

THE MEANINGS AND MANAGEMENT OF COMPLEMENTARY AND
ALTERNATIVE MEDICINE (CAM) USE IN LATER LIFE

By

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Abstract:

The purpose of this thesis was to explore why and how seniors used complementary and alternative medicine (CAM) as well as the meanings they attached to their use of unconventional therapies. To this end, I conducted in-depth, individual interviews with 43 older adults—15 men and 28 women. Based on these data, I found that while all participants recognized the importance of conventional healthcare and continued to use its services, a number of people distrusted and were dissatisfied with medical doctors and treatments as well. Though these negative feelings were not sufficient to push seniors towards CAM, they certainly played a role in their decision-making. What informants particularly valued about unconventional approaches was that they allowed them to assert greater control over their health and, to some extent, their aging process. As a result, they viewed CAM as being an integral part of their aging lifestyles and actively incorporated these therapies into their treatment regimens. These findings overall contribute to the relatively scant, albeit growing, body of research on CAM use in later life, seniors' management of regimens, and older patients' dissatisfaction with and distrust of conventional medicine. Theoretically, the findings of this work demonstrate the importance of meaning in later life and specifically, how meanings attached to conventional and unconventional care can influence older adults' health-related perceptions and practices.

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The use of complementary and alternative medicine (CAM) in Canada is widespread and increasing. Indeed, it has been estimated that as many as 5.4 million Canadians use CAM (Park 2005). What remains less well known, however, is the nature of CAM use specifically among Canada's older population (Andrews 2002; Astin et al 2000; Cherniack et al 2001; Foster et al 2000; Ness et al 2005; Willison and Andrews 2004). Some findings suggest that seniors tend to use alternative healthcare less often than young adults (Eisenberg et al 1998; Wellman et al 2001; YCHS 1999) due to their more limited financial resources (Fulder and Monro 1985) and profound faith in medical science (Haug 1994; Wellman et al 2001). Recent research, on the other hand, contends that this trend may be due to underreporting by the elderly because such treatments are not differentiated from conventional therapies, especially when they are recommended by a medical practitioner (Ballantyne 2002). It is further maintained that the behaviour of late life users is poorly understood because many studies frequently do not take into account all types of medicines employed by older adults. Moreover, when these different remedies are considered, scholars largely describe the prevalence of use for each agent individually, overlooking the combined use of these assorted medications (Ballantyne et al 2005). While understanding the broad rates of CAM consumption in late life is certainly valuable, this kind of work reveals very little about *how* and *why* seniors use unconventional therapies, and even less about what these treatments *mean* to them (Andrews 2002). The neglect of these types of key issues, overall, has thus contributed to a dearth of knowledge about older persons' unique experiences with complementary and alternative medicine (Andrews 2002).

These gaps in the literature are somewhat surprising given that seniors must frequently cope with chronic conditions and other indicators of poor health, and it is precisely these factors which are outlined as key predictors of CAM use in the literature (Grzywacz et al 2007). This paucity is equally of concern because the elderly generally consume a great deal of medication, making them more vulnerable to complications linked to CAM treatment or mixed therapy use (e.g., use of both conventional and unconventional therapies). In addition, older adults are the main consumers of healthcare and a disproportionate amount of their money is spent meeting their medical needs (Astin et al 2000; Foster et al 2000). With the aging of the baby boom cohort, the number of elderly persons will grow and the demand for all medical services, including unconventional remedies, will likely increase as well. Hence, there is a pressing need to comprehend seniors' management of medications at this time along with the individual and broader sociological factors underlying their use of CAM.

In this thesis, I focus on these critical issues and specifically explore why and how older adults used alternative healthcare as well as the meanings they attached to their use of unconventional therapies. What will be revealed from these collective papers is that these seniors viewed CAM as an integral part of their aging lifestyle, namely because it represented a way for them to assert greater control over their health and thereby, their aging process. Accordingly, they actively incorporated these approaches into their treatment regimens and in this way, challenged the stereotypical image of the passive older patient.

Influential Bodies of Knowledge:

There are three main, substantive bodies of knowledge that inform and in turn are informed by this study. These works specifically focus on: (i) the contextual background of patients' expressions of dis/satisfaction and dis/trust with conventional healthcare, (ii) complementary and alternative medicine (CAM) use, and (iii) the management of medications in general. A brief overview of each of these literatures is presented below.

Patient Dis/satisfaction and Dis/trust

The public's perception of conventional medicine¹ has increasingly become an area of academic interest. While early scholars theorized that individuals were essentially passive patients with tremendous faith in modern medicine, research over the past few decades, in contrast, has argued that the lay populace is quite critical and skeptical, especially in relation to the value of 'experts' (Calnan, 1984; Calnan and Williams, 1996; McQuaide, 2005). Beyond this theoretical speculation, however, it remains relatively unclear empirically what people actually think about conventional medicine. This ambiguity is particularly noted in relation to patient views of dis/satisfaction and dis/trust.

The comprehensive research that does exist in this field indicates that both younger and older patients value physicians' caring attitude, as well as, their ability to provide proficient and personal care (Burke et al 2003; Feddock et al 2005; Katic et al 2001; Sullivan et al 2000; Thom and Campbell 1997; Williams and Calnan 1991). It is not surprising then that people tend to report considerable dissatisfaction and distrust when these attributes are lacking (Andrews 2002; Bankauskaite and Saarelma 2003; Burke et al 2003; Coyle 1999a; Coyle 1999b; Hupcey et al 2004; Hupcey et al 2000; Phillips 1996; Wellman et al 2001). These feelings can in turn impact the therapeutic relationship along with patients' help-seeking behaviour (Calnan 1995; Hupcey and Miller 2006; Hupcey et al 2000; Jacobs et al 2006; Rose et al 2004; Thorne and Robinson 1988; Ware and Davies 1984).

Given the gravity of these potential outcomes, why then are these different views poorly understood? The primary reason for this lack of clarity is a host of conceptual and methodological limitations confronting this work. For example, the constructs 'satisfaction', 'dissatisfaction', 'trust', and 'distrust' have been, for the most part, inadequately conceptualized by scholars, making it difficult for them to examine accurately these concepts (Coyle and Williams 1999; Fitzpatrick and Hopkins 1983; Hupcey and Miller 2006; Hupcey et al 2000; Locker and Dunt 1978; Pearson and Raeke 2000; Rose et al 2004; Williams 1994; Williams and Calnan 1996a). Researchers, in addition, have relied a great deal on survey techniques, which are certainly successful in uncovering global rates of satisfaction and trust, but less able to shed light on patients' detailed concerns (Williams 1994; Williams and Calnan 1991). Moreover, this body of

¹ A system in which medical doctors and other healthcare professionals (e.g., nurses, pharmacists, therapists) treat symptoms and diseases using pharmaceuticals, radiation and/or surgical procedures (National Cancer Institute, U.S. National Institutes of Health: http://www.cancer.gov/Templates/db_alpha.aspx?CdrID=449752)

literature has generally overlooked various subgroups of patients; in the particular case of the elderly, this neglect has contributed to the misconception that seniors are usually highly satisfied consumers of healthcare (Beisecker 1996; Jaipaul and Rosenthal 2003). These types of negative and positive views need to be investigated more systematically, in order to understand thoroughly the opinions of healthcare users, including those in hard to reach groups (Conway and Hockey 1998; Coyle and Williams 2000; Locker and Dunt 1978; Williams 1994).

Use of Complementary and Alternative Medicine (CAM)

A body of knowledge closely related to issues of patient dis/satisfaction and dis/trust is that dealing with the use of complementary and alternative medicine (CAM). In Canada and throughout the Western world, the use of CAM has increased dramatically among the general population (deBruyn 2002; Furnham 1996; Millar 2001; Sharma 1992). This popularity, in turn, has sparked much interest in why people turn to unconventional therapies. A number of possible reasons have been proposed to account for this phenomenon. Social scientists have mostly conceptualized these motives in terms of a push/pull debate. *Pushes* refer to factors or experiences that create a sense of dissatisfaction with conventional care. Contributing to this frustration is usually: ineffective or limited treatment options, fear of adverse side effects, and/or poor communication with medical doctors (Paterson and Britten 1999; Vincent and Furnham 1996). It is important to note that while these types of difficulties with physicians and treatments may certainly encourage users to explore other avenues (e.g., CAM), it is rare for them to abandon mainstream medicine altogether (Cant and Sharma 1999; Furnham 1996).

An alternate explanation for the widespread use of CAM is that people are *pulled* towards its practices. What many individuals appear to be particularly drawn to is: the naturalness and perceived safety of therapies (Kaptchuk and Eisenberg 1998), the holistic nature of treatments (Pawluch et al 1994), and the time and attention given to them by providers (Furnham 2005; Sharma 1996). Some, however, report an attraction to alternative healthcare as well due to its compatibility with their personal worldviews (Astin 1998; Siahpush 1999ab). Overall, it seems likely that a variety of elements (e.g., medical history, finances) come into play alongside a mixture of push/pull factors to influence initial and subsequent decisions to use CAM; these reasons may also change over time. The choice to use unconventional care is thus complex and in short, cannot be explained simply in terms of dissatisfaction with conventional medicine or an attraction to CAM (Furnham and Vincent 2003; Low 2004).

Similar trends are observed in late life. Indeed, from the little that is known about seniors' use of CAM, it appears—based mainly on rates of consumption (Astin et al 2000; Cherniack et al 2001; Foster et al 2000; Ness et al 2005)—that they too are swayed by a range of push and pull factors. An in-depth understanding of these issues, however, is lacking due to various methodological limitations (Andrews 2002; Ballantyne 2002; Willison and Andrews 2004) coupled with stereotypical beliefs about older adults and their health-related behaviours (Fulder and Monro 1985). Hence, greater efforts are

needed to understand the views of a more mixed group of users, and their unique experiences with complementary and alternative medicine.

Management of Medications

An important topic linked to the use of conventional and unconventional therapies is how these regimens are managed by users. Non-compliance is often a key concern related to this issue and as such, is thoroughly discussed in the medical literature on the management of medication. From the physician's point of view, this disobedience occurs when the patient fails to adhere to his/her prescribed treatment—an act which is essentially regarded as irrational and deviant (Conrad 1987; Donovan 1995; Stimson 1974; Trostle 1988; Trostle et al 1983; Wertheimer and Santella 2003; Zola 1980). Individuals, on the other hand, often do not view such behaviour in the same light. Indeed, when consumers tweak professional recommendations (i.e. the *prescribed medication practice*) and make their own decisions about how to take medication (i.e., create their own *medication practice*), they rarely perceive their actions as 'non-compliant' or as a deliberate attempt to disobey the doctor's advice (Conrad 1985). This kind of *self-regulation* rather serves as a means for people to accommodate better their unique needs, and use medicines more appropriately within the context and constraints of everyday life (Conrad 1985). Consumers thus behave as *active agents* (Conrad 1985; Stimson 1974) or *smart consumers* (Kelner and Wellman 1997) in their treatment plan rather than as passive and obedient recipients of medical advice.

As a way to assert greater control over health and well-being, some individuals also incorporate different types of complementary and alternative therapies into their treatment regimens. Although less direct attention has been given to how users work through the practical issues related to their *CAM practice* (Foote-Ardah 2003), the existing research suggests that these remedies are also actively negotiated with the help of various informal and formal sources, such as CAM providers, friends, and the media (Gillett et al 2002; Kelner and Wellman 2003; Low 2004; Sharma 1992; Truant and Bottorff 1999). Hence, on the whole, the notion of scientific efficacy seems to play only a limited role in many individuals' decision-making, and what instead appears to be increasingly important are other more social and emotional issues.

In later life, this type of an autonomous approach is observed as well. Contrary to popular stereotypes, a number of seniors have been found to assume responsibility for their conventional (Berman and Iris 1998; Conway and Hockey 1998; Dill et al 1995; Lumme-Sandt and Virtanen 2002; Lumme-Sandt et al 2000; Townsend et al 2003) and unconventional regimens (Andrews 2003; Arcury et al 2005; Boon et al 2003; Kelner and Wellman 2000; Nichols et al 2005; Wellman et al 2001); however, relatively little is known, overall, about such decision-making (Belcher et al 2006; King and Pettigrew 2004; Lumme-Sandt et al 2000; McKenzie and Keller 2001). This knowledge gap is somewhat surprising given that older adults are recognized as being significant users of medical drugs, as well as combinations of prescription and non-prescription remedies (Ballantyne et al 2005); the complexity of this use can make them more vulnerable to contra-indications and other complications linked to treatment. As a result, there is a need

to understand better how elderly persons select and use different types of medicines in their everyday lives (Ballantyne et al 2005; Ballantyne 2002), in order to gain insight to whether or not they are making informed and appropriate healthcare choices.

In sum, it appears that many consumers of healthcare are:

- reporting expressions of satisfaction and trust when they believe that their medical doctors are caring and providing them with competent and personal care;
- experiencing feelings of dissatisfaction and distrust when they sense that physicians are inattentive, abrupt, and lack sufficient technical skills;
- increasingly turning to complementary and alternative medicine (CAM);
- opting to explore unconventional therapies because of their frustration with conventional medicine (push factor) and/or their attraction to CAM (pull factor);
- making their own decisions about how to take their medications, but generally do not view their behaviour as non-compliant; and
- actively negotiating their use of CAM with the help of various informal and formal resources.

Similar observations are noted among seniors, but these different bodies of research are much more limited relative to the works focusing on the general population. Hence, there is a need to investigate further the health-related actions, attitudes, decision-making, and experiences of older adults, as well as other sub-groups of patients and CAM users. In addition to these gaps in knowledge, there is a need to:

- uncover systematically the positive and negative views of all healthcare consumers as well as the underlying reasons for these sentiments;
- comprehend how and why people use CAM;
- examine what unconventional therapies mean to users; and
- explore these broad issues using qualitative methodologies as well in order to grasp adequately individuals' unique understandings of different systems of medicine.

Therefore, in this study I examine seniors' experiences with healthcare and specifically, shed light on 2 key research questions:

- Why do seniors turn to complementary and alternative medicine?
- How do seniors negotiate their use of complementary and alternative medicine?

To this end, I highlight older adults':

- detailed concerns regarding conventional doctors and therapies;
- meanings of CAM use; and
- management of treatment regimens.

These issues are investigated using in-depth interviews, a qualitative methodology in line with the theoretical framework guiding this study—symbolic interactionism.

Theoretical Framework—Symbolic Interactionism²:

The overarching theoretical framework that informs this study is symbolic interactionism. As described by Herbert Blumer (1969, 47), it is a “down-to-earth [micro level] approach to the study of human group life and human conduct.” It specifically aims to understand the ways in which people interpret their life-situations, and carry out activities in conjunction with others on a daily basis (Prus 1996). Central to symbolic interactionist thought is the notion of *the self*, as introduced by George Herbert Mead (1962). The self is a *social object* that develops in interaction, and transforms or remains unchanged as a result of interaction. The self first emerges during childhood (play stage) through symbolic interaction with others (e.g., parents), and eventually becomes a mature self (game stage) with the development of a *generalized other* (i.e., internalization of the general norm in society) (Mead 1962). By understanding the generalized other, the individual comprehends what type of behaviour is acceptable and anticipated in a range of social situations. S/he can then also evaluate him/herself from the perspective of the generalized other. Given though that there are many different groups in society, people often tend to have more than one generalized other and accordingly, more than one self.

Mead identifies two aspects of the self: the *I* and the *me*. The *me* encompasses the norms of society and the *I* serves as the unpredictable and unique part of the self (Mead 1962). The significance of the self is that a person then becomes an object to his/her own conduct (Mead 1962). In other words, s/he figuratively steps outside of him/herself and acts towards self in the same way as others do so. This practice thus largely depends on assuming *the role of others*; however, symbolic communication with oneself is also important, as without this internal dialogue it would not be possible to communicate symbolically (e.g., via gestures) with others (Mead 1962). When the individual talks to him/herself (i.e., *process of self-interaction*), s/he essentially points out the issues that are facing him/her in a particular situation, and then plans his/her action based on the interpretation of these matters (Blumer 1975; Mead 1962). Individuals are thus perceived as *active constructors* of their own behaviour—interpreting, assessing, defining, and devising their own action—rather than as *passive beings* influenced by external factors.

Following Mead, Blumer (1969) also maintained that people interact with one another by *interpreting* each other’s actions, as opposed to simply *reacting* to these actions. He thus argued that the stimulus-response characterization of human behaviour was insufficient to describe a person’s conduct, and what was in fact missing in this couplet was a middle term, namely interpretation (*stimulus-interpretation-response*). Hence, instead of simply responding to action in an automatic fashion, he claimed that the individual reflects on and defines actions using symbols (*self-indication*) and then reacts to the stimulus. This process, for this reason, can then be viewed as *meaningful interaction*.

² This brief overview simply discusses *some of* the key ideas of symbolic interactionism as outlined by Blumer and Mead, but in no way captures the entire depth of this perspective.

Synthesizing succinctly this general perspective and further summarizing Mead's key ideas, Blumer (1969) ultimately outlined three simple ideas capturing the essence of symbolic interactionism. The first assumption suggests that *people act towards things based on the meanings that they have for them*. The second principle of this theory is that *meanings are not inherent to things, but rather negotiated through social interactions with others*. Objects (i.e., people and things) can thus have an assortment of meanings. These meanings are generally shared in the course of everyday exchanges with others and communicated through the use of language, gestures, and facial expressions. The final tenet of Blumer's (1969) framework describes a process of *interpretation* whereby *the individual reflects on and modifies meanings in light of the situation facing him/her*. Meanings therefore play an important role in action by way of a process of self-interaction (Blumer 1969; Charon 1992; Prus 1996; Wallace and Wolf 1995).

Clearly then, according to both Mead (1962) and Blumer (1969), the essence of society is found in acting units and action. This focus, however, did not preclude them from acknowledging the existence of collective action or the influence of social structure on human conduct as well. Indeed, both scholars recognized the importance of structural elements, but claimed that they *emerged* from action rather than *preceding* or *producing* action (Blumer 2004). In addition, Blumer (1969) argued that these structures (e.g., culture, social systems, social stratification, and social roles) could only serve as the "frameworks" in which action takes place and therefore, they could only *establish* the conditions for action and *not determine* the actual action. What this means is that people do not act within the context of these types of structures; rather, they act in situations. Structural features are thus important in that they shape the circumstances in which action takes place and additionally, supply to individuals the fixed set of symbols that allow them to interpret their situations. However, overall, "a network or an institution does not function automatically...it functions because people at different points do something, and what they do is a result of how they define the situation in which they are called to act." (Blumer 1969, 19)

Methodology:

Given that relatively little is known about seniors' experiences with complementary and alternative medicine, I chose an in-depth, qualitative methodology—consistent with the symbolic interactionist framework—to investigate the reasons underlying their use of CAM, the meanings they attached to therapies, and their management of regimens. This approach also seemed to be the natural choice, as my aim was to focus on the individual and his/her unique stories. An interview format with open-ended questions proved to be particularly beneficial in this regard.

In-depth interviewing is a technique for data collection that is used in qualitative research when the goal is to gather detailed, richly textured, and person-centered information from one or more individuals (Kaufman 1994). It is generally preferred when the researcher wishes to explore what is meaningful to the individual. Hence, when engaging in in-depth interviews, the investigator initiates a conversation with a real person and treats the interviewee as an informant rather than a research subject (Kaufman

1994). Samples tend to be smaller in order to encourage rich dialogue full of ‘thick’ description. Data is also collected with minimal a priori assumptions regarding relationships between phenomena (Bengtson et al 1997). Themes are thus permitted to emerge as observations are made; these patterns are then used to guide the presentation of findings.

Recruitment of Participants

Requests for voluntary participation in this study were made by placing posters at a variety of locations that would attract a diverse group of older adults (Appendix A). These venues included: a fitness center for seniors, an alternative practitioner’s office, health food stores, and recreation centers for seniors. A description of this study was also posted online at various alternative health-related websites. Announcements were made at meetings for seniors helping in the university classroom (senior class assistants) as well. Finally, I sent out a mass e-mail to all my personal contacts (i.e., friends, family, colleagues), requesting that they forward information about the project to anyone interested. Individuals were deemed eligible to participate if they self-identified as a user of CAM, given the subjective and varied nature of what that means to people (Kelner and Wellman 2003). All potential participants, however, were asked to get in touch with me if they wished to share their experiences and take part in the study; the sample was therefore self-selected. I kept track of how I made contact with each respondent, and found that my personal contacts proved to be the most beneficial³, although recruitment from one particular fitness center and health food store was also successful (Appendix B).

Participants⁴

The sample consisted of 43 older adults, 15 men and 28 women. This distribution is reflective of the gendered patterns of CAM use outlined in the literature (de Bruyn 2001; Eisenberg et al 1998; Ni et al 2002; Park 2005; Simpson 2003; Tindle et al 2005). Participants ranged in age from 60 to 89 years old, and more than half of the informants were married or living with a partner. They all resided in and around Hamilton, Ontario, save one person that lived in Vancouver, British Columbia⁵. The majority of respondents were born in Canada, and did not identify themselves as a visible minority (except one) or a member of any particular ethnic group. Most reported holding a university degree and belonging to the middle class; yearly personal income ranged anywhere from less than 19K to more than 80K, with several people refusing to disclose details about their

³ These participants were known by my personal contacts, but I did not know them personally.

⁴ Pseudonyms are used in each of the three substantive articles in order to protect the identities of informants. In addition to ensuring confidentiality, the use of pseudonyms has the extra advantage of portraying participants as individuals rather than data (Low 2006).

⁵ This participant was included in this study for the purpose of better understanding the male perspective, as it was challenging to secure interviews with older, male users of CAM.

earnings. Over three quarters of participants described their health as being good to excellent. The treatments that respondents discussed using overall included: massage, aroma therapy, reiki, reflexology, vitamin therapy, diets, exercise, tai chi, herbal medicine, chiropractic, acupuncture, Traditional Chinese medicine, naturopathy, homeopathy, Ayurvedic medicine, ear candling, meditation, yoga, and therapeutic touch (Appendix C).

Data Collection

Before data collection began, full ethics approval was sought from McMaster University's ethics board. Once this had been obtained, interviews were set up with potential respondents. Data collection continued until saturation, the point at which no new or relevant data emerged from the interview process (Boon et al 1999).

All seniors that took part in this research were notified both verbally and in writing about the purpose of this study (Appendix D); they agreed to participate in it by providing me with their written consent (Appendix E). The interviews were informal and took place either in person (n=15) or over the phone (n=28) depending on the participant's preference. Interviews were tape-recorded and I engaged in on going note-taking as well in order to preserve the authenticity of informants' expressed ideas and feelings. The length of the interviews ranged between thirty minutes and two hours.

The interview guide consisted of open-ended questions in order to encourage discussion with the informant. Some of the general areas that were explored with older consumers included: (1) use of conventional and unconventional treatments, (2) management of regimens, (3) relationships with healthcare practitioners, (4) safety concerns, and (5) effectiveness of therapies. Formal definitions of CAM and conventional medicine—such as those focusing on *what* is being used (e.g., herbs, pharmaceuticals, dietary supplements) or *who* is providing care (e.g., medical doctor, self, naturopath)—were not given to participants. Informants were instead asked to define the two types of care; they generally described both CAM and conventional medicine in terms of the products/services that they were using (i.e., what) *and* the person providing them with these products/services (i.e., who).

The interview began by first asking seniors to explain their views about conventional medicine; I then briefly asked about their own experiences with medical care. Next, I invited them to speak about their personal use of CAM; this discussion dominated most of the interview and provided detailed information about a broad range of topics. The order of questions varied per interview and was contingent upon the content of the previous response. All participants, however, were asked the same questions and probed for clarification (Appendix F).

Data Analysis

After the interviews had been completed, they were transcribed verbatim and entered into QSR Nud-ist 6.0—a qualitative data management and analysis program—for thematic analysis. Briefly, thematic analysis involves reducing a lengthy stretch of discussion to a phrase or a word (i.e., code) which describes the main point of the passage

expressed by the speaker (Luborsky 1994). The theme is then more easily compared with similar sentiments conveyed by the same informant or by others in the study. Among the many recognized benefits of thematic analysis is its direct portrayal of informants' (i) voices, (ii) personal perspectives, and (iii) descriptions of experiences, ideas, and beliefs. These thoughts and feelings may remain inexpressible in the scientific format of direct questions and answers (Luborsky 1994).

An initial, draft coding scheme was developed, largely reflecting the general topic areas covered in the interview guide. During and after the conduct of interviews, though, it became clear that additional codes and sub-codes were needed to capture new themes that were mentioned repeatedly by participants (e.g., distrust of conventional medicine, naturalness, holism). These issues often were not explicitly addressed in the interview questions. New and unanticipated codes thus emerged from both the interview and analysis process. My overall objective was to gain an accurate and in-depth understanding of why and how older adults used CAM, as well as, the meanings that they attached to their use of these therapies.

Overview of Empirical Articles:

This “sandwich thesis” is comprised of three empirical articles, outlined below, broadly addressing the issues of why (Articles 1 and 2) and how (Article 3) older adults in this study used complementary and alternative medicine.

Older Adults' Distrust of and Dissatisfaction with Conventional Medicine

In this article, I look at older adults' experiences with conventional healthcare, focusing specifically on their negative views and encounters with medical doctors and treatments. It is important to note that it is not my intention to imply that seniors turn to CAM *because of* their feelings of dissatisfaction and/or distrust towards conventional medicine, but rather that these negative feelings, along with a myriad of other factors (e.g., meanings of CAM), *contribute to* many consumers' decision to explore different therapeutic options. The main reason given for participants' frustration with physicians was the inadequacy of their inter-personal and technical skills. Remedies, on the other hand, were criticized for their associated risks. The results, overall, draw attention to seniors' willingness to voice their concerns and question professional authority when they feel that their health-related needs are not being sufficiently met.

The Meanings of Complementary and Alternative Medicine (CAM) Use in Later Life

In this article, I explore how older adults understood their use of complementary and alternative medicine. This examination specifically includes a look at the meanings seniors attributed to their use of CAM, the reasons they found these practices to be attractive, and their expectations surrounding use. While the findings fail to provide much support for push/pull explanations of use, the analysis demonstrates that older adults in this study attached a broad range of meanings to their use of CAM, and viewed these treatments to be an integral part of their aging lifestyle.

The Negotiation of Complementary and Alternative Medicine (CAM) Use in Later Life

In this article, I examine how older adults negotiated their use of complementary and alternative medicine. Particular attention is given to the manner in which seniors (1) selected therapies, (2) assessed effectiveness, (3) managed conventional and unconventional care, (4) addressed safety concerns, and (5) dealt with any constraints affecting use. What is revealed from the thematic analysis is that participants worked through the practical dimensions of their CAM practice in a number of ways and on the whole, assumed much control over their treatment regimens.

In the concluding chapter of my thesis, I briefly summarize my key findings and in doing so, revisit the main research objectives I have outlined in this introduction. The significance and contributions of this study to the substantive bodies of knowledge outlined above are discussed, as well as the limitations of this research and suggestions for future research.

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Introduction:

The past half-century has witnessed a significant shift in the public's attitude towards conventional medicine¹ (McQuaide 2005). Once regarded as a tried, true, and trusted provider of care, it is now believed that many are unhappy with conventional practices and lack faith in this system (Calnan and Sanford 2004; Calnan and Williams 1996; McQuaide 2005; Williams and Calnan 1996a). The reasons underlying consumers' frustration and crumbling of support are diverse, and extend beyond some of the obvious difficulties currently plaguing healthcare (e.g., shortage of medical personnel, long waiting lists, underfunding). Indeed, a great deal of this distrust and dissatisfaction also stems from individuals' unpleasant experiences with physicians and/or treatments. It is important to understand these types of negative feelings expressed by patients because they can be long lasting (Annandale and Hunt 1998), and have an effect on the therapeutic relationship as well as on users' health-related behaviours (e.g., delays in care-seeking) (Calnan 1995; Hupcey and Miller 2006; Hupcey et al 2000; Jacobs et al 2006; Rose et al 2004; Thorne and Robinson 1988; Ware and Davies 1984). Few studies, however, have examined such lay views of conventional care in a comprehensive manner (Armstrong et al 2006; Calnan 1988; Calnan 1987; Calnan and Williams 1996; Coyle 1999a; Pearson and Raeke 2000; Williams 1994), and even less work has systematically investigated the opinions of various sub-groups of consumers, such as the elderly (Hupcey et al 2004; Jaipaul and Rosenthal 2003; Lee and Kasper 1998). An in-depth understanding of the older population's concerns is critical, given that these individuals frequently suffer with comorbid illnesses and may be more vulnerable to complications linked to treatment if they are not properly supervised. Moreover, seniors are the main consumers of healthcare, and a disproportionate amount of expenditures is directed at meeting their medical needs (Astin et al 2000; Foster et al 2000). These trends underscore the importance of investigating more closely older adults' beliefs about conventional medicine and specifically, their negative attitudes surrounding conventional care.

In this paper, I explore seniors' experiences with conventional healthcare, focusing in particular on their negative views and encounters with physicians and treatments. I begin with a review of the literature on patient satisfaction/dissatisfaction and trust/distrust, considering the extent of and underlying reasons for these attitudes among both the general public and the older population. Next, I describe the theoretical and methodological approach that guided this study. I then present my results. What will be revealed from this thematic analysis is that many seniors are not passive users of healthcare, as stereotypes may suggest, but rather informed consumers ready and willing to voice their views and make decisions about their own care.

¹ A system in which medical doctors and other healthcare professionals (e.g., nurses, pharmacists, therapists) treat symptoms and diseases using pharmaceuticals, radiation and/or surgical procedures (National Cancer Institute, U.S. National Institutes of Health: http://www.cancer.gov/Templates/db_alpha.aspx?CdrID=449752)

Lay Views of Conventional Medicine:

The public's perception and assessment of conventional medicine has increasingly become an area of scholarly interest. While early theorists examining doctor/patient relations depicted individuals as passive patients—either naturally having faith in modern medicine or accepting it via coercion—work over the past few decades has criticized this model and portrayed the lay populace as more critical and skeptical, especially in relation to the value of 'experts' (Calnan, 1984; Calnan and Williams, 1996; McQuaide, 2005). Beyond these kinds of arguments, however, it remains relatively unclear what exactly the lay public thinks and feels about conventional medicine. Indeed, with some notable exceptions (e.g., Calnan 1988; Coyle 1999a; Hupcey et al 2000; Thom and Campbell 1997; Williams and Calnan 1991) there currently exists little research which has addressed these types of issues in a comprehensive manner. In the following section, the empirical literature focusing on patient satisfaction/dissatisfaction and trust/distrust will be reviewed in greater detail, with particular attention given to the methodological considerations of this work. I will begin by examining the general population's views of conventional medicine; this discussion will be followed by a closer look at older adults' experiences with conventional healthcare.

Patient (dis)trust and (dis)satisfaction:

A key element influencing the process of medical care is the level of trust between patients and their physicians. Although definitions of interpersonal trust (in the context of the medical encounter) tend to vary, all embody the notion of expectations—expectations that health care providers will act in the best interests of the patient and demonstrate proper knowledge, skill, and competence (Davies 1999; Thom et al 2004). There are a variety of potential benefits associated with patient trust. For example, a number of studies have found trust to be a strong predictor of vital health outcomes, such as treatment adherence and continuity of care with the same provider (Hupcey and Miller 2006; Jacobs et al 2006; Safran et al 1998; Thom et al 1999). Despite its apparent importance, though, relatively little is known about the physician behaviours that foster this faith, as rigorous efforts geared towards defining and measuring patients' trust have been scarce (Hupcey and Miller 2006; Pearson and Raeke 2000; Thom 2001; Thom and Campbell 1997).

The information that does exist about doctor-patient trust underscores the crucial role of both physicians' technical competence and their interpersonal characteristics. Thom and Campbell's (1997) landmark study is illustrative in this regard. They specifically highlight, via focus group discussions, seven basic themes related to professional conduct, essential to the development of patient trust: (i) thoroughly evaluating problems, (ii) understanding the patient's individual experience, (iii) expressing caring, (iv) providing appropriate and effective treatment, (v) communicating clearly and completely, (vi) building a partnership, and (vii) demonstrating honesty and respect for the patient. In a later study using quantitative (survey) techniques, Thom (2001) further assesses the importance of these physician behaviours in relation to three variables—sex, age, and length of relationship with physician—and once again observes

these components to be highly predictive of trust in virtually all subgroups of patients for up to six months after the initial medical encounter. What these collective works thus suggest is that a good bedside manner is not just a sought-after amenity but also a key factor—alongside technical proficiency—to providing competent and trustworthy care.

In the perceived absence of this skill and caring, some patients may naturally begin to lose faith in their physician's ability to manage effectively their health and well being. Hupcey and colleagues (2000), in addition, identify—via semi-structured interviews—a number of inhibiting behaviours that may block the development and maintenance of trust in health care providers (e.g., nurses, physicians, technicians, support staff) more generally—not knowing the patient's personal history, not explaining care/procedures, and appearing rigid and unresponsive to individual needs. When faced with such circumstances, some patients may choose to avoid seeking help, change doctors, refuse treatment, and/or withdraw from care completely (Hupcey and Miller 2006; Hupcey et al 2000; Jacobs et al 2006; Thom and Campbell 1997). Others, in contrast, may continue seeing the same medical professionals, especially if they feel that there is no way out of the situation, do not know where else to go, and/or simply do not want to invest the time and energy to find another provider (Hupcey et al 2004; Hupcey et al 2000). In these types of situations, Thorne and Robinson (1988) argue that some people may reconstruct an alternate form of trust in order to continue with care. Their findings—based on in-depth interviews with chronically ill patients and their families—specifically bring to light a three-stage model that demonstrates the way in which interactions with healthcare practitioners can evolve over time. They report that their informants generally entered medical relationships with a naïve level of trust, which was broken in the face of unfulfilled expectations and conflict with providers (stage 1: naïve trust). This shattering of trust then led some to experience considerable anxiety and distrust (stage 2: disenchantment). Over time, a new form of trust was noted among these participants, but it appeared to be rebuilt on a guarded basis (stage 3: guarded alliance). With this reconstructed trust, users were found to exhibit more vigilant behaviour, both trusting and distrusting conventional caregivers.

It would seem then that some individuals' misgivings about their practitioners and, more generally, their care can have serious health-related implications. Such empirical evidence on patient distrust, nevertheless, has been limited and this dearth has left the construct inadequately operationalized (Rose et al 2004). There have been attempts to improve this ambiguity, but some of these efforts have been undertaken within trust-oriented investigations. As such, few studies have focused exclusively on matters tied to healthcare-related distrust. Still, researchers are now acknowledging the distinctiveness of this concept, and contend that distrust cannot be adequately explored using instruments geared towards measuring trust, as it implies much more than the absence of this belief (Corbie-Smith and Ford 2006; Jacobs et al 2006). Moreover, as previously suggested, trust and distrust do not necessarily have to exist in opposition and in fact, can be present simultaneously (Thorne and Robinson 1988). Patient distrust is thus a complex issue, influencing individuals' perceptions and the negotiation of their care in unique ways.

Aside from feelings of trust and distrust, though, expressions of patient satisfaction have also been used to assess the quality of conventional healthcare. *Satisfaction* differs from *trust* in that the former “looks backward, based on past experience, while [the latter] looks forward, an expectation of future behaviour.” (Thom et al 2004, 127) In addition, ‘satisfaction’ tends to describe a patient’s opinion of the doctor’s *behaviour*; whereas, ‘trust’ is largely based on a patient’s perception of the physician’s *motivations* and furthermore contains a strong emotional element that is not present in satisfaction (Hall et al 2001; Thom et al 2004). The two concepts, nevertheless, are also related, as good past experiences generally tend to foster greater trust and trusting patients are more likely to voice satisfaction.

The specific behaviours and circumstances contributing to individuals’ positive assessments of care, on the other hand, are less clear—although it seems that professional competence and the interpersonal nature of the doctor-patient relationship are of importance (Burke et al 2003; Feddock et al 2005; Katic et al 2001; Sullivan et al 2000; Williams and Calnan 1991). The primary reason for this superficial understanding of patient satisfaction is a host of methodological limitations plaguing this body of work (Williams and Calnan 1996a). For example, large-scale satisfaction surveys usually tend to find that patients are pleased with the medical services provided to them, even though somewhat higher levels of discontent are noted in relation to certain aspects of care, such as the patient-provider relationship (Williams 1994; Williams and Calnan 1991). Explanations accounting for these inflated findings include: a social desirability bias, a reluctance to express negative views, the wording of items, and the non-specific nature of survey questions (Cornwell 1984; Williams and Calnan 1996a). The most potent criticism, however, surrounding studies of satisfaction pertains to the general perspective and conceptual framework adopted by this research (Fitzpatrick and Hopkins 1983; Williams 1994; Williams and Calnan 1996a). Specifically, there exists little agreement about the definition of ‘patient satisfaction’, despite the extensive use of this term. Locker and Dunt (1978), in fact, commented on this discrepancy and poor theorization over twenty-five years ago. Since their seminal article was written, a wealth of research has emerged but the concept ‘satisfaction’ still lacks clarity (Staniszewska and Ahmed 1999). Moreover, many scholars have continued to draw on a model which lacks sufficient empirical evidence, and assumes that satisfaction results from the fulfillment of patient expectations (Avis et al 1997; Coyle and Williams 1999; Owens and Batchelor 1996; Staniszewska and Ahmed 1999). These difficulties, overall, have resulted in a partial and possibly misleading understanding of the lay perspectives of patients.

Owing to the shortcomings of satisfaction research, Williams and Calnan (1996b) present an alternate, more fruitful way of understanding lay views of conventional healthcare. Building on a previous framework outlined by Calnan (1988), they propose six important factors at both the macro and micro levels that are likely to influence individuals’ perceptions and assessments of care. The first element, *socio-political values*, proposes that individuals’ views are shaped by the ideologies underlying their respective healthcare system (state-run vs. market based). Hence, although common beliefs such as “don’t waste the doctor’s time with trivial matters” or “use the emergency department for emergencies” are examples of the philosophy adopted by some patients

and healthcare providers in Canada (state-run services), this mentality may not be present in the United States, for instance, where healthcare is privatized and physicians' income is meant to respond to patient needs. The second component addresses the role of *the media* and particularly touches upon its ability to influence lay ideas, as it highlights for consumers not only the positive aspects of conventional medicine but also its risks. The third factor, *lay concepts of health and illness*, deals with the way in which lay images—shaped by personal experience, cultural beliefs, and professional ideology—can structure both thoughts about healthcare and evaluations of its services. For example, a person with “low health norms” (e.g., an underprivileged person) may perceive health as simply being the absence of disease and in turn, define healthcare in terms of its ability to provide curative care. A person with more “positive elements” in their notions of health and illness may, in contrast, regard health as encompassing mental and physical well being and thus assess healthcare based on its provision of preventative and curative services. The fourth part of this framework suggests that the appraisal of care can also be understood in terms of the specific *reasons for seeking help*. In other words, lay evaluations may reflect the degree to which patients' goals have been met within the medical encounter. The fifth element, *past experiences*, underscores the significance of the individual's past encounters as well as those of loved ones. These experiences are deemed important because they are viewed as being able to influence perceptions of care and judgments about its overall efficacy. The final component focuses on the *socio-demographic characteristics* of patients. These mediatory factors are believed to have an impact on each of the five previous parts of this conceptual model. Age is illustrative in this regard, as findings have shown this variable to influence experiences of care, ideology, and possibly even medical evaluations (Calnan 1998; Calnan et al 2003; Coyle and Williams 2001; Williams and Calnan 1991). Together, these elements are perceived as being a more effective tool to uncover individuals' views of conventional medicine, and to understand thoroughly their experiences with medical care.

Despite the development of this comprehensive framework, a particular area of research that remains poorly understood is patient dissatisfaction. One underlying reason for this lack of clarity has been the tendency of scholars to address this issue in the context of official complaints, ignoring the bulk of negative episodes that are not reported and do not require formal action (Coyle and Williams 2001). Another more prominent factor, however, contributing to the ambiguity has been the continued use of satisfaction surveys. Williams (1994) specifically argues that most patients are generally very uncritical of the medical services provided to them and thus only tend to express their dissatisfaction when care is of an extremely poor quality. As a result, rates of user satisfaction tend to be considerably high. Coyle and Williams (1999) additionally highlight that by using satisfaction scales to investigate dissatisfaction, researchers assume that there is a continuum, with satisfaction and dissatisfaction at two extreme ends. It has been found, though, that these expressions at times exist side by side (Avis et al 1997; Williams and Calnan 1991).

Qualitative research furthermore contends that some individuals may not feel qualified to evaluate their medical care (Avis et al 1995; Owens and Batchelor 1996), and/or may prefer to describe things as ‘bothering them’ rather than labeling their

feelings as dissatisfaction (Avis et al 1997). This methodological approach has also uncovered that many individuals may only convey their frustration in response to specific (vs. general) questions (Calnan 1988; Williams and Calnan 1991), or under certain conditions: (i) when they feel there has been a failure in the provision of service, (ii) when there are no mitigating circumstances to excuse the behaviour or failure, and/or (iii) when they are able to justify their discontent (Coyle 1999a; Williams et al 1998). Hence, in many cases, Williams et al (1998) discovered that respondents continued to voice positive sentiments despite facing problems in healthcare.

What then is known about patient dissatisfaction? Few researchers have examined this topic in a direct manner and thus exploration of this field is still in its infancy. The existing literature, nevertheless, suggests that the doctor-patient relationship plays a vital role in individuals' assessments of care. Consequently, many tend to voice their disappointment when they feel that physicians are rude, rushed, lack knowledge or technical skills, and/or fail to communicate clearly their ideas to the patient (Bankauskaite and Saarelma 2003; Burke et al 2003; Coyle 1999a; Coyle 1999b; Phillips 1996). Doctors' over-reliance on pharmaceuticals has also been noted to be a source of frustration, particularly because users tend to be unhappy with the synthetic properties of these products and, to a greater extent, with their ability to cause a host of adverse side effects (Britten 1996; Britten 1994; Pike 2005). Additional insights into the meaning of dissatisfaction are offered by Coyle (1999a), who argues that these types of negative episodes can affect a person's sense of self as well. Using in-depth interviews with 41 adults aged 18 to 79 years, she specifically reports that several participants in her study felt objectified, dehumanized, disempowered, and/or devalued as a result of their untoward experiences with conventional healthcare. Accordingly, she identifies a new concept—personal identity threat—as being better able (than the less theorized variable 'satisfaction') to explain dissatisfaction and to capture the range of attitudes, beliefs, and thoughts expressed by patients using the conventional system.

In sum, it appears that patients' expressions of satisfaction and trust are strongly influenced by both physicians' caring attitude and their technical competency. Hence, when this perceived skill and concern are lacking, many naturally tend to encounter considerable dissatisfaction and/or distrust; these negative attitudes can, in turn, have an effect on the therapeutic relationship as well as on individuals' health-related behaviours (e.g., help-seeking, following physician's recommendations). Despite the impact of these feelings on the provision of proper care, a comprehensive understanding of each of these issues (i.e., satisfaction and dissatisfaction, trust and distrust) is lacking because of a variety of methodological and conceptual limitations plaguing this work. Some scholars have begun to address these difficulties by introducing new tools to grasp more effectively patients' positive and critical views of conventional care. This type of systematic research, however, is still in its infancy and thus the lay experiences of some groups—such as older adults—remain relatively unclear.

Older Adults' Experiences with Conventional Medicine:

One pattern that has emerged from some of the existing quantitative literature is that seniors tend to be more satisfied and trusting users of conventional healthcare. For example, in their study of older Korean Americans, Jang and colleagues (2005) find that approximately 73% of their participants were satisfied with the healthcare services provided to them, and 84% of these informants additionally expressed a high level of trust in their medical care as well. Nerney et al (2001) report similar findings, with 91% of Emergency Department (ED) patients pleased with the global quality of their care, and 82% of these elderly respondents voicing trust in ED staff. A number of possible reasons have been proposed to account for these types of trends: (i) older patients are more familiar with the system and in turn, its potential shortcomings (*maturational explanation*), (ii) older patients were raised during periods of significant hardship (e.g., Great Depression) and are therefore more accepting of the system (*generational explanation*), (iii) older patients have been conditioned to a paternalistic model of care and thus prefer to maintain a passive patient role (*historical explanation*) (Goodsell 1981-2). While these rationalizations may certainly explain the positive feelings reported by some seniors, it is plausible to assume that these findings may also be influenced by the methodological and conceptual limitations previously outlined.

Indeed, qualitative research has managed to show that some late life users of the conventional system do not hold favourable assessments of care. Conway and Hockey (1998), for instance, found—via interviews and focus group discussions—that several older informants expressed a sense of skepticism and disdain towards the institution of conventional medicine, a dislike for its production-like nature of care, and a feeling of disempowerment resulting from the patient role. Other studies, using similar methodological approaches, have also noted that many seniors are wary of conventional medicine and unhappy with its shortcomings—especially its practitioners' incompetent, uncaring and inattentive behaviour, its inability to treat effectively chronic conditions, and its standardization of care (Andrews 2002; Coyle 1999a; Hupcey et al 2004; Kelner and Wellman 2000; Mellor et al 2006; Owens and Batchelor 1996; Wellman et al 2001).

Clearly, a number of older adults can be quite critical of conventional medicine. An in-depth exploration of such issues, though, has been limited because of several problems confronting age-related studies of satisfaction and trust. A key difficulty has been the potential unwillingness of elderly participants to voice negative opinions about their healthcare due to fear of antagonizing their practitioner, who in turn may provide them with even worse care or simply refuse to treat them (Owens and Batchelor 1996); this is an important factor that may partially be responsible for the inflated rates of satisfaction and trust observed in later life. Results may additionally be biased given the tendency of previous work to group all seniors together; this strategy neglects important differences between the young-old (ages 65-74), old-old (ages 75-84), and oldest-old (ages 85 and above) (Beisecker 1996; Jaipaul and Rosenthal 2003). When this differentiation is made, older adults' evaluations of care often tend to vary by cohort. Hupcey and colleagues (2004), for example, found—in their focus group study of 39 community-dwelling seniors—that some patients of increasing age felt that practitioners

were not as thorough with their care, and failed to offer them information about all available treatment options; such perceived neglect impacted participants' feelings of satisfaction and trust towards their providers. Other scholars (Jaipaul and Rosenthal 2003; Lee and Kasper 1998; Smith et al 2002) have also uncovered this sense of unhappiness and/or mistrust among the oldest-old, particularly among those reporting poor health (Jaipaul and Rosenthal 2003).

Overall, it seems—based on the scant body of comprehensive research—that younger and older patients both place great value on physicians' caring demeanor and on their ability to provide competent and personal care. It is not surprising then that some individuals tend to report considerable dissatisfaction and even distrust when they perceive these qualities to be lacking in medical professionals. An in-depth investigation of these positive and negative feelings, however, has been limited by a variety of methodological and conceptual shortcomings plaguing this work. One such difficulty has been the extensive use of survey techniques. While surveys have been successful in revealing *global* measures of satisfaction and trust, they have been less able to expose users' *detailed* concerns and views. Research focusing on satisfaction and trust-related issues has additionally been criticized for its neglect of various subgroups of patients. The elderly, for example, remain relatively overlooked, and the paucity of work to date focusing on seniors has largely depicted them as highly supportive of conventional care; less attention has thereby been given to late-life users' negative attitudes. More qualitative work is thus clearly needed to understand thoroughly the opinions of healthcare users, including those in hard to reach groups. This study begins to address these gaps in the literature by exploring older adults' experiences with conventional medicine and, in particular, their untoward encounters with medical doctors and treatments.

Methodology:

The theoretical framework that informs this study is symbolic interactionism. It is a “down-to-earth approach to the study of human group life and human conduct.” (Blumer 1969, 47) It aims to understand the ways in which people interpret their life-situations and carry out activities in conjunction with others on a daily basis (Prus 1996). At the heart of this micro level perspective are three simple ideas (Blumer 1969). The first is that people act towards things based on the meaning that they have for them. The second premise suggests that these meanings are not inherent to things but rather negotiated through social interactions with others. Objects (i.e., people and things) can thus have an assortment of meanings. These meanings are generally shared in the course of everyday exchanges with others and communicated through the use of language, gestures, and facial expressions. The final tenet describes a process of interpretation whereby the individual reflects on and modifies meanings in light of the situation facing him/her. Meanings therefore play an important role in action by way of a process of self-interaction (Blumer 1969; Charon 1992; Prus 1996; Wallace and Wolf 1995).

The interactionist perspective is particularly appropriate for the questions that I address in this paper, as my intent was to explore older adults' experiences with conventional care; this investigation was undertaken within a broader study on the meanings and management of complementary and alternative medicine (CAM) use in later life². Moreover, a qualitative approach seemed to be the natural choice as it ensured that the emphasis remain on the individual and his/her unique stories. Patients are also more likely to express both their positive and critical views when they are given the chance to voice their detailed thoughts and feelings (Conway and Hockey 1998; Coyle and Williams 2000; Locker and Dunt 1978; Williams 1994). An interview format with open-ended questions proved to be beneficial in this regard.

Recruitment of Participants

Requests for voluntary participation in this study were made by placing posters at a variety of locations that would attract a diverse group of older adults (Appendix A). These venues included a fitness center for seniors, an alternative practitioner's office, health food stores, and recreation centers for seniors. A description of this study was also posted online at various alternative health related websites. Announcements were made at meetings for seniors helping in the university classroom (senior class assistants) as well. Finally, I sent out a mass e-mail to all my personal contacts (i.e., friends, family, colleagues) requesting that they forward information about the project to anyone who may be interested. All potential participants were asked to get in touch with me if they wished to share their experiences and take part in the study; the sample was therefore self-selected.

Participants

The sample consisted of 43 older adults—15 men and 28 women—ranging in age from 60 to 89 years old (Figure 1). More than half of these participants were married or living with a partner, and all resided in Hamilton, Ontario and surrounding areas, save one person that lived in Vancouver, British Columbia. The majority of respondents were born in Canada, and did not identify themselves as a visible minority (only one visible minority) or a member of any particular ethnic group. Most reported holding a university degree and belonging to the middle class; yearly personal income ranged anywhere from less than 19K to more than 80K, with several people refusing to disclose details about their earnings. Over three quarters of informants described their health as being good to excellent and all reported using CAM on a regular basis (Table 1) (Appendix C).

Data Collection

Before data collection began, full ethics approval was sought from McMaster University's ethics board. Once this had been obtained, interviews were set up with

² It is important to note that it is not my intention in this article to imply that seniors (or people more generally) turn to CAM because of their negative experiences with conventional medicine.

potential respondents. Data collection continued until saturation, the point at which no new or relevant data emerged from the interview process (Boon et al 1999).

All seniors that took part in this research were notified both verbally and in writing about the purpose of this study (Appendix D); they agreed to participate in it by providing me with their written consent (Appendix E). The interviews were informal and took place either in person (n=15) or over the phone (n=28) depending on the participant's preference. Interviews were tape-recorded, and I engaged in on going note-taking as well in order to preserve the authenticity of informants' expressed ideas and feelings. The length of the interviews ranged between thirty minutes and two hours.

The interview guide consisted of open-ended questions in order to encourage discussion with the participant (Appendix F). The order of questions varied per interview and was contingent upon the content of the previous response. All participants, though, were asked the same questions and probed for clarification. Some of the key areas that were explored with older adults included: (1) general purpose of conventional care, (2) benefits and drawbacks of mainstream practices, (3) reasons for using conventional medicine, (4) expectations surrounding use, and (5) relationships with medical practitioners. Apart from asking about the general drawbacks of conventional medicine, along with its benefits, informants were not specifically asked about their complaints or sources of dissatisfaction and distrust. These issues arose naturally throughout the course of the interview (e.g., when discussing their relationships with doctors).

Data Analysis

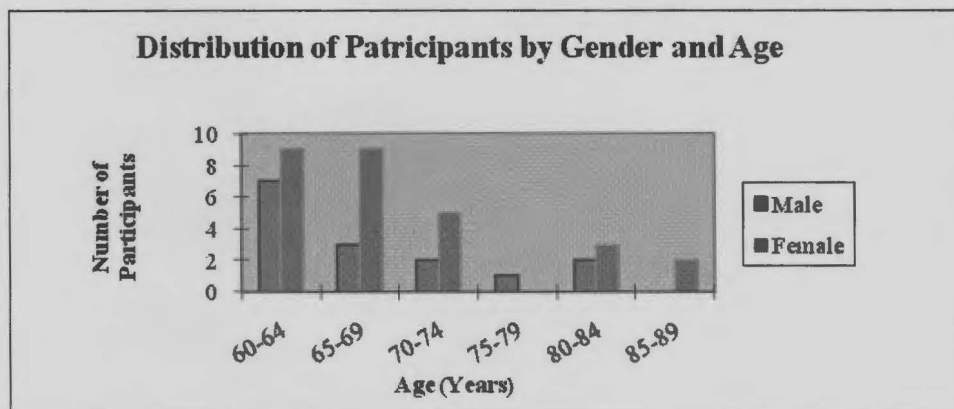
After interviews had been completed, they were transcribed verbatim and entered into QSR Nud-ist 6.0—a qualitative data management and analysis program—for thematic analysis. An initial, draft coding scheme was developed, largely reflecting the general topic areas covered in the interview guide. During and after the conduct of interviews, though, it became clear that additional codes and sub-codes were needed to capture new themes that were mentioned repeatedly by participants. These issues often were not explicitly addressed in the interview questions. Therefore, new and unanticipated codes—such as seniors' distrust in practitioners and treatments—emerged from both the interview and analysis process.

Table 1. Demographic Profile of Participants

<p><u>GENDER:</u></p> <ul style="list-style-type: none"> Females: 28 Males: 15 <p><u>AGE:</u></p> <ul style="list-style-type: none"> 60-64 years: 16 65-69 years: 12 70-74 years: 7 75-79 years: 1 80-84 years: 5 85-89 years: 2 <p><u>MARITAL STATUS:</u></p> <ul style="list-style-type: none"> Married/ living with a partner: 28 Divorced: 4 Widowed: 6 Separated: 3 Never been married: 2 <p><u>LIVE ALONE:</u></p> <ul style="list-style-type: none"> Yes: 14 No: 29 <p><u>HEALTH (self-rated):</u></p> <ul style="list-style-type: none"> Excellent: 11 Very good: 10 Good: 14 Satisfactory: 5 Poor: 2 Did not respond: 1 	<p><u>PLACE OF BIRTH:</u></p> <ul style="list-style-type: none"> Canada: 31 USA: 3 Czechoslovakia: 1 Finland: 1 Jamaica: 1 Holland: 2 Pakistan: 1 Scotland: 1 England: 2 <p><u>ETHNICITY*:</u></p> <ul style="list-style-type: none"> Canadian: 6 British: 6 Jewish: 1 Ukrainian: 1 Irish: 4 Austrian: 1 Finnish: 1 Pakistani: 1 Mayan: 1 German: 1 Scottish: 2 French: 1 Does not identify with any ethnic group: 22 <p><u>VISIBLE MINORITY:</u></p> <ul style="list-style-type: none"> Yes: 1 No: 42 	<p><u>HIGHEST LEVEL OF EDUCATION:</u></p> <ul style="list-style-type: none"> Some high school: 3 High school: 4 Some college: 3 College diploma: 4 RN training: 2 Some university: 2 University certificate: 1 Bachelor's degree: 11 Post graduate degree: 13 <p><u>SOCIAL CLASS (self-rated):</u></p> <ul style="list-style-type: none"> Upper class: 1 Upper-middle class: 13 Middle class: 22 Working class: 4 Retired: 2 Did not respond: 1 <p><u>INCOME:</u></p> <ul style="list-style-type: none"> 19 999 or less: 2 20 000 to 39 999: 8 40 000 to 59 999: 9 60 000 to 79 999: 7 80 000 or more: 5 Did not respond: 12
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*some participants identified themselves as belonging to more than one ethnic group

Figure 1. Distribution of Participants by Gender and Age



Results:

Although older adults in this study regarded conventional medicine as a valuable form of healthcare, many people (coming from all age groups) also revealed that they were unhappy with conventional physicians and remedies for a number of reasons. It is these negative attitudes that will be explored in this section using a narrative format. I will begin by highlighting seniors' untoward experiences with medical doctors and then explain their difficulties with conventional treatments. Within these respective discussions, I will also differentiate participants' feelings of *dissatisfaction* from their *distrust*, as they too made this distinction. Overall, I will describe and identify patterns and regularities in what follows, but the voice of informants will be used as much as possible in order to provide an accurate representation of their concerns. The quotations used below are indented, and the age³ of respondents is given along with a pseudonym in order to protect the identities of these individuals.

Dissatisfaction with and Distrust in Medical Doctors⁴

One key factor underlying a number of participants' critical views of conventional medicine was their unsatisfactory experiences with their healthcare practitioners (i.e., family physicians and/or specialists). Indeed, several older adults identified various deficiencies within their therapeutic relationships, and these shortcomings—broadly revolving around issues of *interpersonal relations*, *expertise*, *professional incompetency*, and *inappropriate decision-making*—contributed to their general sense of wariness and disappointment.

A particularly common source of dissatisfaction reported by more than a few respondents was their physician's negative attitude. Some seniors specifically commented on their doctor's belittling and/or disrespectful character:

“[H]e has a sort of superior attitude...If you ask him a question, he belittles you...I dislike the man immensely.” (Amy, 72)

“[W]ell I didn't like his attitude about me not wanting to take Forteo [medication used to treat osteoporosis]. Like my first reaction about Forteo was to not want to take it. I didn't think that he respected my decision. He just seemed disgusted with me, impatient.” (Ellen, 62)

Several others highlighted their physician's inattentive behaviour:

“[D]octors are rushed...they don't pay attention to everything you're saying and they miss things. I, you have to keep going back. If your problem isn't solved, if

³ Participants identified themselves as belonging to an age group (e.g., 60-64 years old) rather than disclosing their specific age. The age listed, therefore, is the average age of this age group (e.g., an individual reporting their age as being between 60-64 years is listed as 62).

⁴ The terms practitioner, provider, professional, doctor, and physician are used interchangeably throughout this section for variability; they all refer to a medical doctor.

what they suggested to do doesn't work, you know, you have to keep going back to get them to pay attention to whatever it is.”
(Ellen, 62)

“[What] I am hearing from my family, extended family, and friends is that they are not getting the attention they need when they go to their doctor or the hospital. They...have a long time to wait and often times the drugs prescribed are not helping or are adversely... affecting them to the point where several people close to me and family have been on death's door.” (Audrey, 62)

Equally troubling for many participants was providers' busy work schedules:

“[A] doctor only wants to spend two minutes with you and they're not interested in actually a discussion...it's usually a one way discussion with a medical doctor.”
(Audrey, 62)

“In terms of family doctors, they often don't have time. Their practices are so huge and the demands on them are so huge that they don't often have time to address general concerns.” (Nellie, 62)

In fact, a number of older adults admitted that their physicians had ‘one hand on the door knob’ (Robert, 62) during consultations:

“[T]he waiting room has got 10,000 people waiting to go in there and you've been an hour and a half late in your appointment so yeah, you feel rushed.” (Derek, 67)

This rushed behaviour was believed to be responsible for the impersonal style of interaction common between doctors and patients today:

“[T]he doctors either lack of interest or...time, whatever it is, but they just sort of put you through a doctor's appointment like you're on a conveyor belt. They don't really listen.” (Yvette, 67)

“There's no connection between the doctor and the patient [today]. They are simply separate entities who never seem to mesh or get together...when you remove the caring aspect... I mean that's really what does the healing is the caring. And the interest in actually researching the problem and coming back to the individual and saying 'You have a unique problem here and I've looked it up and I've done a lot of research and this is what I suggest would be good for you, the individual.' Everybody is slotted now into a mass and so no one has any individualization anymore.” (Audrey, 62)

Although it is likely that some of these complaints were the result of wider difficulties plaguing the healthcare system, many respondents discussed these problems as if they

stemmed from the inadequacy of physicians, possibly because it was practitioners' actions that were having such a profound effect on their lives.

Apart from these interpersonal concerns, several participants also voiced their discontent with providers' limited range of expertise. These seniors felt that physicians were not sufficiently educated in important topics that they perceived to be essential to the provision of proper care:

"[T]heir [physicians] knowledge of gerontology is lousy." (Yvette, 67)

"[T]hey [physicians] do not get very much training in dietetics. I would like to see them have more training in other areas rather than the general areas." (Laura, 67)

Some older adults further commented that practitioners were not open to such unfamiliar areas as well. For example, informants valued preventative care, but these issues were rarely discussed with them:

"The chief drawback I see is their narrow-mindedness about what health is about and focus on illness as opposed to wellness or prevention or health." (Neil, 62)

"I think that conventional medicine is not addressing the needs of people and rather than using preventive measures in helping people get out of their problems or their illnesses, they just keep feeding pills. You know, going through procedures and this kind of thing. And I rather think they've missed the boat." (Laura, 67)

Similarly, the psychosocial aspects of illness were not usually considered either:

"[C]onventional medicine I guess one thing is very focused on the medical model so the social aspects are...probably really put more in the background." (Eliza, 72)

"Nobody takes into consideration your life style, what you do, who you are, and [what] works with you." (Kevin, 67)

These elements were believed to play a major role in individuals' health and well being.

While these types of relational and knowledge-based issues certainly contributed to many participants' reported dissatisfaction with conventional medicine, it was actually the perceived incompetence and poor judgment of physicians that typically fuelled a number of informants' feelings of distrust. For example, several respondents disclosed incidents involving serious medical mistakes that either they or their loved ones had encountered:

"[M]any years ago when I was in my early 20s I had a problem with rapid heart rate and weight loss and a bunch of other things. And the doctors put me on beta-

blockers, Inderal was the drug. It wasn't even approved. There'd just been a salesman around, told them about it. They put me on that for 23 years, told me never to have children, and it was a thyroid problem.” (Anna, 62)

“[T]his [conventional] system gave me MRSA, the worst infection you can have... the MRSA was given to me on the 12th operation over 14 years... So you know, it's just a thing that one must be wary of more than fully accepting.” (Martin, 62)

More than a few seniors also discussed doctors' over-reliance on pharmaceuticals, which they felt were not always necessary:

“I don't rely on the doctor or even trust doctors as much. I think they sort of tend these days to think a prescription drug is the answer to every problem, and I'd like to think that it isn't.” (Yvonne, 62)

“[T]here is a distrust for the miraculous chemical additions to our bodies which miraculous of course has quotes on it and that's what the doctors think.” (Martin, 62)

Interestingly, in the absence of such problems some participants still voiced their misgivings about physicians' competence:

“I've had two eye surgeries so before I had the first one I went down to the medical science library, got some books out, investigated it. I wanted to find out for myself, yeah. Like I guess I'm not saying that I just totally trust conventional medicine...there are things that can go wrong.” (Eliza, 72)

“[J]ust because you have an MD after your name doesn't mean that you know what works and what doesn't work.” (Yvette, 67)

As a result, they felt that it was important to remain an informed consumer of healthcare.

In short, a number of older adults were dissatisfied with their conventional doctors and distrusted them to some degree as well. Some informants were especially disappointed with their physicians' narrow-mindedness and limited range of expertise, while others were unhappy with practitioners' rude and/or inattentive attitude. The reasons underlying more than a few respondents' sense of wariness, in contrast, largely stemmed from encounters in which seniors felt doctors were incompetent and/or exhibited poor judgment. Several older adults specifically discussed medical errors and professionals' over-reliance on prescription drugs. Many commented that pharmaceuticals were not the answer to every problem and wished that physicians would explore other avenues for treatment with them. Despite these negative experiences, a number of participants continued to receive care from these medical professionals; this

decision was mostly pragmatic, as seniors were aware of the widespread shortage of physicians and recognized the difficulty in securing another family doctor.

While these types of overall concerns are not limited to those in later life, what appears to be unique about this group of older adults is that—contrary to popular belief—they did not yield passively to the authority of physicians. Indeed, many participants expressed over and over again the importance of being well educated about their health because they felt practitioners were capable of making mistakes. As a result, they admitted that they routinely questioned their doctors and voiced their opinions, sometimes even challenging their physician's recommendations. These measures were deemed essential in order to ensure their well-being and protect themselves from any unnecessary complications linked to treatment.

Dissatisfaction with and Distrust of Conventional Treatments

Another source of frustration cited by several older participants was medical treatment. In particular, a number of seniors highlighted a variety of general critiques, which largely reflected their disappointment with the *standardized and inadequate selection of remedies* available to them. Specific complaints, on the other hand, were mostly tied to pharmaceuticals, with the majority of informants expressly stating their reservations about the *strength, composition, manufacturing*, and overall *effectiveness* of drugs. These factors, together, made many respondents painfully aware of the shortcomings of conventional therapies, and further produced feelings of both doubt and discontent.

A key problem attributed to the bulk of mainstream treatments was uniformity. In other words, more than a few older adults perceived medical care as not being tailored to the needs of the individual:

“They [conventional medicine] treat everybody like a one size fits all.”
(Laura, 67)

As each person experiences symptoms in a somewhat different manner, uniform remedies were seen as being potentially inappropriate for some:

“[Y]ou just can't pigeon hole us you know? We're not stamped out. We're not made by cookie cutters... We all are individuals and unique individuals at that.... And each one is as different as the five fingers on our hand... So when you go to a health professional dietician and she gives you one of those things [food guides]... That's fine. That's wonderful. But you know what? That was drawn up for a certain kind of individual. I don't fit the mould. (Kevin, 67)

Many people were equally dissatisfied with the narrow range of options accessible to them or their loved ones:

“[Thirty-five] years ago my mother was diagnosed with breast cancer... she was put in such agony over the conventional treatments of radiation and burning...[I] was in contact with the same cancer society industry three years ago when all they could offer my sister when she had a type of cancer was exactly the same thing. Nothing new over 35 years. Which made me extremely angry.” (Audrey, 62)

“I wasn't getting better after a herniated disk. A year and a half later I was still having trouble so my doctor sent me to her [specialist] and she assessed me and said I had these really loose ligaments and that that was the problem...she said that my options were really limited.” (Ellen, 62)

Some seniors additionally criticized these available choices for their harsh and/or invasive nature:

“Conventional medicine, I had trouble urinating, okay? I went to a specialist and he says well, we've got to do a little incision. You've got a little problem. Well you know what? Nobody even thinks of another way other than zip, zip.” (Kevin, 67)

“[L]et's look at something like high blood pressure. They [patients] go and the doctor, if it's past a certain level, wants them to go on blood pressure medication...it's probably the most efficient way for the doctor to treat it in terms of the number of people the doctor has to see per day...they are now finding that there are a number of other things that could be done before you go the medication route...I think it's a result of our medical system today that we tend to go to the pills first or sometimes even do surgery before other things have been tried.” (Nancy, 62)

Of particular concern was the use of pharmaceuticals. Accordingly, several older adults reported an aversion to drugs:

“I would be inclined to say to the doctor 'Is this [drug] something I can do without? Can I combat the problem by doing something else?' I'm really kind of anti-medicine.” (Allison, 72)

“I walked in and I said 'Look Doctor, I'm 88 years old. Don't ever think of giving me drugs.'” (Donna, 87)

This dislike was partially linked to the synthetic and chemical properties of these products:

“It's just sort of a gut feeling that I have that we should be putting things into our body that are a natural part of the universe and not something fake or plastic that has been created. I don't really like the idea of putting synthetic products and I

think a lot of the drugs that people are taking...probably have synthetic products.” (Evelyn, 67)

“I'm afraid of this chemical world... all the chemicals and stuff... in these [conventional] pills. I don't like it.” (Alma, 67)

Pharmaceuticals were also viewed unfavourably in more than a few cases because they were believed to only address the symptoms of a condition, ignoring the underlying cause of a problem:

“They'll [doctors] give you something to treat your symptom without treating the problem.” (Nina, 72)

“[T]here are things I think that aren't addressed...conventional medicine...they go after the cure, not the cause.” (Kevin, 67)

Drug therapy was thus perceived as offering only a partial solution.

The issue, however, evoking possibly the most dissatisfaction and—to a greater extent—distrust of conventional medication among many informants was the iatrogenic effects of drugs:

“My only change in view is some growing suspicion about the effectiveness of pharmaceuticals because there's a lot of information now ... that indicates that some of them, especially newer ones that may be only partially effective and may have a lot of side effects. And I've had personal experience with side effects of some pharmaceuticals, which has been unpleasant.” (Oscar, 72)

Most viewed these adverse consequences as wreaking havoc on the body:

“[T]hey [drugs] are detrimental on the whole body and the organs. The organs start breaking down and the body breaks down.” (Audrey, 62)

“I think it [drug therapy] brings the body into another stage in un-normal existence.” (Edna, 67)

The underlying theme behind each of these assertions was that pharmaceuticals are harmful; the two most extreme statements of this position being that all medicines are poison or more severely carcinogenic:

“I always think of conventional medicine as poison. Isn't that terrible?” (Halle, 82)

“[E]verybody has got cancer today. Why? Because they're all taking drugs.” (Jennifer, 67)

Alongside these qualms, a number of respondents expressed doubts about manufacturing:

“[R]ecent medicines seem not to have been tested long enough or tested properly and there’s so many interactions that have a really negative effect.” (Allison, 72)

Some participants specifically discussed incidents involving the recall of drugs:

“[My experience with conventional medicine has] made me really leery about a lot of medications and also hearing about the different medications that they’ve been recalled just lately. And one of them was one that I was on and had to go off.” (Halle, 82)

Further reinforcing this wariness of pharmaceuticals was many informants’ mistrust of the drug industry. Several respondents were especially uneasy about companies’ systems of advertising which they felt essentially instilled fear in others:

“I see the millions of dollars that are being spent on advertising through television and radio and print media for these pharmaceutical companies. I see it as fear mongering... ‘If you take my pill right now, you might not get cancer. This is just In case.’ So they are pushing pills when people are not even sick... These large companies are feeding on the fear that they are instilling that you might get it.” (Audrey, 62)

These tactics were deemed to be manipulative and self-serving.

Overall, many seniors’ critical views and negative first-hand encounters contributed to their dissatisfaction with and distrust of conventional treatment. While the pharmaceutical industry was condemned for its avariciousness, drugs were criticized on more than a few occasions for their potential to cause iatrogenic effects. Several informants were seriously uncomfortable with this potency and felt that such a harsh course of action was not always necessary. What these people wished for was treatment tailored to their specific needs in later life, but instead they received a narrow and uniform approach to illness. A number of older adults felt that this medical model only superficially addressed their problems. These experiences, in short, magnified the limitations of the conventional system and compelled many seniors to take greater responsibility for their own well-being. For example, several participants routinely sought information about remedies and voiced their objections regarding treatment when they felt it was necessary. This proactive behaviour is not always observed in later life and can thus be seen as a unique characteristic of this group of older respondents.

Discussion:

The purpose of this paper was to explore seniors' untoward experiences with conventional medicine. The results clearly indicate that many older adults were wary of and unhappy with their physicians and prescribed remedies for a number of reasons. Some informants' main complaints about their doctors broadly revolved around the inadequacy of their various skills. Treatments, on the other hand, were criticized most frequently by these individuals for their associated risks. These overall findings not only contribute to the scant body of literature discussing seniors' unfavourable views of conventional care, but also challenge the image of aged persons as passive users of healthcare—people who rarely verbalize negative opinions or question professional authority (Bury 2000; Calnan et al 2003; Cohen 1996; Coyle and Williams 2001; Haug 1979; Irish 1997; Mellor et al 2006; Wellman et al 2001; Williams and Calnan 1991). Indeed, more than a few participants were found to be 'smart consumers' who were informed about health matters, and preferred to use their own judgment when making decisions about their own care (Kelner and Wellman 1997). Another novel finding of this study was that several older adults voiced feelings of distrust and discontent towards the conventional system regardless of their age cohort or health status. This outcome contrasts with the work of scholars who have observed such critical attitudes in later life mostly among the oldest-old group (Hupcey et al 2004; Jaipaul and Rosenthal 2003; Lee and Kasper 1998), or among those with poor health (Jaipaul and Rosenthal 2003; Lee and Kasper 1998). One final point of interest is that a number of respondents' unpleasant episodes did not appear to influence their sense of self. Researchers have previously noted dissatisfaction to impact personal identity by making individuals feel objectified, dehumanized, disempowered, and/or devalued (Conway and Hockey 1998; Coyle 1999a; Gaylord 1999). It is possible that these seniors' reported participation in supplementary health practices—outside the realm of conventional medicine—helped to alleviate their difficult encounters with physicians and treatments by providing them with an air of empowerment and a form of resistance against the potentially patronizing and paternalistic nature of conventional care (Conway and Hockey 1998; Gaylord 1999).

In addition to these unique findings, however, the results of this study also support work previously undertaken by others. For example, as is commonly reported in the literature, the most frequently cited reason for several participants' distrust of conventional medicine was professional incompetence (e.g., Bakx 1991; Hupcey et al 2004; Hupcey et al 2000; Hupcey and Miller 2006; Jacobs et al 2006; Phillips 1996; Pike 2005; Thom and Campbell 1997). The specific problems encountered by many seniors and/or their loved ones included: inappropriate treatment, misdiagnosis, and/or in some cases negligence. Apart from this issue, though, a number of respondents also lost faith in physicians because of their over-reliance on prescription drugs and surgery. In line with the works of Pike (2005) and Britten (1996, 1994), these informants did not feel that a chemical or surgical solution was the answer to every problem and in fact mistrusted medication to some degree because of their personal views of the pharmaceutical industry as well as their battles with the adverse side effects of treatment. Given these circumstances, more than a few older adults became increasingly vigilant with their care

and routinely questioned their practitioners, while asserting their own opinions (often based on their own review of research); they did *not* abandon mainstream medicine altogether because they still pragmatically recognized its strengths alongside its limitations. These findings concur with those of Thorne and Robinson (1989, 1988), who noted a 'guarded alliance' with providers stemming from feelings of distrust; several of their participants, nevertheless, continued with care but accepted greater responsibility for their well-being by becoming informed users of healthcare.

Still, even with this type of consumerist approach, many respondents in this study experienced dissatisfaction with the medical encounter. Consistent with previous research, a number of older adults specifically voiced disappointment regarding their physicians' negative attitude (Bankauskaite and Saarelma 2003; Conway and Hockey 1998; Coyle 1999a; Coyle 1999b; Hupcey et al 2004; Low 2004; Mellor et al 2006; Phillips 1996), narrow-mindedness (Bakx 1991; Low 2004; Outram et al 2004; Pike 2005), and their limited knowledge in key areas, such as gerontology and dietetics (Bankauskaite and Saarelma 2003; Coyle 1999b; Outram et al 2004). Additional complaints revolved around doctors' busy work schedules, and their inability to provide informants with sufficient time, attention, and care. While short consultations have been found to contribute to patients' discontent (Andrews 2002; Kelner and Wellman 2000; Lin et al 2001; Mellor et al 2006; Outram et al 2004; Pike 2005; Sharma 1992; Williams and Calnan 1991), Cape (2002) has argued that it is actually the *quality* of time spent that influences individuals' perceptions of care. Ogden et al (2004) further contend that the desire for more time may reflect a feeling that the physician did not hear patients' concerns or understand their emotional needs; this perceived negligence may, in turn, leave patients with the impression of being short-changed, as observed in this study on more than a few occasions.

Szasz and Hollender's (1956) classic work on models of doctor/patient interaction is also particularly germane in making sense of these overall grievances against medical professionals. They specifically outline three different ways that physicians and patients can relate to one another, and they additionally argue that when both parties do not subscribe to the same mode of interaction, this inconsistency can result in patient discontent. In this study, it seems that physicians were interacting with many participants based on a "guidance-cooperation" model, which places the practitioner in a position of power and in which the patient, accordingly, is expected to comply with medical instructions and not question these orders. A number of seniors, on the other hand, seemed to prefer a "mutual participation" model, where the doctor and patient work as partners in finding a satisfactory solution. These informants then essentially wanted professionals to listen to what they felt was appropriate for them within their everyday lives and to make recommendations based on this information. When practitioners failed to take their personal experiences and views into account, this lack of consideration contributed to much frustration.

Aside from these difficulties with physicians, many seniors outlined several problems surrounding medical treatments as well. While the majority of these informants conceded that conventional medication was useful and made a difference in their lives, they were still concerned about a variety of issues. A great deal of their apprehension,

though, did not “relate straightforwardly to conventional medicine’s failure to ‘cure’ disease so much as to its failure to ‘cure’ disease on terms that [were] acceptable to [them].” (Sharma 1990, 39) For example, in accordance with previous studies (e.g., Benson and Britten 2002; Britten 1996; Britten 1994; Connor 2004; Paterson and Britten 1999; Traulsen et al 2002), a number of respondents reported reservations about pharmaceuticals and preferred not to take them because they perceived them as being ‘unnatural’, damaging through their adverse side effects and, in short, harmful to the body. Conventional treatments were also criticized by several people for their uniformity and their tendency to alleviate only the symptoms of a condition, while ignoring the underlying cause of the problem. Some participants were equally frustrated with the narrow range of harsh and/or invasive options available to them. These issues have been highlighted in the works of others (Britten 1996; Britten 1994; Low 2004; Sharma 1992; Shumay et al 2001), and have additionally been noted to play a key role in the widespread alienation observed among a number of medical patients today (Bakx 1991).

Overall, it is apparent that many seniors’ (and their loved ones’) untoward *past experiences* with physicians and remedies contributed significantly to their unfavourable assessments of care. There were, however, a variety of other factors—in line with Williams and Calnan’s (1996b) conceptual framework—that shaped participants’ views of conventional medicine as well. For example, *the media* (e.g., print, electronic, television) alerted a number of informants to the risks associated with medication and surgical procedures, and additionally made them aware of incidents involving medical malpractice. Through its various mediums, more than a few respondents were also exposed to the pharmaceutical industry’s system of advertising, which these seniors came to recognize as manipulative and self-serving. Another important element influencing older adults’ beliefs was their *lay images of health and illness*. Participants generally defined health in holistic terms (mental, physical and emotional wellbeing) and as a result, sought both curative and preventative services. They felt that the latter was unavailable through conventional channels, and this realization ultimately illuminated for them the limitations of this type of care. Equally troubling for a number of informants was their physicians’ response to their health-related complaints. Some older adults’ *reasons for seeking help* usually involved the desire to manage their condition in a team-oriented fashion, yet this goal was, in most cases, perceived as being unmet due to doctors’ busy work schedules. Many respondents were especially critical when physicians quickly reached for a prescription pad, assuming that a pill was the answer to every situation. Although these seniors understood that they could not take too much of the doctor’s time (*socio-political values*) because of their overwhelming case load, this inadequate availability was nonetheless a source of frustration. Finally, one last factor contributing to several participants’ views of conventional medicine was their age (*socio-demographic characteristics*). Informants’ ample experience with the system over the years allowed them to become more familiar with its limitations today. An older respondent specifically commented on the lack of progress in cancer research, as her sister was offered the same harsh treatments that her mother was given thirty-five years before. Together, these elements shaped many seniors’ evaluations of conventional medicine and, in particular, their negative views of medical care.

Limitations

Although this study has generated useful findings, its limitations should be acknowledged as well. Informants, for instance, were self-selected and consequently their decision to participate may be linked to traits that could have impacted the outcomes of this research. One specific effect may have been an inclination towards negative views—relative to the general older population—as all participants were self-identified users of CAM and thus more readily able to compare different types of care and assess what they liked and disliked about conventional medicine. This group of older adults was interviewed because the overall aim of this study was to understand how and why seniors used CAM as well as the meanings they attached to their use of these therapies. The issue of older patient dissatisfaction and distrust emerged in the course of this investigation.

Another shortcoming of this work pertains to the interview format (with open-ended questions) used for data collection. Outram et al (2004) have specifically argued that when individuals are asked to discuss their satisfaction with services, they are more inclined to highlight negative rather than positive experiences. While this notion is consistent with the view that qualitative methods are more likely than quantitative approaches to uncover older adults' feelings of dissatisfaction and distrust, it also implies that such data may over-represent negative attitudes. Results should therefore be interpreted with caution.

Conclusion:

In conclusion, this study has demonstrated—via health-related narratives—that some older participants distrusted and were dissatisfied with various aspects of conventional medicine. The reasons underlying these negative views were diverse, yet largely involved a host of unpleasant experiences with medical doctors and/or treatments. What many informants essentially wanted was competent and compassionate care, but instead they reported dealing with overtaxed physicians, unable to provide them with the time and attention they needed to manage their age-related concerns. Owing to this perceived negligence, several participants felt compelled to assume greater responsibility for their own well-being; their proactive behaviour included exploration of therapies outside the realm of conventional medicine. This type of patient alienation, however, can have serious implications for seniors. Older adults, for example, tend to suffer from a number of chronic conditions, and frequently consume a great deal of medication requiring close supervision. If elderly persons are to remain safe and receive quality care, it is imperative that providers strengthen their relationships with them (e.g., open communication) and understand more clearly their unique needs. Moreover, practitioners should discuss seniors' general orientation toward medication and surgery, and not assume that these options are acceptable forms of treatment in every situation. This kind of rapport will help foster greater trust in professionals and additionally allow medical personnel to assist better older adults in making informed and appropriate healthcare choices in later life.

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Introduction:

Canadians are increasingly turning to complementary and alternative medicine (CAM) as either an adjunct to or a substitution for conventional medicine. Indeed, it has been estimated that as many as 3.8 million Canadians use CAM (Millar 2001). Despite this pervasiveness, relatively little is known about the use of unconventional therapies among Canada's elderly population. Although some findings suggest that seniors tend to use alternative healthcare less often than young adults (Eisenberg et al 1998; Wellman et al 2001; YCHS 1999), recent research suggests that this trend may be due to an underreporting of CAM use because such treatments often are not differentiated from conventional therapies, especially when they are recommended by a medical doctor (Ballantyne 2002; Cohen, Ek, and Pan 2002). Evidence demonstrating older adults' interest in CAM is in fact emerging (Wooten and Sparber 2001). Cherniack and colleagues (2001), for example, found in the US that 75% of seniors—in their sample of university clinic patients—were drawn to alternative therapies. Similarly, Ness et al (2005) report use of CAM to be as high as 88% among Americans over 65 years of age. The popularity of alternative healthcare among the elderly is thus undeniably clear, and consequently it can no longer be viewed as a phenomenon of the younger generation.

Still, while understanding the broad patterns of CAM use in later life is valuable, this work reveals very little about how and why seniors choose unconventional care, and even less about what treatments mean to them. It is important to understand the meaning of CAM in users' everyday lives, as it gives some indication about the needs CAM meets as well as the motivations behind use of these therapies (Foote-Ardah 2003; Wellman et al 2001). These types of key issues, however, remain relatively under-explored, resulting in a dearth of knowledge about aged individuals' unique experiences with alternative healthcare (Andrews 2002). These gaps in the literature are of concern because older adults frequently suffer with comorbid illnesses and may be more vulnerable to complications linked to CAM treatment. In addition, seniors are the main consumers of healthcare and a disproportionate amount of expenditures is directed at meeting their medical needs (Astin et al 2000; Foster et al 2000). Moreover, with the aging of the baby boom cohort, the number of elderly persons will grow and the demand for all medical services, including alternative therapies, will likely increase as well. Such expected trends, therefore, underscore the need to comprehend both the individual and broader sociological reasons underlying the use of CAM.

In this paper, I explore how older adults in this study understood their use of complementary and alternative medicine. This examination specifically includes a look at the meanings seniors attached to their use of CAM, the reasons they found these practices to be attractive, and their expectations surrounding use. I begin with a review of the literature on CAM, considering the extent of and reasons for use among both the general public and the older population. Next, I describe the theoretical and methodological approach that guided this work. I then present my results. What will be revealed from this thematic analysis is that seniors assigned a broad range of meanings to their use of CAM and—contrary to popular belief—viewed these treatments to be an integral part of their aging lifestyle.

Use of CAM among the General Public:

The use of complementary and alternative medicine (CAM) has increased dramatically throughout the Western world (Furnham 1996; Sharma 1992). Indeed, a survey for the Fraser Institute found that 74% of Canadians used some form of CAM, and spent an estimated \$3.8 billion on alternative healthcare (Esmail 2007). Analyses of the National Population Health Survey have yielded comparable findings and in fact, have described usership amongst Canadians to range in the millions (deBruyn 2002; Millar 2001; Wiles and Rosenberg 2001). In the United States, such trends have been identified as well. For example, Eisenberg et al (1998) noted in 1997 that 43% of Americans used unconventional therapies, and paid approximately \$27 billion in out-of-pocket expenditures. The United Kingdom has also witnessed this massive growth (Ernst and White 2000; Thomas et al 2001; Zollman and Vickers 1999), reporting an estimated 15 million users of CAM in the year 2000 (House of Lords 2000). Similar patterns are observed throughout the rest of Europe (Sharma 1992) as well as in other developed countries, including Australia (MacLennan et al 1996) and Israel (Kitai et al 1998). Clearly, complementary and alternative medicine has become a global phenomenon. Such results, nevertheless, should be interpreted with caution, as findings can vary both within and between countries. That is, “differences in study hypotheses across studies, over-sampling of certain populations, the methodology used to gain access to the sample, and the manner in which CAM is defined, are but some of the factors involved that can lead to differences in rates of use reported by research.” (Willison and Andrews 2004, 81) These shortcomings aside, the popularity of CAM is undeniable and there is little dispute that a vast number of consumers are turning to alternative healthcare.

Users of CAM generally tend to be female, educated, and of a higher than average social class, and typically are coping with a variety of chronic conditions (Furnham and Vincent 2001). There is little evidence to support the commonly held belief that these individuals are gullible or naïve, with neurotic personalities or peculiar value systems (Furnham and Vincent 2001). As a result, a number of possible reasons have been proposed as to why people turn to complementary and alternative therapies. Social scientists have largely conceptualized these motives in terms of a push/pull debate. *Pushes* refer to factors or experiences that create a sense of dissatisfaction towards conventional care. Contributing to this disappointment are usually: ineffective or limited treatment options, fear of iatrogenic effects, and/or poor communication with medical practitioners (Paterson and Britten 1999; Vincent and Furnham 1996). Some have further suggested that this move towards CAM represents a ‘flight from science’ (Smith 1983), though it seems relatively rare for users to abandon conventional medicine completely (Cant and Sharma 1999; Furnham 1996). For example, Lupton (1997) found that participants in her study continued to believe in the strengths of medical care and its ability to fight illness and disease even if they were using CAM. They generally sought alternatives when conventional remedies were unavailable or when these treatments had been tried but did not succeed. In some instances, CAM was used alongside conventional approaches as well. Therefore, it appears that individuals are considering a broad range of

therapeutic options (medical pluralism) and using CAM as an adjunct to conventional care, not as a replacement for it (Cant and Sharma 1999; Furnham 1996).

An alternate explanation accounting for the prevalence of CAM is that consumers are in fact *pulled* towards its practices. What many users appear to be particularly drawn to is the naturalness and perceived safety of therapies (Kaptchuk and Eisenberg 1998), the holistic quality of treatments (Pawluch et al 1994), and the time and attention given to them by practitioners (Furnham 2005; Sharma 1996). Apart from these issues, however, some also seem to be attracted to alternative healthcare due to its compatibility with their personal philosophies about health and life (Astin 1998; Siahpush 1999ab). Indeed, researchers have found high levels of CAM use among those with worldviews including a belief in preventative health measures (Furnham and Bhagrath 1993), a concern for the environment (Furnham 2002), and recognition that individuals are responsible for their own well-being (Pawluch et al 1994). It thus appears, according to this perspective, that the attributes of CAM and its underlying principles are responsible for its extensive appeal.

Overall, though, it seems likely that a variety of push *and* pull factors come into play to influence initial and subsequent decisions to use CAM; these reasons may change over time as well. Accordingly, Furnham and Vincent (2003, 75) contend that it seems “incorrect to talk of patients simply being ‘pushed’ or ‘pulled’... [as it is a] combination [of factors], together with their particular medical history, that leads patients to consult CAM practitioners.” Low (2004) further argues that characterization of consumers’ motivations in push/pull terms is problematic, as it deters attention away from what is really at issue for individuals (e.g., finding acceptable solutions for health conditions). She thus suggests that it may be more worthwhile to focus on such elements as the social processes involved in users’ participation in CAM. The decision to use unconventional care is therefore complex, and simply cannot be explained by a mere dissatisfaction with conventional medicine or an alternative ideology. Similar trends are noted among late life users as well.

Older adults’ use of CAM:

From the little that is known about CAM use in late life, it appears that older adults are exploring more and more complementary and alternative medicine. For example, in their regional survey of Medicare enrollees residing in California, Astin and colleagues (2000) found use of CAM among seniors to be slightly over forty percent. Foster et al (2000) report similar findings nationally, with 30% of the elderly in their sample—or 10 million Americans when extrapolated to the adult population—using one or more alternative modalities. Despite this popularity, few studies have examined the extent of and motives for CAM use among the older population (Andrews 2002; Astin et al 2000; Cherniack et al 2001; Foster et al 2000; Ness et al 2005; Willison and Andrews 2004). The reasons for this dearth of information are not clear, although they may be linked to the dated misconception that seniors are not significant users of unconventional care. Rationalizations accounting for this misguided belief typically focus on aged persons’ lack of financial resources, their inability to pay for private health care (Fulder

and Monro 1985; Irish 1997), and their profound faith in medical science as well as in the authority its professionals, such as physicians (Wellman et al 2001). Recent research, however, has challenged these contentions and furthermore, has argued that low rates of CAM use observed in later life may be due to under-reporting by the elderly because such treatments are regarded the same as conventional medicine, especially when recommended by a medical practitioner (Ballantyne 2002). Hence, findings may be tainted by methodological and conceptual issues and—as with the more general literature on CAM use—results should be interpreted with caution.

Qualitative research, nevertheless, has indicated that older adults are interested in complementary and alternative healthcare and moreover, appear to be influenced by a number of push and pull factors. Conway and Hockey (1998), for instance, found—via interviews and focus group discussions—that several aged informants expressed a sense of skepticism and disdain towards the institution of conventional medicine, a dislike for its production-like nature of care, and a feeling of disempowerment resulting from the patient role. Other studies have also reported seniors to be disappointed with the inadequacies of conventional medicine—especially its failure to provide sufficient time and attention to patients, its inability to treat effectively chronic conditions, and its standardization of care (Andrews 2002; Kelner and Wellman 2000; Wellman et al 2001). Still, it is important to note that when faced these types of circumstances, older adults are not likely to reject conventional care altogether. Many instead have been known to supplement these approaches with a variety of unconventional therapies in order to enhance the quality of their overall healthcare (Kelner and Wellman 2000).

Another rationale accounting for elderly persons' interest in CAM pertains to the actual nature of therapies and/or the role that they play in older users' lives. For example, participants in Conway and Hockey's (1998) study perceived CAM as attractive because it provided them with a sense of authority in terms of their treatment, and also offered them a form of resistance against the condescending nature of conventional care. Andrews (2002), on the other hand, discovered that seniors were drawn to the holistic and individualistic qualities of CAM therapies. Wellman et al (2001) and Kelner and Wellman (2000), in contrast, observed older adults to be particularly pleased with the time and attention given to them by alternative practitioners. CAM is, therefore, valued and chosen for a variety of reasons revolving around personal need and/or health beliefs.

In sum, it is clear that CAM use is increasing among the general public as well as the older population. The underlying reasons for this widespread consumption are diverse and involve a number of push and pull factors. Most work examining CAM use, however, has largely relied on quantitative methods and consequently, this research has been less able to uncover how and why users turn to CAM, and what CAM means to these individuals (Andrews 2002). Furthermore, many studies have generally treated users as a homogenous group and overall, neglected the unique experiences of various subgroups of consumers (Andrews 2003). As a result, there is a need for both more qualitative work and research focusing on different subsets of users. This study begins to address these gaps in the literature by exploring older adults' experiences with CAM and

in particular, the many meanings they attach to their use of complementary and alternative medicine.

Methodology:

The theoretical framework that informs this study is symbolic interactionism. It is a “down-to-earth approach to the study of human group life and human conduct.” (Blumer 1969, 47) It aims to understand the ways in which people interpret their life-situations and carry out activities in conjunction with others on a daily basis (Prus 1996). At the heart of this micro level perspective are three simple ideas (Blumer 1969). The first is that people act towards things based on the *meaning* that they have for them. The second premise suggests that these meanings are not inherent to things but rather negotiated through *social interactions* with others. Objects (i.e., people and things) can thus have an assortment of meanings. These meanings are generally shared in the course of everyday exchanges with others and communicated through the use of language, gestures, and facial expressions. The final tenet describes a process of *interpretation* whereby the individual reflects on and modifies meanings in light of the situation facing him/her. Meanings therefore play an important role in action by way of a process of self-interaction (Blumer 1969; Charon 1992; Prus 1996; Wallace and Wolf 1995).

The interactionist perspective is particularly appropriate for my study as my objective was to understand seniors’ experiences with complementary and alternative medicine. Moreover, a qualitative approach seemed to be the natural choice as it ensured that the emphasis remain on the individual and his/her unique stories. As Adler (1999, 219) explains: “By promoting participants’ views and understandings, qualitative researchers can interpret CAM phenomena in terms of the meanings that people bring to them.” An interview format with open-ended questions proved to be beneficial in this regard.

Recruitment of Participants

Requests for voluntary participation in this study were made by placing posters in a variety of locations that would attract a diverse group of older adults (Appendix A). These venues included a fitness center for seniors, an alternative practitioner’s office, health food stores, and recreation centers for seniors. A description of this study was also posted online at various alternative health-related websites. Announcements were made at meetings for seniors helping in the university classroom (senior class assistants) as well. Finally, I sent out a mass e-mail to all my personal contacts (i.e., friends, family, colleagues) requesting that they forward information about the project to anyone who may be interested. Individuals were deemed eligible to participate if they self-identified as a user of CAM, given the subjective and varied nature of what that means to people (Kelner and Wellman 2003). All potential participants, however, were asked to get in touch with me if they wished to share their experiences and take part in the study; the sample was therefore self-selected.

Participants

The sample consisted of 43 older CAM users—15 men and 28 women (Figure 1). This distribution is reflective of the gendered patterns of CAM use outlined in the literature (de Bruyn 2001; Eisenberg et al 1998; Ni et al 2002; Park 2005; Simpson 2003; Tindle et al 2005). Participants ranged in age from 60 to 89 years old, and more than half of the informants were married or living with a partner. They all resided in Hamilton, Ontario and surrounding areas, save one person that lived in Vancouver, British Columbia. The majority of respondents were born in Canada, and did not identify themselves as a visible minority (only one visible minority) or a member of any particular ethnic group. Most reported holding a university degree and belonging to the middle class; yearly personal income ranged anywhere from less than 19K to more than 80K, with several people refusing to disclose details about their earnings. Over three quarters of participants described their health as being good to excellent. Most informants used CAM to control chronic health problems, although some experimented with various therapies to resolve acute conditions as well. The treatments that respondents discussed using overall included: massage, aroma therapy, reiki, reflexology, vitamin therapy, diets, exercise, tai chi, herbal medicine, chiropractic, acupuncture, Traditional Chinese medicine, naturopathy, homeopathy, Ayurvedic medicine, ear candling, meditation, yoga, and therapeutic touch (Appendix C) (Table 1).

Data Collection

Before data collection began, full ethics approval was sought from McMaster University's ethics board. Once this had been obtained, interviews were set up with potential respondents. Data collection continued until saturation, the point at which no new or relevant data emerged from the interview process (Boon et al 1999).

All seniors that took part in this research were notified both verbally and in writing about the purpose of this study (Appendix D); they agreed to participate in it by providing me with their written consent (Appendix E). The interviews were informal and took place either in person (n=15) or over the phone (n=28) depending on the participant's preference. Interviews were tape-recorded and I engaged in on going note-taking as well in order to preserve the authenticity of informants' expressed ideas and feelings. The length of the interviews ranged between thirty minutes and two hours.

The interview guide consisted of open-ended questions in order to encourage discussion with the informant. The order of questions varied per interview and was contingent upon the content of the previous response. All participants, however, were asked the same questions and probed for clarification (Appendix F). Some of the key issues that were explored with consumers included: (1) general purpose of complementary and alternative therapies, (2) specific reasons for choosing CAM, (3) expectations surrounding use, (4) experiences with conventional medicine, and (5) relationships with alternative and medical practitioners. Formal definitions of CAM and conventional medicine—such as those focusing on *what* is being used (e.g., herbs, pharmaceuticals, dietary supplements) or *who* is providing care (e.g., medical doctor, self, naturopath)—were not given to participants. Informants were instead asked to define

the two types of care; they generally described both CAM and conventional medicine in terms of the products/services that they were using (i.e., what) *and* the person providing them with these products/services (i.e., who).

Data Analysis

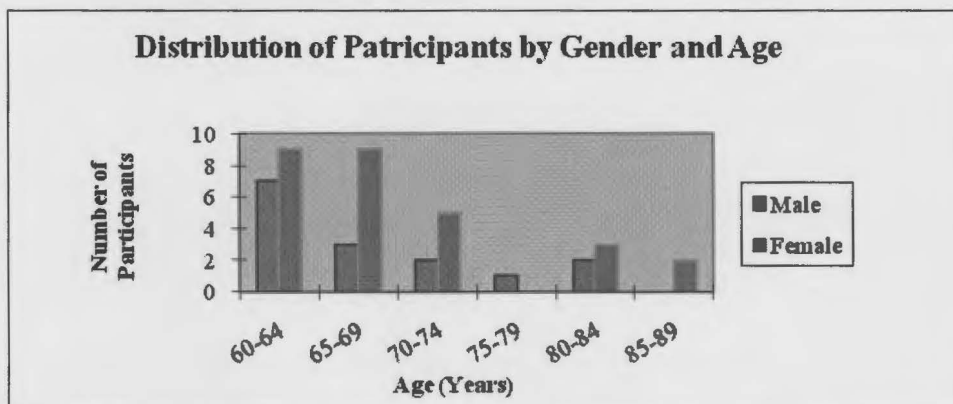
After interviews had been completed, they were transcribed verbatim and entered into QSR Nud-ist 6.0—a qualitative data management and analysis program—for thematic analysis. An initial, draft coding scheme was developed, largely reflecting the general topic areas covered in the interview guide. During and after the conduct of interviews, though, it became clear that additional codes and sub-codes were needed to capture new themes that were mentioned repeatedly by participants (e.g., holism, naturalness). These issues often were not explicitly addressed in the interview questions. New and unanticipated codes thus emerged from both the interview and analysis process. My overall objective was to gain an accurate and in-depth understanding of the many meanings that older adults attached to their use of complementary and alternative medicine.

Table 1. Demographic Profile of Participants

<p><u>GENDER:</u></p> <ul style="list-style-type: none"> Females: 28 Males: 15 <p><u>AGE:</u></p> <ul style="list-style-type: none"> 60-64 years: 16 65-69 years: 12 70-74 years: 7 75-79 years: 1 80-84 years: 5 85-89 years: 2 <p><u>MARITAL STATUS:</u></p> <ul style="list-style-type: none"> Married/ living with a partner: 28 Divorced: 4 Widowed: 6 Separated: 3 Never been married: 2 <p><u>LIVE ALONE:</u></p> <ul style="list-style-type: none"> Yes: 14 No: 29 <p><u>HEALTH (self-rated):</u></p> <ul style="list-style-type: none"> Excellent: 11 Very good: 10 Good: 14 Satisfactory: 5 Poor: 2 Did not respond: 1 	<p><u>PLACE OF BIRTH:</u></p> <ul style="list-style-type: none"> Canada: 31 USA: 3 Czechoslovakia: 1 Finland: 1 Jamaica: 1 Holland: 2 Pakistan: 1 Scotland: 1 England: 2 <p><u>ETHNICITY*:</u></p> <ul style="list-style-type: none"> Canadian: 6 British: 6 Jewish: 1 Ukrainian: 1 Irish: 4 Austrian: 1 Finnish: 1 Pakistani: 1 Mayan: 1 German: 1 Scottish: 2 French: 1 Does not identify with any ethnic group: 22 <p><u>VISIBLE MINORITY:</u></p> <ul style="list-style-type: none"> Yes: 1 No: 42 	<p><u>HIGHEST LEVEL OF EDUCATION:</u></p> <ul style="list-style-type: none"> Some high school: 3 High school: 4 Some college: 3 College diploma: 4 RN training: 2 Some university: 2 University certificate: 1 Bachelor's degree: 11 Post graduate degree: 13 <p><u>SOCIAL CLASS (self-rated):</u></p> <ul style="list-style-type: none"> Upper class: 1 Upper-middle class: 13 Middle class: 22 Working class: 4 Retired: 2 Did not respond: 1 <p><u>INCOME:</u></p> <ul style="list-style-type: none"> 19 999 or less: 2 20 000 to 39 999: 8 40 000 to 59 999: 9 60 000 to 79 999: 7 80 000 or more: 5 Did not respond: 12
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*some participants identified themselves as belonging to more than one ethnic group

Figure 1. Distribution of Participants by Gender and Age



Results:

In this section, I will describe how older adults understood their use of complementary and alternative medicine. This examination will specifically include a look at the meanings seniors associated with their use of CAM, the reasons they found therapies to be appealing, and their expectations surrounding use. It is important to note though that while participants were interested in CAM for a variety of reasons (outlined below), this attraction developed gradually *over time* as respondents became more familiar with treatments and practitioners. Informants' *initial* motivations for seeking CAM were thus based on a different set of factors, such as curiosity, personal need, and/or recommendations from loved ones.

Results are presented using a narrative format and the organization of findings is modeled after the work of Pawluch and colleagues (2000), who examined lay constructions of CAM use among a different population of users, namely those coping with HIV. Overall, I will identify and explain patterns and regularities in what follows; however, the voice of informants will be used as much as possible in order to provide an accurate representation of their understandings of CAM. The quotations used below are indented, and the age¹ of respondents is given along with a pseudonym in order to protect the identities of these individuals.

CAM as an adjunct to conventional medicine

Some researchers have noted that users of CAM are not necessarily rejecting mainstream practices, but rather turning to different unconventional therapies as a way to supplement, complement, or enhance the effects of conventional treatments (Kelner and Wellman 1997b; Lupton 1997; Pawluch et al 2000). The findings of this study support this contention. Indeed, seniors had not abandoned conventional medicine, because they recognized its benefits and felt that such care played an important role in their health and well-being. Most participants typically relied on these approaches to deal with acute illness as well as any other type of health-related crises:

“[I]f I broke my leg I sure wouldn't go to a herbalist...I would go to a doctor and I would definitely get that fixed... If I was in an accident or it was something like that. If push came to shove and I did actually need surgery...there's not anybody in alternative medicine that would be able to do that.” (Anna, 62)

“If you get hit by some illness that is major...if I'm diagnosed with cancer I am not going to do an alternative thing...I'll head straight for the doctor for that.” (Allison, 72)

¹ Participants identified themselves as belonging to an age group (e.g., 60-64 years old) rather than disclosing their specific age. The age listed, therefore, is the average age of this age group (e.g., an individual reporting their age as being between 60-64 years is listed as 62).

CAM, on the other hand, was often included in their regimens as a wellness strategy, so that they could basically avoid the onset of such serious problems and in turn the use of medical drugs:

“Well at my age I just expect [to keep] everything under control so I can do what I want to do. I mean my lifestyle, I'm busy all the time and I like to keep going and there's nothing worse than [to] have something, you know, that you can't handle. And there's no way that I am going to take drugs.” (Donna, 87)

“I think maintenance is superior to getting sick. If you can, maintenance and prevention like that's superior to getting sick and treating. Basically I think you just don't want to get into medicines if you can avoid it.” (Allison, 72)

In addition to this purpose, unconventional remedies were also used by many people to address their more chronic health issues (e.g., arthritis), especially those for which conventional care could only offer them harsh and unacceptable options. When this route was not possible and conventional treatment was necessary, several older adults used CAM alongside mainstream medicine. In some instances, this approach was undertaken as a means to mitigate the adverse side effects of conventional therapies:

“I usually take one [Acidophilus] in the morning or in the evening...I had to have an antibiotic... that gave me diarrhea and problems so...I started it and that helped me sort that out.” (Eliza, 72)

“When I first started I had a very bad radiation burn and they kept saying you have to come off because of it. It wouldn't heal. Well I started taking Vitamin E and using it as a rub on, and it all healed up.” (Norma, 82)

On other occasions, a few informants employed this combination to enhance the effects of their medical drugs:

“Well I think complementary helps you or helps what you're taking [conventionally] to do a better job.” (Nadine, 87)

This increased effectiveness, in one or two cases, even allowed respondents to reduce their prescribed dosage:

“I find that fish oil complements very well the antidepressant medication and makes it more effective so that I've been able to cut back.” (Nancy, 62)

Overall, then, many seniors used a mixture of conventional and unconventional practices to address better their unique needs, and to compensate for any perceived shortcomings in their total healthcare. They recognized that later life could be marked by a variety of ailments and in essence wanted to reap the benefits of all systems in order to experience

aging in a more comfortable and independent manner. Older adults, nevertheless, valued both of these traditions of medicine, but CAM was seen as offering the added advantage of a less invasive form of healing.

CAM as a less invasive choice

The perceived ‘gentleness’ of complementary and alternative medicine was appealing to a number of older adults. Several participants, therefore, turned to CAM as an alternative to harsh surgical procedures. For example, David (age 82) used chelation therapy to improve three arterial blockages in his heart and was ultimately able to avoid bypass surgery:

“I had two arteries that were rather severely blocked and the third one with a small blockage in it...Dr. X [alternative practitioner] decided he would start with a series of six [chelation] treatments spaced one month apart...after six months we had another treadmill stress test and it showed...I now [only] had one minor one [blockage]. So I went for another six treatments and then I had no blockages showing up on the test, so as far as I was concerned it had fixed my problem...I personally think that my going for chelation therapy well it certainly made me able to avoid bypass surgery and I think in the long run it has extended my life...It's a non-invasive procedure that worked for me and the alternative would have been surgery.”

Likewise, Kevin (age 67) experimented with an herbal product to relieve prostate related problems and evade surgical treatment:

“I had trouble urinating, okay? I went to a specialist and he says well, we've got to do a little incision. You've got a little problem...Nobody even thinks of another way other than...cutting me up, okay? That's the bottom line. If I can get by with something like this [Magistral, an alternative treatment for prostate problems]... I'll keep taking that.”

Anna (age 62) also used alternative methods—instead of opting for a steel spine—to cope with her back pain:

“I've got two herniated disks and my chiropractor has got me literally from 52% disabled to 14% disabled using acupuncture alone. So whereas doctors would have wanted to perform surgery and give me a steel spine...I'm absolutely not having that. I will go to different ways and my different ways have worked.”

These types of favourable experiences underscored for many participants the general value of alternative approaches to health and healing. Such positive outcomes also served to illuminate that a harsh course of action was not always necessary, as less invasive options can at times be equally beneficial. This understanding was particularly important

for seniors, who feared that aggressive procedures would impact their quality of life. Older adults admitted that they were already coping with a variety of conditions and thus wanted to avoid measures that would further complicate later life. They appreciated that CAM was able to address their ailments without jeopardizing their well being. Consequently, many investigated different unconventional therapies and discussed potential routes for treatment with their CAM practitioners as an alternative to conventional channels.

CAM as a patient-oriented practice

While older adults clearly favoured various aspects of complementary and alternative medicine, several people described their experiences with CAM providers to be appealing as well. What many seniors were particularly happy with was their active involvement in treatment decisions:

“[M]y experience with CAM providers is that they involve the patient as an active practitioner and give the patient responsibilities to get well, get better, and maintain health. And in my experience with traditional medicine, there's a little less of patient involvement.” (Neil, 62)

“[T]he woman that I go to for massage therapy is very...sensitive to my needs...if I say as I did this morning, I've had a fall. I've really hurt my rib cage and my knees. Can you really work on those?' And she will say 'Oh yeah, okay. I can feel it. Let's look at your knee. Oh yeah, your knee is swollen...she'll go to the areas where I'm telling her that there's pain.” (Noreen, 62)

A number of participants also expressed satisfaction with the amount of time that professionals spent with them during consultations:

“[T]he time you spend is allocated based on the need as I explain it at the initial inquiry for time. So it's much more based on my need than any other system. So right off the bat I'm happier.” (Martin, 62)

“Yes I do [have a better relationship with the osteopath than the GP]... I think it is [because we have more time together]. Yes. We're laying there and we chat while he's poking me, you know.” (Yvonne, 62)

The informal nature of the practitioner-client relationship was equally pleasing:

“I'm very fond of the massage therapist. She's like another daughter and I enjoy my time with her, the socializing part of it.” (Noreen, 62)

“[T]he doctor of natural medicine, I interrelate with [him in] another capacity [as well]... he's my Tai Chi master. So I can check with him... 'What do you think of this formula?'... it's also friendship based.” (Nancy, 62)

Indeed, more than a few older adults revealed that they were completely at ease with CAM providers, and did not hesitate to discuss issues that were troubling them. They felt secure with these individuals and did not fear belittlement and/or disrespect. This friendly attitude was refreshing given the stressful encounters that some informants had endured with medical doctors. Adding further to this contentment was professionals' availability for consultations on a regular basis:

“I can call at any time and get in and see them within two weeks. It's much better than the medical profession.” (Edna, 67)

“It's a more reliable one [relationship]... because I consistently go every week. You only go to a GP when something is wrong.” (Yvette, 67)

Several respondents appreciated this attention because it was deemed to be missing in conventional care:

“[A] lot of people don't even have a family doctor. And you... nearly always have to wait particularly [to see] the specialist. The waiting list is huge. That's a main reason why it's so nice to have someone you can go to and have an appointment in a very short time, any time you want.” (Amber, 82)

In short, the quality of this patient-centered care helped many informants to manage better their various health conditions. Seniors were pleased that professionals welcomed their input during consultations, and were further grateful that these providers regularly gave much thought to their health and well-being. This interest and open discussion made participants feel safe and cared for in an efficient manner. Older adults felt that this type of consideration was especially important for them as users of CAM, given that late life is often marked by a number of ailments which typically require use of conventional medications as well. They also admitted that such candid communication and friendly interaction was generally inadequate within medical encounters due to an assortment of factors, such as doctors' busy work schedules. Several seniors, therefore, sought support from CAM practitioners and valued their guidance surrounding the use of 'natural' remedies.

CAM as a natural approach

Many older adults reported an attraction to CAM because they viewed these—mostly herbal, homeopathic, Ayurvedic, and vitamin—therapies as being natural and free of any chemical additions:

“Well [with CAM] you know that you're putting natural things into your body, they're not chemical.” (Halle, 82)

“I feel they're natural and I'm afraid of this chemical world... all the chemicals and stuff... in these [conventional] pills. I don't like it.” (Alma, 67)

A number of participants felt that this purity was better for their health and well-being:

“[I]t [herbal tea] doesn't have caffeine, [and] I think it's probably better for me to drink it than regular tea.” (Evelyn, 67)

“I drink bilberry tea every day....So the natural things, I think they're so much better on your system.” (Alma, 67)

Natural products were also favoured by some because they were believed to be safe:

“I don't think there's any danger...my kids have said to me 'Well why are you taking all these things? If you ate well you'd probably [be fine]'. And I do eat well. But I just figure well they're not going to hurt me...” (Allison, 72)

“[The benefit of CAM is that] you'd also have a natural product that would not harm you in any way.” (Frank, 62)

This perceived safety assured many seniors that they would not suffer any adverse side effects linked to treatment:

“I prefer not to take prescription medications because of side effects that come from them whereas the alternative medicines are more natural. (Yvette, 67)

“[With conventional medicine there are] the side effects and there's so many contraindications. With the natural products there's usually no complications as much as they'd [critics, skeptics] love to prove that there are.” (Anna, 62)

Some substances were additionally described as harmless because they were seen as being a part of the earth or more generally, the universe:

“[A]ll these [CAM] things are from the earth. Like vegetables, fruit.” (Norbert, 72)

“It's just sort of a gut feeling that I have that we should be putting things into our body that are a natural part of the universe and not something fake or plastic that has been created... I don't really like the idea of putting synthetic products and I think that a lot of the drugs that people are taking I think probably have synthetic [ingredients].” (Evelyn, 67)

One final reason given by a few respondents' for their preference of natural treatments was that such practices have a long history:

"It's the naturalness [that I like]...it's just stuff that I know has been done for centuries in other cultures like ear candling." (Alma, 67)

"I knew about cinnamon [helping to lower cholesterol] because that's Ayurvedic, East Indian medicine, so it's been around for centuries." (Anna, 62)

Overall, a number of seniors appreciated the perceived naturalness of CAM therapies because it allowed them to address their aging needs in a less toxic manner. Several informants were coping with a variety of chronic conditions, and the purity of these treatments reassured them that they would be able to manage these problems without experiencing difficulties. This safety was regarded as a refreshing change from the complications they encountered with conventional remedies. Many participants, therefore, turned to unconventional care not only to manage their existing conditions, but also for health promotion purposes. Indeed, all older adults understood the real possibility of ill health in later life and consequently explored alternative routes to maintain their good health and ensure their well being.

CAM as a health maintenance/wellness strategy

A particularly alluring aspect of CAM reported by several participants was that it fit well into their healthy lifestyles:

"I'm using them because they're compatible with my experience and my lifestyle and I like the results they give me. I guess that's sort of a practical answer." (Oscar, 72)

"I don't see it [CAM] as a strange thing to do. I don't see it as like a little box that I reach into every once in a while. I see it as me. I see it as this is who I am and this is what I do. This is my life." (Audrey, 62)

Specifically, it helped them to maintain a sense of well being in later life:

"Oh [CAM is] definitely for my wellbeing. I'm not taking it just to think 'Geez I've got fifty bucks to spend...I take it for my wellbeing.'" (Nina, 72)

"[F]ortunately I'm pretty healthy, whether it's because I've been taking them [CAM], you know, for a long time, whether that's the reason why, it just keeps my health up.... So I'm very fortunate. I think it just helps me maintain my health." (Tamara, 67)

Some older adults required this assistance—largely in the form of dietary supplements—in order to ‘boost’ their system:

“Well I think they [complementary and alternative therapies] enhance your quality of life. Boost your immune system...I think they help in promoting good health.” (Robert, 62)

“That's [multivitamin] just as a supplement for the regular diet. It's just sort of to, you know, if I'm down a bit in Vitamin C or I'm down a bit in Vitamin D or whatever, it just sort of gives a bit of a boost.” (Roger, 62)

This added help was also seen as necessary to cope better with the aging process:

“Well I got to a point in my life where I turned I guess 50, 55... and, you know, it's the old story of once you get to that age you know you've had so much of your life and you think 'Well how much more do I have left?' And you start to think 'Well maybe I can enhance that just a little bit.' And you start to look at products that might just do that for you...these CAM type products.” (Roger, 62)

“Well I feel that they're very healthful in their benefits to me. They kind of maintain healthy respiration, circulation, health of organs, strength of muscles, all the things that I need to keep going and be comfortable about it.” (Oscar, 72)

A number of other people further claimed that they needed unconventional products to improve various deficiencies, such as those in their diet:

“All of them [CAM] are to maintain health. And to in some ways cope with wanting to stay in a fairly decent diet because it's not always easy to get omega 3s in your life if you're a vegetarian for example.” (Martin, 62)

“Most of this stuff is health stuff...with Vitamin E and Vitamin C we were brought up with the fact that we're not taking enough of those vitamins in our diet. So it just sort of supplements it.” (Kevin, 67)

While most seniors made a conscious effort to eat well, many felt that extra support was inevitable because of the deteriorating state of the environment:

“[T]hey're anti-oxidants. You know what our pollution is like here. Our percent of oxygen in the atmosphere is down...to 21%. It used to be 22% five years ago...In five years, six years it's dropped 1%. That's not very good is it?” (Kevin, 67)

“I think there's pollution and...pesticides [are] used on the crops...I feel that I take those [products] to supplement the vitamins and nutrition that

you need and you're not getting in your foods today.” (Tamara, 67)

The condition of the soil was a particular concern:

“I take these things simply because I know how produce is grown in general. The soil is worn out and if the soil is not replenished with organic products like manure and green manure and things like that then you're not getting as good a product out of it.”

(Laura, 67)

“The soil is so over used and pesticides and herbicides...you have to supplement your food diet with natural vitamins because a lot of them are not there any more...you have to supplement to better your food, the nutritional value in your food. That's one of the major things that you should do.” (Anna, 62)

Hence, these supplements and therapies were seen as a way to ensure healthy living in later life. Many seniors admitted that they had reached an age which made them ponder their remaining years, and this reflection prompted them to maximize their quality of life during this time. Older adults all greatly valued their self-sufficiency and thus actively engaged in treatments not only to maintain their general sense of well-being, but also to prevent the onset of illness. These measures were deemed to be a smart and practical way to better their lives and ultimately improve their aging process.

CAM as preventative care

While participants described conventional remedies as cure-oriented, complementary and alternative medicine was viewed as preventative. This distinction played an important role in many seniors' decision to use CAM. Indeed, several older adults believed that preventative care was a practical choice:

“I believe in prevention rather than cure so if you can, you know, bolster your immune system and so on and become healthy, then you don't need some of the others [conventional medications].” (Robert, 62)

“The times I feel like...I might be coming down with something', well rather than wait till I come down with it, I delve into the alternative medicines.” (Nina, 72)

As a result, more than a few respondents experimented with various herbal products and dietary supplements in hopes of averting minor conditions:

“I kept getting a lot of colds so I was advised by various people to eat a lot of Vitamin C. So I down a lot of Vitamin C every day. It seems to help.” (Frank, 62)

“The cranberry [pills] I take because I'm prone to bladder infections and it seems to stave them off. It helps.” (Yvonne, 62)

Prevention of more serious problems was equally important:

“I've been taking B complex and those things which are designed for your mental, um, brain. And also Vitamin E which is really good for that. And omega 3, 6 and 9 is another thing that enhances your brain power...the biggest fear of old people is to lose their marbles. And I guess eventually we all get slacker and slacker but to actually get Alzheimer's or something like that is just alarming to us.” (Allison, 72)

“Yeah [selenium], that's for prostate. It's not because I have a prostate condition. It's simply [because] Dr. X [alternative practitioner] says that it helps prevent having prostate problems.” (David, 82)

In general, several participants used unconventional therapies as a pragmatic line of defense against the deterioration in old age. Many seniors were aware of the vulnerability that can potentially accompany later life and therefore sought ways to avoid these obstacles and, in turn, the use of harsh conventional remedies. These older adults further admitted that they feared a number of illnesses—particularly those robbing them of their independence—and, for this reason, actively explored new and innovative ways to address more comprehensively their aging needs and enhance their total body health.

CAM as a holistic approach

The desire for holistic healthcare served as a key factor underlying several respondents' use of complementary and alternative medicine:

“I once in a while need to see a professional but that professional doesn't necessarily have to be in the medical field. It could be someone who could help me understand my emotions, my feelings, understand why I've got the ache in my shoulder which could be related to my emotions. So I'm looking for total, whole-body health and healing.” (Audrey, 62)

Many older adults specifically emphasized the connection between the mind, body and spirit as well as the importance of this inter-relationship in achieving a sense of well-being:

“[B]ody, mind, spirit, it all has a lot to do with how you function as a person.” (Anna, 62)

“[M]y mother wasn't working on any other part of her body...She was working on nutrition but she wasn't working on getting rid of old grudges and things like that

and sort of setting her life up to be a little happier. I think that has a lot to do with illness as well.” (Anna, 62)

This total body care was believed to be missing within conventional approaches:

“[What] separates CAM from allopathic medicine is that CAM is holistic and looks at the mind and the body and the spirit, uh, as opposed to detailed and looking at pieces, like the broken toes or noses as though they were the whole thing.” (Neil, 62)

“Well I don't think they address the whole person. I think conventional medicine does not, and I know this for a fact having worked with physicians for almost 30 years who taught and were teaching students, that they do not get very much training in dietetics. I would like to see them have more training in other areas rather than the general areas.” (Laura, 67)

A number of participants, therefore, turned to various complementary and alternative therapies (often manual therapies) for balance and healing:

“The real purpose [of CAM] is to keep your body, your mind, and your spirit balanced...drugs work against your body.” (Audrey, 62)

“I feel much more in balance with my own body and my own self, my physical, emotional self. And I also feel more connected with Mother Nature and the earth and the world around us.” (Ariel, 62)

They even sought professionals adopting such a comprehensive perspective:

“[S]he [chiropractor] tends to look at her care of me holistically. I'm not just a skeleton. I have other needs as well.” (Yvette, 67)

“I'd like them to be well informed on what is out there in terms of both sides, the pharmaceutical and the supplements and the whole body/mind approach preferably...So balanced and informed in their approach.” (Nancy, 62)

In essence, many seniors felt that it was important to treat the entire person, as opposed to only the physical manifestations of disease. They believed that illnesses had a variety of underlying causes, beyond physiology, that needed to be explored in order to manage disease more effectively. This type of complete care, however, was thought to be missing within conventional approaches, typically focusing on pieces of a person. Accordingly, several older adults considered other more holistic therapeutic options. These choices enabled them to maintain a sense of equilibrium in later life so that they could possibly escape the deterioration of old age.

Discussion:

The purpose of this paper was to explore the meanings underlying seniors' use of complementary and alternative medicine (CAM). It was found—as in Cartwright and Torr's (2005) study—that conventional medicine provided the comparative framework against which respondents contrasted and defined their experiences with alternative healthcare. The results also indicate that older adults were attracted to unconventional treatments for a variety of reasons and attached a broad range of meanings to their use of CAM. It is important to note, though, that these meanings were not 'mutually exclusive' or 'fixed' (Pawluch et al 2000). Seniors, in other words, found unconventional therapies to be appealing on a variety of levels simultaneously and in short, their experience with alternative healthcare was comprised of many different themes.

Several participants, for example, turned to CAM as *an adjunct to conventional medicine*. Whereas mainstream care was largely confined to acute illnesses and other types of medical crises, CAM was incorporated into regimens as a means to combat more chronic problems. Unconventional therapies were also employed by a number of informants in order to retain their good health, so that they could, in turn, avoid the use of potent prescription medications. When conventional treatment was inescapable, many respondents supplemented these remedies with CAM modalities; this strategy was mostly undertaken to minimize the adverse side effects of drugs and/or to enhance the effectiveness of pharmaceuticals.

This form of medical pluralism is increasingly seen among more than a few patients today, as it allows individuals to choose providers and therapies that can deal best with their particular concerns; they thus do not have to decide on one specific approach for all healthcare issues (Kelner and Wellman 1997b). CAM treatments, for instance, provided several older participants with the relief they needed in a *less invasive* and harsh manner. This perceived 'gentleness' was valued by seniors as it reassured them that—unlike aggressive conventional remedies with their adverse side effects—their quality of life would not be jeopardized in any way. Similarly, CAM professionals offered many respondents the attention they craved during consultations but were not receiving through conventional channels. *Providers' careful consideration* was greatly appreciated for many reasons, but especially because it allowed older adults to feel safe and discuss openly their age-related difficulties without fear of belittlement or disrespect. Together, these findings concur with those of Andrews (2002), who further adds that this combined use of systems in many ways challenges the dominance of conventional medicine, as well as the stereotypical image of seniors as passive users of healthcare—individuals who rarely verbalize their views or question professional authority.

The attraction to CAM, nevertheless, extended beyond these general elements. A number of informants specifically revealed that they also were drawn to the *naturalness of alternative healthcare*. This purity was frequently equated with safety and therefore older adults were not fearful—as they were with synthetic conventional remedies—of experiencing a host of negative side effects. Kaptchuk and Eisenberg (1998: 1061) attribute this understanding to the commonly held belief that nature is innocent and wholesome. Hence, "by using natural treatment or changing one's life habits to conform

to ‘nature’s’ norms, a person connects to what is perceived to be a less artificial version of personhood.” These views surrounding the naturalness and alleged harmlessness of unconventional therapies is highlighted in many studies. It has been found to play a key role in both older and younger individuals’ decision to use CAM (Andrews 2003; Andrews 2002; Boon et al 2003; Cartwright and Torr 2005; Connor 2004; Furnham 2002; Shumay et al 2001; Siahpush 1999ab). These properties, however, tend to be particularly valued by aged users because they frequently suffer from various chronic conditions for which conventional care can only offer harsh and aggressive solutions.

Apart from these attributes, older adults expressed further interest in CAM due to factors tied to lifestyle. Several respondents spoke about making changes to their diet and exercise regimens, and revealed that the ethos of many unconventional treatments fit well with these healthy choices. Seniors additionally disclosed that they would often reflect on their remaining years, and hoped that use of CAM therapies would help them to preserve their self-sufficiency for as long as possible; in essence, they wanted to endure later life with the least amount of difficulty or disability. Participants, therefore, accepted CAM as part of their aging lifestyle and explored unconventional practices as a strategy to *maintain good health and ensure their well-being* overall.

As part of their long-term plan, many older adults also used alternative healthcare as a *preventative approach* against specific conditions. Respondents, in particular, feared a number of illnesses— especially those causing physical and/or mental incapacitation— and thus attempted to avert these diseases for as long as possible. These general measures were deemed practical and necessary in order to ‘boost the system’ and thereby, help the body heal using its natural forces—much like in Boon et al’s (2000) sample of breast cancer survivors. This desire to retain a sense of wellness is commonly found among users of CAM (Kessler et al 2001; King and Pettigrew 2004; Sternberg et al 2003; Williamson et al 2003). In fact, over half (58%) of the participants in Eisenberg et al’s (1998) study reported having this expectation. Seniors, nevertheless, felt that this goal was unattainable via conventional treatment, as they described it as being more focused on illness and the control of symptoms. Informants, in other words, understood that the two systems differed in their scopes of practice, but still believed that each had its own unique benefits to offer them.

One particular advantage of CAM highlighted by a number of seniors was that it addressed their healthcare needs in a *holistic* manner. This type of multifaceted care— involving harmonization and balance of the whole body—was deemed to be missing within conventional approaches, as physicians generally looked at the individual in ‘pieces’. Several participants, in contrast, felt that consideration of the mind, body and spirit as inter-relating entities was important in later life, namely because of all the changes that normally take place during old age (e.g., retirement, widowhood, physical decline) which can have an impact on overall health and well-being. Seniors, therefore, sought CAM practitioners that adopted such an all-encompassing approach and even attempted to seek medical doctors subscribing to this type of philosophy. Such an attraction to holism among CAM consumers has been well-documented by a number of scholars as well, including Astin (1998), Pawluch et al (1994), Siahpush (1999ab), and Furnham and colleagues (Furnham 2000; Furnham 1994; Furnham and Beard 1995;

Furnham and Bhagrath 1993; Furnham and Forey 1994; Furnham and Kirkcaldy 1996; Furnham and Smith 1988; Vincent and Furnham 1996).

Overall, these different themes contributed to older adults' continued interest in complementary and alternative medicine. In the literature, these and other factors are often presented in terms of a push/pull debate (Kelner and Wellman 1997a; Sharma 1990; Vincent and Furnham 1996). That is, users are said to be either pushed away from conventional medicine and thereby pushed towards CAM or pulled towards unconventional therapies and in turn pulled away from conventional care (Low 2004). The results of this study, however, are unable to support fully such push/pull explanations of CAM use. While participants certainly expressed dissatisfaction with conventional care, this discontent was not the prime motivation underlying their CAM use and rather served as one of many factors influencing decision-making. Seniors, in addition, had not abandoned mainstream practices, as they still recognized its benefits alongside its limitations. In line with this finding, Cant and Sharma (1999) argue that CAM users may not be disappointed with conventional medicine per se, but more so with the nature of treatments for a particular condition and, in the case of this research, the quality of relationships with medical professionals. Sharma (1992) further contends that these types of concerns are not limited to consumers of unconventional therapies, as they are also common complaints expressed by the general public. Hence, what these works collectively suggest is that dissatisfaction with conventional medicine cannot fully account for the use of complementary and alternative healthcare.

In addition, pull-based explanations of CAM use are weakly substantiated by the findings of this study as well. Specifically, only four out of the forty-three participants appeared to be drawn towards unconventional treatments. Two of these individuals were particularly interested in the naturalness of CAM. One woman preferred natural therapies because of a serious medical mistake made in her past which prevented her from having children; the second woman revealed that she had chosen a natural way of living and even opted for thermograms in the place of mammograms. The two other respondents confided that they had reached an age prompting them to reflect on their remaining years and thus they were proactively searching for ways to maintain their good health; it was this quest that led them towards unconventional modalities. The remaining informants though, did not express such a philosophical orientation nor did they report that they were 'shopping for an ideology' when they *initially* sought CAM (Low 2004: 50). These participants rather admitted that they had first turned to such practices because their parents had used them, they were recommended to them by loved ones, they were curious about them, and/or they were simply trying to find relief for a condition for which they found little or no help elsewhere. Hence, it was only after they became familiar with CAM therapies and began interacting with other users and practitioners that they came to value such qualities as holism and naturalness. These beliefs were then a product of respondents' participation in alternative healthcare, not the motivating forces behind their use. Push and pull discussions conceal this important temporal dimension. Such ideological factors may, consequently, be better used in understanding why individuals continue to use complementary and alternative medicine (Low 2004; Sharma 1990).

Limitations

Although this study has generated useful findings, its limitations should be acknowledged as well. All informants, for instance, primarily reported having favourable experiences with unconventional therapies. No one admitted that they had encountered any serious problems with CAM and thus there was no mention of the adverse side effects that can accompany some treatments (Jonas 1996). Furthermore, all informants used CAM on a regular basis and considered them to be a vital part of their daily regimens. This focus failed to provide detailed information about new or infrequent users of CAM. It is important to distinguish between these types of consumers, as their experiences and motivations for seeking alternative healthcare are likely to differ as well

Conclusion:

In conclusion, this study has demonstrated that these older adults attached a broad range of meanings to their use of complementary and alternative medicine. What seniors particularly valued about CAM was that these therapies allowed them to assert some degree of control over their health and shop around for treatments that they perceived as being more accommodating to their needs as they aged. Participants, in essence, wanted to preserve their quality of life and endure their remaining years with the least amount of difficulty and disability. CAM was seen as especially beneficial in this regard, as it enabled them to address some of their concerns in what they viewed as a less harsh and aggressive manner. In addition, unconventional therapies offered informants a means by which they could proactively work towards maintaining their sense of wellness and in turn avoid the use of conventional medication. CAM thus represented a way for seniors to care for themselves more comprehensively and overall to experience aging in a somewhat more acceptable fashion.

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Introduction:

As more and more seniors are living independently and longer with comorbid illnesses, their decisions about treatment have become of the utmost importance. This concern not only pertains to the management of a mixed cocktail of pharmaceuticals, but increasingly to a range of unconventional approaches used as well. Indeed, from the little that is known about complementary and alternative medicine (CAM) use in late life, it appears that many older adults are exploring unconventional care (Astin et al 2000; Cherniack et al 2001; Foster et al 2000; Ness et al 2005). Despite this growing interest, it remains relatively unclear *how* seniors actually negotiate their use of CAM, especially when employed alongside medical drugs (Andrews, 2002; King and Pettigrew 2004). It is important to understand the ways that older adults work through—on their own and/or with the help of CAM providers—the different ‘how to’ decisions related to use or put another way, the ‘practical dimensions’ of care (Gillett et al 2002), as it gives some indication about what happens to medicines in people’s homes, outside of the healthcare system (Lumme-Sandt, 2000). Moreover, as the elderly become more involved in a variety of conventional and unconventional health practices, their choices may inadvertently make them more vulnerable to contra-indications and other complications linked to CAM or mixed therapy use (Nichols et al 2005). These trends thus underscore the need to investigate further how seniors manage their regimens and make decisions about their use of unconventional treatments in their everyday lives.

In this paper, I explore how older adults in this study worked through the practical issues related to their use of complementary and alternative medicine. This examination specifically includes a look at the ways in which seniors (1) selected therapies, (2) assessed effectiveness, (3) managed conventional and unconventional care, (4) addressed safety concerns, and (5) dealt with any constraints affecting use. I begin with a review of the literature on the management of medications, considering how many people in both the general public and older population negotiate their use of medical drugs, as well as, CAM in their daily lives. Next, I describe the theoretical and methodological approach that guided my work. I then present my results. What will be revealed from my thematic analysis is that—contrary to popular belief—seniors assumed much control over their treatment regimen and in this way challenged the stereotypical image of the passive older patient.

The Management of Medications in Everyday Life

One of the primary concerns in the medical literature on the management of medication is non-compliance. It is in fact estimated that as many as 50-70% of patients and an even higher rate of chronically ill persons do not take their medication as prescribed or, more generally, do not follow their doctor’s directives (Wertheimer and Santella 2003). While the incidence of this type of behaviour has sparked much concern within the medical community about the safety of the patient, social scientists have approached this issue from an alternate angle. They specifically argue that the entire notion of ‘compliance’ presupposes a medically centered orientation and mainly serves to define the nature of the patient-provider relationship from the medical profession’s

worldview (Conrad 1987; Conrad 1985; Donovan and Blake 1992; Trostle 1988). Individuals' conduct is thus primarily judged "in terms of physicians' authoritative knowledge, which assumes that doctors hold the only valid explanations of illness and advise the most appropriate behaviour" (Hunt et al 1989, 315). Accordingly, when people's health-related choices seem to challenge this power or expertise, their activities are deemed troublesome and treated as deviant. From the patient's point of view, however, such practices are understood quite differently and, once they are seen in this light, another perspective on 'compliance' becomes clear.

Indeed, people have their own views about taking medication. Most sufferers of illness, especially chronic illness, spend just a small part of their lives in the 'patient role', and therefore the medical relationship may not be the sole or the most salient element affecting their care-related choices (Conrad, 1985; Conrad 1987; Roberson 1992). The advice from doctors, in essence, has to compete with the beliefs and recommendations of various others before a person decides for him/herself which course of action is most appropriate and effective (Donovan 1995; Donovan and Blake 1992; Zola 1980). Individuals thus behave as *active agents* (Conrad 1985; Stimson 1974) in their treatment plan or, put another way, as *smart consumers* (Kelner and Wellman 1997) rather than as passive and obedient recipients of medical advice. What this basically means is that "they have experienced a shift in thinking about themselves as 'patient' to viewing themselves as owner of their body, acknowledging that they are the experts in what works best for them" (Paterson et al 2001, 336). The physician's orders, as Conrad (1985) explains, then become the *prescribed medication practice*, and the rational interpretation of these instructions—within the context of lay beliefs and everyday life—constitutes the actual *medication practice*. In his landmark study (1985), for example, a number of participants altered, in varying degrees, their epilepsy-related regimen in an attempt to (i) meet their day-to-day social needs (e.g., exam stress, alcohol consumption), (ii) test the progression or existence of their condition, (iii) manage perceived levels of dependence on family, friends, doctors, or drugs, and (iv) minimize the potential stigma associated with taking pills in public. This kind of *self-regulation*, however, was not conceived by informants as a form of non-compliance, but rather as an alternate strategy to achieve a sense of normality and, moreover, to exercise greater control over their health and illness.

Foote-Ardah (2003) extends this framework on the management of regimens, and further contends that taking medication can be understood as part of an individual's overall *treatment practice*. This not only includes the prescribed medication and medication practices, but also a third type that she identifies as the *CAM practice*. The latter is different from the two aforementioned elements in that it includes remedies that are not medically prescribed but often self-prescribed. It also shares similarities with the medication practice, as both are self-regulated and initiated as a means to cope effectively with daily life. It is not surprising then that people with HIV in Foote-Ardah's (2003) study reported turning to CAM for almost the same reasons that epileptics in Conrad's (1985) work adjusted their medications.

Compared to the work on the management of medical regimens, less direct attention has been given to *how* individuals negotiate their use of complementary and

alternative therapies (Nichter and Thompson 2006). The research that does exist suggests that people usually work through such practical issues in various ways. Some users, for example, rely extensively on their own judgment and, in turn, engage in a process of experimentation to ascertain which remedies and dosages are most appropriate for their particular needs (Nichter and Thompson 2006). Many often feel comfortable proceeding in this manner because they generally tend to view CAM as being natural (Andrews 2003; Andrews 2002; Boon et al 2003; Cartwright and Torr 2005; Connor 2004; Furnham 2002; Health Canada 2005; Shumay et al 2001; Siahpush 1999ab) and therefore relatively safe (in terms of side effects and contra-indications) unless taken in large amounts (Low 2004b; Nichter and Thompson 2006). This method is additionally chosen because of the perceived importance of subjective experience as well as the belief that each person responds to treatment in a unique manner (Boon et al 1999; Caspi et al 2004; Gillett et al 2002; Low 2003; Nichter and Thompson 2006). Product instructions are also frequently deemed vague and confusing, especially in terms of how items should be used and under which conditions (Nichter and Thompson 2006).

Apart from this self-directed approach, decisions about the management and assessment of CAM are also made with the assistance and/or advice of ‘health confidants’—people with whom one discusses health matters (Wellman 2003)—such as family members and friends (Low 2004a; Sharma 1992; Truant and Bottorff 1999; Wellman 2003). CAM practitioners, however, are a favoured choice as well, namely because these professionals are often regarded as being more collaborative than medical doctors and therefore more willing to consider individual views about treatment (Eisenberg et al 1998; Eisenberg et al 1993; Kelner 2003). In addition, most users are generally able to spend a fair bit of time with CAM providers; for this reason, they are frequently able to understand thoroughly the nature of remedies and introduce them into their regimens without worrying a great deal about contra-indications or other adverse effects (Kelner 2003; Siahpush 1999c). Hence, the cooperation and candid communication present within these expert and lay interactions assists consumers to make more informed choices and address better their unique needs. A number of chronically ill persons, in particular, have been found to value the help and support from such trusted sources (Caspi et al 2004; Gillett et al 2002; Thorne et al 2002), although many coping with acute conditions (e.g., cancer) have reported benefitting from this aid as well (Balneaves et al 2007; Boon et al 1999; Ohlen et al 2006; Truant and Bottorff 1999). Sharma (1992) attributes this reliance on counsel to the personal nature of unconventional treatments. Wellman (2003) further adds that these recommendations essentially provide people with a sense of legitimacy, given that remedies are not formally approved by medical science. Accordingly, when health networks are large and varied, consumers are more likely to be involved in a variety of complementary and alternative approaches (Wellman 2003).

Another equally important influence on users’ decision-making is the media (Boon et al 1999; Kelner and Wellman 2003; Low 2004a; Robinson and Cooper 2007; Sharma 1992; Wiles and Rosenberg 2001). Indeed, magazines advertise an assortment of products (e.g., nutritional supplements); scientific journals discuss the most up-to-date research findings (e.g., about safety, efficacy); and both popular books (e.g., books

written by Andrew Weil, Deepak Chopra) and broadcasts (e.g., radio, television) offer insight to a variety of CAM-related topics. More recently, the Internet has also become a widely used tool. Although some material retrieved online is regarded as questionable, this medium has undeniably allowed people to access easily a broad range of information and in this way facilitated their ability to shop around for the best products and services (Cohen et al 2001; Fox and Rainie 2002; Kelner and Wellman 2003).

Overall, it is likely that a number of factors come into play to influence which therapies consumers select, and how they ultimately decide to use and assess them. Truant and Bottorff's (1999) study is particularly illustrative in this regard. Using grounded theory, these scholars explore the decision-making process surrounding use of CAM within a sample of women coping with breast cancer. Their interviews reveal that, while participants did not abandon conventional measures, unconventional therapies represented a means for them to regain control during a time of uncertainty in their lives. In the initial phases of their illness, they expressed a sense of desperation to cover all their bases and, as a result, quickly selected treatments based on their prior experiences or on the counsel of trusted others. Once this pre-surgery urgency had passed, they then carefully considered an assortment of therapies that they viewed as being compatible with their individual beliefs (i.e., made sense to them), and further modified their regimen according to the perceived effectiveness of remedies. At this stage and those following, lay persons were turned to again for guidance; however, complementary therapy practitioners and print media were consulted as well. Medical doctors were rarely contacted for information about CAM, and few women disclosed their interest in these practices to physicians, namely because they wished to avoid any type of negative response and/or felt that these professionals were unapproachable or otherwise uninformed about treatments. Respondents, therefore, only turned to these providers for assistance with their conventional care and essentially depended on other available resources to make appropriate choices regarding their unconventional regimen.

In sum, while doctors expect patients to comply with their medical instructions, patients do not always firmly follow their advice. Many instead rationally make their own decisions about how to take medication and, in this respect, create a "medication practice". Such behaviour, however, is generally not viewed by consumers as a form of non-compliance, nor is it usually intended to be a deliberate attempt to disobey the physician's orders. This style of management rather serves as a means for people to accommodate better their unique needs and to use medication more appropriately within the context and constraints of everyday life. To this end, many also introduce different types of complementary and alternative therapies into their "treatment practice"; they negotiate these remedies in the same active manner, largely using information acquired from a range of informal sources. It thus seems that, on the whole, the notion of scientific efficacy plays only a limited role in individuals' decision-making, and what instead appears to be increasingly important are other more social and emotional issues; similar trends are noted in late life.

Older Adults' Management of Medications

Although older adults are recognized as being significant users of medical drugs as well as combinations of prescription and non-prescription remedies, very little is known about *how* seniors actually negotiate their conventional and unconventional regimens (Belcher et al 2006; King and Pettigrew 2004; Lumme-Sandt et al 2000; McKenzie and Keller 2001). The reasons for this dearth of information are not entirely clear. It is argued though that they may be linked to popular beliefs that aged persons tend not to use CAM and moreover, typically assume a traditional patient role, managing their medication by simply adhering to the doctor's directives; this assumption is often based on their presumed lower levels of education, greater respect for authority figures, and increased dependency on healthcare in later life (Haug 1994). Ballantyne et al (2005), however, contend that this paucity exists because many studies often do not consider all types of drugs used by older adults. In addition, when these different medicines are taken into account, researchers frequently only describe the prevalence of use for each agent individually. Hence, there is inadequate understanding of the elderly's complex medication-taking behaviour and particularly of the ways in which they approach their regimens in their everyday lives.

A number of qualitative works have begun to explore how older adults reason and make decisions about their use of medicines. While some of these studies have reported that seniors tend to play a passive role in the medical encounter and thereby allow physicians to make appropriate choices for them (Berman and Iris 1998; Goodsell 1981-2; Kelner and Wellman 2000; Low 2004b; Lumme-Sandt et al 2000; Lupton 1997), more than a few have also indicated that many aged persons prefer to manage actively their own care (Berman and Iris 1998; Conway and Hockey 1998; Dill et al 1995; Lumme-Sandt et al 2000; Townsend et al 2003). Lumme-Sandt and Virtanen (2002), for example, found—via focus group discussions—that the majority of their elderly participants applied their own initiative and assumed responsibility for their medication (i.e., prescription and over-the-counter drugs), even though they highly respected their doctors. This sense of independence primarily stemmed from their belief that each individual is ultimately accountable for their own health and well-being. Therefore, one cannot blindly follow medical advice. Many respondents opted not to use certain prescribed drugs because of perceived side effects and other hazards associated with synthetic products, or else consumed items in minimal doses; this course of action was deemed prudent and practical. There were a small number of informants (i.e., 3 out of 34) who did not adopt such an autonomous approach. These people took great pride in their compliant behaviour and felt that it was a vital aspect of their 'life-control'. Overall, though, most preferred to make their own decisions—based on biomedical and other logics—as it enabled them to gain a more meaningful place in their treatment program and in short to control the degree of risk posed to them by their drug regimen.

This type of hands-on approach is seen not only in relation to the management of conventional remedies in later life. Many seniors, increasingly, have also been found to negotiate their own use of complementary and alternative medicine (CAM) (Andrews 2003; Arcury et al 2005; Boon et al 2003; Kelner and Wellman 2000; Nichols et al 2005;

Wellman et al 2001). Andrews (2002), for instance, observed that a number of older users, in his interview-based study, proactively supplemented their mainstream care with a variety of unconventional practices as a result of information obtained from magazines as well as other lay (e.g., friends, relatives) and more formal sources (e.g., family doctor). These treatments were used on a regular basis and viewed by participants as an “everyday and common experience”. Although some admitted seeking the advice of alternative health practitioners before working through the practical aspects of care, several others relied primarily on their personal judgment to tailor therapies to their unique needs. In both cases, elderly respondents displayed considerable market knowledge about chosen remedies and the different therapeutic options available to them. It is not surprising then that most managed independently—and in some cases covertly from physicians—their combined use of conventional and unconventional treatments. By adopting such a self-directed approach, many seniors gained a sense of empowerment and on the whole demonstrated their proficiency as healthcare consumers.

In sum, it appears that a number of younger as well as older consumers are actively managing their use of medicines, albeit with the assistance of various formal and informal sources. This initiative is often undertaken in order to meet more effectively individual needs and moreover to accommodate users’ day-to-day lifestyle. While much research has examined this type of rational decision-making in relation to medical drugs, little is known about how people negotiate their use of unconventional therapies, and even less is understood on the subject of older adults’ management of treatment regimens. This dearth of information is surprising given that seniors tend to use more prescription and non-prescription medication relative to other segments of the population and therefore may be more vulnerable to complications (e.g., contra-indications) linked to treatment. As a result, there is a need to understand better the manner in which older persons’ select and use different types of medicines in their everyday lives (Ballantyne et al 2005; Ballantyne 2002). This study begins to address this gap in the literature by focusing on the ways that older adults worked through the practical dimensions related to their use of complementary and alternative medicine.

Methodology:

The overall theoretical framework that informs this study is symbolic interactionism. It is a “down-to-earth approach to the study of human group life and human conduct.” (Blumer 1969, 47) It aims to understand the ways in which people interpret their life-situations, and carry out activities in conjunction with others on a daily basis (Prus 1996). At the heart of this micro level perspective are three simple ideas (Blumer 1969). The first is that people act towards things based on the *meaning* that they have for them. The second premise suggests that these meanings are not inherent to things, but rather negotiated through *social interactions* with others. Objects (i.e., people and things) can thus have an assortment of meanings. These meanings are generally shared in the course of everyday exchanges with others and communicated through the use of language, gestures, and facial expressions. The final tenet describes a process of

interpretation whereby the individual reflects on and modifies meanings in light of the situation facing him/her. Meanings therefore play an important role in action by way of a process of self-interaction (Blumer 1969; Charon 1992; Prus 1996; Wallace and Wolf 1995).

The interactionist perspective is particularly appropriate for my study as my objective was to understand seniors' experiences in relation to the management of complementary and alternative medicine. Moreover, a qualitative approach seemed to be the natural choice as it ensured that the emphasis remain on the individual and his/her unique stories. As Adler (1999, 219) explains: "By promoting participants' views and understandings, qualitative researchers can interpret CAM phenomena in terms of the meanings that people bring to them." An interview format with open-ended questions proved to be beneficial in this regard.

Recruitment of Participants

Requests for voluntary participation in this study were made by placing posters at a variety of locations that would attract a diverse group of older adults (Appendix A). These venues included: a fitness center for seniors, an alternative practitioner's office, health food stores, and recreation centers for seniors. A description of this study was also posted online at various alternative health-related websites. Announcements were made at meetings for seniors helping in the university classroom (senior class assistants) as well. Finally, I sent out a mass e-mail to all my personal contacts (i.e., friends, family, colleagues), requesting that they forward information about the project to anyone who may be interested. Individuals were deemed eligible to participate if they self-identified as a user of CAM, given the subjective and varied nature of what that means to people (Kelner and Wellman 2003). All potential participants, however, were asked to get in touch with me if they wished to share their experiences and take part in the study; the sample was therefore self-selected.

Participants

The sample consisted of 43 older CAM users—15 men and 28 women (Figure 1). This distribution is reflective of the gendered patterns of CAM use outlined in the literature (de Bruyn 2001; Eisenberg et al 1998; Ni et al 2002; Park 2005; Simpson 2003; Tindle et al 2005). Participants ranged in age from 60 to 89 years old, and more than half of the informants were married or living with a partner. They all resided in Hamilton, Ontario and surrounding areas, save one person that lived in Vancouver, British Columbia. The majority of respondents were born in Canada, and did not identify themselves as a visible minority (only one visible minority) or a member of any particular ethnic group. Most reported holding a university degree and belonging to the middle class; yearly personal income ranged anywhere from less than 19K to more than 80K, with several people refusing to disclose details about their earnings. Over three quarters of participants described their health as being good to excellent. Most informants used CAM to control chronic health problems, although some experimented with various therapies to resolve acute conditions as well. The treatments that respondents discussed

using overall included: massage, aroma therapy, reiki, reflexology, vitamin therapy, diets, exercise, tai chi, herbal medicine, chiropractic, acupuncture, Traditional Chinese medicine, naturopathy, homeopathy, Ayurvedic medicine, ear candling, meditation, yoga, and therapeutic touch (Appendix C) (Table 1).

Data Collection

Before data collection began, full ethics approval was sought from McMaster University's ethics board. Once this had been obtained, interviews were set up with potential respondents. Data collection continued until saturation, the point at which no new or relevant data emerged from the interview process (Boon et al 1999).

All seniors that took part in this research were notified both verbally and in writing about the purpose of this study (Appendix D); they agreed to participate in it by providing me with their written consent (Appendix E). The interviews were informal and took place either in person (n=15) or over the phone (n=28) depending on the participant's preference. Interviews were tape-recorded and I engaged in on going note-taking as well in order to preserve the authenticity of informants' expressed ideas and feelings. The length of the interviews ranged between thirty minutes and two hours.

The interview guide consisted of open-ended questions in order to encourage discussion with the informant (Appendix F). The order of questions varied per interview and was contingent upon the content of the previous response. All participants, however, were asked the same questions and probed for clarification. Some of the key issues that were explored with consumers included: (1) effectiveness of treatments, (2) trusted sources of health-related information, (3) management of mixed therapy regimens, and (4) safety concerns. Formal definitions of CAM and conventional medicine—such as those focusing on *what* is being used (e.g., herbs, pharmaceuticals, dietary supplements) or *who* is providing care (e.g., medical doctor, self, naturopath)—were not given to participants. Informants were instead asked to define the two types of care; they generally described both CAM and conventional medicine in terms of the products/services that they were using (i.e., what) *and* the person providing them with these products/services (i.e., who).

Data Analysis

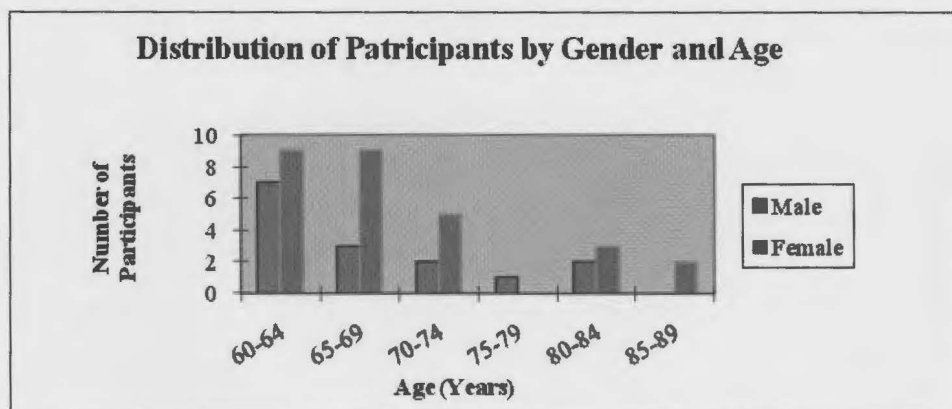
After the interviews had been completed, they were transcribed verbatim and entered into QSR Nud-ist 6.0—a qualitative data management and analysis program—for thematic analysis. An initial, draft coding scheme was developed, largely reflecting the general topic areas covered in the interview guide. During and after the conduct of interviews, though, it became clear that additional codes and sub-codes were needed to capture new themes that were mentioned repeatedly by participants (e.g., naturalness). These issues often were not explicitly addressed in the interview questions. New and unanticipated codes thus emerged from both the interview and analysis process. My overall objective was to gain an accurate and in-depth understanding of how older adults worked through the practical dimensions of their CAM practice.

Table 1. Demographic Profile of Participants

<p><u>GENDER:</u></p> <ul style="list-style-type: none"> Females: 28 Males: 15 <p><u>AGE:</u></p> <ul style="list-style-type: none"> 60-64 years: 16 65-69 years: 12 70-74 years: 7 75-79 years: 1 80-84 years: 5 85-89 years: 2 <p><u>MARITAL STATUS:</u></p> <ul style="list-style-type: none"> Married/ living with a partner: 28 Divorced: 4 Widowed: 6 Separated: 3 Never been married: 2 <p><u>LIVE ALONE:</u></p> <ul style="list-style-type: none"> Yes: 14 No: 29 <p><u>HEALTH (self-rated):</u></p> <ul style="list-style-type: none"> Excellent: 11 Very good: 10 Good: 14 Satisfactory: 5 Poor: 2 Did not respond: 1 	<p><u>PLACE OF BIRTH:</u></p> <ul style="list-style-type: none"> Canada: 31 USA: 3 Czechoslovakia: 1 Finland: 1 Jamaica: 1 Holland: 2 Pakistan: 1 Scotland: 1 England: 2 <p><u>ETHNICITY*:</u></p> <ul style="list-style-type: none"> Canadian: 6 British: 6 Jewish: 1 Ukrainian: 1 Irish: 4 Austrian: 1 Finnish: 1 Pakistani: 1 Mayan: 1 German: 1 Scottish: 2 French: 1 Does not identify with any ethnic group: 22 <p><u>VISIBLE MINORITY:</u></p> <ul style="list-style-type: none"> Yes: 1 No: 42 	<p><u>HIGHEST LEVEL OF EDUCATION:</u></p> <ul style="list-style-type: none"> Some high school: 3 High school: 4 Some college: 3 College diploma: 4 RN training: 2 Some university: 2 University certificate: 1 Bachelor's degree: 11 Post graduate degree: 13 <p><u>SOCIAL CLASS (self-rated):</u></p> <ul style="list-style-type: none"> Upper class: 1 Upper-middle class: 13 Middle class: 22 Working class: 4 Retired: 2 Did not respond: 1 <p><u>INCOME:</u></p> <ul style="list-style-type: none"> 19 999 or less: 2 20 000 to 39 999: 8 40 000 to 59 999: 9 60 000 to 79 999: 7 80 000 or more: 5 Did not respond: 12
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*some participants identified themselves as belonging to more than one ethnic group

Figure 1. Distribution of Participants by Gender and Age



Results:

In this section, I will explore how older adults: (1) selected CAM therapies, (2) assessed the effectiveness of these treatments, (3) managed conventional and unconventional approaches, (4) addressed safety concerns, and (5) dealt with any constraints affecting their use of CAM. Results are presented using a narrative format and the organization of findings is inspired by the work of Gillett et al (2002), who examined the management and assessment of CAM use among a different population of users, namely those coping with HIV/AIDS. Overall, I will describe and identify patterns and regularities in what follows; however, the voice of informants will be used as much as possible in order to provide an accurate representation of their practical concerns. The quotations used below are indented, and the age¹ of respondents is given along with a pseudonym in order to protect the identities of these individuals.

Selecting Complementary and Alternative Therapies:

While many older adults relied heavily on the recommendations of their physicians and pharmacists when choosing conventional remedies (prescription and over-the-counter medication), complementary and alternative therapies were often selected based on expert and/or lay opinions. Several participants, for example, revealed that they experimented with various CAM modalities after hearing about them from family and/or friends:

“[E]very time I said to anybody that got migraines it was 'Oh, have you tried feverfew [an herbal remedy]?' So I tried it. I guess some things I try and see. (Ellen, 62)

“That Lakota product has been on the market for two years or more...I just started taking it. It's taken me that long, but I've had enough feedback from other people like family members and friends that have been using it and found such great results.” (Jennifer, 67)

A number of men, in particular, reported using different treatments as a result of their partner's research and advice:

“I listen a lot to my wife...I rely on my wife for that [CAM information] with her [graduate] training, particularly of omega 3.” (Eric, 62)

“[W]e sit down and we determine both from the studies and based on my age and on my experience what supplements are probably needed in my diet. And I'm very, very fortunate. My spouse is a biochemist. I trust him.” (Martin, 62)

¹ Participants identified themselves as belonging to an age group (e.g., 60-64 years old) rather than disclosing their specific age. The age listed, therefore, is the average age of this age group (e.g., an individual reporting their age as being between 60-64 years is listed as 62).

Suggestions made by sales associates at health food stores were also perceived by some as being reliable and even sufficient to start using new products:

“I got the hot flashes; terrible ones. And I was in the health food store. Asked the chap in there if there was anything for such a thing and someone else was asking the same question and he said 'Yes, this is it. Newfem.' Took that and I was fine.” (Halle, 82)

Although seniors understood that each person can respond to unconventional remedies in different ways, many claimed that the potential benefits of CAM could only be uncovered if they actually tried therapies. They were generally not fearful of encountering any adverse effects, primarily because they trusted the people who were advising them. The positive experiences and perceived knowledge of these individuals convinced informants that they too could find relief for their age-related conditions (e.g., arthritis, menopause), especially those for which conventional care could only offer a harsh course of action.

Apart from this guidance from loved ones and retail workers, several older adults also valued professional counsel. Though not all participants consulted CAM practitioners, those that did obtain this type of help admitted that they depended on these providers to recommend appropriate treatments and reassure them that these choices did not interfere with their conventional regimen:

“[T]he main help there was X ... He's trained in massage therapy and traditional Chinese medicine, so I would pick his brains and slowly, very, very slowly, introduce things that first of all would support the antidepressants and work with them, not interact. (Nancy, 62)

“Dr. XX [alternative practitioner] writes it [treatment] down...it's a prescription with all the dos and don'ts and when to take it and of course...he asks you first what you're on. He has a list of all the stuff I'm taking before he recommends a certain thing. (Nadine, 87)

A small minority of seniors sought such aid from their medical doctors; however, a number of informants felt uncomfortable addressing these issues with physicians and further felt that these professionals lacked adequate knowledge about CAM. Pharmacists, in contrast, were perceived as being well informed about both systems of medicine. Many respondents thus readily turned to these individuals for assistance:

“I talk to the [pharmacist]... He's got a pretty good view of everything. He can tell you what's good on both sides of the fence so to speak. (Roger, 62)

Several participants, in fact, admitted that they relied more often on their pharmacists than their actual physicians because they were more accessible, less judgmental and overall in a better position (due to their knowledge base) to watch out for them and prevent the occurrence of any negative consequences (e.g., contra-indications).

Another commonly reported means of selecting CAM therapies was through print media. Several older adults specifically revealed that they opted to use various remedies after reading about them in newspaper and/or popular magazine articles (e.g., *Prevention*, *Vitality*):

“[W]hen I read an article and it says it's good for something I usually consider it if I'm not getting very much of it. For instance this Vitamin D. Vitamin D I read in this article and I thought, you know, I think I should add that to my list.

(Allison, 72)

“I would read about something, you know, that my body might not have and I read about it in *Vitality* magazine or like this goat weed stuff that I got for my bladder and if I find it doesn't work I just quit. (Evelyn, 67)

These participants generally did not hesitate to try treatments that sparked their curiosity because they believed that they could simply stop using them if they turned out to be unsatisfactory. As a result of this casual attitude, many of these seniors did not bother to research extensively remedies (beyond the initial source) before use; some even claimed that looking at works with lengthy reference lists was not necessarily helpful because this information could be forged.

There were, however, a number of informants that disagreed with this stance and instead preferred to investigate thoroughly an assortment of therapies before deciding on one specific modality:

“I'm not just going to take a piece of internet information and go with it. I wouldn't do that... You [also] need more than just that [recommendation from loved ones]. One source of information is not going to make me take something. I would really want to research it.” (Lionel, 62)

Respondents expressing this type of perspective essentially believed that it was important to gather information from a range of sources, in order to be able to evaluate critically the value of different treatments. This exploration generally included consideration of personal testimonials, as well as facts obtained through well-established research journals and other media outlets (e.g., internet, lay publications, radio, and television).

Overall, though, older adults relied most on their own judgment and intuition when selecting CAM therapies. While lay and professional advice was taken into consideration, seniors largely believed that they knew their bodies best and therefore opted for treatments that would accommodate their late life needs most appropriately. Participants, in essence, wanted to preserve their quality of life and endure their remaining years with the least amount of difficulty or disability. The wide array of unconventional choices facilitated this outcome by allowing respondents to manage their age-related conditions in ways that were more acceptable to them. Alternative healthcare thus enabled informants to experience old age somewhat on their own terms, and further made it possible for them to reduce, to some extent, their dependence on healthcare

practitioners, given that these treatments are not always mediated by professionals. Hence, for many seniors, the actual selection of CAM therapies was a secondary issue. What was instead most important to these participants was that the multitude of available choices made it easier for them to shed the stereotypical role of the passive older patient and assume greater control over their health and well-being by judging what works best for them in later life.

Assessing the Effectiveness of CAM:

Once informants selected and began using CAM, they evaluated the efficacy of therapies in a couple of ways. These methods of validation were subjective as well as objective, and completely differed from the positivistic approaches (e.g., randomized control trials) highly endorsed by policy-makers and medical practitioners. Indeed, a number of respondents did not require or rely on scientific evidence when determining the effectiveness of their unconventional care, and some further claimed that such proof was unnecessary because of the success of many CAM practices over countless centuries:

“[G]inseng or one of the herbs that had been used for 5,000 years in China...somebody wants to do research on it. Why would you do that when it's worked for many, many, many years in China? Why would you even think of bothering to do research?”
(Anna, 62)

These individuals were thus more likely to assess the value of treatments based on their personal experiences. That is, if they sensed a physical and/or mental difference after use, they concluded that remedies were working for them. Amber (age 82), for example, knew that Reiki was helping her because she felt taller and more relaxed after her sessions:

“[A]fter Reiki I always feel taller somehow, as if I'd straightened out. You know, everything was crunched up. And I have this feeling of being taller and my skin is very soft as if all the impurities, the things which have gone through my body which have been sort of stuck. And I always feel that way and also relaxed.”

Norbert (age 72), on the other hand, did not report these immediate effects, but still believed that CAM was beneficial because he felt more energetic over time:

“Oh, it's [ginseng tea] invigorating...really you feel [it] after you have taken it for a couple of months, at least. You feel a little difference in you, like you feel more energetic, more active...[but] none of these things will affect [you] right away like you are taking ah, shot of whisky.”

Participants who did not encounter such positive outcomes—usually within a three-to-six month time frame or after tweaking their regimen on more than one occasion—typically abandoned products and/or therapies and opted to explore other unconventional avenues.

There were, however, several older adults who did not depend as heavily on their own perceptions when assessing the efficacy of CAM. While these seniors certainly took into account their individual experiences, they recognized that more objective measures were also needed to judge adequately the usefulness of any type of care. One particular approach favoured by more than a few informants was laboratory tests. Results indicating an improvement in health were interpreted by participants as a sign that unconventional therapies were indeed working:

“[W]hen my cholesterol appeared to be a little high we did some reading and took a look at taking, as I said, lecithin, flax, co-enzyme Q10. Started a regime of that and in about four or five months I guess my cholesterol readings were fine so I would say that would be an effect.” (Lionel, 62)

“So Dr. XX [alternative practitioner] decided he would start with a series of six [chelation] treatments spaced one month apart... So after six months we had another treadmill stress test and it showed whereas before I'd had two serious blockages and one minor one, I now had one minor one. So I went for another six treatments and then I had no blockages showing up on the test, so as far as I was concerned it had fixed my problem.” (David, 82)

Accordingly, treatments were deemed ineffective when medical tests showed that a particular condition was getting worse or not being helped significantly. In these instances, many respondents experimented with different modalities of CAM and/or turned to mainstream care, especially if they were coping with a more serious problem.

All participants, nevertheless, were not able to evaluate the effectiveness of CAM in such a straightforward manner. Some older adults, for example, found it challenging to ascertain whether remedies were of use to them because they were involved in a number of healthful practices concurrently. As a result, they could not isolate the agent(s) responsible for their sense of wellness:

“[H]ow do you know that that [diet, exercise] or the herbal tea or the medication is actually affecting my body? Well you don't. And I've never been involved in any study that's said yes, this is causing the improvement or the medication is causing the improvement. I don't know. But it would be interesting in a study to do that kind of work on the herbs to see if you can come up with any evidence that yes, in fact they do work. As long as you get someone like me who is taking everything, I don't know.” (Evan, 67)

Other informants reported difficulty assessing efficacy because they did not encounter clear-cut effects as they did with conventional approaches:

“Like if you've got a headache, you take a couple of Tylenol and the headache goes away. You know it helps you. Okay? You can't prove that [with CAM]. You can take Udo's oil [for example]. You can't tell it's helping or not. Now they've

got all kinds of testimonials and all that kind of stuff, but then again so does Coca Cola.” (Derek, 67)

“Like if you've got a sore throat and the doctor gives you something for a sore throat and it goes away, you think okay, fine the medicine has worked. But with the CAM stuff I'm never sure if it's really doing what it's supposed to. I don't know if my neuro tubes are getting any brighter or not you know.” (Roger, 62)

This lack of unequivocal proof—in the way of feeling better or improved lab results—was incredibly frustrating for respondents, particularly because they spent a fair bit of money on treatments. Despite this uncertainty, however, a number of seniors did not discontinue their use, as they believed that CAM was not harming them and remained open to the possibility that it could be helping their aging process:

“I've taken Udo's oil which is supposed to help you with your arteries and all that. In fact I just finished a bottle of it...that thing costs like \$25, \$30. Lasts you maybe three weeks. And I can't tell you it helps me or it doesn't help me. But I know this much. It doesn't hurt me that I know of.” (Derek, 67)

Interestingly, though, even when a few of these participants sensed some sort of benefit, they were still hesitant to attribute these outcomes to the efficiency of unconventional remedies and instead questioned whether these effects were merely psychological in nature (i.e., placebo effects).

In short, the majority of older adults in this study assessed the efficacy of complementary and alternative therapies in two main ways: personal experiences and medical tests. That is, some seniors deemed CAM effective if they simply felt better after use, while others required more concrete proof to judge if remedies were working for them. A small number of informants, however, were not able to make any conclusions about the efficacy of unconventional treatments via subjective or objective means. These individuals were largely accustomed to the clear-cut effects encountered with conventional care and thus expressed doubt when this type of evidence was lacking. All respondents, nevertheless, remained relatively committed to CAM because they either hoped or believed that it was helping their aging process and in essence wanted to explore every avenue that could potentially enhance their quality of life. Participants basically wanted to spend their remaining years in an independent fashion and prevent the onset of illness and/or disability. While CAM certainly was used with this objective in mind, seniors conceded that more conventional approaches were also needed in order to establish the best line of defence against the obstacles of old age.

Managing Conventional and Unconventional Approaches:

Although informants in this study were pleased with complementary and alternative therapies, they also underscored the importance of conventional healthcare. Indeed, mainstream medicine was viewed as offering a range of unique benefits and

playing a key role in seniors' health and well-being. Accordingly, more than a few participants reported involvement in a variety of health practices to address their aging needs more comprehensively and to improve the quality of their lives. This effort to combine CAM with conventional treatment, however, generally was not undertaken with the assistance of medical doctors. Many respondents specifically claimed that physicians lacked sufficient knowledge and/or interest in unconventional remedies to provide them with any type of meaningful guidance:

“[H]e [family doctor] doesn't know a lot about them [unconventional therapies] and I understand why they [medical doctors] can't. So there's not much sense [talking to him about CAM]. (Nancy, 62)

“I don't think they [medical doctors] care. I don't think that's [CAM] their focus... my doctor I don't think is really into that and so I've never bothered to ask him about them.” (Lionel, 62)

Several others further added that practitioners were not open to different forms of healthcare and/or simply did not have the time to deal with such issues:

“I just happened to mention it [CAM use] and he [medical doctor] was quite cross... 'How dare he [naturopath] recommend this or that', you know.” (Amber, 82)

“It's hard to talk to her. She's busy. She's in a hurry... She's not easy to talk to now. She's too busy.” (Yvonne, 62)

Older adults, therefore, resorted to alternate means to manage their mixed therapy regimens.

A number of seniors, for example, refrained from discussing their use of CAM with medical doctors and instead turned to them for help with conventional treatments only. Physicians were viewed as being exceptionally qualified in this area and, as such, these informants firmly followed their recommendations:

“I don't play around with the prescriptions cause I think if you start doing that, in my view you're asking for trouble.” (Roger, 62)

“In the case of working with a doctor I tend to be, to stick to their regimen. I tend to consider that a responsible way to deal with them more so than with CAM because it's more informal I guess.” (Oscar, 72)

One participant even explicitly mentioned that he would be willing to cope with dreadful side effects until he had a chance to discuss an appropriate course of action with a professional:

“[M]y view is that these people are well trained, exceptionally well trained and experienced and, you know, even if I had some terrible side effects I would hang with it until I got a chance to talk with him and say 'This is what I'm having. What do you think?' kind of thing.” (Roger, 62)

Complementary and alternative medicine, on the other hand, was used in a more independent and flexible manner yet, interestingly, most stored it alongside their prescription medication:

“I'm not as careful with those [CAM] but I would never miss some of the other [conventional] medications. But I mean I put those [CAM] in my [pill box] the same as I do the other [conventional] medications but if, for instance, I were to miss taking a dosage I would pick out certain [conventional] medications that I'd be sure to take the next time and I could easily leave behind the calcium. But I would never leave behind the [conventional medication] which I take four times a day.” (Rachel, 62)

It is important to note that these respondents were not less committed to their unconventional care, but rather believed that there would be less severe consequences if circumstances prevented them from taking these pills. This difference may, in part, be due to their perception of CAM as a self-prescribed *wellness* practice as opposed to a physician-advised *medical* treatment:

“No I consider you have food that you take everyday and herbal things that you take everyday and you've got medicines. Medicines today are taken uh, to do something, considered to do something that is sort of not right with your body. But all these other things, uh, you're...you're trying to improve what the body already does. So it's not that you're taking these things for...these are not taken for medical [purposes]...they are taken for body enhancement.” (Evan, 67)

“No, I really don't [think of CAM as part of my medical treatment]. Not in terms of the Tiazac [heart medication]. No. I mean that's [conventional medication] all sort of related to my heart and the rest of it is just for my general overall health and wellbeing.” (Roger, 62)

Surprisingly when a particular unconventional product (Glucosamine Chondroitin) was suggested by a family doctor, one older, male informant reported using this item more carefully, and further opted to store it along with his daily pharmaceuticals rather than with the other herbal products he used:

“As far as the Glucosamine Chondroitin I just think probably my family doctor may have suggested it to me and I thought well if he suggested it and it's a herbal treatment, got to be something to it...I take [it] regularly [and] I keep in the bathroom [along with my conventional medication]...The herbal tea, the herbal

stuff, the Echinacea and the tea it's kind of a kitchen thing. The other stuff is a bathroom thing.” (Evan, 67)

These participants clearly differentiated between therapies but nevertheless recognized the value of both types of care.

There were more than a few older adults who exhibited a different style of medication management. These individuals treated CAM and conventional medicine in a similar fashion and viewed both as vital parts of their medical treatment, namely because each uniquely contributed to their sense of wellness in later life:

“Well it all has to do with your health. I mean I wouldn't be taking the alternate ones if I didn't think they were going to be good for my health.” (David, 82)

“I take those [conventional medication] and I'm going to take them for the rest of my life so they're just such an ongoing thing that I don't even think about them. I would not rely on just that. I would definitely have to take my CAM as well. I count CAM very high in my regime but it doesn't mean that it puts my prescriptions in a lesser role. I guess they're pretty much equal.” (Emma, 67)

Seniors remained equally committed to their different regimens and appeared not to discriminate between approaches. Pills, for instance, were placed in medication trays together and taken in the same disciplined manner:

“I keep everything in the same pill tray. It's part of my routine with breakfast and supper meals. I take a certain dosage of the pills whether they're prescription or supplements. It's the same.” (Eric, 62)

While professional (conventional and unconventional) suggestions certainly were taken strongly into consideration before using remedies, respondents ultimately proceeded with what they felt was most appropriate for them. In some cases, this tactic translated into strict adherence and in others it called for a certain degree of adjustment:

“[W]hen I had migraines and I was told [by my doctor that]... I could take up to four pills a day... I discovered that I needed that many [2] in the summer but in the winter I hardly needed any... So I titrated it myself. I eased up on it. I could tell when I was feeling susceptible to migraines and when I wasn't and I just kept adjusting the dose for me and the doctor didn't tell me how to do that, didn't even suggest that I do that, and yet I felt confident enough to do it because I knew how the drug worked and I wasn't thinking that it would be harmful... I felt like I had control there when it was a prescribed drug. So I don't feel more in control when it's pills that I'm taking or vitamin or mineral supplements.” (Ellen, 62)

“I know there's some medications like antibiotics you have to take until the end but the other [pharmaceutical] ones I had a tendency just not to use them except as needed.” (Allison, 72)

When treatments were deemed unsuitable altogether, participants did not hesitate to stop using therapies. One woman, in fact, disclosed that she would periodically take a break from all medication when she began feeling overwhelmed with this process:

“[T]here are times when I get so fed up with taking pills and it's been a couple of years since I've done this, I've just said I'm taking a holiday and I go for two weeks without anything cause I just get fed up with swallowing pills...both kinds.” (Ellen, 62)

These older adults thus asserted much control over their own healthcare and without a doubt preferred to steer their regimens towards what they believed was most suitable for their aging bodies.

Overall, it is clear that seniors did not all manage their regimens in the same way. Some respondents differentiated between therapies and opted to follow conventional treatment (as prescribed) more meticulously, while others used all remedies in the same manner, according to perceived need. Each and every informant, nevertheless, valued the two systems of medicine and believed that both were important to their health and wellbeing in later life. Seniors remained committed users of each approach, and relied on this dual effort not only to maintain their sense of independence, but also to avert the pitfalls of old age in a safe and efficient manner.

Safety Concerns:

One key concern regarding complementary and alternative medicine is that it is ‘unproven’ and thereby risky to use. A number of older adults in this study agreed to some extent with this position, and spoke in some depth about the possible perils of CAM:

“But there are a lot of people out there who don't know that [CAM can be dangerous] and they just think 'I'll take it. It's natural. It can't hurt you.' But it can, it can be dangerous. Overdoses can be dangerous too in some of this stuff.” (Jennifer, 67)

“One of the problems I have with a lot of the remedies you can buy, particularly the herbal remedies are that you never know what you're buying...the label sometimes leaves a bit to be desired.” (David, 82)

They added that such danger was not limited to unconventional care and in fact can accompany all types of therapies, including conventional treatments:

“[R]ecent [conventional] medicines seem not to have been tested long enough or tested properly and there’s so many interactions that have a really negative effect.” (Allison, 72)

“[C]onventional medicine has scientific data to back [it] up... [but] [t]hey've had some failures too, eh? Like thalidomide [drug given to pregnant women to combat morning sickness] was a disaster. So I like to take as little of anything as I can put point blankly to tell you the truth.” (Derek, 67)

Several respondents, therefore, opted to use only small doses, and/or experiment with a minimal number of remedies in order to remain safe:

“I don't take a lot because there can be side effects if you do, but I don't take enough to worry about it.” (Eliza, 72)

“I think I've read enough [to know] that if I were being foolhardy and taking large quantities of a particular CAM that that could cause problems. But I don't take unusual amounts.” (Emma, 67)

Many participants also underscored the importance of being well informed about health matters and, to this end, routinely sought advice from qualified professionals and/or investigated products and services before use:

“I think the consumer has to educate him or herself in order to recognize any problems that there might be with regard to safety...I think you have to know your own body and know how you react to certain things.” (Laura, 67)

“[T]here’s a pharmacist that...does compounding and he has a...a natural mindset okay? But he’s a pharmacist. He knows an awful lot about interactions with herbs. I would always go to the pharmacist and say ‘Okay. My doctor has put me on this medication. What are the contraindications? What should I not use in conjunction with this?’...He’s far smarter than I am in this kind of a situation...and he would tell me.” (Anna, 62)

These measures, together, were deemed the best way to avert contra-indications as well as the onset of any other adverse outcomes.

There was a small group of older adults who expressed a more nonchalant attitude about complementary and alternative approaches. These individuals felt that treatments were relatively benign, and they further claimed that any potential risks associated with CAM would be minor in comparison to those resulting from conventional therapies:

“I don't think that this [CAM] is a serious thing. I think of it as kind of basic. But I don't think of it as anything to really be too concerned about. You know. I really don't think any of that stuff is going to do me in.” (Allison, 72)

“[T]he risk is 100 times less than if I was going to decide to take a pharmaceutical or something from a drug store...the side effects with natural products has no comparison whatsoever. If you had a drug in one hand and a vitamin C in the other hand, um, or you know, just a leafy green vegetable I would see that there would be no comparing that safety issue.” (Audrey, 62)

Informants mostly viewed unconventional care in this manner because they perceived its remedies to be natural and free of any chemical additions:

“I feel they're natural and I'm afraid of this chemical world... all the chemicals and stuff... in these [conventional] pills. I don't like it.” (Alma, 67)

“Well [with CAM] you know that you're putting natural things into your body, they're not chemical.” (Halle, 82)

This purity was equated with safety and, as a result, seniors were not fearful of experiencing a host of negative side effects:

“[The benefit of CAM is that] you'd also have a natural product that would not harm you in any way.” (Frank, 62)

“[A]ll these [CAM] things are from the earth. Like vegetables, fruit...[T]he best thing about these things, if it doesn't do you any good, it doesn't do you any harm.” (Norbert, 72)

Some participants—as aforementioned—also expressed little apprehension because they recognized that they could simply stop or modify treatments if they were found to be unsuitable or ineffective. This flexibility was reassuring for respondents and contributed to their lack of concern for safety issues.

In contrast, all informants conveyed some degree of unease about their physician-prescribed medications. These synthetic remedies were described as toxic substances causing an assortment of iatrogenic effects:

“[T]here are a lot of risks...if you take a prescription drug...sometimes it can cause secondary problems.” (Tamara, 67)

“[E]verybody has got cancer today. Why? Because they're all taking drugs.” (Jennifer, 67)

These adverse consequences were viewed as wreaking havoc on the body:

“[T]hey [drugs] are detrimental on the whole body and the organs. The organs start breaking down and the body breaks down.” (Audrey, 62)

“I think it [drug therapy] brings the body into another stage in un-normal existence.” (Edna, 67)

A number of seniors, therefore, attempted to address their aging needs via unconventional means as much as possible because they were seen as being less hazardous to health:

“I prefer not to take prescription medications because of side effects that come from them whereas the alternative medicines are more natural. (Yvette, 67)

When this route was unavailable to participants, many continued to use CAM alongside conventional approaches, namely because it provided some sort of safeguard against the possible risks of mainstream medicine and, more generally, against the potential obstacles of old age.

Overall, many older adults appreciated complementary and alternative healthcare because it allowed them to address their aging needs in a less harmful manner. Several respondents were coping with a variety of chronic conditions, and the nature of unconventional treatments essentially reassured them that they would be able to manage these problems without experiencing any significant difficulties. This safety was regarded as a refreshing change from the complications of conventional remedies. A number of participants, however, disagreed with this stance and acknowledged that danger can also be present when dealing with CAM. These seniors thus opted to use all therapies with caution, and additionally ensured their well-being in later life by attempting to become—despite some constraints— informed consumers of healthcare.

Constraints Affecting CAM Use:

Older adults are often not viewed as significant users of complementary and alternative medicine because of a variety of age-specific factors (e.g., fixed income) that are believed to inhibit the use of these therapies in later life. Though a number of seniors in this study confronted different obstacles while exploring remedies, these constraints did not prevent them from experimenting with CAM, but rather appeared to limit somewhat the extensiveness of their use. Many (self-prescribing) respondents, for example, reported that they did not participate in a wide array of unconventional therapies because they were overwhelmed with the range of choices available to them and felt that they simply did not have sufficient knowledge about these products to use them in an appropriate fashion:

“You go in there there's hundreds of different things you can buy and I don't have the knowledge so I just can't take them... some of the stuff in the store I don't even understand what the hell it is. I can read the label and I still don't understand.” (Derek, 67)

Several participants, therefore, refrained from trying new remedies and instead chose treatments that were well-known or else recommended by family and/or friends. There

were some informants who attempted to learn more about unfamiliar modalities, but a number of these respondents still found it difficult to ascertain which therapies were most suitable for them. One older, male participant attributed this ambiguity to the absence of qualified CAM practitioners in Canada:

“Oh not here. I don't know anybody here. In Pakistan, yes plenty of people. But I don't know anybody who is an expert; there might be some, what say there, quacks! I'm not too sure but in Pakistan there are people, there are people who can [help].” (Norbert, 72)

Others, in contrast, discussed the dearth of sound research available to them. While the majority of older adults were able to get hold of a wealth of information, via the Internet and/or other traditional means (e.g., library), many questioned the reliability of this material:

“Well another barrier for me is finding good information ‘cause I don't trust the publications that health food stores put out. I'll look at them but I take them with a grain of salt. First of all I need to figure out if it makes sense to me metabolically and then I need to go see what the research has been on it. And so, you know, it's not readily available. It's not easy to find.” (Ellen, 62)

“I wouldn't be able to read medical literature, but kind of popular material, sometimes on the internet or magazine articles or something that would give me some background. That kind of literature you can't entirely trust though... it's probably not going to be scientific and thoroughly critiqued.” (Oscar, 72)

More than a few seniors thus relied on their own judgment and addressed their aging needs in ways that they deemed most fit.

Apart from this scarcity of adequate information, some informants expressed difficulties gaining access to certain unconventional treatments as well. Participants specifically mentioned their interest in various products and practices that were either scant or else only available in the United States. The latter case was especially frustrating for respondents because they found the journey across the border to be inconvenient and not always possible. Moreover, when items were ordered via postal services, seniors reported that goods were frequently delayed or rejected due to Canadian rules and regulations. An older woman, in particular, spoke at great length about her trials and tribulations with importing a potent and pure form of Omega 3:

“[W]e can't get the Sears Lab product [Omega 3] in Canada. They won't ship it across the border because Canada will not let it in. They will let some things in but they won't let others. They'll let the bars in that have the omega 3 in them but they won't let the pills...the purest form is an ethyl ester instead of being a triglyceride so it's in a different chemical form and they won't let it in.” (Ellen, 62)

She later outlined the challenges that her practitioner faced when trying to obtain an ingredient for Prolotherapy²:

“Like the worst of the pain was alleviated by the Prolotherapy but I’m still having my sacroiliac joints slip and get into bad positions and get stuck there and then that’s somewhat painful...[the practitioner] ordered a different ingredient for [Prolotherapy] injection that has a reputation for working better... he couldn’t find a source in Canada and then he found a source in the United States and they wouldn’t ship to Canada and then he found a course in the United States that would ship to Canada. So it’s here... but it took him about two and a half months to get it.” (Ellen, 62)

This situation was incredibly stressful for her, as this treatment was viewed—by both conventional and unconventional providers—as being the only option available to deal with her painful loose ligaments.

Another factor restricting seniors’ use of CAM was their own ‘Western sensibilities and attitudes’ about health and healing (Gillett et al 2002). A few participants specifically revealed their biases toward science and clinical trials while discussing complementary and alternative approaches:

“[M]y own mind [prevents me from using some therapies]. I mean if I look at some stuff and think 'Oh yeah, that's all very well but how often does it work?' So I tend to be very fact oriented and I guess almost empirical in some respects...[but] if something miraculous were to appear in a report and 'Clinical trials have shown' blah, blah, blah, I might think about it.” (Roger, 62)

“I’m a little bit leery about trying a lot of things that, you know, haven’t been tested. But no. We’re fairly open.” (Robert, 62)

Despite such preconceived notions about the nature of evidence, these individuals remained open to the possibilities of unconventional care. Informants primarily exhibited this type of support because they wanted to ‘cover all their bases’ and protect themselves from the potential problems of old age. These respondents were thus able to put their partiality aside to some extent, namely because their desire to retain their sense of independence outweighed any possible doubts about CAM.

It would seem then that while older adults encountered various obstacles while exploring complementary and alternative medicine, these difficulties did not deter them from using CAM, but rather appeared to constrain their use in certain ways. The most common problems reported by seniors pertained to the quality of available information and the accessibility of specific treatments; however, a number of personal factors appeared to serve as impediments for participants as well. Even with these limitations, informants were able—for the most part—to address their aging needs effectively.

² Prolotherapy is a form of injection therapy used to treat injured ligaments.

Overall, they felt that greater efforts were needed to inform a broader range of aged persons about the possibilities of alternative healthcare. With this added insight, they believed that the elderly could potentially reduce, to some degree, their dependence on pharmaceuticals and thereby experience late life in a more acceptable manner.

Discussion:

The purpose of this paper was to explore how older adults negotiated their use of complementary and alternative medicine (CAM). It was found—in line with the work of Gillett et al (2002) on this same topic but among people living with HIV/AIDS—that participants actively employed a variety of strategies to work through the practical dimensions of their CAM regimen. When selecting therapies, for example, seniors relied heavily on their own intuition as well as on information proactively garnered from a range of sources. The advice of ‘health confidants’ (Wellman 2003) was an especially popular resource, consistent with other studies (Andrews 2002; Sharma 1992; Wellman 2003), as informants trusted the experiences and knowledge of these individuals. In most cases, counsel was sought from lay persons, such as family, friends, and even health food store employees, but the expert opinion of CAM practitioners and pharmacists was taken into account by several people as well. Medical doctors, on the other hand, were rarely approached when choosing different modalities—as indicated in other inquiries (Eisenberg et al 2001; Eisenberg et al 1998; Ramsay et al 1999; Scott et al 2003; Truant and Bottorff 1999)—namely because respondents felt uncomfortable broaching the issue with these professionals. Many seniors thus resorted to other means to make informed decisions about unconventional treatments.

The media, in particular, was a frequently consulted tool, supporting Sharma’s (1992, 5) argument that “it is not possible to discuss the way in which people use complementary medicine without also discussing their exposure to health information provided by the media.” Although the literature is somewhat inconsistent about the actual value of this resource (Low 2004a), more than a few participants in this study acknowledged its usefulness and in addition, admitted that they experimented with various remedies based on material they encountered via popular magazines, broadcasts (television, radio), the Internet as well as research journals (albeit to a lesser extent). Clearly, then, the outlets that many older informants turned to were largely informal in nature; this suggests that seniors were not overly dependent on medical expertise, contrary to certain age-related findings (Arcury et al 2005; Low 2004b; Lupton 1997), and moreover—substantiating previous work (Andrews 2002; Connor 2004; Kelner and Wellman 2003; Low 2003; McKenzie and Keller 2001; Wellman et al 2001)—did not generally require scientific verification to select complementary and alternative therapies.

Similarly, when evaluating the effectiveness of unconventional treatments, several respondents did not base their decisions on clinical outcomes or other scientific measures. A number of participants in fact commented that such technical proof was unnecessary, given the success of numerous remedies over the course of hundreds of years. More than a few seniors thus privileged their own experience above all other sources of information about efficacy, and—akin to Kelner and Wellman’s (2000) sample of alternative therapy

patients—deemed CAM helpful if they sensed a physical and/or mental change. Some older adults, however, reported encountering these effects immediately after use, while others explained, in accordance with “alternative ideologies of healing” (Low 2003; Pawluch et al 1994), that the benefits of CAM were more gradual, arising with continuous care. When informants required further confirmation regarding the value of treatments, many relied on laboratory test results to ascertain efficiency, much like those interviewed by Gillett et al (2002) and Low (2003) respectively. There were, nevertheless, instances on occasion where participants were unable to judge—via subjective or objective means—whether or not remedies were of use; such ambiguity has previously been noted among CAM users living with HIV/AIDS (Gillett et al 2002). The reason for the uncertainty in this study was either seniors’ involvement in a variety of healthful practices concurrently or the absence of clear-cut effects therapeutically. In the latter cases, individuals generally revealed that they were accustomed to the quick fixes of conventional medicine. Interestingly, though, even when such recognizable outcomes were not achieved, several older adults did not abandon therapies. This decision was mainly undertaken because they perceived treatments to be relatively harmless and, moreover, wanted to “cover all their bases” in case they had made an erroneous assessment. It seems then that, on the whole, respondents employed a good deal of rational reasoning in their accounts of efficacy; however, their mode of thinking still at times diverged from that of medical professionals.

This difference in perspective was not limited to only the evaluation of remedies. Indeed, it was also apparent in the way that many informants managed their medications. These individuals specifically approached their conventional and unconventional regimens in an autonomous yet informed fashion, and ultimately proceeded with what they felt was best for them in their everyday lives—a trend increasingly seen among both medical (Conrad 1985; Donovan and Blake 1992; Hunt et al 1989; Lumme-Sandt and Virtanen 2002; Lumme-Sandt et al 2000; Roberson 1992; Rogers et al 1998; Trostle et al 1983) and alternative (Foote-Ardah 2003; Gillett et al 2002; Kelner and Wellman 2000; Lumme-Sandt et al 2000; Nichter and Thompson 2006) patients today. Hence, while they carefully considered the recommendations of physicians and other health practitioners, it was not uncommon for them to modify dosages to create a more acceptable “treatment practice” (Foote-Ardah 2003), and/or to stop using remedies altogether if they deemed them to be inappropriate (e.g., in the case of adverse side effects). Although this type of behaviour is often construed as irrational and non-compliant within the medical community (Conrad 1987; Donovan 1995; Stimson 1974; Trostle 1988; Trostle et al 1983; Wertheimer and Santella 2003; Zola 1980), such “active agency” (Conrad 1985) or “smart consumerism” (Kelner and Wellman 1997) was actually undertaken quite rationally (within the context of their personal beliefs, responsibilities, and preferences) and for this reason may be better labeled—as Donovan and Blake (1992) suggest—“reasoned decision-making”.

This active style of negotiation was often assumed by participants because—again consistent with the “alternative therapy ideology” (Pawluch et al 1994)—they felt that each person is different and thus treatment should be tailored to the individual’s body and condition. This view, as Low (2003) contends, clearly stands in contrast to the

biomedical notion of generic disease. In addition, seniors—like several of those in Berman and Iris' (1998) work—wanted to think for themselves, and further believed that they could do something about their own health and potentially control various aspects of the aging process. Control, in fact, seems to be a key motivator for self-regulation among other groups of consumers as well, such as those coping with chronic illnesses including epilepsy (Conrad 1985; Trostle et al 1983) and HIV/AIDS (Foote-Ardah 2003; Gillett et al 2002). For older adults, however, this authority over regimens appears to be particularly noteworthy because, as Andrews (2002) explains based on his findings, it challenges the stereotypical image of the passive late-life patient.

Such a hands-on approach to the management of medicines, nevertheless, was not reported by all respondents. That is, some informants admitted assuming a more traditional patient role and thereby allowed their physicians to take charge of their conventional care. At first glance, this type of behaviour appears to resemble what is described in Lumme-Sandt et al's (2000) "patient repertoire" and Britten's (1996) "orthodox accounts". The individuals belonging to these two groupings specifically underscored the value of medical opinion and the importance of following the doctor's advice. Upon closer inspection, however, it becomes clear that such classifications are not entirely appropriate for the participants in this study. Indeed, even though older adults voiced sentiments similar to those in the two aforementioned works, the language that many used demonstrated another orientation, one that is closer to what is outlined in Britten's (1996) "unorthodox accounts". In particular, a number of seniors expressed themselves by using active phrases, such as "my view is", "I think", and "I consider this to be". These types of words seem to reflect consumers' personal philosophy as well as their moral ideas regarding medication use (Britten 1996). Hence, while these informants would be regarded as "compliant" according to medical professionals, this adherence was an explicit and conscious choice and for this reason should not be interpreted as passivity.

Interestingly, this style of management was generally not adopted by respondents when using complementary and alternative therapies. Participants, instead, were more likely to negotiate the use of these remedies in a more independent and flexible manner. One explanation for this variation may be older adults' perception of CAM as a self-initiated wellness strategy, as opposed to a physician-prescribed medical treatment. This difference though did not mean that seniors held conventional care in higher esteem, but rather that they were more concerned about the potential risks to their health and wellbeing if they did not adequately follow their practitioners' recommendations. As a result, in line with earlier investigations (Foote-Ardah 2003; Nichter and Thompson 2006), CAM was viewed as being a more viable option for self-regulation.

It would seem then that some informants were comfortable assuming full responsibility for their use of unconventional therapies because they considered them to be relatively uncomplicated and, in short, safe for lay control compared to conventional approaches. This impression may have thus been an added reason why—alongside professionals' lack of knowledge, interest, and open-mindedness—many did not look to medical doctors for help to diversify their regimens. A key factor contributing to this perceived harmlessness was the commonly held user belief that such remedies are essentially natural and therefore free of any chemical or, in other words, hazardous

additions (Andrews 2003; Andrews 2002; Boon et al 2003; Cartwright and Torr 2005; Connor 2004; Furnham 2002; Health Canada 2005; Shumay et al 2001; Siahpush 1999ab). Older adults, in turn, were not fearful of encountering a range of adverse side effects as they were with conventional therapies; as a result, they asserted greater control over their own care. This general conception of CAM, however, can be perilous for seniors because they tend to consume more medication relative to other segments of the population (Ballantyne et al 2005), and thus may be more vulnerable to complications linked to treatment if their regimens are not properly managed (Hoblyn and Brooks 2005; Ness et al 2005). All participants, nevertheless, did not share these types of views. A number of seniors specifically acknowledged the possible dangers of CAM, but further qualified their opinion by stating that risk can be present with any kind of therapy. Hence, these informants attempted to educate themselves about all treatments employed in order to minimize their chances of experiencing any negative outcomes. In addition, some opted to use unconventional remedies in very small doses, suggesting that—like those examined in Nichter and Thompson's (2006) work on dietary supplement use—these individuals regarded CAM to pose a potential threat when taken mainly in large amounts. Despite the recognition of such conceivable problems though, several respondents still revealed a greater unease about the iatrogenic effects of conventional therapies. Accordingly, they tried to address their aging needs safely via unconventional approaches as much as possible.

The effort on the part of seniors to incorporate CAM modalities into their treatment regimens was an easier process for some rather than others. Although older adults did not appear to encounter any significant barriers that completely prevented them from using alternative healthcare, they admitted facing certain obstacles that somewhat constrained the extensiveness of their use. Cost, surprisingly, was not identified among these impediments, but many wished that there were more measures in place, as with conventional medication, to assist with these expenses in late life. The limitations, then, that several respondents dealt with were mostly related to “community resources” and other more “personal factors” (Kelner and Wellman 1997). For example, in line with the work of Gillett et al (2002), a number of participants reported that they felt overwhelmed by the wide range of choices available to them, and therefore primarily selected products and services that seemed reasonable to them, or else were recommended by trusted others; this strategy was regarded as being the most pragmatic because informants simply did not have enough background about the different therapies to make a sensible decision. The main reason given for this inadequate knowledge base was the absence of sound research amidst the wealth of material available to the public; this shortcoming is commonly noted among users of unconventional care (Foote-Ardah 2004; Gillett et al 2002; Low 2004a). One person, however, stated that it was also challenging to make informed decisions because—unlike his homeland Pakistan—there lacked qualified CAM practitioners in Canada. Still, this search for reliable information was not the only hurdle confronting respondents. Consistent with other studies (Boon et al 1999; Foote-Ardah 2004; Gillett et al 2002; Low 2004a), several recounted difficulties gaining access to treatments as well. Such problems largely pertained to the unavailability of remedies in Canada and the struggle to import much needed items from the US due to our national

regulations. Apart from these largely extraneous issues, a few participants further spoke about another more personal limitation, namely their partiality towards clinical data. While these individuals—like those described in earlier investigations (Foote-Ardah 2004; Gillett et al 2002)—were relatively open to the possibilities of CAM, they admitted that their biases at times still got in the way, as they hesitated to give certain remedies a try when these products or services seemed a little too unconventional from their Western point of view. In these instances, seniors thus relied on treatments that were more widespread and, in short, ones that made greater sense to them.

Limitations:

Although this study has generated important findings, its limitations should be acknowledged as well. All respondents, for instance, managed either their use of CAM or their mixed therapy care (i.e., conventional and unconventional therapies) with considerable ease. No one admitted that they had encountered any serious problems and thus there was no first-hand discussion of the adverse side effects that can accompany some CAM treatments, or of the contra-indications that can occur when using different remedies in tandem (Jonas 1996). Furthermore, all informants were regular users of CAM modalities and considered them to be a vital part of their daily treatment regimens. This focus failed to provide detailed information about how new or infrequent users deal with their CAM care, especially when employed alongside mainstream approaches. It is important to distinguish between these types of consumers, as their experiences with alternative healthcare are likely to differ as well.

Conclusion:

In conclusion, this study has demonstrated that older adults actively managed and made decisions about their treatment regimens. Some seniors, for example, chose to adopt a flexible approach with their CAM practice, but elected to pursue another path with their conventional care and allowed their physicians to make appropriate choices for them. A number of other informants, in contrast, opted to use all remedies in an autonomous fashion, and essentially worked through the practical issues related to their use based on what they felt was best for them in their everyday lives. Such proactive behaviour, overall, is becoming increasingly popular in late life, and this trend has important implications for both policy and practice. In particular, it underscores the dire need for the government to financially support efforts geared towards educating the older public about the efficacy, benefits, and possible dangers of unconventional therapies. Physicians and other health professionals, in addition, need to ask seniors about their use and management of all medicines on a regular basis, as older patients frequently fail to mention CAM or consciously decide not to discuss it within medical consultations (Cohen, Ek, and Pan 2002). These types of omissions, however, can be especially deleterious for the elderly, as they tend to consume numerous prescription and non-prescription medications (Ballantyne et al 2005) and for this reason, may be more vulnerable to complications linked to treatment. Hence, if older adults are to remain safe, it is imperative that practitioners clearly communicate with them and understand better

their aging needs. This kind of rapport, in short, will be more beneficial for seniors, and will enable them to make informed and appropriate healthcare choices in later life.

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The purpose of this thesis was to explore why and how older adults used complementary and alternative medicine (CAM)—two key issues that have remained relatively under-explored in the literature, particularly via qualitative methodologies (Andrews 2002). To this end, I conducted in-depth interviews with seniors and specifically asked about their experiences with both conventional and unconventional care. My discussions with participants revealed that many of those being treated medically held feelings of dissatisfaction and distrust for conventional medicine. Though these sentiments were not sufficient for them to be pushed towards other therapeutic options, they certainly played a role in their overall decision-making. These findings stand in contrast to previous work which has observed seniors to be passive users of healthcare—people who rarely verbalize negative opinions or question professional authority (Bury 2000; Calnan et al 2003; Cohen 1996; Coyle and Williams 2001; Haug 1979; Irish 1997; Mellor et al 2006; Wellman et al 2001; Williams and Calnan 1991).

The main complaints that several respondents expressed with regard to physicians broadly pertained to the quality of consultations and the nature of medical training. A number of participants specifically spoke about their disappointment with doctors' narrow-mindedness in terms of treatment and the etiology of disease, as well as their limited range of expertise in key areas, such as gerontology and dietetics. Others further added that they were frustrated with providers' inattentive and/or negative attitude, which essentially discouraged them from sharing their concerns and/or disclosing their use of unconventional therapies to them. The factors that fostered older adults' sense of wariness, on the other hand, generally revolved around practitioners' incompetent behaviour and poor judgment overall. Many, in particular, reported incidents involving medical errors, ranging from mild to almost fatal. Several people also discussed physicians' excessive dependence on pharmaceuticals for each and every problem. Despite these untoward experiences, though, these older adults continued to receive care from their medical doctors; this decision was mostly pragmatic, as seniors were aware of the widespread shortage of physicians and recognized the difficulty in securing another family doctor.

Physicians, however, were not the only source of dissatisfaction and distrust. Indeed, more than a few seniors highlighted their assorted concerns regarding mainstream treatment as well. While the majority of informants conceded that conventional medication was useful and had made a difference in their lives, a number of people were still uneasy about taking pharmaceuticals, namely because they viewed them as unnatural and potentially hazardous to health (e.g., via adverse side effects). Several participants further claimed that such a harsh course of action was not always necessary. What most wished for was treatment tailored to their specific needs in later life, but instead they received a narrow and uniform approach to illness, which they felt often only superficially addressed their condition(s). These overall experiences magnified the limitations of conventional care, and contributed to many seniors' eventual decision to explore new therapeutic options.

Complementary and alternative medicine was a popular choice among older adults; unconventional therapies were used as either an adjunct to or a substitute for mainstream care, depending on the nature of users' health-related problems. In other

words, consumers sought providers and remedies that could best deal with their particular concerns, rather than opting for one specific system to deal with all of their issues (Kelner and Wellman 1997). This form of medical pluralism was deemed the most effective way to optimize their care and compensate for any shortcomings in either approach.

While seniors' *initial* motivations for seeking alternative healthcare often had little to do with actual therapies (e.g., curiosity, personal need), over time they, much like the users in Low's (2004) study, came to greatly value CAM and, in turn, attached an assortment of meanings—flexible in nature—to its practices. Some, for example, admitted that they appreciated unconventional care because they perceived its treatments to be gentle and, on the whole, less harsh and invasive than several conventional options. Others, alternatively, discussed the appeal of their close relationships with CAM providers, which facilitated open communication about their age-related difficulties and abolished any type of fear of belittlement or disrespect. Equally attractive was the naturalness of unconventional therapies. This alleged purity was frequently equated with safety and therefore a number of older adults were not fearful of experiencing a host of negative side effects as they were with synthetic remedies. Owing to these perceived benefits, many seniors turned to these approaches not only to manage their existing conditions, but also for health promotion purposes so that they could live out their remaining years with the least amount of difficulty or disability. As part of their long-term plan, respondents relied on treatments as a preventative strategy as well. Participants feared a number of illnesses—especially those causing physical and/or mental incapacitation—and thus hoped to avert these conditions for as long as possible. CAM was viewed as having the potential to achieve these different objectives and moreover, to do so in a holistic manner. This type of multifaceted care—involving harmonization and balance of the whole body—was important to several informants and, overall, added to the general appeal of alternative healthcare.

Given that seniors regarded CAM as being attractive in so many ways, it is not surprising then that they continued to use treatments and incorporated them into their daily regimens. Participants generally selected therapies based on what they felt was most appropriate for their aging needs, but they also carefully considered recommendations from a number of trusted sources of advice (e.g., CAM providers, family members, friends, etc.) as well as the information they gathered from the media (e.g., magazines, television and radio broadcasts, the Internet). Medical doctors were usually not consulted about unconventional remedies—as indicated in other inquiries (Eisenberg et al 2001; Eisenberg et al 1998; Ramsay et al 1999; Scott et al 2003; Truant and Bottorff 1999)—because many informants felt uncomfortable discussing CAM with them, and additionally felt that medical doctors lacked sufficient knowledge and/or interest in these treatments. For these reasons, several respondents did not rely on them or look to any type of scientific measure to evaluate therapies as well. These individuals, instead, used their own judgment and specifically deemed CAM effective if they sensed a physical and/or mental change after use. Others, however, claimed that they still required more concrete proof and thus supplemented their own perceptions with laboratory tests; results indicating an improvement assured seniors that treatments were in fact working. This evaluation process though was easier for some than for others. That is, a minority of older

adults maintained that it was difficult for them to ascertain effectiveness because they were accustomed to the clear-cut effects of conventional medicine, which often did not accompany various unconventional therapies. Still, despite such uncertainty, not all respondents abandoned these particular treatments; a few of these individuals continued with use, as they believed that remedies were not harming them and, moreover, felt that they could potentially be helping their aging bodies, unbeknownst to them.

It would seem then that older adults' health-related beliefs were not always consistent with those of medical professionals. This divergence was apparent in the ways that some people managed their mixed therapy regimens on a daily basis as well. These individuals preferred to assume full responsibility for their conventional and unconventional care, and ultimately proceeded with what they believed was most appropriate for them in their everyday lives—a trend increasingly seen among both medical (Conrad 1985; Donovan and Blake 1992; Hunt et al 1989; Lumme-Sandt and Virtanen 2002; Lumme-Sandt et al 2000; Roberson 1992; Rogers et al 1998; Trostle et al 1983) and alternative (Foote-Ardah 2003; Gillett et al 2002; Kelner and Wellman 2000; Lumme-Sandt et al 2000; Nichter and Thompson 2006) patients today. Hence, while professional recommendations were carefully considered, it was not uncommon for them to modify dosages or stop remedies altogether based on what their bodies were telling them. This style of active negotiation was undertaken as a means for seniors to address more effectively their unique needs, and to gain more control over their health and well-being. Such a hands-on approach, however, was not favoured by all older adults. Some informants chose to allow their doctors to take charge of their conventional care, as they regarded these professionals to be experts in this field. CAM, on the other hand, was what they managed in a flexible manner, namely because they perceived these therapies to be geared towards body enhancement rather than medical treatment.

Many felt comfortable and capable of negotiating their own use of CAM because they believed that it was safe—relative to conventional medicine—for lay control. A key factor contributing to this assumed harmlessness was, as aforementioned, the naturalness of remedies. There were a number of seniors, though, that disagreed with this stance. These people felt that risk could accompany any type of therapy and as a result generally opted to use treatments in small doses and tried to remain as informed as possible. This search for sound research was often difficult for many participants because they claimed that there were very few sources of reliable information. A number of older adults thus hesitated to try unfamiliar products and services amidst the overwhelming range of choices available to them. Others reported not using certain remedies because it was problematic for them to get-hold of these items, or else they just seemed too far-fetched from the Western biomedical point of view that still dominated their thinking. Seniors, therefore, mostly relied on therapies that were more widespread and, in short, ones that made the greatest sense to them.

Contributions to Knowledge:

This thesis adds to the scant albeit growing body of research examining *complementary and alternative medicine (CAM) use in later life*. The empirical findings

of this study make a contribution to knowledge in that they shed light on why and how the young-old (in particular) use CAM, as well as on the meanings they attach to unconventional therapies. These types of key issues related to use have been relatively under-explored in the CAM literature, which has largely focused on broad trends of consumption among the general population (Andrews 2002). It is important though to understand seniors' unique views and behaviours because older adults frequently suffer from comorbid conditions and may be more vulnerable to complications linked to multiple treatments. The benefit of my qualitative work then is that it offers a closer look at the young-old's actions, attitudes, and decision-making. For example, I found that seniors turned to alternative healthcare in the early years of late adulthood because they essentially equated aging with future decline and disability. Hence, unconventional care represented a way for them to control their own health and specifically a means by which they could proactively work towards manipulating their aging process and preserve their quality of life.

These young-old consumers were generally comfortable assuming responsibility for their CAM use because they perceived unconventional therapies as more natural, less invasive, and on the whole safer than conventional medicine. Many, however, also felt that they were capable of managing their conventional regimen because they believed that they understood their needs and respective bodies best. Hence, while professional recommendations and other trusted sources of information were considered, they ultimately proceeded with what they felt worked well for them in their daily lives. It is important to understand the ways that older adults work through decisions related to medication use, as it gives some indication about what happens to medicines in people's homes, outside of the healthcare system. Moreover, given that the elderly often tend to have complex regimens, this knowledge can be important in terms of their safety. Very little, however, is known about how seniors actually negotiate their conventional and unconventional regimens. The findings of this study thus contribute to the under-explored field of the *management of medications in later life*.

Apart from these various understandings about seniors' medicine use, this thesis contributes to a greater awareness of aging persons' detailed concerns about conventional doctors and treatments. It is vital to comprehend such negative feelings expressed by patients because they can be long lasting and have an effect on the therapeutic relationship as well as on users' health-related behaviours (e.g., delays in care-seeking). Few studies, however, have examined these kinds of lay views of conventional care in a systematic and in-depth manner. These findings, therefore, add to the nascent field of *older patient dissatisfaction and distrust*, and further represent one of the few efforts to discuss these sentiments in a direct manner, rather than via inferences from work on satisfaction and trust. This overall insight is quite interesting given that older adults are often assumed to be highly satisfied and trusting consumers of conventional healthcare. It is equally informative as it suggests that this younger generation of seniors may be more willing to vocalize their grievances in order to ensure that they are being cared for effectively.

Theoretical Contributions

The overarching theoretical framework that informed this study is symbolic interactionism. It is a micro-level approach focusing on how people create meaning through their everyday exchanges with others and how this meaning in turn shapes their behaviour. At the heart of this perspective are three key ideas, outlined by Blumer (1969), which capture the essence of symbolic interactionism:

1. People act towards things based on the meanings that they have for them;
2. Meanings are not inherent to things, but rather negotiated through social interactions with others and shared through symbols (e.g., gestures, language, facial expressions); and
3. Meanings are modified through a process of interpretation in light of the things that the individual encounters

Conrad (1985) uses this interactionist framework to understand patients' management of medical regimens, and specifically argues that the meanings attached to medications in people's everyday lives are salient for comprehending the nature of users' medication-taking behaviour.

Extending this perspective to complementary and alternative medicine use in later life, this study has demonstrated that meanings attached to conventional and unconventional care can influence older adults' health-related perceptions and practices as well. For example, a number of seniors defined CAM as a natural treatment (i.e., lacking chemical or synthetic additions) and for this reason, believed that it was safe. They approached remedies with this impression in mind, and thus did not hesitate to use conventional and unconventional therapies in tandem or else experiment with different treatments. In addition, many viewed medical doctors as experts in conventional healthcare, but less knowledgeable, interested, and supportive of unconventional remedies. Several of these individuals therefore relied on physicians for medical care, but concealed their use of CAM from them.

The meanings attributed to these different objects generally arose out of seniors' everyday exchanges with others. A number of people, for instance, reported that their views of CAM (e.g., natural, holistic) developed as they became more familiar with modalities and began interacting with other users and practitioners. It is likely that this interaction was also responsible for perceptions of CAM as a wellness strategy rather than a medical treatment, given that such contact occurred in a Western context largely oriented towards biomedicine.

These overall meanings, however, were not fixed. Indeed, several older adults spoke about how their meanings of conventional medicine had changed over time, as a result of a series of negative experiences with doctors and treatments. These encounters made seniors reflect on the limitations of conventional care, and even though they still valued it, they no longer perceived it as having all of the answers to their health-related issues.

Limitations:

While this study has provided much insight into why and how older adults use complementary and alternative medicine (CAM), its limitations should be recognized as well. My findings, for instance, may not be *generalizable* to all late life users of CAM given the qualitative nature of this work. The themes outlined in this study, however, may be *transferable* to other seniors using CAM in relatively good health but living with minor chronic illness, as well as other groups of chronically ill users trying to maintain wellness.

A second shortcoming of this work pertains to the means by which seniors were recruited for interviews. Informants specifically were asked to contact me (via posters) if they wished to take part in the study and as a result, the sample was self-selected; individuals' decision to participate may thus be linked to traits that could have impacted the findings of this investigation. This approach was chosen though because it was deemed the most effective way to access people (self-prescribing and seeking professional help) willing to share their health-related experiences, which can be incredibly personal and emotionally charged. The drawback of this strategy, however, was that it was difficult to enlist a more mixed group of participants—despite active attempts to attract a diverse sample—resulting in an over-representation of certain views. In particular, two thirds of the sample was female and the same proportion of respondents was between the ages of 60 and 69 years. This composition clearly biased results towards female and young-old perspectives. Though women are usually found to be among the main users of alternative healthcare (de Bruyn 2001; Eisenberg et al 1998; Ni et al 2002; Park 2005; Simpson 2003; Tindle et al 2005), it would have still been interesting to understand more thoroughly the experiences of men, as well as the reasons underlying any potential gender differences. This variation began to emerge to some extent in that men often admitted relying on their partners for help to negotiate their regimens. Beyond this slight glimpse, though, it was difficult to make any further observations. It was equally challenging to make any comparisons between the young-old, old-old, and oldest-old. Previous research (Jaipaul and Rosenthal 2003; Lee and Kasper 1998; Smith et al 2002) has discovered that the latter hold distinct views, but the constraints of this work prevented an in-depth exploration of such issues.

The characteristics of the overall sample also made it impossible to examine the influence of important factors, such as race/ethnicity and class; participants were mostly white, educated, middle class, and with sufficient financial means to purchase unconventional products and services. Hence, there was not any opportunity to look into the kinds of practices that impoverished or uneducated seniors use on a daily basis to manage their health and well-being. Similarly, it was not feasible to explore if older adults approach their regimens in a unique manner when they come from cultural backgrounds heavily invested in CAM. The potential significance of this issue began to materialize, but it was difficult to pursue this matter with only one informant fitting this profile. It is possible that if the recruitment of participants had extended to other large urban centers, such as the Greater Toronto Area, there would have been more diversity in the sample.

A more varied group could have also shed light on the experiences and choices of seniors in poor health and/or those who are institutionalized. The respondents in this study were all relatively healthy, independent, and proactive in terms of their healthcare. This composition, however, is not surprising given that access to the more vulnerable segment of the elderly population is often difficult, due to their many physical and/or mental limitations. If possible though, it would certainly be interesting to gain insight to the meanings they attribute to CAM, as well as the ways they work through the practical issues related to use, especially when their medication regimens are so closely monitored by attendant health professionals.

Suggestions for Future Research:

Although this study has made some important contributions to our understanding of CAM use in late life, the findings of this study also open up new question areas for future investigation. As a first order, future work should look at a more diverse group of older adults, and explore how the meanings and management of CAM are influenced—if at all—by age, gender, race/ethnicity, and/or class. This examination may then also shed light on whether there are health beliefs more commonly held by older women and/or the young-old that might encourage them to turn to unconventional care.

In addition to these socio-demographic comparisons, it would be interesting to investigate if seniors' views are affected by type of therapy, frequency of use, and even the degree to which treatments are integrated into the conventional system or endorsed by mainstream practitioners. This information could clarify which remedies are highly valued in later life, what needs they meet and what role medical validation plays in older adults' choices.

Further research could also explore users' negative experiences with CAM in late life in order to become aware of what problems typically arise, why they are occurring, and what measures are needed to prevent complications. These issues are of the utmost importance given older adults complex regimens and their tendency not to disclose their use of CAM to medical doctors. These omissions though can obviously have serious implications for the elderly, and thus it is vital that their decision-making be carefully considered.

It would be equally worthwhile to examine the kinds of practices (medical, CAM, or other) that non-users (e.g., passive seniors) employ in late life to address their health and/or cope with illness. These individuals may wish to experiment with CAM, but they may not have the knowledge of how or where to access these services and/or the funds with which to do so. Becoming aware of the barriers that prevent the elderly from participating in alternative healthcare can certainly provide an understanding of the types of resources (e.g., educational) that are needed to help facilitate safe use of CAM in later life.

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APPENDICES

APPENDIX A: Poster for Participant Recruitment

**ARE YOU INTERESTED IN PARTICIPATING IN A STUDY
ON THE USE OF COMPLEMENTARY AND
ALTERNATIVE MEDICINE (CAM) IN CANADA?**

I am a researcher in the Ph.D. program in Sociology at McMaster University conducting an interview study about the use of complementary and alternative medicine (e.g., **herbal teas, vitamins, minerals, herbs, chelation, massage therapy, garlic, ayurveda, etc.**) among older adults (i.e., **60 years or older**).

Project Title: The Meaning and Management of Complementary and Alternative Medicine (CAM) Among Older Canadians

Participation will involve ***a short interview (telephone or in person)*** of approximately 40-60 minutes discussing your use of conventional, complementary and alternative medicine.

Please contact me if you are interested. I will give you more information and then you can decide if you would like to participate in this study.

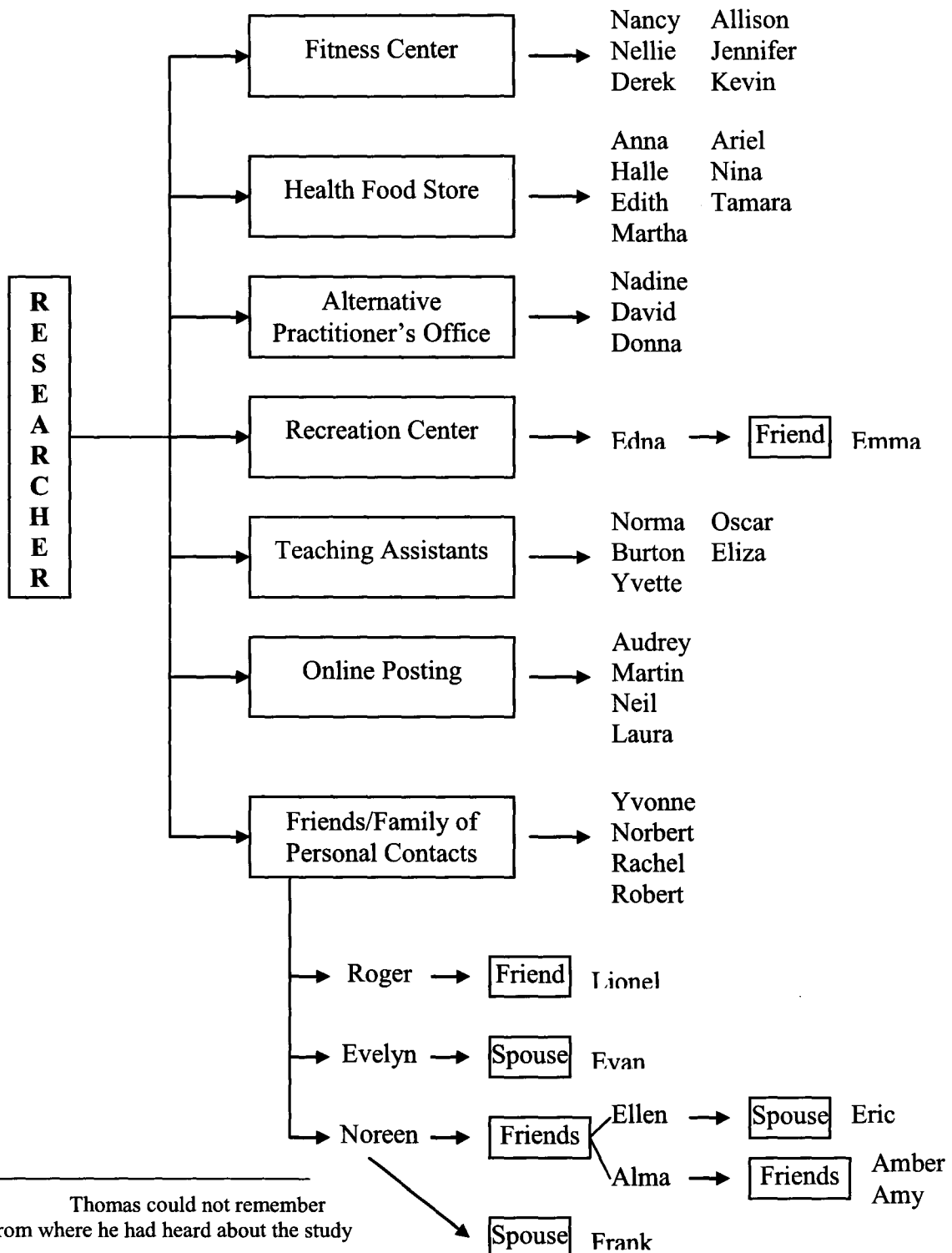
Thank you.

Patricia Khokher

khokher_patricia@yahoo.ca

(905) 527-2772 **or** (905) 525-9140, extension 27414

APPENDIX B: Recruitment Strategies¹²



¹ Thomas could not remember from where he had heard about the study

² Pseudonyms are used to protect informants' identities

APPENDIX C: Background Information Questionnaire

Please take a moment to answer the following questions. The information will be used as part of my doctoral research project; it will assist in constructing a thorough profile of seniors using complementary and alternative medicine. The information you provide will be held in strict confidence; no real names will be used, only pseudonyms. *You are not obliged to answer all questions, though I would like to learn as much about you as possible.*

(1) Where did you hear about my research study?

(2) Which age group best describes you?

60-64 years old

65-69 years old

70-74 years old

75-79 years old

80-84 years old

85-89 years old

Over 90 yrs old

(3) What is the highest level of education you have completed?

Some high school

High school completed

Some community college

Diploma from community college

Some university

Completed Bachelor's degree

Post graduate degree (MA, PhD)

Other (please specify) _____

(4) Do you live alone?

No

Yes

(5) At present are you...

Married or living with a partner

Divorced

Widowed

Separated

Never been married

Other (please specify) _____

(6) Were you born in Canada?

No

Yes → IF YES GO TO 8

(7) Where were you born? _____

(8) Do you see yourself as a member of any particular ethnic group (e.g., British, French, Caribbean, Italian, Philippine, Scottish, Ukrainian, Vietnamese etc)?

No Yes (*please specify*) _____

(9) Are you a member of a visible minority group?

No Yes

(10) What is your religious background?

Christian

Muslim

Hindu

Sikh

Buddhist

Agnostic

Atheist

Other (*please specify*) _____

(11) How would you describe your health?

Excellent

Very good

Good

Satisfactory

Poor

Other (*please specify*) _____

(12) How would you describe your social class?

Upper class

Upper-middle class

Middle class

Working class

Other (*please specify*) _____

(13) Please indicate the category that best describes your total yearly income before taxes.

19 999 or less

20 000 to 39 999

40 000 to 59 999

60 000 to 79 999

80 000 or more

THANK YOU.

APPENDIX D: Letter of Information

My name is Patricia Khokher. I am a Ph.D. student in the Department of Sociology at McMaster University, Hamilton. I am conducting a study of older adults' management and use of complementary and alternative medicine (CAM) in Canada as part of my doctoral dissertation project. Results of this study are intended to contribute to a greater understanding of CAM consumption and the management of conventional and alternative regimens in general. It is hoped that my research will assist in the formulation of relevant health care policy as well. Overall, my study will be shared with a variety of audiences including health care practitioners and researchers.

If you agree to participate in this research, your participation will involve an interview that will take approximately 40 to 60 minutes. The questions will largely be open-ended regarding your management and use of CAM. I would like to tape record the interview. The tapes will be transcribed word for word and then erased. No identifiers will be on the interview transcripts and they will be kept in a locked filing cabinet until the end of the study, at which time these will also be destroyed unless you give permission that they may be retained. Every effort will be made to maintain the confidentiality of the interview material. Unless you indicate otherwise, any material used in the publication resulting from this study will have identifying characteristics or statements omitted or will be paraphrased to help ensure confidentiality.

Participation in this study is voluntary and you will receive no payment if you agree to participate. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time without consequences of any kind. You may exercise the option of removing your data from the study. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

This letter is yours to keep. If you have any questions about this study or your participation in it, please do not hesitate to contact me at 905-525-9140 ext. 27414 or email me at usaboy@interlog.com. This study has been reviewed and received ethics clearance through the McMaster Research Ethics Board (MREB). If you have any questions about the conduct of this study or your rights as a research subject you may contact:

McMaster Research Ethics Board Secretariat
c/o Office of Research Services
McMaster University
1280 Main Street West
Hamilton, ON L8S 4M4

Telephone: 905-525-9140,
ext.23142
E-mail: srebsec@mcmaster.ca

Thank you for your interest in this research.

Patricia Khokher

APPENDIX E: Project Consent Form

I have read the project information form for the study “The Meaning and Management of Complementary and Alternative Medicine (CAM) Among Elderly Canadians”, have had the nature of this research explained to me and I agree to participate. All questions have been answered to my satisfaction.

Please indicate (with your initials) your agreement or disagreement to each of the following requests and sign the form at the bottom as well.

- (1) Do you agree to be interviewed? Yes _____ No _____
- (2) Do you agree to the taping of the interview? Yes _____ No _____
- (3) Do you wish to remain anonymous? Yes _____ No _____
- (4) May your transcript be kept after the study has been completed for future reference by Patricia Khokher? Yes _____ No _____
- (5) Would you like a draft copy of the final research report? Yes _____ No _____
(please provide address below)

Name of Participant

Signature of Participant

Date

Signature of Investigator:

In my judgement, the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

Signature of Investigator

Date

APPENDIX F: Interview Guide

Conventional Medicine

Opening (General) Questions:

- What do you consider to be conventional medicine?
- In your opinion, what is the purpose of using conventional medicine? (i.e., why would someone use this type of medicine?)
- What are the benefits and drawbacks of conventional medicine?

- In the past month, have you taken any conventional medication? Which ones?
- Why are you taking this medication (reasons for each one)?
 - what are your personal expectations/hopes for this medication?
- Who gave you this medication?
 - describe relationship
- When do you take this medication?
- Where do you keep this medication?
- How do you feel after taking this medication?

Complementary and Alternative Medicine

Opening (General) Questions:

- What do you consider to be complementary and alternative medicine (CAM)?
- Who would you identify as an “expert” in counseling the use of CAM?
- In your opinion, what is the purpose of using CAM? (i.e., why would someone use this type of medicine?)
- What are the benefits and drawbacks of CAM?

- How did you begin using CAM?
- In the past month, which CAM therapies have you used?
- Why are you using these specific therapies?
 - what are your personal expectations/hopes for these therapies?
- How did you obtain CAM products?
- Does CAM constitute a main, complementary or alternative therapeutic intervention?

Management of Regimens:

- Do you take your CAM products at the same time as your conventional/prescription medication? Please explain reasons.
 - do you consider these products to be part of your medical treatment?
 - do you worry about any possible side effects from taking (conventional meds) and (CAM) together?
- Where do you keep the CAM products?
- How do you feel after use?

Information/awareness:

- Do you consult with anyone in your use of CAM? Please explain reasons.
 - describe relationship
- Do you feel comfortable discussing your use of CAM with your primary care physician? If no, why not?
 - is your primary care physician aware that you are using CAM? If no, why not?
- What sources of information do you rely on and trust when looking for CAM related health information?
 - why do you trust this information?