeworld models it is feasible to derive increasingly definitive findings from the implementation of theory to the collected data. The outcomes that emerge from this process are situated in the three ensuing thematic areas, with each of these contributing to understanding the basis and positioning of participant interaction with EBM.

6.3.1 Communicative action is philosophically rich

The literature identifies congruence of practitioner and patient belief within practice, and the theorised data proposes a participant-held praxis within a profession-wide interaction with society. From this it appears likely there is convergence between patient, practitioner, and professional ontologies. This presents as reproduction of a professional culture where philosophy has a pivotal role in identity, practice delivery, patient patronage, and clinical outcomes. How this manifests within professional-practitioner cultural reproduction or patient–practitioner interaction differs.

The former of these applies a lens of praxis based on normative ideals to develop professional consensus, and the latter represents the application of praxis to contextualised lived experience in the practice setting. Thus the former is profession–practitioner accord and the later patient–practitioner shared understanding. A common philosophy connects each of these, and participants described this as contributing to communicative action that directs decision making in practice. This can be termed the ‘linguistification of the sacred as an unfettering of the rationality potential of action oriented to mutual understanding’ (Habermas, 1987). Thus the philosophical perspective operating across the profession–practitioner–patient continuum is pivotal to communicative action within practice.

6.3.2 Communicative action directs clinical reasoning

Communicative action arises from patient-practitioner interaction based on recognition of the unique circumstances of each patient. From this emerges communicative action that informs ends-focussed decisions guided by mutual recognition of desirable ends (Habermas, 2001). Such decision making arises from the union of patient needs and practitioner expertise, with the resultant understanding directing an epistemologically plural set of options. Here communicative action contributes to reasoned knowledge implementation that is consensually assessed within an iterative and patient-focussed process.

In other words, ongoing communicative action directs and assesses knowledge, which leads to continuation or reorientation of applied interventions in a practice-based evidence model. The resulting depth of knowledge use results from a philosophically rich communicative action combining with specific knowledge interests. These correlate to each presenting case, which influences the level of prioritisation afforded to information sources. Accordingly, knowledge is tailored to patient realities, which makes its application targeted to defined areas of decision making in context.

6.3.3 Communicative action resists manipulated EBM

Communicative action informs emancipatory positions towards unwanted and intrusive knowledge forms (Hodge, 2008). When EBM presents as a manipulated imperative, it can potentially infiltrate and manipulate the lifeworld. The majority of participants recognised and resisted such attempts through the use of communicatively sourced reason that maintains lifeworld structures and their reproduction (Cooke, 2012). The manipulated form of EBM is largely impotent against this type of well-reasoned communicative action and strongly reproduced philosophical structures, and the participant data bear this out.

In the instances of lifeworld imbalance it appears there may be participant removal from the communicative forum of peers and the profession, or there may be instances of individual philosophical instability. This is not to say pluralistic philosophy does not successfully integrate EBM, but rather it is the unsuccessful integration or failed resistance that contributes to lifeworld unease. Concomitantly, expressed participant concern for the philosophical fidelity of the professions into the future may be associated with this theme.

From the collation of the entire data and findings to this point, there is now sufficient information to focus on the research question.

6.4 Discussion in relation to the literature and research question

From the thematic, critical, and theoretical analysis it is possible to reflect on the emergent findings in relation to the questions from the literature review. These are discussed within the four defined areas of critique, philosophy, causality, and reasoning, which are then brought together into the fifth area of the knowledge interface. This latter topic discusses findings that address the research question.

6.4.1 Critique

The primary recommendation to emerge from the literature was the necessity for a critical analysis of the CAM-EBM interface, and because of this critique was applied within a Critical Theory framework. This enabled a critical lens to be used, and the findings from this assisted in clarifying participant positions in relation to EBM. Without critique and the provision of techniques that searched for signs of domination and suppression, it is unlikely the duality of reasoned and resistant placement of EBM within practice dynamics would be clarified.

The literature identifies a manipulated form of EBM attempting to impose ideological domination through distorted knowledge. Participants perceive this as a corruption of the EBM model and as an increasingly pervasive problem. When critique was applied to discussion on this topic it was evident participants experience coercive justificatory criteria attempting to confine reason to an EBM-based instrumentality. In other words, EBM is used as a conduit for ideological perspectives to be imposed on others. This is a disrespectful position based on the pursuit of power that does not recognise difference (Forst, 1996, 2014; Honneth, 2007). As the literature notes, and a few participants displayed, there can also be an ideologically driven counter-position from within CAM that manifests in similar ways.

As discussed, some participants are experiencing lifeworld unease, while the majority maintain a balanced resistant state. It was through the use of critique within Critical Theory that these positions were elucidated and clarified, and there are now identified areas where interventions can be used to enhance resistance. As a result, the application of critique was highly effective and provided pivotal information to understanding the participant-EBM interface.

6.4.2 Philosophy

The primacy of practitioner philosophy within the healthcare setting was borne out in participant conversations. Ontological and epistemological positions provide contrasting knowledge to EBM that is praxis based and formative of, and reflexive towards, implicit and explicit knowledge. Therefore philosophy has a primary role in the healthcare practice of participants. Interestingly, the lack of clarity around philosophical concepts noted within the literature does not preclude the active implementation of these within practice; but it does seem to affect their linguistic expression.

In particular the notion of the self-healing capacities of the individual remain central to clinical method, but reference to this topic was muted. This reflects

Nissen's (2011b) findings of a lessening of expression of such concepts, which appears to be the case here. This is not a trivial matter, particularly as the literature explains increasingly rigorous ways of perceiving such philosophical concepts. Within the applied frame of critique it can be conjectured that suppression of the voicing of this philosophical idea is occurring due to its lack of empirical support and perceived implausibility.

Therefore the question from within the literature remains: how to proceed with philosophical analysis for the CAM professions. The situation of poorly described philosophical notions is problematic and leads to easy dismissal of theory. Several participants noted the fragility of this situation and signal alerts regarding the viability of the current philosophical framework. Therefore the need for erudition and engagement with academic philosophy is acute. Unless the testing of ideas takes place in a rigorous forum it is unlikely participants will be able to communicate a clear and reflexive discourse on this topic. Therefore the primal role of philosophy is juxtaposed against its underdeveloped nature and vulnerability to devastating critique.

6.4.3 Causality

The literature notes the importance of theories of causality for the rationale of controlled trials and the structuring of the EBM hierarchy of research methods. CAM conceptions of causality are not sufficiently clarified but are situated within complex interactions between holistic entities and substance-based natural kinds with inherent teleological properties. This reflects a speculative notion as opposed to an empirically derived proposition. While this could be problematic, in actuality causality is only ever inferred and is never identified by direct sense observation. In other words, it is a power that can only ever be perceived as an association between events. Thus it could be seen as equally plausible as any other approach, and is so by most study participants. The distinction lies in the ability of research methods to repeatedly show an association that indicates causality, and it is in this area that controlled trials within a realist philosophy have significant worth.

As a rule participants identified causal associations within the instigation of therapeutic interventions and patient outcomes. However, an intervention in the context of holistic practice and teleological theory is notoriously difficult to causally isolate. Thus causality is described as an associative event that may emerge from some type of change: for example, elimination of a certain food class from the diet, initiation of lifestyle change, uptake of relaxation exercises, ingestion of nutritional supplementation or consumption of a four-week course of a medicinal plant mixture. In actuality, it is likely to be all of these that are co-prescribed within a packaged therapeutic intervention. Participants are aware these interventions occur within a highly complex and contextual situation, and the methods applied within EBM are as incapable as any other type of method at identifying a definitive causal association in these instances. Thus the clarification of cause and the empirical recognition of its associative occurrence for CAM are slippery notions.

CAM theory consistently outlines how engagement with, and support of, teleological properties are the basis of healing; yet very few participants discussed this as the primary therapeutic target. However, philosophical underpinnings situate this as *the* causal power in achieving patient remediation, and therefore it was assumed this would be the focus within discussions. However, this was not the case, and this may be due to the causal discourse of EBM overriding that of CAM. Here the reductionist mechanistic process of controlled trials is described as better able to represent causal association than clinically based observations of practitioners. Reinforcing this is the knowledge that EBM investigation into a CAM claim will often derive no link between intervention and outcome, thus leading to the declaration of no causal association. This is unsurprising, for reasons already discussed.

This situation relates to the previous discussion on philosophical clarity and reiterates its importance. For example, recent philosophical work in the area of natural kinds, biological theory, and notions of causality (Mumford & Anjum, 2013; Slater, 2013, 2015; Vandenbroucke, Broadbent, & Pearce,

2016) raise questions that can be of use, notably in relation to a stable basis for natural kinds and tendencies within causal powers. Consequently, it is important to engage with these developments to clarify philosophical positions and associated causal propositions.

6.4.4 Reasoning

The participant data has enabled a conceptualisation of applied reasoning to be clarified that correlates to phronesis and practical reasoning operating within the context of ends–means coherence. This was the preferred mode of reasoning for the majority of participants and forms an integral aspect of praxis. Such an approach to the use of reason was consistently placed in relation to the patient and their contextual needs, and because of this means–end instrumental reasoning is unlikely to be prioritised. This contributes to understanding why participants displayed a critical response to EBM propositions that were removed from their lived experience, and it is evident that this reasoning forms the backbone to the resistance against an overbearing interpretation of EBM.

A feature of this practical reasoning is its contextual footing. It emerges from inherently complex, undetermined and dynamic situations where the ends can be continually shifting and impossible to isolate from their lived reality. Thus instrumental reasoning has a deficit of capability in such situations, as there is no controlled environment with pre-determined ends. It is difficult to see any justification for the prioritisation of this reasoning in such conditions, as this would appear to be exclusive of the patient situation and therefore ethically questionable.

There is an interrelationship between philosophy, knowledge, and reasoning, and participant discussion bears out this linkage. Rationale for decision making relates to the philosophical perspective of the participant and the applied clinical method. Clinical decisions are made with this in mind, and are contextualised to the perception of what works for patients in relation to

their being and to their presenting complaint. This reflects the role of recognition in reasoning, and it is the interaction between two people as equal agents co-producing communicative action that leads to the preference for practical reasoning. For participants all decisions had practical ends as their arbiter.

Reasoning and its role within knowledge choice and use are intimately linked to this patient–practitioner dynamic. This again relates to participant praxis and the spiralling nature of philosophy–knowledge–reasoning interaction. As such the interconnected nature of these assist in understanding how participant reason was developed and applied. Concomitantly, the rationale for epistemological pluralism can be easily explained from this position and the approach to causal explanation can also be rationalised.

An aspect of the question from the literature in relation to CAM reasoning is the potential for this to inform research agendas and causality. Based on the participant discussions, the literature investigations across other healthcare sectors and the emergent understanding of participant praxis and phronesis, it would seem feasible that practical reasoning can have a role in these areas.

6.4.5 The knowledge interface

From this information it is possible to propose an answer to the question as to whether EBM affects the beliefs and work practices of the participants. From the gathered data and associated analysis and theorisations, it can be said that the participants taking part in this research *integrate* EBM into their work practices. Yes, it has an effect on work practices, and no, it does not affect beliefs. What occurs is belief-laden reasoning that integrates EBM into the knowledge pool that is applied in work practice. Therefore EBM enhances participant practice as far as it is able. This answer to the research question is made with the caveat is that this is relative to the idiographic nature of the findings and is not a wholly accurate statement for all participants.

Accompanying this answer is a visualisation of the participant-EBM interface. Figure 6.5 extends the literature review-based CAM-EBM philosophy–reason–knowledge nexus and illustrates the findings as they match to the literature and theory.

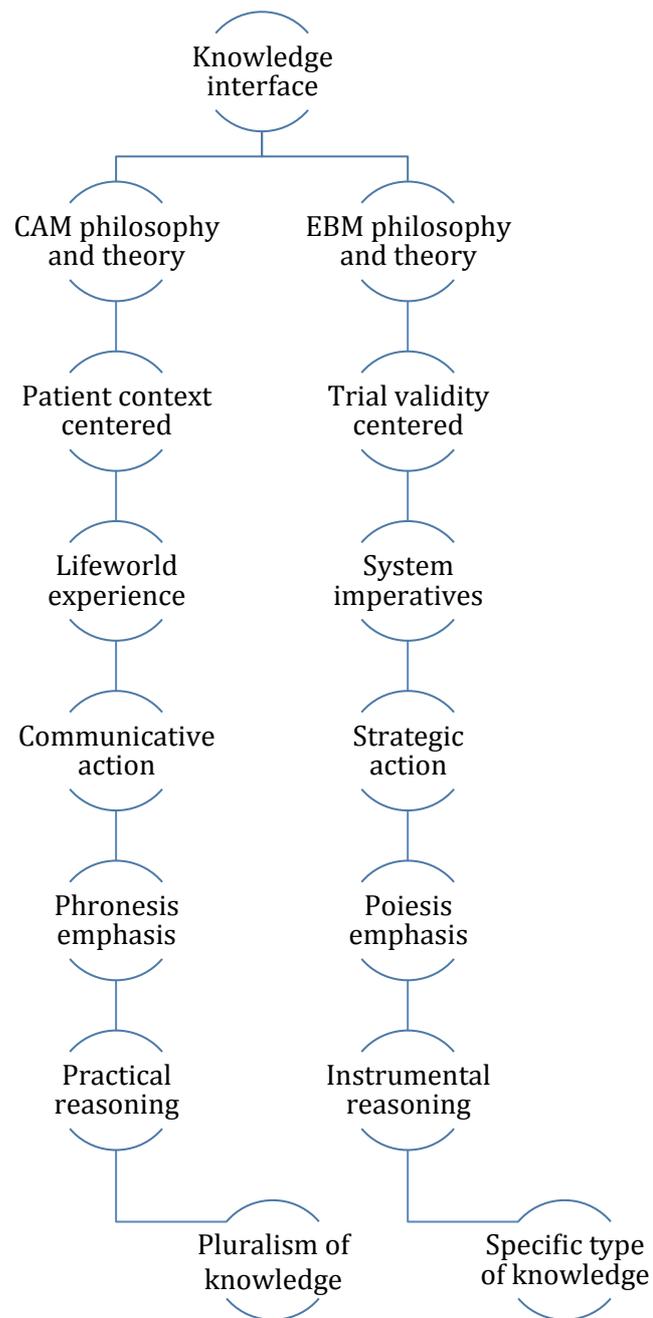


Figure 6.5: Participant-EBM interface

This does not promote a binary duality that cleaves CAM and EBM even more deeply than the distinctions that already occur within the literature, and it is stressed there are intersection points between the two knowledge branches. For example, communicative action may interrogate and concur with trial validity associated with an imperative; instrumental reasoning may be applied in an acute presentation; or specific knowledge may be needed due to a highly defined presentation. This makes this interface inherently dynamic for participants and in no way suggests a static bifurcation. Therefore this model can be viewed as having plasticity that can be shaped to individual and contextually dependent situations.

This model is taken forward to the ensuing chapter to form the basis for the concluding remarks. This occurs within the qualification that these findings are contextual to this thesis and are representative of the participants and their analysed discourses. The qualitative nature of this project informs the theoretical framework and as such it brings benefits and constraints to the findings. The depth of understanding that has emerged from the analysis has developed within a particular theoretical lens that shapes outcomes. Qualitative research is idiographic and specific to context, and it has served its purpose well in this thesis. A reflexive acknowledgment of its capacities and limitations must be considered in the application of findings.

6.5 Conclusion

This chapter has clarified participant praxis and practice and used models of these as the basis for theoretical analysis. The resultant findings emphasise the role of communicative action and practical reasoning and confirm the underpinning emphasis of philosophy for participants. These findings were discussed in relation to literature and theory, and provide outcomes in the areas of critique, philosophy, causality, and reasoning. These collectively lead to the ability to answer the research question, and to the development of a model of the dynamic participant-EBM interface.

The following chapter concludes this thesis through discussing outcomes of the research. These lead into a discussion of future directions for the knowledge developed here, and suggest ways this can be applied to the advancement of the N&WHM professions. This is the personal conjecture of the researcher and, in accordance with the stipulations of this research, does not represent the generalisation of findings.

CHAPTER 7: CONCLUDING REMARKS

Decisions about knowledge use in healthcare occur relative to philosophy, values, ideologies, politics, economics, professional considerations, societal milieu and a myriad of other influencing factors. To assert otherwise negates the genealogy of knowledge and isolates knowledge holders from the context of their practices. This thesis acknowledges and integrates such context in its theory, design, and analysis, and prioritises the participant experience of this into its content. The result is a contextualised and situated understanding of the N&WHM practitioner negotiation of EBM and an appreciation of the effect of this on beliefs and work practices. The chapters within this work have contributed to this understanding in the following way:

- Chapter 1 reviews the literature and pinpoints the issues of relevance in relation to the research question. From this review the dynamics of the CAM-EBM interface are described and a philosophy–reason–knowledge nexus model emerges. Primary considerations arise, with philosophy, reasoning, and causal forces identified as topics relevant to practitioner belief and work practice.
- Chapter 2 outlines the theoretical framing of the thesis. Critique and Critical Theory form the conceptual basis and the CAM-EBM interface dynamics are modelled on the interaction between a practically reasoned practitioner lifeworld and an instrumentally reasoned EBM operating as a system imperative. A theoretical model is developed based on the interrelated theories of three contemporary critical theorists.
- Chapter 3 explains the research design and outlines the theoretical, methodological, and methods processes of the data collection and analysis, which clarifies design decisions and choices. Qualitative meta-theory, hermeneutic methodology, focus group and interview methods, and investigation by thematic and discourse analysis, are explained. This design is primarily active in the ensuing two chapters.

- The fourth and fifth chapters present the thematic and discourse analysis of data. The former contains descriptions of the thematic analysis process and situates participant utterances against emergent themes. Separate focus group and interview findings are condensed to provide final themes that are taken forward for discourse analysis. These are analysed and distilled to identify salient features of the participant-EBM interface.
- Chapter 6 collates these findings and identifies participant praxis and tacit and explicit knowledge within a practice model. The research data are situated within the theoretical framework, which results in development of outcomes. Subsequent findings are thematically derived and five key areas are discussed in relation to the literature and the research question.

These chapters form understandings in three areas: contributions, relevant problems, and future directions. These are now discussed in turn and are followed by a summation of research limitations and final words.

7.1 Contributions from this research

The contributions of this research lie in understanding the effect of EBM on N&WHM practitioner beliefs and work practice, where two main findings are revealed: (1) minimal effect on practitioner belief as a result of engagement with EBM and (2) selective benefits of EBM for work practice. These findings emerge from practitioner application of epistemological pluralism serving a praxis-oriented practice with a balance of tacit and explicit knowledge. These affects are negotiated through communicative action in the practitioner-EBM interface where a continuum of profession-practitioner-patient interaction guides knowledge use.

In terms of negotiating intransigent interpretations of EBM, this research found the presence of logic and reason underpinning negotiation strategies for the majority of participants. It is evident there is an epistemological

inquisitiveness within participants that accommodates both non-realist and realist-informed research alongside practically and instrumentally reasoned findings. This reveals ontological heterogeneity that enables epistemological pluralism to integrate EBM outputs. This emphatically contradicts literature critical of a CAM epistemology based on inflexible philosophies that reject EBM. This finding exposes the fundamental error within such criticism and illuminates delimiting imperatives within the proposed arguments; thus future interactions can refute such mistaken assertions.

7.2 Future directions

This work has explored the practitioner–EBM interface and analysed its effect on belief and work practice. From this it is evident there is a need to augment the balanced lifeworld and support the colonised lifeworld. Thus there are six emergent directions for future consideration and action. These are discussed with the caveat that the professions and practitioners are active stakeholders within these areas.

1: Critique, discuss and respond to the content of this thesis through communicative action.

This research is focused on individual practitioners in the group and singular setting, and there is the need to assess it for relevance to differing contexts. This can be achieved through profession–practitioner communicative action, which is ardently promoted as an outcome from this work.

2: Reflect practical reasoning as the primary form of applied knowledge in practice.

Tacit knowing, in conjunction with explicit knowledge, has a role in clinical practice, and inquiry should reflect this. At a minimum this suggests a mixed methods approach to capture the breadth of practitioner work and their praxis, meaning such research should be supported and promoted.

3: Maintain and expand on the practice-based evidence model of clinical assessment.

Practice-based evidence generation entails assessment of effectiveness of interventions through testing therapeutic outcomes, which incorporates practical reasoning focussed on ends. This means how practitioners practically work, what knowledge they apply in this work, and what they are trying to achieve in their work is primal. Therefore the instigation and clinical application of practice-based research should be supported and promoted.

4: Develop CAM academic philosophy and integrate this throughout educational delivery.

Pursuit of ontological and epistemological coherence should be prioritised, as the way practitioners perceive the world informs their understanding of knowledge in the world. To recognise this and to marry and incorporate these informants of belief and action within inquiry will eventuate in claims and warrants that are philosophically grounded and defensible across the professions. This revitalised philosophy can then be integrated throughout education to advance the foundations of N&WHM practice.

5: Pursue an enhanced theorisation of causality to inform clinical decision making.

A philosophically well-founded concept of causality is absent for N&WHM. However, the teleological concept can be increasingly well theorised and grounded in contemporary philosophical thought; for example through consideration of causal pluralism as a global concept (Russo & Williamson, 2007) where complex multiple causes are acknowledged, and causal singularism as a context-specific necessity (Moore, 2009; Rota, 2009) where individual traits dictate degrees of causal effect. Orienting intellectual effort

to interacting with these types of concepts will assist in representing a philosophically congruent N&WHM practice.

6: Utilise theory to explore potential outcomes of professional action.

Theory can be used to investigate professional decision making. For example, the recent submission for WHM statutory regulation in the United Kingdom is said to have 'limited evidence of effectiveness of herbal medicines in improving health outcomes' (Walker, 2015, p. 28). When regulation based on a system imperative such as EBM is pursued as a way to professionalise, this requires 'transcendence of values and validity claims into the empirical conceptual apparatus' (Habermas, 1987). The outcomes of this are decision making becoming deontologised or rule bound, and belief systems being sanitised as the lifeworld transforms to fulfil the imperative. The theory applied in this work would recommend such possibilities undergo rigorous communicative action to ensure successful negotiation.

7.3 Limitations of this research

There are three main limitations to consider when reviewing these findings:

1. The research sample differs from comparable literature-based cohorts in that it has a higher level of academic qualification with greater length of time in practice; thus representing well-educated and experienced practitioners. This implies a high level of participant knowledge, a good understanding of research principles and considerable practice expertise. This unique set of characteristics reflects the idiographic nature of qualitative research and limits generalisation.
2. The insider position of the researcher emphasises inter-subjective techniques that may preclude the benefits of outsider objectivity. This relates to the inherent boundaries of qualitative research and must be considered as a limitation affecting transferability of findings.

3. The thesis findings are specific to a theoretical framework that models outcomes by unifying data. This serves to limit findings according to the Platonic principle of plenitude, where everything that is theorised to be possible should, in realist terms, be actual. For those with this type of philosophical orientation, the theorisation within this thesis may be a limiting feature.

7.4 Final words

N&WHM practitioner beliefs and work practices are the fulcrum of patient engagement. It is evident that patient–practitioner congruence of philosophy, knowledge co-production and clinical action are unquestionable. EBM provides useful knowledge within this exchange of attitude and agency and it adds to the broad pool of available know-how. Its capacities and limitations are fully comprehended by the N&WHM practitioners partaking in this research, and their varying styles of engagement with this model were reasoned and balanced. Certain concerns about this engagement do exist and can be addressed through measures that aim to enhance the beliefs and work practices of the N&WHM professions.