

A Foot in Both Camps: A Constructivist Grounded Theory Study Exploring the Experience of Nurses who Became Homeopaths

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Submitted in fulfillment of the requirements for the degree of
Doctor of Philosophy

Central Queensland University
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September 2019

Abstract

The demand for complementary and alternative medicine (CAM) has risen substantially in western nations such as Australia, raising the question of where CAM fits in the contemporary landscape of health care. One of the most contentious CAM therapies is the practice of homeopathy, which utilises highly diluted substances to affect a therapeutic response. Critics assert that homeopathy is scientifically implausible, while proponents argue that it has a long history of use to support its principles and practice. Even though it lacks the support of the medical and scientific communities, homeopathy is practised by several primary health care providers. This research aimed to understand the factors attracting qualified nurses to the practice of homeopathy and the influence if any, their respective identities as nurses and homeopaths had on their nursing and homeopathic practice.

Using constructivist grounded theory methodology, data was collected via semi-structured interviews with 15 registered nurses who were also registered homeopaths, from three states of Australia. Data from the study resulted in the development of a substantive theory, the 'Theory of Congruent Positioning', which proposes that the nurses in this study were attracted to the practice of homeopathy through a process of experiential and transformative learning, whereby they connected with the core tenets of homeopathic philosophy. The Theory of Congruent Positioning also provides insights into how the respective nursing and homeopathic identities of the nurses in this study were expressed in the respective nursing and homeopathic practice environments.

Findings suggested that in the homeopathic practice environment, the nursing identity of these nurses was readily expressed and nursing knowledge was transferred without constraint, making a positive contribution to their homeopathic practice. In the nursing

practice environment, the homeopathic identity of the nurses in this study was constrained due to organisational, territorial and epistemological constraints. Despite these constraints, homeopathic knowledge had a positive impact on the nursing practice of these nurses. However, the incongruence between the philosophical orientation of the nurses in this study and their actions as nurses resulted in the majority of them leaving the nursing workforce to practise as homeopaths. This study contributes to the body of knowledge by being the first study to explore the experience of nurses who are homeopaths in Australia.

Acknowledgements

Sincerest thanks to my longest standing supervisor, Dr Wendy Hillman, whose patience and support has been unwavering. Thanks also to Professor Trudy Dwyer, my associate supervisor for a period of time, and to Dr Leone Hinton and Associate Professor Jennie Barr, my associate supervisors in the final stages of the project. I would also like to acknowledge the initial supervisors of this project, Professor Ysanne Chapman and Professor Melanie Birks for helping me begin this research journey. You each played a part in this project coming to fruition and I thank you all for giving your time and sharing your knowledge. Many thanks also to those who participated in this research. I am grateful to have spent time hearing your stories and correlating them into this body of work. Without you this study would not have been possible.

Special thanks to my dear friends, Julie and Marty, who never faltered in their belief in my ability to pull this off. From the beginning, you have imparted words of wisdom, read drafts and revived me with chai, laughter and good company. You two are the best of the best and I am truly blessed to have you in my life.

To my family, thanks for keeping me grounded. Summer, for reminding me that I had no time for an existential crisis and offering practical solutions to the ‘catastrophes’ that occurred along the way. Emmanuel for just ‘knowing’ I would complete. Special thanks to Kisharn, whose belief in me encapsulated in a short note of four lines, given to me with a journal part way through this journey, got me through many tough days. Whenever I felt like giving up, I would re-read that note and draw upon those words to find belief in myself. Finally, I want to thank my partner Robert, for standing strong and tall like the Totara protecting the forest, ensuring that I survived the storm. You are my rock!

Acknowledgement of Professional Services

I am grateful for the assistance of the following people who assisted me in presenting this thesis:

Professional editor, Lyn Forbes-Smith, who provided proof-reading services according to the guidelines laid out in the university-endorsed national guidelines; “The editing of research theses by professional editors”.

Chris Holmes from designbychannel.co.uk who created digital diagrams of the three key concepts and the theoretical model that was developed from the data.

Ingrid Kennedy, who provided proof-reading and formatting services according to the guidelines laid out in the university-endorsed national guidelines; “The editing of research theses by professional editors”.

Acknowledgement of Support Provided by the Australian Government

This RHD candidature was supported under the Commonwealth Government's Research Training Program/Research Training Scheme. I gratefully acknowledge the financial support provided by the Australian Government.

Statement of Authorship and Originality

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Abbreviations and Acronyms

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AHA	Australian Homoeopathic Association
AHPRA	Australian Health Practitioner Regulation Agency
ANPA	Australian Naturopathic Practitioners Association
AROH	Australian Register of Homoeopaths
ATMS	Australian Traditional Medicine Society
CAM	Complementary and Alternative Medicine
CDC	Centres for Disease Control and Prevention
CMA	Complementary Medicines Australia
EBP	Evidence-based Practice
GP	General Practitioner
HREC	Human Research Ethics Committee
ICN	International Council of Nurses
IPE	Interprofessional Education
NCCIH	National Center for Complementary and Integrative Health
NHAA	National Herbalists Association of Australia
NHMRC	National Health and Medical Research Council
NHS	National Health Service
NICM	National Institute of Complementary Medicine
PCC	Person-centred care
RACGP	Royal Australian College of General Practitioners
RCT	Randomised controlled trial
TCM	Traditional Chinese Medicine
VoIP	Voice over Internet Protocol
WA	Western Australia
WHO	World Health Organization

Glossary of Key Terms

Biomedicine (Interchangeable with the terms ‘conventional medicine’, ‘allopathic medicine’ and ‘Western medicine’)	Medical sciences, as practised by a person who holds the title of a medical doctor (MD).
CAM	A diverse range of health care practices that are not integrated into a society’s dominant health care system.
Category	Categories are formed from the abstraction of codes. They depict the themes or patterns found occurring in codes and inform the development of higher-level concepts.
Client (Interchangeable with the term ‘patient’)	Term used to describe a person who accesses the services of a health care practitioner and/or is receiving nursing or medical care.
Code	A label that is assigned to depict what is happening in a specific piece of data.
Concepts	Abstract ideas that account for the data and form the grounded theory.
Enrolled Nurse (EN)	A person qualified and licensed to practise as an enrolled nurse.
Integrative Medicine	A model of care that combines biomedicine with CAM.
Models of Care	A term that broadly defines the way that health services are delivered. Models of care can pertain to specific areas of health care.
Paradigm	A philosophical position related to how the world is perceived. Can be used interchangeably with the term ‘worldview’.
Person-Centred Care (PCC)	A philosophical approach to health care that places the individual at the centre of the care they receive. Also known as ‘client-centred’ and ‘patient-centred care’.
Properties	Defining characteristics of a category or concept.
Registered Nurse (RN)	A person qualified and licensed to practise as a registered nurse in Australia.
Traditional Medicine	Knowledge, skills and practices based upon theories, beliefs and experiences that are indigenous to different cultures and used in health promotion and treatment (WHO, 2019a).

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Chapter 1.

Research Overview

1.1 Introduction

This thesis chronicles a constructivist grounded theory study exploring the experience of 15 nurses who became homeopaths. It investigates their personal journeys, examining the factors leading them to homeopathy and their experience of working in two vastly different sectors of the Australian health care system. Using the grounded theory methods of concurrent data collection and analysis, a substantive grounded theory was developed that explains these nurses' attraction to the practice of homeopathy and how they navigated working in two vastly different sectors of the Australian health care system. In addition, valuable insights are gained into how being a nurse and a homeopath influenced their respective nursing and homeopathic practices. An interdisciplinary approach was taken in interpreting the data utilising concepts, insights and theories from psychology, education, nursing, and social science. These concepts and theories were then integrated into a data-driven theory developed using the inductive approach of grounded theory. As noted by Palmer (2001), the complex real-world issues that researchers explore seldom fall neatly into disciplinary classifications (p. vii). Exploring different disciplinary perspectives allows for a broadening of investigation, whereby common ground between disciplines can be discovered and the researcher can gain an interdisciplinary understanding of the area under examination (Repko, 2008). In keeping with a constructivist perspective that acknowledges the researcher as a co-creator, rather than an objective observer (Charmaz, 2008, pp. 401–402), I will refer to myself in the first person throughout the thesis.

The aim of this preliminary chapter is to introduce the research and my positionality as the researcher, to the topic being explored. The rationale for the research, its objective, scope, originality, and significance are discussed and presented as background information to prepare the reader for the following chapters of the thesis. The chapter concludes with an overview of the thesis structure and the conventions used in the writing of this thesis. Evans and Gruba (2004) advise that a thesis introductory chapter be kept succinct, asserting that its sole purpose is to introduce the research (p. 12). I have concluded that an understanding of CAM and homeopathy is imperative for readers of the thesis. Rather than place a section on these topics in this chapter, thereby making it a long introductory chapter, I have chosen to discuss them in Chapter Two, *Contextualising CAM and Homeopathy*, of the thesis.

1.2 Positionality of the Researcher

Research is a shared undertaking between the researcher(s) and participants (Bourke, 2014; Charmaz, 2008; Råheim et al., 2016). Everyone involved brings their existing knowledge and life experience into the process, all of which impacts the research in various ways (Bourke, 2014; Charmaz, 2014; Råheim et al., 2016). Therefore, it is important for a researcher to acknowledge their positionality in relation to the research being undertaken. With this in mind, I have chosen to locate my positionality as the researcher at the front of this section so that the reader is aware of the connections I have to nursing and homeopathy and how they led to this research being undertaken.

After completing secondary school, I trained as an enrolled nurse, during an era when hospital-based training was the standard way that nurses were educated. Early in my nursing career I observed many nurses still present in the wards long after their shift had finished. Sometimes they could be found reading to a young child, assisting in a birth that began before their shift ended, reassuring someone as they drew their last breath, or simply

keeping someone company. The empathy and compassion of the nursing staff I came into contact with during those early years made an indelible impression on me. The nurses I observed were very adept at taking care of their client's physical needs, which extended from basic care such as toileting and showering through to the administration of medications, and performing, or assisting, with simple and complex medical procedures. In addition, it was my observation that nurses advised on health matters, offered emotional support, acted as confidants and generally took an interest in the life of their clients.

The all-encompassing and holistic approach to health care that I witnessed appealed to me greatly, and I happily remained in the nursing profession for over a decade. During my nursing career, I worked in both the public and private sectors of the New Zealand and Australian health systems. A chance encounter with homeopathy as I was about to embark upon my registered nursing training sparked a curiosity in me about homeopathy that ultimately changed my career trajectory. That chance encounter involved my dog, Sacha, a two-year-old Rhodesian ridgeback cross. Sacha had a dermoid sinus, a genetic disorder that generally requires surgery to close the sinus, on the back of her neck that became infected and a large abscess had formed. The veterinary surgeon I consulted believed that surgery would only yield temporary results and would need to be repeated. At this point, I had very little knowledge of homeopathy, however, I had a neighbour who was a homeopath and felt I had nothing to lose by seeking her advice.

After due consideration, my neighbour prescribed a homeopathic remedy for Sacha that I administered twice daily for two weeks. Within 24 hours of beginning the remedy, the abscess burst and over the next few days the lump disappeared. Over the next 12 months, two more abscesses came up. Each time, the abscess would resolve quickly after a few days of administration of the homeopathic remedy. I was impressed with the apparent fast action

of the remedy but still had my doubts. Was the positive response due to the remedy, or would the abscess have resolved anyway? When I told my neighbour about the response to the remedy, she was less impressed with the results than I was and prescribed a different homeopathic remedy, with instructions for me to administer it if another abscess occurred.

A few months later another abscess appeared, and I gave Sacha the new homeopathic remedy as directed. Within hours of administering the new remedy to Sacha, the abscess began getting smaller and smaller and within days had disappeared. From that point on no more abscesses occurred and Sacha enjoyed good health until her death of natural causes at 10 years of age. During the time that I had been using homeopathy with Sacha, I became more and more curious about homeopathic philosophy and practice. I began seeking homeopathic treatment for myself and then my children. Eventually my neighbour became the primary health care provider to my family and myself. Wanting to know more about treating my own family with homeopathy, I embarked upon a four-year homeopathic training course.

During my homeopathic study, I had one doctor and several nurses as classmates. I noted that the other homeopathic classes also had a similar number of nurses and doctors among the students. In addition, two of my lecturers were general practitioners (GPs), who were also practising homeopaths. These GPs lectured homeopathic students on medical sciences as well as homeopathic prescribing. While attending homeopathic seminars and conferences I became aware of a significant number of homeopaths who also identified as nurses. I was interested in why these nurses were in the homeopathic profession. What led to them practising homeopathy? Why had they engaged with a practice that was rejected by the medical and scientific communities? I was also curious about how they navigated being both a nurse and a homeopath and wondered if being a nurse and a homeopath had

any influence on their respective nursing and homeopathic practices. These questions led to me embarking on this research journey.

1.3 Rationale for the Research

In recent years the landscape of health care has altered significantly in western nations such as Australia. Increased rates of chronic illness and consumer demand for a multidisciplinary approach to health service delivery have resulted in an extension of the scope of practice of some health care providers and an increasingly diverse range of health care practitioners and services (Canizares, Hogg-Johnson, Gignac, Glazier, S Badley, 2017; Queensland Health, 2018a; J. Singer & Adams, 2014; Tannenbaum & Tsuyuki, 2013; Wardle, Sibbritt, Broom, Steel, & Adams, 2016). Included in the changing face of health care is the growing presence of complementary and alternative medicine (CAM), which in recent decades has become an increasingly popular factor in the health care choices of individuals (Coulter & Willis, 2007; Frass et al., 2012; Reid, Steel, Wardle, Trubody, & Adams, 2016; Xue, Zhang, Lin, Da Costa, & Story, 2007). Current indicators suggest that consumer demand for CAM is unlikely to alter anytime soon (Complementary Medicines Australia [CMA], 2018; Reid et al., 2016; von Conrady & Bonney, 2017). Therefore, it appears that CAM will remain a part of the evolving environment of health care for the foreseeable future.

Not surprisingly, consumer interest in CAM has captured the interest of stakeholders, policy makers and researchers (Baggoley, 2015; House of Commons, 2010; Reid et al., 2016; Spinks & Hollingsworth, 2012; M. Weir, Wardle, Marshall, & Archer, 2014). Increasingly, questions are being asked about the role of CAM in the provision of contemporary health care (Dodds, Bulmer, & Murphy, 2014; Hunter, Corcoran, Leeder, & Phelps, 2013; J. Singer & Adams, 2014; van der Werf, Duncan, von Flotow, & Baars, 2018). Consumer demand for CAM has given rise to integrative models of health care that

incorporate CAM alongside biomedical interventions, suggesting that a significant number of individuals utilising and providing health care services are interested in this type of approach (Hook, Plump, & Geist-Martin, 2018; J. Singer & Adams, 2014; Templeman & Robinson, 2011; Yun, Sun, & Mao, 2017). In addition, studies suggest there are numerous benefits to integrating CAM into conventional health care, including better client outcomes (Grace & Higgs, 2010; Templeman & Robinson, 2011) along with increased cost effectiveness (Guarneri, Horrigan, & Pechura, 2010; Herman, Poindexter, Witt, & Eisenberg, 2012). However, there are also significant challenges associated with incorporating CAM alongside biomedical interventions and practices (C. L. Ross, 2009; Tahir, Thomas, & Li, 2015; Templeman & Robinson, 2011). Central to these challenges are the epistemological and ontological differences between CAM and biomedicine (Keshet, 2009; Possamai-Inesedy & Cochrane, 2013).

Of particular interest to this body of work, is the CAM practice of homeopathy, whose epistemology and ontology are vastly opposed to that of biomedicine, causing some commentators to question whether the homeopathic and biomedical paradigms are incommensurable (Coulter & Willis, 2004; Evangelatos & Eliadi, 2016; Stoneman, Sturgis, Allum, & Sibley, 2013). There is no doubt that homeopathy is one of the most contentious CAM practices in the world today (Caulfield & DeBow, 2005; Crawford, 2016; Goldacre, 2007; Milgrom, 2008; Rutten, Mathie, Fisher, Goossens, & van Wassenhoven, 2013; Sekonyela, 2016). From its inception in the 18th century through to the present day, homeopathy has courted controversy at every turn (Ernst, 2002, 2015; Goldacre, 2007; Wardle, Adams, & Sibbritt, 2013a; Willis, 1990). It is as equally derided by its critics, as it is applauded by those who laud its virtues. Those critical of homeopathy consider it a non-scientific practice lacking an evidence base (Crawford, 2016; Ernst, 2010; Goldacre, 2007; National Health and Medical Research Council [NHMRC], 2015; Royal Australian

College of General Practitioners [RACGP], 2015). Proponents however argue that homeopathy has a proven track record of positive outcomes, with a growing body of research in support of its clinical validity (British Homeopathic Association, 2019a; P. Fisher & Ernst, 2015; Manchandra, 2016; Rutten et al., 2013).

Despite the ongoing controversy and debate that surrounds homeopathy, millions of people utilise it worldwide (Colas, Danno, Tabar, Ehreth, & Duru, 2015; Ghosh, 2010; Manchandra, 2016; Relton, Cooper, Viksveen, Fibert, & Thomas, 2017) and several countries incorporate it into their health care systems and/or publicly funded national health schemes (National Health Portal of India, 2016a; Relton et al., 2017; European Committee for Homeopathy, 2019a). In addition, a number of primary health care providers practice homeopathy, often as an adjunct to their existing conventional health care practice (Colas et al., 2015; Ekins-Daukes, Helms, Taylor, Simpson, & McLay, 2005; Marian et al., 2008; Markun, Maeder, Rosemann, & Djalali, 2017; S. Ross, Simpson, & McLay, 2006). The intersection of conventional models of health care and CAM has sparked interest in the attitudes and level of knowledge that primary health care providers, such as nurses, have in relation to CAM (Hall, Leach, Brosnan, & Collins, 2017; Rojas-Cooley & Grant, 2009; Shorofi & Arbon, 2010, 2017). Although research suggests that nurses generally have a positive attitude towards CAM, it also indicates that they lack adequate knowledge of CAM (Aveni et al., 2017; Bjerså, Stener-Victorin, & Fagevik Olsén, 2012; Chang & Chang, 2015; Hall, Leach, Brosnan, & Collins, 2017; Shorofi & Arbon, 2010, 2017; B. F. Walker et al., 2017).

Given the widespread use of CAM among the general population and the fact that the nursing workforce constitutes a significant proportion of health care workers globally (World Health Organization [WHO], 2019a), it is arguable that there is a need for nurses

to have a certain level of knowledge and understanding of CAM (Christina, Abigail, & Cuthbertson, 2016; Hall et al., 2017; Rojas-Cooley & Grant, 2009). Without adequate knowledge of CAM, nurses are unable to have informed discussions with clients on the potential risks and benefits of CAM use, which could have significant implications in relation to the care provided to clients and their safety (Hall et al., 2017; Rajas-Cooley & Grant, 2009). However, despite being at the forefront of primary health care, nursing education in relation to CAM is limited. Consequently, nurses lack an opportunity to increase their knowledge of CAM from within the nursing profession (Broom & Adams, 2009; Hall et al., 2017). A small number of studies have indicated that nurses number among those who work in the CAM industry (Andrews, 2003; Cant, Watts & Rushton, 2011; Bensoussan, Myers, Wu, & O'Connor, 2004; Gowing & Gale, 2019; Johannessen, 2004, 2009; Shuval, 2006). However, many of these studies are dated. Overall, there appears to be limited research on nurses who work in the field of CAM, particularly in relation to nurses who are qualified CAM practitioners. In addition, research is limited on the profile of the Australian CAM workforce and no existing studies could be found that have specifically explored the homeopathic workforce of Australia (J. Adams et al., 2017; Bensoussan et al., 2004; Bensoussan & Myers, 1996; Frawley, 2016; Leach, 2013; Leach, McIntyre, & Frawley, 2014; Steel et al., 2018). The paucity of studies on nurses who practise CAM and the wider CAM workforce, indicates a gap in the literature. Given the ontological and epistemological differences between CAM and the biomedical model of care and the increasing intersection of the two approaches, these topics are worthy of further examination.

1.4 Research Objective

This research had two main objectives. The first objective was to explore what attracts qualified nurses to the practice of homeopathy and the influence, if any, being a nurse and

homeopath had on their respective nursing and homeopathic practice. The second objective was to develop a substantive theory explaining the experience of these nurses.

1.5 Research Question

The research questions that guided this study were:

1. What attracts qualified nurses to the practice of homeopathy?
2. How, if at all, does being a qualified nurse and a homeopath influence the respective nursing and homeopathic practices of these nurses?

1.6 Scope of the Study

This research was carried out with participants from three states of Australia; namely: Queensland, New South Wales and Victoria. The majority of participants worked in metropolitan cities, with only a small number working in regional areas. Figure 1 shows a map of Australia highlighting the states of Queensland, New South Wales and Victoria.



Figure 1. Map of Australia highlighting the states of Queensland, New South Wales and Victoria. Adapted from “Australia” by Mapchart, n.d.

(<https://mapchart.net/australia.html>). In public domain.

This study is limited to the experience of nurses who became homeopaths. It is acknowledged that other conventional health care professionals, such as medical practitioners, also number among those who practise homeopathy (Ernst, 2018; European Committee for Homeopathy, 2020). Therefore, the same research questions could be asked of doctors who practise homeopathy. However, nurses were chosen as the focus of this study due to my personal experience as a nurse/homeopath, as outlined in section 1.2 of this chapter, and my accessibility to this particular group of health care practitioners. Furthermore, limiting participants to nurses allowed for this research to be manageable in size for the fulfilment of a Doctor of Philosophy, while also providing rich data for analysis and the development of a substantive theory.

1.7 Significance and Originality of the Study

This research explains participants' attraction to the practice of homeopathy and the influence their nursing and homeopathic identities had on their respective nursing and homeopathic practice. Findings reflect and connect several existing concepts, such as experiential and transformational learning, identity salience, cognitive dissonance, value congruence, and moral distress. Insights are gained into what nurses who are attracted to the practice of homeopathy are looking for professionally, their respective job satisfaction as nurses and homeopaths, and how these factors influenced their future career choices. In addition, the findings also provide insights into the expression of participants' nursing and homeopathic identities in the respective nursing and homeopathic practice environments. These insights provide an understanding of how participants integrated their nursing and homeopathic knowledge and how this influenced their respective practice as nurses and homeopaths.

During the initial stages of this study a limited literature review, detailed in Chapter Three, was undertaken. Once data collection and analysis commenced a more comprehensive search of the extant literature began, which is detailed in Chapters Five to Eight of the thesis. Both reviews of the literature included searches of databases such as Academic Search Complete, EbscoHost, SocINDEX, Science Direct, Scopus and CINAHL, as well as a search of the grey literature. In the more detailed review of the literature undertaken during the later stages of the study, searches focused on the categories and concepts being developed from the data. During these reviews of the literature it was identified that although some research on homeopathic practitioners and their practice has been conducted (Brien, Prescott, Owen & Lewith, 2004; Brien, Lehance & Lewith, 2004; Eyles, Leydon, Lewith & Brien, 2011), it is limited when it comes to the experience of homeopaths in Australia (Levy, 2017). In addition, much of the research on homeopathic practitioners and their practice has tended to focus on clients' perspectives, rather than that of the practitioners (Eyles et al., 2010).

A greater number of studies were found exploring nurses attitudes towards CAM (Aveni et al., 2017; Bjerså, Stener-Victorin, & Fagevik Olsén, 2012; Chang & Chang, 2015; Gowing & Gale, 2019; Hall et al., 2017; Shorofi & Arbon, 2010, 2017; B. F. Walker et al., 2017). Although these studies provide an understanding of how nurses feel about CAM, within the context of the health care system, and its inclusion into nursing education and practice, they offer little information on nurses' attitudes to homeopathy. Other research has explored nurses professional use of CAM and provided valuable insights into the incorporation of CAM in nursing practice (J. G. Anderson et al., 2016; Balouchi et al., 2018; Buchan, Shakeel, Trinidade, Buchan, & Ah-See, 2012; Cant, Watts, & Rushton, 2012; Cant et al., 2011; Chan & Schaffrath, 2017; Gowing & Gale, 2019; Johannessen, 2009; Shorofi & Arbon, 2010, 2017; Shuval, 2006; Xue, Zhang, Holroyd, & Suen, 2008). However, these

studies commonly relate to nurses' use of therapeutic touch, massage and other mind-body therapies, rather than the practice of homeopathy. A small number of studies specifically set out to explore why nurses leave the nursing workforce to practise CAM (Andrews, 2003; Johannessen, 2009). Although these studies are of relevance to this study and are discussed further in section 8.2 of the thesis, they focused on the experience of British and Norwegian nurses and were conducted over a decade ago. To the best of my knowledge, no studies have explored the intersection of nursing and homeopathy through the lens of nurses who have chosen to become homeopathic practitioners. Therefore, this study makes an original contribution to the nursing and homeopathic literature, as it explores the subjective experience of a group of health care providers not previously examined. Given the scarcity of research in this area, it is envisaged that the findings will be useful to other researchers exploring an array of topics related to the intersection of CAM and nursing, the CAM workforce of Australia and nurses' knowledge of CAM.

1.8 Conventions used in this Thesis

In addition to the table of definition and key terms provided in preceding pages, the following conventions are used in this thesis:

- P = participant
- 'Single quotation marks' are used when a particular term is being described for added emphasis
- "Double quotation marks" are used for direct quotes
- *Italic* is used to present quotations from participants' interviews
- The homeopathic community in Australia is relatively small; therefore, for the purposes of confidentiality the gender-neutral pronouns 'they/their' are used,

rather than the gendered pronouns, ‘he/she’ when discussing participants and their narratives.

1.9 Organisation of Thesis

This chapter has provided an overview of the research, including my positionality as the researcher, the research objective, questions and the significance and scope of this study. This introductory chapter is followed by eight further chapters, all with their own role to play in the presentation of this study. Chapter Two provides the reader with a definition of CAM and discusses homeopathy and the core principles upon which it is founded. Included in the chapter is a discussion of where homeopathy is situated in the Australian health care system and its status as a health care profession. Chapter Three discusses the role of literature in grounded theory research and presents background information relative to this study within the context of a preliminary literature review. The research design and methodology of the study are explored in Chapter Four, inclusive of an in-depth discussion on grounded theory. The rationale for using this methodology and the specific grounded theory methods utilised in this study are outlined. In addition, the reader is introduced to the core category of congruent positioning that was developed from the inductive grounded theory methods utilised in undertaking the study.

Chapter Five explores the first of the two key concepts that informed the core category of congruent positioning; namely: connecting philosophically. The chapter explores participants’ initial engagements with CAM and their subsequent continued engagement with homeopathy. Findings from the chapter directly answer the research question: ‘What attracts nurses to the practice of homeopathy?’ The following two chapters, Chapters Six and Seven, explore the second of the two key concepts informing the core category of congruent positioning; namely: intersecting identities. During data analysis it was

identified that the concept of intersecting identities had two aspects to it: sharing common ground and navigating opposing paradigms, which are also presented in these chapters. Chapter Six presents the concept of intersecting identities within the context of sharing common ground, which explores participants' identities as nurses and homeopaths and the intersection of these respective identities in the homeopathic practice environment. Included in Chapter Six, is a discussion on the expression of participants' nursing identities in the homeopathic practice environment and its subsequent influence on their homeopathic practice.

Chapter Seven presents the concept of intersecting identities within the context of navigating opposing paradigms. The chapter explores the intersection of participants' respective nursing and homeopathic identities within the context of the nursing practice environment. Furthermore, it includes a discussion on the expression of participants' homeopathic identities in the nursing practice environment and the influence of their homeopathic identities on their nursing practice and future career choices. Together, Chapters Six and Seven answer the research question: 'How, if at all, does being a qualified nurse and a homeopath influence the respective nursing and homeopathic practices of these nurses?' Chapter Eight situates the key findings of this study in the literature and explores the concepts of 'positioning' and 'congruence', within the context of this study and the extant literature. The substantive Theory of Congruent Positioning developed from this study is presented and discussed. The study concludes with Chapter Nine: a discourse around the research's theoretical contribution to knowledge, recommendations, limitations and finally, my concluding statement.

Chapter 2.

Contextualising CAM and Homeopathy

2.1 Introduction

It is imperative that the reader understand the practices that constitute complementary and alternative medicine (CAM) and have a basic knowledge of the core principles of homeopathy before reading further. This understanding is important, as there is considerable confusion and ongoing debate over what constitutes CAM and how CAM is defined (Coulter & Willis, 2004; Hegyi, Petri, Roberti di Sarsina, & Niemtzow, 2015; Leivers, 2005; van der Riet, 2011). Moreover, there is uncertainty with regards to the differences between homeopathy and other CAM practices such as naturopathy which are also often misunderstood (Leivers, 2005). In addition, the homeopathic principles upon which homeopathic practice is founded conflict with biomedical knowledge and practices, making them particularly relevant to the experience of participants in this study. Therefore, while Chapter One, *Research Overview*, introduced the research, the purpose of this chapter is to contextualise CAM and homeopathy, in terms of what they are and how they are situated in the landscape of health care, particularly within the Australian context. The chapter begins with an exploration of the definition of CAM and how the various CAM therapies are commonly categorised. Homeopathy and the core principles that underpin its practice are then discussed. Finally, this chapter explores homeopathy's place in the Australian health care system, its status as a profession, and concludes with a synopsis of the key points made.

2.2 Defining CAM

The way in which CAM is defined has been the subject of debate for decades (Coulter & Willis, 2004, 2007; Robles, Upchurch, & Kuo, 2017; Wieland, Manheimer, & Berman, 2011; Wootton, 2005; Zollman & Vickers, 1999). Most commonly, CAM is defined as

practices that sit outside of the dominant system of health care (National Center for Complementary and Integrative Health [NCCIH], 2018; Wieland et al., 2011; WHO, 2019b). For example, the WHO (2019b) defines CAM as being “health care practices that are not part of that country’s own tradition or conventional medicine and are not fully integrated into the dominant health-care system” (para. 2). It is within the context of the WHO (2019b) definition of CAM that the term CAM will be used in this thesis.

The term ‘CAM’ encompasses a broad range of diverse and often unrelated practices (Coulter & Willis, 2007; NCCIH, 2018). For instance, dietary supplements, massage, yoga, prayer and meditation are all grouped together under CAM, alongside practices such as naturopathy, herbalism and homeopathy (NCCIH, 2018; Wieland et al., 2011). However, grouping such a heterogeneous range of products and practices under a single term can be problematic. For example, Tippens, Marsman and Zwickey (2009) contend that the term prayer fails to differentiate between the varying spiritual practices used by some CAM practitioners and the standard meaning of the term (p. 435). In addition, when prayer is included as a CAM practice studies show a marked increase in the rates of CAM utilisation (Chui, Abdullah, Wong, & Taib, 2014; Robles et al., 2017; Tippens et al., 2009). It is argued by Tippens et al. (2009) that the inclusion of prayer as a CAM practice can result in misleading statistics of CAM use and that this factor needs to be considered when exploring how CAM is defined.

In order to distinguish the different products and practices encompassed under CAM, the National Center for Complementary and Integrative Health (NCCIH), (2018) suggested two subgroups, classifying them as “natural products” and “mind and body practices” (para. 8). Table 1 illustrates the sub headings used by NCCIH (2018), and the CAM practices and interventions classified under those headings.

Table 1.

CAM Categorisation

Natural Products	Mind and Body Practices
Herbs	Acupuncture
Vitamins and Minerals	Massage/Healing touch
Probiotics	Meditation
Dietary Supplements	Movement therapies
	Relaxation techniques
	Spinal manipulation (chiropractic/osteopathy)
	Tai chi and qi gong
	Yoga
	Hypnotherapy

Note. Adapted from “Complementary, Alternative, or Integrative Health: What’s in a Name?” by NCCIH, 2018 (<https://nccih.nih.gov/health/integrative-health>). In public domain.

Notably, naturopathy, homeopathy, traditional medicine, Ayurveda and Traditional Chinese Medicine (TCM) are absent in either of NCCIH’s (2018) categories. Rather, these CAM practices are described as “other complementary health approaches” because they fail to fit within the categories of natural products or mind and body practices (NCCIH, 2018, para. 11). The creation of the sub heading other complementary health approaches by NCCIH (2018), highlights the difficulties of trying to categorise the diverse range of therapies, practices and medicines that constitute CAM.

Although NCCIH’s (2018) classification of the various CAM therapies provides a framework for categorising CAM, it fails to accurately sum up the various individual CAM practices. For example, the term mind and body practices provides little insight into what yoga or movement therapies comprise, other than that their practices are somehow related to mind and body. However, creating a universal operational definition that identifies the

specific therapies that constitute CAM is challenging for several reasons (Coulter & Willis, 2004, 2007; Wieland et al., 2011). CAM practices often intersect with a variety of different therapeutic approaches being utilised in clinical practice (Cochrane Complementary Medicine, 2019). For instance, practitioners of Traditional Chinese Medicine (TCM) might utilise acupuncture in their treatment regime alongside other interventions common to TCM (Cochrane Complementary Medicine, 2019; NCCIH, 2013). Naturopathic practice can also incorporate a range of diverse therapeutic interventions, including homeopathy (Endeavour College of Natural Health, 2019; Fleming & Gutknecht, 2010; Shinto et al., 2008). Consequently, creating an operational definition that accounts for these variations is complicated.

One aspect common to most CAM practices is the notion of vitalism: a belief that all living organisms have a life sustaining vital force (Coulter, Snider & Neil, 2019; Coulter & Willis, 2007; Grimes, 2012; Haresnape, 2013; Künne, 2015). In Traditional Chinese Medicine this force is known as ‘qi’ (Koopsen & Young, 2009, pp. 139–140), while homeopaths speak of the ‘vital force’ (Hahnemann, 1998, pp. 97–98). As noted by Coulter et al., 2019, subscribing to vitalistic principles results in a different perception of health and illness, the role of the health care provider and the provision of health care (p. 60). Central to the concept of vitalism is the self regulating ability of the body to find balance: the aim of an intervention is to stimulate this force and support the process (Coulter & Willis, 2019, p. 64). Consequently, a holistic view of health is adopted: one where disease and illness are not primarily associated with biological factors (Coulter et al., 2019).

The terms holistic and holism have their origins in the Greek language, having been derived from the Greek word, ὅλος-holos, meaning total or whole (Papathanasiou et al., 2013, p. 1). A holistic approach to health care is a multifaceted approach that recognises that human

beings are complex multidimensional entities and that all the components constituting the human organism are interrelated (Huljev & Pandak, 2016; Papathanasiou et al., 2013). Rather than being a different mode of treatment or intervention, holistic health care is a philosophical approach that considers mental, emotional, physical, spiritual and sociological factors as an integrated whole instead of reducing them into separate components (Huljev & Pandak, 2016; Papathanasiou et al., 2013). Given that CAM practices are underpinned by vitalistic principles, Coulter and Willis (2007) propose that this aspect of CAM could be used for the purposes of analysis and definition (p. 216). However, although CAM practices share a belief in vitalistic principles, the depth and degree of that belief can vary between different CAM practices (Coulter et al., 2019), so its usefulness in defining CAM is debatable.

Another difficulty in defining CAM is that the boundaries between CAM and conventional medical practices are becoming increasingly fluid. Several practices that have historically been defined as CAM, are being utilised in a variety of conventional health care settings (NCCIH, 2018; J. Singer & Adams, 2014; Wieland et al., 2011). In Australia for example, chiropractic science and osteopathy are now registered health care professions, recognised by the Australian Health Practitioner Regulation Authority (AHPRA), (2017). Health professions recognised by AHPRA are regulated by national legislation that is consistent across all states and territories of Australia (AHPRA, 2015). The inclusion of CAM practices on the national register of health professions raises the question of whether these practices are still considered as CAM. Arguably, once CAM practices become registered health care professions and are incorporated into, or alongside, conventional models of health care, they are situated within the domain of the dominant health care system. If CAM practices cease to become CAM once statutory regulation is conferred upon them, any operational definition of CAM would need to be regularly updated to reflect these changes.

Furthermore, a universal operational definition of CAM would need to consider the cultural context of the various CAM practices. Practices considered to be CAM in one region of the world, can be a part of the dominant health care system in other regions. For instance, the Indian government has actively striven to incorporate traditional forms of medicine into the mainstream health care structure of India (Bhandari, 2015; Samal, 2014; Sen & Chakraborty, 2016). In China traditional healing practices remain a part of the fabric of society (Yuan, Ma, Ye, & Piao, 2016). However, in Australia, traditional forms of medicine are largely absent from the primary health care system (S. Oliver, 2013). These factors further contribute to the challenges of creating a universal operational definition of CAM.

Aside from the debate over how to define CAM, the naming of CAM has also been a topic of deliberation. In addition to the term complementary and alternative medicine or CAM, the terms ‘complementary medicine’ and ‘complementary therapies’ are also widely utilised to describe CAM practices (NCCIH, 2018; van der Riet, 2011). The term complementary is widely used to refer to a CAM practice that is utilised concurrently with biomedical treatment, while the term alternative is used to refer to the replacement of biomedicine with a non-biomedical approach (Ayers & Kronenfeld, 2010; Barrett, 2003; NCCIH, 2018). The National Institute of Complementary Medicine (NICM) (n.d.), suggest that the term CAM is “outdated” and argues that the term complementary medicine is more instep with key stakeholders in the Australian CAM sector (p. 3). Similarly, van der Riet (2011) states a preference for the use of the term complementary therapies, suggesting that the term is less divisive than CAM and helps close the gap that exists between biomedicine and CAM (p. 4). It is further suggested by van der Riet (2011) that as many CAM practices pre-date modern medicine, the term alternative is misleading (p. 4).

As noted by Coulter and Willis (2004), the naming of CAM has significant consequences both socially and politically, as it is representative of the historical power complexities that dominate the field of health care (p. 587). Whether one uses the term complementary medicine or CAM, these practices are framed as complementary and/or alternative to biomedicine (Coulter & Willis, 2004, 2007; Gale, 2014). Either way, biomedical dominance is affirmed (Coulter & Willis, 2004, 2007; Gale, 2014). After much deliberation over the use of the term complementary medicine versus CAM, the term CAM, was chosen for use in the thesis, due to the widespread use of this term in the medical, nursing and social science literature (Cevik & Selcuk, 2019; Gale, 2014; Groenewald, Beals-Erickson, Ralston-Wilson, Rabbitts, & Palermo, 2017; Indra, 2018; Kolkman, Visser, Vink, & Dekkers, 2011). Furthermore, where specific CAM practices, such as homeopathy or naturopathy, are specifically discussed they are referred to by name. An overview of homeopathy and its core principles will now be presented.

2.3 Homeopathic Philosophy and Practice

Homeopathy is a complete system of medicine with its own theoretical basis and practice procedures that was developed in the late 18th century by Samuel Hahnemann, a German chemist and physician (Baars & Hamre, 2017; Loudon, 2006) Hahnemann practised medicine in an era where medical practices included bloodletting and the administration of toxic substances such as arsenic, in potentially harmful doses (British Homeopathic Association, 2019b; D. P. Thomas, 2014; Winston, 1999). Hahnemann reportedly became dissatisfied with the medical interventions of the time and it was from this malcontent that his interest in a new approach to treating illness was born (British Homeopathic Association, 2019b; J. Weir, 1933). Since its inception, various forms of homeopathy have evolved, with some iterations having little in common with the homeopathic principles established by Hahnemann (Golden, 2007; Levy, 2017; Levy, Ajjawi, & Roberts, 2010). As a

consequence, not all homeopaths necessarily identify with, or practice in accordance with, the principles founded by Hahnemann.

As noted by Levy (2017), some homeopathic practitioners utilise aspects of Hahnemann's approach combined with that of prominent homeopaths who have built upon and extended Hahnemann's approach (p. 67). Other practitioners adopt what Levy, Ajjawi and Roberts (2010) call an "artistic-therapeutic" approach that was developed by contemporary homeopathic theorists (p. 1321). Although there are different approaches to the practice of homeopathy, the approach taken by participants in this study was informed by Hahnemann and followed the core principles of homeopathy outlined in this chapter. Participants' approach to their homeopathic practice will be further explored in Chapter Five of the thesis, *Connecting Philosophically*. Homeopaths who follow Hahnemann's homeopathic principles are commonly described as practising classical or Hahnemannian homeopathy (Ernst, 2013, para. 4; International Academy of Classical Homeopathy, 2016a, para. 1). The core tenets of classical homeopathy include the concepts of the law of similars, minimum dose, and totality of symptoms (Bellavite, Conforti, Pontarollo, & Ortolani, 2005), which will be explored in turn. Table 2 provides a summary of the core principles of classical homeopathy.

Table 2.

Summary of the Core Principles of Classical Homeopathy

Core Principles of Classical Homeopathy	
Law of Similars	A homeopathic remedy capable of causing a similar state as that found in an illness can cause a counter reaction by stimulating the body's own defence mechanism or 'vital force'.
Minimum Dose	The dose of the remedy is the minimum amount required to stimulate a therapeutic response.
Totality of Symptoms	The illness is considered as part of the 'totality' of the whole person, in terms of symptoms and pathology. The remedy chosen must match the individual, not the name of the illness.

Note: Adapted from "Immunology and Homeopathy. 1. Historical Background".

Bellavite et al., 2005 <https://dx.doi.org/10.1093%2Fecam%2Fneh141>). In public domain.

2.3.1 Law of similars

In addition to his role as a physician, Hahnemann spoke several languages and reportedly worked translating texts (J. Weir, 1933; Winston, 1999). According to Winston (1999), as Hahnemann became more interested in less invasive therapeutic interventions than the medical practices of the time, he virtually gave up his medical practice in favour of chemistry and translating (p. 4). Apparently, it was while translating a text written by an eminent physician of the time, Dr William Cullen, that Hahnemann's journey with homeopathy began (Ernst, 2016; Winston, 1999). Hahnemann questioned Cullen's explanation that the bark of the plant *China Officinalis*, which contains quinine, was effective in the treatment of malaria due to its astringent qualities and its effects on the stomach (Ernst, 2016, p. 22; Jonas, Kaptchuk, & Linde, 2003, p. 393; Winston, 1999, p. 4). Testing Cullen's theory, Hahnemann began taking repeated doses of *Cinchona* to determine its actions, noting that it produced symptoms similar to those found in people suffering from malaria (Ernst, 2016; Jonas et al., 2003). Hahnemann's self-experimentation with

Cinchona was the start of his experimentation of a variety of substances on family, friends and other volunteers, leading to the development of homeopathy as a system of medicine.

The process of giving a homeopathically prepared substance to volunteers who have no known illness and meticulously recording the effects of the substance on their physical, mental and emotional wellbeing is known as a proving (Liga Medicorum Homoeopathica Internationalis & European Committee for Homeopathy, 2014; European Committee for Homeopathy, 2019b). Hahnemann's experiment with Cinchona was essentially the first homeopathic proving and paved the way for Hahnemann's theory of the law of similars, which posits that substances that cause specific symptoms in an otherwise healthy individual can be used to treat similar symptoms that present during illness (Clausen, Moss, Tournier, Lüdtke, & Albrecht, 2014; Jonas et al., 2003). The law of similars is fundamental to homeopathy and is known as "similia similibus curentur", or "let likes be cured by likes" (European Committee for Homeopathy, 2019c, para. 1). Although the law of similars is fundamental to homeopathic doctrine, it should be noted that other physicians and philosophers such as Paracelsus and Hippocrates, had suggested similar notions prior to Hahnemann's development of homeopathy (Bellavite et al., 2005; J. Weir, 1933). The importance of the law of similars to homeopathic doctrine is evident in the name homeopathy, which is derived from the Greek words "homoios" meaning similar and "pathos", meaning suffering (Şenel, 2019, p. 165).

An example of the law of similars and its use in homeopathic practice can be found in the homeopathic use of the plant Belladonna, which is known to be poisonous and produce severe symptoms when ingested (Berdai, Labib, Chetouani, & Harandou, 2012; Lee, 2007). Belladonna poisoning symptoms commonly include fever, dilated pupils, flushing of the skin and delirium (Berdai et al., 2012; Lee, 2007). The homeopathic remedy Belladonna

might therefore be utilised in intense fevers that produce symptoms similar to those found in Belladonna poisoning (International Academy of Classical Homeopathy, 2016b; Kent, 1999a). However, it is important to note that there are numerous homeopathic remedies that can be utilised for a fever (Kent, 1999b, p. 1278; Worden, 2019, para. 7) and that the selection of a particular remedy is based upon its similarity to the presenting symptoms of the unwell individual. Given the poisonous nature of Belladonna, the homeopathic remedy of the same name is a diluted form of the original substance. The dilution of substances leads to another core principle of homeopathy, that of the minimum dose.

2.3.2 Minimum dose

The way in which homeopathic remedies are produced and prescribed are underpinned by the concept of the minimum dose, which relates to giving the smallest amount of a homeopathic remedy to stimulate a therapeutic response (Jonas et al., 2003; School of Homeopathy, 2017). Central to the concept of minimum dose is the dilution process used in the preparation of homeopathic remedies (Jonas et al., 2003; Rehman & Ahmad, 2017). During the development of homeopathy, Hahnemann sought to reduce the toxicity and subsequent side effects of the remedies through a process of dilution (Bellavite et al., 2005; Jonas et al., 2003). After considerable experimentation, Hahnemann eventually settled upon producing homeopathic remedies in a process known as potentisation, where remedies are serially diluted and succussed, or shaken (Chikramane, Suresh, Bellare, & Kane, 2010; Shah, 2016).

Serial dilutions of homeopathic remedies can involve few dilutions, or the dilutions can number in the hundreds (Chikramane et al., 2010; Grimes, 2012). Two of the most common potency scales used in the preparation of homeopathic remedies are the decimal and centesimal scales (I. R. Bell & Boyer, 2013; Rehman & Ahmad, 2017). Homeopathic

remedies prepared using the decimal scale involve the starting material being diluted 1:10, while those prepared using the centesimal scale are diluted 1:100 (I. R. Bell & Boyer, 2013, p. 34; Udhayam Homoeo Pharmacy, 2014, para. 24–25). The centesimal scale is denoted by the inclusion of the letter ‘c’ following the number of times it has been diluted (I. R. Bell & Boyer, 2013, p. 34; Rehman & Ahmad, 2017, p. 23), or if in Europe by the letters ‘CH’ (Lotus Health Institute, 2019, para. 2). A homeopathic remedy with the potency of 30c has gone through a process of 1:100 dilution thirty times (I.R. Bell & Boyer, 2013, p. 34). In contrast, a homeopathic remedy with the potency of 200c has been diluted 1:100 two hundred times (Croce, 2000a). At each stage of the dilution process one part of the preparation is added to 99 parts of alcohol/water (Udhayam Homoeo Pharmacy, 2014, para. 25). Homeopathic remedies prepared using the decimal scale are commonly denoted by the letter ‘x’, though some countries use the letter ‘d’ rather than the letter ‘x’ (I. R. Bell & Boyer, 2013; Rehman & Ahmad, 2017). Figure 2 provides an illustration of homeopathic potentisation from a mother tincture¹ of the original substance to a 3c or 3x dilution.

¹ A mother tincture is typically a maceration of a base substance, such as herbs, which is then mixed with alcohol (Gupta, Tailang, Pathak, Lo khande, & Sunil, 2010)

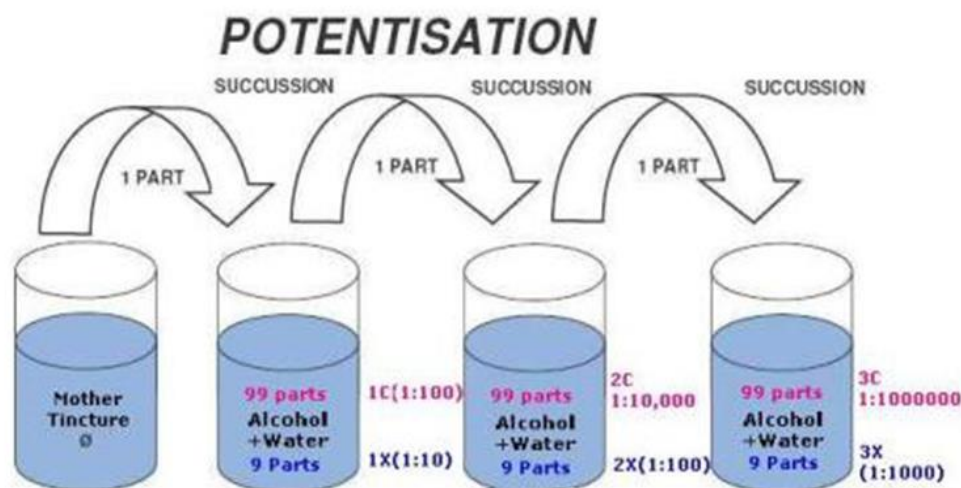


Figure 2. Homeopathic potentisation. From “How, What and Why of Homoeopathic Medicines,” by Udhayam Homoeo Pharmacy, 2014, para. 15 (<https://pharmacy.curative-medicine.com/about-homoeopathy>). In public domain.

The serial dilution of homeopathic remedies is arguably the most controversial aspect of homeopathy (Coulter & Willis, 2004; Grimes, 2012; Loudon, 2006; Rao, Roy, Bell, & Hoover, 2007; Rutten et al., 2013). Research in the area of high dilutions has historically evoked strong emotions (Maddox, Randi, & Stewart, 1988; Y. Thomas, 2007, 2015). Perhaps the most widely known research in the area of high dilutions is that of a study led by French immunologist, Jacques Benveniste, which suggested that immunoglobulin E antibodies² exert an effect even after being highly diluted (Davenas et al., 1988). The findings by Davenas et al. (1988), published in the esteemed scientific journal *Nature*, created a furore (Maddox et al., 1988; Y. Thomas, 2007). Moreover, attempts to replicate the findings of Davenas et al. (1998) produced mixed results and in a subsequent edition of

² Antibodies are a vital component of the human immune system. They attach themselves to invading organisms to stop them replicating and entering cells (Flies & Webb, 2016). Immunoglobulin E antibodies are understood to be important in allergic reactions and adaptive immunity (Amarasekera, 2011).

Nature, the work of Benveniste and his research team were labelled a “delusion” (Maddox et al., 1988, p. 287).

Benveniste’s research on high dilutions came to the forefront of debate again recently after Nobel laureate, Luc Montagnier, the co-discoverer of HIV, spoke about his own research and how it compared to that of Benveniste. In an interview with *News of the Week* reporter Martin Enserink, it was reported that Montagnier stated that he believed Benveniste’s findings had validity (Enserink, 2010). These comments followed on from Montagnier’s own research, which discovered that bacterial and viral deoxyribonucleic acid (DNA) produced electromagnetic waves even at high dilutions (Montagnier, Aïssa, Ferris, Montagnier, & Lavallée, 2009; Montagnier et al., 2011). In the Enserink (2010) interview, Montagnier was asked how the findings from his study related to homeopathy. Montagnier responded by stating that he was unable to confirm that homeopathy was right about everything, but that he could confirm that high dilutions are water structures that mimic the original molecules and therefore, can not be considered nothing (Enserink, 2010, p. 1732). Montagnier decided to move to China to continue his studies into high dilutions, citing a fear around the topic of high dilutions in Europe and a subsequent lack of research funding, as factors in his decision to relocate (Enserink, 2010, p. 1732).

The controversy surrounding high dilutions relates to the understanding that substances diluted beyond a certain point contain no biologically active components (Jonas et al., 2003; Smith, 2012a). For instance, homeopathic remedies that have been diluted beyond the point of a 12c contain no detectable trace of the original starting material (Rehman & Ahmad, 2017). Consequently, critics argue that any therapeutic effect from highly diluted homeopathic remedies is scientifically implausible (Coulter & Willis, 2004; Grimes, 2012;

Jonas et al., 2003; Smith, 2012a). Homeopathic dilutions were summed up by Smith (2012a) as follows:

Simple arithmetic shows that to receive just one molecule of the diluted agent from a fairly standard homeopathic dilution of 1×10^{30} , the patient would have to consume over 30,000 litres of the homeopathic solution. And many homeopathic medicines are diluted to even greater extremes, ranging from up to 1×10^{400} , meaning that to receive just one molecule of agent the patient would have to consume more matter than is present within the entire universe. Thus, for homeopathic dilutions to have mechanistic effects, it would appear necessary to reject virtually all that science has painstakingly elucidated over the last 200 years concerning the composition of matter itself. (p. 510)

Smith's (2012a) comments on homeopathic dilutions are understandable, given that current scientific knowledge dictates that the more a substance is diluted, the more its potency and action is reduced (Coulter & Willis, 2004; Grimes, 2012; Lees et al., 2017; Smith, 2012b). However, homeopaths consider homeopathic remedies of high dilution to have a deeper action than those of a lower potency (I. R. Bell & Koithan, 2012; Croce, 2000a; Grimes, 2012). Therefore, a homeopathic remedy that has been diluted two hundred times is considered to act at a deeper level than a remedy diluted 30 times (Croce, 2000a). Essentially, homeopaths consider the actions of highly diluted homeopathic remedies to act differently from those of the lower potency scale. It is important to understand that this perceived difference of action is unrelated to the measurable amount of the original substance in a remedy; rather, the difference is related to the potency's response on the vital force (I. R. Bell et al., 2004; Haresnape, 2013).

Homeopaths seek to restore balance by stimulating the self-regulating capabilities of the vital force through the indicated homeopathic remedy (I. R. Bell et al., 2004; Haresnape, 2013). The potency of a homeopathic remedy is generally selected according to various criteria, including the health and vitality of the individual, the presenting complaint and the individual response to that complaint (National Health Portal, 2015). Once a remedy and its potency are decided upon, a minimum dose of the selected homeopathic remedy is then used to achieve a therapeutic response. Choosing the indicated homeopathic remedy for each case is a complex process involving the third and final homeopathic principle to be discussed in this chapter; namely: the totality of symptoms.

2.3.3 Totality of symptoms

Case taking in homeopathy is a client centred, holistic and individualised approach that involves a complex combination of active listening, recording of subjective symptoms and objective observation along with open and targeted questioning (Eyles, Leydon, Lewith, & Brien, 2011; Prousky, 2018). Homeopathic consultations can be lengthy, often lasting an hour or more in duration (Eyles et al., 2011; Loudon, 2006). During that time, the client is asked about their presenting complaint, which essentially relates to why they have come. They are then given the space to talk about other aspects of their lives that include, but are not limited to, their physical, mental and emotional health, relationships, spirituality and general wellbeing (Eyles et al., 2011; Prousky, 2018). It should be noted that although lengthy consultations are common in homeopathic practice, shorter approaches to case taking do exist. In his dissertation exploring the clinical reasoning and decision making in homeopathy, Levy (2017) shares a personal experience of attending teaching hospitals in India and witnessing homeopathic consultations that took up to an hour, while others were much shorter (p. 48). However, Levy (2017) does make the distinction that the shorter

consultations were generally in relation to acute cases, while the longer consultations related to chronic cases, which are typically more complex (p. 48).

Regardless of what approach to case taking is taken, the primary aim of a homeopathic consultation is to find a homeopathic remedy that matches the core problem within the context of the clients mental, emotional and physical self, while also considering external factors that may be impacting the case. Homeopaths are warned by Hahnemann (1998) about the dangers of “symptomatic treatment” based upon a single symptom (p. 96). According to Hahnemann (1998), the totality of symptoms is a reflection of the essence of the disease and will guide a homeopath to the appropriate homeopathic remedy (p. 96). Therefore, during the process of deciding on a remedy, the totality of symptoms are considered, rather than a single presenting complaint (Hahnemann, 1998, pp. 105--106). This style of case taking is a highly individualised process whereby the homeopath tries to identify the disturbance that is central to the case and dispense the homeopathic remedy that matches the disturbance (Eyles et al., 2011; Prousky, 2018).

In homeopathic practice, the complex process of selecting an indicated homeopathic remedy is aided by using homeopathic materia medicas and repertories (Kent, 1999a, 1999b; National Center for Homeopathy, 2017). Homeopathic repertories consist of an extensive compilation of different symptoms and diseases, along with the homeopathic remedies that have been found to be useful in their treatment (Kent, 1999b; National Center for Homeopathy, 2017). Homeopathic materia medicas complement homeopathic repertories through the outline they provide of the profile of the various homeopathic remedies. Each remedy in a homeopathic materia medica has a detailed profile of its actions in relation to mental and emotional symptoms, as well as its indications for the various systems of the body and its general attributes (Kent, 1999a; National Center for

Homeopathy, 2017). As there are thousands of homeopathic remedies, homeopathic materia medicas and repertories are important clinical tools utilised by practising homeopaths to assist in their process of remedy selection.

Discussion on the core principles of homeopathy has illustrated some of the key differences between homeopathy and biomedicine, especially regarding their epistemological and ontological differences. In addition to these disparities, homeopathy and biomedicine hold vastly different positions in the health care system of Australia, which will now be explored.

2.4 Situating Homeopathy in the Australian Health Care System

Australia's health care system is a complex network of public and private health care providers and settings (Australian Institute of Health and Welfare [AIHW], 2018). It includes a diverse range of occupations and qualified professionals, including nurses and midwives who constitute the bulk of the health care workforce, with over 315,000 registered nurses and midwives employed in Australia in 2016 (AIHW, 2016a, p. 46). Australian health care services are funded through a variety of means. For instance, public hospital funding is the responsibility of the state, territory and federal governments, while their management is under the control of the state and territory governments (AIHW, 2018, p. 42). Although private hospitals are licensed and regulated by the various levels of Australian government, they are owned and operated by the private sector (AIHW, 2018, p. 42). Underpinning the Australian health care system is Medicare, a public health insurance scheme whereby Medicare cardholders have access to free treatment at public hospitals (AIHW, 2018, p. 44). A portion of some medical services and pharmaceutical prescriptions are also subsidised under the Medicare system (AIHW, 2018, p. 44). However, a number of medical and allied health services remain unsubsidised, including most CAM practices (AIHW, 2018, p. 44).

Presently, the only CAM practices eligible for a Medicare subsidy are acupuncture, provided the treatment is performed by a medical practitioner (Department of Health, 2019a), osteopathy and chiropractic services, when referred by a medical practitioner (Department of Health, 2019b, 2019c). All CAM practices subsidised by Medicare are regulated health care practices (APHRA, 2017). Fifteen health care practices are regulated under the National Registration and Accreditation Scheme for health professions (APHRA, 2017). Table 3 outlines the health professions currently regulated under statute to practise in Australia.

Table 3.

Health Professions Regulated under Statute to Practise in Australia

Statutory Regulated Health Professions in Australia	
Aboriginal and Torres Strait Islander Health Practice	Optometry
Chinese Medicine	Osteopathy
Chiropractic	Paramedicine
Dentistry	Pharmacy
Medicine	Physiotherapy
Medical Radiation Practice	Podiatry
Nursing and Midwifery	Psychology
Occupational Therapy	

Note: Adapted from “National Boards,” by AHPRA, 2017

(<https://www.ahpra.gov.au/National-Boards.aspx>). In public domain.

Of these licensed practices, only three CAM therapies are included in the national registration and accreditation scheme for health professions in Australia: osteopathy, chiropractic and Chinese Medicine, which includes the practice of acupuncture (Chinese Medicine Board of Australia, 2019, p. 8). CAM practices, such as homeopathy, that are not subsidised by Medicare operate on a pay for service basis where individuals pay for these

services privately. Although most CAM practices have no official recognition in Australia, steps have been taken by some sectors of CAM to self-regulate their fields of practice (Wardle, Steel, & McIntyre, 2013). Self-regulation typically involves the formation of professional associations and setting minimum standards of education and practice for practitioners (Australian Health Ministers' Advisory Council, 2013; Australian Homoeopathic Association [AHA], 2019a). Homeopathy is one of the CAM therapies in Australia that has followed the pathway of self-regulation (AHA, 2019a, 2019b; Australian Register of Homoeopaths [AROH], n.d.a).

The largest professional association solely representing homeopathy in Australia, is the AHA (2019a). To be eligible for membership of the AHA, practitioners must meet the criteria set by the Australian Register of Homoeopaths (AROH), the national registration body of professional homeopaths (AHA, 2019c; AROH, n.d.a). The role of AROH (n.d.a, n.d.b) is multifaceted and includes the setting of national standards for homeopathic practice, accrediting homeopathic courses, registering suitably qualified homeopaths for practice and dealing with complaints from members of the public. AROH registered homeopaths have met national competency standards for homoeopathic education and are required to meet annual professional development and insurance requirements and adhere to a code of professional conduct and standards of practice (AROH, n.d.b, n.d.c). Practitioners may also be “subject to other statutory or legal requirements” such as the Therapeutic Goods Act and Therapeutic Goods Advertising Act, Fair Trading and “public health legislation in the state or territory in which they practise” (AROH, 2018a, p. 4).

In August 2019, the number of registrants listed on AROH's website was small, totalling 417 (AROH, 2018b). However, these numbers may not accurately indicate how many people are actually practising homeopathy in Australia. For instance, AROH registrants

can take a leave of absence from their practice, during which time their name will not appear on the directory (AROH, 2018b). Other CAM practitioners, such as naturopaths, may utilise homeopathy as a therapeutic intervention in their professional practice (Australian Naturopathic Practitioners Association, 2018; Endeavour College of Natural Health, 2019; Fleming & Gutknecht, 2010; Shinto et al., 2008) and therefore would not be listed on AROH's register. In addition, self-regulation of unregistered health practitioners is currently voluntary, consequently, anyone can call themselves a homeopath, regardless of the qualifications they may or may not hold (Australian Health Ministers' Advisory Council, 2013, p. 17).

The Australian Health Ministers' Advisory Council (2013) describes an unregistered health practitioner as any person providing a health service who is not registered with any of the professions "regulated under the National Registration and Accreditation Scheme for health professions" (p. 5). Homeopaths in Australia are therefore under no obligation to register with AROH or be members of any professional association; they can legally practise outside the domain of any professional regulatory body (Australian Health Ministers' Advisory Council, 2013). The lack of regulation of CAM practices, such as homeopathy, has been the subject of discussion among stakeholders for a number of years (Australian Health Ministers' Advisory Council, 2013; Lin et al., 2009; Naturopaths and Herbalists Association of Australia [NHAA], n.d.; Wardle et al., 2013b). The primary aim of statutory regulation is to protect the public (AHPRA, 2019; Lin et al., 2009; Wardle, 2011). Therefore, some commentators argue that statutory regulation is a necessary and desirable outcome for CAM practices, as it would set consistent levels of education for practitioners and offer further protection to those accessing CAM services (NHAA, n.d.; Wardle, 2011; Wardle et al., 2013b).

Many CAM practices are subject to the same safety concerns as other health care approaches, including medicine. For instance, herbal interventions have the potential to interact with pharmaceutical treatments, thereby providing an element of risk for health care consumers (Lin et al., 2009). Consequently, it is vital that practitioners utilising herbal medicine are well educated in the field of herbal medicine and have a solid understanding of biomedical interventions and how various herbal medicines might interact with them. It is equally important that biomedical practitioners have a good understanding of various CAM practices and any potentially harmful interactions that might occur with concomitant use of CAM and biomedical treatments (Giannelli, Cuttini, Da Frè, & Buiatti, 2007; von Conrady & Bonney, 2017). In addition, CAM is no different to other sectors of health care in relation to rogue practitioners who fail to uphold the best interests of their clients and practise in unsafe and unethical ways (Wardle, 2010). Although, self-regulation may provide a pathway for consumer complaint and for the relevant professional association to instigate action against a particular practitioner, the question of whether this provides enough protection for consumers, remains (Lin et al., 2009; Wardle, 2010; Wardle, Adams, Lui, & Steel, 2013c; Wardle et al., 2013b).

Alternatively, arguments against statutory regulation of CAM include that it would impose an extra financial burden on practitioners and could be perceived as legitimising CAM (NHAA, n.d; Wardle et al., 2013b). Overall, it appears that CAM practitioners and associations generally support statutory regulation (Australian Health Ministers' Advisory Council, 2013, p. 40; Wardle et al., 2013c). However, some CAM practitioners' question whether statutory regulation could result in CAM practices adopting a more conservative approach as they endeavour to fit within a health care system dominated by the biomedical approach (Canaway, 2009). According to Coburn (1993) and Cant and Sharma (1999), chiropractic is an example of the subordination of a CAM practice to the dominant

biomedical approach in a bid to become a state sanctioned health care practice. Coburn (1993) asserts that the official recognition of chiropractic in Canada and elsewhere in the world, has been achieved by minimising the more controversial aspects of its practice and aligning with the dominant scientific paradigm (p. 134). Interestingly, Cant and Sharma (1999) suggest that post the inclusion of chiropractic as a statutory regulated practice in the United Kingdom, there was no shift in the direction of health care; rather the scope of chiropractic practice narrowed (p. 147). Biomedicine remained unchallenged and continued to dominate among the elite realm of state sanctioned health care practices (Cant & Sharma, 1999). Despite the potential pitfalls associated with statutory regulation, CAM industry stakeholders appear to generally favour statutory regulation over self-regulation (CMA, 2014a; NHAA, 2014; M. Weir, 2016).

An important point to consider when discussing the Australian health care system and homeopathy's place within it, are the differences between publicly funded health care services and the private 'fee for service' basis that homeopathic practitioners generally operate under. The former is subject to, among other factors, tightly controlled resource allocations and clinical governance, as well as various policy developments that influence the delivery of health care services (Berger, Braehler & Ernst, 2012; Cant et al., 2011; Kluge 2007). Although it is beyond the scope of this thesis to explore how resourcing impacts the provision of services, it is widely acknowledged that financial constraints influence the level and type of care provided by frontline health care professionals, such as nurses (Australian Nursing and Midwifery Federation, 2014a; Pearce et al., 2011; Scott et al., 2019). For example, funding cuts negatively impact the staffing ratios of nurses, which remain static or decrease, leading to a rise in nurses' workloads, a decrease in positive client outcomes and increased levels of dissatisfaction among nursing staff (Australian Nursing and Midwifery Federation, 2014a; Berger et al., 2012; Scott et al., 2019; Watkins et al.,

2017). These factors all impact on the time nurses have to build relationships with clients and engage in shared decision making (Berger et al., 2012). Working as nurse in the public health care system of Australia is therefore, a very different experience to working as a homeopath, where one has the freedom to tailor the format and length of consultations to the individual needs of the client (Eyles et al., 2011).

There are also notable differences in the demographics of individuals accessing public health services to those who utilise the services of CAM practitioners. Research suggests that CAM consumers tend to be females with high levels of education and income (Bishop & Lewith, 2010; MacLennan, Myers & Taylor, 2006; Reid et al., 2016). Furthermore, individuals utilising CAM are more likely to have chronic health complaints, or multiple health concerns (Bishop & Lewith, 2010; Metcalfe, Williams, McChesney, Patten, Jetté, 2010; Reid et al., 2016). In contrast, individuals utilising public health care services are typically from a range of diverse socio-economic backgrounds and present with a variety of acute and chronic health conditions (AIHW, 2016; RACGP, 2018).

No discussion of CAM and its place in Western health care systems would be complete without considering CAM within the context of a 'profession'. The concept of a profession has been the subject of much debate and discussion with regard to the professionalisation of occupations, and how a profession is defined (Aukett, 2017; Brante, 2011; Cruess, Cruess, Boudreau, Snell, & Steinert, 2015; Freidson, 2001; Saks, 2012). Although various descriptions of the characteristics of a profession can be found in the literature, typically the professionalisation of occupations involves a monopoly of specialised services and knowledge, autonomy over its own practice and the formation of a professional body with standards of practice and a code of ethics (Brante, 2011; Freidson, 2001; Khoury, 2012; Reed, 2018; Saks, 2012; Willis, 1990). Access to professional bodies and their area of

specialised knowledge is only accessible to those that meet certain criteria (Freidson, 2001; Turner, 1987; Willis, 1990).

Through the process of professionalisation, an occupation becomes a skilled and knowledgeable specialist within a particular domain, thereby establishing a dominant position (Freidson, 1974, p. 116; Turner, 1987, pp. 140–141). One way of maintaining professional dominance is to limit or oppose the professionalisation of occupations that threaten one's own professional monopoly (Freidson, 1974; Willis, 1999). The professionalisation of occupations can therefore be considered as a complex process involving socio-political factors that result in occupations gaining dominance (Freidson, 2001; Willis, 1990). The same socio-political factors that assist an occupation in establishing itself as a profession can prevent an occupation from gaining professional status. For instance, although many CAM practices have specialised knowledge, CAM epistemology may lack legitimacy according to the state, as is the case with many CAM practices in Australia. Consequently, referring to CAM practices without statutory regulation as professions, is contestable. However, as noted by Cant et al., (2011) new occupational strategies in relation to professionalism have been developed, where professional standing is separate from any state sanctions (p. 530). Rather, professionalism is based on practitioners' application of knowledge in practice (Cant et al., 2011). As homeopaths, participants in this study held specialised knowledge that informed their homeopathic practice. In addition, participants were registered homeopaths, making them subject to standards of practice and a code of ethics. Therefore, for the purposes of discussion in the thesis, homeopathy is referred to as a profession and participants as members of the homeopathic profession.

2.5 Summary

CAM is a diverse range of health care practices that sit outside the domain of the dominant biomedical model of health care in western nations, such as Australia. Included in the categorisation of CAM is the practice of homeopathy, which was developed by Samuel Hahnemann in the late 18th century. The core principles of homeopathy founded by Hahnemann are controversial and conflict with current scientific knowledge. Homeopathy therefore lacks legitimacy as a health care practice in Australia and operates as a self-regulated industry without official recognition. This chapter has provided an overview of CAM and homeopathy to set the scene for the rest of the thesis. The following chapter, Chapter Three, *Background*, will discuss the role of literature in grounded theory research and provide background to this study in the form of a preliminary review of the literature.

Chapter 3. Background

3.1 Introduction

Chapter Two of the thesis defined complementary and alternative medicine (CAM) and discussed the core principles of homeopathy and how they relate to homeopathic practice. Homeopathy was located within the Australian health care system and its status as a health care profession was explored. To stay true to the chosen research approach of grounded theory, the aim of this chapter is to provide a preliminary review of the literature that was undertaken prior to the commencement of data collection. To situate this study within a grounded theory framework, the chapter begins with a discussion on the role of literature in grounded theory and how the relevant literature was used in this study. The preliminary review of the literature begins with a brief discussion on the foundation of CAM and the prevalence of CAM use in Australia. Next, the historical relationship between CAM and biomedicine is explored, followed by an overview of homeopathy, its emergence in Australia and biomedical opposition to its practice. The relationship of CAM and nursing is then briefly examined before the chapter concludes with a synopsis of the key points outlined in the chapter.

3.2 The Role of Literature in Grounded Theory

Undertaking a thorough review of relevant literature is a standard component of the research process, as it allows the researcher to evaluate existing research, thereby assisting in identifying key concepts and gaps in the literature (Birks & Mills, 2011; Boote & Beile, 2005; Dunne, 2011). In addition, a literature review can assist in establishing a theoretical framework that guides and provides structure to the research (Paré & Kitsiou, 2017). However, review of the literature prior to the commencement of a grounded theory study is a contentious issue (Birks & Mills, 2011; Charmaz, 2014; Corbin & Strauss, 2008; Dunne,

2011; Ramalho, Adams, Huggard, & Hoare, 2015). Traditionally, grounded theory studies have no theoretical framework guiding their research before data collection and analysis commences (Charmaz, 2014; Corbin & Strauss, 2008; Glaser, 1998; Strauss & Corbin, 1998). The aim of grounded theory research is to develop theory from the data, rather than test an existing theory (Birks & Mills, 2011; Charmaz, 2014; Corbin & Strauss, 2008; Glaser & Strauss, 2009). Consequently, a review of the literature relevant to the substantive area of enquiry is generally deferred until the later stages of a study's analysis (Glaser, 1978, 2001; Glaser & Strauss, 2009).

As there is no way to predict what will emerge from the data, some grounded theorists argue that performing a literature review can lock the researcher into preconceived ideas, thereby restricting the scope of the research (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1998). According to Glaser (2001), the time to review relevant literature is during the 'sorting and writing up phase' (p. 133). However, not all grounded theorists, or researchers utilising grounded theory methodology, agree with the notion of delaying the literature review (Dunne, 2011; Thornberg, 2012). These commentators argue that all researchers bring a varying collection of existing knowledge and experience to their research (Corbin & Strauss, 2008; Dunne, 2011; Strauss & Corbin, 1998). Therefore, it is virtually impossible for a researcher to be a blank slate with no prior knowledge of the subject matter (Corbin & Strauss, 2008; Charmaz, 2014; Cutcliffe, 2000; Strauss & Corbin, 1998).

The challenge for researchers is to use their existing knowledge and experiences in a way that enhances theory development rather than constrains it (Strauss & Corbin, 1998; Timonen, Foley & Conlon, 2018). In addition to the existing knowledge and experiences that researchers hold, there are certain situations whereby a preliminary review of the

literature is impossible to avoid. For example, literature reviews are an important part of a research project where proposals are required for funding bodies, ethics' boards, or to fulfil university requirements for confirmation of candidature (Hallberg, 2010; Lo, 2016; Timonen et al., 2018). In these instances, the literature review provides the researcher with an awareness of existing knowledge on the topic of the study and assists in identifying gaps in the literature, thereby justifying the research (Birks & Mills, 2011; Dunne, 2011, Hallberg, 2010).

As a doctoral candidate, I was required to prepare a proposal for confirmation of candidature for this study in order to be given approval to proceed. Part of this process necessitated the validity of the proposed research topic; therefore, I conducted a literature review in order to develop a proposal that would meet university requirements. The function of the review of the literature was to provide a background to the proposed topic and confirm that the study would add to existing knowledge. Consequently, the literature review focused more on the broader picture of CAM within the historical, social and political context of health care practices. An extensive review of the literature in the substantive area of enquiry was largely avoided. Rather, I undertook a fundamental search that related to nurses who hold CAM qualifications and work in the field of CAM. The result of the preliminary review of the literature indicated a paucity of studies on nurses who also work as CAM practitioners. The scarcity of results indicated that this study would contribute to knowledge on the experience of nurses who choose to practise homeopathy. Presented in this chapter are the results of that preliminary literature review. In keeping with grounded theory methods, the preliminary review of literature was followed by further review of the literature during data collection and analysis, in response to emerging concepts and to aid theoretical sensitivity (Charmaz, 2006, 2014; Corbin & Strauss, 2008). The result of this more extensive review of the literature is used to support discussion in

Chapters Five to Eight of the thesis. Search strategies utilised in the review of the preliminary literature will now be discussed.

3.2.1 Search strategies

The preliminary review of the literature sourced information from academic journals, books and websites. Search criteria included key terms such as: grounded theory, complementary and alternative medicine, CAM, nursing, nurse, holistic, homeopathy, CAM workforce, complementary therapies, CAM, and health professionals. Databases searched included: Academic Search Complete, EbscoHost, SocINDEX, Science Direct, Scopus and CINAHL. In addition to peer reviewed literature, grey literature was also searched and utilised in this study. The role of grey literature within the context of this study will now be discussed.

3.2.2 The role of grey literature in this study

Although academic peer reviewed journal articles were primarily reviewed and utilised in this study, grey literature has also contributed. The University of Canberra (2019) describes grey literature as, “information that is either unpublished or not published commercially” (para. 4). Grey literature commonly relates to a range of information that includes, but is not exclusive to, government and organisational documents and reports, blog posts and theses (University of Canberra, 2019; University of New England, 2019). In this study, government, nursing and homeopathic websites and books provided not only historical and current information in relation to the health care sector, nursing and homeopathy, but also relevant details regarding codes of practice and legislation. In addition, there is considerable discourse relevant to the ongoing debate surrounding homeopathy in the grey literature, which provided valuable insight into how homeopathy is perceived by governments, various members of the health care sector, the general public, and lobbyists.

Grey literature was primarily sourced through internet searches, including searches of key websites such as those relating to the Australian Government and to the nursing and homeopathic professions. Furthermore, grey literature used in relation to the topic of homeopathy was sourced from homeopathic practitioners, educators and/or institutions that are well known within the homeopathic community. Use of grey literature alongside peer reviewed literature allowed for a thorough evaluation of the research topic.

Discussion will now turn to the results of the initial preliminary review of literature, which provides background to this study. As previously stated in the chapter, this preliminary review of the literature was undertaken in the early stages of the study before commencement of data collection and is representative of the literature reviewed at that time. I avoided performing an extensive review of the literature directly related to the substantive area being explored. Rather, this section of the chapter provides an overview of the subject matter within the context of the foundations of CAM and the relationships between CAM, biomedicine, homeopathy and nursing. In keeping with the grounded theory approach applied to this study, which is further explained in Chapter Four *Research Design*, an extensive review of the literature was delayed.

3.3 Foundation of CAM

Every culture has its own personal history of healing traditions, many of which pre-date modern medicine (Abou El-Soud, 2010; Narayanasamy & Narayanasamy, 2006; Vanderploeg & Yi, 2009). These traditions were, and in some cases still are, deeply imbedded into daily life (Di Stefano, 2006; Narayanasamy & Narayanasamy, 2006). For instance, the use of herbs as medicine is evident in ancient civilisations (Abou El-Soud, 2010, Koopsen & Young, 2009), while traditional Chinese Medicine (TCM) has a history of use that dates back thousands of years in China and is still widely utilised among Chinese

emigrants worldwide (Lai & Chappell, 2006; Lam, 2001; Vanderploeg & Yi, 2009). Many of these traditional practices and medicines are now considered within the context of CAM, particularly when practised in cultures foreign to their origin, or in nations where biomedicine is the dominant form of health care (WHO, 2002, p. 1; Zollman & Vickers, 1999). Studies indicate that in recent years, there has been renewed interest in CAM in many western nations of the world, including Australia (Baer, 2008; Coulter & Willis, 2004). Despite biomedical dominance, CAM appears to be increasingly utilised by health care consumers in these nations. Of particular relevance to this study is the utilisation of CAM in Australia, which will now be explored.

3.4 CAM use in Australia

Studies exploring CAM utilisation among the Australian public indicate that its use has increased significantly (MacLennan, Wilson, & Taylor, 1996, 2002; MacLennan et al., 2006; Xue et al., 2007). A population study by MacLennan et al., (1996), of 3,027 individuals living in South Australia, found that 48.5% of their respondents utilised CAM and 20.3% had visited a CAM practitioner in the past year. A repeat of MacLennan et al.'s original 1996 study showed an increase in CAM usage from the period 1993–2000 (MacLennan et al., 2002). Extrapolation of the data from MacLennan et al.'s., (2002) study to the Australian population indicated that the overall expenditure on CAM had more than doubled in the seven years from 1993–2000. Although a further repeat of the study by MacLennan et al., (2006) found a decline in expenditure on CAM products, little change in overall CAM use was identified. A rise in visits to CAM practitioners from previous studies was noted and the authors concluded that there remained significant utilisation of CAM in the South Australian population (MacLennan et al., 2006).

The studies by MacLennan, et al., (1996, 2002, 2006) sampled a single regional area of Australia. Following on from these studies, Xue et al. (2007) conducted a national population-based survey on CAM use in Australia that sampled 1067 individuals from all states and territories in Australia. Findings from Xue et al.'s (2007) survey indicated that CAM usage in Australia was higher than that reflected in previous studies and that the number of visits made annually to CAM practitioners was nearly equivalent to visits made to medical practitioners. Aside from the large population studies done by MacLennan et al. (1996, 2002, 2006) and Xue et al. (2007), a number of other studies have been conducted on CAM utilisation in Australia, all indicating that a significant proportion of the Australian public utilise CAM (Adams, Sibbritt, & Young, 2009; Bensoussan & Myers, 1996; McGregor & Peay, 1996; Sibbritt, Adams, Easthope, & Young, 2003; Wilkinson & Simpson, 2001). The rise in consumer interest in CAM in countries where biomedicine is the dominant form of health care is interesting, given that biomedicine and CAM have a relationship this is characterised by opposing perspectives and a battle for dominance. That relationship will now be explored.

3.5 Historical Relationship of CAM and Biomedicine

Biomedicine shares the same roots as CAM, having also grown out of traditional practices dating back thousands of years (Gurib-Fakim, 2006). However, medicine as it is practised in the 21st century has little in common with the traditional practices from which it originated. These ancient practices were steeped in the belief of a connection between nature and healing (Abou El-Soud, 2010; Koopsen & Young, 2009). As civilisations changed, so too did healing practices and the way that health was perceived (Orfanos, 2007). During the middle ages religion played a significant role in how health was viewed, with illness assigned to evil spirits and sinful action (Orfanos, 2007; Yapijakis, 2009).

The shift from theocratic medicine to the realm of science is credited to Hippocrates, who attempting to rationalise and understand the underlying mechanisms occurring in various stages of disease, advocated a keen observation of disease processes (Grammaticos & Diamantis, 2008; Orfanos, 2007; Yapijakis, 2009). Hippocrates rejected theocratic medicine, but he maintained the belief that individuals were physical, mental and spiritual entities (Friedson, 1970a; Grammaticos & Diamantis, 2008; Orfanos, 2007). Hippocrates' impact on medicine was substantial, as evidenced by him frequently being referred to as the "father of modern medicine" (Grammaticos & Diamantis, 2008, p. 2; Yapijakis, 2009, p. 508). Hippocratic medicine heralded a shift from theocratic medicine to rational medicine, thereby assisting in the formation of clinical observation and professional standards that are the cornerstone of current medical practice (Orfanos, 2007; Yapijakis, 2009). However, Hippocrates' influence on modern medicine extended beyond that of clinical practice to the moral and ethical obligations of medical practitioners (Orfanos, 2007; Sakula, 1984). The Hippocratic Oath, the Declaration of Geneva and other ethical codes have informed and inspired the framework of medical ethics (Australian Medical Association, 2006; Bujalkova, 2001; Sakula, 1984).

Another notable influence on medicine was that of Cartesian Dualism, which is credited to Rene Descartes, a 17th century French philosopher, mathematician and scientist (González-Hernández, Domínguez-Rodríguez, Fabre-Pi, & Cubero-González, 2010; Mehta, 2011). It was argued by Descartes that the mind and body were separate entities and that the body, excluding the mind, was subject to the law of mechanics (Mehta, 2011). Mind and body were therefore considered as separate entities with no unifying aspects (Mehta, 2011). The concept of mind body dualism had a significant impact on scientific and medical knowledge, paving the way for medical sciences such as anatomy and physiology (González-Hernández et al., 2010; Mehta, 2011). Previously held holistic and spiritual

aspects of health and healing that had once been so prevalent were largely ignored, in favour of the new more scientifically oriented approach, which focused on body organs and disease carrying organisms (DiStefano, 2006; Mehta, 2011). Such an analytical approach to scientific medical enquiry provided fertile ground for the concepts of positivism, a philosophy of science holding the position that unless something can be verified scientifically it has no merit (Goldenberg, 2006; Mehta, 2011). Those who subscribe to a positivist perspective reject knowledge claims that are unable to be scientifically verified (Goldenberg, 2006; Mehta, 2011).

Scientific verification became the hallmark of the medical profession (Friedson, 1970a; Willis, 1990). Having an allegiance with science and technology provided medicine with the opportunity to use scientific verification to support claims of efficacy, thereby gaining a level of legitimacy not afforded other health occupations (Friedson 1970a; Willis, 1990). Medicine's legitimacy enabled it to achieve a high status of authority, which was utilised politically to assert medical dominance (Friedson, 1970a; Willis, 1990). Historically, medical dominance over CAM can be seen in the medical profession's efforts to ensure that CAM would not be taught in medical schools or universities, that it had no access to research funding and would be unable to obtain statutory registration (Coulter & Willis, 2004, p. 588). Of particular interest to this discussion is the impact of these constraints upon the CAM practice of homeopathy. Following, is an historical overview of homeopathy, its emergence in Australia and the impact of medical dominance on homeopathy's trajectory in terms of legitimacy, and finally how it is perceived as a health care practice.

3.6 Homeopathy and its Emergence in Australia

The development of homeopathy by the German physician, Samuel Hahnemann in the late 18th century, created considerable controversy. At a time when bloodletting and emetics were major tools of physicians (Greenstone, 2010), Hahnemann's new therapeutic approach, which had been developed as an alternative to the crude and rudimentary medical practices of the time, attracted significant criticism from his peers (Bellavite et al., 2005, p. 447; Winston, 1999, p. 5). Despite the disapproval from Hahnemann's colleagues, numerous medical practitioners took up the practice of homeopathy, many of whom added substantially to the body of literature on homeopathic philosophy, prescribing and practise (Winston, 1999).

One of these physicians, Constantine Hering, had been tasked with discrediting homeopathy (Bellavite et al., 2005; Winston, 1999). However, while Hering was studying the teachings of Hahnemann and conducting experiments based upon Hahnemann's theories, he sustained an injury to his hand that became gangrenous. After the wound failed to respond to conventional treatments of the time, amputation was suggested. Hering sought homeopathic treatment instead and recovered from his injury with his hand intact (Winston, 1999). From that point forward, Hering became an avid convert of homeopathy (Winston, 1999), and became known as the "father of homeopathy" in America (Satti, 2005, p. 115). By the end of the 19th century, homeopathy had spread widely through Europe, to North America and Asia (Bellavite et al., 2005; Jonas et al., 2003; WHO, 2001). According to Bellavite et al. (2005) homeopathy was also being taught at American universities in Boston, Iowa, Michigan and Minnesota (p. 449). In addition, numerous homeopathic journals were being published and a considerable number of homeopathic clinics, hospitals and pharmacies were being established worldwide (Bellavite et al., 2005). Homeopathy's popularity was aided in no small part by the success of homeopathic treatment during the

typhus outbreak in Leipzig, Germany in 1831 and the European cholera epidemic of the early 1800s (Jonas et al., 2003; Leary, 1987; Winston, 1999). Homeopathy reportedly outperformed medical intervention significantly, with far fewer deaths recorded among those treated homeopathically, compared to those treated medically (Leary, 1987; Winston, 1999). However, when considering these outcomes, it needs to be remembered that these epidemics predated the discovery of antibiotics in the late 1920s (Aminov, 2010).

The movement of homeopathy from its origins in Germany to Australia is one that is still being recorded and updated as new information is sourced and verified. The following information is a correct representation of what was known at the time of writing. According to Armstrong (2005), Australia's first homeopath was Dr Steven Simpson who arrived in New South Wales in 1840. Simpson had qualified in medicine in Edinburgh and later discovered homeopathy while travelling in Europe, with some reports suggesting that he had studied with Hahnemann (Armstrong, 2005, 2008). Simpson's arrival in Australia was followed by others also intent on practicing homeopathy, among them a number of "medical missionaries" (Armstrong & Torokfalvy, 2010, para. 3 & 4; Winston, 1999, p. 563). By adding homeopathy to their skill set, these missionaries could attend to the physical needs of their congregation, as well as to their spiritual wellbeing (Armstrong & Torokfalvy, 2010). During the early years of Australia's colonial history, there was a scarcity of qualified medical practitioners in many areas and therefore inhabitants relied heavily on alternative sources of treatment (Armstrong & Torokfalvy, 2010).

One of the more notable regional examples of homeopathy's use in Australia was in Western Australia (WA) where Dom Rosendo Salvado, a Benedictine monk, established a monastery in New Norcia. According to reports, the community of New Norcia used homeopathy as their primary source of medicine (Australian Homoeopathic Association

[AHA] WA Branch, 2011, para. 2). Evidence of homeopathic utilisation among this community includes a collection of homeopathic items used by Salvado, such as books and homeopathic remedies, along with documentation of orders sent to England for replacement homeopathic supplies which are housed today in the New Norcia museum (AHA WA Branch, 2011). As homeopathy grew in popularity, free homeopathic dispensaries servicing the needs of the impoverished were set up in Geelong, Melbourne, Ballarat, Adelaide and Sydney, and in 1876 the first Australian homeopathic hospital was established in Spring Street, Melbourne (Armstrong, 2007; Armstrong & Torokfalvy, 2010). In 1885, the Melbourne Homeopathic Hospital was relocated to St Kilda Road, Melbourne on completion of its new premises. Figures 3 and 4 show images of the New Melbourne Homeopathic Hospital.



Figure 3. Image of the new Melbourne Homoeopathic Hospital 1885–1934. Adapted from “History of Homoeopathy in Australia” by Armstrong, 2007 (<https://www.historyofhomeopathy.com.au/hospitals/item/367-melbourne-homopathic-hospital.html>). In public domain.



Figure 4. Image of a ward in the new Melbourne Homoeopathic Hospital. Adapted from “History of Homoeopathy in Australia” by Armstong, 2007 (<https://www.historyofhomeopathy.com.au/hospitals/item/367-melbourne-homopathic-hospital.html>). In public domain.

Following the establishment of the Melbourne Homeopathic Hospital, homeopathic hospitals were established in Hobart, Launceston and Sydney (Armstrong & Torokfalvy, 2010; Gill, 1990). These hospitals existed for over sixty years before succumbing to the changing landscape of health care, which included new medical treatments such as antibiotics (Armstrong & Torokfalvy, 2010). Furthermore, these hospitals suffered from a lack of suitably qualified homeopathic practitioners to service them and faced increasing opposition to their existence from the medical profession (Armstrong & Torokfalvy, 2010).

Some years after the closure of these homeopathic hospitals, the Australian Medical Faculty of Homoeopathy lobbied for a return of homeopathic health services in Sydney (Armstrong, 2006). The efforts of the Australian Medical Faculty of Homoeopathy resulted in the establishment of a homeopathic outpatient clinic in 1990 at Balmain Hospital, Sydney (Armstrong, 2006). In April, 2019 I placed a phone call to Balmain hospital, which confirmed that the homeopathic clinic is still in operation: one of the last links with an era of greater acceptance of homeopathy in Australia. Although the decline of homeopathy was

attributable to several factors, opposition from the medical community had a significant impact, and this will now be considered.

3.6.1 Biomedical opposition and oppression of homeopathy

As homeopathy's popularity grew worldwide, it gained the support of many prominent members of society (Loudon, 2006; Nicholls, 2005; Spiegel & Kavalier, 2002; Willis, 1990). For instance, in Britain, homeopathy has enjoyed royal benefaction dating back to Queen Victoria (Loudon, 2006; Nicholls, 2005). Similarly, in Australia, homeopathy found favour among many notable members of society, including archbishops and parliamentarians (Armstrong & Torokfalvy, 2010, para. 5; Willis, 1990, p. 58). The 19th and 20th centuries were arguably the golden age of homeopathy: consumer interest was high and homeopathic hospitals and dispensaries were being set up to meet this demand (Centre for Australian Homoeopathic History, 2011; University College of London Hospitals, n.d.). According to Willis (1990), homeopathy gained considerable support in the Australian state of Victoria that extended into the twentieth century (p. 58). However, at the time of homeopathy's growing popularity and acceptance among the public, medicine was in the early stages of its professional development (Willis, 1990). According to Willis (1990), homeopathy posed the greatest threat to the "political and social power" of the medical profession and therefore needed to be contained (p. 59).

One effective way for occupational groups to gain control over others is through the legitimization of knowledge, the establishment of professional societies and by becoming state sanctioned (Freidson, 1970, pp. 72–73; Timmermans & Oh, 2010, p. S95; Willis, 1990, pp. 18–19). Policies and legislation can then be implemented excluding certain people and occupations (Friedson, 2001; Timmermans & Oh, 2010, p. S95; Willis, 1990). According to Willis (1990), doctors in all western nations in the mid-1800s were working towards

legitimising their practice through statutory registration (p. 46). The eventual establishment of the 1858 Medical Act provided statutory registration to “legally qualified” medical practitioners and paved the way for the formation of a medical council to oversee the registration and deregistration of practitioners as well as monitor standards of education (M. Roberts, 2009, p. 37). The growing legitimisation and authority of medicine had significant implications for medical physicians who practised other therapies, as they could now be excluded. For instance, Willis (1990) discussed the particularly strong foothold that homeopathy gained in the Australian state of Victoria that resulted in the Medical Society of Victoria refusing membership to homeopaths regardless of any medical training they had undergone (p. 59). However, according to Templeton (1969, as cited in Willis, 1990) this action only served to increase the popularity of homeopathy (p. 59). Willis (1990) suggests that it was the 1906 legislation restricting the registration of new homeopaths to only one per year that resulted in the medical profession’s final dominance over homeopathy (p. 59).

Additionally, there were calls for the Medical Act 1858 to criminalise practices considered to be “quackery” (M. Roberts, 2009, p. 37), a term commonly applied to practices that fall outside the bounds of biomedicine (Loudon, 2006). An editorial piece by Wakely (1858) featured in the *Lancet*, illustrates how strongly critics of CAM opposed these various practices.

Quackery, in a thousand shapes is the curse of the age, and the besotting sin of our civilizations ... systems of fraud and folly grow apace. It behoves us strongly to resist these treacherous encroachments. Their professors are strong in vigour and unblushing in effrontery: homoeopathists, mesmerists, hydropathists, and the like, they are men who have sacrificed science and debased morality by embracing falsehood and practising deception. The members of an honourable profession

cannot, therefore, hold any terms with them ... medicine can only flourish like the oak. She must keep herself pure from the polluting touch of quackery. (p. 483)

Wakely (1858) uses terms such as fraud and deception when discussing practices such as homeopathy (p. 483). In contrast, medicine is situated as a pure and honourable profession (p. 483). Such moral positioning of homeopathy is still evident today. For instance, homeopathy is described by some commentators as an “unethical” practice (Smith, 2012a, p. 509; Shaw, 2010, p. 130), while medicine is presented as being scientific and therefore trustworthy (Smith, 2012a). Despite the continued attacks on homeopathy, it has managed to survive, and in some parts of the world, flourish (House of Commons, 2010; Ghosh, 2010; Prasad, 2007).

In the United Kingdom, there are four homeopathic hospitals funded by the National Health Service (NHS) (House of Commons, 2010). It should be noted however, that the NHS funding of homeopathy is under pressure from lobbyists who consider state funding of homeopathy to be a waste of public resources, due to the lack of scientific evidence supporting homeopathy’s therapeutic use (Boseley, 2010; House of Commons, 2010; Relton, O’Cathain, & Thomas, 2008). This lobbying assisted in the decision to stop NHS funding of homeopathy in the United Kingdom (NHS England, 2017). The British Homeopathic Association challenged the action of NHS England, but in 2018 the decision by NHS England to cease funding homeopathy was upheld by England’s high court (Donnelly, 2018). In contrast to what is happening in the United Kingdom, a report commissioned by the Swiss Federal Social Insurance Office on the findings of a five-year study into homeopathy and some other forms of CAM, supported the continued insurance coverage of homeopathy (Bornhöft, Ammon, Righetti, Thurneysen, & Matthiessen, 2011). The Swiss report reviewed relevant publications, current research, efficacy, safety, and the

cost effectiveness of homeopathy and deemed that there was enough evidence to support the use of homeopathy as a therapeutic treatment (Bornhoft et al., 2006, p. 19).

Situated amongst CAM and medicine is the practice of nursing, which is connected to both practices, by way of its tradition of practice long before the advent of modern medicine. The relationship of nursing to CAM will be explored within a historical and contemporary context.

3.7 The Relationship between CAM and Nursing

The current exemplar of the nursing profession is an amalgamation of the ancient and the modern (Ehrenreich & English, 1973; Kearney, 2010). Historically, nursing was associated with the care given by women to members of their family, or others of their community (Egenes, 2009). Although nursing education and practices have evolved over the years, the roots of nursing are from another era. Consequently, when considering the relationship between nursing and CAM, it is important to consider the origins of nursing itself, which are inextricably bound to traditional healing practices (Ehrenreich & English, 1973). Stories abound about sacred wisdom held by women, and of feminine healing traditions in various diverse cultures of the world (Ehrenreich & English, 1973; Minkowski, 1992). In these stories, women are indelibly linked to the concepts of healing and nursing:

Women have always been healers. They were the unlicensed doctors and anatomists of Western history. They were abortionists, nurses, and counselors [*sic*]. They were pharmacists, cultivating healing herbs and exchanging secrets of their uses. They were the midwives travelling from home to home and village to village. For centuries women were doctors without degrees ... they were called ‘wise women’ by the people, witches or charlatans by the authorities (Ehrenreich & English, 1973, p. 3).

With this history in mind it is arguable that a link between CAM and nursing is evident in these stories of women as herbalists, midwives and pharmacists. Most of these women would have had no formal nursing training, rather, their knowledge would have been passed from generation to generation (Cook & Webb, 2002; Egenes, 2009). However, they performed a role in society akin to modern nursing practice.

Florence Nightingale is credited with changing the face of nursing education and practice, thereby paving the way for the recognition of nursing as a profession (Egenes, 2009; Miracle, 2008; Selanders, 2010). While nursing in the Crimean War (1835–1856), Nightingale identified poor hygiene as a significant contributor to the mortality rate of soldiers (Fee & Garofalo, 2010; Miracle, 2008). Amidst unsanitary conditions and with minimal supplies, Nightingale was able to implement changes that included improving the diet of the injured soldiers and the hygiene of the military hospital. These simple measures instigated by Nightingale, increased the survival rates of the injured and sick (Fee & Garofalo, 2010; Neuhauser, 2003). Upon her return to England, Nightingale established the Nightingale School of Nursing in London (Fee & Garofalo, 2010).

Although Nightingale's life and work remain a part of nursing folklore and are included in nursing curricula worldwide, some commentators question her relevance to modern day nursing practice (Gourlay, 2004; Miracle, 2008). A full analysis of Nightingale's work and its relevance to current nursing practice is beyond the scope of this thesis. However, it is historical fact that Nightingale formalised nursing training and in so doing laid the foundations upon which modern nursing education is built. In addition, Nightingale's writings suggest that she had an awareness of the environmental determinants of health and the importance of an individual's emotional, mental and spiritual state on their health outcomes (Gourlay, 2004; Miracle, 2008; Nightingale, 1860). Post Nightingale, several

other nursing theorists also promoted concepts of holism. These include, but are not exclusive to, Peplau's Theory of Interpersonal Relations (Peplau, 1992), Watson's Theory of Human Caring (Watson, 1985) and Neuman's Systems Model (Neuman & Fawcett, 2011).

Tovey and Adams (2003) refer to the linking of historical nursing figures, events and core values of nursing with CAM as "nostalgic referencing" (p. 1470). They further suggest that nostalgic referencing is used to legitimise the argument supporting the integration of CAM into nursing practice and to promote a particular ideology of nursing (p. 1470). Although nostalgic referencing is undoubtedly commonplace in discussions on the relationship between CAM and nursing, there is validity to the suggestion that the philosophy of nursing aligns with those of CAM. Aside from nursing theorists who have espoused holistic concepts, professional nursing bodies commonly position nursing within the framework of a holistic practice (Australian Nursing Federation, 2011; International Council of Nurses [ICN], 2012). It is therefore arguable that the theoretical base of nursing practice is fundamentally holistic, as it has always had a multifaceted approach to the delivery of nursing care that can be compared to the holistic principles underpinning CAM (Dossey, 2012; Papathanasiou, Sklavou, & Kourkouta, 2013).

Given this history, it is not surprising that a number of nurses express an interest in CAM (Booth-LaForce et al., 2010; Cant et al., 2012; Dutta et al., 2003; Holroyd, Zhang, Suen, & Xue, 2008; Shorofi & Arbon, 2010). Nurses' interest in CAM, combined with consumer demand, resulted in the inclusion of CAM in nursing education and practice in various regions of the world (Baer, 2008; Booth-LaForce, 2010; Cant et al., 2012; Dutta et al., 2003). For instance, in their study exploring the extent of CAM integration by National Health Service (NHS) hospital based nurses and midwives, Cant et al. (2012) note that

during the 1990s CAM was increasingly included in nursing and midwifery education and practice in England (p. 135). However, the types of CAM utilised were limited to therapies such as massage, aromatherapy and acupuncture (Cant et al., 2012, p. 136). According to Cant et al. (2012), some respondents were interested in intergrating homeopathy into their professional practice, though this was never achieved (p. 136). In addition, although CAM was utilised by respondents, it was never state sanctioned and its use was restricted to certain settings; namely: midwifery, dermatology, oncology and pain management (Cant et al., 2012, p. 137).

Support for CAM in nursing practice during the 1990s was also evident in Australia, with formation of the Holistic Nurses' Association of New South Wales (NSW) in 1995 (Baer, 2009; Redmond, 2000). According to Redmond (2000), the NSW holistic nurses association liaised with the NSW nurses' registration board and the NSW nurses' association regarding the formation of policies on the utilisation of CAM in nursing practice (Redmond, 2000, p. 95). It is unclear when the Holistic Nurses' Association of NSW ceased operating, but a Google search suggests that it has been non- operational for a number of years. In addition, the *Australian Journal of Holistic Nursing* was published from 1994–2005 (National Library of Australia, n.d.). Attempts were made in 2013 to contact some of the people involved in the publication of this journal to gain more information on the Australian holistic nursing movement, but unfortunately emails went unanswered.

In *Complementary Medicine in Australia and New Zealand* Baer (2009), discusses nursing schools in Australia that included CAM in their curricula (pp. 116–117). It is noted by Baer (2009) that many Australian nurses, like their North American counterparts, became involved with mind-body therapies, which at the time were recognised by the Royal

College of Nursing, Australia as being a part of holistic nursing practice (p. 117). What is possibly less well-known was the inclusion of naturopathy in the nursing curricula of two Australian Universities (Baer, 2009, pp. 116–117). Although these programs are no longer in existence (Baer, 2008), the role of CAM in contemporary nursing practice remains a topic of discussion.

Several commentators argue for the integration of CAM (Booth-LaForce et al., 2010; Dutta et al., 2003; Helms, 2006; Xu, 2004), while another view is that CAM has no place in the professional practice of nurses (Morrall, 2008). The complexity of the issue means that no unified agreement has been made and the extent to which CAM has been integrated into nursing curricula and practice can differ from country to country and institution to institution (Booth La-Force et al., 2010; Dutta et al., 2003; Halcón, Leonard, Snyder, Garwick, & Kreitzer, 2001).

3.8 Summary

This chapter has explored the role of literature in a grounded theory study, and it has outlined the way the literature has been utilised. The chapter explained that a preliminary review of the literature was conducted to fulfil university requirements for the purpose of confirmation of candidature and presented that preliminary review. Rather than an extensive search in the substantive area of study, the literature reviewed provided background to the historical relationships between CAM, biomedicine, nursing and homeopathy. To ascertain the level of research on nurses who also hold CAM qualifications and work in the field of CAM, a basic search in this area was undertaken. The results of that search indicated a gap in the literature, thereby justifying that this study be undertaken. The following chapter, Chapter Four, *Research Design*, will outline the research design and discuss in depth the methods utilised to accomplish the research aims.

Chapter 4. Research Design

4.1 Introduction

Chapter Three provided background to the study and positioned it within the preliminary review of the literature. The aim of this chapter is to present an account of the research design. Included in this chapter is detailed discussion of the recruitment process, including sampling of research participants, methodological and ethical considerations. The aim of the research was to gain an understanding of the factors attracting nurses to the practice of homeopathy and the influence, if any, being a nurse and homeopath had on their respective nursing and homeopathic practice. Gaining that understanding was achieved through the inductive process of grounded theory that is outlined in this chapter. Through adhering to the process of grounded theory, a substantive theory was developed that interprets the experience of participants in this study. The chapter begins with a discussion on qualitative research and grounded theory. This is followed by a discussion on ethical considerations, sampling and recruitment, and the process of data collection, including the specific data collection and analysis methods utilised during this study. Lastly, the chapter discusses the evaluation of grounded theory studies and applies them to this study, before concluding with a summation of the key points made in this chapter.

4.2 Qualitative Research

Qualitative research is a form of social inquiry that utilises non-statistical methods of analysis to explore subjective human experiences and is widely used to gain an understanding of people, cultures, and society (Austin & Sutton, 2014; Borbasi & Jackson, 2012; Hammarberg, Kirkman, & De Lacey, 2016). Therefore, a qualitative research design is appropriate where the aim of the study is to find the answer to questions relating to what, how, or why of a phenomenon (Charmaz, 2008, pp. 397–398; Rosenthal, 2016, p. 510).

Qualitative research allows researchers to explore how people interpret and give meaning to their subjective experiences (Malagon-Maldonado, 2014; Hammarberg et al., 2016). Within a qualitative study, participants take centre stage and are active participants in the research process. At the forefront are the experiences of participants and their subsequent interpretation of those experiences (Corbin & Strauss, 2008; Hammarberg et al., 2016; Holloway & Galvin, 2016). The ranges of qualitative research designs available to researchers are diverse. Therefore, choosing a research design involves consideration of several factors, which include the discipline the study is situated within, the nature of the research question, and the philosophical position of the researcher (Corbin & Strauss, 2008; Creswell, Hanson, Plano Clark, & Morales, 2007; Holloway & Galvin, 2016). The methodology chosen for a study provides a framework for the research process and adds to the rigour of a study (Liamputtong, 2013). Some methodologies are better suited to answering certain types of questions than others. For instance, ethnography is commonly used for studies relating to culture (Liamputtong, 2013), while feminist methodology is used for studies relating to women, particularly where the research is beneficial to women and gives voice to their experiences (Liamputtong, 2013). The research methodology chosen for this study was grounded theory, which will now be explored.

4.3 Grounded Theory

Grounded Theory is an inductive research method that is used extensively in qualitative research, where the aim of the research is to produce theory from the data, rather than examine any existing theory (Birks & Mills, 2011; Corbin & Strauss, 2008; Charmaz, 2014; Glaser & Strauss 1967; Polit & Beck, 2017; Strauss & Corbin, 1990, 1998; Urquhart, 2013). Sociologists Barney Glaser and Anselm Strauss developed grounded theory in the 1960s after identifying a gap in qualitative methods of analysis (Birks & Mills, 2011; Corbin & Strauss, 2008; Charmaz, 2014; Urquhart & Fernández, 2013). Conducting a study into

death and dying, Glaser and Strauss noted a lack of existing theories suitable for explaining the experience of the individuals they were researching (Creswell et al., 2007; Glaser & Strauss, 1967). Combining Glaser's experience in quantitative research and Strauss's experience in social science, Glaser and Strauss (1967) developed a method of qualitative data collection and analysis that resulted in a theoretical construct around death and dying. The approach taken by Glaser and Strauss (1967) was a significant departure from the qualitative research methods of the time, which had their emphasis in substantiating existing theories, rather than generating new theory (p. 10). The methods developed by Glaser and Strauss (1967) were presented in their seminal book, *The Discovery of Grounded Theory*, which they hoped would advance the systematic collection, coding and analysis of data for the purpose of generating theory (p. 18).

The concepts and strategies advanced by Glaser and Strauss (1967) can be considered as revolutionary (Charmaz, 2014, p. 7; Thomas & James, 2006, p. 767; Urquhart, 2013, p. 14). In their seminal work, Glaser and Strauss (1967) challenged existing methodological norms and paved the way for a new perspective on qualitative research (Charmaz, 2014; Urquhart 2013). Specifically, Glaser and Strauss (1967) showed that through the application of systematic analytical methods, qualitative research could generate theory. In applying their methods, Glaser and Strauss gave credibility to qualitative research as a standalone methodological approach (Charmaz, 2014; Thomas & James, 2006). Since its development, there have been various adaptations of grounded theory (Birks & Mills, 2011; Charmaz, 2014; Clarke, 2005; Cutcliffe, 2005; Health & Cowley, 2004; Thornberg, 2012; Urquhart 2013), which will now be considered.

4.3.1 Evolution of grounded theory

Adaptations to Glaser and Strauss's (1967) version of grounded theory have resulted in diverse approaches to the methodology and its subsequent methods being used in a vast array of grounded theory studies (Chun Tie, Birks, & Francis, 2019; Urquhart, 2013). The divergence in opinion over the way grounded theory should be conducted has its origins in a disagreement between Glaser and Strauss that occurred following the publication of Strauss and Corbin's (1990) book, *Basics of Qualitative Research* (Chun Tie et al., 2019; Birks & Mills, 2011; Charmaz, 2014). In this body of work, Strauss and Corbin (1990) suggested the use of more technical procedures during data analysis, which was a significant deviation from Glaser's version of grounded theory (Birks, Chapman, & Francis, 2006; Charmaz, 2008, 2014; Urquhart, 2013).

Essentially, Glaser disagreed with the analytic procedures advocated by Strauss and Corbin (1990), believing that Strauss had deviated from the grounded theory methods they had originally developed (Birks et al., 2006; Charmaz, 2008, 2014; Glaser, 1992; Urquhart, 2013). As noted by Urquhart (2013), Glaser favoured the use of open, selective and theoretical coding, while Strauss and Corbin (1990) suggested using open, axial and selective coding as well as coding for process (p. 19). Glaser also took issue with Strauss and Corbin's (1990) use of a coding paradigm and conditional matrix (Urquhart, 2013, p. 19). It was Glaser's belief that these analytical methods would result in concepts being forced, rather than allowing for their emergence from the data (Cutcliffe, 2005; Glaser, 1992; Urquhart, 2013). It was contended by Glaser that the version of grounded theory presented by Strauss and Corbin (1990) produced "full conceptual description", rather than theory (Cutcliffe, 2005, p. 426; Heath & Cowley 2004, p. 142; Charmaz, 2014, p. 11).

The divergence in opinion between Glaser and Strauss ultimately resulted in the emergence of two strands of grounded theory: Glaserian grounded theory and Straussian grounded theory, respectively (Birks, Chapman & Francis, 2006; Higgenbottom & Larudsen, 2014, Urquhart, 2013). Glaserian grounded theory is based upon the original work of Glaser and Strauss (1967) and is also referred to as classic grounded theory, while the works of Strauss and Corbin became known as Straussian grounded theory (Birks et al., 2006, pp. 6–7; Higginbottom & Lauridsen, 2014, p. 8; Urquhart, 2013, pp. 18–21). The dispute between the two authors became public when Glaser (1992) refuted the methods advocated by Strauss and Corbin (1990) in his book, *Emergence vs forcing: Basics of Grounded Theory Analysis*.

Criticism of their work was countered by Strauss and Corbin (1998) who asserted that the procedures they outlined were guidelines only, stating that “our version of qualitative analysis offers a cluster of very useful procedures—essentially guidelines, suggested techniques, but not commandments” (p. 4). In later revisions of their work, Strauss and Corbin distanced themselves from the formulaic approach they had outlined in their earlier work (Charmaz, 2014). It is asserted by Corbin that the aim of the revision was to combine the good aspects of their earlier work with a contemporary approach (Corbin & Strauss, 2008, p. ix). Corbin also emphasises that the analytic techniques should not be viewed as a “recipe for doing qualitative research”, but as a way of assisting researchers to “make sense” of the data (Corbin & Strauss, 2008, p. ix).

Following on from Glaser and Strauss (1967) and Strauss and Corbin (1990, 1998), a third version of grounded theory; namely: constructivist grounded theory, emerged in the mid-1990s (Birks & Mills, 2011; Charmaz, 2000, 2006, 2014; Higgenbottom & Lauridsen, 2014). Constructivist grounded theory was developed by Kathy Charmaz and quickly

became a popular and widely utilised form of grounded theory (Birks & Mills, 2011; Chun Tie et al., 2019; Higgenbottom & Laruidsen, 2014). According to Charmaz (2014), constructivist grounded theory follows the inductive and open-ended approach of Glaser and Strauss (1967) while emphasising the flexibility of grounded theory (pp. 12–13). The emergence of constructivist grounded theory challenged the rigidity and formulaic methods of earlier versions of grounded theory (Charmaz, 1999, 2014). Charmaz’s constructivist grounded theory approach is described by Creswell et al. (2007), as being less concerned with the research methods and more focused on the experience of the participants (p. 250). Although Charmaz’s constructivist approach varies from that of Glaser, Charmaz (2006, 2014) utilises the grounded theory methods outlined by Glaser and Strauss (1967). However, these methods are applied in a more flexible approach than that of Glaser and Strauss (1967), and Strauss and Corbin (1990, 1998).

Rather than being an objective collector and analyst of data, Charmaz (2008) asserts that the researcher is an active participant in the construction of the unfolding story (p. 402). The story being told is therefore influenced by participants and researcher. The term constructivist was chosen by Charmaz (2014) to “acknowledge subjectivity and the researcher’s involvement in the construction and interpretation of data” (p. 14). Charmaz’s notion of a researcher being a co-creator in the research process is a departure from the stance taken by positivists and post-positivists who subscribe to notions of objectivity (Guba & Lincoln, 2005; Denzin & Lincoln, 2005; Charmaz, 2014). Constructivism challenges the notion of objectivity, asserting instead that reality is subjective and that multiple realities exist (Guba & Lincoln, 2005; Charmaz, 2014). Although Glaser contends that the Glaserian version of grounded theory holds no particular philosophical position (Licqurish & Siebold, 2011, p. 12; Singh & Estefan, 2018, p. 3), it is arguable that aspects of Glaserian and Straussian grounded theory unequivocally sit within the positivist or

post-positivist paradigm (Charmaz, 2014; Urquhart, 2007, 2013). A comparison of key differences between objectivist grounded theory, which Charmaz (2014, p. 235), asserts is mainly represented by Glaser’s approach, and constructivist grounded theory is outlined in Figure 5.

Objectivist Grounded Theory	Constructivist Grounded Theory
<i>Foundational Assumptions</i>	<i>Foundational Assumptions</i>
Assumes an external reality Assumes discovery of data Assumes concepts emerge from the data Views representation of data as unproblematic Assumes the researcher is a neutral observer	Assumes multiple realities Assumes mutual construction of data through interaction Assumes researcher constructs categories Views representation of data as problematic, relativistic, situational and partial Assumes the researcher’s values and actions affect the views.
<i>Objectives</i>	<i>Objectives</i>
Aims to achieve context-free generalisations Aims for abstract conceptualisations that transcend historical and situational locations Aims to create theory that fits, works, has relevance and is modifiable (Glaser)	Considers generalisations as partial, conditional, and situated in time, space, positions, action and interactions Aims for interpretive understanding of historically situated data Specifies range of variation Aims to create theory that has credibility, originality, resonance and usefulness
<i>Implications for Data Analysis</i>	<i>Implications for Data Analysis</i>
Views data analysis as an objective process Sees emergent categories as forming the analysis Sees reflexivity as one possible data source Gives priority to researcher’s analytic categories and voice	Acknowledges subjectivities throughout data analysis Views co-constructed data as beginning the analytic direction Engages in reflexivity throughout the research process Seeks and (re)represents participants’ views and voices as integral to the analysis

Figure 5. Comparison of objectivist and constructivist grounded theory. Adapted from “Constructing Grounded Theory” by Charmaz 2014, p. 236. In public domain.

Although there are significant philosophical differences between objectivist and constructivist grounded theory that shapes the research process, the core processes undertaken during data collection and analysis remains the same (Charmaz, 2014). However, given the various iterations of grounded theory, there is a need for researchers to clearly state which version of grounded theory has underpinned their study, and to outline the methods utilised (Urquhart, 2013). This disclosure is necessary, as the philosophical orientation of the researcher and the methods they use influence the way that data is collected and analysed (Bailey, 2008; Charmaz, 2014; Urquhart, 2013). This study was primarily influenced by the work of Strauss and Corbin (1998), and Corbin and Strauss, (2008). The rationale for choosing grounded theory in this study and the choice of the methodological approach of Strauss and Corbin will now be discussed.

4.3.2 Rationale for using grounded theory

The rationale for choosing grounded theory in this study was based on three factors. Firstly, there was limited literature relating to the research aim of exploring and explaining the phenomena of nurses becoming homeopathic practitioners, and the influence, if any, being a nurse and homoeopath had on their respective nursing and homeopathic practice. Grounded theory is an appropriate research design for topics that have a paucity of information relating to them (Birks & Mills, 2011; Glaser, 1978). Secondly, the lack of literature around the research topic meant that the research would not be testing any existing theories. Grounded theory explains phenomenon through the development of theory, rather than verifying any existing theory; hence it was considered an appropriate methodology for this study (Charmaz, 2014; Corbin & Strauss, 2008; Glaser, 1967; Urquhart, 2013). Thirdly, given the complexities of nursing and the various social interactions involved in its practice, grounded theory is considered an appropriate research methodology for use in nursing research (Birks et al., 2006; Hernandez, 2010; Polit & Beck, 2017).

As previously stated in section 4.3.1 of the chapter, the version of grounded theory used in this study was primarily influenced by Strauss and Corbin (1998) and Corbin and Strauss (2008). Although I would consider myself philosophically positioned more towards constructivism, at the beginning of this journey I had little knowledge of grounded theory and viewed the clear guidelines provided by Strauss and Corbin as a roadmap that might prevent my getting ‘lost’ in the process of data collection and analysis. Researchers and students who are new to grounded theory may be confused and conflicted as they navigate the vast body of literature on and around the differing variants of grounded theory (Birks & Mills, 2011). This was certainly true of my experience. Having a set of strategies to follow lessened any feelings of insecurity I had about conducting the research process correctly. However, as I progressed further into data collection and analysis, I found the structured guidelines for data analysis outlined by Strauss and Corbin (1998) too rigid and began to favour the less prescriptive methods outlined in Corbin and Strauss (2008). In the later edition of Corbin and Strauss’s (2008) seminal work, *Basics of Qualitative Research*, there was more emphasis on flexibility in the application of analytical procedures than their earlier versions. Researchers are encouraged by Corbin and Strauss (2008) to consider the procedures outlined as guidelines, rather than techniques that must be followed (p. x). According to Charmaz (2014), Corbin and Strauss (2008) moved away from the post positivist stance of their earlier work and became more oriented towards constructionism (p. 234). Grounded theory methods will now be considered.

4.3.3 Grounded theory methods

Grounded theory research consists of systematic methods that are specific and unique to grounded theory (Glaser & Strauss, 1967). The following elements are considered by key grounded theorists to be essential components of a grounded theory study:

- Concurrent data collection and analysis

- Coding and categorising of the data that moves codes from low level concepts to high level concepts
- Memo writing to elaborate categories, explore relationships between categories and identify gaps
- Constant comparative analysis
- Theoretical sensitivity
- Theoretical sampling
- Identification of core category/categories

(Glaser & Strauss, 1967; Charmaz, 2006, 2014; Corbin & Strauss, 2008).

In addition, another element which could be considered an essential component of grounded theory research is the delayed literature review. As discussed in Chapter Three of the thesis, *Background*, delaying the literature review until data collection and analysis has begun is common to grounded theory. However, several grounded theorists challenge the notion that delaying the literature review is a necessary component of grounded theory, arguing instead that an early review of the literature can inform the study positively, without necessarily resulting in any forcing of the data (Dunne, 2011; Charmaz, 2014; Thornberg, 2012). In conducting this research, all the key components necessary for a grounded theory study were adhered to. A brief outline of these components and their role in a grounded theory study will now be considered. The process of data collection and analysis in grounded theory research is non-linear; however, for the purposes of discussion, each of these components will be discussed separately in no specific order.

4.3.3.1 Concurrent data collection and analysis

When data is sourced from interviews, the process of concurrent data collection and analysis involves coding and comparing each interview as it is completed against other

interviews, before any further data is collected (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Polit & Beck, 2017; Strauss & Corbin, 1990, 1998; Charmaz, 2014). Constant comparative analysis of data assists in the identification and formation of categories (Corbin & Strauss, 2008; Charmaz, 2014; Chun Tie et al., 2019; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). As this process of data analysis continues, it becomes necessary to source further information that will expand upon, or saturate the concepts under development, which is fulfilled by theoretical sampling (Birks & Mills, 2011; Charmaz, 2014; Chun Tie et al., 2019).

4.3.3.2 Theoretical sampling

Theoretical sampling is an important component of grounded theory, guiding the researcher in directions that they may not have previously considered (Butler, Copnell & Hall, 2018; Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). As codes and categories are abstracted and concepts emerge, it is necessary for the researcher to collect further data to fill in these concepts, making sure all dimensions are fully explored (Corbin & Strauss, 2008). However, it is important to note that not every category or concept that emerges from the research must be theoretically sampled. The researcher identifies categories and concepts that are dominant in the data and theoretically samples these to further develop them (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). The direction being followed is dictated by the data, rather than the researcher (Corbin & Strauss, 2008). In this way, new threads of information are uncovered and developed whilst keeping the study grounded in the data. Figure 6 illustrates the use of theoretical sampling within a grounded theory study.

inform “theoretical categories” (Charmaz, 2014, p. 213). Theoretical sampling is closely related to the theoretical sensitivity of the researcher. As the researcher begins to think about the data in abstract ways, sampling can be focused on exploring and developing the emerging concepts, and in turn theory (Glaser & Strauss, 1967; Charmaz, 2014; Strauss & Corbin, 1998).

4.3.3.3 Theoretical sensitivity

Theoretical sensitivity is defined by Charmaz (2014) as “the ability to understand and define phenomena in abstract terms and to demonstrate abstract relationships between studied phenomena” (p. 161). Over the duration of the research process, the sensitivity of the researcher to the significance of concepts and to the emerging theory increases (Charmaz, 2014; Strauss & Corbin, 1998). Development of sensitivity to emerging concepts is aided through constant comparative analysis, which includes the development of analytic codes (Charmaz, 2014). Through the process of coding, the researcher is continually being stimulated to think abstractly about the data and consider its meaning and relevance (Charmaz, 2014).

4.3.3.4 Coding of data

Coding is the first step in the conceptual ordering of data (Corbin & Strauss, 2008; Charmaz, 2014; Charmaz & Belgrave, 2012). Through the coding process, a substantive grounded theory is generated that explains the data (Charmaz, 2014). Therefore, careful and detailed coding is imperative in grounded theory research as it breaks the data apart so that any variances, differences, and similarities in the data can be identified (Birks & Mills, 2011, Charmaz, 2014; Strauss & Corbin, 1998). Early coding tends to be quite general with refinement occurring as analysis progresses (Corbin & Strauss, 2008; Strauss & Corbin,

1990, 1998; Urquhart, 2013). The specific coding process undertaken in this study is discussed in-depth in section 4.3.3.5 of the chapter.

4.3.3.5 Memoing

Another integral part of grounded theory research is the writing of memos (Corbin & Strauss, 2008; Charmaz, 2014; Lempert, 2007; Strauss & Corbin, 1990, 1998). Memos serve several different purposes including exploring a specific piece of data, making comparisons between data and theorising about concepts (Charmaz, 2014; Lempert, 2007; Corbin & Strauss, 2008). Researchers can use memos to record their emotions, beliefs and reflections about the research process as well as to record the decisions they make in relation to the study, thereby providing an audit trail of how the research was undertaken (Birks & Mills, 2011). Memos are also considered vital to the emerging theory: stimulating the researcher to think of concepts when reviewing the data, and highlighting areas requiring further expansion (Birks & Mills, 2011; Charmaz, 2014; Corbin & Strauss, 2008; Lempert, 2007; Strauss & Corbin, 1998). It was suggested by Glaser (1998) that theoretical memos are a way of capturing the meaning and ideas of one's emerging theory (p. 178). The next section of the chapter will discuss the specific processes taken in this study, beginning with the process of the recruitment of research participants. A visual representation of the grounded methods used in this study, illustrating how each element of the process leads to the development of a substantive grounded theory, is also presented in Figure 7.

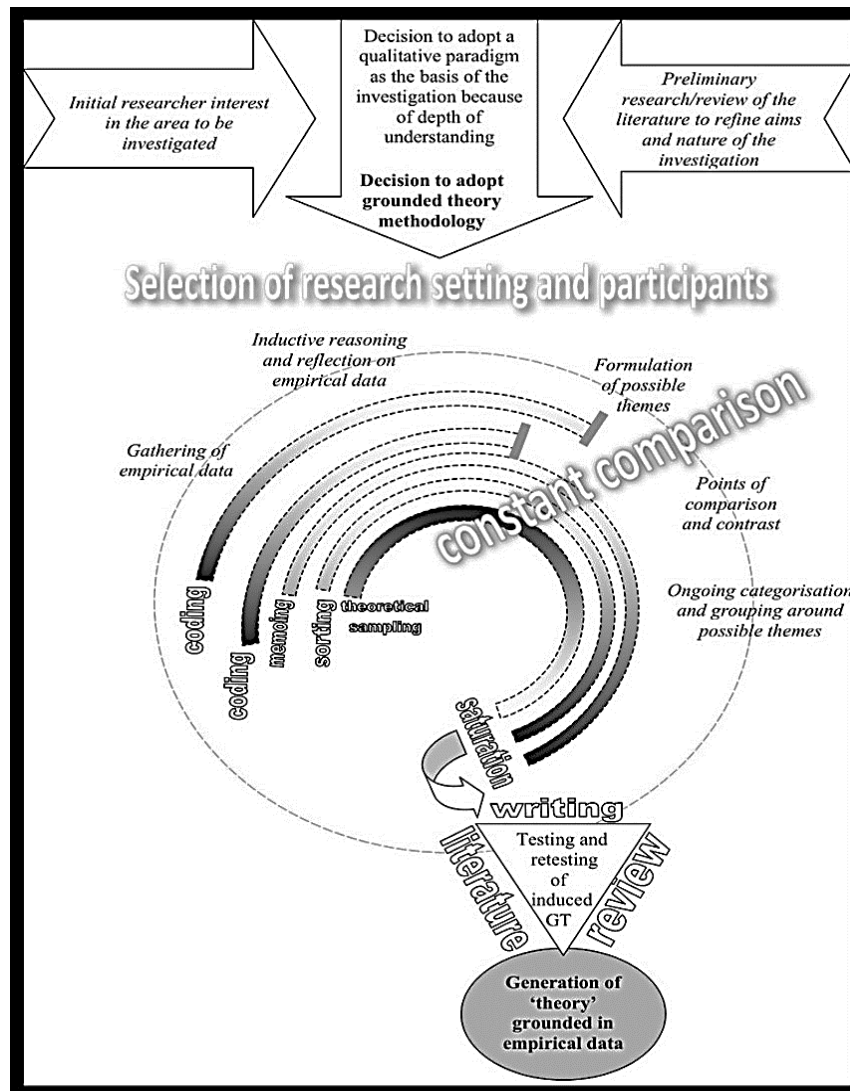


Figure 7. Model of grounded theory. From “Becoming: An Explanatory Grounded Theory of Secondary School Teaching as a New Career” by Fisher, 2012, p. 74 (<http://hdl.cqu.edu.au/10018/1005799>). In public domain.

4.4 Research Participants

As explained in Chapter One, *Research Overview*, this study set out to explore why nurses become homeopaths and the influence, if any, of being both a nurse and a homeopath with regard to their respective nursing and homeopathic practice. The focus was on nurses who had engaged with homeopathic education and practice. I did not actively attempt to recruit anyone who had engaged with nursing education after becoming homeopaths. I also did

not actively recruit people who had left homeopathy for full time nursing practice, or those who had returned to nursing after qualifying as homeopaths. However, these cohorts were also not excluded from participating in the study. The recruitment notice (Appendix A) asked Australian registered nurses and homeopaths working in both professions to participate in the study. All respondents were nurses registered to practise in Australia who had later become engaged with the practice of homeopathy. Therefore, all participants recruited for this study were current registered nurses in Australia who later became qualified homeopaths registered with the Australian Register of Homoeopaths (AROH). Furthermore, all participants had worked concomitantly as nurses/homeopaths.

The criteria for inclusion in this study required that respondents:

- Held current registration as a registered nurse in Australia
- Held current registration as a homeopath with AROH.
- Be willing to tell the story of what attracted them to homeopathy and the influence, if any, being a nurse and a homeopath has on their respective nursing and homeopathic practice.

It is a requirement in Australia that national nursing registration standards are met in order to practise as a nurse (Nursing and Midwifery Board of Australia, 2019a). As discussed in Chapter Two of the thesis *Contextualising CAM and Homeopathy*, although there is currently no compulsory registration of homeopaths in Australia, the homeopathic industry initiated a self-regulatory framework in the late 1990s (AROH, n.d.a). Today, AROH (n.d.a) is the national registering body for professional homeopaths in Australia. Homeopathic practitioners registered with AROH are required to meet and abide by AROH's code of professional conduct and standards of practice (AROH, 2015a, 2015b).

I considered this cohort of health care providers to be the most appropriate for providing insights into the research questions, as they had experience working in both professions.

A total of 18 respondents expressed interest in participating in the study. One respondent was ineligible to participate due to still being a student homeopath rather than a qualified homeopathic practitioner. Two respondents met the inclusion criteria; however, for personal reasons they never participated in the study. In total, 15 participants were interviewed over the duration of the study. As outlined in section 1.5 of Chapter One, *Research Overview*, these participants lived and worked in the Australian states of Victoria, New South Wales and Queensland. Most of them worked in metropolitan areas, with a small number working in regional locations. Participants ranged in age from their late 20s to early 60s, with the majority being between 35 and 55 years of age. 12 participants had over 15 years experience in the nursing workforce, while three participants had 10 to 15 years experience. There was also considerable variance in participants' experiences as homeopathic practitioners: four participants had practised homeopathy for less than 10 years, nine participants had practised for 10–20 years and two participants had been homeopaths for 20–30 years.

Once data collection was being undertaken, it was discovered that some participants worked as nurses solely to maintain their nursing registration. Consequently, the hours these participants worked in nursing were minimal. At the time of data collection, nursing registration requirements dictated that nurses and midwives participate in a minimum of 20 hours continuing professional development annually, and that those hours be relevant to the context of their practice (Nursing and Midwifery Board of Australia, 2010³). Although

³ The Nursing and Midwifery Board of Australia (2010), *Registration standard: Continuing professional development*, has been retired. However, the requirements for continuing professional development remain the same in the new version (Nursing and Midwifery Board of Australia, 2016).

participants who worked minimal hours as nurses could arguably be considered as being primarily non-active members of the nursing profession, they all held current nursing registration, had been working as nurses at the time they became homeopaths, were registered with AROH, and had considerable previous experience working concomitantly as a nurse and a homeopath. Not only were these individuals eligible for the study, but their experience with both professions was considered relevant to the factors that lead nurses to the practice of homeopathy and to the influence, if any, being a nurse and homeopath had on their respective nursing and homeopathic practice. For these reasons, these individuals were included in the study.

During the interview process, several participants disclosed that they held other complementary and alternative medicine (CAM) qualifications in addition to homeopathy. Several participants were qualified naturopaths and a small number of others had trained in massage, yoga and Bowen therapy. It is not uncommon for CAM practitioners to hold multiple CAM qualifications and practise across disciplines (Ang & Wilkinson, 2013). As I was aware of this fact, it was remiss of me to fail to take this into consideration and ask potential participants during the selection process if they practised other CAM disciplines besides homeopathy. However, the inclusion of participants qualified in other CAM practices besides homeopathy had no negative impact on the study in any way. All participants who held qualifications in other forms of CAM all identified as homeopaths, with homeopathy constituting the bulk of their CAM practice.

4.4.1 Ethical considerations

Prior to embarking on a research project, researchers need to consider ethical conduct. As such, the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research 2007* (2007a) and the NHMRC *Australian Code*

for the Responsible Conduct of Research (2007b), informed the ethical considerations of this study. Researchers are responsible for complying with the ethical principles of integrity, respect for persons, justice and beneficence (NHMRC, 2007b, p. 9). The following paragraphs will address each of these principles and discuss how they were adhered to during this study.

Integrity was upheld by ensuring the research met the standards required by Central Queensland University. It was further maintained by the supervisors overseeing the study keeping a check on the progress of the research and the way in which it was being conducted. To meet Central Queensland University requirements, a proposal for the research was presented as confirmation of candidature which included internal and external peer review. Along with submission of a written proposal, an oral defence of the proposal was also presented. Prior to recruitment of participants, ethics approval was sought and granted from Central Queensland University Human Research Ethics Committee (CQUHREC); approval number H12/08–165. Through these processes, the merit and integrity of the proposed research was examined.

Justice in relation to research, comprises equitable processes such as recruitment of participants and burden of participation, ensuring there is no exploitation of participants and that the results of the research are accessible to participants (NHMRC, 2007b). The principle of justice was adhered to during the progression of this study, beginning with unbiased recruitment of participants who were provided with information pertaining to selection criteria. Included in this information were details of potential time requirements. These points, along with participant willingness to participate, were reconfirmed prior to the commencement of interviews. It is also intended that a plain language statement

outlining the findings of the study be made available within four weeks of finalising the thesis to all participants who expressed an interest in receiving this information.

Beneficence concerns the avoidance, or management of harm or discomfort to participants (NHMRC, 2007b). All participants were fully informed of the aim of the study and how it would be conducted via an introductory letter (Appendix B), information sheet (Appendix C) and informed consent form (Appendix D). The information supplied included notice of a participant's right to withdraw from the research without repercussion, and also provided contact details of supervisors overseeing the study and Central Queensland University's Office of Research. Participants were advised that if they had any problem with the way the research was being conducted, or with the researcher, to contact the research division of the university or the supervisors of the study directly. Risk to participants was deemed low. There were no physical or psychological harm factors identified and any potential risk was anticipated as being limited to discomfort. Furthermore, the information sheet (Appendix C) that participants received prior to commencement of interviews provided contact details for counselling services if they needed such support.

Every attempt was made to protect the identity of participants and ensure confidentiality of information. Anonymity and confidentiality are core elements to ethical research practice (NHMRC, 2007b). Pseudonyms were used and it was ensured that participants were not easily identifiable through their direct quotes by checking quotes prior to inclusion for identifying content or context. In addition, gender neutral pronouns were used when discussing participants and their quotes. All information sourced from participants was kept in a secure location as de-identified data. Audio files were stored on a password protected computer which was accessible only by myself and backed up onto an external hard drive

that was kept in a locked filing cabinet in my office at Central Queensland University. Interview transcripts were stored in the same manner as audio files and as de-identified hard files, kept in a locked filing cabinet in my office at the university. Data obtained during the research will be kept for five years post conclusion of this study, as per university protocol, after which it will be disposed of securely.

4.4.2 Participant recruitment and sampling

Once ethical clearance from the university's Human Research Ethics Committee (HREC) was confirmed, recruitment of participants began with purposive sampling which is widely utilised in qualitative research to recruit participants from a population identified as relevant to the topic being studied (Liamputtong, 2013; Palinkas et al., 2015). As this study was exploring the experience of nurses who were homeopaths and I had existing contacts within the homeopathic community, recruitment began with this community. Homeopaths, who were known to be nurses, were sent a recruitment notice (Appendix A), outlining the research, and were invited to respond with an expression of interest if they wished to be involved in the study. In addition, colleagues were asked to distribute the recruitment notice throughout the homeopathic community. The recruitment notice was also placed in the Australian Homoeopathic Association (AHA) newsletter that was sent to all registered members with further recruitment notices made available on the AHA stand at the 2012 annual homeopathic conference in Brisbane.

In keeping with grounded theory methods, there was no predetermined number of participants required for the study. Sample size in grounded theory, like all qualitative research, is shaped by saturation of the data rather than quantity of participants (Liamputtong, 2013; Glaser & Strauss, 1967). As stated by Liamputtong (2013), the emphasis of sample size is on "flexibility and depth" (p. 19). Data saturation was discussed

in section 4.3.3.2 of the chapter, where it was noted that data is considered saturated when no new concepts emerge from interviews and the properties of the developed concepts have been fully explored (Corbin & Strauss, 2008; Charmaz, 2014; Glaser, 2001; Strauss & Corbin, 1998). Initially, purposive sampling for this study produced nine respondents who were subsequently interviewed. As new concepts kept emerging and questions of the data remained unanswered from these nine participants, snowball sampling was utilised to find participants who could provide additional information. Snowball sampling is widely utilised in qualitative research, especially in hard to reach populations (Heckathorn, 2011; Liamputtong, 2013; Kirchherr & Charles, 2018; Waters, 2015). Essentially, it involves the researcher asking existing participants or other connected parties if they know of anyone who meets the inclusion criteria that might be interested in participating in the study (Liamputtong, 2013; Kirchherr & Charles, 2018; Waters, 2015).

Although my personal involvement with the homeopathic community afforded me access to members, there were limitations to that access. Firstly, my contacts were primarily limited to the geographical location of Queensland. Secondly, very few members of the Queensland homeopathic community knew me personally and it was my experience that several potential participants appeared reluctant to speak to someone with whom they had no personal connection. However, when referred by someone who had already participated in an interview for the study, they were more likely to become involved. It is possible that some members of the homeopathic community may have been reluctant to speak about homeopathy due to the heavy criticism of homeopathy that had widespread media coverage around the time of participant recruitment (Lavelle, 2010; Lewis, 2019; Medew, 2012). One Australian lobby group, The Friends of Science in Medicine, whose membership consisted of doctors and scientists, was particularly active at this point in time and had garnered considerable media attention (Lewis, 2019). The use of snowball sampling

enabled me to circumvent these issues and thereby gain access to potential participants who had previously been inaccessible.

Following the recruitment drive, respondents' enquiries were replied to and their suitability checked against the inclusion criteria. If respondents met the inclusion criteria, they were invited to join the study and were sent an introductory letter (Appendix B), information sheet (Appendix C), and informed consent form (Appendix D). Following the posting or emailing of these documents, respondents were contacted within 10 days to ensure that the documents had been received and that participants were clear about the research process. Upon receipt of the completed documents, respondents' informed consent was once again confirmed, and they were contacted to arrange an interview at a mutually agreeable time. The recruitment process is illustrated in Figure 8.

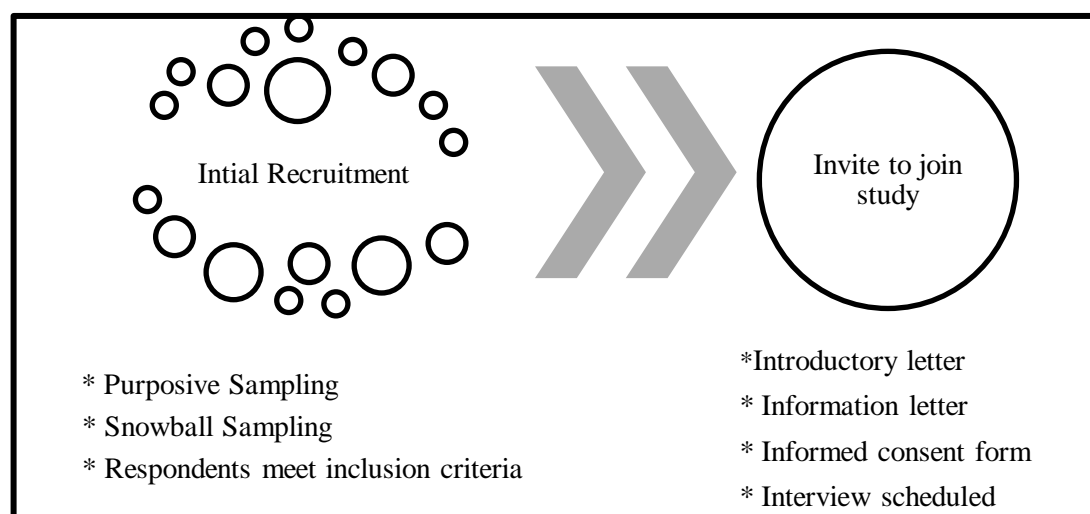


Figure 8. Recruitment process of this study

4.5 Data Collection and Analysis

Data collection and analysis in this study was undertaken using the grounded theory approach of concurrent data collection and analysis. As discussed in section 4.3.3 of the chapter, an essential component of grounded theory is the concurrent data collection and

analysis where preliminary data is coded before further data is collected (Corbin & Strauss, 2008; Birks & Mills, 2011; Glaser & Strauss, 1967; Polit & Beck, 2017; Strauss & Corbin, 1990, 1998). It should be noted that data collection and analysis are simultaneous processes and were treated that way in the undertaking of this study. The information provided in this chapter, relating to how I undertook data collection and analysis, separates the process of data collection and analysis solely for the purposes of discussion. Data collection for this study began with interviewing those participants who were selected from the recruitment process and will now be explored.

4.5.1 Interviews as a mode of data collection

The use of interviews as a mode of data collection is common practice in qualitative research, as they can produce in-depth accounts of participants' experiences relating to the area under investigation (Bolderston, 2012; Liamputting 2013; McGrath, Palmgren, & Liljedahl, 2018). Interviews are generally structured, semi-structured, or unstructured, depending on the purposes of the research and preference of the researcher (Bolderston, 2012; McGrath et al., 2018; Punch, 2014). Structured interviews follow a predetermined line of inquiry (Punch, 2014; Stuckey, 2013), while unstructured interviews have no boundaries imposed on the field of inquiry (Punch, 2014; Qu & Demay, 2011). Semi-structured interviews fall between structured and unstructured interviews (Bolderston, 2012; Qu & Demay, 2011) and was the mode of data collection chosen for this study.

Semi-structured questions were considered the best option for collecting data for this study for two reasons. Firstly, this approach allowed for guiding questions within a flexible framework (Bolderston, 2012; DeJonckheere & Vaughn, 2019). It provided space for participants to tell their story without the imposition of strict boundaries of inquiry, while also allowing me the space to follow emergent concepts (Bolderston, 2012; DeJonckheere

& Vaughn, 2019). . There are aspects of both semi-structured and narrative interview styles present in this approach. With semi-structured interviews the topics covered are set by the researcher, but are flexible and guided by the narratives of participants (Austin & Sutton, 2014; Bryman, 2016, p. 468). In narrative interviews, the aim is to allow participants to tell their story with as little disturbance as possible from the interviewer. The participants are in control of the direction of the interview and its content (Anderson & Kirkpatrick, 2016). In this study, the questions were of a topic directed by me; however, they were broad questions that allowed the conversation to be dictated by each participant's story. Secondly, a semi-structured interviewing approach is congruent with grounded theory research as it provides flexibility and control (Charmaz & Belgrave, 2012, p. 348), while also providing a framework for a novice grounded theory researcher, such as myself. Once the mode of data collection was decided, it was necessary to consider how interviews would be conducted, and this will now be discussed.

4.5.2 Voice over Internet Protocol (VoIP) technology as an interview medium

When considering interviewing options with the first two participants, it became apparent that there would be difficulties in travelling to a location and scheduling several interviews over two or three days. Participants were busy and some of them were non-committal about when they could participate in an interview. In addition, participants were located across three states of Australia, making the cost of travelling prohibitive. The logistical and financial ramifications of having an interview cancelled after flying to a location needed to be considered. In addition, locating participants in one geographical area that were able to agree to an interview within a certain time frame was potentially problematic. Having time constraints could potentially pressure participants into fitting into a schedule dictated by my travel plans and budget, rather than the interview being at a time convenient for them.

Location and timing of interviews are important factors, as participants are giving up their time to participate and are more likely to engage in an interview at a location and time that they are comfortable with, rather than one that presents them with difficulties (Bolderston, 2012; King & Horrocks, 2010; Liamputtong, 2013).

Trying to fit a set number of interviews into a certain space of time also raised the issue of how concurrent data collection and analysis would be managed. Travelling to a set location with a limited amount of time allocated would have meant that several interviews would have to be conducted within a short time frame. I was concerned that not allowing a reasonable time frame between interviews could make it difficult for me to analyse one interview before undertaking the next, thereby raising the potential of failing to follow up on emergent concepts. Given these factors, other interviewing options needed to be considered that were suitable for the research design. Phone and video link interviews were considered as a possible option. I decided that I would ask participants how they would prefer the interviews to be conducted. Following these discussions, it was decided that interviews would be conducted via VoIP technology, as most participants preferred this approach.

The use of internet technology is one way of overcoming access and financial issues that can be encountered when undertaking research (Bolderston, 2012; King & Horrocks, 2010; Lo Iacono, Symonds, & Brown, 2016). Consequently, VoIP technology such as Skype are increasingly being utilised by researchers (Deakin & Wakefield, 2014; Lo Iacono et al., 2016; Symonds, Symonds, & Brown, 2016). Although VoIP technologies are unable to provide the same level of contact between participants and researcher that face-to-face interviewing does, some of the available technology can offer a form of face to face interaction in a neutral, non-threatening space (Hanna, 2012). In this study, VoIP was

chosen as the preferred mode of contact with participants, due to the time constraints expressed by them, their varied geographic locations and their personal preference of mode of interviewing. As well, visual contact with participants provided access to any non-verbal communication (Bolderston, 2012; Lo Iacono et al., 2016).

All participants in this study were asked about their level of comfort with using VoIP technology. Had any participants expressed hesitation, an alternative arrangement such as a phone interview would have been organised. However, participants were familiar with VoIP technology and committed to a video link interview without hesitation. The advantages in using VoIP technology included a great deal of flexibility for participants, who were able to fit the interview in around their busy schedules. Some participants chose to do their interview in between seeing clients, while others chose to do an evening interview at the end of their working day. Additionally, the use of VoIP technology allowed for adherence to the grounded theory methods of concurrent data collection and analysis, and theoretical sampling. Interviews were able to be scheduled far enough apart to allow for coding and comparison of data before subsequent interviews were undertaken.

4.5.3 Interview process

Participants were emailed a reminder of the interview three days before the interview was scheduled. Reminding participants of the upcoming interview verified that they were still comfortable participating in the research and reiterated information such as the approximate time needed for the interview, which participants had received earlier in an information letter. As the interviewer, it was my responsibility to arrange the interviews at a time and place conducive to participants being able to talk freely (Jacob & Furgerson, 2012; King & Horrocks, 2010). Reminding participants of the interview schedule and the

expected time commitment ensured that participants had a realistic expectation of the period of time required. They were therefore able to allocate an adequate amount of time for the interview process. Contacting participants a few days prior to scheduled interviews also allowed for any changes to arranged interviewing times to be accommodated without significant disruption to either party.

The interviews were audio taped with the full knowledge and consent of participants. Audio taping of the interviews was chosen to minimise any potential distractions from the written recording of the conversation, and to ensure that no valuable data was missed in the recording of the interview. Incomplete or inaccurate records of interviews can be an issue that researchers encounter during the interview process (King & Horrocks, 2010; Tessier, 2012). Audio taping of the interviews allowed full attention to be given to the participants and information to be recorded verbatim, thereby eliminating the risk of information being incorrectly recorded. According to Covan (2007), the recording of verbatim data from interviews is not considered necessary by either Glaser or Strauss, who prefer capturing the context of what is said, by whom and at what time, through field and interviewer notes (pp. 68–69). Strauss reportedly taught students that any important concepts will repeatedly come up and be recognised by the interviewer without the need for verbatim recording or transcripts (Covan, 2007, p. 69). However, as a novice grounded theory researcher I had concerns about missing vital pieces of data, which audio taping and verbatim transcripts helped allay (Polit & Beck, 2017, p. 507).

When it came time to conduct the interview, my first contact with participants via video link involved me thanking them for their time and checking that both parties had good visual and audio contact. This initial contact allowed time for troubleshooting of any minor problems that participants or I might have been experiencing. Next, each participant's

consent for the interview was verbally confirmed. Participants were then reminded that the interview would be audio taped and were asked if they were still comfortable with this process. If any participants had expressed reservations or concerns about the interview being taped, I would have discussed their concerns with them and advised that a hand-written account of the interview was an option. However, all participants expressed feeling comfortable with the audio taping of the interview. Participants were reminded that they could request that the tape be turned off, or the interview suspended, at any time. I considered this process to be important in establishing trust with participants, which is important to the success of interviews (King & Horrocks, 2010; McGrath, Palmgren & Liljedahl, 2018).

Following this exchange, participants were asked if they had any questions about the research that they would like to discuss before commencing the interview. Although there had been prior discussion with participants about the research during the recruitment process, this allowed space for participants to ask questions they may have thought of since that time. In addition, it allowed for informal discussion that essentially broke the ice, thereby helping put participants at ease (Fontana & Frey, 2005; Kilanowski, 2012). During this early interaction with participants I noted that they visibly relaxed and we were able to establish a good rapport that continued throughout each interview. Once the interview began, I used open-ended questions to encourage participants to tell the story of their journey with homeopathy. The interviews were guided by the following three main questions that all participants were asked:

- Tell me why you became a homeopath
- How, if at all, does being a homeopath influence your nursing practice?
- How, if at all, does being a nurse influence your homeopathic practice?

During each interview a pad and pencil were kept accessible so that any concepts spoken about by participants could be noted and followed up on if necessary. Participants were encouraged to tell their story in their own words and interruption was kept to a minimum. Any response from me was generally related to prompting participants to continue with their train of thought or probing of their response. Prompting is used by interviewers to encourage participants to continue with their response, while probing encourages participants to extend upon any partial responses (Jacob & Furgerson, 2013; King & Horrocks, 2010). Most participants were quite loquacious, speaking freely and passionately about their experiences, thereby requiring minimal prompting or probing.

As the research progressed, questioning evolved in response to emerging concepts as per the principles of grounded theory (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). For example, as the concept of conflict emerged, participants were asked specific questions relating to conflict. Initially these questions were quite broad, such as “Tell me about any conflict that you might have experienced in being a nurse and a homeopath”. However, these questions became more specific as the concept of conflict became further developed. If participants said that they experienced conflict, they were asked how they managed that conflict and further specific questions pertaining to their answers were asked. Participants’ replies to these questions were then compared to the data from other interviews. Variations in participants’ experiences with conflict were noted and followed up in subsequent interviews. In addition, participants would sometimes suggest interviewing someone else in response to emerging concepts. For instance, one participant said, “oh, you should interview [names another person], they have a totally different perspective than me on the conflict found in working both professions”. This participant’s statement led me to people who had experienced considerable conflict with their nursing practice. Interviewing these participants offered an alternative perspective to those who

said they had no conflict in being a nurse and a homeopath, thereby assisting in fully exploring the concept of conflict.

At the conclusion of each interview, participants were once again thanked for their participation and asked if they had anything further to add. This gave participants time to think about what they had said and consider whether they wanted to build upon or change anything they had spoken about. Furthermore, it also provided participants with an opportunity to discuss anything they thought was important, but which had failed to be covered. King & Horrocks (2010), note that it is not uncommon for participants to divulge further valuable information at this late stage of the interview process (p. 56). Providing participants are happy to continue with the interview, this can provide an opportunity for further targeted questioning (King & Horrocks, 2010, p. 56).

Once it was clear that participants had nothing further to add, they were asked if they knew of anyone else who met the inclusion criteria and who might be interested in participating in the study. Gathering further research participants in this way is an example of snowball sampling. Participants were also asked permission for post interview contact should there be a need to clarify anything in the data. All participants were open, without hesitation, to being contactable. Immediately after ceasing contact with participants, any non-verbal responses of interest that occurred during the interview were documented. In addition, any questions that had arisen from the interview process along with a memo of my personal thoughts was recorded in my research notes. As previously discussed in section 4.3.3.4 of the chapter, memos are a vital component of grounded theory research, providing insight into the researcher's observations and responses, as well as that of the data (Birks & Mills, 2011; Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998).

Transcription of all 15 interviews was done by myself, as I believed this would facilitate immersion in the data and assist with identification of emerging concepts (Bailey, 2008; Bazeley & Jackson, 2013, p. 57). Although transcription is a laborious process, with one-hour interviews taking several hours to transcribe (Bailey, 2008; Markle, West, & Rich, 2011), it kept me closely connected to the data. As early concepts were being abstracted into higher level concepts (Corbin & Strauss, 2008), the interviews were re-listened to and transcripts re-read to ensure the concepts truly reflected participants' stories. Repeated listening to interviews provided familiarity with the data (Bazeley & Jackson, 2013, p. 58) and raised awareness of the subtle nuances that may be missed in reading a written transcript which may not capture emotion (Bazeley & Jackson, 2013; Markle et al., 2011; Urquhart, 2013). Paying close attention to participants' intonations and where the emphasis was placed on certain words or phrases (Bazeley & Jackson, 2013, p. 58), assisted in the interpretation of their narratives. It is asserted by Bailey (2008) that transcription is not merely a mechanical procedure but is a revelatory deed that can lead to unearthing unexpected phenomena (pp. 130–131).

Rather than providing a transcript of interviews to participants, a report of the research will be made available to participants after successful submission of this thesis. Although providing transcripts to participants can help in clarifying data while respecting the rights of participants to the ownership of the information that has been shared, studies also indicate that participants can find transcripts embarrassing and difficult to read (Hagens, Dobrow, & Chafe, 2009; Mero-Jaffe, 2011). In addition, changes made by participants have the potential to alter the transcript, rendering it an inaccurate reflection of the interview (Hagens et al., 2009).

4.5.3.1 Challenges encountered with interviewing

Problems encountered during interviewing related to the use of a digital audio recorder, technological issues with video link and errors made that were attributable to my inexperience with interviewing for research purposes. Each of these factors is discussed in turn beginning with the issues related to the audio recordings of the interviews. The decision to use an external digital audio recorder, rather than install software that allows for internal recording, was largely due to my lack of knowledge and confidence in downloading and using the required software for use with video link. Using external digital audio recording devices can result in issues relating to the quality of the audio recording during playback (Bazeley & Jackson, 2013, p. 57; Hanna, 2012, p. 241). At times I did find the audio quality lacking, and some recordings had to be listened to several times during transcription to accurately decipher what participants were saying. Although this made transcription a laborious process, it never adversely affected the outcome of the study. However, I acknowledge that using internal recording software rather than an external recording device might have produced a higher quality recording, thereby making the process of transcription easier.

Technical difficulties were encountered with video contact during some of the interviews. These difficulties required the video function to be disabled so the interview could continue without further interruption. In one instance, a participant encountered problems with poor connection during the interview, which was resolved by the participant disabling their video function. The result of this action was loss of visual contact with the participant, however the participant was still able to maintain visual contact with me. I considered stopping the interview and asking that it be rescheduled, but in this case the participant had a full schedule and finding a suitable interview time had been difficult. With these factors in mind, it was decided to continue with the interview rather than risk losing a participant.

In another instance, visual display was disabled from my location after technical issues began 30 minutes after commencing the interview. There were significant problems with video quality and sound delays that were resolved by disabling my video. Although the participant lost visual contact with me, I was able to maintain visual contact with the participant. I believe any negative impact on the interview arising from the participant losing visual contact with me would have been minimal. We had established a rapport in the thirty minutes before any problems manifested and the interruption was a minor inconvenience that we resolved quickly before continuing with the interview. Another participant had no webcam available, so although she had visual contact with me, I had no visual contact with her. After having conducted two previous interviews with no visual display, I decided to continue with the interview rather than reschedule when, and if, a webcam became available. My personal belief is that the lack of visual contact in any of these interviews had minimal negative impact, if any. However, I acknowledge that any non-verbal forms of communication may have been missed.

I encountered other challenges as a consequence of my inexperience as a grounded theory researcher. My intention for the interviews was to allow participants the space to direct the conversation and for me as the researcher to follow them, adapting to the situation as it occurred. It is necessary to be aware during the interview process of the significance of what is being conveyed by participants to emerging concepts within the research and be flexible in guiding or following the path of conversation (Birks & Mills, 2011; Corbin & Strauss, 2008). However, at times participants deviated widely from the question being asked, which resulted in some interviews being well over an hour in duration and producing data not relevant to the research topic. After conducting two or three interviews, my interviewing skills did improve: I became better at following up on emergent themes as they developed and questioning became more specific.. Although interviews became more

focused on specific areas of the data their duration was still around 45 minutes. The difference was that the information gathered was more pertinent to the research topic than some of my earliest interviews.

Another issue that arose related to familiarity. As a member of the homeopathic community, participants considered me as a colleague, even though most had never met me personally. Although this was helpful for creating an atmosphere of open disclosure, it also meant that some participants tried to solicit my opinion on certain topics they raised during the interview process. Familiarity with an area of research and the participants involved can result in a shift in the relationship between researcher and participant, potentially resulting in a confusion of boundaries (Manderson, Bennett, & Andajani-Sutjahjo, 2006). It is suggested by Fontana and Frey (2005) that researchers avoid conversations where participants are questioning the researcher and seeking their personal opinions (p. 713). However, Fontana and Frey (2005) acknowledge that other authors advocate a more empathetic interviewing style. During interviewing for this study questions that were posed by participants were answered, but personal opinions were avoided, and the conversation was guided back to the participants' experiences.

As each interview was completed, they were coded and compared with other interviews as per the grounded theory methods outlined in section 4.3.3 of the chapter. The specific processes utilised in the coding of data in this study; namely: open coding, axial coding and selective coding will now be discussed. Although coding is not a linear process (Birks & Mills, 2011; Charmaz, 2014; Corbin & Strauss, 2008), for the explanatory purposes of this chapter, the various forms of coding used in this study will be discussed separately beginning with open coding.

4.5.4 Open coding

Open coding began the analytic process of this study. During open coding, pieces of data are assigned labels that represent what is being said by the participant in that specific section of data (Corbin & Strauss, 2008; Charmaz, 2014; Strauss & Corbin, 1990, 1998; Urquhart, 2013). Open coding of the data in this study was done line by line or incident by incident, to ensure that nothing was missed (Birks & Mills, 2011; Holton, 2010). Line by line coding requires that the researcher look at the data in minute detail (Birks & Mills, 2011; Corbin & Strauss, 2008; Strauss & Corbin, 1990, 1998). During this process, codes stay close to the data and the researcher is stimulated to think about what has been said and to ask questions of the data in relation to what is going on (Birks & Mills, 2011; Corbin & Strauss, 2008; Charmaz, 2014; Strauss & Corbin, 1990, 1998). It also enables identification of emerging concepts, which can then be compared to other incidents (Charmaz, 2006). Meticulous initial coding helps prevent researchers imposing their own baggage onto the data and challenges them to see common events from a new perspective (Charmaz, 2014). Figure 9 is an extract of some initial open coding on extracts from two interviews in this study using line by line/incident by incident coding:

Excerpt of Initial Open Coding	
Interview A	
I was seeing the statistical back up that these kids were getting less infections so finally after about 6 months I put my hand up and said can you treat stressed mothers and then I felt the benefits first hand because I was a cranky tired mum and I stopped fighting with the kids. It's amazing and that was the penny dropping moment for me	seeing results getting less infections asking for help feeling benefits first hand penny dropping moment
Interview L	
I had always thought to study complementary therapies. I've done yoga training. I've done shiatsu practitioner, so it was when I saw how homeopathy helped my baby that's when I thought ok what's in this, I want to know more	wanting to study CAM done yoga/shiatsu seeing results wanting to know more

Figure 9. Example of line by line/incident by incident open coding from this study

Particular notice was taken of the terms used by participants. For instance, ‘penny dropping moment’ became an early code. Codes that are formed from a participant’s own words are known as in vivo codes (Birks & Mills, 2011; Charmaz, 2014). In vivo codes are described by Birks and Mills (2011) as codes that capture, “participants’ words as representative of a broader concept in the data” (p. 174). In the transcript featured in Figure 9, the in vivo code ‘penny dropping moment’ conveys that at that moment in time the participant became aware of their altered response to a particular situation and attributed it to their homeopathic treatment. In vivo codes can provide insight into a participant’s view of what is happening at that moment in time. However, Charmaz (2006) reminds the researcher that in vivo codes need to be subjected to the same rigorous comparison and analysis as any other code (p. 55).

During the process of open coding and comparison of codes, data is abstracted and categories formed. For example, the statement in the coding example in Figure 9 where the participant talks about thinking of studying CAM and of having previously done yoga and shiatsu, was later abstracted to the category ‘orientation towards CAM’. The forming of

this category is an example of abstraction of data, where lower level concepts are abstracted into higher level concepts (Corbin & Strauss, 2008; Charmaz, 2014). Doing yoga or shiatsu is a low-level concept, as it only applies to the participant engaging in these activities. Orientation towards CAM is a higher-level concept, as it can relate to multiple situations and be applied across several interviews (Corbin & Strauss, 2008, p. 52).

4.5.5 Axial coding

Axial coding is a contentious feature of Straussian grounded theory (Birks & Mills, 2011; Charmaz, 2014). During axial coding, the relationships between categories and sub categories are explored and data that has been fractured during open coding is put back together (Strauss & Corbin, 1998). According to Strauss and Corbin (1998), axial coding answers the where, why, who, when, how, and with what consequences questions, thereby unearthing the relationships between categories (p. 127). However, not all grounded theorists see axial coding as a necessary, or valuable, addition to the analytic process of grounded theory (Glaser 1992; Charmaz, 2014; Urquhart, 2013). Critics of axial coding consider it to be applying a procedural framework to what should be an emergent process (Glaser 1992; Charmaz, 2014).

Corbin and Strauss (2008) only briefly mention axial coding, which is a significant departure from their previous work on coding in grounded theory research (Charmaz, 2014; Urquhart, 2013). Axial coding was used in this study to explore the relationship between categories and sub-categories, but the advice of Strauss and Corbin (1998) to not adhere too rigidly to the analytic process and lose the essence of what is being represented was heeded (p. 129). Therefore, coding at this stage of the analysis explored the relationship between categories and sub categories, noting the conditions under which certain phenomenon arose and the actions taken by participants in response to those conditions.

However, this analysis was never performed within a rigid framework. Labelling of conditions under which certain phenomenon occurred as causal, intervening or contextual was never applied. Rather, sub categories were developed that provided further information and clarification of what was going on in that particular piece of data (Strauss & Corbin, 1998). For example, the category ‘seeking CAM’ included the sub categories ‘chronic health conditions’ and ‘orientation towards CAM’. These sub categories and their respective properties provided further information on the factors relating to participants seeking CAM and the relationship between them.

4.5.6 Selective coding

The process of selective coding involves the abstraction of codes to a theoretical level and subsequent integration and refinement of the substantive theory (Strauss & Corbin, 1998; Urquhart, 2013). This aspect of data analysis proved to be personally challenging, as I struggled with taking the conceptual leap required to develop theory (Corbin & Strauss, 2008; Charmaz, 2014). I was fearful of moving away from the narratives of the participants and worried that I might be misinterpreting their experience. One of my supervisors suggested that I contact some participants and ask them if they felt my interpretation of the data resonated with them. Member checking, where research participants verify the final concepts is one way of ensuring the credibility of the research findings (Birt, Scott, Cavers, Campbell, & Walter, 2016; Noble & Smith, 2015). However, Glaser (2002), argues against member checking in grounded theory research, due to the conceptual nature of a grounded theory study. Glaser’s (2002) view is that as participants’ only source of reference is their own experience, they are unable to see or understand the overall conceptual picture (p. 25). Although I think there is merit to Glaser’s perspective, to alleviate my anxiety I contacted three participants to discuss with them the dominant concepts that I was seeing in the data.

Two of the participants I contacted were working in nursing and homeopathy, while one had left the nursing profession to pursue private practice as a homeopath. These participants were chosen as their experiences were different from one another and their perspectives on being a nurse and a homeopath varied. Two of the participants contacted felt that my interpretation of the data at that stage of analysis fitted with their experience. However, one participant who worked as a nurse and a homeopath challenged my thought process around the concept of conflict. As a result of my discussions with these three participants, I went back to the data and refined the concept of conflict to what I believed better represented the variations evident in the data. Member checking, working closely with my supervisors and going back to the raw data helped with my ability to move forward towards theoretical development. An integral part of theory development in grounded theory is the identification of a central or core category (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Holton, 2010; Strauss & Corbin, 1998), which will now be discussed.

4.5.7 Core category

A core category is an abstract concept, under which all other categories can be incorporated (Strauss & Corbin, 1998). Its primary function is to integrate the theory and explain the essence of the research (Charmaz, 2014; Holton, 2010; Corbin & Strauss, 2008).

The criteria for a core category in grounded theory is as follows:

- All major categories can be related to it
- Appears frequently in the data
- Explanation of relationship of categories to core category is logical
- Label of core category is abstract so that it can have use in other substantive areas

- As the theory is refined analytically through integration with other concepts, the theory grows in depth and explanatory power
- The concept can explain variation as well as the primary point made by the data

(Strauss, 1987, as cited in Strauss and Corbin (1998, p. 147).

Choosing a core category can be a difficult decision for a researcher, due to the abundance of data and the closeness of the researcher to the data (Corbin & Strauss, 2008; Strauss & Corbin, 1998). In addition, Strauss and Corbin (2008) suggest that more than one core category may be identified, and the researcher may have trouble choosing one to represent the study. If two dominant categories are identified, Strauss and Corbin (2008) suggest the researcher looks for the one that best embodies the core of the data (p. 105). However, a researcher may opt to choose more than one core category (Strauss & Corbin, 2008). In a grounded theory masterclass hosted by La Trobe University, Melbourne, Australia that I attended in early 2014, Charmaz spoke about how multiple core categories can provide depth and variation to a study.

In this study, two core categories were identified; namely: ‘positioning’ and ‘congruence’. Trying to identify if one of these concepts overrode the other in terms of analytic power, I engaged in a process of reviewing and refining categories (Corbin & Strauss, 2008). During this process, I was constantly asking question of the data in relation to what was going on (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Eventually, I decided that the two categories together provided more depth. Consequently, I settled upon congruent positioning as the core category. The development of congruent positioning as the core category arising from the research was aided greatly by revisiting memos that had been written throughout the process of the study. As discussed in section 4.3.3.4 of the chapter,

memos are an important component of a grounded theory study. The use of memo's in this study will now be explored.

4.5.8 Use of memos in this study

The practice of writing memos was employed for the duration of this study from the start of data collection, as I tried to make sense of the research process and my role in it. In addition to my thoughts and reflections, memos were written relating to every aspect of the research process. Through memoing, I could easily identify what I had done at each step of the study's progression. I could then reflect upon these and discuss any issues or uncertainty I was experiencing with my supervisors. As I developed various categories, memos were written to explore them and expand my thinking, especially as I moved towards the more conceptual level of theory development. Figure 10 is an excerpt of a memo written in relation to the category 'connecting with holistic principles.'

Connecting with Holistic Principles
<p>Participants' narratives to date have all had reference in some form or another to 'connecting with holistic principles.' What does that mean?</p> <p>They were exposed to concepts of holism through their exposure to CAM and they connected with the holistic principles underpinning the CAM modality or modalities they were exposed to. The principles underpinning CAM made sense to them.</p> <p>Participants speak about seeing health differently once they engaged with naturopathy and/or homeopathy and were exposed to concepts of holism. They speak about 'having never thought of health in this way' and of it being 'new' and 'revelatory'. What are the consequences of connecting to holistic principles and viewing health from a different perspective at a personal and professional level?</p> <p>There is an obvious connection to the category 'dissatisfaction', as participants speak about becoming increasingly 'frustrated' or 'dissatisfied'. These two categories need to be compared. There could also be a relationship between the categories 'connecting with holistic principles' and 'seeing people differently'. Several participants spoke about becoming less judgemental of people/clients due to their involvement with homeopathy. It is like they have an expanded perspective. They talk about stopping to consider all the factors contributing to the situation a person is in, rather than immediately judging them. Is this another aspect of 'connecting to holistic principles'? Is it exposure to the concepts of holism that result in them seeing people differently? I need to go back to this category, compare the two and see how they relate.</p>

Figure 10. Excerpt of a memo from this study: connecting with holistic principles

This memo was written during the latter stages of open coding where I have noted that the category 'connecting to holistic principles', has a relationship to another category. Exploration of the relationship between these two categories eventually led to the development of a higher order category of 'transforming perspectives.' As discussed in section 4.3.3.5 of the chapter, the writing of memos allows the researcher to think about the data from a variety of perspectives and to analyse and reflect on what the researcher is seeing in the data (Birks & Mills, 2011; Corbin & Mills, 2008; Strauss & Corbin, 1998). Memos are described by Charmaz (2014), as a way to "catch your thoughts, capture the comparisons and connections you make and crystallize questions and directions for you to pursue" (p. 162). Memoing is an important tool for assisting with theoretical sampling as it helps to identify gaps that can be filled by more specific sampling, thereby assisting the

researcher to develop higher order concepts (Charmaz, 2014; Corbin & Strauss, 2008). Management of collected data will now be considered.

4.5.9 Data management software

Increasingly, data management software is being utilised to assist in the management of large data sets typically generated in qualitative research (Bazeley & Jackson, 2013; Cope, 2014). Open coding of interviews in this study resulted in the generation of over one hundred codes. To assist in the management of data and support data analysis, I used the computer software program NVivo (Version 10) in this study. Transcripts of participants' interviews were imported into NVivo and data was analysed using the available coding features. Codes were refined and reduced as data was compared and abstracted. During this process, codes that were found to be fundamentally saying the same things were abstracted into categories. As data began to be considered from a more conceptual perspective, further refinement of categories occurred.

One advantage of data management software is the easy retrieval of coded information (Bazeley & Jackson, 2013; Corbin & Strauss, 2008). NVivo functionality also allowed for the easy creation of categories and sub categories that could be viewed in a single screen, thereby assisting the comparison and refinement of these categories during the later stages of coding. In addition, memos could be written and stored alongside the relevant codes and categories. Although data management software offers many advantages, Cope (2014) cautions that these advantages need to be considered alongside the limitations of software management programs (p. 322). Personally, I found NVivo extremely helpful for all the reasons listed above, but it also proved problematic when my coding was lost due to a malfunction of the program. Although numerous attempts were made to restore the data, these attempts were futile, and it became apparent that open coding would need to be

repeated. The second round of open coding was done manually using pen and paper, rather than NVivo. Once codes were abstracted into categories, and concepts began emerging, I imported the data back into NVivo and the software was used to assist with data management and further coding from that point onwards. Although starting over was a laborious process, it was assisted greatly by the fact that I had stored copies of memos relating to various codes and categories in a folder on my computer. Appendix E provides images of screen captures taken during varying stages of data analysis with NVivo, post the malfunction and loss of early coding.

4.6 Evaluating a Grounded Theory Study

Numerous different terms such as quality, reliability, vigour, validity and usefulness are applied to the evaluation of qualitative research (Anderson, 2010; Corbin & Strauss, 2008; Charmaz, 2014; Strauss & Corbin, 1990, 1998). In addition, there is considerable debate over appropriate ways to examine the rigour of a study, especially in relation to grounded theory research (Cooney, 2011; Corbin & Strauss, 2008; Charmaz, 2014). Corbin states in Corbin and Strauss (2008) that no set evaluation criteria should be applied across all forms of qualitative methodologies, arguing instead that each method should have its own criteria by which it is judged (p. 302). Glaser and Strauss (1967) suggest that the methods used for collecting, analysing and generating theory and the usefulness of the generated theory form the criteria upon which the credibility of a grounded theory study is judged (p. 224). Birks et al. (2006) note that Strauss and Corbin (1990, 1998) reiterate evaluating grounded theory on the methods used and suggest extensive criteria for evaluation of the research process and the empirical grounding of findings (p. 7). In Strauss and Corbin (2008), Corbin focuses more on the quality of the research which encompasses the methods used, the aim of the research, and researcher attributes such as self-awareness and experience (pp. 302-303). The evaluation criteria for grounded theory suggested by Charmaz (2014)

is based upon credibility, originality, resonance and usefulness (pp. 337–338). Evaluation of this study follows the criteria suggested by Charmaz (2014) as it avoids positivist tenets such as verification yet encompasses much of the criteria suggested by Glaser and Strauss (1967), Corbin and Strauss (2008), and Strauss and Corbin (1990, 1998) in an uncomplicated manner. These four criteria suggested by Charmaz (2014) will now be discussed in turn.

4.6.1 Credibility

The credibility of this study is demonstrated in the development of a substantive theory grounded in participants' voices. Theory development was achieved using interviews in which participants were able to tell their story in their own words, thereby achieving familiarity with participants' experiences in relation to the research topic (Charmaz, 2014). Data was collected and analysed in accordance with the principles underlying grounded theory methods and an audit trail of this process exists. Memos written during the research process show comparison of categories and concepts and provide insight into the observations made and how these related to the data.

4.6.2 Originality

Originality is demonstrated through the new insights that this study provides on the experience of nurses who are homeopaths (Charmaz, 2014). A substantive theory was generated that is grounded in the narratives of participants and explains the factors attracting them to the practice of homeopathy. In addition, the substantive theory provides insights into the influence participants' respective nursing and homeopathic identities had on their nursing and homeopathic practice. To my knowledge, there are no other studies that have explored the experience of nurses who are qualified homeopathic practitioners and have worked in both professions concomitantly.

4.6.3 Resonance

Resonance is demonstrated through the careful construction of categories and concepts that are grounded in the data, thereby being a true representation of participants' experiences (Charmaz, 2014). Through constant comparative analysis and theoretical sampling, these categories and concepts were fully developed to provide rich detail of the studied phenomenon. Resonance in this study was further demonstrated via member checking with some of the participants, as outlined in section 4.5.6 of the chapter. These participants were contacted as theoretical development was occurring, to see if the proposed interpretation of the data resonated with their experience.

4.6.4 Usefulness

Usefulness is demonstrated by the capacity for further research to extend upon the substantive areas identified in this study (Charmaz, 2014). In addition, the insights provided by this study contribute to the body of knowledge on the intersection of nursing and CAM and nurses' professional use of homeopathy, from the perspective of nurses who are CAM practitioners. Currently, the voices of this cohort of health professionals are absent in the nursing, homeopathic and CAM literature.

4.7 Summary

This chapter explored grounded theory as a research methodology and discussed the suitability of grounded theory for this particular research. The research aim and questions were outlined along with a detailed discussion of the methods utilised in undertaking this research, thereby providing an audit trail of how this research was conducted. Included in the chapter was information on participants, ethical considerations, recruitment, the process of data collection and analysis and the challenges encountered during the interview process. The core category of congruent positioning was introduced, and an evaluation of the

credibility, originality, resonance and usefulness of this study was presented. Findings from the study are disseminated over the following three chapters, with each chapter exploring key concepts that were identified through the grounded theory method of concurrent data collection and analysis. Each of these chapters discusses these findings within the context of the codes and categories formed during analysis and their subsequent abstraction to key concepts.

Chapter 5. Connecting Philosophically

If you've got open eyes, you can see what's possible and you see how it [homeopathy] works" (Participant I).

5.1 Introduction

Chapters One to Four of the thesis have outlined the aim of this study, provided background to the research topic and discussed the methodology used in the research and the positionality of the researcher. Chapters Five to Seven will present the findings of the data analysis within the context of the key concepts that informed the core category of congruent positioning. The aim of this chapter is to present the first of these concepts; namely: connecting philosophically. The findings presented in this chapter directly answer the research question: 'What attracts qualified nurses to the practice of homeopathy'? The chapter begins by presenting the findings associated with participants seeking complementary and alternative medicine (CAM), followed by an examination of their continued association with homeopathy. The decision by participants to seek CAM and their subsequent continued involvement with homeopathy is then considered within the context of experiential and transformative learning. The chapter concludes with a synopsis of its main points. Figure 11 provides a visual representation of the concept, connecting philosophically, outlining the main categories that informed it. These categories and their properties provide the framework of discussion for the chapter.

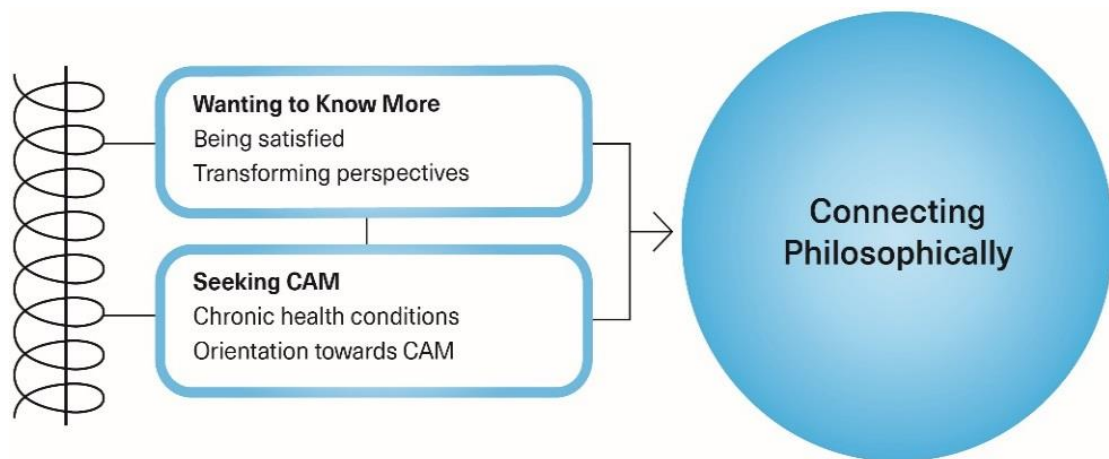


Figure 11. Concept of connecting philosophically developed from this study

5.2 Seeking CAM

At the beginning of the interview process participants in the study were asked the guiding question, “What attracted you to the practice of homeopathy?” In response, participants recounted stories about seeking CAM and the role this played in their eventual decision to become homeopathic practitioners. Consequently, participants’ attractions to the practice of homeopathy was identified as being linked to the factors that led them to seek CAM, and it is at this point that the chapter commences to present participants’ journeys of becoming homeopaths. During the course of data collection and analysis, two key factors were identified as being influential in participants’ decisions to seek CAM. These two factors were labelled, ‘chronic health conditions’ and ‘orientation towards CAM’. Rather than participants falling neatly within one of these two influences, there tended to be an intersection of factors. For instance, some participants who sought CAM in response to a chronic health condition had an existing orientation towards CAM, as evidenced by the following participant’s narrative:

I had eczema on my hands ... cortisone certainly didn't have any long-lasting effects and I didn't really want to do that. I like natural things. I was looking for alternative

health care that was more natural and something that was about long-term health.

(Participant E)

Homeopathic treatment for eczema was sought by Participant E after cortisone, a biomedical treatment frequently used to treat the symptoms of eczema (Lundin et al., 2018), had a limited therapeutic effect on their skin condition. Although the condition of eczema was a driving factor in Participant E seeking CAM, an orientation towards CAM is expressed in Participant E's statement about 'liking natural things'. Consequently, a chronic health condition and an orientation towards CAM were instrumental in Participant E seeking CAM. The term natural is often used in reference to CAM practices and interventions, which are commonly referred to as natural medicine or natural therapies (Fouladbakhsh, Balneaves, & Jenuwine, 2013; Xiong & Guan, 2017). Although Participant E's reason for seeking CAM involved a chronic health concern and an orientation towards CAM, not all participants who sought CAM in response to health concerns were oriented towards CAM. The intersection of the two key factors identified as being influential in participants' decision to seek CAM varied between participants: as a result, they are explored separately, beginning with chronic health conditions.

5.2.1 Chronic health conditions

Health conditions considered to be chronic are defined as those of long duration and with continued effects that can lead to a poorer quality of life (Australian Institute of Health and Welfare [AIHW], 2019; Department of Health, 2017). All participants in this study who sought CAM in response to chronic health conditions saw a homeopathic practitioner, even though they had little to no knowledge of homeopathy at that point in time. These participants expressed no particular preference for homeopathy as a form of treatment.

Their decision to seek homeopathic treatment was solely based upon the referral of others in their social networks:

Somebody said to me “Have you ever tried homeopathy?” Actually, I’d never heard of it. (Participant K)

A good neighbour said “Have you tried homeopathy? It helped my son’s asthma or eczema or something” and I said, “I don’t know much about it, but I will try anything. (Participant A)

Even though participants knew very little about homeopathy, none of them expressed having any concerns or reservations about seeking homeopathic treatment. Rather, participants appear to have unreservedly trusted the suggestions offered by other people. Research indicates that the response of participants to the recommendations of others is relatively common. Several studies suggest that the utilisation of CAM is frequently made on the advice of trusted members of an individual’s social network (Bishop & Lewith, 2013; Fagerlin, Wang, & Ubel, 2005; Frawley et al., 2014; Verhoef, Mulkins, Carlson, Hilsden, & Kania, 2007). In addition, some researchers have reported that a number of nurses have a positive attitude towards CAM (Chang & Chang, 2015; Shorofi & Arbon, 2010, 2017; Somani, Ali, Saeed Ali, & Sulaiman Lalani, 2014), and are among the group of health care workers most likely to utilise CAM personally (Bahall & Legall, 2017; Johnson, Ward, Knutson, & Sendelbach, 2012). Participants in this study seeking CAM for chronic health conditions had often endured years of living with their complaint:

I had a skin condition for many years, which was essentially eczema. (Participant B)

I had a chronic, chronic condition, like boils, abscesses, under my arms. I'd had years of antibiotics. I had one on my face, my knees, back of my legs. It was just a real chronic thing I'd had from when I was a child. (Participant K)

Antibiotics had been used to treat Participant K's recurring abscess, indicating that medical treatment had been sought prior to seeking homeopathic treatment. However, despite the use of antibiotics, the abscesses continued to occur. CAM treatments are often sought as a last resort after other avenues of treatment have been ineffective, or biomedical options have been exhausted (Efthimiou, Kukar, & MacKenzie, 2010; Lambert, Morrison, Edwards, & Clarke, 2010). In general, a primary health care worker, such as a general practitioner (GP) is usually the first point of contact for people accessing the Australian health care system (AIHW, 2018, p. 41; Australian Medical Association, 2010). When the interventions implemented by a GP are ineffective, or more specialised expertise is required, specialist help may be employed (Jiwa et al., 2008; Department of Health and Human Services, 2018). For some individuals, this can be a time of despair, as evidenced by Participant A, who speaks of the despondency felt within the confines of a constant round of antibiotics and specialists with no long-term resolution in sight:

I got into it [homeopathy] with three sick children with chronic earaches. They were living on antibiotics. Between the three kids they had about sixty courses of antibiotics and three sets of grommets. The specialist said they would grow out of it when they are about eight and I was going "I cannot keep doing this for another six years". I was absolutely at my wits end. As soon as the antibiotics finished, four days later up would come another earache. (Participant A)

The medical practitioners that Participant A had consulted were unable to offer any other treatments and the thought of spending several more years dealing with the same issue was

a distressing thought. A similar experience of limited biomedical options was shared by another participant who sought homeopathy in relation to a case of recurrent tonsillitis:

My first experience with homeopathy was at a stressful time in my life and my boy was unwell, so I took my boy to the homeopathic clinic. He had full on bacterial infections ... the GP had said, "He's had four lots of antibiotics in a six-month period, he really needs to have his tonsils out". I was just "No, I can't do that."

(Participant D)

Antibiotics were having a limited effect on Participant D's son's recurrent tonsillitis, so it was suggested by a GP that his tonsils be surgically removed. The surgical removal of tonsils due to recurrent infections is common practice (Burton, Glasziou, Chong, & Venekamp, 2014). Despite the fact that tonsillectomies are a common biomedical intervention, Participant D rejected the notion of surgery, preferring to seek alternative options instead. The reasons behind Participant D's reluctance to accept a surgical intervention failed to be followed up on in the interview, so the motives behind Participant D choosing homeopathic treatment over surgery is unknown. However, although tonsillectomies are common procedures, opinions vary on whether any positive outcomes from this surgical intervention compensates for the risks (Burton et al., 2014).

It is also well known that undergoing surgical procedures can be an anxious and fearful time for children and their parents (Aranha, Sams, & Saldanha, 2016; Bayne & Kirkland, 2008; Scrimin, Haynes, Altoè, Bornstein, & Axia, 2009). In addition, studies suggest that CAM utilisation in children is common (Italia, Wolfenstetter, & Teuner, 2014; Lorenc, Ilan-Clarke, Robinson & Blair, 2009; Magi et al., 2015). A systematic review of CAM use in acute respiratory tract infections in children indicates that the prevalence rates of children utilising CAM across the world is as high as one in two children (Lucas, Leach, & Kumar,

2018). Although various CAM modalities are utilised in the treatment of children, research suggests that homeopathy is a popular choice of therapeutic intervention (D. Adams et al., 2013; Italia et al., 2014; Längler et al., 2011; Lee & Kemper, 2000; Lucas et al., 2018). However, there are notable geographical variances to homeopathy's pattern of use. For instance, although homeopathy is a popular choice of treatment in Germany and the United Kingdom, it is less popular in Turkey and South Korea (Italia et al., 2014). No studies specific to the prevalence of homeopathic utilisation among children in Australia could be found.

Research indicates that parents utilise CAM with their children for a variety of reasons (Dannemann et al., 2008; S. C. Hughes & Wingard, 2006; Italia et al., 2014; Madsen et al., 2003; Wong, 2009). Included among the reasons that parents utilise CAM with their children is their desire to do everything possible to improve the health of their children, and the fact that CAM increases available health care options (J. H. Doering, Reuner, Kadish, Pietz, & Schubert-Bast, 2013; O'Keefe & Coat, 2010, p. 298). Not surprisingly, parents' personal use of CAM is also a factor in CAM utilisation among children (Barnes, Bloom, & Nahin, 2008; Levy & Hyman, 2015).

Data from this study indicates that chronic health conditions were a significant factor in participants seeking CAM, and supports the findings of previous studies (Armstrong, Thiébaud, Brown, & Nepal, 2011; Brien, Leydon, & Lewith, 2012; Falci, Shi, & Greenlee, 2016; Mbizo et al., 2018; Ventola, 2010). It is acknowledged that advances made in surgery and public health have transformed communities and extended the lives of many individuals (Abelson, Rupel, & Pincus, 2008, p. 25; Australian Bureau of Statistics [ABS], 2011; Ünal, Critchley, Fidan, & Capewell, 2005). However, it is also recognised that biomedicine has significant limitations, especially in relation to chronic disease

(Abelson et al., 2008; Fuller, 2017; Swerissen, Duckett, & Wright, 2016). Some chronic diseases respond well to non-pharmacological interventions such as dietary and lifestyle changes as well as various CAM interventions (Allam & Arjona, 2013; Fuller, 2017; Goyal et al., 2014; Khan et al., 2008; Swerissen et al., 2016; M. Yang, Jiang, Wang, & Xu, 2017). However, biomedicine is typically oriented towards pharmacological treatment which is often accompanied by significant side effects, or surgical intervention (Allam & Arjona, 2013; R. G. Hughes & Blegen, 2008; Swerissen et al., 2016). Seeking homeopathic treatment expanded the health care options of participants in this study when biomedical treatments were ineffective or were considered by participants to be undesirable.

As previously mentioned in section 5.2 of the chapter, the second factor identified as influencing a participant's decision to seek CAM was labelled as, 'orientation towards CAM'. Participants who were characterised as having an orientation towards CAM were identified as being favourably disposed towards CAM utilisation. Essentially, these participants' existing perspectives of health and wellbeing aligned with that of CAM. The experience of these participants will now be explored.

5.2.2 Orientation towards CAM

Having an orientation towards CAM can be considered within the context of a worldview, or philosophical orientation. Worldviews encompass a range of personal beliefs that are acquired over a lifetime of experiences regarding the nature of reality (B. Fisher, 2012; Mezirow, 1997; Schlitz, Vieten, & Miller, 2010). The combination of these personal beliefs creates a philosophy of life (Gutierrez & Park, 2015, p. 85; Koltko-Rivera, 2004). Worldviews evolve in response to an individual's personal experiences and how that experience is interpreted (Biniecki & Conceição, 2014; B. Fisher, 2012; Mezirow, 1997). For example, it was noted that several participants in this study, with an existing orientation

towards CAM, had been exposed to CAM practices and holistic concepts during their formative years:

I had parents who used osteopaths and things like that when I had injuries from sport, so I had exposure to natural therapies early on and probably that continued. I'd always look at other ways rather than just going to the doctor. Even with nursing, I was doing massage, you know I believed in healing in other ways. (Participant L)

My grandad was a Uniting Church minister, but he was also head of a museum for Indigenous studies, archaeologist and anthropologist. I'd been raised with the understanding of the Dreamtime and with that found natural medicine and shamanism in different populations fascinating, so there was always that in the background. (Participant O)

Participants' childhood exposures to CAM ranged from the utilisation of CAM, to being introduced to cultural practices and traditions that espouse holistic concepts. Having that exposure appears to have influenced these participants' perceptions of CAM, making them receptive to the philosophy and practice of CAM. Although a growing body of literature exists on CAM utilisation in children (Dannemann et al., 2008; S. C. Hughes & Wingard, 2006; Levy & Hyman, 2008; Lucas et al., 2018; Wong et al., 2009), no literature could be found on the impact of childhood exposure to CAM or holistic principles as a predictor of CAM utilisation in adulthood. Therefore, any apparent correlation between participants' early exposures to CAM, and their subsequent attraction to CAM, is purely speculative at this point. Future research into this area could provide insights into the health care choices adopted by adults who have been exposed to CAM during their formative years.

In contrast to the participants in this study who sought homeopathic treatment for chronic health conditions, the majority of participants with an orientation towards CAM sought

CAM for the purposes of studying it, rather than personal use. These participants were attracted to the CAM therapy that aligned with their personal beliefs. This finding supports research suggesting individuals are attracted to CAM as it reflects their worldview, or philosophy of health (Astin, 1998; Bishop et al., 2007; McFadden et al., 2010; Islahudin, Shahdan, & Mohamad-Samuri, 2017; Strattan & McGivern-Snofsky, 2008). However, the body of research cited here focused on factors related to CAM utilisation, while findings from this study suggest that philosophical congruence also influences the decision of individuals to undertake formal CAM education. As stated by Participant F:

I just wanted to see if there were other things out there so I could do more for my patients that modern medicine couldn't do ... I went along to the [names college] open day and the person giving the spiel on homeopathy just really stood out to me. It sounded like something that really connected with what I believed health to be about, so I went along to the information class specifically on that and ended up signing up for it straight away. (Participant F)

The information that Participant F received about homeopathy 'connected' with a personal perspective of health and was the catalyst for Participant F to engage with formal homeopathic education. Similarly, Participant I, talked about their understanding of nutrition as a key factor in becoming involved with naturopathy:

What got me into the whole naturopathy, natural therapies thing, was my understanding of nutrition. I felt people weren't being nourished properly. (Participant I)

Nutritional medicine is an important aspect of naturopathy (Australian Naturopathic Practitioners Association, 2018) and aligned with Participant I's personal beliefs on health. As mentioned in section 4.4 of Chapter Four of the thesis, *Research Design*, several

participants in this study were attracted to naturopathy before they became interested in homeopathy:

I wanted to be a naturopath. I enrolled and did nutrition and so on, but after a while I decided I didn't want to do herbs and naturopathy anymore. I wanted to do homeopathy. I kind of converted over. (Participant J)

I did a naturopathy course and then homeopathy came in. It was just part of the course. I remember trying to resist getting involved with homeopathy, because I thought if I get involved with it that will be it for the rest of my life. It will consume me. I could see how amazing it was. (Participant I)

During their naturopathic education, these participants were automatically exposed to homeopathy, due to the fact that a number of different interventions and practices are incorporated into naturopathic practice. These interventions and practices include, but are not exclusive to: nutritional medicine, herbal medicine and homeopathy (Australian Naturopathic Practitioners Association, 2018; Endeavour College of Natural Health, 2019; Southern School of Natural Therapies, n.d.). Naturopathic students who wish to gain a deeper understanding and knowledge of homeopathic philosophy and practice are able to choose homeopathy as an elective subject (Endeavour College of Natural Health, 2019; Southern School of Natural Therapies, n.d.). However, participants in this study who had trained as naturopaths decided to engage in homeopathic education that was separate from their naturopathic studies. When these participants were asked why they had decided to study homeopathy, they typically responded that they felt homeopathy had a broader approach than naturopathy:

I felt it [homeopathy] dealt with the entire being and the entire issue, not just tiny little snippets that actually weren't healing the person. (Participant O)

I studied naturopathy and realised that it still wasn't addressing the whole healing aspects and for me it's homeopathy. Naturopathy doesn't really address the mental emotional picture that homeopathy can get straight in and address. (Participant H)

Participants spoke about homeopathy dealing with the 'entire issue' and of being able to address the 'mental emotional' state of clients. Although naturopathy is founded upon holistic principles (Australian Naturopathic Practitioners Association, 2019), these participants felt that homeopathy was able to address gaps that they perceived to be present when using a naturopathic approach. As discussed in Chapter Two of the thesis, *Contextualising CAM and Homeopathy*, the homeopathic approach includes a strong focus on the mental and emotional state of individuals (Croce, 2000b; National Health Portal of India, 2016b). The way in which homeopathy addresses all aspects of an individual appealed to these participants and was influential in their attraction to the practice of homeopathy.

During data analysis, it was identified that participants in this study with an orientation towards CAM were notably dissatisfied with certain aspects of nursing practice. Participants' dissatisfaction was closely associated with their orientation towards the holistic principles of CAM. Therefore, the dissatisfaction with nursing expressed by these participants became a sub-category of 'orientation towards CAM' and will now be discussed.

5.2.2.1 Dissatisfaction with nursing

Two factors were identified as being related to the dissatisfaction with nursing expressed by participants with an orientation towards CAM. These two factors informed the sub-category of dissatisfaction with nursing and during data analysis they were labelled as 'lacking a holistic approach' and 'lacking autonomy'. These findings are consistent with

those of the first national survey on nurses' attitudes to work and work conditions in Australia, which found that areas of concern for respondents included having no voice, or autonomy, within their nursing practice and increased workloads that inhibited the ability to deliver holistic care (Holland, Allen, & Cooper, 2012, p. 44). The categories, 'lacking a holistic approach' and 'lacking autonomy', along with their properties will now be explored in turn.

5.2.2.1.1 *Lacking a holistic approach*

As discussed in section 2.2 of the thesis, holistic health care is a philosophical approach, whereby mental, emotional, physical, spiritual and sociological factors are viewed as an integrated whole, rather than reduced to individual and non-related components (Huljev & Pandak, 2016; Papathanasiou et al., 2013). Practice based upon a holistic approach is therefore, inclusive of all these factors. It is asserted by Huljev and Pandak (2016) that holistic practice should be the aim of all health care providers. However, participants in this study felt that the biomedical model of health care lacked a holistic approach, which led to them feeling dissatisfied with the biomedical approach and with certain aspects of their nursing practice. Participants M and O explained:

I thought that there was no preventative medicine in a lot of today's medicine, and I was very dissatisfied with feeling that nursing was a band aid fix. We constantly were seeing the same people come back in to have the same thing addressed. There were so many situations that I just felt we weren't really addressing the roots of health, so that was one of my interests in homeopathy in the first place.
(Participant M)

I remember talking to this oncologist [and asking] "How do you feel about diet as far as endorsing a certain dietary regime with patients with cancer of the bowel?"

Do you see that as a point of relevance as a part of health care and the health care you're providing?" He said, "There's absolutely no significance whatsoever", and that sort of thing frustrated me. (Participant O)

These participants felt frustrated with what they perceived as a lack of preventative care, acting as a catalyst for them to seek a career in CAM. For years, an acute model of care has dominated biomedicine and informed its practices, often at the expense of a preventative approach (Fani Marvasti & Stafford, 2012; Russell, Rubin, & Leeder, 2008; Stieber, 2005). The overarching purpose of preventative health care is to keep people as healthy as possible by preventing disease or stemming its progression (Bipartisan Policy Centre, 2015, p. 12). Increasingly, there have been calls for the adoption of a more preventative approach to health care that acknowledges and addresses the social determinants of health (Bipartisan Policy Center, 2015, p. 12; Egger, Binns, & Rossner, 2009; Moodie, 2008; Sharma & Majumdar, 2009; Department of Health, 2012).

Social determinants of health relate to the conditions that people live and work amongst and include the political and economic systems that underpin societies (WHO, 2019b). Calls for a broader approach to health care have been in response to the recognition that factors such as poverty, social exclusion and gender inequality have a significant impact on the health and wellbeing of individuals (Cockerham, Hamby, & Oates, 2017; WHO, 2019b). In addition, in recent decades there has been a substantial rise in chronic illnesses such as diabetes, obesity and heart disease (Jackson & Sheill, 2017; S. McHugh et al., 2016; Fani Marvasti, & Stafford, 2012). It is now acknowledged that chronic illness can be directly associated with social factors (Cockerham et al., 2017; Daniel, Bornstein, & Kane, 2018). Therefore, it is important that health care systems, models of health care and individual practitioners take a broad approach to the delivery of health care services.

Some commentators have even suggested that aspects of CAM could be a valuable resource in relation to preventative approaches to health care (Hawk, Adams, & Hartvigsen, 2015; Ali & Katz, 2015). Studies indicate the individuals who utilise CAM are more likely to take personal responsibility for health and engage in activities considered health promoting (Davis, Weeks, & Coulter, 2011; Karlik et al., 2014; McFadden, Hernández, & Ito, 2010). Therefore, it is asserted by Hawk et al. (2015) that the utilisation of CAM practitioners in certain areas of preventative care is worth exploring. However, integrating CAM practitioners into primary care is a complex issue that would require interprofessional collaboration between CAM and the medical profession, among other factors (M. M. Anderson et al., 2016; Hawk et al., 2015).

Interprofessional collaboration is a term used to describe a working relationship between clients, families, communities and a team of health care practitioners from different professional backgrounds (Canadian Interprofessional Health Collaborative, 2010, p. 8; WHO, 2010, p. 7). Aspects central to the concept of interprofessional collaboration include shared decision making, respect, trust and partnership (Canadian Interprofessional Health Collaborative, 2010, p. 8). One form of interprofessional collaboration between medical and CAM practitioners that has grown in recent decades is that of health clinics and services offering integrative medicine, described by the Australasian Integrative Medicine Association (2018) as a philosophy of health care focused on individualised care that combines medical interventions with evidence-based CAM (para. 1).

Although integrative health care clinics incorporating biomedical and CAM knowledge are becoming increasingly prevalent (Eisenberg et al., 2016; Ernst, 2016; Gaboury, Lapierre, Boon, & Moher, 2011), it should be noted that there are several different models of integrative health care. These models of care may involve various sectors of health care

services and providers, not all of which include CAM (Grant & Bensoussan, 2014; WHO, 2016). However, for the purposes of this discussion, the terms ‘integrative medicine’ and ‘integrative health care’ relate to integrative models of care that do incorporate CAM. Critics of integrative medicine suggest that it is merely another way of rebranding CAM which could have serious consequences for health care consumers (Haggan, 2016; McLachlan, 2010).

Concerns about integrative medicine have also been expressed by some CAM practitioners who suggest that it could be used to co-opt CAM and distance the various CAM practices from their holistic principles (Baer & Coulter, 2008). These concerns of CAM practitioners are not totally unfounded. Possamai-Inesedy and Cochrane (2013), make the point that in Australia, acupuncture performed by a medical practitioner is covered under Medicare, Australia’s publicly funded health care scheme, while seeking the same treatment from a practitioner of Traditional Chinese Medicine (TCM) involves an out of pocket cost to the consumer (p. 70). Typically, TCM practitioners would have substantially more training in acupuncture than a medical practitioner (Z. Ali, 2010; Possamai-Inesedy & Cochrane, 2013; Zheng, 2014). In addition, although medical acupuncture originated from Chinese acupuncture, the philosophical foundations that underpin TCM often fail to be incorporated into the practice of medical acupuncture (White, 2009). Arguably, biomedicine has co-opted acupuncture by taking a specialised body of knowledge and utilising it within a biomedical paradigm with no connection to its philosophical roots (Possamai-Inesedy & Cochrane, 2013).

The case of acupuncture in Australia outlined by Possamai-Inesedy and Cochrane (2013) highlights the ontological and epistemological differences between biomedicine and CAM and the difficulties of negotiating these in integrative models of health care. As Kaptchuk

and Miller (2005) ask, whose worldview is given precedence in integrated approaches that combine CAM with biomedicine and whose is being discounted (p. 288). In addition to ontological perspectives, there is also the question of how CAM and biomedical epistemology are integrated. Studies suggest that CAM practitioners working in integrative health care clinics are often relegated to a subordinate role, with the primary role being held by biomedical practitioners (Baer & Coulter, 2008; Grant & Bensoussan, 2014; Hollenberg, 2006). The subordination of CAM practitioners illustrates a power disparity between biomedical and CAM practitioners that is indicative of the legitimacy of biomedical epistemology in relation to that of CAM (Hollenberg, 2006; Kovic, 2016; Shuval, 2006). Inequitable relationships do little to build trust, which is an important component of interprofessional collaboration initiatives based upon true partnership (Canadian Interprofessional Health Collaborative, 2010, p. 16; B. N. Green & Johnson, 2015, p. 3).

Another area of frustration for participants in this study that was identified as being related to ‘lacking a holistic approach’, involved the client-nurse relationship. During data analysis this factor was labelled as ‘getting to know clients’ and will now be explored.

5.2.2.1.1.1 Getting to know clients

The client-nurse relationship is an important aspect of nursing practice that is widely recognised as a therapeutic relationship built upon trust and respect (British Columbia College of Nursing Professionals, 2019; Pullen & Mathias, 2010). Nursing practice that takes place outside of the context of interpersonal interactions is described by Freshwater (2002) as an “empty routine” (p. x). A significant source of dissatisfaction for participants related to them feeling that nursing practice had become over medicalised at the expense of the client-nurse relationship. As some participants noted:

You're just there to supervise them after surgery or whatever. Give them medications and get them out ... it started to become a much more medical drugs, pharmaceutical based health care practice, rather than the nursing. (Participant N)

You sit on the bed and have a chat with someone, and someone will call back "Why are you sitting on the bed talking to someone? Get on with it." Probably being trained in mental health before I did general [nursing], it was just such a shock when suddenly everything was about the charts and the pain relief, but there wasn't a lot of total patient care. (Participant K)

The perceived medicalisation of their nursing practice was seen by participants as a departure from what they described as 'nursing' or 'total patient care'. These comments from participants display a striking similarity to sentiments expressed by Florence Nightingale (1860), who, over 150 years ago, wrote, "I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultices" (p. 6). The comments of participants in this study, and Nightingale's commentary on the nursing profession, raise the question about what nursing is and how it is defined. According to the International Council of Nurses (ICN), (2019) nursing is the autonomous and collaborative care of individuals, families, groups and communities whether they are ill or not (para. 1). In addition, the ICN (2019) describes nursing as encompassing health promotion and disease prevention, as well as the care of ill and disabled people across a range of clinical and community settings (para. 2). When participants in this study were asked what they believed nursing to be, they said:

It's talking with people, understanding what the situation is. What it's like for them.

Trying to create an intervention with them, that improves things for them.

(Participant N)

I guess, its client centred, it's holistic. Especially looking at community health nursing, it's working with the whole organism, watching the whole organism develop and move forward. It also can be very intimate. You try to get the real feel of the person. (Participant G)

Nursing is described by participants as a 'client centred and holistic practice' that attempts to understand the experience of the client from the client's perspective. Participants' narratives support Skår's (2010) findings that nurses associate spending time getting to know clients as part of providing holistic care. However, participants in this study felt that this aspect of nursing was being lost amid the technology and medicalisation of contemporary nursing practice. One participant who had nursed in critical care for many years spoke at length about life saving interventions that sometimes result in individuals becoming incapacitated and requiring high level care for the rest of their lives. Participating in and witnessing these situations caused this particular participant to question whether the actions being taken were necessarily in the best interests of the client:

There was a series of critical events over the space of that year that made me realise that nursing was getting to the point where it was all about the number of people you saved, not whether saving the person's life was in their best interests. One lady we resuscitated 3 times. We knocked off her kidneys because of various drug interactions. So, we manage to save this lady, and I put that in inverted commas. She had MS [multiple sclerosis], shot kidneys, her heart was no good and she had a 13 year old daughter, and I remember saying to the senior registrar, "What the hell did we do there?" You know, would it not have been more compassionate to allow that lady to die? (Participant C)

Participant C's personal account of nursing in critical care highlights the intersection of medical advances and the ethical and moral dilemmas that can accompany these types of innovations (Korhonen, Nordman, & Eriksson, 2015; Montgomery, Grocott, & Mythen, 2017; Raza et al., 2016; P. A. Singer, 2000). It is widely recognised that nursing practice is being profoundly changed by medical and technological advancements (Healy & Fallon, 2014; Huston, 2013; Montgomery et al., 2017; Rodts, 2011). Not surprisingly, the increasing use of and reliance on technology has sparked vigorous debate about the direction of nursing and whether it is becoming more reliant on technological advances at the cost of holistic nursing care (Harley & Timmons, 2010; J. A. Johnson, 2015). Balancing medical and technological innovations within the context of holistic care is one of the many challenges facing the nursing profession today.

As stated in section 5.2.2.1 of the chapter, the second factor relating to the dissatisfaction of participants in this study was the concept of autonomy. Participants' frustrations around the topic of professional autonomy will now be explored.

5.2.2.1.2 *Having no autonomy*

Professional autonomy is described by Skår (2010) as "having the authority to make decisions and the freedom to act in accordance with one's professional knowledge base" (p. 2226). The issue of autonomy in relation to nursing has been a topic of discussion for decades (Cassidy & McIntosh, 2014; Skår, 2010; Varjus, Leino-Kilpi, & Suominen, 2011; Wilkinson, 1997). Much of that discussion has centred on autonomy of the nursing profession within the context of its relationship with biomedicine (Cassidy & McIntosh, 2014; Sena, 2017) and the professional autonomy of nurses (Cassidy & McIntosh, 2014; Skår, 2010; Varjus et al., 2011; Wilkinson, 1997). The professional autonomy of nurses is of particular interest to this discussion, as several participants in this study spoke about

being frustrated with the lack of autonomy they felt they had within their nursing practice.

As these two examples explain:

Sometimes I found I was in a situation where I could see that some sort of treatments would produce better patient outcomes, but I wasn't in a position to implement them because instructions or orders had come from on high. I was often doing what I thought was pretty stupid sort of stuff and not helpful to the patient. (Participant N)

You need autonomy. You need to be able to be given responsibility and patient care would improve, but patients wait a long time for very little I think ... if I hadn't done natural therapies I might have been interested in being a nurse practitioner, but I think the issue of nurses going to naturopathy, or homeopathy, or other caring modalities, I'm not sure if the reasons are widely different really. The thing is you get more autonomy. (Participant I)

A greater degree of autonomy was seen by participants as a means of utilising their knowledge in a way they saw as being helpful to their clients. However, the ability of participants to make autonomous decisions was constrained by the hierarchical nature of nursing practice environments. In these practice environments, nurses are ranked according to their qualifications and experience (Queensland Health, 2018b). It was stated by Participant I that the role of nurse practitioner would have been an area of interest had they not already engaged with CAM. The scope of practice for nurse practitioners, also known as advanced practice nurses, is an expansion of that of a registered nurse (RN) and provides more autonomy (Queensland Health, 2018a). In Australia, nurse practitioners hold a master's degree and work in advanced clinical roles which can involve ordering diagnostic procedures and prescribing certain medications (Queensland Health, 2018a, 2018b; Nursing and Midwifery Board of Australia, 2017). Nurse practitioners are able to work

autonomously as the primary care provider without the direct supervision of a medical practitioner, or collaboratively as a member of a team of health care providers (Nursing and Midwifery Board of Australia, 2017; Queensland Health, 2018b).

Research indicates that positive client outcomes are associated with nurses working autonomously in extended roles (Cowan et al., 2006; Desborough et al., 2016; Desborough, Forrest, & Parker, 2012; Woo, Lee, & Tam, 2017). In addition, research suggests high levels of satisfaction among clients who have accessed nurse practitioners (Eriksson, Lindblad, Möller, & Gillsjö, 2018; Jennings, Lee, Chao, & Keating, 2009). Extended roles for nurses have largely been welcomed by the nursing community (Brodsky & Van Dijk, 2008; Oxtoby, 2016). However, the response among medical practitioners to the increased autonomy of nurses has been mixed (Brodsky & Van Dijk, 2008; Oxtoby, 2012, 2016). Although some individuals in the medical community see value in extended nursing roles, some sectors of the medical profession have failed to support these initiatives (Australian Medical Association, 2010, 2019; Finnegan, 2017; Oxtoby, 2016; Permut, 2016; Royal Australian College of General Practitioners [RACGP], 2016). Both the Australian Medical Association (2010, para. 5.11) and the American Medical Association (Permut, 2016), along with the Royal Australian College of General Practitioners (RACGP), (2016) perceive the role of nurse practitioner as overstepping a nurse's scope of practice, arguing that physicians should be the ones leading primary health care services, not nurse practitioners.

Opposition from medical bodies to roles that increase the autonomy of nurses is indicative of the historical and contemporary boundary challenges that the nursing profession faces in a system of health care that is dominated by biomedicine and where all other health care workers are positioned as supporting elements to biomedical practitioners (Abood, 2000;

Hunter, Corcoran, Phelps, & Leeder, 2012; D. Kenny & Adamson, 1992; S. J. Roberts, 1996). However, some commentators suggest that biomedical dominance is increasingly being eroded due to economic health care reforms, state control of resources and the increasing focus on proven clinical outcomes (Allsop, 2006; Cooper et al., 2012; A. Kenny, 2004; Willis, 2006). Furthermore, the increasing autonomy of other health care professionals, and consumer demand for CAM, have challenged biomedical dominance (Allsop, 2006; Cooper et al., 2011; A. Kenny, 2004; Willis, 2006). Despite these challenges, the medical profession remains hugely influential and still has the most political power when it comes to influencing policy (A. Kenny, 2004; J. M. Lewis, 2006; Pesce, 2010; Willis, 2006). In addition to the individual factors influencing participants in this study to seek CAM, some participants' comments can be considered from the broader perspective of social changes that have accompanied consumer interest in CAM. These aspects of participants' comments will be explored within the context of postmodernism and its influence, if any, on participants' involvement with CAM.

5.2.3 Postmodernism and CAM

Postmodernism is described by Eastwood (2000) as “processes and trends that purportedly are transforming modern Western society and its values, organisations and institutions (modernity) into a new social reality (postmodernity)” (p. 96). The new age and green movements of the 1960s and 1970s are frequently cited as being responsible for spawning back to nature philosophies and bringing an increasing awareness of the role of the environment on health and wellbeing (Baer, 2004; Coulter & Willis, 2007; Eastwood, 2000). Some commentators suggest that the emergence of postmodernist philosophy resulted in an increasing availability and acceptance of CAM practices that previously had existed at a grass roots level (Baer, 2004; Coulter & Willis, 2007; Eastwood, 2000; Siahpush, 1999). Aside from an increased focus on environmental factors, the emergence

of postmodernist philosophy is associated with consumerist attitudes, notions of individual responsibility, anti-science and anti-authority sentiments (Coulter & Willis, 2007; Sampson, 1995; Sampson & Atwood, 2005; Siapush, 1999). Several authors therefore argue that the holistic philosophy of CAM, along with its emphasis on individual responsibility for, and active participation in health, is congruent with postmodernism and appeals to a range of individuals in a postmodern era (Coulter & Willis, 2004; O'Callaghan & Jordan, 2003; Siapush, 1999).

Postmodernist philosophy and its influence, if any, on participants in this study engaging with CAM was never explicitly explored during this research. However, the association of environmental factors with health and the concept of individual responsibility were evident in the narratives of some participants. As one participant said:

We're going down a very slippery road of patching things up, practising medicine and agriculture in a way that is not looking at the sustainability of health ... what's sustainable in health care and what's sustainable in the way we grow our food, which is the root of health. We should be looking at the ground up. (Participant M)

Participant M talks about the sustainability of medical and agricultural practices in relation to health, asserting that these practices are currently unsustainable. These comments can arguably be considered within the context of the ecologically sustainable ideology that underpinned the green movement of the 1960s (Mertig & Dunlap, 2001; Rome, 2003). Another participant in this study, when asked about being attracted to homeopathy stated:

Coming from the medical perspective I realised that people weren't getting better. They were coming to the doctors and handing over their power of getting well to the doctors and not taking responsibility for their own health, so that led me to the natural medicine arena. (Participant H)

Along with the perceived failure of biomedicine in improving health outcomes, the concept of individual responsibility with regard to one's own health was instrumental in Participant H turning to CAM. Although the meaning of 'taking responsibility for one's own health' failed to be explored further in the interview with Participant H, it is reasonable to assume the meaning relates to the choices an individual makes that could potentially change their health outcomes (Scott & Schurer, 2008, p. 3).

The notion of individual responsibility is a contentious issue. It is a core aspect of the politicisation of health and of neoliberal policies that have shaped health care reform in several countries of the world, including Australia (Buyx, 2008; Cappelen & Norheim, 2005; Fries, 2008; Horton, 2007; McGregor, 2001; Steinbrook, 2006). Neoliberalism, also known as economic rationalism, is founded upon principles of individualism, deregulation, and decentralisation (Horton, 2007, p. 1), which critics argue come at the expense of any sense of social responsibility to others (Horton, 2007; McGregor, 2001; Sakellariou & Rotarou, 2017; Yadavendu, 2015). Collective responsibility, including that of the government, is replaced with the notion of individual responsibility (McGregor, 2001; Yadavendu, 2015). With regard to health care, individuals are held accountable for their own health, thereby reducing the onus on the state to implement public health initiatives designed to improve the health and wellbeing of the general population (Yadavendu, 2015).

A significant issue with the concept of individual responsibility in relation to health and wellbeing, is that not all individuals are positioned equally in society (Hogan, de Araujo, Caldwell, Gonzalez-Nahm, & Black, 2018; Sakellariou & Ratarou, 2017; Tricco, Lillie, Soobiah, Perrier, & Straus, 2012; Yadavendu, 2015). Health and wellbeing are impacted by a wide range of determinants, many of which can be out of the control of the individual (Harvey, 2006; Sakellariou & Ratarou, 2017; Talbot & Verrinder, 2010, p. 15; Tricco et al.,

2012; Yadavendu, 2015). For instance, individuals who are socially disadvantaged have poorer health outcomes than those who are socially advantaged (Hogan et al., 2018; Horton, 2007; Sakellariou & Ratarou, 2017; Tricco et al., 2012).

Socially disadvantaged populations include, but are not exclusive to, people of colour (Hogan et al, 2018), ethnic minorities (Tricco et al., 2012) and those living in poverty, or with a disability (Sakellariou & Ratarou, 2017; Tricco et al., 2012). Suggesting that these individuals should be doing more to help themselves ignores the inequality of wealth and power that exists in society and the impact of this power differential on the health and wellbeing of those less advantaged than others (Horton, 2007; Sakellariou & Ratarou, 2017; Yadavendu, 2015). Therefore, the notion of individual responsibility has been associated with victim blaming, whereby individuals are held responsible for situations that might be out of their control (Andreou, Kouta, & Ioannou, 2015; Martin, 2001; McClean, 2005). For instance, some health conditions such as obesity and addiction are framed as being self-inflicted, ignoring any social and environmental factors that might be contributing to these conditions (Jancey et al., 2016, p. 1).

Taking personal responsibility for and being an active participant in the construction of one's own health is common in CAM discourse (Agarwal, 2018; McClean, 2005). However, McClean (2005) suggests that the emphasis on personal responsibility for one's own health found in CAM can arguably be viewed as a personal biography of illness that redresses the "depersonalisation" of the biomedical approach, rather than within the context of apportioning blame (p. 630). Therefore, individual responsibility can be seen as a way of gaining some degree of ownership and control over one's own health (McClean, 2005). It does not necessarily refer to the neoliberal agenda of self-sufficiency without any form of societal or mutual responsibility (Beck & Beck-Gernsheim, 2002, p. xii; McClean, 2005).

Rather, it can be viewed as being linked to the concept of empowerment, which is a core aspect of CAM philosophy (Barrett et al., 2004; Hilbers & Lewis, 2013). Empowerment, in relation to health promotion, is described by WHO (1998), as a process whereby individuals gain greater autonomy over decisions and acts that affect their health (p. 6). CAM practices are typically generated towards engaging individuals with their own health care, placing control, where possible, back into the individual's own hands (Barrett et al., 2004; Corp, Jordan, & Croft, 2018; Hilbers & Lewis, 2013).

Whether the willingness of participants in this study to engage with CAM can be explained by the post-modern hypothesis, is debatable. As asserted by Coulter and Willis (2004), although studies indicate that CAM users hold beliefs or opinions congruent with postmodernist thought, it is more difficult to translate these findings into solid evidence linking postmodernism to CAM utilisation. However, data from this study indicated a complex relationship between the various factors influencing participants' decisions to not only seek CAM, but to also engage in the process of becoming a homeopathic practitioner. Participants' continued involvement with homeopathy will now be explored.

5.3 Wanting to know more

Participants' narratives suggest that their personal experiences were a fundamental factor in their decision to continue their involvement with homeopathy. Based upon those experiences, participants wanted to know more about homeopathy, as the examples below illustrate:

As treatment went on, I became more and more interested and after a while I thought I have to know more about this. At some point I decided to go and study it [homeopathy]. (Participant B)

When I saw how homeopathy helped my baby, that's when I thought "ok, what's in this? I want to know more." (Participant L)

Trying to understand homeopathy and how it worked led participants to formal homeopathic education. Key factors in participants taking this step towards practitioner level education, related to their level of satisfaction with their personal experience of homeopathic treatment and their emerging understanding of, and connection to, the holistic principles underpinning homeopathic practice. During data analysis, these two factors were labelled as 'being satisfied' and 'transforming perspectives'. These factors will now be considered in turn.

5.3.1 Being satisfied

The term satisfied is used in this discussion within the context of an emotional or cognitive response to an experience (Giese & Cote, 2000, p. 2; Oliver, 2010, p. 8). Participants in this study reported high levels of satisfaction with their experience of seeing a homeopath. They spoke about having a positive emotional response to homeopathy that began with their initial experience of a homeopathic consultation. As they shared:

I remember that first consultation, an hour and a half later I walked out of that clinic and as a mother went "Oh someone finally listened to the whole story". I will always remember that. I just felt so listened to ... for me it was therapeutic as a mother that someone had taken a thorough overview of this sick child. I always remember that. (Participant A)

It was an amazing experience to have a consultation. Never had I been asked so many questions before. Just the whole process was quiet, in-depth and thorough. She [homeopath] asked me about some parts of myself that on some level had

nothing to do with my skin and on another level made complete sense that everything was connected. (Participant B)

Participant B describes the homeopathic consultation as ‘quiet, in-depth and thorough’ and talks about the notion of all things being connected, a core tenet of holistic principles, as making ‘complete sense’. Although the majority of participants in this study expressed having a positive perception of homeopathy after their first homeopathic consultation, there was one negative case who thought the principles underpinning homeopathy were illogical. Participant C had been living in India and sought medical help for an allergic reaction. However, the doctor at the medical clinic was busy with an outbreak of gastroenteritis, so Participant C was directed by reception staff to a homeopath who worked in the medical practice. Participant C spoke about that first experience with homeopathy, saying:

I thought he [homeopath] was a complete whack job. I said “Well, what is homeopathy?” It was so weird that I thought he’s nuts. That’s the biggest load of crap I’ve ever heard. It didn’t make any sense to my logical mind. Anyway, I thought well you paid for it you better use it and it worked and I didn’t go back to see him again. (Participant C)

Although Participant C thought the prescribed homeopathic treatment worked, there was no consideration of going back to the homeopath, as Participant C felt the whole notion of homeopathy was ‘crap’. Sometime later, while still living in India, Participant C was exposed to the homeopathic treatment of some local people with serious health concerns. The positive outcomes from the homeopathic treatment of these cases caused Participant C to re-evaluate homeopathy. Several of the cases that resulted in Participant C’s change of mind were spoken of at length. One of these cases involved a child who had been burnt

from the neck to the lower back after a kerosene lamp had caught hold of the nightgown the child was wearing. Participant C described the event as follows:

For me it would have been a unit, morphine up to the eyeballs, you know the cleaning up of the wounds, dressings. They [clinic staff] never touched the wound, the plastic that had got into it, never touched it. He [homeopath] used Causticum and Cantharis , only those two things and I watched the progression of this full thickness burn ... slowly but surely over the space of three months this girl healed, no contractures⁴, nothing. Now, you sit there in awe when you see that happen, especially in India with the squalor, the filth, and the germs ... when you see that type of case, you can't deny its action and it was this that really made me realise that there is a complementary alternative to allopathic medicine. Through clinical experience I had to then question my previous assumptions that it was a load of crap. (Participant C)

Seeing the response to the homeopathic treatment despite a lack of hygienic conditions caused Participant C to consider homeopathy as a 'complementary alternative to allopathic medicine'. The positive response to homeopathic treatment that participants experienced personally, or witnessed, was a significant factor in their satisfaction with homeopathy and their subsequent decision to undertake formal studies in homeopathy. During data analysis, this aspect of participants' satisfaction with homeopathy was labelled as 'seeing results' and will now be explored.

⁴ The term 'contracture', with regard to burns, refers to post burn scars that can occur from the damage done to the layers of the skin (Goel & Shrivastava, 2010).

5.3.1.1 *Seeing results*

The positive outcomes from homeopathic treatment reported by participants in this study support a number of studies that found high levels of client satisfaction and client reported positive outcomes from homeopathic treatment (Güthlin, Lange, & Walach, 2004; Marian et al., 2008; Spence, Thompson, & Barron, 2005; Steinsbekk & Lüdtkke, 2005; Thompson, Viksveen, & Barron, 2016). Several of the participants in this study experienced the resolution of health complaints that in many cases had failed to respond to biomedical treatments:

After years of antibiotics I went to a homeopath and never needed antibiotics after that. I continued to see a homeopath whenever anything was wrong. Then I decided to study it and that was the beginning of the end. (Participant K)

She [homeopath] actually treated me as well [as the son] and I went back in a week and I went “What did you do, you fixed my belly?” I’d had those symptoms for 18 years. I was hooked, I think. I used homeopathy then for myself and my child for a long time and toyed with the idea of studying it. I thought it was quite fascinating and it was obvious to me when my boy had tonsillitis that homeopathy assisted him. (Participant D)

Although the majority of participants reported quick resolutions to health complaints for which they had sought homeopathic treatment, two participants had no relief from their presenting complaint of eczema for a considerable length of time. These participants not only had a slow response, but also reported that their complaints worsened after commencing homeopathic treatment. However, despite the worsening of their condition, they continued with the treatment, explaining:

Somehow, I persevered with homeopathy even though my eczema got worse. It took about a year and a half for the eczema to go, but there were lots of other things that improved along the way and eventually then my eczema did go. (Participant E)

My skin probably got worse ... it didn't resolve the skin complaint, that actually took some years to change. (Participant B)

When these participants were asked why they continued with the homeopathic treatment, they expressed feeling that while their presenting complaint of eczema failed to improve, they felt improvement in other ways, stating:

I felt much more energised, I did have some chronic fatigue at that time and I definitely felt that first remedy. (Participant E)

A lot of things did change, my temperament became more easy [sic], my sleep improved, I had a lot of heat in my body, I was always hot and that kind of moderated a little bit, so there were other changes that occurred ... On reflection I felt there was continued improvement. I was interested in what it was doing. I think I found the relationship very therapeutic as well. I think I benefited from going along once a month and talking about what was going on in my life and I really valued that. (Participant B)

Participant B acknowledged the therapeutic value of the relationship formed with the homeopath providing treatment. It could be contended that any perceived improvements in Participant B's health were a result of this therapeutic relationship, rather than the effect of any prescribed homeopathic intervention. Ernst (2012), a well-known critic of homeopathy, argues that while there are numerous instances of positive experiences with homeopathy, including observational studies, these experiences are not evidence of causality. Rather,

Ernst (2012) suggests that the reported conditions might have resolved on their own without any intervention, or that any positive response is due to the placebo effect. As previously discussed in section 5.2.1 of the chapter, the majority of the health conditions experienced by participants in this study were chronic and had been treated biomedically with limited success. Some conditions had been ongoing for 10 years or more. Therefore, it is debatable that these conditions would have resolved on their own without any intervention. Ernst's (2012) other assertion that any positive response to homeopathy is due to the placebo effect is a common argument. Any perceived or reported beneficial effect of homeopathic treatment is frequently assigned to the placebo effect (Haresnape, 2013; Shang et al., 2005; Teixeira, Guedes, Barreto, & Martins, 2010; Tokeley, 2014).

The placebo effect is described as a positive response to a pharmacologically inert intervention or therapeutic act (Benedetti, 2014; Kamper & Williams, 2013). Controlled drug trials assign a number of participants to a control group that is given a placebo or dummy pills that contains no active ingredient and is therefore pharmacologically inert (Blease, Bishop, & Kaptchuk, 2017; Gupta & Verma, 2013; Kaptchuk et al., 2008). Any positive outcomes in the group assigned the placebo are then assessed as being due to the placebo effect (Gupta & Verma, 2013). However, an inert substance is unable to induce any effect, positive or negative; therefore, the placebo effect is considered to be a psychological response (Benedetti, 2014; Gupta & Verma, 2013). Although the exact mechanism of how the placebo effect works is poorly understood (Miller & Miller, 2015; Wager & Atlas, 2015; Weeks & Newman, 2011; Yalcin & Bump, 2004), research indicates that an expectation of a positive response and the relationship between client and clinician are notable factors in its occurrence (Benedetti, 2014; Brown, 2015; Kaptchuk et al., 2008). The placebo effect can therefore be broadly considered as a clinically therapeutic encounter between client and clinician that is a factor in most treatment encounters (Miller &

Kaptchuk, 2008; Miller & Miller, 2015). However, participants in this study challenge the notion that any perceived benefits from homeopathy are purely placebo:

When you see the results, you think “Well if that’s placebo, I want more of that”.

When you see the results with children and animals, you question that’s what it is.

(Participant I)

There is something about the [homeopathic] consult that is therapeutic and everybody says that, but there’s more in the [homeopathic] medicine and matching the right medicine to the person. We see it again and again that giving one medicine does nothing, then when you change the prescription to the right one, it does everything. (Participant E)

Participant E’s narrative acknowledges the therapeutic nature of a homeopathic consultation and also notes that at times, a selected remedy may fail to have any therapeutic effect. Moreover, prescribing the ‘right’ remedy and getting a positive effect indicates to Participant E that successful outcomes from homeopathic treatment are dependent on more than the therapeutic relationship. In section 2.3.3 of Chapter Two *Contextualising CAM and Homeopathy*, it was explained that selecting a homeopathic remedy is a complex process of matching a remedy to the individual, not just to their symptoms.

The second factor identified as being associated with participants wanting to know more about homeopathy related to participants gaining an understanding of the philosophy upon which homeopathy is founded. Regardless of whether participants sought homeopathy for the treatment of health concerns, or with the intention of studying it, at some point all participants spoke about making a connection with homeopathy, and this will now be discussed within the context of transforming perspectives.

5.3.2 Transforming perspectives

Findings from this study suggest that exposure to homeopathic philosophy and practice had a significant effect on the way that participants perceived health and wellbeing. For participants with no existing orientation towards CAM, it was the first time they had been exposed to thinking about health from a holistic perspective, and it had a notable impact on them:

When I was going to a homeopath, I grasped the fact of the individuality of each child. They each responded to their illness differently and they needed the relevant homeopathic [remedy] to suit their coping strategies with illness. The whole thing, I went “Hey, this is a really good system.” (Participant A)

Just seeing the body, not treating the illness that was what really blew me away. That was just a whole new thing, because unknowingly I’d been trained in nursing the part. I never actually completely conceived of it as considering the whole and looking from the inside out ... when I discovered that other way of looking at things it just opened up a whole new world, because there’s so many levels to that. (Participant K)

Participant K talks about ‘unknowingly being trained in nursing the part rather than the ‘whole’ and of exposure to holistic concepts as ‘opening up a new world’. Participants’ understanding of health and wellbeing altered, regardless of whether they had an existing orientation towards CAM or not. Participants who were oriented towards CAM also talked about their awareness expanding once they engaged with homeopathic education:

Once I got enrolled and started studying it [homeopathy], it’s like your whole world opens up and you think about so many different possibilities. (Participant J)

It [homeopathy] gave me more insight into what we're doing wrong. I think it gave me more insight into just where modern medicine has gone, with the overload and reliance on chemical drugs. (Participant N)

Although participants talk about the different possibilities that the homeopathic approach to health opened up, they still critically appraised homeopathy. Many participants talked about how homeopathy challenged their existing knowledge and perspectives and the difficulties they had in accepting and understanding the homeopathic approach. As they explained:

I was so heavily indoctrinated. Things had to be done this way and they had to have very medical, scientific sounding names. There was quite a rub in studying homeopathy with its symptom focused approach in the patient's own words, whereas of course that's irrelevant in medical care. (Participant O)

I think it's harder when you're a health professional coming in to study [homeopathy]. I had these questions. I think people who have a science based or medical background have got this indoctrination that you have to unravel to be open to homeopathy. Other people who weren't indoctrinated with western medicine didn't have that struggle. (Participant E)

Participants' existing knowledge and understanding, formed through their nursing education and practice, conflicted with the new information they were receiving as student homeopaths. That knowledge had to be evaluated and reconciled with homeopathic philosophy and practice in a process that Participant E described as an 'unravelling of indoctrination'. Participants' experiences with seeking homeopathy and their continued engagement with it can therefore be considered within the context of experiential and transformative learning.

5.4 Experiential and Transformative Learning

At its simplest, learning is the process of gaining knowledge through the transformation of the myriad of personal interactions and experiences that one encounters daily (Kolb, 1984; Mezirow, 1997). Learning can be formal, where it is structured and provided by an educational institution, or informal, where it occurs outside the bounds of formal education (Halliday-Wynes & Beddie, 2009; Marsick & Watkins, 2001). A considerable portion of informal learning is believed to occur incidentally, through day to day interactions (Conlon, 2004). Participants in this study gained their knowledge of homeopathy through both formal and informal means. Initially, participants were exposed to homeopathy informally through their social networks and their own personal experience. Later, participants gained further knowledge of homeopathy formally by engaging with homeopathic education.

One of the best known and most influential theories of experiential learning was developed by Kolb (1984). Building upon existing human development and learning models, Kolb's theory of experiential learning suggested that learning is a process of adaptation involving shared communications, re-learning and conflict resolution, all of which result in the creation of knowledge (Kolb & Kolb, 2005, p. 194). The four stages of Kolb's experiential learning theory comprise: "Concrete Experience" (stage of personal involvement); "Reflective Observation" (stage of reflecting on what has happened); "Abstract Conceptualisation" (stage of processing what has happened and linking it to previous experiences) and "Active Experimentation" (stage of experimenting with what works) (Fewster-Thunte & Batteson, 2018, p. 4; Kolb & Kolb, 2005, p. 194). According to Kolb and Kolb (2005), it is through concrete experience and abstract conceptualisation that individuals grasp an experience, which is then transformed through the process of reflective observation and active experimentation (p. 194).

Kolb's experiential learning model can be related to the experience participants in this study had with homeopathy. The stage of concrete experience can be related to participants' exposure to homeopathy. It was at this stage that participants became personally involved with homeopathy, either through seeking homeopathic treatment, or by exposure to it through formal CAM education. Reflective observation can be seen in participants' reflection on their homeopathic experience, while abstract conceptualisation can be associated with the processing of their experience and linking it to their previous health care experiences. The stage of active experimentation relates to participants becoming actively involved with homeopathy through further homeopathic utilisation and engaging in formal homeopathic education. Figure 12 provides a visual representation of participants' experience with homeopathy through the lens of experiential learning theory.

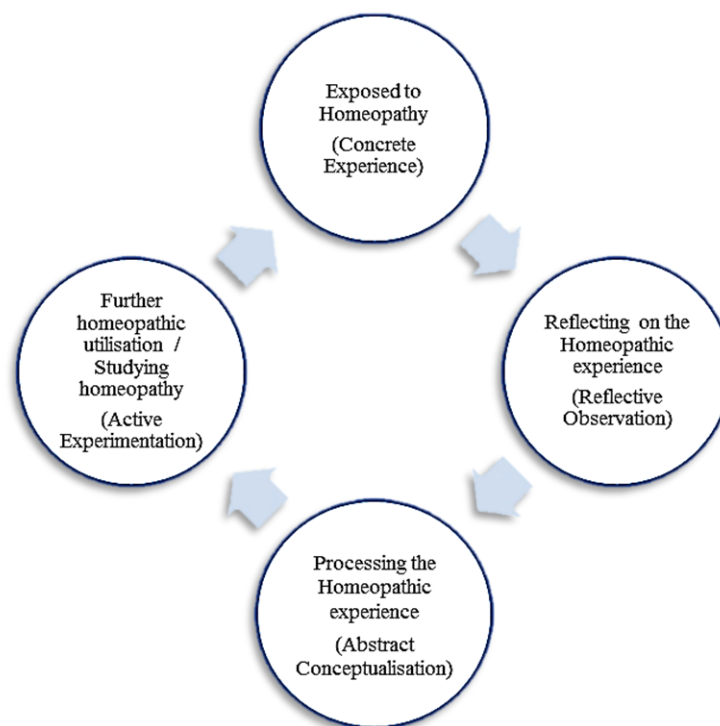


Figure 12. Participants' experience with homeopathy through the lens of experiential learning theory. Adapted from "Experiential Learning: Experience as the Source of Learning and Development" by Kolb, 1984. In public domain.

Kolb's (1984) theory of experiential learning has been widely applied in many diverse fields including agricultural (Baker, Robinson, & Kolb, 2012; Shoulders & Myers, 2013), nursing (Lisko & O'Dell, 2010; Poore, Cullen, & Schaar, 2010) and interprofessional education (Fewster-Thuente & Batteson, 2018). However, like all theories, it has also attracted criticism, and a number of alternative learning models have been developed that build upon Kolb's (1984) theory (Bergsteiner, Avery, & Neumann, 2010; Bontchev, Vassileva, Aleksieva-Petrova, & Petrov, 2018; Jarvis, 2006, 2012; Kayes, 2002; Kolb & Kolb, 2005). One critic, Jarvis (2006), considers Kolb's theory of experiential learning to have several gaps including failing to account for the way that people are changed by the learning process (p. 10). The process of learning can be a transformative experience, shaping and challenging one's values, perceptions and assumptions (Mezirow, 1997; Jarvis, 2006, 2012). Research undertaken by Jack Mezirow in the 1970s identified 10 phases of transformational learning which are illustrated in Table 4.

Table 4.

Mezirow's Ten Phases of Transformative Learning

Phase	Learned
Phase One	A disorienting dilemma
Phase Two	Self-examination
Phase Three	A critical assessment of assumptions
Phase Four	Recognition of one's discontent and its connection to the process of transformation
Phase Five	Exploring options for new roles and relationships
Phase Six	Planning a course of action
Phase Seven	Acquiring knowledge and skills to implement one's plan of action
Phase Eight	Provisionally trying new roles
Phase Nine	Building confidence and competence in new roles and relationships
Phase Ten	Reintegration into one's life dictated by one's new perspective

Note. From, 'Transformational Learning Theory' by Mezirow, 2011, p. 19. In public domain.

According to Mezirow (1997, 2011), the process of transformative learning involves a disorienting dilemma, something that challenges one's existing understanding and frame of reference. One's frame of reference includes personality traits, emotions, values and the lens through which the world is viewed (Mezirow, 1997, 2011). The term frame of reference is defined by Mezirow (1997) as "the structures of assumptions through which we understand our experiences" (p. 5). It is suggested by Mezirow (1997) that these existing assumptions are transformed through a process of critical reflection which precipitates a change in one's frame of reference (p. 7). Once there is change in one's frame of reference, a change of action follows (Mezirow, 1997, 2011).

Like Kolb's theory of experiential learning, Mezirow's theory of transformative learning, has been vigorously critiqued (Illeris, 2014a; Kang & Cho, 2017). The main points of criticism which mostly relate to claims that Mezirow's theory is "too narrow and too cognitively oriented," are briefly outlined by Illeris (2014a, p. 574). Despite these criticisms the experience of participants in this study can be viewed within the context of transformative learning, using Mezirow's concepts. Exposure to homeopathic philosophy and practice can be considered as a disorienting dilemma that caused participants to critically reflect upon their existing knowledge and perspectives on health and wellbeing. During this process, participants altered their frame of reference or perspective, which is reflected in participants becoming more aware of the concepts of holism in relation to health and wellbeing.

Participants' growing awareness often resulted in a shift in their worldview and influenced their action of engaging with formal CAM and homeopathic education. In making that decision to become homeopaths, participants' identity as individuals and health care providers was altered. Jarvis (2006) notes that learning has an enormous impact on identity,

with each individual experience adding to one's personal biography (p. 47). It is proposed by Illeris (2014b) that the changing of one's identity is at the essence of transformative learning (p. 40). The shift in the identity of participants in this study as health care providers, and the influence this had on their respective nursing and homeopathic practice, is explored in the following two chapters, *Intersecting Identities: Sharing Common Ground* and *Intersecting Identities: Navigating Opposing Paradigms*.

5.5 Summary

Participants' decisions to become homeopathic practitioners were a complex series of intersecting factors that were embedded in a process of experiential and transformative learning. As participants went from seeking CAM to making the decision to engage with formal homeopathic education, they had their beliefs and existing knowledge challenged by homeopathic philosophy and practice. During this process, their perspectives of health and wellbeing shifted as they came to understand and relate to the holistic philosophy that underpins the practice of homeopathy. It is therefore suggested that connecting with the core tenets of homeopathic philosophy, which can be seen in all aspects of participants' involvement with homeopathy, was the overarching factor in them being attracted to the practice of homeopathy.

Chapter 6.

Intersecting Identities: Sharing Common Ground

*... I use my homeopathic skills, I use my teaching skills,
I use my nursing skills. (Participant C)*

6.1 Introduction

Chapter Five of the thesis explored the concept of connecting philosophically. It suggested that participants' experiences with homeopathy were a process of experiential and transformative learning that resulted in them connecting with homeopathic philosophy, and was fundamental in their decision to engage with formal homeopathic education and subsequently become homeopathic practitioners. The aim of this chapter is to present the second of the two primary concepts that informed the core category of congruent positioning; namely: intersecting identities. During data analysis, it was identified that the concept of intersecting identities had two aspects to it; namely: sharing common ground and navigating opposing paradigms. This chapter explores the intersection of participants' respective nursing and homeopathic identities within the context of sharing common ground, while Chapter Seven explores it within the context of navigating opposing paradigms. Together, these two chapters answer the second research question: 'How, if at all, does being a qualified nurse and a homeopath influence the respective nursing and homeopathic practices of these nurses?' The focus of discussion in this chapter relates to participants' respective professional identities as nurses and homeopaths, the expression of their nursing identity in the homeopathic practice environment and the influence of their nursing identity on their homeopathic practice. It should be noted that it is beyond the scope of this thesis to discuss the vast body of literature on identity. Rather, the chapter begins with a discussion on identity, emphasising the participants' professional identities as nurses and homeopaths. Following, is an exploration of the expression of participants' nursing identity in the homeopathic practice environment and how being a nurse impacted on their

practice as homeopaths. The chapter concludes with a synopsis of its key points. Figure 13 provides a visual representation of the concept, intersecting identities: sharing common ground, outlining the categories that informed it. These categories and their properties provide the framework of discussion for the chapter.

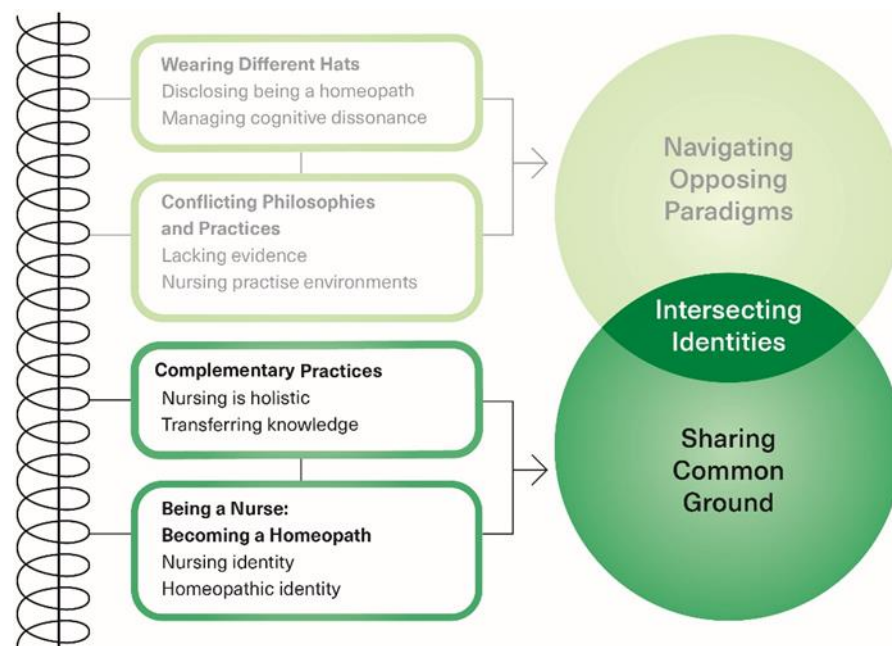


Figure 13. Concept of intersecting identities: sharing common ground developed from this study.

6.2 Being a Nurse: Becoming a Homeopath

Prior to becoming homeopaths, all participants in this study were members of the nursing profession. Participants therefore had a professional identity as a nurse before engaging with formal homeopathic education:

I'd been nursing for years by the time I became a homeopath. (Participant C)

*I registered [as a nurse] in New Zealand and then I just travelled and nursed ...
I ended up in Sydney and did a naturopathy course and then homeopathy.*
(Participant I)

Most participants had been engaged in the practise of nursing for over a decade before becoming involved with homeopathic education. During this period, participants can be considered as being in a simultaneous state of being and becoming (Jarvis, 2006, p. 117). Essentially, while they were being nurses, they were becoming homeopaths. The concept of being was explored by Martin Heidegger (1962) in his seminal book, *Being and Time*. Although it is beyond the scope of this thesis to fully explore this body of work, Heidegger (1962) refers to the state of being as, “a priori condition” (p. 31). Similarly, Natanasabapathy and Maathuis-Smith (2018) describe it as a reflection of how a person is at the present time (p. 2). The process of becoming can be viewed as a transition towards some change that alters or transforms the individual (Natanasabapathy & Maathuis-Smith, 2018, p. 2).

The chapter will show that the nursing identity of participants in this study remained strong and continued to inform their practice as health care providers. However, during the transition from being a nurse and becoming a homeopath, participants’ understanding of the principles and practice of homeopathy grew and their identity as health care providers evolved to include that of homeopath. The different stages of this process can be considered within the framework of threshold concepts which represent points of transformed understanding that occur during the learning process (Meyer & Land, 2003; Natanasabapathy & Maathuis-Smith, 2018). According to Meyer and Land (2003), threshold concepts are transformative, likely to be irreversible and to involve exposure to knowledge that is contradictory to one’s current understanding (pp. 5–13). The

transformative aspect of threshold concepts involves an ontological and conceptual shift whereby one's perspective and/or identity alters (Meyer & Land, 2003, p. 5; Natanasabapathy & Maathuis-Smith, 2018, p. 5).

The process of learning is different for each individual; therefore, transformation can occur quite quickly or evolve over longer periods of time. However, regardless of individual variances, there are points, or thresholds, along the way where the understanding of students grows (Natanasabapathy & Maathuis-Smith, 2018). Figure 14 shows Natanasabapathy & Maathuis-Smith's (2018) interpretation of the transition from 'being to becoming' during a course of study, using threshold concepts.

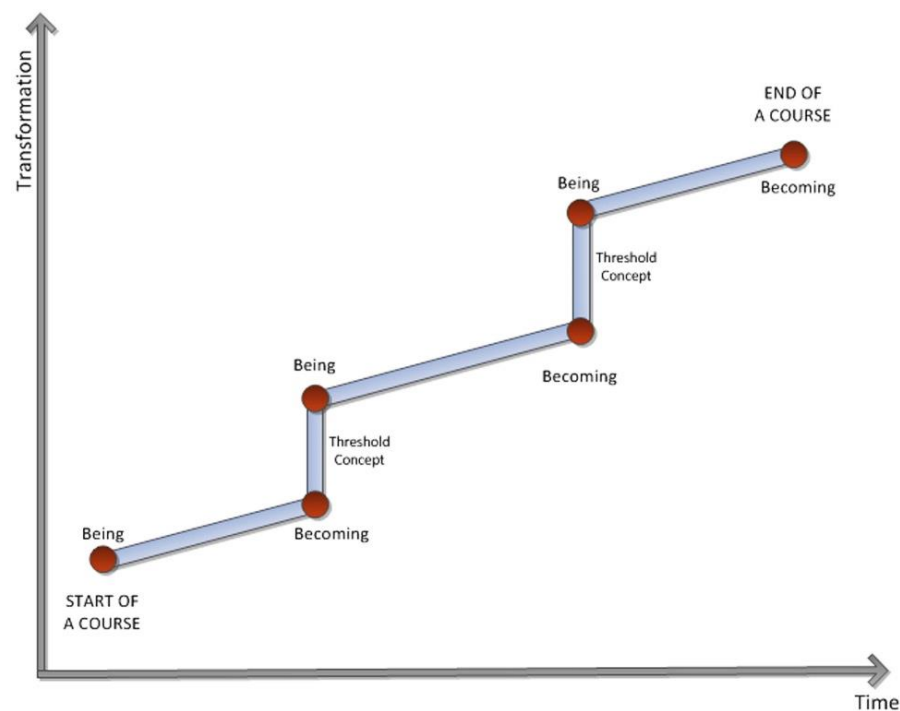


Figure 14. Transition from 'Being' to 'Becoming' during a course of study. From Natanasabapathy & Maathuis-Smith, 2018, p. 6, 'Philosophy of being and becoming: A transformative learning approach using threshold concepts.'

<https://doi.org/10.1080/00131857.2018.1464439>. In public domain.

As discussed in Chapter Five of the thesis, *Connecting Philosophically*, homeopathic philosophy and practice challenged participants' existing worldviews and knowledge and resulted in a transformation in relation to their perspectives on health and wellbeing. In addition to altering their perspectives, participants' identities as health care professionals also underwent a transformation. Identity has been shown to be a complex construct involving how people see themselves and the meanings behind who they perceive themselves to be as individuals and as members of social groups (Burke, 2004; Goffman, 1959; Tajfel & Turner, 1979; Whannell & Whannell, 2015). In addition to the meanings one attaches to oneself, identity is also influenced by the sets of meanings that are attached by other people (Burke, 2004; Tajfel & Turner, 1979; Slay & Smith, 2011). For example, the concept of motherhood and what it means to be a mother has numerous meanings attached to it originating from individual, societal and cultural perspectives (Fouquier, 2011; Ussher, Charter, Parton, & Perz, 2016; Valencia, 2015). Therefore, the process of identity construction takes place amid pre-existing societal and cultural structures, rather than separate from them, and is subsequently influenced by these structures (Adler & McAdams, 2007; Burke, 2004; Tajfel, 1969).

Rather than identity being a singular construct, each individual holds multiple identities (Goffman 1959; M. D. Johnson, Morgeson, Ilgen, Meyer, & Lloyd, 2006; Stets & Burke, 2000). A number of factors shape identity, including, but not exclusive to, the notion of self (Karwowski, 2016; Ryan & Deci, 2012); culture (Dalley & Martin, 2015; Whembolua, Conserve, & Tshiswaka, 2015); gender (Pizzorno, Benozzo, & Carey, 2015) and profession or occupation (Pratt, Rockmann, & Kaufmann, 2006; Skorikov & Vondracek, 2011). Of particular relevance to this discussion is professional or occupational/organisational identity, hereafter referred to as professional identity. Constructing a professional identity is a complex process that involves changes in understanding and identity as the transition

is made from lay person to professional (K. Adams, Hean, Sturgis, & Clark, 2006; Benner et al., 2010; Crigger & Godfrey, 2014; Skorikov & Vondracek, 2011). This transition is influenced by the formal attainment of knowledge, skills and values that are characteristic of a specific profession (Becker & Carper, 1956; M. Johnson, Cowin, Wilson, & Young, 2012; Motlagh, Karimi, & Hasanpour, 2012). Although profession specific knowledge and values are vital components in forming professional identity, a sense of professional identity can also develop prior to formal education through existing knowledge and perceptions of a profession (K. Adams et al., 2006; Arreciado Mara  n & Isla Pera, 2015; Wilson, Cowin, Johnson, & Young, 2013). During data analysis, participants' respective identities as nurses and homeopaths were labelled as 'nursing identity' and 'homeopathic identity' and will now be discussed in turn.

6.2.1 Nursing Identity

Nursing identity is a complex concept that has been extensively explored from a variety of differing perspectives (Andrew, 2012; E. Bell, Campbell, & Goldberg, 2015; Hercelinskyj, Cruickshank, Brown, & Phillips, 2014; Mazhindu et al., ...2016). A full exploration of nursing identity and the body of literature attached to it is beyond the scope of this chapter. Rather, nursing identity is discussed within the context of the participants in this study and the literature that is relevant to their experience. The narratives of participants in this study suggested that they strongly identified as nurses, regardless of whether they had left the nursing workforce to pursue a career in homeopathy or had remained in nursing while also working as homeopaths. The following two extracts from participants' narratives exemplify their strongly held nursing identities. At the time of data collection, the first of these participants, Participant M, had maintained their nursing registration but had left the nursing workforce to work as a homeopath. The second participant, Participant H, had

remained in the nursing workforce while also working part time in homeopathy. These participants said:

I still appreciate the nursing profession and everything within nursing. You know, it's a part of who I am. (Participant M)

I've been nursing for 25 years, it's in my blood. (Participant H)

Being a nurse is an integral part of participants' identities, as evidenced by their statements about nursing being a 'part of who they are' and of it 'being in their blood'. Participants' narratives are reminiscent of the well-known saying "once a nurse, always a nurse" (College & Association of Registered Nurses of Alberta, 2008, p. 12), which implies that a professional nursing identity is enduring. Construction of a professional nursing identity is an ongoing process that formally begins as a student nurse and continues into professional nursing practice (Crigger & Godfrey, 2014; M. Johnson et al., 2012; Williams & Burke, 2015). Key aspects to enabling a professional nursing identity include acquiring professional competence through nursing education and the socialisation process of what it means to be a nurse (M. Johnson et al., 2012; S. Walker et al., 2014; ten Hoeve, Jansen, & Roodbol, 2013). Included in this process is the clinical experience of working within the nursing profession (M. Johnson et al., 2012; S. Walker et al., 2014). Although all the aforementioned factors are vital to the formation of a professional nursing identity (M. Johnson et al., 2012), nursing identity is also inextricably linked to the image of nursing (ten Hoeve et al., 2013; Yazdannik, Yekta, & Soltani, 2012). Several participants in this study spoke about how their decision to become nurses had been influenced by the image of nursing as a caring profession:

When I had a careers assessment at school, they said, "You're a very caring person you should think about nursing." (Participant E)

Participant E had been identified as a caring individual by others and therefore considered suitable for a career in nursing, highlighting the widely held association of nursing as a caring profession (Sargent, 2012; Shields, 2014). Another participant in this study had self-identified as a caring person:

I went into nursing because I'm basically a caring personality ... my personality has always been more towards the caring profession in any form. (Participant M)

The personal attribute of a caring personality was associated by Participant M as one suited to a career in nursing. The concept of caring is often cited as the reason for individuals becoming nurses (Eley, Eley, Bertello, & Rogers-Clark, 2012; Jirwe & Rudman, 2012; K. McLaughlin, Moutray, & Moore, 2010; Wilkes, Cowan, & Johnson, 2015; Price, McGillis Hall, Angus, & Peter, 2013). However, the image of nursing as a caring profession and nurses as altruistic and caring individuals can arguably be viewed as a social construct and not necessarily a true representation of the nursing profession or what it is to be a nurse (Arreciado Marañón & Isla Pera, 2015; Gordon & Nelson, 2005; Haigh, 2010; Price & McGillis Hall, 2014; Sargent, 2012).

As noted by Gordon and Nelson (2005), the nursing profession itself has contributed enormously to the socially constructed image of nursing through recruitment campaigns using gendered virtue scripts (p. 66). These recruitment drives have often portrayed nursing as a caring profession and nurses as angels of that care (Gordon & Nelson, 2005, p. 66). According to Gordon and Nelson (2005), as recently as 2002 the Ohio Health Systems produced a brochure for National Nurses Week that read:

People believe there are beings

That come to you in your darkest hour

Guide you when your life hangs in the balance

Cradle you.

Calm you.

Protect you.

Some people call them guardian angels

We call them nurses (p. 66).

The concept of nurses as caring guardian angels is an enduring and pervasive script that has permeated nursing discourse and public opinion for years (Durning, 2010; Gordon & Nelson, 2005). Although caring holds a prominent place in the identity of nursing, there is no definitive definition of caring in relation to nursing practice (Blasdell, 2017; Sargent, 2012). Despite the lack of a standard definition, caring has been conceptualised in the nursing literature in numerous ways (Lachman, 2012; Morse, Solberg, Neander, Bottorff, & Johnson, 1990; Sargent, 2012, Watson, 1985, 1997). These conceptualisations include caring being portrayed as something nurses are morally obliged to do (Lachman, 2012; Morse et al., 1990); a necessary or desirable attribute (Loke, Lee, Lee, & Mohd Noor, 2015; Roach & Maykut, 2010); an intervention that is therapeutic in itself (Andersson, Willman, Sjöström-Strand, & Borglin, 2015; Morse et al., 1990); a theoretical framework of nursing practice (Watson, 1985, 1997) and as being the essence of nursing identity (Watson, 1997, 1999).

As a profession, nursing has fought hard for the recognition of its own body of knowledge and the professional expertise held by nurses (Gordon & Nelson, 2005; Kessler, Heron, & Dopson, 2015). Vast changes have occurred since the nineteenth century when nursing was

viewed as a menial occupation with little value assigned to the role (Gordon & Nelson, 2005). Today, nursing is recognised as a complex and diverse practice comprising medical, human and social sciences (J. K. Anderson, Croxon, & McGarry, 2015; Sargent, 2012; Warelow, 2007; Valentine, Ordóñez, & Millender, 2014). Situating caring as a core component of nursing is considered by some commentators as devaluing the other attributes of professional nursing practice, thereby limiting the professional role of nurses (Gordon & Nelson, 2005; Sargent, 2012; Sturgeon, 2008). Consequently, Sargent (2012) suggests that the concept of caring should be considered from the perspective of a discourse of nursing, rather than as a concept that guides nursing practice. Despite debate on the notion of caring and its relationship to nursing practice, the concept of caring remains central to nursing practice and nursing identity (Andersson et al., 2015; Blasdell, 2017; Shields, 2014; Song, 2016).

6.2.2 Homeopathic identity

There is a paucity of literature on the construction of professional identity within the context of the homeopathic practitioner (Fixsen & Ridge, 2012). However, considering that the literature indicates that social and cultural factors (Adler & McAdams, 2007; Burke, 2004; Tajfel, 1969), along with profession-specific education and socialisation are significant factors in the construction of professional identity (Becker & Carper, 1956; M. Johnson et al., 2012; Motlagh et al., 2012), it is probable that these factors also influence the professional identity of homeopathic practitioners. As previously discussed in section 6.2 of the chapter, participants in this study had cemented their nursing identity before becoming homeopaths. They had all been members of the nursing profession for a number of years before engaging with homeopathy. Also, it was noted that when participants in this study discussed their professional identities, they often included one or more other identities in addition to their nursing and homeopathic identities:

I lecture, I nurse, I'm a naturopath and a homeopath. (Participant H)

I'm a nurse, I'm a homeopath and an educator. (Participant C)

All the professional identities mentioned by participants related to the field of health care, such as nurse educators and naturopaths. When participants talked about their homeopathic identity it was with a similar intensity as when they spoke about their nursing identity. They became animated and spoke quite passionately, suggesting that in addition to identifying strongly as nurses, participants identified equally as intensely as homeopaths:

I'm a homeopath at heart. (Participant D)

Whenever I'm travelling, I put homeopath and nurse on the immigration papers and my husband says, "Why do you do that, why don't you just put nurse? People don't know what a homeopath is half the time", but I feel like I'm not being true to myself if I only put one. (Participant E)

Participant E talks about 'not being true to self' if only one identity is acknowledged. The need to identify as both a nurse and a homeopath when filling out travel documents demonstrates a complexity to how Participant E self identifies. There is no distinction or preference given to one identity over the other. Rather, Participant E identifies as both a nurse and a homeopath across various social situations. As individuals hold multiple identities and can be members of several different groups simultaneously, the intersection of identities across various social settings is common (Brenner, Serpe, & Stryker, 2014; Dovidio, 2005; Kulich, de Lemus, Kosakowska-Berezecka, & Lorenzi-Cioldi, 2017). However, it was noted that although participants in this study spoke of themselves as being nurses and homeopaths, how they identified was contextual to specific situations:

If you asked me what I saw myself as, a homeopath or a nurse, I would say well both, but a homeopath primarily. That's how I earn my living and that's what I spend the most of my time doing. (Participant B)

If I'm doing more of one [nursing or homeopathy] I'll mention that one first, so whatever's taking up the most of my time. (Participant O)

The way in which these participants identified professionally was based upon the working environment and the nature of work being undertaken at that point in time. Their nursing or homeopathic identity was activated in response to these factors (Stets & Burke, 2000, p. 229; Willets & Clarke, 2012). Activation of identity is known as “salience” and relates to the likelihood of an identity being enacted across various social situations (Brenner et al., 2014, p. 232). The salient identity of an individual can alter within different groups or in response to different circumstances (Willets & Clarke, 2012). Although the salient identities of participants in this study tended to be situational to the working environment that dominated most of their time, there was one negative case to the situational activating of identity. This particular participant identified as a homeopath, despite working more hours as a nurse than as a homeopath:

I'm a homeopath and I have a second profession as a child health nurse ... it's interesting how I define myself as a homeopath when four shifts a week are actually nursing. (Participant D)

Participant D notes the difference in the greater number of hours spent working as a nurse while identifying as a homeopath. The reference to nursing as a ‘second profession’ suggests that Participant D’s homeopathic identity is more prominent than their nursing identity. Identity prominence is closely linked to identity salience and relates to the subjective importance of an identity in relation to other identities (Brenner et al., 2014).

Salience and prominence are differentiated by Brenner et al. (2014) as a behavioural (salience) and emotional (prominence) response. According to McCall and Simmons (1978, as cited in Brenner et al., 2014), individuals have a desire to enact identities placed high on the prominence hierarchy as these are important to how they perceive themselves. Burke and Stets (2009) describe the salience hierarchy as representative of the situational self, while the prominence hierarchy is symbolic of the ideal self (pp. 40–41). The higher an identity is positioned in the prominence hierarchy, the more importance it holds (Burke & Stets, 2009, p. 40).

Although the majority of participants in this study identified strongly as homeopaths, there was one negative case involving a participant who expressed being less self-assured in their identity as a homeopath. This participant talked about lacking confidence in their identity as a homeopathic practitioner, stating:

I still haven't solidified the confidence around my homeopathic identity as a practitioner. Nursing is such a team sport and I keep looking for the team work. I love that we share ideas at the beginning and end of a shift, and we troubleshoot together. We're there to support each other and almost debrief each other. I miss that with homeopathy. (Participant O)

Participant O's narrative suggests that their lack of confidence in their homeopathic identity is linked to the solitary nature of homeopathic practice. Professional confidence can be considered with the context of an evolutionary self-belief that is closely linked to professional identity (K. E. Holland, Middleton, & Uys, 2013). Clinical exposure and interaction with other nurses, particularly those assigned to support and mentor, are recognised as important factors in the development of professional confidence in nurses (Kim, Lee, Eudey, & Dea, 2014; Porter, Morphet, Missen, & Raymond, 2013;

Toal-Sullivan, 2006; Woods et al., 2015). Although no literature could be found on the professional confidence of homeopaths, it is likely that its development is dependent upon factors similar to those that cultivate the professional confidence of other health care workers such as nurses. Another participant in this study, with a background in homeopathic education, shared similar thoughts to Participant O in relation to the isolation of homeopathic practitioners and how this compares to the experience of nurses:

They [homeopaths] are isolated, which is the complete antithesis of nursing training where you finish and you work in a team automatically ... you're working with other nurses, you're managed by nurses and you have all these multidisciplinary teams that you can find information from. It's very safe in a way. What we do in homeopathy is the opposite. You graduate as a homeopath, you work on your own, you're isolated. (Participant B)

The experience of homeopaths, post-graduation, is described by Participant B as an 'antithesis' to the post-graduation experience of nurses. The ongoing professional support available for nurses due to the team-based nature of the nursing practice environment is considered by Participant B as a 'safe' approach. In contrast to the team-based practice environments that a significant portion of nursing practice takes place within, the homeopathic practice environment is commonly one where practitioners work alone in sole practice, often having limited contact with their peers (Shuval, 2006). However, homeopathic practitioners in Australia can access professional support through workshops, conferences, webinars and mentoring services provided by the Australian Homoeopathic Association (AHA), (2019). Currently there is a paucity of research relating to the professional issues affecting complementary and alternative medicine (CAM) practitioners,

including their support needs (Fairhurst, 2015), indicating that future research in this area is warranted.

Although participants in this study had multiple professional identities in their role as health care professionals, of special interest to this study was their nursing and homeopathic identities and the intersection of these identities in the respective nursing and homeopathic practice environments. Participants' narratives suggest that they felt that their nursing and homeopathic identities informed each other regardless of where they were working:

I've always felt that it was important to keep your feet in both camps because one informs the other. When I'm a nurse the homeopathy and the education informs that. When I'm an educator the nursing and the homeopathy informs that. When I'm a homeopath the education and the nursing inform that. It's like there is really little delineation, it depends on the context. (Participant C)

I have always mixed and matched nursing and homeopathy. Always used my naturopathic hat as well. (Participant I)

Participants' narratives depict an image of a fluid and non-linear interplay between their intersecting professional identities and their practice as nurses and homeopaths, with each area informing the other. The relationship between participants' respective nursing and homeopathic identities and practice, as perceived by participants, is represented in Figure 15 as a cog in a continual state of interaction.

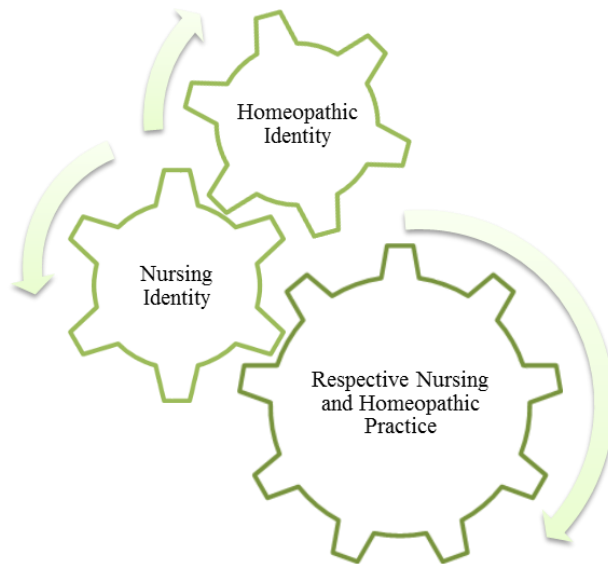


Figure 15. Participants’ perception of the relationship between their respective nursing and homeopathic identities and practices.

The fluid intersection of participants’ identities as nurses and homeopaths suggests a congruence between their respective nursing and homeopathic identities. Notably, participants also frequently referred to their respective professional identity and practice as nurses and homeopaths as being ‘complementary’ to each other. Participants’ assertions that nursing and homeopathy are complementary practices will now be explored.

6.3 Nursing and Homeopathy are Complementary Practices

It was explained in Chapter Two of the thesis, *Contextualising CAM and Homeopathy*, that nursing and homeopathy sit within two very different sectors of the health care system of Australia. Nurses are the largest health workforce in Australia and are registered members of the Australian health care system (AIHW, 2018, p. 65). In contrast, homeopathy is situated on the fringes of Australian health care as a self- regulated profession with no official recognition (AHPRA, 2017; Wardle et al., 2013a). In addition, nursing is a valued profession that has often been appraised as the most trusted of all health professions

(Olshansky, 2011). In contrast, homeopathy has historically been positioned as a fraudulent and unethical practice (Liddle, 2015; Shaw, 2010; Smith, 2011).

Despite the different standing that nursing and homeopathy have in the Australian health care system and the criticism that homeopathy attracts from members of the medical and scientific communities, participants never considered their respective nursing and homeopathic practices, or identities, as incongruent:

I love nursing and I love my homeopathic practice as well. I think they complement each other. (Participant E)

I have no conflict with professional identity. I think both [nursing and homeopathy] complement each other beautifully. (Participant O)

Participants talk about ‘loving’ nursing and homeopathy and having no conflict in being members of two very diverse sectors of health care professionals. During data analysis, participants’ statements about nursing and homeopathy being complementary to each other were identified as having two key factors. Firstly, participants believed that nursing and homeopathy shared common ground in terms of the philosophy underpinning their respective practices. Secondly, participants considered nursing and homeopathic knowledge to be transferable from one practice domain to the other. During data analysis, these two factors were labelled as ‘nursing is holistic’ and ‘transferring knowledge’ respectively and will be discussed in turn.

6.3.1 Nursing is holistic

Participants often spoke about nursing in terms of it being holistic. They had a firm belief that at its core, nursing was a holistic practice that seeks to care for the whole person. Therefore, nursing and homeopathy were perceived to have similar aims:

The real link between the two [nursing and homeopathy] is the needing to care for the person, rather than the disease. (Participant F)

It's [nursing] client centred, its holistic, especially with community health nursing. It's working with the whole organism, watching the whole organism develop and more forward. (Participant G)

Participants talked about nursing being focused on the care of the individual rather than the disease, describing it as a 'client-centred' and 'holistic' practice that works with the individual as a 'whole'. Client-centred care, hereafter referred to as person centred-care (PCC), is an approach to health care that situates the individual at the centre of the care they receive (Delaney, 2018; McCormack et al., 2015). In recent years, the appropriateness of an approach to health care service delivery that places the individual at the centre of their care has been increasingly acknowledged (Aoun, O'Brien, Breen, & O'Connor, 2018; Currie et al., 2014; McCormack et al., 2015; Taylor, 2009; World Health Organization [WHO], 2015). The essence of PCC can be summed up in the phrase, "no decision about me, without me" (Coulter & Collins, 2011, p. 1; Wolstenholme, Ross, Cobb, & Bowen, 2017, p. 1218).

There are numerous considerations of PCC in the literature, each identifying a variety of core elements that inform it (Delaney, 2018; Kitson, Marshall, Bassett, & Zeitz, 2012; Pelzang, 2010; WHO, 2015). Many of these interpretations of PCC acknowledge self-determination along with respect and a holistic approach as the foundation of PCC (Delaney, 2018; Kitson et al., 2012; Pelzang, 2010). Notably, the WHO's (2015) description of person-centred health care services fails to identify self-determination or autonomy as a core principle. Rather, a person-centred approach to health service delivery is described by WHO (2015) as being an approach that sees individuals, families and

communities as participants and beneficiaries of health systems who should be given support to help them “make decisions and participate in their own care” (p. 7). WHO’s (2015) description of individuals as participants and beneficiaries of health systems is arguably passive. The individual is not situated as having autonomous rights in relation to actions taken or decisions made that concern them or their care. Client autonomy is an important aspect of health care as it acknowledges the right of individuals, where possible, to make decisions relating to their care, even when it conflicts with advice from medical professionals (Frank, 2013).

Responding to claims that autonomy-focused PCC provides clients with information and then leaves them to their own devices, Frank (2013) notes that respect for a client’s autonomy involves a process of active listening and respectful dialogue (p. 60). Client autonomy is not about devaluing the expertise of clinicians, but of empowering the client. When an individual is incapacitated or unable to make decisions for themselves, PCC respects the autonomy of the person designated to make those decisions on behalf of the client (Frank, 2013, p. 60). Although the era of the doctor being held up as the only person capable of knowing what approach to health care is in the client’s best interests appears to be coming to an end, clinical knowledge remains a valued and vital component in assisting clients in making informed decisions (deBronkart, 2015).

The emergence of PCC and its philosophy of including clients in the decision-making process is a significant departure from the paternalism that has traditionally dominated health care delivery (deBronkart, 2015; Delaney, 2018; Taylor, 2009). Paternalism is defined by Holm (2017) as “actions taken, or decisions made, by another person with the intention of benefitting that person” (p. 963). Historically, health care systems dominated by biomedicine have been paternalistic systems that do things for and to an individual as

opposed to being based upon mutual participation (Kaba & Sooriakumaran, 2007; Murgic et al., 2015). Paternalistic health care systems situate the knowledge of health care providers as the supreme authority when it comes to decision making, which can be in conflict with what a client desires (Cody, 2003; Murgic et al., 2015). A paternalistic approach to health care reduces the power of individuals and reinforces medical dominance (Kaba & Sooriakumaran, 2007). The well-known phrase, doctor knows best, is representative of the paternalism that has traditionally dominated the field of medicine (Bodkin & Donnelly, 2016; E. Jackson, 2018).

Although the holistic approach espoused by PCC is a relatively new approach to health service delivery, concepts of holistic practice have been a significant part of nursing discourse since the beginning of modern nursing practice. As discussed in section 3.7 of the thesis, Nightingale and several other nursing theorists promoted a holistic approach to nursing. In addition, nursing literature abounds with articles related to nursing within the context of it being a holistic practice. For instance, a search of the Academic Search Ultimate database in April 2019 using the search term ‘holistic nursing’, resulted in 3,105 retrievals. In addition, some nursing journals and associations are solely dedicated to the topic of holistic nursing (American Holistic Nurses Association, 2019; Ovid Technologies, 2019; Sage Journals, 2019).

During data analysis, it was identified that a key aspect of participants’ assertions that nursing and homeopathy were both grounded in holistic philosophy was their belief that both practices shared a common goal of aiming to enhance the wellbeing of clients. The concept of wellbeing will now be explored within the context of participants’ perspectives and the extant literature.

6.3.1.1 Enhancing wellbeing

Wellbeing is commonly associated with subjective emotions such as happiness and satisfaction with life, making it a difficult concept to define (Centres for Disease Control and Prevention [CDC], 2018; Drabsch, 2012). Although subjective factors such as satisfaction with life are considered a component of wellbeing, external factors such as economic, environmental and social circumstance are also known to influence wellbeing (CDC, 2018; Dooris, Farrier, & Froggett, 2018; Drabsch, 2012; Sointu, 2006; Tozer, Khawaja, & Schweitzer, 2018). Given the broad factors that are considered to contribute to wellbeing, it can be considered as a holistic concept encompassing all aspects of one's life (Dooris et al., 2018; Sointu, 2006). Participants in this study expressed feeling that as nurses and homeopaths, they focused on enhancing the wellbeing of those in their care as a desired outcome of practice, saying that:

I think its [nursing and homeopathy] more that you want your patient to get well or have that sense of wellbeing. Improved health and it's just helping people. Helping people to be the best they can be. (Participant H)

It's [nursing and homeopathy] just that real desire to help a person, not necessarily just to get over a disease or sickness, but to actually help them come back to a state of wellness within themselves. (Participant F)

Wellbeing is talked about by participants as a subjective feeling or sense of wellness rather than as an absence of illness, raising the question of the relationship of wellbeing to the concept of health. A well-known definition of health is that of the WHO (2019), who define health as, "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (p. 1). Criticism of the WHO's definition of health frequently centres on its subjectivity and the use of the word 'complete' (Balog, 2017;

Huber et al., 2011; Misselbrook, 2014). It is argued by Huber et al. (2011), that the use of the term ‘complete’ situates most of the population as unhealthy, thereby contributing, albeit unintentionally, to the increased medicalisation of societies and the redefining of illness (para. 3) For instance, according to Huber et al. (2011), advances in screening technology tend to result in the reduction of thresholds such as those for blood glucose and cholesterol, which determine the appropriateness of medical interventions (p. 1). Huber et al. (2011) argue that reducing these thresholds creates a market for pharmaceutical interventions to treat conditions that might previously not have been classified as a “health problem” (p. 1).

Furthermore, Huber et al. (2011) argue that in 1948 when the WHO definition of health was instated, patterns of disease were vastly different to what they are today (p. 1). Chronic disease generally led to death. However, in the 21st century, individuals often live with chronic illness, adapting to their situation (Huber et al., 2011; Misselbrook, 2014). Therefore, the notion of a complete state of physical, mental and social wellbeing is an unrealistic ideal. (Misselbrook, 2014; Huber et al., 2011). As stated by Misselbrook (2014), individuals can feel a sense of wellbeing despite being pathologically ill or disabled and it is their interpretation of their experience that is of most importance (p. 582).

Sointu (2006) suggests that as wellbeing is based on holistic concepts of health and is grounded in personal subjective experience rather than scientific rationality, and as such, challenges the way that biomedicine defines health and illness. Although the subjective nature of wellbeing might arguably challenge biomedicine, it fits comfortably with the holistic concept of health found within CAM philosophy and discourse (Sointu, 2006). The concept of wellbeing is also a common concept in nursing literature and discourse (Allen & Watts, 2012; Keeling & McQuarrie, 2014; Younger, 2011). For instance, the code

of conduct for nurses in Australia states that nurses support the “health and wellbeing” of individuals requiring nursing care (Nursing and Midwifery Board of Australia, 2018a, p. 7). The inclusion of wellbeing within nursing literature and codes of practice supports the assertions of participants in this study that nursing and homeopathy have similar aims. Whether or not these aims are achieved in nursing practice is however debatable and is discussed further in Chapter Seven of the thesis, *Intersecting Identities: Navigating Opposing Paradigms*.

As mentioned in section 6.3 of the chapter, the second factor identified from the data that related to participants’ belief that nursing and homeopathy were complementary practices, involved the transfer of knowledge. The transference of participants’ respective nursing and homeopathic knowledge from one practice domain to the other will now be explored.

6.3.2 Transferring knowledge

Knowledge is a complex construct that is influenced by a variety of historical, social and cultural factors (B. Chang, 2014; Kimmerle, Moskaliuk, Oeberst, & Cress, 2015; McKenna, Pajnkihar, & Murphy, 2014, p. 24; Shi, Visschers, & Siegrist, 2015). Knowledge gained in one context and transferred to another context is known as transferable knowledge (Lundgren & Robertsson, 2013). Transferable knowledge can relate to the transfer of knowledge between situations that share some degree of similarity, or it can be abstract and relate to situations that are dissimilar to each other (Lundgren & Robertsson, 2013; Stevens & Miretzky, 2014). Knowledge that applies across diverse situations is considered to be more generic than situated knowledge, which is restricted to the particular situation or context of where it was obtained (Morgan, 2014).

In terms of this study, transferable knowledge relates to the transference of participants’ respective nursing and homeopathic knowledge into their respective nursing and

homeopathic practices. However, there was a vast difference in participants' abilities to transfer nursing knowledge into their homeopathic practice in comparison to their abilities to transfer homeopathic knowledge into their nursing practice. Earlier in the chapter at the end of section 6.2.2, it was mentioned that participants' narratives presented an image of a fluid interplay between their respective nursing and homeopathic identities and practice. Although this conclusion can be made from the data, other findings indicate that participants faced challenges relating to the expression of their homeopathic identity. These findings highlighted that participants' homeopathic identities and practices were inhibited in the nursing practice environment by a variety of factors including epistemological and organisational boundaries. Consequently, this aspect of the intersection of participants' respective nursing and homeopathic identities and practices is subsequently discussed in Chapter Seven of the thesis, *Intersecting Identities: Navigating Opposing Paradigms*. Of particular relevance to this discussion is the transfer of participants' nursing knowledge into their homeopathic practices, which will now be explored.

6.3.2.1 Integrating nursing knowledge into homeopathic practice

Nursing practice is informed by a body of knowledge from a variety of sources (Carnago & Mast, 2015; Fairbrother, Cashin, Conway, Symes, & Graham, 2016; Flott & Linden, 2016; McKenna et al., 2014). Included in the knowledge that nurses hold is specialised knowledge of biomedical practices and interventions (Mazzotta, 2016; Shuval, 2006). Historically, biomedicine and its approach to clinical practice has heavily influenced nursing education and practice (Mazzotta, 2016; Pearson, Vaughan, & FitzGerald, 2005; Wall, 2015). Although contemporary nursing curricula has increasingly incorporated human sciences including the socio-cultural, legal and political factors relevant to understanding health and health care delivery (Birks, Cant, Al-Motlaq, & Jones, 2007; University of Newcastle, 2019), it can be argued that biomedicine still has a significant

influence on contemporary nursing knowledge and practice (Matthews, 2015; Mazzotta, 2016; Shuval, 2006). For instance, in Australia most nursing practice takes place in primary health care settings such as hospitals where the biomedical model of health care is dominant (Department of Health, 2017b). Consequently, in the course of their professional practice, nurses are involved in the implementation of biomedical practices and interventions (Mazotta, 2016; Shuval, 2006; Swayze & Rich, 2011).

The majority of participants in this study entered into their nursing training before schools of nursing were relocated into the university sector. Previously, nursing education was undertaken within hospitals where the biomedical model was dominant; therefore, biomedicine would have greatly influenced these participants' experiences as student nurses. Participants in this study frequently spoke about using the knowledge and experience they had gained from being members of the nursing profession when working as homeopaths, suggesting that their nursing identity became salient in the homeopathic practice environment:

My feet are well and truly entrenched in allopathic medicine. I've always said that as a homeopath, I use both. I use all the clinical pathology, anatomy, physiology, pathophysiology and physical examination, that whole understanding of medicine, the whole lot. (Participant C)

Nursing gives me a really good background in understanding disease processes. So, when you're taking a case, or looking at a case, to really understand the disease processes behind it dictates how I prescribe [homeopathy]. (Participant F)

Participants talk about being firmly 'entrenched in allopathy' and of nursing providing an 'understanding of disease processes' and influencing how they prescribe as homeopaths. The narratives of participants in this study support Shuval's (2006) findings of a conscious

and active awareness of biomedical knowledge in nurses who are CAM practitioners, which in turn influences their CAM practice (p. 1792). Participants in this study commonly spoke about how they were always nursing when they were working as homeopaths:

I think I'm a nurse all the time actually to be honest with you. I'm a nurse and I'm a homeopath. I'm looking in kid's ears. I'm checking their glands. I'm looking at their throat. I'm nursing all the time. (Participant K)

I've often said that with homeopathy I am still nursing every day. I'm a nurse but I give a homeopathic remedy, that's the big difference. I see loads of mums, babies, there's antenatal and postnatal stuff going on. I use my nursing every day within my homeopathic practice. (Participant A)

The statement from Participant A about 'nursing every day' when working as a homeopath and of being a 'nurse who gives a homeopathic remedy' is indicative of the intersection of participants' respective nursing and homeopathic identities and the transfer of knowledge between the two practices. Nursing knowledge includes explicit or taught knowledge such as the knowledge and ability to perform a range of technical skills (Ewertsson et al., 2011) in addition to tacit knowledge such as interpersonal skills which are obtained through personal experience (R. J. Evans & Donnelly, 2006; Kontos & Naglie, 2009; Kothari, Bickford, Edwards, Dobbins, & Meyer, 2011; Pérez-Fuillerat, Solano-Ruiz, & Amezcua, 2019). As previously mentioned, knowledge can also be situated, where it relates to a specific area of health care (Morgan, 2014). Many of the participants in this study had knowledge relating to specific areas of health care. For instance, participants with experience in midwifery and child health had situated knowledge in matters relating to pregnancy, birth and child health and development, while participants with a background in mental health had knowledge specific to that sector of health care. When speaking about

their nursing practice, participants' situated knowledge was evident in their narratives, as shown in the following two interview extracts:

[As a homeopath] *I use my midwifery skills and of course with babies, I look after babies in that post-natal period ... looking after kids from a paediatric point of view, inspecting their ears, checking their tonsils, doing all those types of things.*
(Participant C)

I seem to attract people that have mental emotional issues. I often get people come in and then as I sit down and start talking, I say, "Oh my other job is as a mental health nurse. That's a really good combination for you, I'll be able to assess whether you need to be referred on, or whether you are safe. (Participant E)

The situated knowledge and experience that participants had in their respective areas of nursing was integrated into their homeopathic practice as a part of the consultation process, and was used to assist with clinical decision making. In the case of Participant E, this might involve referring a client back to their GP or mental health specialist. In addition to the transfer of situated nursing knowledge, tacit nursing knowledge was also transferred into the homeopathic practice of participants. Tacit knowledge can be a difficult concept to define as it is generally considered to be knowledge that is accessed without any prior deliberation (Benner, 1984, as cited in Kontos & Naglie, 2009, p. 689; R. J. Evans & Donnelly, 2006; A. Lam, 2000; Kothari et al., 2011). In *The Tacit Dimension* Polanyi (1966) wrote that in reconsidering human knowledge, his starting point would be that we know more than we can tell (p. 4).

Terms such as intuition and hunches are often used to describe tacit ways of knowing (Brock, 2015; Dörfler & Ackermann, 2012; Young, 2018). One participant in this study

spoke about the difficulty in defining and quantifying this type of knowledge in relation to nursing skills, stating:

So many nursing skills are quite intangible. All of that stuff you get from observation, it's hard to quantify. With just a snapshot of observation you know very quickly what is going on because you have been immersed in that environment for so long ... So, do I use those skills as a homeopath? Well probably, yes. Are they nursing skills? I don't know. I'm not quite sure what nursing skills are.

(Participant B)

Participant B expresses being uncertain about what constitutes nursing skills. According to R. J. Evans and Donnelly (2006), much of the knowledge utilised by nurses is “invisible” and nurses themselves are unaware of it (p. 151). Participants in this study commonly used terms such as ‘intuition’ or ‘nursing nose’ to describe their way of knowing:

Once you get into natural therapies you sit there as a nurse and you realize how much you know about patients and their care. I call it my ‘nursing nose’. You look at someone and think “No, that’s not right, that doesn’t sound right, they need to do this, or they need to go off and have this test.” (Participant I)

Being a nurse has improved, I believe, my abilities as a natural practitioner. It has added a depth of knowledge that I use all the time and draw on all the time, even my intuition with patients. (Participant O)

Participant O talks about drawing upon nursing knowledge, including intuition, all of the time when working as a CAM practitioner and believes that nursing knowledge added a ‘depth of knowledge’ to their homeopathic practice. Benner and Tanner (1987) define intuition as a “form of understanding without a rationale” (p. 23). According to Brien, Dibb

and Burch (2011), the varying definitions of intuition suggest that it holds different meanings for different people (p. 1). In nursing practice, intuition is recognised as being an influential factor in the decision-making process of nurses especially in relation to client care (Cork, 2014; Johansen & O'Brien, 2016; Melin-Johansson, Palmqvist, & Rönnerberg, 2017; Robert, Tilley, & Petersen, 2014). As a form of nursing knowledge, C. Green (2012), asserts that intuition is grounded in experiential learning and is a valid form of knowledge that adds to the scientific knowledge influencing nursing practice. A significant factor identified as enabling the integration of nursing knowledge into the homeopathic practices of participants in this study related to the confidence that participants had in their nursing knowledge and their abilities as nurses, which will now be explored.

6.3.2.1.1 Having confidence in nursing knowledge

A primary aim of nursing education is to produce competent and confident nurses with knowledge of safe practices (Nursing and Midwifery Board of Australia, 2017; Woods et al., 2015). The narratives of participants in this study suggested that the confidence they had gained through their nursing experience provided them with a level of self-assurance when managing complex cases in the homeopathic practice environment:

When you're a nurse, with the training you've got vast amounts of hours and then you work with patients' day in and day out, managing complex situations. Managing not only patients, but their families and carers and stuff like that. You get very confident in that and you have a persona that is your professional background from nursing. (Participant B)

[As a homeopath] It doesn't faze me when somebody comes in up to their eyeballs on a list of medications, having this intervention and that scan, going into hospital

for this surgery, or coming out from hospital. I'm very familiar with that area so I can work in with it quite well. (Participant N)

Biomedical medications and interventions are described as 'familiar' by Participant N. Having a level of familiarity with the various biomedical treatments and procedures provided Participant N with a high level of confidence in the homeopathic practice environment, when dealing with clients who were also engaged with the biomedical health care system. One aspect of their familiarity with biomedical interventions that participants talked about related to their ability to discuss biomedical treatments and procedures with clients when working as homeopaths. Participants felt that nursing provided them with the knowledge and experience to talk with clients about any procedures they might have been about to undergo, or had experienced, stating that:

It [being a nurse] just gives you more insight and more understanding, and when someone says "Oh God! I've just had a barium enema", you know exactly what they've been through. If you're talking to them about a procedure you can actually tell them, you can describe it to them. "Look it's not that bad, you just have to do this, this and this". That's really nice for the patients. (Participant I)

Participant I speaks about being able to reassure and support clients in the homeopathic practice environment who were undergoing biomedical treatments and procedures. Providing explanations of medical procedures and allaying the anxiety of those in their care are standard components of nursing practice (Karlsson, Rydström, Enskär, & Englund, 2014; Major & Holmes, 2008). The narratives of participants in this study suggested that they continued performing this role when working as homeopathic practitioners. They drew upon their knowledge of medical procedures, the way the health care system operates along with their knowledge of human anatomy, physiology and pathophysiology and used it to

inform their homeopathic practice. A notable aspect of participants' nursing knowledge and its subsequent transference to their homeopathic practice was its impact on participants' referral practices to biomedical practitioners, which will now be examined.

6.3.2.1.2 Referring homeopathic clients to biomedical practitioners

Participants' narratives indicated that they regularly referred clients from the homeopathic practice environment back to their GPs. They talked about how as nurses and homeopaths they were taught to know the scope of their practice and to refer when appropriate:

As a homeopath we are taught to know the limits of our process and then you need to know how to refer. Now as a nurse, I also learnt that. I learnt that you need to know your limits and refer. (Participant C)

Having the skills that I've learnt in mental health, I feel more equipped if I have patients that are distressed in clinic, or they're becoming unwell psychotically. I have the skills to understand how risky they are, do they need to go to hospital? (Participant E)

Participant E talks about how knowledge gained through mental health nursing was used to assess if a client in the homeopathic practice environment needed to be referred. Findings from this study on the referral practices of participants support those of Grace, Vemulpad and Beirman (2006) who found that CAM practitioners' referrals to biomedical practitioners were linked to the quality of the CAM practitioner's education, their awareness of the limitations of their clinical knowledge and experience, as well as awareness of the limitations of the CAM modality being practised.

Studies examining the referral practices of CAM practitioners to biomedical health care providers when working in private practice are lacking in number and scope, especially in

relation to those practising unregistered CAM therapies (Bensoussan et al., 2004; Casey, Adams, & Sibbritt, 2008; Footracer, Monaghan, Wiśniewski, & Mandel, 2012). A 2004 Australian workforce survey of naturopaths and practitioners of Western herbal medicine conducted by Bensoussan et al. (2004) found that only 7% of participants referred to a GP in approximately half of their cases, while 73% of participants indicated that their referral to GPs was occasional. Participants in Bensoussan et al.'s (2004) study included medical practitioners, nurses and pharmacists who also practised naturopathy or Western herbal medicine, as well as CAM practitioners working within these areas of CAM. However, no distinction was made between the referral practices of participants with a medical, pharmaceutical or nursing background and those participants who solely had a CAM background. Therefore, the referral practices of the naturopaths and herbalists in Bensoussan et al.'s (2004) study are not clear. A later examination of the clinical practices of herbalists undertaken by Casey et al. (2008) suggested that herbalists in Australia commonly refer clients to biomedical practitioners for medical assessment and treatment. No studies could be found on the referral practices of homeopaths.

During data analysis, two main factors were identified as influencing the decision of participants in this study to refer homeopathic clients to biomedical practitioners. The first of these factors related to participants referring clients for standard diagnostic tests, while the second related to participants' referral of clients whom they identified as being beyond the scope of their professional practice. Participants' patterns of referral were labelled as 'standard testing' and 'recognising scope of practice' and will be discussed in turn.

6.3.2.1.2.1 Standard testing

Sending clients from their homeopathic practice back to their GPs for standard diagnostic tests was common practise among participants. Participants expressed feeling that the

information provided from this type of testing was useful to them as homeopathic practitioners:

I'm always sending people back to their GP to get blood tests and things.

Why should I act in ignorance? I need to know what's happening. (Participant C)

I send patients back to their GP because I want them to get investigations and

I don't do that myself. I get someone else to do that and those results are useful.

It's always useful to know what is going on with the patient in terms of pathology.

(Participant B)

The diagnostic tests for which participants referred their clients to GPs, enabled them to gain knowledge about their client's health. Research indicates that CAM practitioners commonly utilise diagnostic tests such as pathology reports to guide clinical practice, often referring clients back to their GPs for this purpose (Bensoussan et al., 2004; Casey et al., 2008; Grace et al., 2006). In Australia, CAM practitioners such as naturopaths, herbalists and homeopaths are unable to order tests for clients utilising Medicare-funded testing services (Department of Health, 2019, pp. 19–20). Consequently, CAM practitioners must either request these tests through service providers that have access to funded testing services, such as GPs, or use non-rebatable services that incur a cost.

The issue of CAM practitioners requesting investigations via general practitioners has recently become a focus of attention after the Royal Australian College of General Practitioners (RACGP) (2019a, 2019b) recommended their members refuse unnecessary test requests coming from naturopathic practitioners. The action taken by the RACGP reportedly resulted over concerns about liability, litigation, rebate fees and client safety (Hoffman, 2016). In future, CAM practitioners will need to forge a collaborative relationship with GPs to continue having access to Medicare funded testing options,

otherwise, CAM consumers may be forced to pay out of pocket for tests requested by their CAM practitioners. The second factor identified relating to the referral practices of participants to biomedical health care providers related to a recognition of the boundaries relating to their scope of practice, which will now be discussed.

6.3.2.1.2.2 *Recognising scope of practice*

Recognising one's scope of practice as a health care provider is an extremely important factor of professional practice (Nursing and Midwifery Board of Australia, 2018; Pharmacy Board of Australia, 2014). Nurses registered in Australia are bound by standards and codes of practice that set their scope of practice, thereby informing them of the boundaries of their clinical nursing practice. Scope of practice is described by the Nursing and Midwifery Board of Australia (2016b), as that "in which nurses are educated, competent to perform and permitted by law" (p. 6). Decisions made in professional practice should be undertaken with consideration of one's own scope of practice as well as of that of the respective profession and service provider (Nursing and Midwifery Board of Australia, 2016b). In contrast, as discussed in section 2.4 of the thesis, the homeopathic profession has no statutory regulation; therefore, there is no legal requirement that homeopaths adhere to any legislated standards of practice that are specific to the homeopathic profession. However, homeopaths who choose to be registered, such as those who participated in this study, agree to abide by the professional standards set by AROH.

Being aware of boundaries in relation to one's professional homeopathic practice is an important component of the scope of practice outlined by AROH (2015a). Registered homeopaths are instructed in AROH's (2015a) *Code of Professional Conduct*, to recognise the limits of the treatment they can provide and to refer to other health care providers when appropriate (p. 5). Participants in this study showed a high level of awareness of the

appropriateness of homeopathy as a therapeutic intervention, and of clinical situations that were beyond their scope of practice, stating that:

Homeopathy is not the be all and end all of everything. Homeopathy is a tool and sometimes people need a different tool ... like with chronic schizophrenia, really you are not going to do a whole lot with homeopathy with that. You're never going to change that because there have already been structural changes in the brain that are irreversible. I don't care if they see the best guru ever, that's not going to change. (Participant B)

Homeopathy is magic, but it's not that magic. You still have to work out what's going on. I always give the example of a headache. Someone's got a headache and you've got to work out is it somewhere between dehydration or a brain tumour ... if it's dehydration they need water not a homeopathic remedy, and if it's a brain tumour they need a diagnosis, and somewhere in between there are thousands of things. (Participant I)

Participants make the point that there are times when homeopathic treatment may not be the best option and that other treatments or interventions might be a more appropriate course of action. One area of concern that has been raised in relation to people seeking CAM is the potential for delay in seeking medical treatment (Ayers & Kronenfeld, 2012; Greenlee et al., 2016). Although research suggests significant concomitant use of CAM and biomedicine by CAM users (Chang, Wallis, & Tiralongo, 2015; Ventola, 2010), some studies also indicate a negative association with biomedicine by some CAM consumers, which could potentially stop them from seeking medical advice (Bishop, Yardley, & Lewith, 2007; Usher, Fox, Lafarge, & Mitchell, 2013).

Several participants in this study spoke about cases where referral to biomedical health care providers had been complicated by reluctance on the part of the client to seek medical advice. Participants felt that their nursing knowledge combined with their knowledge of the way the medical system worked assisted them in supporting these clients and directing them to the most suitable resources. One case spoken about at length by a participant involved a client with a fear of doctors that prevented them from seeking medical advice.

Participant A said:

This woman had bulging breast tumours ... she was a foreigner who had a fear of white coats. I said, "No way, you have to get this seen to. You've got to do it and then you ring me back. You'll need a mammogram. You must do it and you must ring me back to make sure you've done that", and she did. I said "So, when is it booked in". She said, "In two months." I said, "No way are you waiting two months. You must have this seen to tomorrow". I arranged it for her. She ended up straight to the surgeon who took her breast off that weekend ... those sorts of clients I'm all over the top of them. She was going to accept a two month wait, but that's my confidence as a nurse and dealing with system. We know the system, the medicines, and the hospitals. We understand the wait times, what specialists need, and we understand the referral system. (Participant A)

The client that Participant A talked about is described as 'a foreigner with a fear of white coats.' Fear and distrust of medical practitioners and practices has its roots in varying causations (Kannan & Veazie, 2014, López-Cevallos, Harvey, & Warren, 2014; Renzaho, Polonsky, McQuilten, & Waters, 2013). The factors relating to mistrust of medical practitioners include, but are not exclusive to: personal negative experiences (Clark, Gilbert, Rao, & Kerr, 2014; Harris, Cooper, Relton, & Thomas, 2012), and different cultural norms

with regards to health care (Foundation House, 2012, p. 276; Han & Ballis, 2007). In some cultures, traditional medicine is the dominant form of health care, and the biomedical model that is dominant in western nations is therefore foreign, which can be potentially frightening (Clark et al., 2014; Han & Ballis, 2007; Renzaho et al., 2013). Differences in cultural health care practices can result in a distrust of, and reticence to utilise, biomedical health care providers and their services (Foundation House, 2012, p. 276; Han & Ballis, 2007). However, there is some evidence to suggest that migrants and refugees are potentially likely to accept and utilise CAM practices that are familiar to them (Foundation House, 2012, p. 276; Han & Ballis, 2007; J. Singer & Adams, 2011). CAM practitioners are therefore well placed to act as a bridge between individuals who are reluctant to seek medical advice and the biomedical health care system, especially those who have knowledge and experience with biomedicine and its approach.

Another participant in this study told a story about undertaking a homeopathic consultation as a student homeopath in a student clinic. Student clinics are an important component of homeopathic education, providing students with the opportunity to observe cases being taken and to take cases themselves under the supervision of qualified and experienced homeopaths (The Contemporary College of Homoeopathy, 2018; Grover, 2015). During the student clinic, Participant O saw a client who presented with abdominal swelling that the client believed to be a symptom of menopause. The client wanted a homeopathic remedy to assist this phase of life and expressed a reluctance to seek medical advice due to a traumatic experience with the medical profession during childhood. The way in which this client's fear was dealt with and the progress of the case was spoken about at length by Participant O:

She [the client] was feeling bloated, losing her period, a bit of spotting, etc. I just felt she had cancer of the ovaries. I know we're not meant to diagnose, but it set the flags waving for me. I would never have drawn that conclusion if it was not for my nursing background. I was concerned that the swelling in her abdomen was actually ascites⁵, not bloating. I told my supervisor about my concerns. (Participant O)

The boundaries around scope of practice in terms of diagnosis is acknowledged by Participant O. Homeopaths attempting to diagnose conditions beyond their clinical expertise are in breach of AROH's (2015) *Code of Professional Conduct* (p. 5). However, Participant O's nursing knowledge and experience led to the consideration of other possible causes of the client's symptoms and resulted in the supervisor of the student clinic being informed of Participant O's concerns. Together, Participant O and the supervisor worked upon a plan of action to encourage the client to engage with medical professionals, which Participant O achieved by talking to the client:

I said, "Look, we're more than happy to move forward with you, however we can't diagnose, it's not within our scope. I can't tell you if you've entered early menopause, but what can tell you is a blood test. Working with you going forward, we need to do it in a professional way that encompasses all medical professionals". I understood her pains and anxieties, but I said, "Medicine does have a lot of very relevant diagnostic tools that we can't use, and I would feel a lot more comfortable knowing that you've had the blood tests that need to be taken. If you could just go to a GP to have those done and then I could follow you up in a week. (Participant O)

Following the client up within the week allowed for verification that medical advice had been sought. In this case, the client followed the advice given by Participant O and was

⁵ Ascites is a build of excess fluid in the abdomen (Queensland Health, 2017).

subsequently diagnosed with ovarian cancer and underwent surgery. Participant O credits having a background in nursing as fundamental to making an assessment that resulted in the client being referred to a GP. The experience of participants suggests that the knowledge they had of the biomedical health care system enabled them to direct clients who had disengaged with biomedicine back into the health care system and receive the most appropriate treatment. Cases such as these highlight the value of nursing knowledge to participants when they practised as homeopaths, and indicates that having a solid grounding in biomedical sciences and extensive clinical experience is important for CAM practitioners as it provides a significant depth to these practitioners' clinical knowledge that ultimately impacts positively on their referral practices. However, given the status of CAM in the health care sector, gaining clinical exposure for CAM students equal to that of nursing students is difficult. One participant who had been head of homeopathy at an Australian CAM college for over a decade talked about discussions that had been held on how nursing experience could be used to increase the clinical exposure of student homeopaths, saying:

One of the things that was talked about for a little while was how awesome it would be if everybody who was studying homeopathy had to do the one-year nursing assistant training. I think they've discontinued that one-year assistant nurse training, but that's something we talked about, thinking that would really be the icing on the cake to make a homeopath a good practitioner. (Participant J)

Experience working in a nursing practice environment was seen by Participant J as a way of turning a homeopath into a 'good practitioner'. Other participants also felt that homeopaths would benefit from exposure to these types of clinical practice environments:

I was in this course at a college that only taught homeopathy and I remember saying to them [students], “Go to the hospital and get a job as a cleaner, a tea lady or something and you’ll be amazed what you learn.” They thought I was completely potty, but in the old days that’s what the med [medical] students used to do, they used to get jobs as nurses’ aides and care for patients and have a lot more insight into patient care. (Participant I)

What would be a wonderful situation is if there were homeopaths in the community being able to do rotations in a hospital setting, so they become familiar with the system. (Participant N)

Participant N suggests that homeopaths doing rotations in hospital settings would be beneficial to them as homeopathic practitioners. According to an archived enrolment guide for 2014, students undertaking a Bachelor of Naturopathy degree at Australia’s Southern Cross University (2013) were able to complete their required clinical hours in a student clinic as well as in local hospital settings (p. 1.2). However, a course search of Southern Cross University’s website indicates that the Bachelor of Naturopathy degree is no longer offered, and no other examples could be found of CAM students doing clinical placements in conventional health care settings. Participant N’s suggestion about homeopaths working in hospitals and Southern Cross University’s utilisation of local hospitals for clinical placements of naturopathic students can be viewed within the context of interprofessional education (IPE).

IPE is a learning approach whereby members of different professions learn with, about and from each other (National Center for Interprofessional Practice and Education, 2018; WHO, 2010, p. 7). According to the WHO (2010), IPE enables effective collaborative practice, which strengthens the health care system and results in improved health outcomes. (p. 10).

To date, CAM has largely been left out of the discussion on the IPE of the healthcare workforce, even though non-regulated and complementary health care workers are included in the WHO's (2010) definition of health worker in their *Framework for Action on IPE and Collaborative Practice* (p. 13). In the first study including CAM into an investigation of IPE, Netherwood and Derham (2014) explored the value of IPE with undergraduate students of nursing, midwifery and CAM. It was concluded by Netherwood and Derham (2014) that IPE challenged prejudices, increased students' awareness of each other's knowledge and skills and resulted in students becoming receptive to a more holistic approach to health care. Given consumer demand for CAM and its increasing use at the point of primary care (Grace et al., 2006; Wardle, Sibbritt, & Adams, 2014), including CAM in further IPE research is therefore warranted.

6.4 Summary

During the process of becoming a homeopath, participants' understanding of homeopathic principles and practices grew and their identity as health care professionals altered to include that of homeopath. Participants considered their respective nursing and homeopathic identities and practice to be complementary to each other, with one approach informing the other. Both nursing and homeopathy were seen by participants as both being grounded in holistic principles with similar aims of supporting the wellbeing of clients within a holistic framework. Explicit and tacit nursing knowledge was integrated into participants' homeopathic practices, suggesting that their nursing identity became salient in the homeopathic practice environment. Data from the study indicates that the nursing knowledge and experience held by participants had a positive influence on their homeopathic practice. Participants were able to communicate with their homeopathic clients about biomedical procedures and interventions and, where necessary, engage them with the appropriate biomedical practitioners or services. Therefore, the findings presented

in the chapter partially answer the second research question: ‘What influence, if any, does being a qualified nurse and a homeopath have on the respective nursing and homeopathic practice of these nurses?’

Chapter 7.

Intersecting Identities: Navigating Opposing Paradigms

... I'm probably more suited to the homeopathic philosophy and way of thinking. (Participant F)

7.1 Introduction

Chapter Six of the thesis presented the first aspect of the concept of intersecting identities; namely: sharing common ground. It explored the intersection of participants' respective nursing and homeopathic identities within the context of the homeopathic practice environment and suggested that participants' nursing identities became salient when they worked as homeopaths, which had a positive effect on their homeopathic practice. The aim of this chapter is to present the second aspect of the concept of intersecting identities; namely: navigating opposing paradigms. The chapter begins with a discussion of the concept of conflict within the context of homeopathic and biomedical philosophy and practice. This is followed by an exploration of the intersection of participants' respective nursing and homeopathic identities in the nursing practice environment. Discussion then examines cognitive dissonance in relation to the experience of participants and the extant literature. The chapter concludes with a synopsis of the key points outlined in the chapter. A visual representation of the concept, intersecting identities: navigating opposing paradigms, outlining the main categories that informed it is shown in Figure 16. Each of these categories and their properties provide the framework for discussion in the chapter.

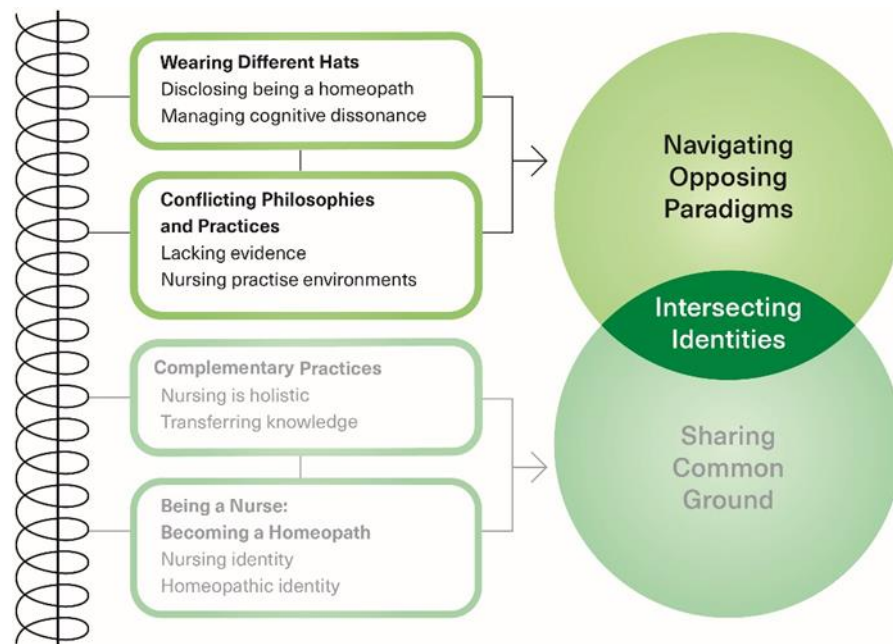


Figure 16. Concept of intersecting identities: navigating opposing paradigms, developed from this study.

7.2 Conflicting Philosophies and Practices

The data from this research suggested that the conflicting paradigms of biomedicine and homeopathy was a significant factor in the experience of participants in this study. In the literature the term ‘conflict’ has broad connotations. It can be used to denote a battle or war as well as disagreement, or an incompatibility of opinions, principles or interests (Barki & Hartwick, 2004; Coleman, 2003; B. T. Jones & Metzger, 2016; Tjosvold, 2006). Some commentators contend that conflict is often poorly defined by researchers, with studies defining it in terms of the context in which it occurs, the impact it has and how it is managed, thereby avoiding providing a concise definition of conflict itself (Hartwick & Barki, 2004; Tjosvold, 2006). In considering the concept of conflict within the context of this study, I decided that an incompatibility of ideas was the most apt description. Incompatible ideas are those that lack compatible elements, so they are therefore in conflict with each other (Wegman, 1985, p. 24).

Central to the conflict arising from the incompatible ideas of biomedicine and homeopathy are their conflicting philosophies and practices. As discussed in Chapters Five, *Connecting Philosophically*, and Six, *Intersecting Identities: Sharing Common Ground*, of the thesis the epistemological and ontological differences between biomedicine and homeopathy result in two very different approaches to health and wellbeing. Participants' comparisons of the homeopathic and biomedical approach highlight these differences. When participants discussed the homeopathic approach, they described it in the following ways:

It's [homeopathy] about minimal intervention, looking at general health, lifestyle issues, lifestyle choices, the importance of the mental emotional side of health. Hearing the story of the past and how it's affecting the present. (Participant G)

It's understanding that wholeness and health is much more than treating a particular disease or problem. You need to look at the person in the totality and you have to listen to what they are saying. (Participant N)

Participants' interpretations of homeopathic approaches are that they involves all aspects of an individual's life, including the story of their past. The subjective experience of the client is valued, and health is considered from a broader perspective than that of just a disease or problem. In contrast, when participants described the biomedical approach, they spoke about it as being based upon division and separation:

Within the medical field everything is divided up into different body systems. You know, you've got your cardio-thoracic wards. Everything is so separated. (Participant O)

With the number of specialists involved, its isolation approach medicine. You have the heart specialist, the kidney specialist, the bowel surgeon. Some people are going between five specialists, but no one looks at the whole picture. (Participant A)

The biomedical model is described by Participant A as an ‘isolation approach to medicine’ and participants use the example of medical specialties to support their argument that biomedicine reduces the human body into separate physiological parts, rather than considering the human organism as a whole. Although the large number of biomedical specialties (Medical Board of Australia, 2016) can arguably be viewed from a reductionist perspective, it should be acknowledged that reducing complex processes down to its smallest components has provided enormous understanding of the physiological mechanism of the different systems of the human body (Ahn, Tewari, Poon, & Phillips 2006; Beresford, 2010; Federoff & Gostlin, 2009; Power, 2017). Criticism of the biomedical approach typically rests on this physiological understanding not being applied within the context of the whole organism, thereby resulting in biomedicine being labelled as reductionist (Ahn et al., 2006; Beresford, 2010; Ma, Zhou, Fan, & Sun, 2016).

Coulter and Willis (2004) argue that the epistemology of biomedicine and complementary and alternative medicine (CAM) is incompatible or “logically inconsistent”, especially when one considers the epistemology of homeopathy (p. 587). The difficulties in reconciling the approaches of biomedicine and homeopathy was evident in the narratives of participants in this study as discussed in section 5.3.2 of the thesis. Several participants spoke about how it took them a relatively long period of time to reconcile those differences:

It took a good six months to grasp the whole [homeopathic] philosophy and paradigm fully. I struggled and struggled with it until finally I felt I really got it. I

thought I understood it in the beginning, but the more you go into it, you know it takes a lot of grappling to really feel you know it. (Participant G)

The [homeopathic] medicines, because they are so dilute how can they really work? I doubted it for a long time, even after I graduated and started in my clinic I doubted, but over the years I've seen results and I don't have any doubts anymore. I know they work, but we can't prove how they work. (Participant E)

Even after starting in homeopathic practice Participant E had doubts about the plausibility of homeopathy, due to the high dilutions of the homeopathic remedies. Section 2.3.2 of Chapter Two of the thesis, *Contextualising CAM and Homeopathy*, outlined how homeopathic remedies are prepared in a process that involves a process of serial dilutions. Some homeopathic remedies have been diluted hundreds of times, while others remain closer to the original starting material used to prepare the remedy (Grimes, 2012; Udhayam Homoeo Pharmacy, 2014). The high dilutions of homeopathic remedies are a primary factor in the scepticism surrounding homeopathy, due to a lack of scientifically plausible evidence demonstrating the mechanism of action of homeopathic remedies (Kaur, 2013; NHMRC, 2015; House of Commons, 2010). Scientific validation of health care interventions and practices has become a dominant factor within health care, as evidenced by the rise of evidence-based medicine (EBM) and evidence-based practice (EBP), hereafter referred to as EBP, unless in a direct quote. The issue of evidence is a significant factor in the conflict between biomedicine and homeopathy and during data analysis was labelled as 'lacking an evidence base'.

7.2.1 Lacking an evidence base

An evidence-based approach to health care has become firmly entrenched in the landscape of modern health care practices (Duggal & Menkes, 2011; A. Hunter & Grant, 2005;

Lehane et al., 2019; Petr & Walter, 2009). Participants in this study related the evidence-based movement to the scepticism surrounding homeopathy and questioned the motives of those opposing homeopathy on the basis that it lacked evidence:

There's a lot of scepticism about homeopathy. Mainly due to what they call evidence-based medicine. (Participant E)

The whole anti homeopathy thing is completely unexamined, it's off the cuff. It's just repeating what's been said before. Nobody can say the material, or the literature isn't there. The anti-homeopathy forces don't give a toss about what evidence is there, that's not their agenda. (Participant I)

Participant I challenges the perception that homeopathy lacks evidence, arguing that sufficient literature is available in support of homeopathy. Participant I also implies that critics of homeopathy have an ulterior motive for criticising homeopathy on the basis of a lack of evidence to support its clinical use. In considering the points made by participants, it is necessary to consider the notion of evidence within the context of EBP. The underlying premise of EBP is that clinical decisions should be made upon the best available current evidence (Lavender & Richens, 2015; Leach & Gillham, 2011; Sackett et al., 1996). An EBP approach to clinical decision making is promoted as a way of moving forward from clinical decisions based upon unsubstantiated clinical experience and of scientifically unproven practices (Sackett et al., 1996; C. M. Lee & Hunsley, 2015; Sheridan & Julian, 2016).

When discussing evidence in relation to interventions used in health care it is important to note the difference between the term's, 'efficacy' and 'effectiveness'. The term efficacy relates to the positive outcomes from an intervention tested in ideal or controlled conditions such as a drug trial (S. Y. Kim, 2013; Revicki & Frank, 1999; Porzsolt et al., 2015; Singal,

Higgins, & Waljee, 2014). The term effectiveness is used in relation to the outcomes from interventions tested in less controlled settings (Revicki & Frank, 1999; Porzsolt et al., 2015; Singal et al., 2014) which are sometimes referred to as “real-world conditions” (Porzsolt et al., 2015, p. 48; Revicki & Frank, 1999, p. 424). Although the evidence-based approach to health care is dominated by the biomedical model, it has also been embraced by other sectors of health care including nursing (Holland & Rees, 2010; Melnyk & Fineout-Overholt, 2005; Vogel, 2015).

The premise of EBP originally included the integration of clinical experience with clinical evidence from research (Sackett et al., 1996). However, certain types of evidence such as randomised controlled trials (RCTs) have been privileged over other types of evidence (Barry, 2006; Dijkers, Murphy, & Krellman, 2012; Fisher & Happell, 2009; Kemm, 2006; Shah & Chung, 2009; McMaster, 2008). Figure 17 provides a visual representation of the evidence pyramid utilised by the Australian Therapeutic Goods Association (TGA).



Figure 17. Evidence pyramid. Adapted from “Hierarchy of Evidence Sources”, by Therapeutic Goods Administration (TGA), 2019 (<https://www.tga.gov.au>). In public domain.

The higher up the pyramid a level of evidence sits, the more validity it has in terms of quality (TGA, 2019). Therefore, observational studies and expert opinion are relegated to a subordinate position in the evidence hierarchy, while RCTs are considered the gold standard of clinical research (Bondemark & Ruff, 2015; Bothwell, Greene, Podolsky, & Jones, 2016; Kemm, 2006; Sullivan, 2011; Upshur, 2005). RCTs are a method of scientific enquiry where individuals are randomly assigned to two groups, one of which receives the intervention being tested while the other group receives an alternative intervention or placebo (Kendall, 2003; Porter & O'Halloran, 2012). Analysis involves comparison of the outcome from the two groups to determine efficacy and, or effectiveness (Kendall, 2003; Porter & O'Halloran, 2012; Porzsolt et al., 2015). Although RCTs are a valuable scientific method of enquiry concerns have been raised over the emphasis placed upon them. Some commentators note that the privileging of RCTs can jeopardise other expert clinical knowledge utilised in clinical decision making, regardless of positive client health outcomes, that might be yet unresearched (Kemm, 2006; Thorgaard, 2014; Upshur, 2005).

Other commentators argue that RCTs fail to consider the complexities of health care practices that involve multifaceted and individualised approaches (Barry, 2006; Bothwell et al., 2016; Pearson, 2010; Walach, Falkenberg, Fønnebø, Lewith, & Jonas 2006). For instance, Barry (2006), suggests that RCT trials of homeopathy reduce the complex and individualised approach underpinning homeopathic prescribing that normally occurs in a clinical situation (p. 2647). Two people presenting with the same health condition could be prescribed two completely different homeopathic remedies (Barry, 2006, p. 2649). Although these individuals share a diagnosis, the symptomatic presentation of their complaint, their response to it and their personality traits could be totally different (Barry, 2006). Therefore, it is argued that the reductionist nature of RCTs fails to allow for the type of individualised prescribing common to homeopathy, or to acknowledge the importance

of the context in which an intervention takes place (Barry, 2006; Duggal & Menkes, 2011; Miles, 2009).

As discussed in Chapter Five of the thesis, *Connecting Philosophically*, there is more to the practice of homeopathy than the act of giving a homeopathic remedy. The consultation process itself can be therapeutic and needs to be considered as a factor in any analysis of outcomes (Brien, Lahance, & Lewith, 2004; Prousky, 2018). Despite the fact that some commentators reject RCTs as an appropriate method of assessing homeopathy, several researchers have used RCTs to assess the efficacy of homeopathy (Ernst, 2011; Faculty of Homeopathy, 2016; Mathie et al., 2018). A review of RCTs of homeopathic treatment from 1950 to 2014 identified that most of these studies involved non-individualised homeopathic treatment (Faculty of Homeopathy, 2016). It is arguable that the conclusions made from RCTs on non-individualised homeopathic treatments are potentially misleading as they are not representative of the individualised prescribing typical of homeopathic practice.

Concerns about the limitations of EBP using RCTs as best practice, extend beyond that of the CAM community to other areas of health care including public health and nursing (Baumann, 2010; Kemm, 2006; Fisher & Happell, 2009; Sheridan & Julian, 2016). According to Sheridan and Julian (2016), an “evidence vacuum” has been created due to the over reliance on results from clinical trial and systematic reviews that are not necessarily always reliable or applicable to all individuals (p. 204). In the case of recovery-oriented mental health nursing, Fisher and Happell (2009) argue that EBP is inconsistent with the consumer ideals underpinning the recovery model, due to its focus on scientific validation over subjective and clinical experience. Baumann (2010) argues that nurses should use a framework of practice that respects the complexity and rights of each individual, utilising knowledge from a variety of sources to guide practice.

A pluralistic approach to EBP that combines quantitative methods of enquiry such as RCTs, with qualitative methods are one way of reducing the tensions between EBP and complex health care practices such as mental health nursing and CAM (ANPA, 2013, pp. 6–7; Barry, 2006; Fisher & Happell, 2009; Fønnebø et al., 2007; Verhoef & Vanderheyden, 2007). A revised model of EBP proposed by Duggal and Menkes (2011) shown at Figure 18, combines research evidence with practice-based evidence without privileging one type of evidence over another. In addition, Duggal and Menkes’ (2011) revised model of EBP includes the preference of the individual, which in an era of person-centred care is a vital component of any practice approach.

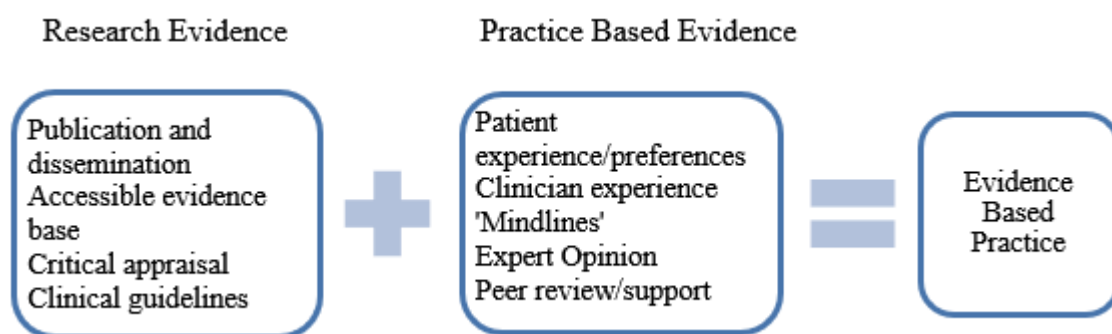


Figure 18. A revised model of evidence based practice. Adapted from “Evidence-based Medicine in Practice” by Duggal and Menkes, 2011, *International Journal of Clinical Practice*, 65, p. 643. In public domain.

Despite the limitations of EBP discussed in this chapter, there are commentators who reject the argument that RCTs are unsuitable for assessing the effectiveness of complex health care practices, such as homeopathy (Ernst, 2003; Hansen & Kappel, 2010). Rather, Hansen and Kappel (2010) argue that RCTs are the only objective way to determine clinical effectiveness of an intervention. Notably, a number of widely used biomedical interventions lack conclusive scientific evidence to support their clinical use, yet they are still utilised by the medical profession (Frank, 2002; Goldacre, 2012; Patashnik, Gerber, &

Dowling, 2017). Therefore, the motives behind the push for CAM practices to be assessed within the current framework of EBP have been questioned by some commentators who suggest that the ideals of EBP can be utilised to co-opt or oppress CAM, thereby maintaining biomedical dominance (Barry, 2006; White & Willis, 2004).

The ideals of EBP can also be used to influence policies that impact CAM service providers and consumers, such as the recent Australian Government review of health insurance rebates for CAM practices (Department of Health, 2019e). The purpose of the Australian Government's review of health insurance rebates for CAM practices was to identify CAM practices considered to lack credible evidence supporting their "clinical efficacy, cost effectiveness and safety and quality" (Baggoley, 2015, p. 3). CAM practices in Australia that have been found to be lacking credible evidence have had their eligibility for private health insurance rebates withdrawn (Department of Health, 2019e). The Australian Government's review of CAM was informed by reports from Australia's NHMRC (Baggoley, 2015). In the case of homeopathy, the NHMRC's (2015) report, concluded that there was no reliable evidence supporting the effectiveness of homeopathy for any of the health conditions considered (p. 6).

Publication of the NHMRC's (2015) findings drew considerable criticism from proponents of homeopathy who allege that the NHMRC's (2015) review was biased and methodologically flawed (Complementary Medicines Australia [CMA], Australian Homoeopathic Association [AHA] & Australian Traditional Medicine Society [ATMS], 2016; Homeopathyresearch, 2017). A complaint was subsequently lodged with the Commonwealth Ombudsman over the way the NHMRC (2015) review of homeopathy was conducted (CMA, AHA, & ATMS, 2016). For a full analysis of the alleged flaws of the

NHMRC (2015) review see Homeopathyresearch (2017). At the time of writing no outcome from the complaint to the Commonwealth Ombudsman was known.

It is against this backdrop of epistemological and ontological differences and ongoing conflict between biomedicine and homeopathy that participants in this study navigated being nurses and homeopaths. These differences and the conflict related to them had particular relevance for participants when they were nursing in health care settings dominated by the biomedical model. However, before discussing the intersection of participants respective nursing and homeopathic identities in the nursing practice environment, it is first necessary to explain what is meant by the term ‘nursing practice environment’.

7.2.2 Nursing practice environment

The term nursing practice environment is used in this chapter to describe the organisational structure in which nursing practice occurs and includes the factors that enable or limit nursing practice (Sleutel, 2000; Lake, 2002; Lake & Friese, 2006). Nurses practice within a variety of organisational settings that include, but are not exclusive to, schools, hospitals, prisons and community health facilities (Australian Primary Health Care Nurses Association [APNA], 2017a, 2017b; Peters, McInnes, & Halcomb, 2015). Therefore, the environments they work within can vary markedly. For example, the primary health care sector in Australia has considerable diversity in the size and types of services that are provided (AIHW, 2016b). The diversity of the clinical settings and services provided by nurses was evident in this study by the various practice environments participants had nursed within:

I was charge sister in a very large cardio thoracic ward when I was 25.

My background was always in cardio thoracic and intensive care. (Participant C)

I've worked for many, many years in mental health. I've done general [nursing].

(Participant K)

In addition to their general nursing, participants had moved into different areas of nursing practice or specialised in certain areas. The diversity of nursing practice environment makes it difficult to make absolute statements about them. However, participants in this study had primarily nursed in primary health care settings that were underpinned by the biomedical model of health care. In biomedically dominated practice environments the boundaries of authority and legitimacy are firmly aligned with biomedical principles and CAM practices such as homeopathy are not generally welcomed or accepted (Salmonsén & Ahlzén, 2018; Shuval & Gross, 2008; Shuval, 2006). Consequently, participants experienced tensions between the two approaches to care and treatment and often spoke about their nursing practice in terms of limitations and restrictions:

In psychiatric nursing pretty much what you do that has value is about the relationship you have with patients, and that is limited to a certain extent by the nature of the environment, which is essentially biomedical. (Participant B)

The government facility where I work it's about how you do things and what you should do, whereas you work as a homeopath you can help people in a way that works for them without any restriction around how that's done ... it feels freer as a homeopath because I feel that I can speak my truth. (Participant D)

Participants talk about feeling their nursing practise was restricted and of relationships with clients being limited by the nature of the nursing practice environment. As discussed in section 2.4 of the thesis, there are numerous constraints when working as a health care professional in the public health care system. Constraints, such as a lack of resourcing can result in excessive workloads, thereby limiting the time that health care professionals have

to build relationships with clients (Berger, et al., 2012; Dixit & Sambasivan, 2018). CAM can provide nurses with an opportunity to engage with a holistic approach, which can be missing among the task-oriented routine of nursing practice (J. G. Anderson et al., 2016; Cant et al., 2012). It was also noted that when participants spoke about their respective nursing and homeopathic practices, they often used the term ‘wearing different hats.’ The meanings behind participants’ use of this turn of phrase will now be explored.

7.3 Wearing Different Hats

During data analysis ‘wearing different hats’ became an in vivo code to represent the compartmentalising of participants’ respective nursing and homeopathic identities. Participants spoke about each respective practice area having its own hat and of compartmentalising their respective nursing and homeopathic identities and practice, depending on the practice environment they were working within. However, as discussed in Chapter Six, *Intersecting Identities: Sharing Common Ground*, the data suggests that in the homeopathic practice environment participants integrated their nursing knowledge into their homeopathic practice without constraint. Essentially, their nursing identity appeared to be readily expressed when they worked as homeopaths. In contrast, it was noted that in the nursing practice environment they appeared to compartmentalise their homeopathic identity and try and separate it from their nursing practice:

When I’m nursing, I don’t wear that hat [homeopath/naturopath]. I compartmentalise. The hospitals or the patients don’t understand the different roles, so I try not to merge them. (Participant H)

I’ve always been very professional. You are being employed as a nurse. You can’t put your homeopathic hat on. (Participant A)

Participant A associates compartmentalising nursing and homeopathy with behaving professionally which can be considered within the context of boundary negotiation (Shuval, 2006, p. 1785). The term boundary is used in this discussion within the context of Lamont and Molnar's (2002) description of boundaries as "markers of difference which make for separation and exclusion" (pp. 180–181). According to Shuval (2006), nurses who are CAM practitioners have several "critical" boundaries to negotiate when nursing in biomedically dominated health care settings (p. 1786). These boundaries relate to the medical and nursing professions as well as nursing practice environments and include boundaries of authority, territory and epistemology (Hirschhorn & Bourgeault, 2008; Shuval, 2006, p. 1786). For instance, nurses are bound by professional nursing standards and the organisational and authoritative constraints associated with nursing practice environments (Nursing and Midwifery Board of Australia, 2018; Shuval, 2006). In addition, there are substantial differences in the epistemological legitimacy of homeopathy and biomedicine (Hirschhorn & Bourgeault, 2008; Salmonsén & Ahlén, 2018; Shuval, 2006; Teixeira, 2011). The data indicated that the most common way that participants navigated boundary constraints was through compartmentalising their respective nursing and homeopathic identities and practice.

Interestingly, although participants talked about wearing different hats and of not wearing their homeopathic hat when nursing, the compartmentalisation of their homeopathic identity and practice had contextual variances which will now be explored, beginning with the disclosure of being a homeopath.

7.3.1 Disclosing being a homeopath

In conversation about their homeopathic identity in relation to their nursing practice, participants spoke about their disclosure of being a homeopath. They talked about how as

homeopaths they are ‘outside the box’ and how being an outsider can result in negative responses, once their identity as a homeopath is known by others. Those negative responses were most often spoken about in relation to members of the medical profession:

You’re outside the box when you practise homeopathy, because most of the medical side ridicule us. I think you have to have a fairly strong sense of your own self to practise something that really is so diminished. (Participant K)

I ran into a doctor I knew socially, he said, “I didn’t know you had returned from England, what are you doing now? I said, “I’ve evolved into a homeopath”. He just went cold and said, “dissolved”, and walked away. (Participant A)

Being ridiculed and having their homeopathic identity dismissed as something less than what they were before becoming homeopaths was an experience most participants appeared to be familiar with. These types of negative responses to the topic of homeopathy are not uncommon (Bennett, 2018; Pray, 2010; Smith, 2012a). Therefore, homeopathy can arguably be considered within the context of a stigmatised identity. In *Stigma: Notes on the Management of a Spoiled Identity*, Goffman (1963) characterised stigma as reducing those who are stigmatised to a tainted and discounted person (p. 12). Goffman calls people without stigma, ‘normals’ and asserts that normals discredit those who are stigmatised, treating them as if they are not human (p. 15). Therefore, stigmatised identities are those that are perceived negatively by others, resulting in them becoming socially devalued. (Crocker, Major, & Steele, 1998; Goffman, 1963; Quinn & Earnshaw, 2013). For instance, stigma is evident in relation to individuals with mental health disorders who are marginalised in society due to their health condition (Bradshaw & Moxham, 2005; Charles & Bentley, 2016). In addition to stigma relating to one’s personal identity, certain groups,

occupations and professions can also be stigmatised (Ashforth, Kreiner, Clark, & Fugate, 2007; Ashforth & Kreiner, 2014; Butler, Chillias, & Muhr, 2012; Kamise, 2013).

Stigmatised occupations and professions have been characterised as “dirty work” (Ashforth et al., 2007, p. 151; Ashforth & Kreiner, 2014, p. 82). According to Hughes (1958, as cited in Ashforth & Kreiner, 2014), work considered to be dirty is perceived by others as “distasteful”, “demeaning” or “immoral” (p. 82). The stigma attached to this type of work can be categorised as a physical, social or moral taint (Hughes, 1958, as cited in Ashforth & Kreiner, 2014, p. 82; Valtorta, Baldissarri, Andrighetto, & Volpato, 2019, p. 1). Occupations associated with a physical taint, include that of garbage collectors and funeral workers, as they deal with products of waste and death (Ashforth et al., 2007, p. 151; Ashcroft & Kreiner, 2014, p. 84). Socially tainted occupations typically include those where an individual has a relationship where they are subordinate to others or deals with individuals or groups that are stigmatised such as maids, psychiatrists and mental health nurses. (Ashforth et al., 2007, p. 151; Ashcroft & Kreiner, 2014, p. 84; Valtorta et al., 2019, p. 1). Lastly, morally tainted occupations relate to those whose character is questionable (Ashforth et al., 2007, p. 151; Ashcroft & Kreiner, 2014, p. 84; Valtorta et al., 2019, p. 1). These occupations are generally considered to be sinful or deceptive (Ashforth et al., 2007; Ashcroft & Kreiner, 2014; Valtorta et al., 2019). For instance, people who sell used cars are often depicted as masters of deception, whilst sex work is commonly portrayed as sinful and has endured centuries of objection based upon this premise (Ashforth et al., 2007; Weitzer 2009, p. 89).

Given the portrait of morally tainted occupations, homeopathy can arguably be considered within this context. Negative discourse surrounding homeopathy frequently portrays homeopathy as an unethical, immoral and fraudulent practice (Ernst, 2009; Knapton, 2018;

Smith, 2012a). It was reported by Knapton (2018) that some critics have described homeopathy as “witchcraft” (para. 24) and even compared CAM to the pornographic and tobacco industries, suggesting that CAM is as “controversial and morally tainted” as these industries are often perceived to be (para. 8). These kinds of descriptive terms are loaded with moral implications, thereby placing a moral taint upon homeopathy and by extension those who work in the homeopathic industry. Such representations of homeopathy are indicative of Goffman’s (1963) assertion that beliefs are constructed around stigma that can be used to dehumanise individuals and present them as a danger (p. 15). Central to the notion that homeopathy is a potentially dangerous and unethical practice is the concept of EBP (Shaw, 2010; Smith, 2012a; Zawila-Niedzwiecki & Olender, 2016), which as discussed in Section 7.2.1 of this chapter, is used to discredit homeopathy.

Given that being a member of a stigmatised occupation can result in condemnation from others, some members of the homeopathic community may understandably choose to not disclose their line of employment to certain individuals (Benjamin, Bernstein, & Motzafi-Haller, 2010). However, despite the negative perception of homeopathy and the potential for conflict in disclosing being a homeopath, only one participant in this study expressed reluctance in revealing their homeopathic identity to colleagues in the nursing practice environment:

I think it probably would have been hard [to divulge being a homeopathic practitioner] if I'd been in A&E [accident and emergency] or critical care but being in oncology I found the nurses there were very open. Having said that, I certainly didn't announce it to all the oncologists, they found out through other nursing staff. We had oncologists on the ward that would laugh if they found out a patient was trying to meditate. (Participant O)

Fellow oncology nurses were described by Participant O as being ‘open’ and they were perceived to be less likely to respond negatively to Participant O’s status as a homeopath than the oncologists that also worked alongside Participant O. Therefore, a strategy of selective disclosure was used by Participant O whereby only select colleagues were directly told of Participant O’s identity as a homeopath. The selective disclosure of information is commonly associated with the withholding of certain information for personal gain or to boost one’s legitimacy (Marquis, Toffel, & Zhou, 2016; Nelson, Gallery, & Percy, 2010). However, in the case of Participant O, there was no personal gain or legitimacy to be had in withholding information about being a homeopath. Rather, Participant O’s strategy of selective disclosure minimised the risk of potential conflict with colleagues who it was thought might respond negatively towards homeopathy.

Research indicates that in certain situations selective disclosure has been shown to lessen negative responses (Bos, Kanner, Muris, Janssen, & Mayer, 2009). Participant O’s decision to selectively disclose her homeopathic identity to fellow oncology nurses, due to them being more ‘open’, is supported by research that suggests that oncology nurses generally have a positive attitude towards CAM (Hann et al., 2004; Hassan et al., 2014; Rojas-Cooley & Grant, 2009). Participant O also expressed thinking that it would be difficult to disclose being a homeopath if one were employed in certain areas of nursing. However, other participants in this study who worked in a variety of nursing practice environments expressed no reservations about informing their colleagues of their identity as a homeopath:

I always make everyone know in a very short space of time I’m a homeopath and I don’t know why, because once I’ve put it out there, I’m comfortable to let that go.
(Participant E)

My workplace knows I'm a homeopath, so there's open disclosure that I have a second profession. (Participant L)

Although open disclosure of their homeopathic identity to colleagues was common for the majority of participants, disclosure of their homeopathic identity to nursing clients was more complex. Some participants had no problem with letting clients know that in addition to nursing, they worked as homeopaths:

If people ask what I do I usually explain naturopathy, then homeopathy and then we go from there, but that's usually about it. (Participant H)

Patients will always tend to ask how I am, what I've been doing, and I'll always bring up the fact that I'm also a homeopath and I do other things. (Participant F)

Participant F talks about always letting clients know about being a homeopath if the opportunity presents itself. Other participants were more reluctant to enter into these types of discussion. These participants said they would never initiate a discussion with clients about their homeopathic identity:

If somebody would say to me, because I'm well known here, "You're a homeopath as well aren't you?" I would say, "Yes I am". I would never say, "I'm a homeopath." (Participant C)

I never brought up my natural medicine, but other nurses did. So, other nurses would often tell clients. (Participant O)

These participants never personally brought up the fact they were homeopaths when talking with clients. However, sometimes their colleagues informed clients, or their identity as a homeopath was known in the community. These participants would then be placed in the

situation of having to navigate client's enquiries and interest in their homeopathic practice. The disclosure of the information that participants were homeopaths was identified as having two key factors related to it. During data analysis these factors were labelled 'providing advice' and 'integrating homeopathy into nursing practice.' Each of these factors will be explored in turn.

7.3.1.1 Providing advice

Nurses are trusted health care professionals who provide advice to clients on a variety of matters including CAM (Brenan, 2017; Buchan et al., 2012; Milton, 2018; Sibiya et al., 2017). Some studies have indicated that nurses who utilise CAM personally or hold CAM specific knowledge are more likely to recommend CAM to their clients than nurses with no personal experience of CAM (Xue et al., 2008; Spencer et al., 2016). However, the way that participants in this study dealt with nursing clients' interest in homeopathy varied. Some participants were very cautious about providing any advice, while others would recommend homeopathic remedies. Participants who were cautious tried to establish a boundary between their respective nursing and homeopathic practices:

If people asked, I would give bits of information [on homeopathy], but never from a medical perspective and I made it very clear that I'm working within the medical realm at the moment and it's not permitted for me to endorse other practices.
(Participant O)

I see people in the hospital that are really stuck. The medicines clearly aren't working, and I know there's another approach, but because there's a conflict of interest I can't say anything. (Participant E)

These participants spoke about 'not being able to endorse other practices' and of there being a 'conflict of interest'. The Nursing and Midwifery Board of Australia (2018a) describes a

conflict of interest as occurring when the financial, professional, personal interests, relationships or beliefs of a nurse affects the provision of nursing care, or results in personal gain (p. 13). When participants in this study are employed as nurses, they work under the jurisdiction of the nursing profession and their employer. However, participants also worked privately as self-employed homeopaths. Therefore, the interests involved are that of their employer and working within the scope of approved nursing practice according to nursing registration requirements, and their own interests as homeopaths. Given the intersection of interests it is important for participants to ensure that no conflict of interest occurs. Several participants had no reservations about discussing homeopathy and/or other CAM practices with nursing clients:

I often ask, if there's a particular problem, "have you thought of alternatives?"

Most of them haven't, so I then explain that there are lots of alternatives [to biomedicine] out there. I explain naturopathy and homeopathy. (Participant D)

Sometimes I will say [to nursing clients], "go to the health store there's these little pill things called Arnica that might help that post-operative bruise. So, I gently encourage, but I certainly don't breach any code of ethics or anything. (Participant A)

These participants willingly provided advice to clients and Participant A talked about gently encouraging clients to try homeopathy as a therapeutic intervention. It is Participant A's belief that in making these suggestions no professional codes of conduct are breached. In addition to providing advice to clients in the nursing practice environment, participants in this study also talked about referring nursing clients to other CAM practitioners. Participants were very clear in stating that they never referred these clients to themselves.

Rather, they referred them to other CAM practitioners in the same way that they would refer to any other health care professional:

Not that I made a point of talking about homeopathy, but when it did come up, I spoke to some patients. If they were interested, I would just refer them to homeopaths that they could go to and discuss that particular problem with.

(Participant N)

I don't refer to myself and I don't only particularly refer to a homeopath. I refer as I would to any other health professional like physiotherapists or speech therapists.

(Participant D)

In referring clients to other CAM practitioners, participants provided a pathway for clients to seek CAM without creating a conflict of interest, as they received no financial or personal gain. Interestingly, many of the participants who suggested homeopathy to clients or referred them to other homeopaths had previously spoken about how they never wore their homeopathic hat when working as a nurse. However, suggesting homeopathic remedies to clients in the nursing practice environment, or advising them to seek homeopathic treatment, can arguably be viewed as an enactment of participants' homeopathic identities. Homeopathy is not a standard feature of nursing or biomedical practice and would not normally be suggested within the context of nursing care.

According to Caza & Creary (2016) even though individuals with multiple professional identities may try to compartmentalise them, these identities can become “co-activated”, resulting in multiple identities being utilised alongside each other (p. 278). Participants' inclusion of recommendations for homeopathic remedies and/or referrals to homeopathic practitioners could therefore be considered within the context of a co-activation of their homeopathic and nursing identities. Another example of participants' homeopathic

identities becoming salient in the nursing practice environment relates to the second factor identified as being connected to participants' disclosures of being a homeopath; namely: the integration of homeopathy into their nursing practice, which will now be explored.

7.3.1.2 Integrating homeopathy into nursing practice

Participants in this study believed that nurses were well placed to prescribe homeopathy in certain circumstances. They expressed feeling that Australia should emulate the way that other countries have integrated homeopathy in their health care systems, stating that:

We know in India and South America they use Aconite and Arnica all over the place in emergency departments. We should be doing that here too and the more people who can do some research about it the better. (Participant J)

To me nurses are ideally positioned to prescribe first aid homeopathy routinely, if they were properly trained. (Participant A)

From Participant A's perspective, nurses educated in homeopathic first aid are well positioned to facilitate the integration of homeopathy into nursing practice. However, other participants who had tried to gain approval to utilise homeopathy in their nursing practice spoke about the difficulties they had faced:

I don't know if you've had experience with it, but trying to bring in any sort of complementary therapies into a mainstream medical centre, especially a public run hospital, is extremely hard ... I find the biggest block is homeopathy, they're almost more willing to accept acupuncture, naturopathy and things like that. (Participant F)

I was very hopeful of being able to officially use homeopathy at one stage but then conservative elements creep into organisations and conservative people vote in

those organisations. Medical people are involved and really it's too big to be able to change. (Participant G)

These participants talk about trying to integrate homeopathy into public hospitals as being extremely hard and of the barriers as being too big to change. However, several participants did recall a time during the early years of their nursing career when they were able to integrate CAM into their professional practice, explaining:

One of my first areas of work as a nurse was oncology. The [nurse] in charge was very open to other ways of supporting patients and I thought that was really insightful. You know, like doing some reflexology points, or using aromatherapy. I used aromatherapy a lot when I was a student nurse. (Participant L)

When I was doing geriatrics I remember the doctor there, he used to send me some clients. He always sent his mothers with mastitis, never gave them antibiotics. In the nursing home he'd say "Have you got something that could help her?" There were a couple of cases of shingles and I brought in a few remedies and they helped. It was such a good feeling and I thought "Oh imagine if this was a possibility."
(Participant K)

Although Participant K spoke about utilising homeopathy, the majority of participants in this study utilised mind-body therapies, such as those utilised by Participant L, in their professional nursing practice rather than homeopathy. This finding reflects those of previous research, which indicates that mind-body therapies are the CAM practices most utilised in nurses' professional practice (J. G. Anderson et al., 2016; Buchan et al., 2012; Shorofi & Arbon, 2010, 2017). One participant in this study also talked about teaching an introduction to homeopathy as an elective to nurses at an Australian university:

After many meetings we had an introduction to homeopathy as an elective in a Masters degree, so we taught one subject in a nursing program which was fantastic. It was well attended. I think there were 40 nurses who enrolled. (Participant J)

Participants' experiences of including CAM in nursing education and in their professional practice occurred primarily during the 1990s and 2000s. There are similarities in the experience of participants in this study with Gowing and Gales's (2019) analysis of CAM use in nursing practice and education in the United Kingdom during the 1980s and 1990s. According to Gowing and Gale (2019), CAM influenced and shaped nursing practice in the United Kingdom (UK) during this period of time by increasing awareness of a holistic approach to nursing practice. Ring to nurses' interest in CAM, nursing organisations supported and facilitated CAM education for nurses (Gowing & Gale, 2019).

Gowing and Gale (2019) note that although there was an explosion of interest in utilising CAM in nursing practice in the UK in the 1980 and 1990s, this waned in the 21st century. It is suggested by Gowing and Gale (2019) that the decline in interest in CAM was due to political and financial factors that limited the use of "non-essential forms of care" and that the concept of holistic care had been co-opted by the medical community, resulting in an increased focus on person centered care (p. 228). Gowing and Gale (2019) posit that the greater emphasis on person centered approaches to nursing care may have resulted in less interest in CAM as the values attached to these approaches were mainstreamed (p. 228). However, it is suggested by Cant et al. (2012) that CAM services in the NHS were always marginal and their decline can be linked to changes in clinical governance, fiscal constraints and biomedical dominance (p. 137).

Interestingly, few participants in this study spoke about utilising any form of CAM in their contemporary nursing practice. Though one participant did mention a workplace policy that prohibited staff from using CAM, stating that:

One of our workers was doing an aromatherapy course and she was looking up the policy and the policy has changed into something draconian about us not being able to do any natural therapies at all. (Participant G)

The workplace policy mentioned by Participant G is an example of a territorial boundary, which defines the boundaries of practice (Shuval, 2006). In this instance, the employing facility has issued a directive that health care professionals in their employment are not to utilise CAM. The boundaries of practice have been clearly outlined. However, not all employers have position statements on the professional use of CAM, as noted by one participant who stated:

It [employing facility], doesn't have a position statement on complementary therapies. (Participant L)

Given that not all employers have position statements on the use of CAM, a search was conducted for policies and statements from Australian nursing and midwifery bodies in relation to CAM. In personal correspondence with the policy manager for the Australian College of Nursing (June 15, 2015), I was informed there were no plans to produce a position statement on CAM. An assessor for the Australian Nursing and Midwifery Accreditation Council (June 15, 2015) and a national customer service representative from AHPRA (June 17, 2015) also advised via personal correspondence that they too have no position statements on CAM.

A search of the websites of the Australian Nursing and Midwifery Federation (2014) and the Australian College of Midwives (2019) failed to find any position statements on CAM, and emails sent to them asking about their position on CAM remain unanswered. Further internet searches found that the only state, territory or national Australian nursing organisation with a readily accessible and current position statement on CAM was the New South Wales Nurses and Midwives Association, (2018). The position of the New South Wales Nurses and Midwives Association (2018) is that “individuals have the right, wherever possible, to the health care of their choice” (p. 2). The New South Wales Nurses and Midwives Association (2018) further state that the criteria for nurses and midwives to assess the appropriateness of utilising CAM in their professional practice are that they have adequate knowledge of the CAM therapy being utilised, there be contemporary evidence to support its use, that its use be endorsed in writing from the employing facility, that other health practitioners involved in the treatment of the individual be informed of the use of CAM and its use be documented (pp. 2–3).

The lack of position statements with guidelines on CAM from other state, territory and national Australian nursing and midwifery bodies is puzzling given the increasing demand for and utilisation of CAM among Australians (CMA, 2018; Reid et al., 2016; von Conrady & Bonney, 2017). Official bodies representing other sectors of health care in Australia, such as medicine (Australian Medical Association, 2018), pharmacy (Pharmaceutical Society of Australia, 2018) and oncology (Clinical Oncology Society of Australia, 2013) have all produced position statements, or recommendations, relating to CAM, in response to the growing utilisation of CAM among health care consumers. The only guidelines able to be found from the Nursing and Midwifery Board of Australia that could be interpreted within the context of CAM was the *Nursing Practice Decision Flowchart*, which highlights that nurses should ask themselves if the activity they are bringing into their nursing practice

complies with professional standards and is supported by evidence (Nursing and Midwifery Board of Australia, 2013). In addition, the Nursing and Midwifery Board of Australia's (2018a) *Code of Conduct for Nurses*, states that nurses provide EBP (p. 5). However, this document fails to define EBP within the context of nursing practice.

A definition of EBP can be found in the Nursing and Midwifery Board of Australia's (2016b) *Registered Nurses Standards for Practice*, which defines EBP as "accessing and making judgements to translate the best available evidence, which includes the most current, valid and available research findings into practice" (p. 6). The Nursing and Midwifery Board of Australia's (2016b) definition of EBP is arguably ambiguous, as it fails to define what constitutes 'valid' research findings within the context of nursing practice. For example, the Australian Medical Association's (2018) position statement on CAM states that "evidence based scientific research in the form of randomised controlled trials is required to validate CAM" (para. 2.2). Regardless of whether one agrees with the Australian Medical Association's (2018) stance of situating RCT's as the only source of valid evidence, their position is not ambiguous. The boundary between the professional practice of medical practitioners and CAM has been clearly established by the Australian Medical Association's (2018) position statement.

Although participants in this study never gave homeopathic remedies to clients within the bounds of their nursing practice or provided unsolicited advice on homeopathy, they did draw upon their homeopathic knowledge in other ways. There was a consensus among participants that their homeopathic knowledge was beneficial to their nursing practice, which will now be considered

7.3.1.2.1 Homeopathic knowledge is beneficial to nursing practice

Participants felt that being a homeopath provided another dimension to their nursing practice. They commonly spoke about having a different understanding of people and how that impacted their nursing practice when nursing people who were anxious or dealing with difficult situations, stating that:

With homeopathy it gives you that understanding of where the anxiety could be based or why it's manifested in a certain way, whereas before all you could say was "Ok, they're anxious". There wasn't that behind the scenes look at it. (Participant F)

As a homeopath what really comes spilling over into nursing is a real understanding of the constitutional types of people. The way they deal with grief and loss, the way that they deal with situations that are difficult. It's almost like it gives me leverage to use when it comes to helping them. (Participant C)

Participant C talks about the constitutional make up of individuals and how recognising this aspect of people assists in knowing how best to help clients. In homeopathy the constitution of an individual is assessed based upon their physicality, their personality, how they respond to the external environment and any health problems that commonly affect them (National Health Portal, 2016a; Steinsbekk, Bentzen, Fønnebø, & Lewith, 2004; van Haselen, Cinar, Fisher, & Davidson, 2001). Understanding an individual's constitutional type can provide an insight into how that person functions in the world, thereby assisting homeopaths in finding the most appropriate homeopathic remedy for each person (National Health Portal, 2016c; Steinsbekk et al., 2004; van Haselen et al., 2001).

Aside from gaining an understanding of an individual's constitutional make up from their experience with homeopathy, participants also spoke about how homeopathy had changed the way that they viewed people. Specifically, participants spoke about homeopathy

helping them to become less judgemental in their encounters with clients in the nursing practice environment:

It [homeopathy] definitely makes me less judgemental when people come in with whatever it is; their ideologies. It's just made me a lot more open to accepting people as individuals and their freedom to choose whatever they feel is best by them, so long as it's not deliberately hurting other people. (Participant O)

With homeopathy, I got a little less judgemental. It's not a nice thing to admit being judgemental when you're a nurse, but you know that thing when you work in emergency and someone comes in and they've injected something or other? They're off their faces and the nurses go "Argh, here they are again". I probably got less judgemental about people from that point of view. Seeing how people get into the place they're in, rather than thinking "Oh god, why don't they stay in AA [Alcoholics Anonymous]" or "Why do they do this?" I became less judgemental, that's one thing I can say for sure. (Participant J)

Participants speak about being more accepting and of trying to understand extenuating circumstances that might have influenced an individual's current situation, which they attribute to their experience with homeopathy. Rather than condemnation, participants try to suspend judgment and understand things from the client's perspective. One participant in this study spoke about the difficulties in finding a nursing practice environment compatible with a non-judgemental approach to clients. This participant had moved from several different areas of nursing to another, trying to find a workplace congruent with their approach. One of the practice environments spoken about was in the field of drug and alcohol rehabilitation:

Again, that model [drug and alcohol rehabilitation] didn't suit me very much because most of the nurses there were from a staff nursing background. I'd be saying to the clients "Tell me about it, tell me how you feel about that" and they'd be saying "Get over there, take off those sunglasses, that's drug seeking behaviour". We were just a clash. (Participant G)

The approach used by Participant G was to try and gain an understanding of the client's perspective, rather than pass a moral judgement on the client. However, Participant G's approach was at odds with that of other nursing staff and eventually Participant G moved on to another nursing practice environment. Hill (2010) makes the point that a difficult aspect of clinical practice is encountering situations at odds with one's own moral positioning and reminds us that health care workers are human and therefore moral judgements from the wider community can seep into their practice (p. 12). Consequently, clients can be labelled as "bad" (Hill, 2010, p. 12). In an exploration of the qualities valued in nurses by individuals utilising nursing services, Griffiths, Speed, Horne and Keeley (2012) found that clients valued a professional attitude with an emphasis on individualised and non-judgemental care. In contrast, clients reported negative feelings about their interaction with nurses who they perceive as being judgemental (Griffiths et al., 2012). Participants in this study attributed their non-judgemental approach to their involvement with homeopathy. Further research could shed more insight into what aspects of homeopathic philosophy, education, and/or practise, if any, results in the adoption of a non-judgemental approach to clinical practice.

Another aspect arising from participants' experiences with homeopathy and its influence on their nursing practice related to participants pausing and reflecting on their professional

practice. Often this time of reflection resulted in them making small changes to their nursing practice, as stated by these two participants:

My different understanding of humans allows me to think and ask myself to be more thoughtful in my nursing practice. (Participant D)

Homeopathy made me a bit more conscious of taking that extra time out to connect with the person and understand their experience. Even though as a nurse you always did that, sometimes with nursing you can get caught up with the actual practical aspects of what you have to do within a shift and not actually take time to sit down with the patient. (Participant F)

Participants say they became more thoughtful in their nursing practice and were reminded of making time for clients, to ‘connect’ with them and ‘understand their experience’. Participant F makes the point that this is something nurses do anyway, but that the practical aspects of nursing practice can be a barrier to having time to get to know clients.

When asked how those barriers to nurse-client communication was overcome in the nursing practice environment, Participant F said:

There’s not always the amount of time I would like, but there’s always five minutes whether it’s as you’re taking medications out or setting up an IV [intravenous] line⁶, there’s time to just say, “How are you going with things? How’s the family? To do things like that. (Participant F)

⁶ An intravenous line, or catheter, is a device that is commonly used with people who are hospitalised to administer products such as fluids, blood and medications (Royal Children’s Hospital Melbourne, 2018.)

Participant F used the time when undertaking other tasks related to clients nursing care, to talk with them. Taking five minutes to check in with clients while performing other tasks is arguably not the most conducive environment for meaningful communication with clients. According to Kourkouta and Papathanasiou (2014), honest, open communication is more likely to occur when a client is the centre of attention and time is not a pressing issue. The experience of other participants in this study also indicated that time constraints were a significant barrier to meaningful nurse-client interactions:

In a big surgical unit having 20 patients, I hated that sort of nursing running around like a chook, not quite knowing everyone you're dealing with and racing, racing, racing. (Participant A)

With nursing you're dashing around. You've 18 patients to look after on that shift, or you've got 15 minutes because the next child health client might be here. (Participant D)

Terms such as 'racing' and 'dashing around' are used by participants to describe their way of working in the nursing practice environment. Nursing workloads are an area of considerable concern, with increasing workloads associated with decreased client-nurse interaction, negative client outcomes and increased levels of dissatisfaction among nurses (Aiken et al., 2014; Ball, Murrells, Rafferty, Morrow, & Griffiths, 2014; Ross, Rogers, & King, 2019). During data analysis it was identified that nursing in health care settings dominated by biomedicine and where client interaction was limited by time constraints, could be a dissonant space for the majority of participants in this study to work within. The dissonance participants experienced and how this was resolved will now be explored within the context of cognitive dissonance.

7.3.2 Managing cognitive dissonance

As discussed in Chapter Five of the thesis, *Connecting Philosophically*, becoming involved with homeopathy altered the way that participants thought about many aspects of health and wellbeing. In becoming homeopaths, participants had subscribed to the concept of an individualised and holistic approach to health care. A significant aspect of participants' altered perspectives related to reconciling the different approach of homeopathy with nursing in health care settings dominated by biomedical interventions and practises. Although previously, participants had been involved in administering certain treatments, they talked about no longer being able to participate in the same practices and of looking for other options:

I love mental health, but I couldn't do ECT⁷ [electroconvulsive therapy]. I went back to [names clinic] at one point and I think I'd studied and looked at life so differently that I just couldn't mentally, emotionally and physically go in and be part of administering ECT. That was a really big one for me. (Participant K)

The conflict with me is I do give the medicine and it's not that I feel like I'm doing something morally wrong, but now I'm just always thinking is there something better, or is this really needed and that comes up more than, say, it would have before [becoming a homeopath]. (Participant F)

Questioning their nursing practice and no longer being able to be involved in certain practices indicates a point of conflict for participants that can be viewed through the lens of cognitive dissonance. A theory of cognitive dissonance was developed by Festinger (1957) who outlined it as a psychologically uncomfortable state arising from an

⁷ Electroconvulsive therapy (ECT) is a procedure used in some psychiatric disorders, whereby an electrical current is passed through the brain (Beyond Blue, 2019).

inconsistency between two elements (p. 2). Of special interest to this discussion is dissonance arising from an inconsistency between beliefs and actions. Festinger (1957) asserts that although dissonance can be a daily event in reaction to passing occurrences and interactions, it can also be the result of being exposed to new information or knowledge that conflicts with existing knowledge (pp. 4–5). Dissonance can therefore be fleeting or enduring (Festinger, 1957). According to Festinger (1957), finding ways to reduce or avoid cognitive discomfort is a natural response by individuals (p. 3) and commonly includes changing one's beliefs, actions, or perceptions of the action (pp. 18–24). Data from this study suggested that the cognitive dissonance experienced by participants was managed through the rationalisation of their nursing practice.

7.3.2.1 Rationalising nursing practice

As explored in section 7.3.2 of the chapter, participants' philosophical positioning towards an individualised and holistic approach to health care often placed them at odds with the more reductionist approach of biomedicine. This conflict resulted in most participants having difficulty participating in practises that they were not entirely comfortable with. It was noted that when talking about these situations, participants would justify their nursing practice in the following ways:

I felt that I was just there giving loving support to patients who had chosen this avenue, so that's how I could reconcile doing it [nursing]. I had to just keep reminding myself that this was their journey and what they had chosen.
(Participant O)

While I didn't necessarily want to treat in that manner it was my job at that point in time and of course I needed an income, so I was quite comfortable doing it on that basis. The vast majority of people, that is what they wanted. (Participant N)

The rationalising of participants' nursing practices involved an internal dialogue that included participants telling themselves that were supporting clients in their choice or it was their job. Rationalising their actions in this way allowed participants to continue practising in a manner that was incongruent with their beliefs. Festinger (1957) suggests that rationalising is a common response to cognitive dissonance. Using the example of a smoker, Festinger (1957) discussed how rationalising one's actions can reduce cognitive dissonance (p. 2). For instance, although the negative health implications of smoking are well known, Festinger says that smokers might convince themselves that life contains lots of dangers and as they are unable to avoid them all, they may as well continue smoking (p. 2).

It should be noted that although most of the participants in this study expressed a degree of conflict with their nursing practice and rationalised it, a small number of participants said they had no conflict in being a nurse and a homeopath and therefore never felt the need to rationalise their actions as a nurse. These participants appear to have successfully compartmentalised their nursing and homeopathic identities and practice, and once again spoke in terms of wearing different hats:

There is no conflict. Absolutely not, it's like a three-cornered hat [nurse, nurse educator and homeopath] and it depends what angle I've got it on. I've always felt it's been well integrated. (Participant C)

People say how can you work in that area [mental health] and give out those psychotherapeutic drugs when you're a homeopath, and I don't really think about it. Somehow, I've got a different hat on. I'm in that modality and I'm just working within the bounds of that. If someone needs sedation, I don't have a moral conflict because I'm working in that system. (Participant E)

Participant E talks about having no ‘moral conflict’ and of working within the bounds of the system in which nursing practice is situated. Participants who said that they felt no discomfort with their nursing practice could possibly be less prone to experiencing cognitive dissonance than the other participants (Nolan & Nail, 2014). Researchers who have expanded upon Festinger’s theory of cognitive dissonance suggest that only those individuals with a low tolerance of inconsistency have a tendency towards experiencing cognitive dissonance (Nolan & Nail, 2014). Other individuals have no preference for consistent cognitions (Nolan & Nail, 2014). However, it was noted that participants in this study who expressed having no cognitive discomfort, all cited financial reasons for remaining within the nursing profession:

I do nursing for the money, so I can maintain a lifestyle. (Participant H)

My kids have changed school to a very expensive one, so my commitment is to try and cover their school fees with my nursing, or my income and of course I needed a steady income. That’s what pushed me to go back to nursing more regularly.

(Participant E)

Essentially, nursing provided the steady income needed by these participants to support their lifestyles. Myers Kiser (2015) suggests that situations exist where an individual learns to operate within a dissonant space as it is impossible to resolve the conflict (p. 124). It could therefore be argued that these participants’ need for financial security resulted in them learning to function within the space of nursing. However, it was also noted that all but one of the participants who said they felt no conflict with their nursing practice worked in practice environments that allowed time for meaningful interaction with clients:

Because it’s [the mental health unit] so small, when it’s quiet I can do some really deep work with the patients. (Participant E)

In oncology you're dealing with life and death scenarios so you can have quite deep experiences with people even though you've only known them a short time. They will open up and let you in. (Participant F)

Participants used the term 'deep' when discussing their interactions with clients in these nursing practice environments. It could be argued that in these practice environments there was an opportunity for participants to get to know and understand the experience of clients. In section 7.2.2 of the chapter, nursing practice environments were discussed, and it was noted that not all nursing practice environments support meaningful communication between nurses and clients. Some practice environments might therefore be more dissonant spaces than others for nurses who have an orientation towards holistic principles and practice, or who are CAM practitioners. For instance, one participant expressed having no conflict when nursing in the area of coronary and critical care:

I used to do coronary care and intensive care. They were two of the main things I did. That's when you absolutely need modern medicine, so you know, there's not a conflict. (Participant J)

Coronary and intensive care were perceived by Participant J to be areas of nursing where biomedical care is vital. Consequently, when Participant J was nursing in these areas, there was no dissonance between beliefs and actions. There appears to be a lack of research on nurses' philosophical orientation and its relationship, if any, to the nursing practice environments they choose to situate themselves within. Future research could shed further insights on this topic. Although a small number of participants in this study were comfortable working concomitantly as a nurse and a homeopath, the experience of the other participants was markedly different. For most participants, the cognitive discomfort of their

nursing practice became too difficult and they chose to leave the nursing workforce. The experience of these participants will now be explored.

7.3.2.2 *Choosing to leave nursing*

Participants who chose to leave the nursing workforce expressed feeling increasingly dissatisfied with their nursing practice, the more involved they became with homeopathy. Central to this dissatisfaction was the conflict between the biomedical and homeopathic approach. Participants talked about realising that they no longer ‘fitted’ in nursing and of being disappointed that biomedicine and homeopathy were unable to work together:

With more understanding about homeopathy my tolerance for the allopathic system kind of went down. At some point I realised that it [mental health nursing] wasn't a good fit. (Participant B)

It was more dealing with the disappointment that the both modalities couldn't work together you know, and in fact sometimes giving out drugs and thinking "I can't keep doing this." (Participant K)

Participants' narratives indicate a mounting intolerance for the biomedical approach that challenged their ability to continue nursing and caused them to reassess their nursing career. The experience of these participants is supported by Johannessen (2009) who, in one of the few studies exploring the experience of nurses who become CAM practitioners, found that the conflicting approaches of CAM and biomedicine were a factor in Norwegian nurses leaving the public health sector to practise CAM. When participants in this study talked about their decision to leave the nursing workforce they commonly spoke about that decision in terms of professional satisfaction:

I'm trained to be a nurse, but I don't want to go and nurse people in community settings or hospital settings because it's not very satisfying. It's a question of satisfaction for me in terms of my skills and how I practise. (Participant B)

It's definitely more satisfying [working as a homeopath]. I can get burnt out sometimes with the [homeopathic] clinic and I can be tired. I don't often get frustrated because there's more likely to be a solution rather than a dead end. I go to work every day and I enjoy it and I didn't think that way when I was nursing. (Participant J)

Participants describe working as a homeopath as a more satisfying experience than that of nursing. Job satisfaction is an important issue for the nursing profession due to it being a significant factor in the attrition of nurses (Mazurenko, Gupte, & Shan, 2015; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011). A chronic nursing shortage is evident in many countries of the world, which has serious implications for the provision of nursing care (Happell, 2009; Mazurenko et al., 2015; WHO, 2016). Understanding the factors related to nurses' job dissatisfaction is imperative to gaining a better understanding of the best ways to retain them in the nursing workforce (Wilkes, Doull, Ng Chok, & Mashingaidze, 2016). When participants in this study who had left the nursing workforce were asked if they would consider returning, some of them questioned why they would ever want to go back nursing, saying:

Once you've got an open mind, once your eyes have been opened and you see what's possible, how can you go back? (Participant I)

It's like learning to do something that is far more interesting and complex and ultimately empowering and then having to go back. Why would you do that when you have something that is more potent and powerful and has the profound ability

to heal, not always, but on a far wider level? Why would you go back? It's all about giving people medication. It helps, but it doesn't really do anything profound.

(Participant B)

These participants talked about seeing what is possible with homeopathy and of it having a 'profound ability to heal'. They expressed no desire to return to nursing in biomedical health care settings where the focus is seen to be on pharmaceutical interventions. However, other participants who had left the nursing workforce to practise as homeopaths, said they would return to nursing, if it supported the integration of homeopathy:

I certainly wouldn't mind working in an aspect of the hospital if I was the homeopath as well as the nurse. (Participant K)

I would love to be a homeopathic nurse inside the hospital. (Participant A)

These participants speak about returning to the nursing practice environment within the context of a homeopath or a homeopathic nurse, rather than solely as a nurse. It is unlikely given the current climate of EBP and anti-homeopathy sentiment that utilising homeopathy within nursing practice will be sanctioned anytime soon in Australia. In America, the Homeopathic Nurses Association (2018a) was founded in 1984 to support nurses worldwide. According to their website, the aim of the Homeopathic Nurses Association (2018a), is to work towards homeopathy being integrated into conventional nursing care. The number of nurses who are members of the Homeopathic Nurses Association is unclear, as the only practitioners listed on their website are those that have chosen to have their names in the public domain (Homeopathic Nurses Association, 2018b). The practitioners who are currently listed are primarily based in various states of America (Homeopathic Nurses Association, 2018b). Attempts to obtain information relating to the full membership of the Homeopathic Nurses Association via personal correspondence have been

unsuccessful. Furthermore, no literature could be found on homeopathic nurses working in conventional health care settings in America or other parts of the world.

7.4 Summary

The findings presented in the chapter partially answer the second research question: ‘What influence, if any, does being a qualified nurse and a homeopath have on the respective nursing and homeopathic practice of these nurses? It has shown that as nurses and homeopaths, participants in this study had to navigate the conflicting philosophies and practices of biomedicine and homeopathy, as well as the organisational, territorial, and epistemological boundaries that exist when nursing in health care settings dominated by biomedicine. These boundaries restricted the integration of homeopathy into the nursing practice of most participants. However, despite these constraints, participants’ homeopathic knowledge had a positive impact on their nursing practice in terms of their understanding of, and communication with, clients. Aside from the inability to utilise their homeopathic knowledge and skills fully in the nursing practice environments in which they worked, participants’ abilities to nurse holistically was also inhibited. As a result of these constraints, the majority of participants experienced a level of cognitive dissonance. Resolving the dissonance that they felt, typically resulted in participants leaving the nursing workforce to practise as homeopaths. Alternatively, a small number of participants positioned themselves in areas of nursing where the conflict between their orientation towards holistic principles and practices were minimised.

This chapter is the final chapter relating to the two key concepts connecting philosophically and intersecting identities, that informed the core category of congruent positioning. Presentation of these key concepts focused on the voices of the participants, thereby ensuring they were grounded in the data. The following chapter, Chapter Eight, *Theorising*

Congruent Positioning, discusses the process of theoretical development undertaken in this study and presents the substantive theory that was subsequently developed.

Chapter 8.

Theorising ‘Congruent Positioning’

8.1 Introduction

Chapters Five to Seven of this thesis explored the two primary concepts, connecting with homeopathy and intersecting identities that informed the core category of congruent positioning. The aim of this chapter is to situate this study within the extant literature relating to the core concepts explored in Chapters Five to Seven of the thesis, discuss the process of theory development undertaken and present the substantive Theory of Congruent Positioning that was subsequently developed. The chapter begins by situating this study in the literature before discussing theory generation within the context of grounded theory research. This is followed by a brief discussion of the concepts of ‘positioning’ and ‘congruence’ in relation to this study. The Theory of Congruent Positioning is then explored within the context of the findings of this study and the extant literature. The chapter concludes with a synopsis of the key points made in this chapter.

8.2 Situating Key Findings from this Study in the Literature

As noted in section 1.7 of the thesis, there is a paucity of literature on the homeopathic workforce of Australia and no studies were identified that specifically focused on the experience of nurses who practise homeopathy. However, although existing literature in the field of enquiry is limited there are a number of studies whose findings are relevant to this current study and its contribution to knowledge. Many of these studies have been referenced in Chapters Five to Seven of the thesis, however, those that are particularly significant to the key findings of this study will now be discussed and compared.

Levy (2017) explored the clinical reasoning and decision-making of 12 Australian homeopaths. Some participants in Levy’s (2017) study had experience working in

conventional health care systems: 3 had a background in nursing. Levy (2017) noted that participants' prior professional backgrounds influenced their clinical reasoning, resulting in decision-making based upon multiple sources of knowledge (pp. 199–202). This current study supports Levy's (2017) finding that the prior professional background of homeopaths influences their clinical reasoning. As discussed in Chapter Six *Intersecting Identities: Sharing Common Ground*, nursing knowledge significantly informed the homeopathic practice of participants in this current study, including their referral practices.

A number of studies have explored nurses' attitudes to CAM, as well as their professional use of CAM (J. G. Anderson et al., 2016; Balouchi et al., 2018; Buchan et al., 2012; Cant et al., 2012; Cant et al., 2011; Chan & Schaffrath, 2017; Gowing & Gale, 2019; Hall et al., 2017; Holroyd et al., 2008; Johannessen, 2009; Shorofi & Arbon, 2010, 2017; Shuval, 2006; Xue et al., 2008). It appears from the literature that the CAM practices most used by nurses are mind-body therapies (J. G. Anderson et al., 2016; Cant et al., 2012; Buchan et al., 2012; Shorofi & Arbon, 2010, 2017; Westman & Blaisdell, 2016). It is asserted by Cant et al. (2012) that few nurses utilise herbal medicine or homeopathy in their professional practice, as these therapies compete with biomedicine (p. 533). In contrast, mind-body therapies such as massage can be considered low risk and complementary to conventional modes of treatment (Westman & Blaisdell, 2016). However, there are still barriers to the integration of mind-body therapies into nursing practice (J. G. Anderson et al., 2016; Rushton, 2014).

Among these barriers are nursing practice environments themselves, which are typically under resourced, resulting in time constraints and increased nursing workloads: often leading to job dissatisfaction and the attrition of nurses (J. G. Anderson et al., 2016; Aiken et al., 2014; Ball et al., 2014; Mazurenko, et al., 2015; McHugh et al., 2011; Ross et al., 2019; Rushton, 2014; Zamanzadeh, Jasemi, Valizadeh, Keogh, & Taleghani, 2015). In

addition, nursing practice environments are primarily dominated by a biomedical approach to care, which is underpinned by a different ontology and epistemology to that of CAM (Shuval, 2006; Zamanzadeh et al., 2015). Findings from this current study support previous studies that have indicated that time constraints (J. G. Anderson et al., 2016; Sharp, Mcallister, & Broadbent, 2018; Zamanzadeh et al., 2015) and ontological and epistemological incongruence (Shuval, 2006; Moore et al., 2017; Zamanzadeh et al., 2015) are barriers to the incorporation of CAM and to the successful implementation of holistic nursing practice.

Undertaking a study examining nurses who left the British National Health Service (NHS) to practise CAM, Andrews (2003) aimed to find the reasons why these nurses left and to see if they would return. The demographics of the nurses who participated in Andrews (2003) study were similar to participants in this current study: they practised a variety of CAM therapies, including homeopathy and had a background of working in different nursing disciplines encompassing, general nursing, mental and community health. Many participants also worked as midwives (Andrews, 2003). In addition, the majority of participants were in private practice as CAM therapists, while a minority remained working casually or part-time in nursing (Andrews, 2003). Key factors found by Andrews (2003) to be relevant to the nurses in his study being attracted to the practice of CAM, were negative experiences of the provision of conventional health care services, personal positive experiences with CAM and an orientation towards CAM philosophy. Andrews (2003) concluded that participants' decisions to leave the NHS to practise CAM involved a complex interplay of factors. It was also noted by Andrews (2003) that although many of the participants had cited negative experiences with nursing they would return to the NHS, or work alongside it, if conditions supported their current practices, salaries and autonomy (p. 413).

Findings from this current study support Andrews (2003) conclusion that the decision by nurses' to engage with CAM involves a complex network of multiple factors. However, as outlined in Chapter Five, *Connecting Philosophically*, an orientation towards homeopathic philosophy was identified as the primary factor in participants in this study becoming attracted to the practice of homeopathy. Another point of difference between the current study and Andrews (2003), is that all of the participants in this study had worked concomitantly as nurses and homeopaths and the study explored the intersection of participants' nursing and homeopathic identities in their respective nursing and homeopathic practices. Only a minority of the nurses participating in Andrews (2003) study remained in the nursing workforce while also practising CAM, and the intersection of their CAM and nursing identities were not explored. Additionally, Andrews (2003) did not explore why participants chose to practise a particular CAM therapy. Findings from this current study indicated that participants' motivations for becoming naturopaths were different to their motivations for becoming homeopaths and did not necessarily include an orientation towards CAM/holistic philosophy. Understanding what attracts nurses to specific CAM therapies increases our knowledge of what these nurses are looking for professionally and could assist in developing retention strategies.

In another study exploring why nurses leave the public health service to practise CAM, Johannessen (2009) focused on the experience of Norwegian nurses. Although very few demographics of participants were provided in Johannessen's (2009) study, it was stated that they practised a variety of CAM therapies, including homeopathy (p. 148). Factors cited as attracting participants in Johannessen's (2009) study to the practice of CAM, included an orientation towards holistic philosophy and practice that was unable to be achieved in the task-oriented environment of nursing practice. In addition, the nurses who participated in Johannessen's (2009) study expressed feeling that nursing and CAM shared

the same ideals and that CAM was a way of getting “back to their roots” (p. 150). It was concluded by Johannessen (2009) that the biomedical model of care is not congruent with CAM philosophy and practice.

Findings from this current study support Johannessen’s (2009) conclusion that nursing practice environments dominated by the biomedical model of care are incongruent working environments for nurses attracted to holistic nursing practice, as discussed Chapter Seven *Intersecting Identities: Navigating Opposing Paradigms*, of the thesis, however, evidence from this current study also suggests that some nurses’ with an orientation towards holistic practice can find satisfaction working within certain types of conventional nursing practice environments. These practice environments typically allow for some degree of holistic practise. The main points of difference between this current study and that of Johannessen (2009) is that this study explored the experience of nurses who had worked concomitantly as homeopaths. It is unclear if any of the participants in Johannessen’s (2009) study had remained in nursing while also practising CAM. Additionally, Johannessen (2009) did not provide any information on the CAM practices that participants had left the nursing workforce to practise. As noted above, findings from this current study suggest a variance in factors attracting nurses’ to certain CAM practices.

Shuval (2006), examined the intersection of nursing and CAM through the experience of nurses in Israel who incorporated CAM practices into their professional nursing practice. Shuval’s (2006) findings related to how participants navigated the territorial, epistemological and ontological boundaries between CAM, biomedicine and their nursing practice. Participants in Shuval’s (2006) study practised various forms of CAM, including homeopathy, in addition to working as nurses. It was noted by Shuval (2006), that despite the boundaries separating CAM and biomedicine, participants selectively utilised their

nursing and CAM knowledge in their respective nursing and CAM practices. However, Shuval (2006), identified that integrating CAM knowledge into nursing practice was more difficult than the reverse. Consequently, participants generally utilised a holistic approach to their nursing practice as opposed to using CAM interventions (Shuval, 2006). However, Shuval (2006) also states that the research shows that some of the boundaries between biomedicine and CAM are negotiable and are being redefined (p. 1793).

This current study supports Shuval's (2006) findings relating to how participants navigated the boundaries separating biomedicine and CAM, as discussed in Chapters Five and Six of the thesis, *Intersecting Identities: Sharing Common Ground* and *Intersecting Identities: Navigating Opposing Paradigms*, respectively. However, Shuval's (2006) study indicated a flexibility in some of the boundaries between biomedicine and CAM, particularly with regard to physicians becoming more accepting of certain CAM practices (p. 1793). It is unclear if homeopathy was one of the CAM practices deemed acceptable, as Shuval (2006) did not name the practices gaining greater acceptance by Israeli physicians. There was no evidence of flexibility in the boundaries separating biomedicine and homeopathy in this study: homeopathy remains marginalised within the Australian health care system and its practise actively discouraged by the Australian scientific and medical communities (NHMRC, 2015; RACGP, 2015).

Situating this current study in the literature illustrates that the study reflects and extends existing knowledge, while also making an original contribution to knowledge as outlined in section 1.7 of the thesis. Discussion will now center on the process of theory development in this study and the subsequent generation of a data-driven substantive grounded theory.

8.3 Generating a Substantive Grounded Theory

Theory is often perceived as being divorced from the reality of day to day life (Howell, 2013, pp. 19–20). However, theory enables us to gain insight and understanding of the world in which we live and of ourselves as sentient beings (Howell, 2013, p. 20; Corbin & Strauss, 2008). For instance, Einstein’s theory of relativity paved the way for areas of study and debate on the nature of the universe and its genesis that continues to help us understand the natural world that we inhabit (Martínez-Frías, Hochberg, & Rull, 2006). Theories on human behaviour and the social world have provided enormous insight on the dynamic nature of society and why people act as they do in certain situations (K. R. Allen, 2016; Carter & Fuller, 2015; Davis, Campbell, Hildon, Hobbs, & Michie, 2014; Howell, 2013). Theory is also an important factor in informing and guiding professional practice (Fawcett, 2003; Collingwood, Emond, & Woodward, 2008; Karnick, 2014; El Hussein & Osuji, 2017). However, the way in which theory is defined and perceived can vary between disciplines, and sometimes even within the same discipline, thereby creating a level of confusion (Abend, 2008; Apramian, Cristancho, Watling, & Lingard, 2016; Bendassolli, 2013; Birks & Mills, 2011; Charmaz, 2014).

According to Abend (2008), seven different meanings can be found attached to the term theory in sociological language, while different interpretations of theory are evident in the Glaserian, Straussian and constructivist approaches of grounded theory (Apramian et al., 2016; Charmaz, 2014). According to Charmaz (2014), the various interpretations of theory found in grounded theory discourse are reflective of the wider issue of ambiguity surrounding theory within the social sciences (p. 228). Although different interpretations of theory are evident within grounded theory discourse, the eminent grounded theorists associated with the Glaserian, Straussian and constructivist approaches commonly refer to theory within the context of explanation and/or understanding. For instance, Glaser and

Strauss (1967) describe theory as predictive and explanatory (p. 3), while Thornberg and Charmez (2012), define theory as relationships between abstract concepts that aim for explanation or understanding (p. 41).

Although generation of theory is a primary aim of grounded theory research, many grounded theory studies result in a conceptual descriptive analysis, rather than generate theory (Corbin & Strauss, 2008; Charmaz, 2006, 2014; Glaser & Holton 2005; Glaser & Strauss, 1967; Timonen, Foley, & Conlon, 2018). As explained in Chapter Four *Research Design*, generating theory in grounded theory research is reliant on the constant comparative data collection and analysis inherent in grounded theory methods which includes the process of theoretical sampling (Charmaz, 2014; Glaser & Strauss, 1967; Polit & Beck, 2017; Corbin & Strauss, 2008). It is through this grounded theory process that conceptual ordering of data is abstracted into theory (Birks & Mills, 2011; Charmaz, 2014; Corbin & Strauss, 2008; Glaser & Strauss, 1967). Generating theory using grounded theory methods ensures that the theory is grounded in the data and is therefore representative of the information collected from participants (Glaser & Strauss, 1967; Goldkuhl & Cronholm, 2010). In addition, the progression of theory generation is easily verifiable through the development of codes and categories and their subsequent abstraction, thereby providing credibility to the generated theory (Glaser & Strauss, 1967; Goldkuhl & Cronholm, 2010). In this study as data was being abstracted and higher level concepts developed, searches were undertaken of the extant literature relating to the concept under development. For instance, as the concept of congruence was identified as being relevant to the experiences of participants, a search was conducted of several academic databases, including Academic Search Complete, EbscoHost, SocINDEX, Science Direct, Scopus and CINAHL, as well as Google Scholar. Search terms included: philosophical congruence, philosophical incongruence, congruent worldviews, congruent perspectives, congruence and

incongruence. I selected articles most relevant to the concept under development and began exploring the concept of congruence across different disciplines. Memoing during this process was also fundamental to the theoretical integration of the data: helping me to explore concepts from a theoretical perspective and relate them to the data. Theory generated in grounded theory research can be formal or substantive (Birks & Mills, 2011; Glaser & Strauss, 1967). Formal theories are conceptual and have a wide application due to their generalisability (Charmaz, 2006; Glaser & Strauss, 1967). In contrast, substantive theories relate to specific areas of inquiry (Glaser & Strauss, 1967), such as that found in this study. The substantive grounded theory generated from this study pertains to qualified nurses who are registered homeopaths working in the Australian health care system as nurses and/or homeopaths. It is specific to their experience and explains their attraction to the practice of homeopathy and how their respective identities as nurses and homeopaths were expressed in their nursing and homeopathic practice.

As discussed in section 4.4.4.3 of the thesis, the identification of a core category is integral to the process of developing a grounded theory, as it demarcates the theoretical framework (Charmaz, 2014; Hallberg, 2006; Holton, 2007; Glaser & Strauss, 1967; Corbin & Strauss, 2008). Through my interpretation of the data, two concepts; namely: positioning and congruence, were identified as being reflective of the story the data was telling. After much refining and reworking of my interpretation of the data, I decided that having two core categories added depth to the study, as discussed in section 4.4.4.3 of the thesis. Therefore, the core category of congruent positioning was developed as an overarching concept explaining the essence or core of this research (Charmaz, 2014; Holton, 2007; Corbin & Strauss, 2008). The core category of congruent positioning forms the basis of the substantive grounded theory and is informed by two primary concepts; namely: connecting philosophically and intersecting identities. The concept of intersecting identities has two

aspects to it; namely: sharing common ground and navigating opposing paradigms. These primary concepts provide context to the core category of congruent positioning and are discussed at length in Chapters Five to Seven of the thesis. The core category of congruent positioning is illustrated in Figure 19.

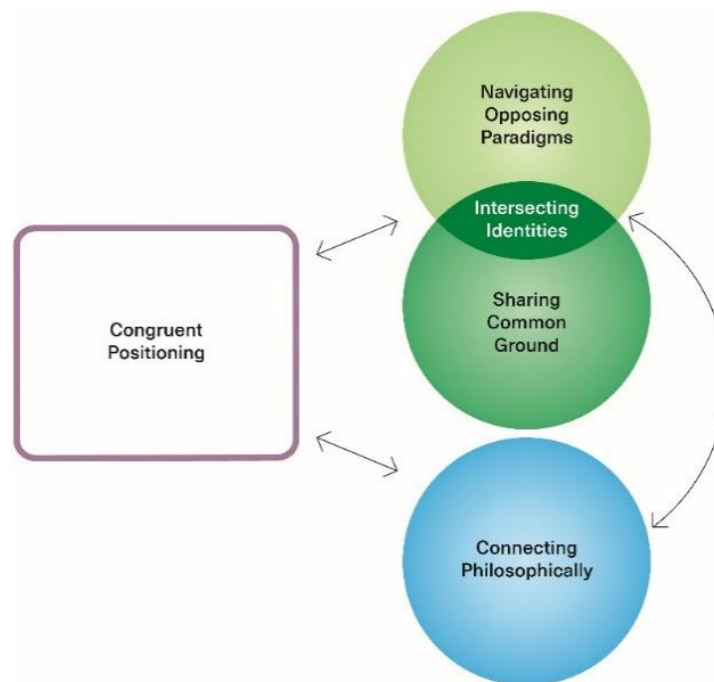


Figure 19. Core category of congruent positioning developed from this study

Once the core category of congruent positioning was identified, a theoretical scheme was developed and refined by checking for gaps in reasoning (Corbin & Strauss, 2008). It is asserted by Corbin and Strauss (2008) that a researcher should be prepared to take their theoretical scheme apart and re-work it until it “feels right” (p. 274). This process proved to be the most difficult part of the study for me. It took a considerable length of time to generate a theory that felt right. Re-working of the theoretical scheme was aided by going back to memos and using them to provide details of how the concepts related. An example of this process is shown in an extract from an integrative memo (Figure 20), that was written to assist in moving data analysis towards a theoretical level.

Integrative memo 28/8/17

What is happening in the data?

Participants have come to view homeopathy as a viable form of health care housed in a holistic model. They repeatedly spoke about being attracted to the individualised and holistic approach of homeopathy. It aligned with what they believed a model of health care should be based upon. This belief in a holistic approach to health care was either existing (orientation towards CAM) or emerging (through personal experience).

Becoming a homeopath resulted in participants gaining a professional identity as a homeopath in addition to their professional identity as a nurse. Participants asserted that nursing and homeopathy are complementary and inform each other. This assertion rests upon their belief that nursing is founded upon holistic principles. They therefore consider nursing and homeopathy to be congruent practices. However, conflict arises when working in the nursing practice environment, due to constraints that hinder holistic practice and restrict their use of homeopathic knowledge. In this environment their philosophical position is at odds with the reality of nursing practice. Essentially there is incongruence.

Participants' main concerns appeared to be the lack of holistic care when nursing in biomedical health care settings. The majority of them left nursing to practise homeopathy, as it was more congruent with their orientation towards holistic practice.

Two dominant concepts that I see are positioning and congruence. I am seeing positioning in terms of positionality—the positionality of participants with regard to holistic principles, homeopathy and nursing. They adopt a positive position on homeopathy that is born from their own personal experience and aligns with an existing or emergent philosophical orientation towards holistic principles. Nursing is positioned as a holistic practice and therefore complementary to homeopathy.

Participants' positionality influences their nursing practise and their decision to either remain in nursing or leave nursing to practise homeopathy. There is also an aspect of physical positioning that relates to where participants locate themselves—inside nursing and outside. So, is positioning philosophical and physical?

Central to the concept of positioning is congruence. In particular congruence between philosophical orientation and practice. It appears to me that this drives participants to position themselves as homeopaths in the first instance and is the key factor in those that leave the nursing profession.

Figure 20. Extract from an integrative memo from this study

Memoing what I was seeing in the data facilitated a refinement of my thoughts as I reviewed the extant literature and explored the concept of congruence and positioning in relation to this study. As literature was reviewed, I discussed my thoughts with my supervisors, had meetings with them, diagrammed out the developing theory and discussed each aspect of it until it made sense within the context of the data and the extant literature.

From this process of asking questions of the data, searching the literature, memoing and reflection, the substantive Theory of Congruent Positioning (Figure 21) was developed.

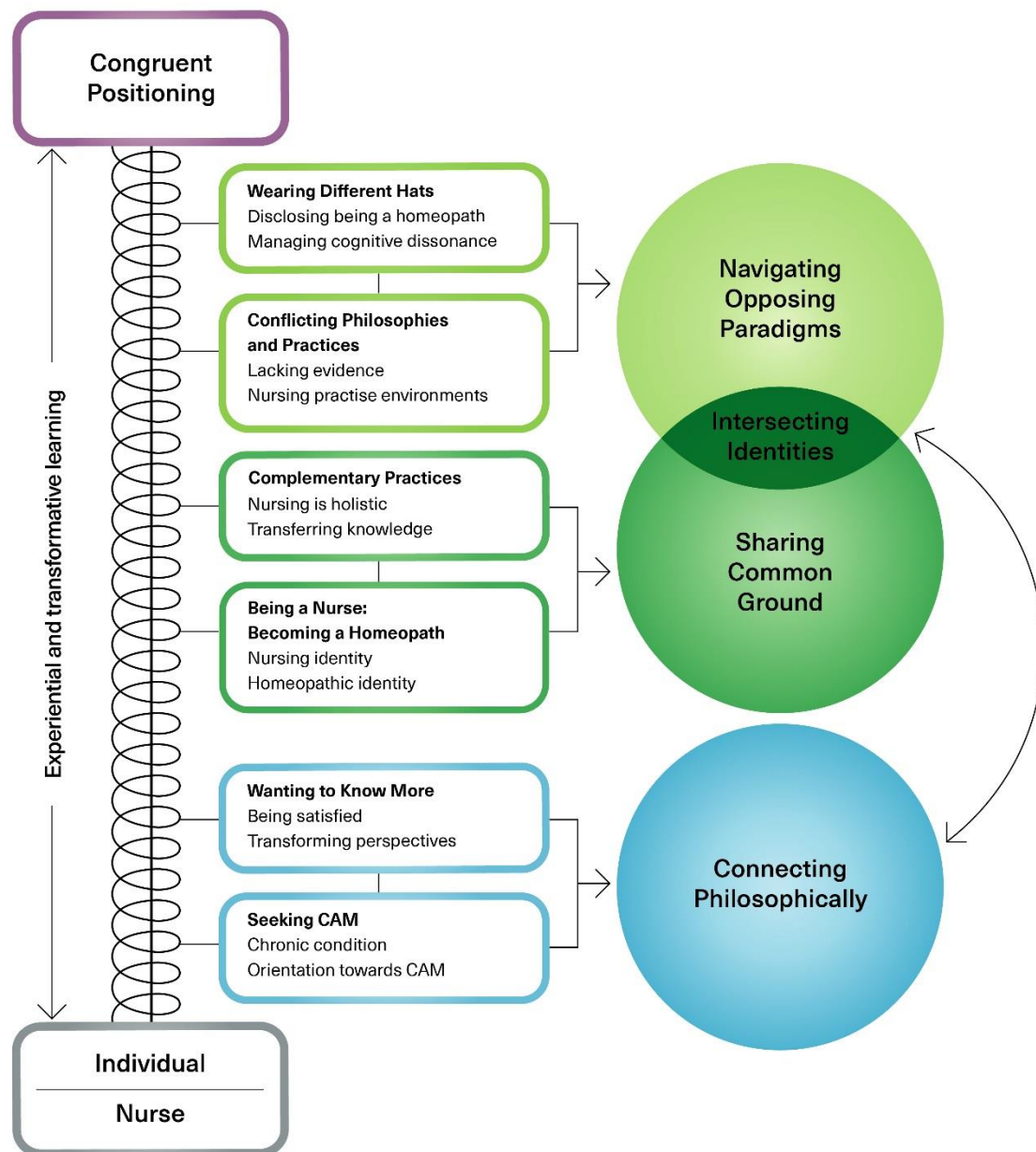


Figure 21. Substantive theory of congruent positioning developed from this study

8.4 Theory of Congruent Positioning

As previously discussed, the Theory of Congruent Positioning is a data-driven theory developed using the inductive approach of grounded theory. The theory suggests that participants in this study were attracted to the practise of homeopathy through a process of

experiential and transformative learning that resulted in them connecting with the holistic philosophy underpinning homeopathic practice. The theory further proposes that participants integrated their nursing and homeopathic knowledge into their respective professional practices, but ultimately positioned themselves in practice environments that were congruent with their orientation towards holistic philosophy and practice. Most commonly, participants chose to leave the nursing workforce and practise as homeopaths. The model depicting the Theory of Congruent Positioning (Figure 21) borrows from Kaoru Ishikawa's fishbone design that was originally developed for use in quality management and is widely utilised for exploring cause and effect (Bilsel & Lin, 2012; Stefanovic, Kiss, Stanojevic, & Janjic, 2014; K. C. Wong, 2011). The straight centre line of the model of the theory is representative of the individual and their experience and as such, it can be considered within the context of a storyline. All participants in this study were nurses before engaging with homeopathy, therefore they are represented at the start of the storyline as individual/nurse. Entwined around the storyline is a spiral. The inclusion of a spiral is symbolic of the various changes that participants went through as they journeyed from nurse to homeopath. A spiral is apt for symbolising the change and growth of participants, because as noted by Yamada and Kato (2006), spirals have historically been associated by many cultures with life and its various cycles of change and transformation (p. 153).

Branching off from the spirals are the main categories and their properties that inform the two primary concepts: connecting philosophically and intersecting identities. Each of these branches can be considered within the context of a 'phase' of their storyline. Although the storyline may appear linear, participants moved back and forth between the phases in a non-linear way. Their understanding of, and connection to, homeopathic philosophy continued to evolve after they became homeopaths and began in homeopathic practice. They were constantly re-evaluating their nursing knowledge in response to their growing

comprehension of homeopathy and its practice. The double headed curved arrow linking the two primary concepts signifies this process. Although participants' storylines are non-linear, for the purpose of discussion each phase of the storyline will now be considered in turn.

The phase of connecting philosophically (Figure 22), was explored through participants' narratives and the extant literature, presented in Chapter Five of the thesis. It directly relates to participants' attraction to the practise of homeopathy. Although participants began seeking complementary and alternative medicine (CAM) for varying reasons, the data suggested that the overarching factor in participants' attraction to the practise of homeopathy was the connection they made with the core tenets of homeopathic philosophy and practice. Homeopathic practice is grounded in a philosophy that emphasises an individualised and holistic approach to clinical practice. Being exposed to homeopathic philosophy and practise transformed the way that participants saw health and wellbeing and made them question their practise as nurses. Participants talked about their previous understanding as being taught about the part, not the whole and of the homeopathic approach as making sense. Basically, participants' philosophical orientation regarding health and wellbeing became congruent with that of homeopathic philosophy. Wanting to know more about the practise of homeopathy, they engaged with formal homeopathic education.

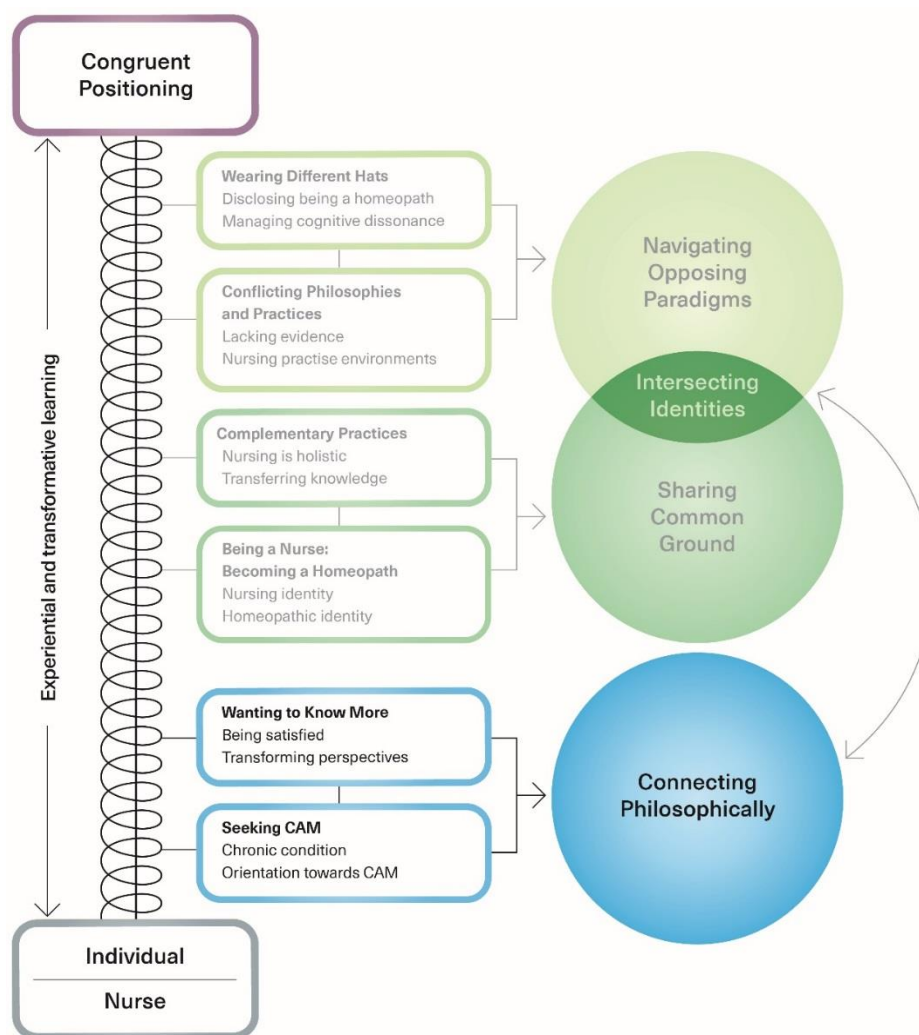


Figure 22. Concept of connecting philosophically

In becoming homeopaths, participants incorporated homeopathic practitioner into their identities as health care professionals, resulting in an intersection of their respective nursing and homeopathic identities. In the model of the theory, this phase of participants' storylines is represented in the concept of intersecting identities. As previously mentioned, the concept of intersecting identities has two aspects to it; namely: sharing common ground and navigating opposing paradigms. These two aspects were explored through the narratives of participants and the extant literature presented in Chapters Six and Seven of the thesis. The two aspects of intersecting identities are indelibly linked, as denoted by the

linking of the circles in the model of the theory. However, for the purposes of discussion they are explored separately.

The concept of intersecting identities: sharing common ground (Figure 23) relates to participants' change in identity as health care professionals as they entered a simultaneous state of being a nurse and becoming a homeopath. During this process, participants transitioned from being a nurse through the stage of being a student homeopath, until finally becoming a qualified homeopathic practitioner. In addition, the concept of intersecting identities: sharing common ground relates to participants' assertions that there was no conflict between their identities as nurses and homeopaths. Rather, participants felt that their nursing and homeopathic identities informed each other, and that nursing and homeopathy were complementary practices both grounded in holistic principles. The data suggested that as homeopaths, participants were able to integrate their nursing knowledge without fear of censure. Therefore, in the homeopathic practice environment participants could create a holistic model of care incorporating their nursing and homeopathic knowledge. The data also indicated that participants' nursing knowledge significantly influenced their nursing practise. Specifically, nursing knowledge was shown to have positively impacted participants' ability to communicate with clients about biomedical practices and interventions. Furthermore, nursing knowledge significantly influenced participants' referral practises, especially with regard to engaging clients with appropriate biomedical practitioners and services.

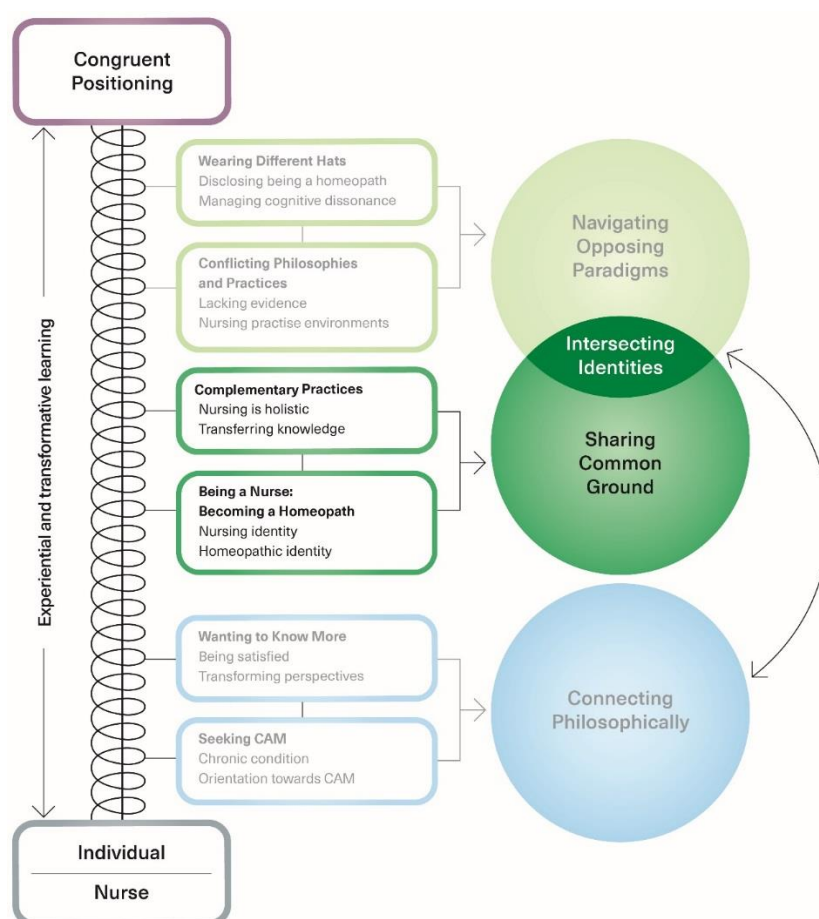


Figure 23. Concept of intersecting identities: sharing common ground

Although the data suggested a congruence of participants' respective nursing and homeopathic identities and practise in the homeopathic practice environment, it also indicated that a congruence of identity and practise seldom occurred in participants' nursing practise. In the nursing practice environment, the intersection of participants' respective nursing and homeopathic identities was explored within the context of intersecting identities: navigating opposing paradigms' (Figure 24). Central to the concept of opposing paradigms were the conflicting philosophies and practices of biomedicine and homeopathy, including their epistemological and ontological differences, and the territorial, organisational and professional boundaries of nursing practice environments. The data suggested that in the nursing practice environment, participants compartmentalised their respective nursing and homeopathic identities in response to the aforementioned factors.

Participants' compartmentalisation of their respective nursing and homeopathic identities was evidenced by their comments about wearing different hats. They spoke about being employed as a nurse and of it being a conflict of interest if they wore their homeopathic hat when they were nursing. The data therefore indicated that participants were unable to fully express their homeopathic identity and integrate their homeopathic knowledge in the nursing practice environment. As a result, participants became increasingly dissatisfied with their nursing practise.

The more involved they became with homeopathy, the more dissatisfied they became with their inability to nurse in a manner that was congruent with their orientation towards holistic principles and practice. The data indicated that most participants experienced some level of cognitive dissonance, due to the conflict between participants' orientation towards holistic principles and their nursing practise. Although these participants tried to reconcile the dissonance between their beliefs and practice, the incongruence became too great and these participants chose to no longer work as nurses. The few participants who did remain working as nurses had compelling financial reasons for continuing nursing and the data suggested that they tended to position themselves in areas of nursing where some degree of holistic practice could be achieved.

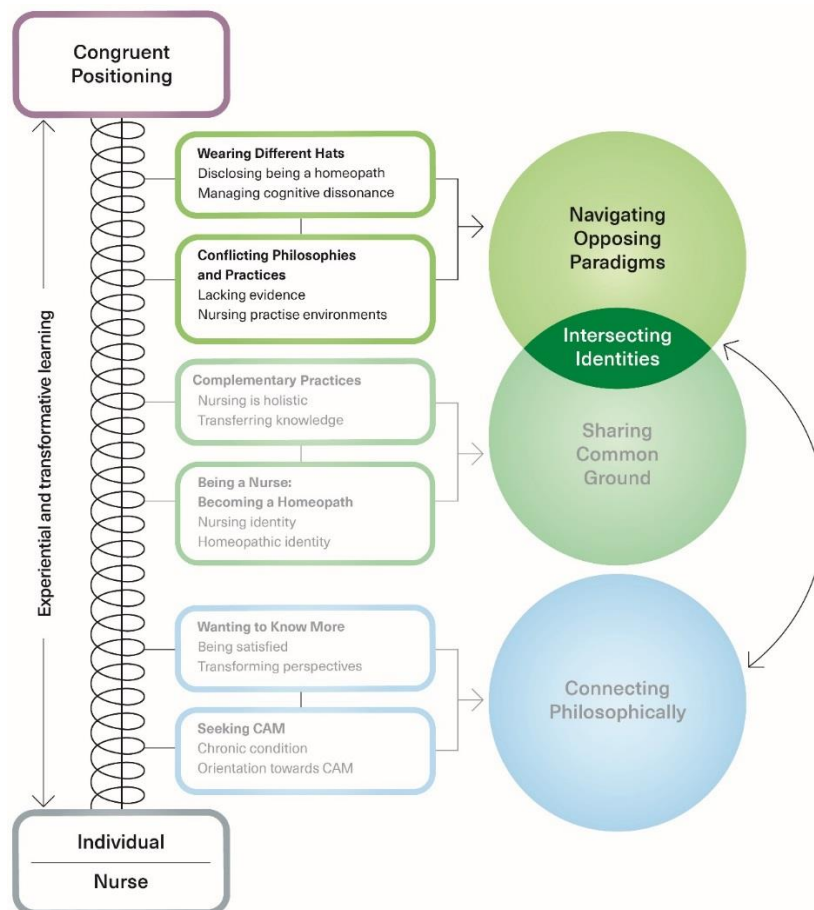


Figure 24. Concept of intersecting identities: navigating opposing paradigms

As explored in Chapter Five of the thesis, *Connecting Philosophically*, the data suggested that participants' journey from nurse to homeopath, including their experience of working in two different sectors of the Australian health care system, were embedded in a process of experiential and transformative learning. This aspect of participants' experience is represented in the model of the theory through the inclusion of experiential and transformative learning linking both ends of the model. The two concepts that formed the basis of the Theory of Congruent Positioning; namely: positioning and congruence, will now be explored within the context of this study.

8.4.1 Defining positioning and congruence within the context of this study

The concept of positioning within the context of this study is two-fold. Firstly, it relates to participants' philosophical positioning and the relationship of that positioning to nursing, homeopathy and biomedicine. At the centre of participants' philosophical positioning was the concept of holism. Participants were attracted to the holistic nature of homeopathic practise and commonly positioned themselves as having an orientation towards holistic principles that was compatible with the philosophy of nursing and homeopathy, but not of biomedicine. Therefore, the biomedical model of health care can be viewed as being incongruent with participants' philosophical orientations towards holistic principles and practise.

The second facet of positioning relates to the physical positioning of participants in terms of where they situated themselves as health care professionals. Central to the philosophical and physical positioning of participants was the concept of congruence. Congruence in relation to this study is defined as compatibility. The incongruence between participants' philosophical orientation and nursing in biomedically dominated health care settings was a significant factor whereby participants decided to physically position themselves as health care professionals in the Australian health care system, as explored in Chapter Seven of the thesis, *Intersecting Identities: Navigating Opposing Paradigms*.

The concept of congruent positioning in relation to this study, therefore, relates to compatible philosophies and practice environments. Key indicators in the data relating to participants' philosophical positioning include:

- an existing or emerging orientation towards holistic principles and practice

- assertion that nursing and homeopathy are complementary practices grounded in concepts of holism
- situating biomedicine as a reductionist practice
- desire to integrate homeopathic and CAM knowledge into nursing practice
- dissatisfaction with the lack of holistic care in biomedical health care settings

Key indicators in the data relating to congruence between participants' philosophical positioning and their practice as health care professionals include:

- attraction to the holistic nature of homeopathic practice
- higher job satisfaction when working as a homeopath than when nursing in biomedical health care settings (due to the holistic nature of homeopathic practice)
- leaving the nursing profession to practise as a homeopath (due to an inability to practise holistically as a nurse in biomedical health care settings)
- positioning oneself in areas of nursing that allow for a degree of holistic practice

The last two indicators relating to participants leaving the nursing profession and positioning themselves in an area of nursing conducive to holistic practice, are evidence of philosophical positioning impacting physical positioning. The Theory of Congruent Positioning will now be explored within the context of the extant literature.

8.4.2 Reviewing the theory of congruent positioning through existing literature

In the literature the concept of positioning is broad, having numerous definitions and associations contextual to various areas. For example, in the field of marketing, positioning

relates to the communication approaches utilised in relation to products, services and brands (Tirado & Gálvez, 2007; Ugglá, 2015; Zelle, 2009). In the social sciences literature that explores the rights and obligations of individuals within a social structure, the term position is often used interchangeably with the term's status and role (Goffman, 1951). In this context the concept of position can be considered in relation to role theory, which posits that human behaviour is guided by rights, duties and expectations that are socially defined (Biddle, 1986; Brookes, Davidson, Daly, & Halcomb, 2007; Goffman, 1951; Şeşen, 2015). Role theory argues that individuals are socially positioned and expected to behave in a particular manner, contingent on identity and the given situation (Biddle, 1986; Goffman, 1951). These expectations can be self-imposed or imposed by others (Goffman, 1951). For example, expectations imposed upon nurses include societal (Rush, Kee, & Rice, 2005; Vandecasteele et al., 2015), organisational (Jacob, McKenna, & D'Amore, 2017; Darch, Baille, & Gillson, 2017; Nursing & Midwifery Board of Australia, 2016b, 2018a) and self (Darch et al., 2017; Rush et al., 2005).

Another way of considering the concept of positions was introduced into the social science literature with Holloway's (1984) analysis of gender difference and subjectivity in heterosexual relationships (Tirado & Galvez, 2007; Zelle 2009). In this analysis, Holloway (1984) discusses the way that men and women are discursively positioned in relation to each other. Building upon Holloway's (1984) concept of positions, psychologist Rom Harré and colleagues developed positioning theory (Davies & Harré, 1990; Harré & van Langenhove, 1991; van Langenhove & Harré, 1999). At the core of positioning theory is the way in which words and discourse are used by individuals to position themselves and others, including ascribing rights and claims for themselves and placing duties upon others (Davies & Harré, 1990; Harré & van Langenhove, 1991; van Langenhove & Harré, 1999; Moghaddam & Harré, 2010; Slocum-Bradley, 2009).

Positioning is described by Davies and Harré (1990) as “the discursive process whereby people are located in conversations as observably and subjectively coherent participants in jointly produced storylines” (p. 48). This can be summed up as a discursive personal biography (Davies & Harré, 1990). It is suggested by van Lagenhove and Harré (1999) that through the discursive positioning of themselves and others, individuals give meaning to their behaviour thereby making it understandable within the context of their storyline (pp. 16–18). Harré and colleagues contrast their concept of positioning with that of role, arguing that positioning is more dynamic than the concept of role. They suggest that positions are fluid, altering in response to changing beliefs (Davies & Harré, 1990). In addition, positions are adopted to represent one’s identity in various contextual situations (Zelle, 2009). In contrast, they argue that the concept of a role is static and fixed (Davies & Harré, 1990; Harré & van Langenhove, 1991). The various forms of positioning identified in positioning theory are summarised in Table 5.

Table 5.

Various Modes of Positioning

Modes of Positioning	
First order positioning	Occurs in response to an individual locating themselves.
Second Order Positioning	Occurs in response to questioning of first order positioning. Has to be negotiated and is intentional.
Third Order Positioning	Second or third order positioning is intentional as it is active. It occurs in response to first order positioning with the aim of challenging or changing it.
Performative and Accountive Positioning	
Moral Positioning	Occurs in response to referencing one’s role and the rights and duties that accompany that within a group or society
<i>Personal Positioning</i>	Personal positioning relates to one’s specific properties or life experiences, rather than a generic role. This can be further categorised as self-positioning or positioning of others.
<i>Self-Positioning: Deliberate</i>	Occurs when an individual portrays them self in a particular way or as a particular identity.
<i>Self-Positioning: Forced</i>	An obligatory response to an external power. For example, a compulsory annual performance review.

Modes of Positioning	
<i>Positioning of Others: Deliberate</i>	Can occur in their presence or absence. Gossiping is an example of deliberate positioning of others in their absence. Positioning of others in their presence allows the speaker to create a place for the others in his or her storyline.
<i>Positioning of Others: Forced</i>	Occurs where one is forced to position others, such as a criminal trial where the witness is required by law to position others.
Tacit Positioning	Generally, first order positioning that happens unintentionally as part of daily social interaction.

Note. Adapted from “Varieties of Positioning” by Harré and van Langenhove, 1991, pp. 403–404. doi:10.1111/j.1468-5914.1991.tb00203.x; “Introducing Positioning Theory” by van Langenhove & Harré, 1999. In R. T. Harré, & L. van Langenhove (Eds.), *Positioning theory. Moral contexts of intentional action* pp. 14–31. In public domain.

According to Zelle (2009), positioning theory can help bridge the “analytical gap between people, institutions, and societies” (p. 1) and is therefore useful across a variety of domains. Certainly, in recent years the application of positioning theory has extended beyond social psychology and is being utilised in research within diverse fields such as education, (Anderson, 2009; Boston, 2015; Kayi-Aydar & Miller, 2018; Tan, 2015) nursing and midwifery (Andreassen & Christensen, 2018; Christensen, Hendriksen, Thomsen, Lund, & Mørcke, 2017; Phillips & Hayes, 2006).

Findings from this study reflect aspects of positioning theory. Of specific relevance to this study is the notion of personal positioning, which relates to one’s own experiences and how one positions oneself and others (Harré & van Langenhove, 1991; van Langenhove & Harré 1999). Personal positioning is evident in how participants self-position or identify themselves as nurses, homeopaths and as holistic health care providers in their narratives. Positioning of others is evident in participants’ positioning of nursing and homeopathy as holistic practices and biomedicine as being reductionist. The discursive positioning of themselves and others in this way portrays a certain image, thereby providing context to the storyline of their experience as nurses and homeopaths (Harré & van Langenhove, 1991;

van Langenhove & Harré, 1999). Positions are generally relational, so if one party is positioned in one way, the others must be positioned in another way (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009; Harré & van Langenhove, 1999). Positioning can therefore infer moral superiority through certain individuals or groups being positioned as trustworthy, while others may be situated as being of a dubious nature (Moghaddam & Harré, 2010, p. 2). For instance, elements of moral superiority are evident in biomedical and CAM discourse, as discussed in section 7.3.1 of the thesis.

Like positioning, the term congruence is used in various ways among different disciplines. However, although there can be slight variations in its use, congruence is commonly associated with the concept of similarity and uniformity (Badea, Tavani, Rubin, & Myer, 2017; Cheung, 2009; Kwon, Ratneshwar, & Kim, 2016). For example, geometric shapes are labelled as congruent when they are of equal size and shape (OpenLearn, 2018). Organisational congruence relates to similarity between an organisation's perspective, values and expectations with that of the individuals they employ or service (Cheung, 2009; Vveinhardt & Gulbovaite, 2017). Congruence within the context of this study was defined in section 8.3.1 of the chapter as compatibility. Congruence as defined in this study and related to philosophical positioning, reflects and extends studies that indicate philosophical congruence with CAM is a factor in CAM utilisation (Astin, 1998; Bishop et al., 2007; McFadden et al., 2010; Islahudin, Shahdan, & Mohamad-Samuri, 2017). The findings from this study extend beyond the factors leading to CAM utilisation to include factors that attract individuals to the practise of CAM. As discussed in Chapter Five of the thesis, *Connecting Philosophically*, the data from this study indicated that participants were attracted to the practise of the CAM therapy that most reflected their philosophical position, specifically in relation to health and wellbeing.

Philosophical congruence as defined in this study also reflects Carl Rogers' theory of therapy, personality and interpersonal relationships, which was developed in relation to client centred therapy (Rogers, 1959). It is hypothesised by Rogers (1959) that individuals inherently have a "tendency toward self-actualization" (p. 196). Self-actualization is described by Rogers (1951) as the tendency to "actualize, maintain and enhance the experiencing organism" (p. 487). It is suggested by Rogers (1959) that self-actualization occurs when there is similarity or relative congruence between an individual's self-concept, how one perceives oneself, and one's ideal self, how one would like to be (pp. 201–206). Congruence is considered by Rogers (1959), as the matching of experience and awareness (p. 206). Incongruence is therefore a discrepancy between self and experience (Rogers, 1959, p. 203). According to Rogers (1959), once a point of relative congruence is reached, tensions between how one perceives oneself and one's actual experiences are lessened (p. 218).

Applying Rogers' notion of congruence and self-actualisation to the experience of participants in this study, it could be argued that participants were able to self-actualise in the homeopathic practice environment. When working as homeopaths, there was no conflict between participants' perception of themselves as holistic health care professionals and the actions they took as homeopathic practitioners. Rather, they were able to integrate their nursing and homeopathic knowledge into a holistic model of care in the homeopathic practice environment. Therefore, when working as homeopaths, there was a congruency between participants' beliefs and their actions. However, when they worked as nurses, it could be argued that their ability to self-actualise was constrained by the epistemological and ontological differences between homeopathy and biomedicine and by the territorial, organisational and professional boundaries of the nursing practice environments they

worked within. Therefore, in these settings there was an incongruence between participants' orientation towards individualised and holistic practice and their actions as nurses.

Rogers' concept of self-actualisation has similarity to Festinger's (1957) theory of cognitive dissonance, which suggests that when an individual is faced with an inconsistency between beliefs and actions, a state of cognitive dissonance occurs that individuals try and resolve in various ways. As discussed in section 7.3.2.1 of the thesis, participants in this study commonly tried to reconcile the conflict between their beliefs and actions by justifying their nursing practise. However, their attempts of reconciliation had limited success, and ultimately the majority of participants left nursing to practise as homeopaths. The few participants who remained working concomitantly as nurses and homeopaths spoke about having compelling financial reasons for remaining in the nursing profession. In most cases, the family's financial security was dependent upon these participants having the guaranteed income that nursing could provide. Consequently, it could be argued that these participants felt they had no option other than to remain in nursing, rather than pursue a full-time career in homeopathy where it can be difficult to obtain regular income.

The experience of these participants, while different to the majority, strengthens rather than minimises the Theory of Congruent Positioning, as most of these participants situated themselves in practice environments that aligned with their philosophical orientation towards holistic principles. The participants worked in nursing practice environments where they talked about being able to form 'meaningful' relationships with clients and in some cases, discerningly utilise their homeopathic knowledge. It could therefore be argued that there was a degree of congruence between the nursing practice environments these participants worked in and their orientation towards holistic practise, thereby reducing any

conflict between their philosophical positioning and their nursing practise. Participants choosing to work in nursing practice environments that support a degree of holistic practise can therefore also be considered within the context of congruent positioning.

Another concept of relevance to the findings of this study is that of value congruence. Values are described by McNeese-Smith and Crook (2003, as cited in Leiter, Jackson & Shaughnessy, 2009) as “ideals that guide judgement, decision making and conduct” (p. 101). Values are an important aspect of human behaviour that underpin and guide not only our personal and social world, but also that of our professional world (Edwards & Cable, 2009; Verplanken, 2004). Value congruence can be defined as compatibility between an individual’s values and that of an organisation, including staff within an organisation such as supervisors and colleagues (Bao, Dolan, & Tzair, 2012; Li, Wang, You, & Gao, 2015; Sortheix, Dietrich, Chow, & Salmela-Aro, 2013). Organisational values are those that guide the expectations surrounding staff behaviour, the way in which resources are distributed and how activities are pursued (Edwards & Cable, 2009; Harrison & Taylor, 2016).

Numerous studies indicate that congruent individual and organisational values result in an engaged workforce with high job satisfaction (Afsar, Cheema, & Bin Saeed, 2018; Dylag, Jaworek, Karwowski, Kozusznik, & Marek, 2013; Edwards & Cable, 2009; Li et al., 2015; Risman, Erickson, & Diefendorff, 2016; Sortheix, 2013; Verplanken, 2003). According to Khan (1990), an engaged workforce is one that connects emotionally and identifies positively with their job (p. 700). Several studies indicate a correlation between value congruence, job satisfaction and retention of employees (Chen & Scannapieco, 2010; Herkes, Churruca, Ellis, Pomare, & Braithwaite, 2019; Leiter et al., 2009; Olubiyi, Smiley, Luckel, & Melaragno, 2019). In contrast, incongruence between individual and

organisational values has been shown to have a negative impact on job satisfaction (Bao et al., 2013; Dotson, Dave, Cazier, & Spaulding, 2014; Leiter & Maslach, 2009; Veage et al., 2014). According to Leiter et al. (2009), value congruence is particularly important in areas such as health care where values guide practise and are a “professional responsibility” (p. 102).

Dotson et al. (2014) explored the relationship between value congruence on nursing retention and suggest that nurses’ perspectives of client care is often not met, leading to the dissatisfaction and attrition of nurses (p. 115). According to Dotson et al. (2014), value congruence has been largely overlooked in research exploring retention of the nursing workforce (p. 115). Dotson et al. (2014) argue that retention strategies aimed at addressing the incongruence between nurses’ perspectives of client care and that of organisational concerns of efficiency and cost effectiveness could positively impact nurses’ intention to remain in nursing practice. The data from this study supports Dotson et al.’s (2014) argument. Findings suggest that if the nursing practice environments in which participants in this study were employed had a philosophy of holistic care, which translated into practise, it is likely that more of them would have stayed working within the nursing profession.

Also of relevance when examining the experience of participants within the context of value congruence is the concept of moral distress, which relates to the distress that individuals suffer due to moral conflict (Corley, 2002; Epstein & Delgado, 2010; Jameton, 1984; Wilson, 2018). Although moral distress was originally identified in nurses, it is now recognised as occurring across disciplines (Epstein & Delgado, 2010; Hellawell, 2015; Rivard & Brown, 2019). The initial definition of moral distress was also limited: it was defined as distress that occurs in response to institutional policies and procedures that inhibit or prevent nurses from acting in a morally appropriate way (Corley, 2002, p. 636;

Jameton, 1984, p. 6). This definition of moral distress has been criticised for making the assumption that there is a single appropriate action, when in reality professional practice and moral decisions are more complex (Johnstone & Hutchinson, 2015; Weinberg, 2009). In addition, it is suggested by Johnstone and Hutchinson (2015), that the dominant narrative of moral distress positions nurses as powerless entities against institutional systems, rather than proactive agents of change, which could result in them failing to act as morally responsible professionals (p. 9).

Despite these criticisms, the concept of moral distress has been widely accepted in nursing and has since been expanded to include other factors that cause moral conflict for nurses, including the tensions between personal moral beliefs and role expectation (Cribb, 2011; Farsides et al., 2004). This type of moral conflict is of particular relevance to this discussion. section 7.3.2 of Chapter Seven of the thesis, *Intersecting Identities: Navigating Opposing Paradigms*, explored the moral conflict that participants felt over certain professional practices that they were expected to perform in their nursing role, as well as conflict that they found less disturbing. The experience of participants in this study suggest a variation in degrees of moral conflict and the distress it causes, which aligns with Cribb's (2011), concept of 'routine moral stress'. Cribb (2011), refers to moral tensions of a less distressing nature as "moral stress" (p. 124). According to Cribb (2011), a lot of moral stress occurs in the course of the normal routine of performing an occupational role (p. 124).

Nursing practice arguably consists of numerous instances of routine moral stress and nurses navigate relationships with clients and their families, their colleagues and their employers on a daily basis (Epstein & Delgado, 2010). It is argued by Cribb that it is reasonable to expect that individuals employed in professional roles that demand a certain level of accountability, such as nurses, manage the routine moral stress that is an inherent part of

their role occupancy. The moral stress that Cribb (2011), refers to is described as being in the “grey area between non-contentious and the objectionable” (p. 124). However, it is important to note that moral conflict is subjective, therefore, the situations that cause moral distress can vary between individuals (Epstein & Delgado, 2010). In addition, factors leading to moral distress are often associated with the daily routine of nursing practice: inequitable resource distribution, lack of autonomy, excessive workloads, and concerns over quality of care (Oh & Gastmans, 2015; Ramos, Barth, Schneider, Cabral, & da Silva Reinaldo, 2016). Findings from this current study indicated that time constraints, nursing workloads and ontological and epistemological incongruence resulted in low levels of job satisfaction, which was primarily resolved by leaving the nursing workforce. These findings support previous research that suggest a correlation between moral distress, decreased job satisfaction and the attrition of nurses (de Veer, Francke, Struijs, & Willems, 2013; Fernandez-Parsons, Rodriguez & Goyal, 2013; Whittaker, Gillum, & Kelly, 2018).

Although the theory of congruent positioning is a substantive theory specific to the experience of nurses who are homeopaths, it could also have relevance to nurses attracted to other forms of CAM underpinned by holistic principles such as naturopathy and herbalism. It could also have relevance to the experience of teachers who are attracted to the Montessori approach to education as well as agriculturists attracted to biodynamic agriculture methods which adopt a more holistic and individualised perspective that differs from conventional educational (Lillard et al., 2017; Montessori Institute, 2013) and agricultural practices (Biodynamic Association, n.d.; Ram & Kumar, 2019). It is suggested by Polit and Beck (2010), that the replication of studies improves the chances for generalisability (p. 1454). Therefore, the potential for the transferability of the Theory of Congruent Positioning developed from this study to the experience of those working in CAM practices based upon concepts of holism, biodynamic agriculture or Montessori

models of education could be tested by future studies among these occupational groups. These studies could explore the premise of the Theory of Congruent Positioning: that individuals are attracted to holistic practices through a process of experiential and transformative learning that alters their worldview, thereby resulting in them positioning themselves in occupational roles and/or environments congruent with their philosophical perspective. As noted by Polit and Beck (2010), replicating studies across contexts strengthens the validity and applicability of their findings (p. 1454). Knowledge is not just gained by new theories or constructs, but also by confirmation of existing ones (Polit & Beck, 2010, p. 1454).

8.5 Summary

This chapter has situated key findings from this study in the literature and discussed the process of theoretical development from the identification of the core category of ‘congruent positioning’, to a theoretical scheme. The Theory of Congruent Positioning which explains participants’ attraction to the practise of homeopathy and the expression of their respective nursing and homeopathic identities in the respective nursing and homeopathic practice environments, was presented. The relationship between the key concepts and their categories that inform the Theory of Congruent Positioning was explored within the context of the findings from this study and the extant literature. The chapter has shown that the Theory of Congruent Positioning reflects, links and broadens other research and theories, thereby making an original contribution to knowledge.

Chapter 9. Conclusion

9.1 Introduction

The aim of this chapter is to bring this thesis to conclusion; therefore, this chapter presents a summary of the thesis. It reviews the aim of the study, the development of the research questions, the findings and conclusions presented in Chapters Five to Seven of this thesis, and how these contribute to the body of knowledge. Also included in this chapter are recommendations that have arisen from the research findings, areas of future research and limitations of the study. Lastly, the chapter concludes with my concluding statement.

9.2 Summary of the Thesis

The aim of this study was to explore what attracts qualified nurses to the practise of homeopathy and the influence, if any, being a nurse and homeopath had on their respective nursing and homeopathic practises, and to develop a substantive theory that explained their experience. That aim was achieved through the inductive process of constructivist grounded theory. The substantive Theory of Congruent Positioning developed from this study is grounded in the experiences of 15 qualified nurses and homeopaths working in the Australian health care system. This theory reflects, correlates and expands various concepts and studies, thereby making an original contribution to existing literature.

The research was introduced in Chapter One which provided context for its undertaking. The chapter began by explaining that despite the considerable controversy that surrounds homeopathy, millions of people use it worldwide. In addition, a number of primary health care providers practise homeopathy, often as an adjunct to their conventional health care practise. The chapter explained that although there are several studies exploring nurses' personal and professional use of complementary and alternative medicine (CAM), there

are limited studies that specifically relate to nurses who hold CAM qualifications and work as CAM practitioners. In addition, it was noted that there is a paucity of current research on the CAM workforce of Australia, with none of the existing studies, to the best of my knowledge, relating specifically to the homeopathic sector. My interest in the topic was also outlined in the chapter, explaining that the genesis of this research lay in my personal experience with nursing and homeopathy. I had observed that a significant number of individuals in the homeopathic community identified as nurses. I was curious as to why these nurses had become homeopaths and how, if at all, being a nurse and a homeopath impacted their respective nursing and homeopathic practices. Lastly, the scope and significance of this study and the conventions used in the thesis were discussed.

Chapter Two contextualised CAM and homeopathy by defining CAM, exploring the different practices that constitute CAM and examining homeopathic philosophy and practice. The various definitions and terms relating to CAM were discussed and the use of the term CAM in the thesis was explained. Three core tenets of homeopathy, namely, the law of similars, minimum dose and totality of symptoms were discussed in relation to classical or Hahnemannian homeopathy. The chapter then situated homeopathy in the landscape of Australian health care and explored its status as a self-regulated profession. Discussion in the chapter highlighted the ontological and epistemological differences between biomedicine and homeopathy as well as the vastly different positions they hold in the landscape of health care in Australia.

Background to the study, within the context of a preliminary review of the literature undertaken prior to commencing data collection, was provided in Chapter Three. The role of literature in grounded theory was examined and justification was provided for the early review of the literature that was undertaken in the study. Search strategies were outlined

and the role of grey literature in relation to the study was considered. This was followed by a brief discussion of the foundation of CAM and the prevalence of CAM use among the Australian population. The historical relationship between CAM and biomedicine was then examined, followed by a discussion on homeopathy, its emergence in Australia and biomedical opposition to it as a health care practice. The relationship between CAM and nursing was then explored and it was identified that there was a paucity of studies relating to nurses who are qualified CAM practitioners and who work in the CAM sector, thereby providing justification for the study.

The study's research design and methods were presented in Chapter Four, giving a detailed account of the how this study was undertaken, its recruitment process, sampling, methodology and ethical considerations. The chapter began with a general discussion on qualitative research before exploring grounded theory and its various approaches. The rationale for using grounded theory in this study was discussed along with a comprehensive description of how the study was conducted. It was explained that the grounded methods used in this study were primarily influenced by Strauss and Corbin (1998, 2008). As the research progressed, I began to reject the more prescriptive approach of Strauss and Corbin's earlier work, preferring their later approach which was less prescriptive and more akin to a constructivist approach. I realised that I was philosophically oriented more towards constructivist grounded theory. In keeping with a constructivist perspective, the study was evaluated using Charmaz's (2014) criteria of credibility, originality, resonance and usefulness (pp. 337–338).

Chapter Five explored participants' initial and continued engagement with CAM and homeopathy within the context of one of the primary concepts developed from the data; namely: connecting philosophically. The factors leading participants to seek CAM and

formally engage with homeopathic education were considered. Findings suggested that participants' attraction to homeopathy was embedded in a process of experiential and transformative learning. During this process, participants' views on health and wellbeing were influenced by their exposure to homeopathic philosophy, which promotes an individualised and holistic approach to clinical practice. At various points, participants began to relate to the homeopathic approach. They talked about homeopathic philosophy making sense and of wanting to know more. The data suggested that connecting with the core tenets of homeopathic philosophy was the overarching factor in participants becoming attracted to the practise of homeopathy.

The second primary concept developed from the data to be explored was intersecting identities. The data suggested that there were two aspects to the concept of intersecting identities, which were subsequently labelled: sharing common ground and navigating opposing paradigms. For the purposes of discussion, these two aspects of intersecting identities were explored separately. In Chapter Six, *Intersecting Identities: Sharing Common Ground*, the intersection of participants' respective identities as nurses and homeopaths was explored within the context of professional identity and the homeopathic practice environment. Participants' assertions that nursing and homeopathy are complementary practices both grounded in holistic philosophy were explored along with the expression of participants' nursing identities in the homeopathic practice environment. It was suggested that in the homeopathic practice environment there was an activation of participants' nursing identities, as evidenced by the integration of nursing knowledge into their homeopathic practice. It was further suggested that participants' nursing knowledge positively influenced their homeopathic practice.

The intersection of participants' respective nursing and homeopathic identities in the nursing practice environment was explored in Chapter Seven, *Intersecting Identities: Navigating Opposing Paradigms*. The conflicting practices and philosophies of biomedicine and homeopathy were discussed and explored within the context of participants' nursing practice. The data suggested that participants compartmentalised their respective nursing and homeopathic identities when they were working as nurses. Therefore, it was suggested that the expression of participants' homeopathic identity was constrained in the nursing practice environments in which they worked. In addition, the data indicated that the majority of participants found the nursing practice environments that they worked within to be incompatible with the ideals of holistic practice, thereby creating a state of cognitive dissonance. Consequently, it was suggested that the nursing practice environment was a dissonant workplace for participants, as their actions as nurses were incongruent with their orientation towards holistic principles. Findings suggest that most participants resolved the conflict between their philosophical positioning and their actions as nurses by eventually choosing to no longer work as nurses. Instead, they chose to work as homeopaths where there was congruence between their philosophical orientation and their actions as nurses. It was noted that the few who chose to remain in nursing tended to position themselves in areas of nursing where some degree of holistic practice was possible, thereby attaining congruence between their beliefs and actions.

Chapter Eight situated this study in the literature and presented the Theory of Congruent Positioning which explains participants' attraction to the practise of homeopathy and how their respective nursing and homeopathic identities were expressed in the respective nursing and homeopathic practice environments. The chapter began by comparing the key findings of this study with other research of relevance. Next, there was a brief exploration of theory in general terms, followed by a discussion of theory development in relation to

grounded theory and this study. The Theory of Congruent Positioning was then presented and explored in relation to its theoretical model, the findings from this study and the extant literature. Discussing the theory within this context, allowed for the theoretical findings to be reviewed in relation to the literature. The study's contribution to knowledge will now be discussed.

9.3 Theoretical Contribution to Knowledge

This study has given voice to a sector of health care workers whose experiences and stories are largely absent in the literature. In addition, there is a lack of current data on the CAM workforce of Australia, especially in relation to the homeopathic sector. I therefore suggest that the findings from this study make a modest, but important contribution to the literature. As discussed in Chapter Eight, *Theorising Positioning and Congruence*, the Theory of Congruent Positioning developed from this research reflects, correlates and broadens other research and concepts. It explains that participants' attraction to the practise of homeopathy was a process of experiential and transformative learning, whereby participants connected to the core tenets of homeopathic philosophy. The theory further explains how participants' respective identities as nurses and homeopaths were expressed in the respective nursing and homeopathic environment. Findings from this study explain that congruency between participants' orientation towards holistic principles and practice and their actions as health care professionals influenced where they positioned themselves in the Australian health care system.

Key findings from this study indicate that nurses oriented towards holistic principles and practice can find it difficult nursing in health care settings where organisational, territorial and epistemological boundaries restrict the inclusion of CAM and where basic components of holistic care are unable to be realised. Working in nursing practice environments that

were incongruent with the philosophical orientation of participants in this study was found to create a state of cognitive dissonance. Essentially, participants' actions as nurses were often in conflict with their orientation towards holistic principles. The majority of participants resolved their cognitive dissonance by leaving the nursing workforce to practise as homeopaths. In the homeopathic practice environment there was congruence between participants' beliefs and actions and they could express their nursing identity without censure. In addition, findings suggest that CAM practitioners with a good understanding of biomedical sciences and the health care system have positive patterns of referral and are well positioned to act as a bridge between biomedicine and CAM. Consequently, the findings of this study have implications for nursing and homeopathic education, practise and future research, which will now be discussed.

9.3.1 Recommendations for consideration by professional nursing bodies

It is acknowledged that retention of the nursing workforce is as complex as the variety of reasons why individuals choose to leave the nursing profession (Halter et al., 2017; Hirschhorn et al., 2010). However, findings from this study indicate that many nursing practice environments fail to support the inclusion of holistic practice. Although nursing is commonly positioned as a holistic practice, these findings concur with previous research suggesting a theory-practice gap in relation to holistic nursing care (Henderson, 2002; Rosa, 2017; Zamanzadeh et al., 2015)

It is therefore suggested that:

- the barriers to holistic nursing practice be reviewed and strategies considered that support nursing practice within a holistic framework. Focus should centre on prioritising holistic practice, supporting individualised care and recognising

the autonomous rights of the individual to choose the interventions and practises, inclusive of CAM, that they believe best support their health and wellbeing.

- CAM practices be considered as a potential specialty of nursing. Nurses who are qualified in CAM could thereby utilise their knowledge and skills as an extension of their scope of practice as nurses. For instance, nurses qualified in therapeutic massage techniques could utilise those skills in their nursing practice.

Furthermore, it is acknowledged that economic and political factors impact health care and that inadequate resources can be a barrier to holistic nursing care. Therefore, it is vital that nursing as a profession advocates for policies and governance that are supportive of models of health care that provide integrative health care, inclusive of CAM practices, (provided no evidence of harm exists), that individuals might normally utilise to support their health and wellbeing.

Another area of note arising from this study is the lack of clear guidelines on the utilisation of CAM in nursing practice. Currently there is a lack of clarity on how CAM is situated in relation to the professional nursing practice of nurses in Australia. Therefore, it is recommended that:

- the role of CAM in nursing practice be reviewed and up to date position statements or guidelines on nurses' professional use of CAM be developed.

Although it is acknowledged that many diverse practices come under the heading of CAM, information is available on the most commonly used CAM practices (NCCIH, 2018). Therefore, a position statement on CAM that

identifies and relates to these CAM practices individually rather than collectively could be a starting point.

9.3.2 Recommendations for consideration by homeopathic regulatory bodies and educators

Findings from this study indicate that clinical exposure outside of the homeopathic profession is limited for student homeopaths. In addition, the referral patterns of participants in this study suggest that CAM practitioners with a solid understanding of biomedical sciences and how the health care system functions have a good ability to recognise cases that are beyond their scope of practice. Therefore, it is recommended that:

- a formal system of mentoring be implemented for student homeopaths that increases their clinical exposure. This mentoring could possibly be based upon an adaptation of the preceptorship model used in nursing. For example, integrative clinics that include homeopathic practitioners are potential sites for students of homeopathy to undertake placement. This style of mentoring would not only increase clinical exposure, but also assist with the socialisation process of student homeopaths, increasing their contact with not only other homeopaths but also other CAM practitioners and conventional health care providers.

Further opportunities for clinical exposure and socialisation could be offered by institutions educating homeopaths through clinical intensives in India or other regions of the world where homeopathy is a recognised component of the health care system.

Aside from recommendations arising from this study, areas of future research were also identified and will now be discussed.

9.3.3 Recommendations for further research

Currently, there is a paucity of research on nurses who are CAM practitioners, who utilise CAM professionally, or who have an orientation towards holistic principles. This lack of available current information offers scope for future studies in these areas. In addition, literature is lacking on the homeopathic workforce of Australia. Areas of future research identified from this study are summarised below:

- Future research could be undertaken focusing on nurses who practise specific CAM practices such as this study has done with homeopathy and test the findings of this research. For instance, studies could explore the experience of naturopaths who are also members of the nursing profession. Existing research involving CAM practices frequently groups a variety of different practices together under the label of CAM. As discussed in section 2.2 of the thesis, this approach is problematic due to the considerable diversity and disparity among CAM practices. In addition, determining any differences in motivating factors to become a practitioner of a specific CAM therapy could extend our knowledge of what nurses are looking for in their professional practice.
- The findings of this study could also be tested by research undertaken with CAM practitioners who used to work in nursing, but who have left the nursing workforce. Possible areas of enquiry could include the clinical decision-making process and referral patterns of this cohort of health care practitioners to see what impact, if any, their nursing experience has had on those factors. In addition, research could explore their decision to leave the nursing workforce and their future career choices, to see if they substantiate this study's findings.
- Future research could explore the referral practices of homeopaths to ascertain the frequency and types of referrals, as well as investigate any notable

differences in these patterns among homeopaths who have worked as nurses and those who have no nursing experience.

- Data from this study indicates that incongruence between participants' orientation towards holistic principles and their actions as a nurse were overarching factors in them leaving the nursing workforce. Literature on nursing retention strategies, reviewed for this body of work, rarely mentioned congruence in relation to the philosophical orientation of nurses and their nursing practice when discussing factors related to positive practice environments and job satisfaction. Consequently, future research could explore value congruence based upon philosophical orientation as a possible retention strategy.
- Data from this study indicated that nurses will direct clients who are interested in CAM to colleagues whom they know to have CAM knowledge/qualifications. In addition, the literature indicates that while nurses appear to have positive attitudes towards CAM, they often lack knowledge on CAM. Nurses who hold nationally recognised CAM qualifications and are registered CAM practitioners are therefore an untapped resource in the Australian health care system. Future research could explore how nurses with nationally recognised CAM qualifications, and who are registered CAM practitioners, could be utilised to educate other nurses on the benefits and risks of CAM. This could be within the context of interprofessional education.
- Several participants in this study with an existing orientation towards CAM had been exposed to holistic concepts and/or CAM in their childhood. Future research could explore the influence, if any, of childhood exposure to CAM on

the health care choices individuals make as adults, as there appears to be a paucity of literature in this area.

- Future research could examine the prevalence of homeopathic utilisation among children in Australia. Although some studies suggest that homeopathy appears to be a relatively popular choice of CAM for children, there appears to be a lack of studies exploring this topic within the Australian context.
- Findings from this study suggest limited data relating to the homeopathic workforce of Australia. Potential areas of research include topics relating to the professional identity of homeopaths and professional issues such as education and socialisation. In addition, research on the homeopathic workforce could provide information on the occupational background of homeopathic practitioners. This information could potentially help identify any patterns of previous employment among this cohort of health care workers, thereby building a 'picture' of those who practise homeopathy.
- The homeopathic consultation was a revelation for many participants in this study, resulting in them altering the way that they interacted with nursing clients, in a positive way. Future research could explore what aspects of homeopathic philosophy, practise and case-taking, if any, might potentially be of value to other health professionals.
- Findings from this study suggest that nurses who are CAM practitioners are well placed to act as a bridge between individuals who are reluctant to seek medical advice and the appropriate conventional health care personnel or services. Therefore, future research could explore how these practitioners could be utilised within conventional primary health care, as opposed to functioning outside the domain of the dominant health care system.

9.4 Limitations of this study

Like all research, this study has limitations, which will now be discussed. First, this study explored a small cohort of homeopathic practitioners who practise within the Australian health care system. Although grounded theory research relies on the saturation of data, rather than the number of participants surveyed or interviewed (Charmaz, 2006, 2014; Vasileiou, Barnett, Thorpe, & Young, 2018), I acknowledge that the sample size of this study may have been limited by external factors. As discussed in section 4.4.2 of the thesis, some potential participants were wary about talking about their experiences as nurses/homeopaths, possibly due to the negative publicity homeopathy was getting in the media at that time. However, it is important to note that despite this limitation, conceptual/theoretical saturation occurred with the sample size of 15 participants, allowing for the development of a data-driven substantive theory, explaining the experience of participants.

Second, this study, like many other qualitative studies, aimed to provide an insightful understanding of a human experience among a specific group of people (Polit & Beck, 2010, p. 1452). Consequently, due to the small sample size of this study and the fact that sampling only occurred across 3 states of Australia the findings of this study are unable to be generalised to other nurses who are homeopaths in other states and territories of Australia. However, whilst the findings of this study may not apply to all nurses who are homeopaths, it is possible that these nurses share a similar experience to participants in this study. Findings from this study are also unable to be generalised to nurses who practise CAM but are not homeopaths. Although there are some similarities in the philosophies underpinning the various CAM practices, more research would be required to test the generalisability of the Theory of Congruent Positioning to nurses who practise other types of CAM therapies. As discussed in section 8.4.2 of the thesis, there could be the potential

for transferability of the Theory of Congruent Positioning, but this would require future research replicating this study across different populations. In addition, the findings from this study are contextual to Australia and may not apply to the experience of nurses who practise homeopathy in other countries. As discussed in Chapters One, *Research Overview*, and Three, *Background*, of the thesis, the status of homeopathy within the health care system of different countries varies. Once again, more research would be needed to see if the findings from this study are applicable to the experience of nurses who practise homeopathy in other parts of the world.

Third, the selection criteria for this study was limited to nurses registered to practise in Australia who were also registered homeopaths in Australia. It is acknowledged that individuals who became nurses after studying homeopathy, those who had left homeopathic practice to become nurses, or returned to nursing after qualifying as homeopaths could also have been included. Although, my interest was in those individuals who had chosen to become homeopaths after becoming nurses for the reasons outlined in Chapter One, *Research Overview*, of the thesis, there was no exclusion criteria on individuals who became nurses after becoming homeopaths. As stated in section 4.4 of Chapter Four *Research Design*, recruitment centred on registered nurses and homeopaths working in both professions and all respondents were nurses who had chosen to become professional homeopaths. Future studies building upon this research could expand upon the selection criteria for this study, thereby adding further variation and depth to the experiences of nurse/homeopaths.

Fourth, given that research is a space occupied by participants and researcher, the positionality of all parties influence the research process, as discussed in section 1.2 of the thesis. Therefore, my experience as a nurse/homeopath undoubtedly influenced this study.

As a nurse/homeopath, I was an ‘insider researcher’ (Fleming, 2018), with my own story. Consequently, there was a need to acknowledge any biases and reflect upon them during the research process. As outlined in section 4.5.8 of Chapter Four, *Research Design*, memos were used to record my thoughts and reflections. I acknowledge that researchers with a different identity, interviewing the same participants, might have a different experience and come to different conclusions.

Finally, geographical and financial considerations limited the mode of data collection to Voice over Internet Protocol (VoIP) technology, as discussed in section 4.5.2 of the thesis. Some technical difficulties were encountered: outlined in section 4.5.3.1 of the thesis, that resulted in non visual contact with a small number of participants. Therefore, non-verbal forms of communication may have been missed.

9.5 Concluding Statement

This study began with my curiosity about the experience of nurses who become homeopaths. I wanted to explore their experience and understand what motivated them to become homeopathic practitioners. I also wondered how, if at all, being both nurse and homeopath, influenced their respective nursing and homeopathic practices. That curiosity resulted in this research, whereby conversations were held with people who were working as nurses and then found themselves engaging with formal homeopathic education. Through their narratives, participants told a story of connection, congruence and incongruence. They spoke about forming a connection to holistic philosophy and of having their eyes opened to another way of considering health and wellbeing through their personal experiences with homeopathy. There was discussion about the congruence of their nursing and homeopathic identities, of how nursing and homeopathy were both grounded in holistic philosophy and of the value of their respective nursing and homeopathic knowledge to their

practise as nurses and homeopaths. However, participants also spoke about incongruence, the tensions between the homeopathic and biomedical paradigms and of the constraints upon their homeopathic identities when they worked as nurses and the barriers to holistic practice. Most participants reached a crossroad where they could no longer reconcile their nursing practice with their ideals of holistic practice, so they left the nursing workforce for the congruence of the homeopathic practice environment.

The story told by participants highlights the appeal of homeopathy and suggests an enhanced approach to providing holistic care through the use of homeopathic principles and philosophy in nursing practice. In an era of person-centred care that emphasises a holistic approach, it is widely recognised that the ideals of person-centred care are seldom met in the daily routine of most nursing practice. The lack of framework to support nurses in providing holistic nursing care is indicative of a system where reductionism remains dominant. The recommendations arising from this study, which are informed by individuals with significant nursing experience, provide a guide for future initiatives and research to reach the ideals of holistic health care at the level of primary nursing care. If it is accepted that health is more than the absence of disease and that person-centred care needs to be at the core of health service delivery, then all health care services should reflect such an approach, not only in rhetoric, but more importantly in everyday practise.

References

- Abelson, B., Rupel, A., & Pincus, T. (2008). Limitations of a biomedical model to explain socioeconomic disparities in mortality of rheumatic and cardiovascular diseases. *Clinical and Experimental Rheumatology*, 26(51), S25–34. Retrieved from <https://www.clinexprheumatol.org/>
- Abend, G. (2008). The meaning of ‘theory’. *Sociological Theory*, 26(2), 173–199. <https://doi:10.1111/j.1467-9558.2008.00324.x>
- Abood, S. (2000). Nursing organizations unite. *American Journal of Nursing*, 100 (11), 23. Retrieved from <https://journals.lww.com/ajnonline>
- Abou El-Soud, N. H. (2010). Herbal medicine in ancient Egypt. *Journal of Medicinal Plant Research*, 4(2), 082–086. Retrieved from <https://academicjournals.org/journal/JMPR>
- Adams, D., Dagenais, S., Clifford, T., Baydala, L., King, W. J., Hervas-Malo, M., . . . Vohra, S. (2013). Complementary and alternative medicine use by pediatric specialty outpatients. *Pediatrics*, 131(2), 225–232. doi:10.1542/peds.2012-1220
- Adams, J., Peng, W., Steel, A., Lauche, R., Moore, C., Amorin-Woods, L., & Sibbritt, D. (2017). A cross-sectional examination of the profile of chiropractors recruited to the Australian Chiropractic Research Network (ACORN): A sustainable resource for future chiropractic research. *BMJ Open*, 7(9), e015830. <https://doi.org/10.1136/bmjopen-2017-015830>
- Adams, J., Sibbritt, D., & Young, A. F. (2009). A longitudinal analysis of older Australian women's consultations with complementary and alternative medicine (CAM) practitioners, 1996–2005. *Age & Ageing*, 38(1), 93–99. <https://doi.org/10.1093/ageing/afn241>

- Adams, K., Hean, S., Sturgis, P., & Clark, J. M. (2006). Investigating the factors influencing professional identity of first-year health and social care students. *Learning in Health and Social Care*, 5(2), 55–68. <https://doi.org/10.1111/j.1473-6861.2006.00119.x>
- Adler, J. M., & McAdams, D. P. (2007). Time, culture, and stories of the self. *Psychological Inquiry*, 18(2), 97–99. <https://doi.org/10.1080/10478400701416145>
- Afsar, B., & Cheema, S., & Bin Saeed, B. (2018). Do nurses display innovative work behavior when their values match with hospitals' values? *European Journal of Innovation Management*, 21(1), 157–171. <https://doi.org/10.1108/EJIM-01-2017-0007>
- Agarwal, V. (2018). Complementary and alternative medicine provider knowledge discourse on holistic health. *Frontiers in Communication*, 3(April). Article 15. <https://doi.org/10.3389/fcomm.2018.00015>
- Agbabiaka, T. B., Wider, B., Watson, L. K., & Goodman, C. (2017). Concurrent use of prescription drugs and herbal medicinal products in older adults: A systematic review. *Drugs & Aging*, 34(12), 891–905. doi:10.1007/s40266-017-0501-7
- Ahn, A. C., Tewari, M., Poon, C.S., & Phillips, R. S. (2006). The limits of reductionism in medicine: Could systems biology offer an alternative? *PLOS Medicine*, 3(6), e208. <https://doi.org/10.1371/journal.pmed.0030208>
- Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., . . . RN4CAST Consortium. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *The Lancet*, 383(9931), 1824–1830. [https://doi.org/10.1016/S0140-6736\(13\)62631-8](https://doi.org/10.1016/S0140-6736(13)62631-8)
- Ali, Z. (2010). Medical acupuncture foundation course. *BMJ*, 340:c828. Retrieved from <https://www.bmj.com/content/340/bmj.c828>

- Allam, M. F., & Arjona, O. (2013). Health promotion or pharmacological treatment for chronic diseases? *Journal of Preventive Medicine and Hygiene*, 54(1), 11–13. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/journals/2879/>
- Allen, K. R. (2016). Feminist theory in family studies: History, reflection, and critique. *Journal of Family Theory & Review*, 8(2), 207–224. <https://doi.org/10.1111/jftr.12133>
- Allen, M., & Watts, T. (2012). Promoting health and wellbeing at the end of life: The contribution of care pathways. *International Journal of Palliative Nursing*, 18(7), 348–354. <https://doi.org/10.12968/ijpn.2012.18.7.348>
- Allsop, J. (2006). Medical dominance in a changing world: The UK case. *Health Sociology Review*, 15(5), 444–457. doi:10.5172/hesr.2006.15.5.444
- Amarasekera, M. (2011). Immunoglobulin E in health and disease. *Asia Pacific Allergy*, 1(1), 12–15. <https://doi.org/10.5415/apallergy.2011.1.1.12>
- American Holistic Nurses Association. (2019). *Welcome*. Retrieved from <https://www.ahna.org/>
- Aminov R. I. (2010). A brief history of the antibiotic era: Lessons learned and challenges for the future. *Frontiers in Microbiology*, 1(134). <https://doi.org/10.3389/fmicb.2010.00134>
- Anderson, C. (2010). Presenting and evaluating qualitative research. *American Journal of Pharmaceutical Education*, 74(8). Article 141. Retrieved from <https://www.ajpe.org/>
- Anderson, C., & Kirkpatrick, S. (2016). Narrative interviewing. *International Journal of Clinical Pharmacy*, 38(3), 631–634. doi:10.1007/s11096-015-0222-0

- Anderson, J. K., Croxon, L., & McGarry, D. E. (2015). Identifying student knowledge and perception of what is valuable to professional practice: A mixed method study. *Nurse Education Today*, 35(12), 1240–1245.
<https://doi.org/10.1016/j.nedt.2015.04.007>
- Anderson, K. T. (2009). Applying positioning theory to the analysis of classroom interactions: Mediating micro-identities, macro-kinds, and ideologies of knowing. *Linguistics and Education*, 20(4), 291–310.
<https://doi.org/10.1016/j.linged.2009.08.001>
- Anderson, M. M., Armstrong, K., Janosz, K. N., Tocco, M., DeVore, N. A., Stachura, G., . . . Patricolo, G. E. (2016). A unique partnership between a health system’s insurance plan and the integrative medicine department benefits patients and helps control costs. *Journal of Hospital Administration*, 5(4), 61–67.
<https://doi.org/10.5430/jha.v5n4p61>
- Anderson, J. G., Friesen, M. A., Fabian, J., Swengros, D., Herbst, A., & Mangione, L. (2016). Examination of the perceptions of registered nurses regarding the use of healing touch in the acute care setting. *Journal of Holistic Nursing*, 34(2), 167–176. <https://doi.org/10.1177/0898010115592744>
- Andersson, E. K., Willman, A., Sjöström-Strand, A., & Borglin, G. (2015). Registered nurses’ descriptions of caring: A phenomenographic interview study. *BMC Nursing*, 14(1). Article 16. <https://doi.org/10.1186/s12912-015-0067-9>
- Andreassen, P., & Christensen, M. K. (2018). ‘We’re at a watershed’: The positioning of PhD nurses in clinical practice. *Journal of Advanced Nursing*, 47(8), 1908–1918.
<https://doi.org/10.1111/jan.13581>

- Andreou, A., Kouta, C., & Ioannou, S. (2015). Cyprus health education curriculum from “victim blaming to empowerment”. *Health Education, 115*(3/4), 392–404.
Retrieved from <https://www.emerald.com/insight/publication/issn/0965-4283>
- Andrew, N. (2012). Professional identity in nursing: Are we there yet? *Nurse Education Today, 32*(8), 846–849. <https://doi.org/10.1016/j.nedt.2012.03.014>
- Andrews, G. J. (2003). Nurses who left the British NHS for private complementary medical practice: Why did they leave? Would they return? *Journal of Advanced Nursing, 41*(4), 403–415. <https://doi.org/10.1046/j.1365-2648.2003.02539.x>
- Ang, S. C., & Wilkinson, J. M. (2013). A preliminary study of complementary and alternative medicine (CAM) practitioners in Singapore. *Complementary Therapies in Medicine, 21*(1), 42–49. <https://doi.org/10.1016/j.ctim.2012.10.004>
- Aoun, S. M., O’Brien, M. R., Breen, L. J., & Connor, M. (2018). ‘The shock of diagnosis’: Qualitative accounts from people with motor neurone disease reflecting the need for more person-centred care. *Journal of the Neurological Sciences, 387*, 80–84. <https://doi.org/10.1016/j.jns.2018.01.026>
- Apriamian, T., Cristancho, S., Watling, C., & Lingard, L. (2016). (Re) grounding grounded theory: A close reading of theory in four schools. *Qualitative Research, 17*(4), 359–376. <https://doi.org/10.1177%2F1468794116672914>
- Aranha, P. R., Sams, L. M., & Saldanha, P. (2016). Impact of preoperative education program on parental anxiety: A pilot project. *Archives of Medicine & Health Sciences, 4*(1), 30–34. doi:10.4103/2321-4848.183374
- Armstrong B. (2006, 2014). *Sydney Homœopathic Hospital*. Retrieved from <https://www.historyofhomeopathy.com.au/hospitals/item/194-sydney-homopathic-hospital.html>

- Armstrong, A. R., Thiébaud, S. P., Brown, L. J., & Nepal, B. (2011). Australian adults use complementary and alternative medicine in the treatment of chronic illness: A national study. *Australian & New Zealand Journal of Public Health*, 35(4), 384--390. doi:10.1111/j.1753-6405.2011.00745.x
- Armstrong, B. (2005, 2008). *Australia's first homœopath*. Retrieved from <https://www.historyofhomeopathy.com.au/articles.html>
- Armstrong, B. (2007, 2017). History of homoeopathy in Australia: The Melbourne homeopathic hospital. Retrieved from <https://www.historyofhomeopathy.com.au/hospitals/item/367-melbourne-homopathic-hospital.html>
- Armstrong, B., & Torokfalvy, P. (2010). History of homeopathy in Australia. Retrieved from <https://www.historyofhomeopathy.com.au/articles.html?start=10>
- Arreciado Marañón, A., & Isla Pera, M. P. (2015). Theory and practice in the construction of professional identity in nursing students: A qualitative study. *Nurse Education Today*, 35(7), 859–863. <https://doi.org/10.1016/j.nedt.2015.03.014>
- Ashforth, B., & Kreiner, G. E. (2014). Dirty work and dirtier work: Differences in countering physical, social, and moral stigma. *The Management and Organization Review*, 10(1), 81--108. doi:10.1111/more.12044
- Ashforth, B., Kreiner, G. E., Clark, M. A., & Fugate, M. (2007). Normalizing dirty work: Managerial tactics for countering occupational taint. *The Academy of Management Journal*, 50(1), 149–174. <https://doi.org/10.2307/20159845>
- Astin, J. A. (1998). Why patients use alternative medicine: Results of a national survey. *The Journal of the American Medical Association*, 279(19), 1548–1553. doi:10.1111/j.1753-6405.2011.00745.x

- Aukett, J. (2017). What is a profession? *British Dental Journal*, 223(5), 323–324.
<https://doi.org/10.1038/sj.bdj.2017.754>
- Austin, Z., & Sutton, J. (2014). Qualitative research: Getting started. *The Canadian Journal of Hospital Pharmacy*, 67(6), 436–440.
<http://dx.doi.org/10.4212/cjhp.v67i6.1406>
- Australasian Integrative Medicine Association. (2018). *What is integrative medicine?*
 Retrieved from <https://www.aima.net.au/what-is-integrative-medicine/>
- Australian Bureau of Statistics. (2011). *Australian social trends, March 2011*. Retrieved from <http://www.abs.gov.au>
- Australian College of Midwives. (2019). *Position statements: Scope of practice for midwives in Australia*. Retrieved from <https://www.midwives.org.au/position-statements?page=1>
- Australian Health Ministers' Advisory Council. (2013). *Options for regulation of unregistered health practitioners*. Retrieved from <https://ris.pmc.gov.au/sites/default/files/posts/2013/08/unregistered-health-practitioners-final-report-decision-RIS.pdf>
- Australian Health Practitioner Regulation Agency. (2015). *AHPRA FAQ. About the National Scheme*. Retrieved from <https://www.ahpra.gov.au/About-AHPRA/What-We-Do/FAQ.aspx>
- Australian Health Practitioner Regulation Agency. (2017). *National Boards*. Retrieved from <https://www.ahpra.gov.au/National-Boards.aspx>
- Australian Health Practitioner Regulation Agency. (2019). *Regulatory principles for the National Scheme*. Retrieved from <https://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>

- Australian Homeopathic Association, WA Branch. (2011). *History of homoeopathy in WA, New Norcia*. Retrieved from <https://www.homeopathywa.org.au/our-history/>
- Australian Homoeopathic Association. (2019a). *Government regulations*. Retrieved from <https://www.homeopathyoz.org/general-interest/government-regulations>
- Australian Homoeopathic Association. (2019b). *About the AHA. Aims and objectives*. Retrieved from <https://www.homeopathyoz.org/about?start=3>
- Australian Homoeopathic Association. (2019c). *About the AHA. Professionalism*. Retrieved from <https://www.homeopathyoz.org/about?start=4>
- Australian Homoeopathic Association. (2019d). *Upcoming events*. Retrieved from <https://www.homeopathyoz.org/events>
- Australian Institute of Health and Welfare. (2016). *Nursing and midwifery workforce 2015, Work characteristics of nurses and midwives*. Retrieved from <https://www.aihw.gov.au/reports/workforce/nursing-and-midwifery-workforce-2015/contents/work-characteristics-of-nurses-and-midwives>
- Australian Institute of Health and Welfare. (2018). *Australia's health 2018*. Australia's health series no. 16. AUS 221. Canberra: AIHW. Retrieved from <https://www.aihw.gov.au/>
- Australian Institute of Health and Welfare. (2019). *Chronic disease*. Retrieved from <https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview>
- Australian Medical Association. (2006). *AMA code of ethics—2004. Editorially revised 2006*. Retrieved from <https://ama.com.au/tas/ama-code-ethics-2004-editorially-revised-2006>
- Australian Medical Association. (2010). *Primary health care—2010*. Retrieved from <https://ama.com.au/position-statement/primary-health-care-2010>

- Australian Medical Association. (2018). *AMA position statement—Complementary medicine—2018*. Retrieved from <https://ama.com.au/position-statement/ama-position-statement-complementary-medicine-2018>
- Australian Medical Association. (2019). *Nurse practitioner proposals must be rejected*. Retrieved from <https://ama.com.au/media/nurse-practitioner-proposals-must-be-rejected>
- Australian Naturopathic Practitioners Association. (2013). *ANPA PHI rebate submission: Evidence in support of private health insurance rebates for naturopathy*. Retrieved from <https://anpa.asn.au/anpa-phi-rebate-submission/>
- Australian Naturopathic Practitioners Association. (2019). *Nutritional medicine*. Retrieved from <https://anpa.asn.au/nutritional-medicine/>
- Australian Nursing and Midwifery Federation. (2014). *Media and publications: ANMF policies*. Retrieved from <http://anmf.org.au/pages/anmf-policies>
- Australian Nursing Federation. (2011). *Nursing and midwifery care*. Retrieved from http://anmf.org.au/documents/policies/P_Nursing_midwifery_care.pdf
- Australian Primary Health Care Nurses Association. (2017a). *Correctional health nursing*. Retrieved from <https://www.apna.asn.au/profession/what-is-primary-health-care-nursing/correctional-health-nursing>
- Australian Primary Health Care Nurses Association. (2017b). *Community health nursing*. Retrieved from <https://www.apna.asn.au/profession/what-is-primary-health-care-nursing/community-health-nursing>
- Australian Register of Homeopaths. (n.d.a). *What is AROH?* Retrieved from <https://www.aroh.com.au/about>
- Australian Register of Homoeopaths. (2015a). *Code of professional conduct*. Retrieved from <https://www.aroh.com.au/Policies>

- Australian Register of Homoeopaths. (2015b). *Standards of practice*. Retrieved from <https://www.aroh.com.au/Policies>
- Australian Register of Homoeopaths. (2018a). *Code of professional conduct*. Retrieved from <https://www.aroh.com.au/Policies>
- Australian Register of Homoeopaths. (2018b). *Standards of practice*. Retrieved from <https://www.aroh.com.au/Policies>
- Australian Register of Homoeopaths. (n.d.b). *Registration with AROH offers the following benefits*. Retrieved from <https://www.aroh.com.au/Why-Register>
- Australian Register of Homoeopaths. (n.d.c). *How to register*. Retrieved from <https://www.aroh.com.au/How-to-register>
- Aveni, E., Bauer, B., Ramelet, A. S., Decosterd, I., Ballabeni, P., Bonvin, E., & Rodondi, P. Y. (2017). Healthcare professionals' sources of knowledge of complementary medicine in an academic center. *PLOS ONE*, 12(9), e0184979. <https://doi.org/10.1371/journal.pone.0184979>
- Ayers, S. L., & Kronenfeld, J. J. (2010). Using factor analysis to create complementary and alternative medicine domains: An examination of patterns of use. *Health*, 14(3), 234--252. <https://doi.org/10.1177/1363459309347491>
- Ayers, S. L., & Kronenfeld, J. J. (2012). Delays in seeking conventional medical care and complementary and alternative medicine utilization. *Health Services Research*, 47(5), 2081–2096. doi:10.1111/j.1475-6773.2012.01406.x
- Baars, E. W., & Hamre, H. J. (2017). Whole medical systems versus the system of conventional biomedicine: A critical, narrative review of similarities, differences, and factors that promote the integration process. *Evidence-Based Complementary and Alternative Medicine*, 2017. Article 4904930. <https://doi.org/10.1155/2017/4904930>

- Badea, C., Tavani, J. L., Rubin, M., & Meyer, T. (2017). Self-affirmation, political value congruence, and support for refugees. *Journal of Applied Social Psychology*, 47(7), 355–365. <https://doi.org/10.1111/jasp.12441>
- Baer, H. A. (2004). *Toward an integrative medicine: Merging alternative therapies with biomedicine*. Lanham, MD: Rowman AltaMira.
- Baer, H. (2008). The emergence of integrative medicine in Australia: The growing interest of biomedicine and nursing in complementary medicine in a southern developed society. *Medical Anthropology Quarterly*, 22(1), 52–66. <https://doi.org/10.1111/j.1548-1387.2008.00003.x>
- Baer, H. A., & Coulter, I. (2008). Taking stock of integrative medicine: Broadening biomedicine or co-option of complementary and alternative medicine? *Health Sociology Review*, 17(4), 331–341. <https://doi.org/10.5172/hesr.451.17.4.331>
- Baggoley, C. (2015). *Review of the Australian government rebate on private health insurance for natural therapies*. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/Content/phi-natural-therapies>
- Bahall, M., & Legall, G. (2017). Knowledge, attitudes, and practices among health care providers regarding complementary and alternative medicine in Trinidad and Tobago. *BMC Complementary and Alternative Medicine*, 17(1). Article 144. doi:10.1186/s12906-017-1654-y
- Bailey, J. (2008). First steps in qualitative data analysis: Transcribing. *Family Practice*, 25(2), 127–131. <https://doi.org/10.1093/fampra/cmn003>
- Baker, M. A., Robinson, J. S., & Kolb, D. A. (2012). Aligning Kolb’s experiential learning theory with a comprehensive agricultural education model. *Journal of Agricultural Education*, 53(4), 1–16. doi:10.5032/jae.2012.04001

- Ball, J. E., Murrells, T., Rafferty, A. M., Morrow, E., & Griffiths, P. (2014). 'Care left undone' during nursing shifts: Associations with workload and perceived quality of care. *BMJ Quality & Safety*, 23(2), 116–125. <https://doi.org/10.1136/bmjqs-2012-001767>
- Balog, J. E. (2017). The meaning of health in the era of value-based care. *Cureus*, 9(2), e1042. <https://dx.doi.org/10.7759%2Fcureus.1042>
- Balouchi, A., Mahmoudirad, G., Hastings-Tolsma, M., Shorofi, S. A., Shahdadi, H., & Abdollahimohammad, A. (2018). Knowledge, attitude and use of complementary and alternative medicine among nurses: A systematic review. *Complementary Therapies in Clinical Practice*, 31(May), 146–157. <https://doi.org/10.1016/j.ctcp.2018.02.008>
- Bao, Y., Dolan, S. L., & Tzafrir, S. S. (2012). *Value congruence in organizations: Literature review, theoretical perspectives, and future directions*. ESADE Business School Research Paper 239. Retrieved from <http://dx.doi.org/10.2139/ssrn.2154976>
- Barki, H., & Hartwick, J. (2004). Conceptualizing the construct of interpersonal conflict. *International Journal of Conflict Management*, 15(3), 216–244.
- Barnes, P. M., Bloom, B., & Nahin, R. L. (2008). *Complementary and alternative medicine use among adults and children: United States, 2007*. National Health Statistics Reports No. 12, 1–23. Retrieved from https://www.cdc.gov/nchs/nhis/nhis_nhsr.htm
- Barrett, B., Marchand, L., Jo, S., Appelbaum, D., Plane, M. B., Blustein, J., . . . Capperino, C. (2004). What complementary and alternative medicine practitioners say about health and health care. *Annals of Family Medicine*, 2(3), 253–259. doi:10.1370/afm.81

- Barrett, B., Marchand, L., Scheder, J., Plane, M. B., Maberry, R., Appelbaum, D., ...
 Rabago, D. (2003). Themes of holism, empowerment, access, and legitimacy
 define complementary, alternative, and integrative medicine in relation to
 conventional biomedicine. *Journal of Alternative and Complementary Medicine*,
 9(6), 937–947. <https://doi.org/10.1089/107555303771952271>
- Barry, C. A. (2006). The role of evidence in alternative medicine: Contrasting biomedical
 and anthropological approaches. *Social Science & Medicine*, 62(11), 2646–2657.
 doi:10.1016/j.socscimed.2005.11.025
- Baumann, S. L. (2010). The limitations of evidenced-based practice. *Nursing Science
 Quarterly*, 23(3), 226–230. doi:10.1177/0894318410371833
- Bayne, A., & Kirkland, P. (2008). Prepare children for surgery one stage at a time. *OR
 Nurse*, 2(8), 36–39. doi:10.1097/01.ORN.0000335524.29937.70
- Bazeley, P., & Jackson, K. (2013). *Qualitative data analysis with NVIVO* (2nd ed).
 London: Sage.
- Beck, U., & Beck-Gernsheim, E. (2002). Individualization: Institutionalized
 individualism and its social and political consequences. London: Sage.
- Becker, H., & Carper, J. (1956). The development of identification with an occupation.
American Journal of Sociology, 61(4), 289–298. Retrieved from
<http://www.jstor.org/stable/2773529>
- Bell, E., Campbell, S., & Goldberg, L. R. (2015). Nursing identity and patient-
 centredness in scholarly health services research: A computational text analysis of
 PubMed abstracts 1986–2013. *BMC Health Services Research*, 15(January).
 Article 3. <https://doi.org/10.1186/s12913-014-0660-8>

- Bell, I. R., & Boyer, N. N. (2013). Homeopathic medications as clinical alternatives for symptomatic care of acute otitis media and upper respiratory infections in children. *Global Advances in Health and Medicine*, 2(1), 32–43.
<https://doi.org/10.7453/gahmj.2013.2.1.007>
- Bell, I. R., & Koithan, M. (2012). A model for homeopathic remedy effects: Low dose nanoparticles, allostatic cross-adaptation, and time-dependent sensitization in a complex adaptive system. *BMC Complementary and Alternative Medicine*, 12(October). Article 191. <https://doi.org/10.1186/1472-6882-12-191>
- Bell, I. R., Lewis, D. A., Lewis, S. E., Brooks, A. J., Schwartz, G. E., & Baldwin, C. M. (2004). Strength of vital force in classical homeopathy: Bio-psycho-social-spiritual correlates within a complex systems context. *Journal of Alternative and Complementary Medicine*, 10(1), 123–131.
<https://doi.org/10.1089/107555304322849048>
- Bellavite, P., Conforti, A., Piasere, V., & Ortolani, R. (2005). Immunology and homeopathy. 1. Historical background. *Evidence-Based Complementary and Alternative Medicine*, 2(4), 441–452. <https://doi.org/10.1093/ecam/neh141>
- Bendassolli, P. (2013). Theory building in qualitative research: Reconsidering the problem of induction. *Forum: Qualitative Social Research*, 14(1), Article 25.
<http://dx.doi.org/10.17169/fqs-14.1.1851>
- Benedetti, F. (2014). Drugs and placebos: What's the difference? Understanding the molecular basis of the placebo effect could help clinicians to better use it in clinical practice. *EMBO Reports*, 15(4), 329–332. doi:10.1002/embr.201338399
- Benjamin, O., Bernstein, D., & Motzafi-Haller, P. (2011). Emotional politics in cleaning work: The case of Israel. *Human Relations*, 64(3), 337–357.
<https://doi.org/10.1177/0018726710378383>

- Benner, P., & Tanner, C. (1987). Clinical judgment: How expert nurses use intuition. *The American Journal of Nursing*, 87(1), 23–31. doi:10.2307/3470396
- Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. Jossey-Bass: San Francisco.
- Bennett, C. (2018, April 22). Homeopathy is quackery plain and simple, whatever the royal family says. *The Guardian*. Retrieved from <https://www.theguardian.com/commentisfree/2018/apr/22/homeopathy-quackery-plain-and-simple-whatever-royal-family-says>
- Bensoussan, A., & Myers, S. P. (1996). *Towards a safer choice: The practice of traditional Chinese medicine in Australia*. Campbelltown, NSW: Faculty of Health, University of Western Sydney.
- Bensoussan, A., Myers, S. P., Wu, S. M., & O'Connor, K. (2004). Naturopathic and western herbal medicine practice in Australia—A workforce survey. *Complementary Therapies in Medicine*, 12(1), 17–27. <https://doi.org/10.1016/j.ctim.2004.01.001>
- Berdai, M. A., Labib, S., Chetouani, K., & Harandou, M. (2012). Atropa belladonna intoxication: A case report. *The Pan African Medical Journal*, 11, 72. Retrieved from <http://www.panafrican-med-journal.com/content/article/11/72/full/>
- Beresford, M. J. (2010). Medical reductionism: Lessons from the great philosophers. *QJM*, 103(9), 721–724. <https://doi.org/10.1093/qjmed/hcq057>
- Berger, S., Braehler, E., & Ernst, J. (2012). The health professional-patient-relationship in conventional versus complementary and alternative medicine. A qualitative study comparing the perceived use of medical shared decision-making between two different approaches of medicine. *Patient Education & Counseling*, 88(1), 129–137. doi:10.1016/j.pec.2012.01.003

- Bergsteiner, H., Avery, G. C., & Neumann, R. (2010). Kolb's experiential learning model: Critique from a modelling perspective. *Studies in Continuing Education*, 32(1), 29--46. doi:10.1080/01580370903534355
- Beyond Blue. (2019). *Electroconvulsive Therapy [ECT]*. Retrieved from [https://www.beyondblue.org.au/the-facts/depression/treatments-for-depression/medical-treatments-for-depression/electroconvulsive-therapy-\(ect\)](https://www.beyondblue.org.au/the-facts/depression/treatments-for-depression/medical-treatments-for-depression/electroconvulsive-therapy-(ect))
- Bhandari, N. (2015). Is Ayurveda the key to universal healthcare in India? *BMJ*, 350:h2879. <https://doi.org/10.1136/bmj.h2879>
- Biddle, B. (1986). Recent development in role theory. *Annual Review of Sociology*, 12, 67--92. Retrieved from <http://www.jstor.org/stable/2083195>
- Bilsel, R. U., & Lin, D. K. J. (2012). Ishikawa cause and effect diagrams using capture recapture techniques. *Quality Technology & Quantitative Management*, 9(2), 137--152. <https://doi.org/10.1080/16843703.2012.11673282>
- Biniecki, S. M. Y., & Conceição, S. C. O. (2014). How living or traveling to foreign locations influences adults' worldviews and impacts personal identity. *New Horizons in Adult Education and Human Resource Development*, 26(3), 39--53. doi:10.1002/nha3.20071
- Biodynamic Association. (n.d.). *What is biodynamics?* Retrieved from <https://www.biodynamics.com/what-is-biodynamics>
- Bipartisan Policy Center. (2015). *A prevention prescription for improving health and health care in America*. Retrieved from <https://bipartisanpolicy.org/library/a-prevention-prescription-for-improving-health-and-health-care-in-america/>
- Birks, M., & Mills, J. (2011). *Grounded theory. A practical guide*. London: Sage.

- Birks, M., Cant, R., Al-Motlaq, M., & Jones, J. (2011). "I don't want to become a scientist": Undergraduate nursing students' perceived value of course content. *Australian Journal of Advanced Nursing*, 28(4), 20–27. Retrieved from http://www.ajan.com.au/ajan_28.4.html
- Birks, M., Chapman, Y., & Francis, K. (2006). Moving grounded theory into the 21st century: Part 1—An evolutionary tale. *Singapore Nursing Journal*, 33(4), 4–10. Retrieved from <https://www.researchgate.net/publication/233751535>
- Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, 26(13), 1802–1811. <https://doi.org/10.1177/1049732316654870>
- Birth Partner. (2019). *Homoeopathic birth kit from Owen Homoeopathics*. Retrieved from <https://birthpartner.com.au/product/homeopathic-birthing-kit-from-owen-homoeopathics/>
- Bishop, F. L., & Lewith, G. T. (2010). Who uses CAM? A narrative review of demographic characteristics and health factors associated with CAM use. *Evidence-Based Complementary and Alternative Medicine: ECAM*, 7(1), 11–28. <https://doi.org/10.1093/ecam/nen023>
- Bishop, F. L., & Lewith, G. T. (2013). Patients' preconceptions of acupuncture: A qualitative study exploring the decisions patients make when seeking acupuncture. *BMC Complementary and Alternative Medicine*, 13(1), 102. doi:10.1186/1472-6882-13-102
- Bishop, F. L., Yardley, L., & Lewith, G. T. (2007). A systematic review of beliefs involved in the use of complementary and alternative medicine. *Journal of Health Psychology*, 12(6), 851–867. doi:10.1177/1359105307082447

- Bjerså, K., Stener Victorin, E., & Fagevik Olsén, M. (2012). Knowledge about complementary, alternative and integrative medicine (CAM) among registered health care providers in Swedish surgical care: A national survey among university hospitals. *BMC Complementary and Alternative Medicine*, 12(1). Article 42. doi:10.1186/1472-6882-12-42
- Blasdell, N. D. (2017). The meaning of caring in nursing practice. *International Journal of Nursing & Clinical Practices*, 4(2017). <https://doi.org/10.15344/2394-4978/2017/238>
- Blease, C. R., Bishop, F. L., & Kaptchuk, T. J. (2017). Informed consent and clinical trials: Where is the placebo effect? *BMJ*, 356:j463. doi:10.1136/bmj.j463
- Bodkin, H., & Donnelly, L. (2016, October 27). The end of doctor knows best as medics are told to let patients make their own decision about treatment. *The Telegraph*. Retrieved from <https://www.telegraph.co.uk/news/2016/10/26/the-end-of-doctor-knows-best-as-medics-are-told-to-let-patients/>
- Bolderston, A. (2012). Conducting a research interview. *Journal of Medical Imaging and Radiation Sciences*, 43(1), 66–76. <https://doi.org/10.1016/j.jmir.2011.12.002>
- Bondemark, L., & Ruf, S. (2015). Randomized controlled trial: The gold standard or an unobtainable fallacy? *European Journal of Orthodontics*, 37(5), 457–461. <https://doi:10.1093/ejo/cjv046>
- Bontchev, B., Vassileva, D., Aleksieva-Petrova, A., & Petrov, M. (2018). Playing styles based on experiential learning theory. *Computers in Human Behavior*, 85(April), 319–328. doi:10.1016/j.chb.2018.04.009
- Boote, D. N., & Beile, P. (2005). Scholars before researchers: On the centrality of the dissertation literature review in research preparation. *Educational Researcher*, 34(6), 3–15. <https://doi.org/10.3102%2F0013189X034006003>

- Booth-LaForce, C., Scott, C. S., Heitkemper, M. M., Cornman, B. J., Lan, M.C., Bond, E. F., & Swanson, K. M. (2010). Complementary and Alternative Medicine (CAM) attitudes and competencies of nursing students and faculty: Results of integrating CAM into the nursing curriculum. *Journal of Professional Nursing*, 26(5), 293--300. <http://dx.doi.org/10.1016/j.profnurs.2010.03.003>
- Borbasi, S., & Jackson, D. (2012). *Navigating the maze of research: Enhancing nursing and midwifery practice* (3rd ed.). Elsevier: Chatswood, NSW.
- Bornhöft, G., von Ammon, K., Righetti, M., Thurneysen, A., & Matthiessen, P. F. (2011). Full discussion of the HTA results. In G. Bornhöft & P. F. Matthiessen (Eds.), *Homeopathy in healthcare –effectiveness, appropriateness, safety, costs: An HTA report on homeopathy as part of the Swiss complementary medicine evaluation programme* (pp. 193–204). https://doi.org/10.1007/978-3-642-20638-2_13
- Bornhöft, G., Wolf, U., von Ammon, K., Righetti, M., Maxion-Bergemann, S., Baumgartner, S., . . . Matthiessen, P. F. (2006). Effectiveness, safety and cost-effectiveness of homeopathy in general practice—Summarized health technology assessment. *Forschende Komplementarmedizin*, 13(2), 19–29. <https://doi.org/10.1159/000093586>
- Bos, A. E. R., Kanner, D., Muris, P., Janssen, B., & Mayer, B. (2009). Mental illness stigma and disclosure: Consequences of coming out of the closet. *Issues in Mental Health Nursing*, 30(8), 509–513. doi:10.1080/01612840802601382
- Boseley, S. (2010, February 23). Stop funding homeopathy, MPs urge. *The Guardian*. Retrieved from <https://www.theguardian.com/society/2010/feb/22/stop-funding-homeopathy-mps-urge>

- Boston, P. (2015). Positioning theory and narratives in the organization: Teaching MSc students to apply theory to practice. *Journal of Family Therapy*, 37(1), 134–139. <https://doi.org/10.1111/1467-6427.12002>
- Bothwell, L. E., Greene, J. A., Podolsky, S. H., & Jones, D. S. (2016). Assessing the gold standard—lessons from the history of RCTs. *The New England Journal of Medicine*, 374(22), 2175–2181. doi:10.1056/NEJMms1604593
- Bourke, B. (2014). Positionality: Reflecting on the research process. *The Qualitative Report*, 19(33), 1–9. Retrieved from <https://nsuworks.nova.edu/tqr/vol19/iss33/3>
- Bradshaw, J., & Moxham, L. (2005). ‘The Psychiatric Consumer’: The use of student stories to inform course development. *Studies in Learning Evaluation Innovation and Development*, 2 (2), 39–48. Retrieved from <http://shiftwork.cqu.edu.au/index.php>
- Brante, T. (2011). Professions as science-based occupations. *Professions and Professionalism*, 1(1), 4–20. <https://doi.org/10.7577/pp.v1i1.147>
- Brenan, M. (2017, December 26). *Nurses keep healthy lead as most honest, ethical profession*. Retrieved from https://news.gallup.com/poll/224639/nurses-keep-healthyleadhonestethicalprofession.aspx?g_source=Economy&g_medium=newsfeed&g_campaign=tiles
- Brenner, P. S., Serpe, R. T., & Stryker, S. (2014). The causal ordering of prominence and salience in identity theory: An empirical examination. *Social Psychology Quarterly*, 77(3), 231–252. <https://doi.org/10.1177/0190272513518337>
- Brien, S. B., Leydon, G. M., & Lewith, G. (2012). Homeopathy enables rheumatoid arthritis patients to cope with their chronic ill health: A qualitative study of patient’s perceptions of the homeopathic consultation. *Patient Education and Counseling*, 89(3), 507–516. doi:10.1016/j.pec.2011.11.008

- Brien, S., Dibb, B., & Burch, A. (2011). The use of intuition in homeopathic clinical decision making: An interpretative phenomenological study. *Evidence-Based Complementary and Alternative Medicine*, 2011. Article 935307.
<https://doi.org/10.1093/ecam/nep153>
- Brien, S., Lachance, L., & Lewith, G. T. (2004). Are the therapeutic effects of homeopathy attributed to the consultation, the homeopathic remedy, or both? A protocol for a future exploratory feasibility trial in patients with rheumatoid arthritis. *Journal of Alternative & Complementary Medicine*, 10(3), 499–502.
doi:10.1089/1075553041323768
- Brien, S., Prescott, P., Owen, D., & Lewith, G. (2004). How do homeopaths make decisions? An exploratory study of inter-rater reliability and intuition in the decision making process. *Homeopathy*, 93(3), 125–131.
<https://doi.org/10.1016/j.homp.2004.04.001>
- British Columbia College of Nursing Professionals. (2019). *Boundaries in the nurse-client relationship practice standard*. Retrieved from
<https://www.bccnp.ca/Glossary/Pages/boundaries.aspx>
- British Homeopathic Association. (2019a). *The evidence for homeopathy*. Retrieved from
<https://www.britishhomeopathic.org/evidence/the-evidence-for-homeopathy/>
- British Homeopathic Association. (2019b). *History*. Retrieved from
<https://www.britishhomeopathic.org/homeopathy/the-history-of-homeopathy/>
- Brock, R. (2015). Intuition and insight: Two concepts that illuminate the tacit in science education. *Studies in Science Education*, 51(2), 127–167.
<https://doi.org/10.1080/03057267.2015.1049843>

- Brodsky, E., & Dijk, D. V. (2008). Advanced and specialist nursing practice: Attitudes of nurses and physicians in Israel. *Journal of Nursing Scholarship*, 40(2), 187–194. doi:10.1111/j.1547-5069.2008.00225.x
- Brookes, K., Davidson, P. M., Daly, J., & Halcomb, E. J. (2007). Role theory: A framework to investigate the community nurse role in contemporary health care systems. *Contemporary Nurse*, 25(1–2), 146–155. doi:10.5172/conu.2007.25.1-2.146
- Broom, A., & Adams, J. (2009). Oncology clinicians' accounts of discussing complementary and alternative medicine with their patients. *Health*, 13(3), 317–336. <https://doi.org/10.1177/1363459308101806>
- Brown, W. A. (2015). Expectation, the placebo effect and the response to treatment. *Rhode Island Medical Journal* (2013), 98(5), 19–21. Retrieved from <http://www.rimed.org/rimedicaljournal/2015/05/2015-05.pdf>
- Bryman, A. (2016). *Social research methods* (5th ed.). Oxford, UK: Oxford University Press.
- Buchan, S., Shakeel, M., Trinidade, A., Buchan, D., & Ah-See, K. (2012). The use of complementary and alternative medicine by nurses. *British Journal of Nursing*, 21(11), 672–674. <https://doi:10.12968/bjon.2012.21.11.672>
- Bujalkova, M. (2001). Hippocrates and his principles of medical ethics. *Bratislavske Lekarske Listy*, 102(2), 117–120. Retrieved from <http://bmj.fmed.uniba.sk/2001/10202-10.PDF>
- Burke, P. J. (2004). Identities and social structure: The 2003 Cooley-Mead Award address. *Social Psychology Quarterly*, 67(1), 5–15. <https://doi.org/10.1177/019027250406700103>
- Burke, P. J., & Stets, J. E. (2009). *Identity theory*. New York: Oxford University Press.

- Burton, M. J., Glasziou P. P., Chong L.Y., & Venekamp, R. P. (2014). Tonsillectomy or adenotonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. *Cochrane Database of Systematic Reviews*. Issue 11. Article CD001802. doi:10.1002/14651858.CD001802.pub3.
- Butler, A. E., Copnell, B., & Hall, H. (2018). The development of theoretical sampling in practice. *Collegian*, 25(5), 561–566. <https://doi.org/10.1016/j.colegn.2018.01.002>
- Butler, N., Chillias, S., & Muhr, S. L. (2012). Professions at the margins. *Ephemera: Theory & Politics in Organization*, 12(3), 259–272. Retrieved from <http://www.ephemerajournal.org/>
- Buyx, A. M. (2008). Personal responsibility for health as a rationing criterion: Why we don't like it and why maybe we should. *Journal of Medical Ethics*, 34(12), 871--874. doi:10.1136/jme.2007.024059
- Canadian Interprofessional Health Collaborative. (2010). *A national interprofessional competency framework*. Retrieved from http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf
- Canaway, R. (2009). A culture of dissent: Australian naturopaths' perspectives on practitioner regulation. *Complementary Health Practice Review*, 14(3), 136–152. <https://doi.org/10.1177/1533210109360308>
- Canizares M., Hogg-Johnson, S., Gignac, M., Glazier, R., & Badley, E. (2017). Changes in the use practitioner-based complementary and alternative medicine over time in Canada: Cohort and period effects. *PLOS ONE* 12(5), e0177307. <https://doi.org/10.1371/journal.pone.0177307>
- Cant, S., & Sharma, U. (1999). *A new medical pluralism: Complementary and alternative medicine, doctors, patients and the state*. Routledge: London.

- Cant, S., Watts, P., & RushshonRushtton, A. (2011). Negotiating competency, professionalism and risk: The integration of complementary and alternative medicine by nurses and midwives in NHS hospitals. *Social Science & Medicine*, 72(4), 529–536. <https://doi.org/10.1016/j.socscimed.2010.11.034>
- Cant, S., Watts, P., & Rushton, A. (2012). The rise and fall of complementary medicine in National Health Service hospitals in England. *Complementary Therapies in Clinical Practice*, 18(3), 135-139. <https://doi.org/10.1016/j.ctcp.2012.05.004>
- Cappelen, A. W., & Norheim, O. F. (2005). Responsibility in health care: A liberal egalitarian approach. *Journal of Medical Ethics*, 31(8), 476–480.
doi:10.1136/jme.2004.010421
- Carnago, L., & Mast, M. (2015). Using ways of knowing to guide emergency nursing practice. *Journal of Emergency Nursing*, 41(5), 387–390.
<https://doi.org/10.1016/j.jen.2015.01.011>
- Carter, M. J., & Fuller, C. (2016). Symbols, meaning, and action: The past, present, and future of symbolic interactionism. *Current Sociology*, 64(6), 931–961.
<https://doi.org/10.1177/0011392116638396>
- Casey, M., Adams, J., & Sibbritt, D. (2008). An examination of the clinical practices and perceptions of professional herbalists providing patient care concurrently with conventional medical practice in Australia. *Complementary Therapies in Medicine*, 16(4), 228–232. <https://doi.org/10.1016/j.ctim.2007.06.002>
- Cassidy, A., & McIntosh, B. (2014). The return of autonomy in nursing: A way forward. *British Journal of Nursing*, 23(11), 562–563. doi:10.12968/bjon.2014.23.11.562

- Caulfield, T., & DeBow, S. (2005). A systematic review of how homeopathy is represented in conventional and CAM peer reviewed journals. *BMC Complementary and Alternative Medicine*, 5. Article 12.
<https://doi.org/10.1186/1472-6882-5-12>
- Caza, B. B., & Creary, S. J. (2016). The construction of professional identity. In A. Wilkinson, D. Hislop, & C. Coupland (Eds.), *Perspectives on Contemporary Professional Work: Challenges and Experiences* (pp. 259–285). Cheltenham, UK: Edward Elgar Publishing.
- Centre for Australian Homoeopathic History (2011). *Timeline: Homoeopathy in Australia*. Retrieved from
<https://www.historyofhomeopathy.com.au/timeline.html>
- Centers for Disease Control and Prevention. (2018). *Well-being concepts*. Retrieved from
<https://www.cdc.gov/hrqol/wellbeing.htm>
- Cevik, C., & Tari Selcuk, K. (2019). Prevalence and correlates of the use of complementary and alternative medicine in adults living in a rural area. *Holistic Nursing Practice*, 33(1), 36–44. Retrieved from
<https://journals.lww.com/hnpjournal/toc/2019/01000>
- Chang, B. (2014). Socio-cultural influences of society on knowledge construction. *International Journal of Knowledge Management*, 10(1), 78–91.
doi:10.4018/ijkm.2014010105
- Chang, H. Y., & Chang, H. L. (2015). A review of nurses' knowledge, attitudes, and ability to communicate the risks and benefits of complementary and alternative medicine. *Journal of Clinical Nursing*, 24(11–12), 1466–1478.
<https://doi:10.1111/jocn.12790>

- Chang, H. Y., Wallis, M., & Tiralongo, E. (2011). Use of complementary and alternative medicine among people with Type 2 diabetes in Taiwan: A cross-sectional survey. *Evidence-Based Complementary and Alternative Medicine*, 2011. Article 983792. <http://dx.doi.org/10.1155/2011/983792>
- Charles, J. L. K., & Bentley, K. J. (2016). Stigma as an organizing framework for understanding the early history of community mental health and psychiatric social work. *Social Work in Mental Health*, 14(2), 149–173. <https://doi.org/10.1080/15332985.2014.964448>
- Charmaz, K. (1999). Stories of suffering: Subjective tales and research narratives. *Qualitative Health Research*, 9(3), 362–382. <https://doi.org/10.1177/104973239900900306>
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 509–535). Thousand Oaks, CA: Sage.
- Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative analysis. London: Sage.
- Charmaz, K. (2008). Constructionism and the grounded theory method. In *Constructionism and the grounded theory* (pp. 397–412). New York, NY: The Guilford Press.
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed). London: Sage.
- Charmaz, K., & Belgrave, L. (2012). Qualitative interviewing and grounded theory analysis. In G. F. Gubrium, J. A. Holstein, A. B. Marvasti, & K. D. McKinney (Eds.), *The Sage handbook of interview research: The complexity of the craft* (2nd ed., pp. 347–365). Los Angeles, CA: Sage.

- Chen, S. Y., & Scannapieco, M. (2010). The influence of job satisfaction on child welfare worker's desire to stay: An examination of the interaction effect of self-efficacy and supportive supervision. *Children and Youth Services Review*, 32(4), 482–486.
<http://dx.doi.org/10.1016/j.childyouth.2009.10.014>
- Cheung, G. W. (2009). Introducing the latent congruence model for improving the assessment of similarity, agreement, and fit in organizational research. *Organizational Research Methods*, 12(1), 6–33.
<https://doi.org/10.1177/1094428107308914>
- Chikramane, P. S., Suresh, A. K., Bellare, J. R., & Kane, S. G. (2010). Extreme homeopathic dilutions retain starting materials: A nanoparticulate perspective. *Homeopathy*, 99(4), 231–242. <https://doi.org/10.1016/j.homp.2010.05.006>
- Chinese Medicine Board of Australia. (2019). *2012/18 Annual report summary*. Retrieved from <https://www.chinesemedicineboard.gov.au/News/Annual-report.aspx>
- Christensen, M. K., Henriksen, J., Thomsen, K. R., Lund, O., & Mørcke, A. M. (2017). Positioning health professional identity: On-campus training and work-based learning. *Higher Education, Skills and Work-Based Learning*, 7(3), 275–289.
doi:10.1108/HESWBL-01-2017-0004
- Christina, J., Abigail, W., & Cuthbertson, L. A. (2016). Nurses' knowledge and attitudes toward complementary therapies for cancer: A review of the literature. *Asia-Pacific Journal of Oncology Nursing*, 3(3), 241–251.
<https://doi:10.4103/2347-5625.189816>

- Chui, P. L., Abdullah, K. L., Wong, L. P., & Taib, N. A. (2014). Prayer-for-health and complementary alternative medicine use among Malaysian breast cancer patients during chemotherapy. *BMC Complementary and Alternative Medicine*, 14(1), 425. <https://doi.org/10.1186/1472-6882-14-425>
- Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *Sage Open Medicine*, 7(January), 1–8. <https://doi.org/10.1177/2050312118822927>
- Clark, A., Gilbert, A., Rao, D., & Kerr, L. (2014). ‘Excuse me, do any of you ladies speak English?’ Perspectives of refugee women living in South Australia: Barriers to accessing primary health care and achieving the quality use of medicines. *Australian Journal of Primary Health*, 20(1), 92–97. <https://doi.org/10.1071/PY11118>
- Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: Sage.
- Clausen, J., Moss, S., Tournier, A., Lüdtkke, R., & Albrecht, H. (2014). CORE-Hom: A powerful and exhaustive database of clinical trials in homeopathy. *Homeopathy*, 103(4), 219–223. <https://doi.org/10.1016/j.homp.2014.07.001>
- Clinical Oncology Society of Australia. (2013). *Position statements*. Retrieved from <https://www.cosa.org.au/publications/position-statements/>
- Coburn, D. (1993). State authority, medical dominance, and trends in the regulation of the health professions: The Ontario case. *Social Science & Medicine*, 37(7), 841–850. [https://doi.org/10.1016/0277-9536\(93\)90137-S](https://doi.org/10.1016/0277-9536(93)90137-S)
- Cochrane Complementary Medicine. (2019). *Operational Definition of Complementary Medicine*. Retrieved from <https://cam.cochrane.org/operational-definition-complementary-medicine>

- Cockerham, W. C., Hamby, B. W., & Oates, G. R. (2017). The social determinants of chronic disease. *American Journal of Preventive Medicine*, 52(1), S5–S12.
doi:10.1016/j.amepre.2016.09.010
- Cody, W. K. (2003). Paternalism in nursing and healthcare: Central issues and their relation to theory. *Nursing Science Quarterly*, 16(4), 288–296.
<https://doi.org/10.1177/0894318403257170>
- Colas, A., Danno, K., Tabar, C., Ehreth, J., & Duru, G. (2015). Economic impact of homeopathic practice in general medicine in France. *Health Economics Review*, 5. Article 18. <https://dx.doi.org/10.1186%2Fs13561-015-0055-5>
- Coleman, P. T. (2003). Characteristics of protracted, intractable conflict: Toward the development of a metaframework-I. *Peace and Conflict: Journal of Peace Psychology*, 9(1), 1–37. https://doi.org/10.1207/S15327949PAC0901_01
- College & Association of Registered Nurses of Alberta (2008). Once a nurse, always a nurse. *Alberta RN*, 64(9), 12. Retrieved from
https://www.nurses.ab.ca/docs/default-source/alberta-rn/abrnnov08.pdf?sfvrsn=d0ad3599_10
- Collingwood, P., Emond, R., & Woodward, R. (2008). The theory circle: A tool for learning and for practice. *Social Work Education*, 27(1), 70–83.
doi:10.1080/02615470601141409
- Complementary Medicines Australia, Australian Homoeopathic Association, & Australian Traditional Medicine Society. (2016). *Executive summary: Complaint to the commonwealth regarding the national health and medical research council (NHMRC) assessment of homeopathy, 2010–2015*. Retrieved from
<https://www.hri-research.org/wp-content/uploads/2017/04/Executive-Summary-to-Ombudsman-Complaint-re-NHMRC-Homeopathy-Review-FINAL.pdf>

- Complementary Medicines Australia. (2014a). *Complementary Medicines Australia submission to Mr Kim Snowball independent reviewer to the National Registration and Accreditation Scheme for Health Professionals*. Retrieved from <http://www.cmaustralia.org.au/Submissions-Archive>
- Complementary Medicines Australia. (2014b). *Media release: The five fundamental flaws of the NHMRC homeopathy review*. Retrieved from http://www.cmaustralia.org.au/Resources/Documents/16%2012%2014_Fundamental_Flaws_of_the_NHMRC_Homeopathy_Review.pdf
- Complementary Medicines Australia. (2018). *Complementary medicines industry audit 2018*. Retrieved from <http://www.cmaustralia.org.au/>
- Conlon, T. J. (2004). A review of informal learning literature, theory and implications for practice in developing global professional competence. *Journal of European Industrial Training*, 28(2–4), 283–295. doi:10.1108/03090590410527663
- Contemporary College of Homoeopathy. (2008, March 10). *Step by step student homeopathic clinic*. [Blog Post]. Retrieved from <https://www.conhom.com/blog/2008/03/step-by-step-student-homeopathic-clinic/>
- Contemporary College of Homoeopathy. (2018). *The homeopathy clinic*. Retrieved from <https://www.conhom.com/clinic.php>
- Cook, G. C., & Webb, A. J. (2002). Reactions from the medical and nursing professions to Nightingale’s “reform(s)” of nurse training in the late 19th century. *Postgraduate Medical Journal*, 78(916), 118–123. <https://doi.org/10.1136/pmj.78.916.118>
- Cook, N. (2018, April 6). *Naturopaths call for government regulation in the name of public safety*. Retrieved from <https://www.nhaa.org.au/mediareleases/news/1094-naturopaths-call-for-government-regulation-in-the-name-of-public-safety>

- Cooke, M., Mitchell, M., Tiralongo, E., & Murfield, J. (2012). Complementary and alternative medicine and critical care nurses: A survey of knowledge and practices in Australia. *Australian Critical Care*, 25(4), 213–223.
<https://doi.org/10.1016/j.aucc.2011.12.055>
- Cooney, A. (2011). Rigour and grounded theory. *Nurse Researcher*, 18(4), 1–22.
doi:10.7748/nr2011.07.18.4.17.c8631
- Cooper, R. J., Bissell, P., Ward, P., Murphy, E., Anderson, C., Avery, T., . . . Ratcliffe, J. (2012). Further challenges to medical dominance? The case of nurse and pharmacist supplementary prescribing. *Health*, 16(2), 115–133.
doi:10.1177/1363459310364159
- Cope, D. G. (2014). Computer-Assisted qualitative data analysis software. *Oncology Nursing Forum*, 41(3), 322–323. <https://doi.org/10.1188/14.ONF.322-323>
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). California: Sage.
- Cork, L. L. (2014). Nursing intuition as an assessment tool in predicting severity of injury in trauma patients. *Journal of Trauma Nursing*, 21(5), 244–252.
<https://doi.org/10.1097/JTN.0000000000000072>
- Corp, N., Jordan, J. L., & Croft, P. R. (2018). Justifications for using complementary and alternative medicine reported by persons with musculoskeletal conditions: A narrative literature synthesis. *PLOS ONE*, 13(7), e0200879.
doi:10.1371/journal.pone.0200879
- Coulter, A., & Collins, A. (2011). *Making shared decision-making a reality: No decision about me, without me*. London: The Kings Fund. Retrieved from
<https://www.kingsfund.org.uk/publications/making-shared-decision-making-reality>

- Coulter, I., Snider, P., & Neil, A. (2019). Vitalism—a worldview revisited: A critique of vitalism and its implications for naturopathic medicine. *Integrative Medicine: A Clinician's Journal*, 18(3), 60–73. Retrieved from <http://www.imjournal.com/index.cfm/>
- Coulter, I. & Willis, E. (2004). The rise and rise of complementary and alternative medicine: A sociological perspective. *The Medical Journal of Australia*, 180(11), 587–589. doi:10.5694/j.1326-5377.2004.tb06099.x
- Coulter, I., & Willis, E. (2007). Explaining the growth of complementary and alternative medicine. *Health Sociology Review*, 16(3-4), 214–225. <https://doi.org/10.5172/hesr.2007.16.3-4.214>
- Covan, E. (2007). The discovery of grounded theory in practice: The legacy of multiple mentors. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 58–74). London: Sage.
- Cowan, M. J., Shapiro, M., Hays, R. D., Afifi, A., Vazirani, S., Ward, C. R., & Ettner, S. L. (2006). The effect of a multidisciplinary hospitalist/physician and advanced practice nurse collaboration on hospital costs. *The Journal of Nursing Administration*, 36(2), 79--85. Retrieved from <https://journals.lww.com/jonajournal/pages/default.aspx>
- Crawford, L. (2016). Moral legitimacy: The struggle of homeopathy in the NHS. *Bioethics*, 30(2), 85–95. <https://doi.org/10.1111/bioe.12227>
- Creswell, J., Hanson, W., Plano Clark V., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseling Psychologist*, 35(2), 236--264. <https://doi.org/10.1177/0011000006287390>

- Crigger, N., & Godfrey, N. (2014). From the inside out: A new approach to teaching professional identity formation and professional ethics. *Journal of Professional Nursing*, 30(5), 376–382. <https://doi.org/10.1016/j.profnurs.2014.03.004>
- Croce, A. J. (2000a). *The thought behind the action –potency: What it is and what it means*. Retrieved from <http://www.homeopathycenter.org/homeopathy-today/thought-behind-action-potency-what-it-and-what-it-means>
- Croce, A. J. (2000b). *The thought behind the action: Why mental symptoms?* Retrieved from <https://www.homeopathycenter.org/homeopathy-today/thought-behind-action-why-mental-symptoms>
- Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology*. (pp. 504–553). New York, NY: McGraw-Hill.
- Cruess, R. L., Cruess, S. R., Boudreau, J. D., Snell, L., & Steinert, Y. (2015). A schematic representation of the professional identity formation and socialization of medical students and residents: A guide for medical educators. *Academic Medicine*, 90(6), 718–725. <https://doi.org/10.1097/ACM.0000000000000700>
- Currie, K., Bannerman, S., Howatson, V., Macleod, F., Mayne, W., Organ, C., . . . Scott, J. (2015). ‘Stepping in’ or ‘stepping back’: How first year nursing students begin to learn about person-centred care. *Nurse Education Today*, 35(1), 239–244. doi:10.1016/j.nedt.2014.06.008
- Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing*, 31(6), 1476–1484. <https://doi.org/10.1046/j.1365-2648.2000.01430.x>
- Cutcliffe, J. R. (2005). Adapt or adopt: Developing and transgressing the methodological boundaries of grounded theory. *Journal of Advanced Nursing*, 51(4), 421–428. doi:10.1111/j.1365-2648.2005.03514.x

- Dalley, C., & Martin, R. J. (2015). Dichotomous identities? Indigenous and non-Indigenous people and the intercultural in Australia. *The Australian Journal of Anthropology*, 26(1), 1–23. <https://doi.org/10.1111/taja.12120>
- Daniel, H., Bornstein, S. S., & Kane, G. C. (2018). Addressing social determinants to improve patient care and promote health equity: An American College of Physicians position paper. *Annals of Internal Medicine*, 168(8), 577. doi:10.7326/M17-2441
- Dannemann, K., Hecker, W., Haberland, H., Herbst, A., Galler, A., Schäfer, T., . . . Kapellen, T. M. (2008). Use of complementary and alternative medicine in children with type 1 diabetes mellitus—Prevalence, patterns of use, and costs. *Pediatric Diabetes*, 9(3), 228–235. doi:10.1111/j.1399-5448.2008.00377.x
- Darch, J., Baillie, L., & Gillison, F. (2017). Nurses as role models in health promotion: A concept analysis. *British Journal of Nursing*, 26(17), 982–988. doi:10.12968/bjon.2017.26.17.982
- Davenas, E., Beauvais, F., Amara, J., Oberbaum, M., Robinzon, B., Miadonnai, A., . . . Benveniste, J. (1988). Human basophil degranulation triggered by very dilute antiserum against IgE. *Nature*, 333(6176), 816–818. <https://doi.org/10.1038/333816a0>
- Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, 20(1), 43–63. doi:10.1111/j.1468-5914.1990.tb00174.x
- Davis, M. A., Weeks, W. B., & Coulter, I. D. (2011). A proposed conceptual model for studying the use of complementary and alternative medicine. *Alternative Therapies in Health and Medicine*, 17(5), 32–36. Retrieved from <https://search.proquest.com/docview/940001522?accountid=10016>

- Davis, R., Campbell, R., Hildon, Z., Hobbs, L., & Michie, S. (2014). Theories of behaviour and behaviour change across the social and behavioural sciences: A scoping review. *Health Psychology Review*, 9(3), 324–344.
doi:10.1080/17437199.2014.941722
- Deakin, H., & Wakefield, K. (2014). Skype interviewing: reflections of two PhD researchers. *Qualitative Research*, 14(5), 603–616.
<https://doi.org/10.1177/1468794113488126>
- deBronkart, D. (2015). From patient centred to people powered: Autonomy on the rise, *BMJ*, 350:h148. doi:10.1136/bmj.h148
- DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health*, 7(2), e000057. Retrieved from <https://fmch.bmj.com/content/7/2/e000057>
- Delaney, L. J. (2018). Patient-centred care as an approach to improving health care in Australia. *Collegian*, 25(1), 119–123.
<https://doi.org/10.1016/j.colegn.2017.02.005>
- Denzin, N., & Lincoln, Y. (2005). Introduction: The discipline and practice of qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 1–32). Thousand Oaks, CA: Sage.
- Department of Health. (2012). *Preventative care*. Retrieved from <http://www.health.gov.au/internet/publications/publishing.nsf/Content/GPSuperClinicsEvaluation-toc~operationsaspect~preventativecare>
- Department of Health. (2017a). *Chronic conditions*. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/content/chronic-disease>
- Department of Health. (2017b). *Publications. NHWDS—Nursing and midwifery fact sheets* 2017. Retrieved from <https://hwd.health.gov.au/publications.html#nrmw>

- Department of Health. (2019a). *Medicare benefits schedule—Item 173*. Retrieved from <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=173&qt=item&criteria=Acupuncture>
- Department of Health. (2019b). *Medicare benefits schedule—Item 10964*. Retrieved from <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=10964&qt=item&criteria=chiropractic>
- Department of Health. (2019c). *Medicare benefits schedule—Item 10966*. Retrieved from <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=10966&qt=item&criteria=osteopathy>
- Department of Health. (2019d). *Private health insurance reforms: Changing coverage for some natural therapies*. Retrieved from <https://www1.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reforms-fact-sheet-removing-coverage-for-some-natural-therapies>
- Department of Human Services. (2019). *Who can apply for a provider number?* Retrieved from <https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/medicare-benefits-health-professionals/apply-medicare-provider-number/who-can-apply-provider-number>
- Desborough, J., Bagheri, N., Banfield, M., Mills, J., Phillips, C., & Korda, R. (2016). The impact of general practice nursing care on patient satisfaction and enablement in Australia: A mixed methods study. *International Journal of Nursing Studies*, 64(December), 108–119. doi:10.1016/j.ijnurstu.2016.10.004
- Desborough, J., Forrest, L., & Parker, R. (2012). Nurse-led primary healthcare walk-in centres: An integrative literature review. *Journal of Advanced Nursing*, 68(2), 248–263. doi:10.1111/j.1365-2648.2011.05798.x

- de Veer, A. J. E., Francke, A. L., Struijs, A., & Willems, D. L. (2013). Determinants of moral distress in daily nursing practice: A cross sectional correlational questionnaire survey. *International Journal of Nursing Studies*, 50(1), 100–108. <https://doi.org/10.1016/j.ijnurstu.2012.08.017>
- Di Stefano, V. (2006). *Holism and complementary medicine*. Crows Nest: Allen & Unwin.
- Dijkers, M. P., Murphy, S. L., & Krellman, J. (2012). Evidence-based practice for rehabilitation professionals: Concepts and controversies. *Archives of Physical Medicine and Rehabilitation*, 93(8), S164–S176. <https://doi.org/10.1016/j.apmr.2011.12.014>
- Dixit, S. K., & Sambasivan, M. (2018). A review of the Australian healthcare system: A policy perspective. *SAGE Open Medicine*, 6(January-December), 1–14. <https://doi.org/10.1177/2050312118769211>
- Dodds, S., Bulmer, S., & Murphy, A. (2014). Consumer value in complementary and alternative medicine (CAM) health care services. *Australasian Marketing Journal*, 22(3), 218–229. <https://doi.org/10.1016/j.ausmj.2014.08.004>
- Doering, J. H., Reuner, G., Kadish, N. E., Pietz, J., & Schubert-Bast, S. (2013). Pattern and predictors of complementary and alternative medicine (CAM) use among pediatric patients with epilepsy. *Epilepsy & Behavior*, 29(1), 41–46. <http://dx.doi.org/10.1016/j.yebeh.2013.06.025>
- Dolfman, M. L. (1973). The concept of health: An historic and analytic examination. *Journal of School Health*, 43(8), 491–497. <https://doi:10.1111/j.1746-1561.1973.tb03740.x>

- Donnelly, L. (2018, June 5). High court backs NHS decision to stop funding homeopathy. *The Telegraph*. Retrieved from <https://www.telegraph.co.uk/science/2018/06/05/high-court-backs-nhs-decision-stop-funding-homeopathy/>
- Dooris, M., Farrier, A., & Froggett, L. (2018). Wellbeing: The challenge of ‘operationalising’ an holistic concept within a reductionist public health programme. *Perspectives in Public Health*, 138(2), 93–99. <https://doi.org/10.1177/1757913917711204>
- Dörfler, V., & Ackermann, F. (2012). Understanding intuition: The case for two forms of intuition. *Management Learning*, 43(5), 545–564. <https://doi.org/10.1177/1350507611434686>
- Dossey, B. M. (2012). *Holistic nursing: A handbook for practice* (6th ed.). Burlington, MA: Jones & Bartlett Learning.
- Dotson, M. J., Dave, D. S., Cazier, J. A., & Spaulding, T. J. (2014). An empirical analysis of nurse retention: What keeps RNs in nursing? *The Journal of Nursing Administration*, 44(2), 111–116. <https://doi.org/10.1097/NNA.0000000000000034>
- Dovidio, J. F., Gaertner, S. L., Pearson, A. R., & Riek, B. M. (2005). Social identities and social context: Social attitudes and personal well-being. In S. Thye & E. Lawler (Eds.) *Social Identification in Groups (Advances in Group Processes, Vol. 22)* Emerald Group Publishing Limited, pp. 231–260.
- Drabsch, T. (2012). *Measuring wellbeing*. Retrieved from <https://www.parliament.nsw.gov.au/researchpapers/Pages/measuring-wellbeing.aspx>

- Duggal, R., & Menkes, D. B. (2011). Evidence-based medicine in practice. *International Journal of Clinical Practice*, 65(6), 639–644.
doi:10.1111/j.17421241.2011.02681.x
- Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal of Social Research Methodology*, 14(2), 111–124.
<https://doi.org/10.1080/13645579.2010.494930>
- Durning, M. (2010). *The “Nurses are angels” myth*. *Nursing link*. Retrieved from
<http://nursinglink.monster.com/nurse-supervisor-jobs/articles/171-the-nurses-are-angels-myth>
- Dutta, A. P., Dutta, A. P., Bwayo, S., Xue, Z., Akiyode, O., Ayuk-Egbe, P., . . . Clarke-Tasker, V. (2003). Complementary and alternative medicine instruction in nursing curricula. *Journal of National Black Nurses’ Association*, 14(2), 30–33. Retrieved from <https://europepmc.org/article/med/15011942>
- Dyląg, A., Jaworek, M., Karwowski, W., Kożusznik, M., & Marek, T. (2013). Discrepancy between individual and organizational values: Occupational burnout and work engagement among white-collar workers. *International Journal of Industrial Ergonomics*, 43(3), 225–231.
<https://doi.org/10.1016/j.ergon.2013.01.002>
- Eastwood, H. L. (2000). Complementary therapies: The appeal to general practitioners. *The Medical Journal of Australia*, 173(2), 95–98. Retrieved from
<https://www.mja.com.au/journal>
- Edwards, J. R., & Cable, D. M. (2009). The value of value congruence. *Journal of Applied Psychology*, 94(3), 654–677. <http://dx.doi.org/10.1037/a0014891>

- Efthimiou, P., Kukar, M., & MacKenzie, C. R. (2010). Complementary and alternative medicine in rheumatoid arthritis: No longer the last resort! *HSS Journal*, 6(1), 108–111. doi:10.1007/s11420-009-9133-8
- Egenes, K. J. (2009). History of nursing. In G. Roux & J. A. Halstead (Eds.), *Issues and trends in nursing: Essential knowledge for today and tomorrow*. (pp. 1–26). Sudbury: Jones & Bartlett.
- Egger, G. J., Binns, A. F., & Rossner, S. R. (2009). The emergence of ‘lifestyle medicine’ as a structured approach for management of chronic disease. *The Medical Journal of Australia*, 190(3), 143–145. doi:10.5694/j.1326-5377.2009.tb02317.x
- Ehrenreich, B., & English, D. (1973). *Witches, midwives, and nurses: A history of women healers*. New York, NY: The Feminist Press.
- Eisenberg, D. M., Kaptchuk, T., Post, D. E., Hrbek, A. L., O’Connor, B. B., Osypiuk, K., ... Levy, D. B. (2016). Establishing an integrative medicine program within an academic health center: Essential considerations. *Academic Medicine*, 91(9), 1223–1230. doi:10.1097/ACM.0000000000001173
- Ekins-Daukes, S., Helms, P. J., Taylor, M. W., Simpson, C. R., & McLay, J. S. (2005). Paediatric homoeopathy in general practice: Where, when and why? *British Journal of Clinical Pharmacology*, 59(6), 743–749.
<https://dx.doi.org/10.1111%2Fj.1365-2125.2004.02213.x>
- El Hussein, M., & Osuji, J. (2017). Bridging the theory-practice dichotomy in nursing: The role of nurse educators. *Journal of Nursing Education and Practice*, 7(3), 20–25. doi.org/10.5430/jnep.v7n3p20
- Eley, D., Eley, R., Bertello, M., & Rogers-Clark, C. (2012). Why did I become a nurse? Personality traits and reasons for entering nursing. *Journal of Advanced Nursing*, 68(7), 1546–1555. <https://doi.org/10.1111/j.1365-2648.2012.05955.x>

- Endeavour College of Natural Health. (2019). *2019 course brochure. Bachelor of Health Science (Naturopathy)*. Retrieved from <https://source.endeavourlearninggroup.com.au/Public%20Documents%20Library/DOCID-3-14637.pdf>
- Enserink, M. (2010, December 24). French Nobelist escapes ‘intellectual terror’ to pursue radical ideas in China. *Science*, 330(6012), 1732. <https://doi.org/10.1126/science.330.6012.1732>
- Epstein, E. G., & Delgado, S. (2010). Understanding and addressing moral distress. *Online Journal of Issues in Nursing*, 15(3), Manuscript 1. doi:10.3912/OJIN.Vol15No03Man01
- Eriksson, I., Lindblad, M., Möller, U., & Gillsjö, C. (2018). Holistic health care: Patients’ experiences of health care provided by an advanced practice nurse. *International Journal of Nursing Practice*, 24(1), e12603. doi:10.1111/ijn.12603
- Ernst, E. (2002). A systematic review of systematic reviews of homeopathy. *British Journal of Clinical Pharmacology*, 54(6), 577–582. <https://dx.doi.org/10.1046%2Fj.1365-2125.2002.01699.x>
- Ernst, E. (2003). Obstacles to research in complementary and alternative medicine. *The Medical Journal of Australia*, 179(6), 279–280. <https://doi.org/10.5694/j.1326-5377.2003.tb05546.x>
- Ernst, E. (2009). Homeopathy, a “helpful placebo” or an unethical intervention? *Trends in Pharmacological Sciences*, 31(1), 1. <https://doi.org/10.1016/j.tips.2009.10.005>
- Ernst, E. (2010). Homeopathy: What does the “best” evidence tell us? *Medical Journal of Australia*, 192(8), 458–460. doi:10.5694/j.1326-5377.2010.tb03585.x

- Ernst, E. (2011). Homeopathy for insomnia and sleep-related disorders: A systematic review of randomised controlled trials. *Focus on Alternative and Complementary Therapies*, 16(3), 195–199. <https://doi.org/10.1111/j.2042-7166.2011.01083.x>
- Ernst, E. (2012). *Why I changed my mind about homeopathy*. Retrieved from <https://www.theguardian.com/science/blog/2012/apr/03/homeopathy-why-i-changed-my-mind>
- Ernst, E. (2013). *The four types of homeopaths: Would Hahnemann approve?* Retrieved from <https://edzardernst.com/2013/03/the-four-types-of-homeopaths-would-hahnemann-approve/>
- Ernst, E (2016). *Homeopathy—The undiluted facts*. Orford, UK: Springer.
- Ernst, E. (2018). Why do so many German doctors practise homeopathy? Retrieved from <https://edzardernst.com/2018/11/why-do-so-many-german-doctors-practise-homeopathy/>
- European Committee for Homeopathy. (2019a). *Countries*. Retrieved from <https://homeopathyeurope.org/regulatory-status/countries/>
- European Committee for Homeopathy. (2019b). *Provings*. Retrieved from <https://homeopathyeurope.org/research/provings/>
- European Committee for Homeopathy. (2019c). *History of homeopathy*. Retrieved from <https://homeopathyeurope.org/homeopathy-in-practice/history-of-homeopathy/>
- European Committee for Homeopathy. (2020). *Regulation*. Retrieved from <https://homeopathyeurope.org/regulatory-status/>
- Evangelatos, N., & Eliadi, I. (2016). Are allopathic and holistic medicine incommensurable? *Complementary Medicine Research*, 23(1), 37–42. <https://doi.org/10.1159/000443996>

- Evans, D., & Gruba, P. (2004). *How to write a better thesis* (2nd ed.). Carlton: Melbourne University Press.
- Evans, R. J., & Donnelly, G. W. (2006). A model to describe the relationship between knowledge, skill, and judgment in nursing practice. *Nursing Forum*, 41(4), 150–157. <https://doi.org/10.1111/j.1744-6198.2006.00053.x>
- Ewertsson, M., Gustafsson, M., Blomberg, K., Holmström, I. K., & Allvin, R. (2015). Use of technical skills and medical devices among new registered nurses: A questionnaire study. *Nurse Education Today*, 35(12), 1169–1174. <https://doi.org/10.1016/j.nedt.2015.05.006>
- Eyles, C., Leydon, G. M., Lewith, G. T., & Brien, S. (2011). A grounded theory study of homeopathic practitioners' perceptions and experiences of the homeopathic consultation. *Evidence-Based Complementary and Alternative Medicine*, 2011. Article 957506. <https://doi.org/10.1155/2011/957506>
- Faculty of Homeopathy. (2016). *Randomised controlled trials*. Retrieved from <https://facultyofhomeopathy.org/randomised-controlled-trials/>
- Fagerlin, A., Wang, C., & Ubel, P. A. (2005). Reducing the influence of anecdotal reasoning on people's health care decisions: Is a picture worth a thousand statistics? *Medical Decision Making*, 25(4), 398–405. doi:10.1177/0272989X05278931
- Fairbrother, G., Cashin, A., Conway, M. R., Symes, M. A., & Graham, I. (2016). Evidence based nursing and midwifery practice in a regional Australian healthcare setting: Behaviours, skills and barriers. *Collegian*, 23(1), 29–37. <https://doi.org/10.1016/j.colegn.2014.09.011>

- Fairhurst, S. (2015). Professional issues in CAM: Is it time to explore the professional support needs of CAM practitioners? *The Journal of Alternative and Complementary Medicine*, 21(10), 653–653.
<https://doi.org/10.1089/acm.2015.0013>
- Falci, L., Shi, Z., & Greenlee, H. (2016). Multiple chronic conditions and use of complementary and alternative medicine among US adults: Results from the 2012 national health interview survey. *Preventing Chronic Disease*, 13(E61).
<http://dx.doi.org/10.5888/pcd13.150501>
- Fani Marvasti, F., & Stafford, R. S. (2012). From sick care to health care—Re-engineering prevention into the U.S. system. *New England Journal of Medicine*, 367(10), 889--891. doi:10.1056/NEJMp1206230
- Fawcett, J. (2003). Theory and practice: A discussion by William K. Cody. *Nursing Science Quarterly*, 16(3), 225–225.
<https://doi.org/10.1177%2F0894318403016003012>
- Federoff, H. J., & Gostin, L. O. (2009). Evolving from reductionism to holism: Is there a future for systems medicine? *JAMA*, 302(9), 994–996.
<https://doi.org/10.1001/jama.2009.1264>
- Fee, E., & Garofalo, M. E. (2010). Florence Nightingale and the Crimean War. *American Journal of Public Health*, 100(9), 1591. Retrieved from
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920984/>
- Fernandez-Parsons, R., Rodriguez, L., & Goyal, D. (2013). Moral distress in emergency nurses. *Journal of Emergency Nursing*, 39(6), 547–552.
<https://doi.org/10.1016/j.jen.2012.12.009>
- Festinger, L. (1957). *A theory of cognitive dissonance*. California: Stanford University Press.

- Fewster-Thuente, L., & Batteson, T. J. (2018). Kolb's experiential learning theory as a theoretical underpinning for interprofessional education. *Journal of Allied Health*, 47(1), 3–8. Retrieved from <https://www.ingentaconnect.com/content/asahp/jah>
- Finnegan J. (2017, November 20). 'Turf wars' heat up: Nurses fire back at American Medical Association's stand on independent practice. *FierceHealthcare*. Retrieved from <https://www.fiercehealthcare.com/practices/ana-opposes-ama-vote-nurses-independent-practice-aprns>
- Fisher, B. J. (2012). Exploring worldviews: A framework. *TeachJournal of Christian Education*, 6(1). Retrieved from <https://research.avondale.edu.au/teach/>
- Fisher, J., & Happell, B. (2009). Implications of evidence-based practice for mental health nursing. *International Journal of Mental Health Nursing*, 18(3), 179--185. doi:10.1111/j.1447-0349.2009.00607.x
- Fisher, P., & Ernst, E. (2015). Should doctors recommend homeopathy? *BMJ*, 351:h3735. <https://doi.org/10.1136/bmj.h3735>
- Fisher, R. J. (2012). Becoming: An explanatory grounded theory of secondary school teaching as a new career. (Unpublished doctoral dissertation). Central Queensland University, Rockhampton, Australia.
- Fixsen, A., & Ridge, D. (2012). Performance, emotion work, and transition: Challenging experiences of complementary therapy student practitioners commencing clinical practice. *Qualitative Health Research*, 22(9), 1163–1175. <https://doi.org/10.1177/1049732312449213>
- Fleming, J. (2018). Recognizing and resolving the challenges of being an insider researcher in work-integrated learning. *International Journal of Work-Integrated Learning*, 19(3), 311-320. Retrieved from <https://www.ijwil.org/>

- Fleming, S. A., & Gutknecht, N. C. (2010). Naturopathy and the primary care practice. *Primary Care: Clinics in Office Practice*, 37(1), 119–136.
<https://doi:10.1016/j.pop.2009.09.002>
- Flies, E., & Webb, C. (2016, November 7). Explainer: What are antibodies and why are viruses like dengue worse the second time? *The Conversation*. Retrieved from <http://theconversation.com/explainer-what-are-antibodies-and-why-are-viruses-like-dengue-worse-the-second-time-68227>
- Flott, E. A., & Linden, L. (2016). The clinical learning environment in nursing education: a concept analysis. *Journal of Advanced Nursing*, 72(3), 501–513.
<https://doi.org/10.1111/jan.12861>
- Fønnebø, V., Grimsgaard, S., Walach, H., Ritenbaugh, C., Norheim, A., MacPherson, H., . . . Aickin, M. (2007). Researching complementary and alternative treatments—The gatekeepers are not at home. *BMC Medical Research Methodology*, 7(7). doi:10.1186/1471-2288-7-7
- Fontana, A., & Frey, J. (2005). The interview: From neutral stance to political involvement. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 695–727). Thousand Oaks, CA: Sage.
- Footracer, K. G., Monaghan, M., Wiśniewski, N. P., & Mandel, E. (2012). Attitudes and practices of massage therapists as related to conventional medicine. *International journal of therapeutic massage & bodywork*, 5(1), 18–24. Retrieved from <https://ijtmb.org/index.php/ijtmb/issue/view/16>
- Fouladbakhsh, J. M., Balneaves, L., & Jenuwine, E. (2013). Understanding CAM natural health products: Implications of use among cancer patients and survivors. *Journal of the Advanced Practitioner in Oncology*, 4(5), 289–306.
doi:10.6004/jadpro.2013.4.5.2

- Foundation House. (2012). Promoting refugee health. A guide for doctors, nurses and other health care providers caring for people from refugee backgrounds (3rd ed.). Retrieved from http://refugeehealthnetwork.org.au/wp-content/uploads/PRH-online-edition_July2012.pdf
- Fouquier, K. F. (2011). The concept of motherhood among three generations of African American women. *Journal of Nursing Scholarship*, 43(2), 145–153. <https://doi.org/10.1111/j.1547-5069.2011.01394.x>
- Frank, L. (2013). Person-centered care, autonomy, and the definition of health, *American Journal of Bioethics*, 13(8), 59–61. doi:10.1080/15265161.2013.802068
- Frank, R. (2002). Integrating homeopathy and biomedicine: Medical practice and knowledge production among German homeopathic physicians. *Sociology of Health & Illness*, 24(6), 796–819. doi:10.1111/1467-9566.00319
- Frass, M., Strassl, R. P., Friebs, H., Müllner, M., Kundi, M., & Kaye, A. D. (2012). Use and acceptance of complementary and alternative medicine among the general population and medical personnel: A systematic review. *The Ochsner Journal*, 12(1), 45–56. Retrieved from <http://www.ochsnerjournal.org/content/12/1/45>
- Frawley, J. (2016). Complementary and alternative medicine in Australia: An overview of contemporary workforce features. *Australian Journal of Herbal Medicine*, 28(4), 103–105. Retrieved from <https://opus.lib.uts.edu.au/handle/10453/116470>
- Frawley, J., Adams, J., Broom, A., Steel, A., Gallois, C., & Sibbritt, D. (2014). Majority of women are influenced by nonprofessional information sources when deciding to consult a complementary and alternative medicine practitioner during pregnancy. *Journal of Alternative and Complementary Medicine*, 20(7), 571–577. doi:10.1089/acm.2014.0028

- Freidson, E. (1974). *Professional dominance: The social structure of medical care*. New Brunswick, USA: Aldine Transaction.
- Freidson, E. (2001). *Professionalism. The third logic*. Chicago: The University of Chicago Press.
- Freshwater, D. (2002). *Therapeutic Nursing*. London: Sage.
- Fries, C. J. (2008). Governing the health of the hybrid self: Integrative medicine, neoliberalism, and the shifting biopolitics of subjectivity. *Health Sociology Review*, 17(4), 353–367. doi:10.5172/hesr.451.17.4.353
- Fuller, J. (2017). The new medical model: A renewed challenge for biomedicine. *Canadian Medical Association Journal*, 189(17), e640–e641. doi:10.1503/cmaj.160627
- Gaboury, I., Lapierre, L. M., Boon, H., & Moher, D. (2011). Interprofessional collaboration within integrative healthcare clinics through the lens of the relationship-centered care model. *Journal of Interprofessional Care*, 25(2), 124–130. doi:10.3109/13561820.2010.523654
- Gale, N. (2014). The sociology of traditional, complementary and alternative medicine. *Sociology Compass*, 8(6), 805–82. Retrieved from <https://onlinelibrary.wiley.com/toc/17519020/2014/8/6>
- Ghosh, A. K. (2010). A short history of the development of homeopathy in India. *Homeopathy*, 99(2), 130–136. <https://doi.org/10.1016/j.homp.2009.10.001>
- Giannelli, M., Cuttini, M., Da Frè, M., & Buiatti, E. (2007). General practitioners' knowledge and practice of complementary/alternative medicine and its relationship with lifestyles: A population-based survey in Italy. *BMC Family Practice*, 8(May). Article 30. <https://doi.org/10.1186/1471-2296-8-30>

- Giese, J. L. & Cote, J. A. (2000). Defining consumer satisfaction. *Academy of Marketing Science Review*, 2000(1), 1–27. Retrieved from <https://www.researchgate.net/publication/235357014>
- Gill, J. (1990). The story of the Launceston Homoeopathic Hospital. Launceston: J. Gill.
- Glaser, B. (1978). Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley, CA: Sociology Press.
- Glaser, B. (1992). Emergence Vs forcing: Basics of grounded theory analysis. Mill Valley, CA: Sociology Press.
- Glaser, B. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.
- Glaser, B. (2001). The grounded theory perspective: Conceptualization contrasted with description. Mill Valley, CA: Sociology Press.
- Glaser, B. (2002). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, 1(2), 23–38. <https://doi:10.1177%2F160940690200100203>
- Glaser, B., & Holton, J. (2004). Remodeling grounded theory. *Forum: Qualitative Social Research*, 5(2). <http://dx.doi.org/10.17169/fqs-5.2.607>
- Glaser, B., & Strauss, A. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago, IL: Aldine.
- Goel, A., & Shrivastava, P. (2010). Post-burn scars and scar contractures. *Indian Journal of Plastic Surgery*, 43(Suppl), S63–S71. doi:10.4103/0970-0358.70724
- Goffman, E. (1951). Symbols of class status. *The British Journal of Sociology*, 2(4), 294–304. doi:10.2307/588083
- Goffman, E. (1959). The presentation of self in everyday life. Doubleday: New York.

- Goffman, E. (1963). *Stigma. Notes of the management of spoiled identity*. Prentice Hall: New Jersey. NJ.
- Goldacre, B. (2007). Benefits and risks of homoeopathy. *The Lancet*, 370(9600), 1672--1673. [https://doi.org/10.1016/S0140-6736\(07\)61706-1](https://doi.org/10.1016/S0140-6736(07)61706-1)
- Goldacre, B. (2012). *Bad Pharma: How drug companies mislead doctors and harm patients*, London: Fourth Estate.
- Golden, I. (2007). An energetic model of homeopathy. *Homœopathic Links*, 20(2): 86--92. <https://doi.org/10.1055/s-2006-955993>
- Goldenberg, M. J. (2006). On evidence and evidence-based medicine: Lessons from the philosophy of science. *Social Science & Medicine*, 62(11), 2621--2632. <https://doi:10.1016/j.socscimed.2005.11.031>
- Goldkuhl, G., & Cronholm, S. (2010). Adding theoretical grounding to grounded theory: Toward multi-grounded theory. *International Journal of Qualitative Methods*, 9(2), 187--205. <https://doi:10.1177/160940691000900205>
- González Hernández, A., Domínguez Rodríguez, M. V., Fabre Pi, O., & Cubero González, A. (2010). Descartes' influence on the development of the anatomoclinical method. *Neurologia*, 25(6), 374--377. <https://doi:10.1016/j.nrl.2009.12.011>
- Gordon, S., & Nelson, S. (2005). An end to angels. *American Journal of Nursing*, 105(5), 62--69. Retrieved from <https://oce.ovid.com/article/00000446-200505000-00031/HTML>
- Gourlay, J. (2004). Florence Nightingale: Still lighting the way for nurses. *Nursing Management*, 11(2), 14--15. Retrieved from https://search-proquest-com.ezproxy.cqu.edu.au/docview/71932005?rfr_id=info%3Axri%2Fsid%3Aprim

- Gowling, C., & Gale, N. (2019). 'You cannot get enough of them!' The rise (and fall of complementary therapies in British nursing practice in the 1980s and 1990s. *Journal of Historical Sociology*, 32(2), 215-231.
<https://doi.org/10.1111/johs.12214>
- Goyal, M., Singh, S., Sibinga, E. M. S., Gould, N. F., Rowland-Seymour, A., Sharma, R., . . . Haythornthwaite, J. A. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis meditation for psychological stress and well-being. *JAMA Internal Medicine*, 174(3), 357–368. doi:10.1001/jamainternmed.2013.13018
- Grace, S., & Higgs, J. (2010). Interprofessional collaborations in integrative medicine. *Journal of Alternative & Complementary Medicine*, 16(11), 1185–1190.
<https://doi.org/10.1089/acm.2009.0402>
- Grace, S., Vemulpad, S., & Beirman, R. (2006). Training in and use of diagnostic techniques among CAM practitioners: An Australian study. *Journal of Alternative & Complementary Medicine*, 12(7), 695–700. doi:10.1089/acm.2006.12.695
- Grammaticos, P. C., & Diamantis, A. (2008). Useful known and unknown views of the father of modern medicine, Hippocrates and his teacher Democritus. *Hellenic Journal of Nuclear Medicine*, 11(1), 2–4. Retrieved from
<http://nuclmed.web.auth.gr/magazine/eng/jan08/2.pdf>
- Grant, S. J., & Bensoussan, A. (2014). The process of care in integrative health care settings—a qualitative study of US practices. *BMC Complementary and Alternative Medicine*, 14. Article 410. doi:10.1186/1472-6882-14-410
- Green, B. N., & Johnson, C. D. (2015). Interprofessional collaboration in research, education, and clinical practice: Working together for a better future. *The Journal of Chiropractic Education*, 29(1), 1–10. doi:10.7899/JCE-14-36

- Green, C. (2012). Nursing intuition: a valid form of knowledge. *Nursing Philosophy: An International Journal for Healthcare Professionals*, 13(2), 98–111.
<https://doi.org/10.1111/j.1466-769X.2011.00507.x>
- Greenlee, H., Neugut, A. I., Falci, L., Hillyer, G. C., Buono, D., Mandelblatt, J. S., ... Hershman, D. L. (2016). Association between complementary and alternative medicine use and breast cancer chemotherapy initiation: The breast cancer quality of care (BQUAL) study. *JAMA Oncology*, 2(9), 1170–1176.
<https://doi.org/10.1001/jamaoncol.2016.0685>
- Greenstone, G. (2010). The history of bloodletting. *British Columbia Medical Journal*, 52(1), 12–14. Retrieved from <https://www.bcmj.org/premise/history-bloodletting>
- Griffiths, J., Speed, S., Horne, M., & Keeley, P. (2012). ‘A caring professional attitude’: What service users and carers seek in graduate nurses and the challenge for educators. *Nurse Education Today*, 32(2), 121–127.
<https://doi.org/10.1016/j.nedt.2011.06.005>
- Grimes, D. (2012). Proposed mechanisms for homeopathy are physically impossible. *Focus on Alternative and Complementary Therapies*, 17(3), 149–155.
<https://doi.org/10.1111/j.2042-7166.2012.01162.x>
- Groenewald, C. B., Beals-Erickson, S. E., Ralston-Wilson, J., Rabbitts, J. A., & Palermo, T. M. (2017). Complementary and alternative medicine use by children with pain in the United States. *Academic Pediatrics*, 17(7), 785–793.
<https://doi.org/10.1016/j.acap.2017.02.008>
- Grover, K. (2015). *The centre for homeopathic education*. Retrieved from <https://hpathy.com/homeopathy-papers/the-centre-for-homeopathic-education/>

- Guarneri, E., Horrigan, B. J., & Pechura, C. M. (2010). The efficacy and cost effectiveness of integrative medicine: A review of the medical and corporate literature. *Explore (NY)*, 6(5), 308–312.
<https://doi.org/10.1016/j.explore.2010.06.012>
- Guba, E., & Lincoln, Y. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 191–215). Thousand Oaks, CA: Sage.
- Gupta, B. K., Tailang, M., Pathak, A. K., Lokhande, A. K., & Sunil, M. (2010). Formulation and standardization of homoeopathic mother tincture of *Cinnamomum Zeylanicum*. *International Journal of Phytomedicine*, 2(1), 41–43.
Retrieved from <http://www.arjournals.org/index.php/ijpm/article/view/85>
- Gupta, U., & Verma, M. (2013). Placebo in clinical trials. *Perspectives in Clinical Research*, 4(1), 49–52. <https://doi.org/10.4103/2F2229-3485.106383>
- Gurib-Fakim, A. (2006). Medicinal plants: Traditions of yesterday and drugs of tomorrow. *Molecular Aspects of Medicine*, 27(1), 1–93.
<https://doi.org/10.1016/j.mam.2005.07.008>
- Güthlin, C., Lange, O., & Walach, H. (2004). Measuring the effects of acupuncture and homoeopathy in general practice: An uncontrolled prospective documentation approach. *BMC Public Health*, 4(1), 6. doi:10.1186/1471-2458-4-6
- Gutierrez, I. A., & Park, C. L. (2015). Emerging adulthood, evolving worldviews: How life events impact college students' developing belief systems. *Emerging Adulthood*, 3(2), 85–97. doi:10.1177/2167696814544501
- Hagens, V., Dobrow, M. J., & Chafe, R. (2009). Interviewee transcript review: Assessing the impact on qualitative research. *BMC Medical Research Methodology*, 9, 47–54. <https://doi.org/10.1186/1471-2288-9-47>

- Haggan, M. (2016, March 21). Integrative medicine ‘health fraud and quackery’.
AJP.com.au. Retrieved from <https://ajp.com.au/news/integrative-medicine-health-fraud-quackery/>
- Hahnemann, S. (1998). *Organon of medicine* (6th ed.). New Delhi: B. Jain.
- Haigh, C. A. (2010). Reconstructing nursing altruism using a biological evolutionary framework. *Journal of Advanced Nursing*, 66(6), 1401–1408.
<https://doi.org/10.1111/j.1365-2648.2010.05274.x>
- Halcón, L., Leonard, B., Snyder, M., Garwick, A., & Kreitzer, M. J. (2001).
 Incorporating alternative and complementary health practices within university-based nursing education. *Complementary Health Practice Review*, 6(2), 127–135.
<https://doi.org/10.1177/153321010100600203>
- Hall, H., Leach, M., Brosnan, C., & Collins, M. (2017). Nurses’ attitudes towards complementary therapies: A systematic review and meta-synthesis. *International Journal of Nursing Studies*, 69(April), 47–56.
<https://doi.org/10.1016/j.ijnurstu.2017.01.008>
- Hall, H., Brosnan, C., Frawley, J., Wardle, J., Collins, M., & Leach, M. (2018). Nurses’ communication regarding patients’ use of complementary and alternative medicine. *Collegian*, 25(3), 285–291.
<https://doi.org/10.1016/j.colegn.2017.09.001>
- Hall, H., McKenna, L. G., & Griffiths, D. L. (2012). Midwives’ support for complementary and alternative medicine: A literature review. *Women & Birth*, 25(1), 4–12. <https://doi.org/10.1016/j.wombi.2010.12.005>
- Hallberg, L. R. M. (2010). Some thoughts about the literature review in grounded theory studies. *International Journal of Qualitative Studies on Health and Well-Being*, 5(3). <https://dx.doi.org/10.3402%2Fqhw.v5i3.5387>

- Halliday-Wynes, S., & Beddie, F. (2009). Informal learning: At a glance. *National Centre for Vocational Education Research*. Retrieved from <https://www.ncver.edu.au/research-and-statistics/publications/all-publications/informal-learning-at-a-glance>
- Hammarberg, K., Kirkman, M., & de Lacey, S. (2016). Qualitative research methods: When to use them and how to judge them. *Human Reproduction*, 31(3), 498–501. <https://doi.org/10.1093/humrep/dev334>
- Han, G. S., & Ballis, H. (2007). Ethnomedicine and dominant medicine in multicultural Australia: A critical realist reflection on the case of Korean-Australian immigrants in Sydney. *Journal of Ethnobiology and Ethnomedicine*, 3(January). Article 1. <https://doi.org/10.1186/1746-4269-3-1>
- Hann, D. M., Baker, F., Denniston, M. M., & Winter, K. (2004). Oncology professionals' views of complementary therapies: A survey of physicians, nurses, and social workers. *Cancer Control*, 11(6), 404–410. doi:10.1177/107327480401100608
- Hanna, P. (2012). Using internet technologies (such as Skype) as a research medium: A research note. *Qualitative Research*, 12(2), 239–242. <https://doi.org/10.1177/1468794111426607>
- Hansen, K., & Kappel, K. (2010). The proper role of evidence in complementary/alternative medicine. *Journal of Medicine and Philosophy*, 35(1), 7–18. <https://doi.org/10.1093/jmp/jhp059>
- Happell, B. (2009). Retaining our nurses: Why aren't we ahead of the pack? *International Journal of Mental Health Nursing*, 18(1), 1–1. <https://doi.org/10.1111/j.1447-0349.2008.00589.x>

- Haresnape, C. (2013). An exploration of the relationship between placebo and homeopathy and the implications for clinical trial design. *JRSM Short Reports*, 4(9). <https://doi.org/10.1177%2F2042533313490927>
- Harley, S., & Timmons, S. (2010). Clinical assessment skills and the use of monitoring equipment. *Paediatric Nursing*, 22(8), 14–18.
doi:10.7748/paed2010.10.22.8.14.c7996
- Harré, R., & Van Langenhove, L. (1991). Varieties of positioning. *Journal for the Theory of Social Behaviour*, 21(4), 393–408. doi:10.1111/j.1468-5914.1991.tb00203.x
- Harré, R., Moghaddam, F. M., Cairnie, T. P., Rothbart, D., & Sabat, S. R. (2009). Recent advances in positioning theory. *Theory & Psychology*, 19(1), 5–31.
<https://doi.org/10.1177/0959354308101417>
- Harris, P. E., Cooper, K. L., Relton, C., & Thomas, K. J. (2012). Prevalence of complementary and alternative medicine (CAM) use by the general population: A systematic review and update. *International Journal of Clinical Practice*, 66(10), 924–939. doi:10.1111/j.1742-1241.2012.02945.x
- Harrison, K. L., & Taylor, H. A. (2016). Healthcare resource allocation decisions affecting uninsured services. *Journal of Health Organization and Management*, 30(8), 1162--1182. <https://doi.org/10.1108/JHOM-01-2016-0003>
- Harvey, P. W. (2006). Social determinants of health—Why we continue to ignore them in the search for improved population health outcomes! *Australian Health Review: A Publication of the Australian Hospital Association*, 30(4), 419–423.
doi:10.1071/AH060419

- Hassan, A., Allam, A., Al Kindi, S., Abu Zeinah, G., Eziada, S., & Bashir, A. (2014). Knowledge, attitudes and practices of oncology nurses towards complementary and alternative medicine for cancer care in Qatar. *Journal of Anesthesia & Clinical Research*, 5(12). doi:10.4172/2155-6148.1000477
- Hawk, C., Adams, J., & Hartvigsen, J. (2015). The role of CAM in public health, disease prevention, and health promotion. *Evidence-Based Complementary and Alternative Medicine*, 2015. Article 528487.
<http://dx.doi.org/10.1155/2015/528487>
- Healy, P., & Fallon, A. (2014). Developments in neonatal care and nursing responses. *British Journal of Nursing*, 23(1), 21–24. doi:10.12968/bjon.2014.23.1.21
- Heath, H., & Cowley, S. (2004). Developing a grounded theory approach: A comparison of Glaser and Strauss. *International Journal of Nursing Studies*, 41(2), 141–150.
[https://doi.org/10.1016/S0020-7489\(03\)00113-5](https://doi.org/10.1016/S0020-7489(03)00113-5)
- Heckathorn, D. (2011). Snowball versus respondent-driven sampling. *Sociological Methodology*, 4(1), 355–366. doi:10.1111/j.1467-9531.2011.01244.x
- Hegyí, G., Petri, R. P., Roberti di Sarsina, P., & Niemtzow, R. C. (2015). Overview of integrative medicine practices and policies in NATO participant countries. *Medical Acupuncture*, 27(5), 318–327. <https://doi.org/10.1089/acu.2014.1085>
- Heidegger, M. (1962). *Being and time*. Oxford: Blackwell.
- Hellawell, B. (2015). Ethical accountability and routine moral stress in special educational needs professionals. *Management in Education*, 29(3), 119–124.
<https://doi.org/10.1177/0892020615584106>

- Helms, J. E. (2006). Complementary and alternative therapies: A new frontier for nursing education? *The Journal of Nursing Education*, 45(3), 117–123. Retrieved from <http://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=1&sid=bf3d5eaf-340a-4c05-93a5-0e14bc400919%40pdv-v-sessmgr03>
- Henderson, S. (2002). Factors impacting on nurses' transference of theoretical knowledge of holistic care into clinical practice. *Nurse Education in Practice*, 2(4), 244–250. [https://doi.org/10.1016/S1471-5953\(02\)00020-3](https://doi.org/10.1016/S1471-5953(02)00020-3)
- Hercelinskyj, G., Cruickshank, M., Brown, P., & Phillips, B. (2014). Perceptions from the front line: Professional identity in mental health nursing. *International Journal of Mental Health Nursing*, 23(1), 24–32. <https://doi.org/10.1111/inm.12001>
- Herkes, J., Churrua, K., Ellis, L. A., Pomare, C., & Braithwaite, J. (2019). How people fit in at work: Systematic review of the association between person–organisation and person–group fit with staff outcomes in healthcare. *BMJ Open*, 9(5), e026266. <https://doi.org/10.1136/bmjopen-2018-026266>
- Herman, P. M., Poindexter, B. L., Witt, C. M., & Eisenberg, D. M. (2012). Are complementary therapies and integrative care cost-effective? A systematic review of economic evaluations. *BMJ Open*, 2(5), e001046. <https://bmjopen.bmj.com/content/2/5/e001046>
- Higginbottom, G., & Lauridsen, E. I. (2014). The roots and development of constructivist grounded theory. *Nurse Researcher*, 21(5), 8–13. <https://doi.org/10.7748/nr.21.5.8.e1208>
- Hilbers, J., & Lewis, C. (2013). Complementary health therapies: Moving towards an integrated health model. *Collegian*, 20(1), 51–60.
doi:10.1016/j.colegn.2012.03.004

- Hill, T. E. (2010). How clinicians make (or avoid) moral judgments of patients: Implications of the evidence for relationships and research. *Philosophy, Ethics, and Humanities in Medicine*, 5(1), 11. <https://doi.org/10.1186/1747-5341-5-11>
- Hirschhorn, K. A., & Bourgeault, I. L. (2008). Structural constraints and opportunities for CAM use and referral by physicians, nurses, and midwives. *Health*, 12(2), 193--213. <https://doi.org/10.1177/1363459307086843>
- Hogan, V. K., de Araujo, E. M., Caldwell, K. L., Gonzalez-Nahm, S. N., & Black, K. Z. (2018). “We black women have to kill a lion everyday”: An intersectional analysis of racism and social determinants of health in Brazil. *Social Science & Medicine*, 199, 96–105. doi:10.1016/j.socscimed.2017.07.008
- Holden, S. C., Gardiner, P., Birdee, G., Davis, R. B., & Yeh, G. Y. (2015). Complementary and alternative medicine use among women during pregnancy and childbearing years. *Birth*, 42(3), 261–269. <https://doi.org/10.1111/birt.12177>
- Holland, K. E., Middleton, L., & Uys, L. (2013). Professional confidence: Conceptions held by novice occupational therapists in South Africa. *Occupational Therapy International*, 20(3), 105–113. <https://doi.org/10.1002/oti.1340>
- Holland, K., & Rees, C. (2010). *Nursing*. Oxford: Oxford University Press.
- Holland, P., Allen, B. C., & Cooper, B. K. (2012). *What nurses want: Analysis of the first national survey on nurses’ attitudes to work and work conditions in Australia*. Department of Management Monash University. Retrieved from <https://researchbank.swinburne.edu.au/items/118dedf6-7ff5-4a22-87aa-130d05c0f5f7/1/>

- Hollenberg, D. (2006). Uncharted ground: Patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings. *Patient Organisation Movements*, 62(3), 731–744.
<https://doi.org/10.1016/j.socscimed.2005.06.030>
- Holloway, I., & Galvin, K. (2016). *Qualitative research in nursing and healthcare* (4th ed.). Chichester, West Sussex, U.K: Wiley-Blackwell.
- Holloway, W. (1984). Gender difference and the production of subjectivity. In J. Henriques, W. Hollway, C. Urwin, C. Venn & V. Walkerdine (Eds.) *Changing the Subject: Psychology, social regulation and subjectivity*, pp. 227–263. London: Methuen & Co. Ltd.
- Holm, S. (2017). Ethical issues in geriatric medicine. In H. M. Fillit, K. Rockwood, & J. B. Young (Eds.), *SPEC—Brocklehurst's Textbook of Geriatric Medicine and Gerontology* (8th ed.). Philadelphia, PA: Elsevier.
- Holroyd, E., Zhang, A. L., Suen, L. K. P., & Xue, C. C. L. (2008). Beliefs and attitudes towards complementary medicine among registered nurses in Hong Kong. *International Journal of Nursing Studies*, 45(11), 1660–1666.
<https://doi:10.1016/j.ijnurstu.2008.04.003>
- Holton, J. (2007). The coding process and its challenges. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 265–289). London: Sage.
- Homeopathic Nurses Association. (2018a). *Home*. Retrieved from
<https://www.nursehomeopaths.org/>
- Homeopathic Nurses Association. (2018b). *Homeopathic nurses*. Retrieved from
<https://www.nursehomeopaths.org/find-a-homeopath>

- Homeopathyresearch. (2017, August 3). *Rachel Roberts: Full scientific analysis of the Australian report*. [Video File]. Retrieved from <https://www.youtube.com/watch?v=dWKHFfRJhWk>
- Hook, C., Plump, B., & Geist-Martin, P. (2018). Advocating for integrative medicine: Providers' stories of resonance, negotiation, and community. *Qualitative Research in Medicine and Healthcare*, 2(1), 30–44. <https://doi.org/10.4081/qrmh.2018.7049>
- Horton, E. S. (2007) *Neoliberalism and the Australian Healthcare System (Factory)*. In Proceedings 2007 Conference of the Philosophy of Education Society of Australasia, Wellington, New Zealand. Retrieved from <https://eprints.qut.edu.au/14444/1/14444.pdf>
- House of Commons. (2010). *Evidence check 2: Homeopathy*. Retrieved from <https://publications.parliament.uk/pa/cm200910/cmselect/cmsctech/45/45.pdf>
- Howell, K. E. (2013). Explaining and understanding theory. In K. E. Howell (Ed.), *An introduction to the philosophy of methodology* (pp. 19–31). London: Sage. doi:10.4135/9781473957633.n2
- Huber, M., Knottnerus, J. A., Green, L., Horst, H., van der, Jadad, A. R., Kromhout, D., . . . Smid, H. (2011). How should we define health? *BMJ*, 343 (July). <https://doi.org/10.1136/bmj.d4163>
- Hughes R. G., Blegen., M. A. (2008). Medication Administration Safety. In R. G. Hughes (Ed.). *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Rockville (MD): Agency for Healthcare Research and Quality (US), Chapter 37. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK2656/>

- Hughes, S. C., & Wingard, D. L. (2006). Children's visits to providers of complementary and alternative medicine in San Diego. *Ambulatory Pediatrics*, 6(5), 293–296.
doi:10.1016/j.ambp.2005.11.007
- Huljev, D., & Pandak, T. (2016). Holistic and team approach in health care. *Signa Vitae*, 11(Suppl. 2), 66–69. doi:10.22514/SV112.062016.14
- Hunter, A., & Grant, A. (2005). Complementary medicine and evidence-based practice. *Evidence-Based Integrative Medicine*, 2(4), 189–194.
<https://doi.org/10.2165/01197065-200502040-00002>
- Hunter, J., Corcoran, K., Leeder, S., & Phelps, K. (2013). Integrative medicine outcomes: What should we measure? *Complementary Therapies in Clinical Practice*, 19(1), 20–26. <https://doi.org/10.1016/j.ctcp.2012.10.002>
- Hunter, J., Corcoran, K., Phelps, K., & Leeder, S. (2012). The integrative medicine team—Is biomedical dominance inevitable? *Journal of Alternative and Complementary Medicine*, 18(12), 1127–1132. doi:10.1089/acm.2011.0393
- Huston, C. (2013). The impact of emerging technology on nursing care: Warp speed ahead. *The Online Journal of Issues in Nursing*, 18(2).
doi:10.3912/OJIN.Vol18No02Man01
- Illeris, K. (2014a). Transformative Learning re-defined: As changes in elements of the identity. *International Journal of Lifelong Education*, 33(5), 573–586.
<https://doi.org/10.1080/02601370.2014.917128>
- Illeris, K. (2014b). *Transformative learning and identity*. New York, NY: Routledge.
- Indra, V. (2018). Complementary and alternative medicine in nursing care. *International Journal of Advances in Nursing Management*, 6(3) 255–257. Retrieved from
<http://ijanm.com/>

- International Academy of Classical Homeopathy. (2016a). *Hahnemannian homeopathy*. Retrieved from <https://www.vithoukas.com/homeopathy/hahnemannian-homeopathy>
- International Academy of Classical Homeopathy. (2016b). *Belladonna*. Retrieved from <https://www.vithoukas.com/learning-tools/books-gv/materia-medica-volume-4/belladonna>
- International Confederation of Midwives. (2017). *Position statement. Midwifery: An autonomous profession*. Retrieved from <https://www.internationalmidwives.org/our-work/policy-and-practice/icm-position-statements/>
- International Council of Nurses. (2012). *Code of ethics for nurses*. Retrieved from <http://www.old.icn.ch/who-we-are/code-of-ethics-for-nurses>
- International Council of Nurses. (2019). *Definition of nursing*. Retrieved from <https://www.icn.ch/nursing-policy/nursing-definitions>
- Islahudin, F., Shahdan, I. A., & Mohamad-Samuri, S. (2017). Association between belief and attitude toward preference of complementary alternative medicine use. *Patient Preference and Adherence*, 11, 913–918. <https://dx.doi.org/10.2147%2FPPA.S132282>
- Italia, S., Wolfenstetter, S. B., & Teuner, C. M. (2014). Patterns of complementary and alternative medicine (CAM) use in children: A systematic review. *European Journal of Pediatrics*, 173(11), 1413–1428. doi:10.1007/s00431-014-2300-z
- Jackson, E. (2018). From ‘doctor knows best’ to dignity: Placing adults who lack capacity at the centre of decisions about their medical treatment. *The Modern Law Review*, 81(2), 247–281. doi:10.1111/1468-2230.12328

- Jackson, H., & Shiell, A. (2017) *Preventive health: How much does Australia spend and is it enough?* Canberra: Foundation for Alcohol Research and Education.
Retrieved from <http://fare.org.au/preventive-health-how-much-does-australia-spend-and-is-it-enough/>
- Jacob, E. R., McKenna, L., & D'Amore, A. (2017). Role expectations of different levels of nurse on graduation: A mixed methods approach. *Collegian*, 24(2), 135–145.
<https://doi.org/10.1016/j.colegn.2016.01.006>
- Jacob, S., & Furgerson, S. (2012). Writing interview protocols and conducting interviews: Tips for students new to the field of qualitative research. *The Qualitative Report*, 17(6), 1--10. Retrieved from
<http://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=asn&AN=88905599&scope=site&authtype=sso&custid=s3716178>
- James Cook University. (2019). *Finding grey literature: Grey literature*. Retrieved from
<https://libguides.jcu.edu.au/grey-lit>
- Jancey, J., Barnett, L., Smith, J., Binns, C., & Howat, P. (2016). We need a comprehensive approach to health promotion. *Health Promotion Journal of Australia*, 27(1), 1–3. https://doi.org/10.1071/HEv27n1_ED
- Jarvis, P. (2006). *Towards a comprehensive theory of human learning* (Vol. 1). New York, NY: Routledge.
- Jarvis, P. (2012). *Adult learning in the social context* (2nd ed.). New York, NY: Routledge.
- Jennings, N., Lee, G., Chao, K., & Keating, S. (2009). A survey of patient satisfaction in a metropolitan emergency department: Comparing nurse practitioners and emergency physicians. *International Journal of Nursing Practice*, 15(3), 213–218.
doi:10.1111/j.1440-172X.2009.01746.x

- Jirwe, M., & Rudman, A. (2012). Why choose a career in nursing? *Journal of Advanced Nursing*, 68(7), 1615–1623. <https://doi.org/10.1111/j.1365-2648.2012.05991.x>
- Jiwa, M., Gordon, M., Arnet, H., Ee, H., Bulsara, M., & Colwell, B. (2011). Referring patients to specialists: A structured vignette survey of Australian and British GPs. *BMC Family Practice*, 9(1), 1–7. doi:10.1186/1471-2296-9-2
- Johannessen, B. (2004). Norwegian nurses' choice to work with alternative/complementary therapy: How will this affect their professional identity? *International Journal for Human Caring*, 8(2), 48–53. doi:10.20467/1091-5710.8.2.49
- Johannessen, B. (2009). Why do Norwegian nurses leave the public health service to practice CAM? *Complementary Therapies in Clinical Practice*, 15(3), 147–151. <https://doi.org/10.1016/j.ctcp.2009.02.014>
- Johansen, M. L., & O'Brien, J. L. (2016). Decision making in nursing practice: A concept analysis. *Nursing Forum*, 51(1), 40–48. <https://doi.org/10.1111/nuf.12119>
- Johnson, J. A. (2015). Tasks and technology versus compassion and caring in nursing: Are they mutually exclusive? *Journal for Nurses in Professional Development*, 31(6), 338. doi:10.1097/NND.0000000000000210
- Johnson, M. D., Morgeson, F. P., Ilgen, D. R., Meyer, C. J., & Lloyd, J. W. (2006). Multiple professional identities: examining differences in identification across work-related targets. *The Journal of Applied Psychology*, 91(2), 498–506. <https://doi.org/10.1037/0021-9010.91.2.498>
- Johnson, M., Cowin, L. S., Wilson, I., & Young, H. (2012). Professional identity and nursing: contemporary theoretical developments and future research challenges. *International Nursing Review*, 59(4), 562–569. <https://doi.org/10.1111/j.1466-7657.2012.01013.x>

- Johnson, P. J., Ward, A., Knutson, L., & Sendelbach, S. (2012). Personal use of complementary and alternative medicine (CAM) by U.S. health care workers. *Health Services Research*, 47(1), 211–227. doi:10.1111/j.1475-6773.2011.01304.x
- Jonas, W. B., Kaptchuk, T. J., & Linde, K. (2003). A critical overview of homeopathy. *Annals of Internal Medicine*, 138(5), 393–399. doi:10.7326/0003-4819-138-5-200303040-00009
- Jones, B. T., & Metzger, S. K. (2016). Conflict dynamics. In A. Farazmand (Ed.), *Global Encyclopedia of Public Administration, Public Policy, and Governance* (pp. 1–8). https://doi.org/10.1007/978-3-319-31816-5_2548-1
- Jones, C., Jomeen, J., & Ogbuehi, O. (2013). A preliminary survey of the use of complementary and alternative medicines in childbearing women. *Evidence Based Midwifery* 11(4), 128–131. Retrieved from <https://search-proquest-com.ezproxy.cqu.edu.au/docview/1470776477?accountid=10016>
- Kaba, R., & Sooriakumaran, P. (2007). The evolution of the doctor-patient relationship. *International Journal of Surgery*, 5(1), 57–65. doi:10.1016/j.ijssu.2006.01.005
- Kahn, W. A., 1990. Psychological conditions of personal engagement and disengagement at work. *The Academy of Management Journal*, 33(4), 692–724. <https://doi.org/10.5465/256287>
- Kamise, Y. (2013). Occupational stigma and coping strategies of women engaged in the commercial sex industry: A study on the perception of “Kyaba-Cula Hostesses” in Japan. *Sex Roles*, 69(1), 42–57. <https://doi.org/10.1007/s11199-013-0293-0>
- Kamper, S. J., & Williams, C. M. (2013). The placebo effect: Powerful, powerless or redundant? *British Journal of Sports Medicine*, 47(1), 6–9. doi:10.1136/bjsports-2012-091472

- Kang, D. J., & Cho, S. (2017). Lost in travel or a different conception? (Mis-)appropriation of transformative learning theory in the Republic of Korea. *Asia Pacific Education Review*, 18(2), 163–174. <https://doi.org/10.1007/s12564-017-9481-x>
- Kannan, V. D., & Veazie, P. J. (2014). Predictors of avoiding medical care and reasons for avoidance behavior. *Medical Care*, 52(4), 336–345. <https://doi.org/10.1097/MLR.0000000000000100>
- Kaptchuk, T. J., & Miller, F. G. (2005). What is the best and most ethical model for the relationship between mainstream and alternative medicine: Opposition, integration, or pluralism? *Academic Medicine*, 80(3), 286–290. <http://dx.doi.org/10.1097/00001888-200503000-00015>
- Kaptchuk, T. J., Kelley, J. M., Conboy, L. A., Davis, R. B., Kerr, C. E., Jacobson, E. E., . . . Lembo, A. J. (2008). Components of placebo effect: Randomised controlled trial in patients with irritable bowel syndrome. *BMJ*, 336(7651), 999–1003. doi:10.1136/bmj.39524.439618.25
- Karlik, J. B., Ladas, E. J., Ndao, D. H., Cheng, B., Bao, Y., & Kelly, K. M. (2014). Associations between healthy lifestyle behaviors and complementary and alternative medicine use: Integrated wellness. *Journal of the National Cancer Institute. Monographs*, 2014(50), 323–329. doi:10.1093/jncimonographs/lgu031
- Karlsson, K., Rydström, I., Enskär, K., & Englund, A. C. D. (2014). Nurses' perspectives on supporting children during needle-related medical procedures. *International Journal of Qualitative Studies on Health and Well-Being*, 9(March). Article 23063. <https://doi.org/10.3402/qhw.v9.23063>
- Karnick, P. M. (2014). What kind of nurse are you? *Nursing Science Quarterly*, 27(3), 211–212. doi:10.1177/0894318414534471

- Karwowski, M. (2016). The dynamics of creative self-concept: Changes and reciprocal relations between creative self-efficacy and creative personal identity. *Creativity Research Journal*, 28(1), 99–104.
<https://doi.org/10.1080/10400419.2016.1125254>
- Kaur, H. (2013). Homoeopathic research—Understanding the challenges. *Journal of Homeopathy and Ayurvedic Medicine*, 2(1). doi:10.4172/2167-1206.1000118
- Kayes, D. C. (2002). Experiential learning and its critics: Preserving the role of experience in management learning and education. *Academy of Management Learning & Education*, 1(2), 137–149. Retrieved from
https://www.jstor.org/stable/40214146?seq=1#page_scan_tab_contents
- Kayi-Aydar, H., & Miller, E. R. (2018). Positioning in classroom discourse studies: A state-of-the-art review. *Classroom Discourse*, 9(2), 79–94.
<https://doi.org/10.1080/19463014.2018.1450275>
- Kearney, G. (2010). We must not forget what we once knew: An exemplar for helping nurses reconnect with their history and rediscover their passion for nursing. *Journal of Holistic Nursing*, 28(4), 260–262.
<https://doi.org/10.1177/0898010110376322>
- Keeling, J. L., & McQuarrie, C. (2014). Promoting mental health and wellbeing in practice. *Mental Health Practice*, 17(5), 26–28.
<https://doi.org/10.7748/mhp2014.02.17.5.26.e873>
- Kemm, J. (2006). The limitations of ‘evidence-based’ public health. *Journal of Evaluation in Clinical Practice*, 12(3), 319–324. <https://doi.org/10.1111/j.1365-2753.2006.00600.x>

- Kendall, J. M. (2003). Designing a research project: Randomised controlled trials and their principles. *Emergency Medicine Journal*, 20(2), 164–168.
doi:10.1136/emj.20.2.164
- Kenny, A. (2004). Medical dominance and power: A rural perspective. *Health Sociology Review*, 13(2), 158–165. doi:10.5172/hesr.13.2.158
- Kent, J. T. (1999a). *Lectures on materia medica*. New Delhi: B. Jain.
- Kent, J. T. (1999b). *Repertory of the homoeopathic materia medica*. New Delhi: B. Jain.
- Keshet, Y. (2009). The untenable boundaries of biomedical knowledge: Epistemologies and rhetoric strategies in the debate over evaluating complementary and alternative medicine. *Health*, 13(2), 131–155.
<https://doi.org/10.1177/1363459308099681>
- Keshet, Y., Ben-Arye, E., & Schiff, E. (2013). The use of boundary objects to enhance interprofessional collaboration: Integrating complementary medicine in a hospital setting. *Sociology of Health & Illness*, 35(5), 666–681.
<https://doi.org/10.1111/j.1467-9566.2012.01520.x>
- Kessler, I., Heron, P., & Dopson, S. (2015). Professionalization and expertise in care work: The hoarding and discarding of tasks in nursing. *Human Resource Management*, 54(5), 737–752. <https://doi.org/10.1002/hrm.21695>
- Khan, N. A., Hemmelgarn, B., Herman, R. J., Rabkin, S. W., McAlister, F. A., Bell, C. M., . . . Canadian Hypertension Education Program. (2008). The 2008 Canadian hypertension education program recommendations for the management of hypertension: Part 2—therapy. *The Canadian Journal of Cardiology*, 24(6), 465–475. [https://doi.org/10.1016/S0828-282X\(08\)70620-2](https://doi.org/10.1016/S0828-282X(08)70620-2)

- Khoury, R. (2012). Can evidence-based medicine achieve professionalisation for the herbal medicine occupation? *Journal of the Australian Traditional Medicine Society*, 18(3), 147–149. Retrieved from <https://search-proquest-com.ezproxy.cqu.edu.au/docview/1095110176?accountid=10016>
- Kilanowski, J. F. (2012). Breaking the ice: A pre-intervention strategy to engage research participants. *Journal of Pediatric Health Care*, 26(3), 209–212.
doi:10.1016/j.pedhc.2012.01.001
- Kim, K. H., Lee, A. Y., Eudey, L., & Dea, M. W. (2014). Improving clinical competence and confidence of senior nursing students through clinical preceptorship. *International Journal of Nursing*, 1(2), 183–209.
<https://doi.org/10.15640/ijn.v1n2a14>
- Kim, S. Y. (2013). Efficacy versus effectiveness. *Korean Journal of Family Medicine*, 34(4), 227–227. <https://doi.org/10.4082/kjfm.2013.34.4.227>
- Kimmerle, J., Moskaliuk, J., Oeberst, A., & Cress, U. (2015). Learning and collective knowledge construction with social media: A process-oriented perspective. *Educational Psychologist*, 50(2), 120–137.
<https://doi.org/10.1080/00461520.2015.1036273>
- King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. London: Sage.
- Kirchherr, J., & Charles, K. (2018). Enhancing the sample diversity of snowball samples: Recommendations from a research project on anti-dam movements in Southeast Asia. *PLOS ONE*, 13(8), e0201710. <https://doi.org/10.1371/journal.pone.0201710>
- Kitson, A., Marshall, A., Bassett, K., & Zeitz, K. (2013). What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing*, 69(1), 4–15.
<https://doi.org/10.1111/j.1365-2648.2012.06064.x>

- Kluge, E.-H. W. (2007). Resource allocation in healthcare: Implications of models of medicine as a profession. *Medscape General Medicine*, 9(1), 57. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925021/>
- Knapton, S. (2018, January 17). Professor reignites war with Prince Charles over homeopathy support. *The Telegraph*. Retrieved from <https://www.telegraph.co.uk/science/2018/01/17/professor-reignites-war-prince-charles-homeopathy-support/>
- Kolb, A., & Kolb, D. (2005). Learning styles and learning spaces: Enhancing experiential learning in higher education. *Academy of Management Learning & Education*, 4(2), 193–212. Retrieved from <http://www.jstor.org/stable/40214287>
- Kolb, D. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice Hall.
- Kolkman, E., Visser, A., Vink, A. M., & Dekkers, W. (2011). CAM-education in the medical curriculum: Attitude towards and knowledge of CAM among Dutch medical students. *European Journal of Integrative Medicine*, 3(1), 17–22. <https://doi.org/10.1016/j.eujim.2011.02.005>
- Koltko-Rivera, M. E. (2004). The psychology of worldviews. *Review of General Psychology*, 8(1), 3–58. doi:10.1037/1089-2680.8.1.3
- Kontos, P. C., & Naglie, G. (2009). Tacit knowledge of caring and embodied selfhood. *Sociology of Health & Illness*, 31(5), 688–704. <https://doi.org/10.1111/j.1467-9566.2009.01158.x>
- Koopsen, C., & Young, C. (2009). *Integrative health: A holistic approach for health professionals*. Sudbury: Jones and Bartlett.

- Korhonen, E. S., Nordman, T., & Eriksson, K. (2015). Technology and its ethics in nursing and caring journals: An integrative literature review. *Nursing Ethics*, 22(5), 561–576. doi:10.1177/0969733014549881
- Kothari, A. R., Bickford, J. J., Edwards, N., Dobbins, M. J., & Meyer, M. (2011). Uncovering tacit knowledge: A pilot study to broaden the concept of knowledge in knowledge translation. *BMC Health Services Research*, 11(August). Article 198. <https://doi.org/10.1186/1472-6963-11-198>
- Kourkouta, L., & Papathanasiou, I. V. (2014). Communication in nursing practice. *Materia socio-medica*, 26(1), 65–67. doi:10.5455/msm.2014.26.65-67
- Kovic, M. (2016): Evidence-based medicine vs. complementary and alternative medicine: It's about epistemology (not about evidence). *Swiss Skeptics Discussion Paper Series 1*(2), 1–27. Retrieved from <https://www.skeptiker.ch/wp-content/uploads/2016/06/Discussion-Paper-CAM-Epistemology-2016-06.pdf>
- Kulich, C., de Lemus, S., Kosakowska-Berezecka, N., & Lorenzi-Cioldi, F. (2017). Editorial: Multiple identities management: Effects on (of) identification, attitudes, behavior and well-Being. *Frontiers in Psychology*, 8(December). <https://doi.org/10.3389/fpsyg.2017.02258>
- Künne, R. (2015). Hahnemann's idea of the vital force: fiction, construct or reality? *Homœopathic Links*, 28(04), 255–259. <https://doi.org/10.1055/s-0035-1566238>
- Kwon, E., Ratneshwar, S., & Kim, E. (2016). Brand image congruence through sponsorship of sporting events: A reinquiry of Gwinner and Eaton (1999). *Journal of Advertising*, 45(1), 130–138. <https://doi.org/10.1080/00913367.2015.1089427>

- Lachman, V. D. (2012). Applying the ethics of care to your nursing practice. *Medsurg Nursing*, 21(2), 112–116. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=ccm&AN=104556501&scope=site>
- Lai, D., & Chappell, N. (2006). Use of Traditional Chinese Medicine by older Chinese immigrants in Canada. *Family Practice*, 24(1), 56–64. <https://doi.org/10.1093/fampra/cml058>
- Lake, E. (2002). Development of the practice environment scale of the nursing work index. *Research in Nursing & Health*, 25(3), 176–188. <https://doi.org/10.1002/nur.10032>
- Lake, E., & Friese, R. C. (2006). Variations in nursing practice environments: Relation to staffing and hospital characteristics. *Nursing Research*, 55(1), 1–9. <https://doi.org/10.1097/00006199-200601000-00001>
- Lam, A. (2000). Tacit knowledge, Organizational learning and societal institutions: An integrated framework. *Organization Studies*, 21(3), 487–513. <https://doi.org/10.1177/0170840600213001>
- Lam, T. P. (2001). Strengths and weaknesses of traditional Chinese medicine and western medicine in the eyes of some Hong Kong Chinese. *Journal of Epidemiology & Community Health*, 55(10), 762–765. <https://doi.org/10.1136/jech.55.10.762>
- Lambert, T. D., Morrison, K. E., Edwards, J., & Clarke, C. E. (2010). The use of complementary and alternative medicine by patients attending a UK headache clinic. *Complementary Therapies in Medicine*, 18(3–4), 128–134. doi:10.1016/j.ctim.2010.05.035

- Lamont, M., & Molnár, V. (2002). The study of boundaries across the social sciences. *Annual Review of Sociology*, 28(August), 167–195.
<https://doi.org/10.1146/annurev.soc.28.110601.141107>
- Längler, A., Spix, C., Edelhäuser, F., Kameda, G., Kaatsch, P., & Seifert, G. (2011). Use of homeopathy in pediatric oncology in Germany. *Evidence-Based Complementary and Alternative Medicine*, 2011. Article 867151.
doi:10.1155/2011/867151
- Lavelle, P. (2010, March 25). Homeopathy under the microscope. *The ABC*. Retrieved from <http://www.abc.net.au/health/thepulse/stories/2010/03/25/2855650.htm>
- Lavender, T., & Richens, Y. (2016). What constitutes good trial evidence? *Journal of Health Visiting*, 4(1), 32–36. <https://doi.org/10.12968/johv.2016.4.1.32>
- Leach, M. J. (2013). Profile of the complementary and alternative medicine workforce across Australia, New Zealand, Canada, United States and United Kingdom. *Complementary Therapies in Medicine*, 21(4), 364–378.
<https://doi.org/10.1016/j.ctim.2013.04.004>
- Leach, M. J., & Gillham, D. (2008). Evaluation of the evidence-based practice attitude and utilization survey for complementary and alternative medicine practitioners. *Journal of Evaluation in Clinical Practice*, 14(5), 792–798.
<https://doi.org/10.1111/j.1365-2753.2008.01046.x>
- Leach, M. J., McIntyre, E., & Frawley, J. (2014). Characteristics of the Australian complementary and alternative medicine (CAM) workforce. *Australian Journal of Herbal Medicine*, 26(2), 58–65. Retrieved from
<https://www.nhaa.org.au/publications/australian-journal-of-herbal-medicine>

- Leary, B. (1987). Cholera and homœopathy in the nineteenth century. *British Homoeopathic Journal*, 76(4), 190–194. [https://doi:10.1016/S0007-0785\(87\)80092-3](https://doi:10.1016/S0007-0785(87)80092-3)
- Lee, C. M., & Hunsley, J. (2015). Evidence-based practice: Separating science from pseudoscience. *Canadian Journal of Psychiatry*, 60(12), 534–540.
doi:10.1177/070674371506001203
- Lee, M. R. (2007). Solanaceae IV: Atropa belladonna, deadly nightshade. *The Journal of the Royal College of Physicians of Edinburgh*, 37(1), 77–84. Retrieved from <https://www.rcpe.ac.uk/college/journal-archive>
- Lees, P., Pelligand, L., Whiting, M., Chambers, D., Toutain, P. L., & Whitehead, M. L. (2017). Comparison of veterinary drugs and veterinary homeopathy: Part 1. *Veterinary Record*, 181(7), 170–176. <https://doi.org/10.1136/vr.104278>
- Lehane, E., Leahy-Warren, P., O’Riordan, C., Savage, E., Drennan, J., O’Tuathaigh, C., . . . Hegarty, J. (2019). Evidence-based practice education for healthcare professions: An expert view. *BMJ Evidence-Based Medicine*, 24(3), 103–108.
<https://doi.org/10.1136/bmjebm-2018-111019>
- Leiter, M. P., & Maslach, C. (2009). Nurse turnover: The mediating role of burnout. *Journal of Nursing Management*, 17(3), 331–339. <https://doi.org/10.1111/j.1365-2834.2009.01004.x>
- Leiter, M. P., Jackson, N. J., & Shaughnessy, K. (2009). Contrasting burnout, turnover intention, control, value congruence and knowledge sharing between baby boomers and generation X. *Journal of Nursing Management*, 17(1), 100–109.
<https://doi.org/10.1111/j.1365-2834.2008.00884.x>

- Leivers, K. (2005). Unravelling the confusion around arnica's herbal and homoeopathic use. *The Pharmaceutical Journal*, 275(September), 289–291. Retrieved from https://www.pharmaceutical-journal.com/libres/pdf/articles/pj_20050903_arnica.pdf
- Lempert, L. B. (2007). Asking questions of the data: Memo writing in the grounded theory tradition. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 245–264). London: Sage.
- Levy, D. (2017). Clinical reasoning and decision-making in homeopathy: An interpretative phenomenological analysis. (Unpublished doctoral dissertation). University of Sydney, Australia.
- Levy, D., Ajjawi, R., & Roberts, C. (2010). How do homeopaths reason and make decisions? Integrating theory, practice, and education. *Journal of Alternative & Complementary Medicine*, 16(12), 1321–1327. <https://doi.org/10.1089/acm.2009.0614>
- Levy, S. E., & Hyman, S. L. (2015). Complementary and alternative medicine treatments for children with autism spectrum disorders. *Child and Adolescent Psychiatric Clinics of North America*, 24(1), 117–143. <https://doi.org/10.1016/j.chc.2014.09.004>
- Lewis, J. M. (2006). Being around and knowing the players: Networks of influence in health policy. *Social Science & Medicine*, 62(9), 2125–2136. doi:10.1016/j.socscimed.2005.10.004
- Lewis, M. (2019). De-legitimising complementary medicine: Framings of the Friends of Science in Medicine-CAM debate in Australian media reports. *Sociology of Health & Illness*, 41(3), 1–21. <https://doi.org/10.1111/1467-9566.12865>

- Li, M., Wang, Z., You, X., & Gao, J. (2015). Value congruence and teachers' work engagement: The mediating role of autonomous and controlled motivation. *Personality and Individual Differences*, 80(July), 113–118.
<https://doi.org/10.1016/j.paid.2015.02.021>
- Liamputtong, P. (2013). *Qualitative research methods* (4th ed.). South Melbourne: Oxford University Press.
- Licqurish, S., & Seibold, C. (2011). Applying a contemporary grounded theory methodology. *Nurse Researcher*, 18(4), 11–16.
doi:10.7748/nr2011.07.18.4.11.c8630
- Liddle, K. (2015, September 18). Why homeopathy must not gain a foothold in the UK. *The Conversation*. Retrieved from <https://theconversation.com/why-homeopathy-must-not-gain-a-foothold-in-the-uk-47659>
- Liga Medicorum Homoeopathica Internationalis & European Committee for Homeopathy. (2014). *Homeopathic proving guidelines. Harmonised by LMHI and ECH*. Retrieved from <http://www.lmhi.org/Article/Detail/44>
- Lillard, A. S., Heise, M. J., Richey, E. M., Tong, X., Hart, A., & Bray, P. M. (2017). Montessori preschool elevates and equalizes child outcomes: A longitudinal study. *Frontiers in Psychology*, 8(October). Article 178.
<https://doi.org/10.3389/fpsyg.2017.01783>
- Lin, V., McCabe, P., Bensoussan, A., Myers, S., Cohen, M., Hill, S., & Howse, G. (2009). The practice and regulatory requirements of naturopathy and western herbal medicine in Australia. *Risk Management and Healthcare Policy*, 2(February), 21–33. <https://doi.org/10.2147/rmhp.s4652>

- Lisko, S. A., & O'Dell, V. (2010). Integration of theory and practice: Experiential learning theory and nursing education. *Nursing Education Perspectives*, 31(2), 106–108 doi:10.1043/1536-5026-31.2.106
- Lo Iacono, V., Symonds, P., & Brown, D. H. K. (2016). Skype as a tool for qualitative research interviews. *Sociological Research Online*, 21(2), 1–15.
<https://doi.org/10.5153/sro.3952>
- Lo, C. O. (2016). Literature integration: An illustration of theoretical sensitivity in grounded theory studies. *The Humanistic Psychologist*, 44(2), 177–189. Retrieved from <https://psycnet.apa.org/PsycARTICLES/journal/hum/44/2>
- Loke, J. C. F., Lee, K. W., Lee, B. K., & Mohd Noor, A. (2015). Caring behaviours of student nurses: Effects of pre-registration nursing education. *Nurse Education in Practice*, 15(6), 421–429. <https://doi.org/10.1016/j.nepr.2015.05.005>
- López-Cevallos, D. F., Harvey, S. M., & Warren, J. T. (2014). Medical mistrust, perceived discrimination, and satisfaction with health care among young-adult rural Latinos. *The Journal of Rural Health*, 30(4), 344–351.
<https://doi.org/10.1111/jrh.12063>
- Lorenc, A., Ilan-Clarke, Y., Robinson, N., & Blair, M. (2009). How parents choose to use CAM: A systematic review of theoretical models. *BMC Complementary and Alternative Medicine* 9(9). doi:10.1186/1472-6882-9-9
- Lotus Health Institute. (2019). *Homeopathic Pharmacy Terminology*. Retrieved from <http://www.alchemilla.com/index.php/homeopathic-medicine-mainmenu-33/15-homeopathic-pharmacy-terminology>
- Loudon, I. (2006). A brief history of homeopathy. *Journal of the Royal Society of Medicine*, 99(12), 607–610. <https://doi.org/10.1258/jrsm.99.12.607>

- Lucas, S., Leach, M., & Kumar, S. (2018). Complementary and alternative medicine utilisation for the management of acute respiratory tract infection in children: A systematic review. *Complementary Therapies in Medicine*, 37(April), 158–166. doi:10.1016/j.ctim.2018.03.001
- Lundgren, S. M., & Robertsson, B. (2013). Writing a bachelor thesis generates transferable knowledge and skills useable in nursing practice. *Nurse Education Today*, 33(11), 1406–1410. <https://doi.org/10.1016/j.nedt.2012.10.019>
- Lundin, S., Wahlgren, C. F., Bergström, A., Johansson, E. K., Dahlén, E., Andersson, N., & Kull, I. (2018). Emollients and topical glucocorticoids in adolescents with eczema. *British Journal of Dermatology*, 179(3), 709–716. doi:10.1111/bjd.17047
- Ma, Y., Zhou, K., Fan, J., & Sun, S. (2016). Traditional Chinese medicine: Potential approaches from modern dynamical complexity theories. *Frontiers of Medicine*, 10(1), 28–32. <https://doi.org/10.1007/s11684-016-0434-2>
- MacLennan, A. H., Myers, S. P., & Taylor, A. W. (2006). The continuing use of complementary and alternative medicine in South Australia: Costs and beliefs in 2004. *The Medical Journal of Australia*, 184(1), 27–31. doi:10.5694/j.1326-5377.2006.tb00092.x
- MacLennan, A. H., Wilson, D., & Taylor, A. (2002). The escalating cost and prevalence of alternative medicine. *Preventative Medicine*, 35(2), 166–173. <https://doi.org/10.1006/pmed.2002.1057>
- MacLennan, A. H., Wilson, D., & Taylor, A. W. (1996). Prevalence and cost of alternative medicine in Australia. *The Lancet*, 347(9001), 569–573. [https://doi.org/10.1016/S0140-6736\(96\)91271-4](https://doi.org/10.1016/S0140-6736(96)91271-4)
- Maddox, J., Randi, J., & Stewart, W. W. (1988). ‘High-dilution’ experiments a delusion. *Nature*, 334(6180), 287–290. <https://doi.org/10.1038/334287a0>

- Magi, T., Kuehni, C. E., Torchetti, L., Wengenroth, L., Lüer, S., & Frei-Erb, M. (2015). Use of complementary and alternative medicine in children with cancer: A study at a Swiss university hospital. *PLOS ONE*, *10*(12), e0145787. <https://doi.org/10.1371/journal.pone.0145787>
- Major, G., & Holmes, J. (2008). How do nurses describe health care procedures? Analysing nurse-patient interaction in a hospital ward. *Australian Journal of Advanced Nursing*, *25*(4), 58–70. Retrieved from http://www.ajan.com.au/Vol25/Vol_25-4_Holmes.pdf
- Malagon-Maldonado, G. (2014). Qualitative research in health design. *Health Environments Research & Design Journal*, *7*(4), 120–134. doi:10.1177/193758671400700411
- Manchandra, R. K. (2016). Integrating homoeopathy in health care. *Indian Journal of Research in Homoeopathy*, *10*(1), 1–5. <https://doi.org/10.4103/0974-7168.179149>
- Manderson, L., Bennett, E., & Andajani-Sutjahjo, S. (2006). The social dynamics of the interview: Age, class, and gender. *Qualitative Health Research*, *16*(10), 1317--1334. doi:10.1177/1049732306294512
- Mapchart. (n.d.). *Australia*. Retrieved from <https://mapchart.net/australia.html>
- Marian, F., Joost, K., Saini, K. D., von Ammon, K., Thurneysen, A., & Busato, A. (2008). Patient satisfaction and side effects in primary care: An observational study comparing homeopathy and conventional medicine. *BMC Complementary and Alternative Medicine*, *8*(1). Article 52. <https://doi.org/10.1186/1472-6882-8-52>
- Markle, D., West, R., & Rich, P. (2011). Beyond transcription: Technology, change and refinement of method. *Forum: Qualitative Social Research*, *12*(3). <https://doi.org/10.17169/fqs-12.3.1564>

- Markun, S., Maeder, M., Rosemann, T., & Djalali, S. (2017). Beliefs, endorsement and application of homeopathy disclosed: A survey among ambulatory care physicians. *Swiss Medical Weekly*, 147(w14505).
<https://doi.org/10.4414/smw.2017.14505>
- Marquis, C., Toffel, M. W., & Zhou, Y. (2016). Scrutiny, norms, and selective disclosure: A global study of greenwashing. *Organization Science*, 27(2), 483–504.
<https://doi.org/10.1287/orsc.2015.1039>
- Marsick, V. J., & Watkins, K. E. (2001). Informal and incidental learning. *New Directions for Adult and Continuing Education*, 2001(89), 25–34.
doi:10.1002/ace.5
- Martin, M. W. (2001). Responsibility for health and blaming victims. *Journal of Medical Humanities*, 22(2), 95–114. doi:10.1023/A:1009074811781
- Martínez-Frías, J., Hochberg, D., & Rull, F. (2006). A review of the contributions of Albert Einstein to earth sciences—In commemoration of the World Year of Physics. *Naturwissenschaften*, 93, 66–71 doi:10.1007/s00114-005-0076-8
- Mathie, R. T., Ulbrich-Zürni, S., Viksveen, P., Roberts, E. R., Baitson, E. S., Legg, L. A., & Davidson, J. R. T. (2018). Systematic review and meta-analysis of randomised, other-than-placebo controlled, trials of individualised homeopathic treatment. *Homeopathy*, 107(4), 229–243. <https://doi.org/10.1055/s-0038-1667129>
- Mazhindu, D. M., Griffiths, L., Pook, C., Erskine, A., Ellis, R., & Smith, F. (2016). The nurse match instrument: Exploring professional nursing identity and professional nursing values for future nurse recruitment. *Nurse Education in Practice*, 18(May), 36–45. <https://doi.org/10.1016/j.nepr.2016.03.006>

- Mazurenko, O., Gupte, G., & Shan, G. (2015). Analyzing U.S. nurse turnover: Are nurses leaving their jobs or the profession itself? *Journal of Hospital Administration*, 4(4), 48–56. <https://doi.org/10.5430/jha.v4n4p48>
- Mazzotta, C. P. (2016). Biomedical approaches to care and their influence on point of care nurses: a scoping review. *Journal of Nursing Education and Practice*, 6(8), 93. <https://doi.org/10.5430/jnep.v6n8p93>
- Mbizo, J., Okafor, A., Sutton, M. A., Leyva, B., Stone, L. M., & Olaku, O. (2018). Complementary and alternative medicine use among persons with multiple chronic conditions: Results from the 2012 National Health Interview Survey. *BMC Complementary and Alternative Medicine*, 18(October). Article 281. doi:10.1186/s12906-018-2342-2
- McClean, S. (2005). ‘The illness is part of the person’: Discourses of blame, individual responsibility and individuation at a centre for spiritual healing in the North of England. *Sociology of Health & Illness*, 27(5), 628–648. <https://doi.org/10.1111/j.1467-9566.2005.00459.x>
- McCormack, B., Borg, M., Cardiff, S., Dewing, J. W., Jacobs, G. C., Janes, N. M., . . . Wilson, V. J. (2015). Person-centredness—The ‘State’ of the Art. *International Practice Development Journal*, 5(Suppl. 1), 1–15. <https://doi.org/10.19043/ipdj.5sp.003>
- McFadden, K. L., Hernández, T. D., & Ito, T. A. (2010). Attitudes towards complementary and alternative medicine influence its use. *Explore (NY)*, 6(6), 380–388. doi:10.1016/j.explore.2010.08.004
- McGrath, C., Palmgren, P. J., & Liljedahl, M. (2018). Twelve tips for conducting qualitative research interviews. *Medical Teacher*, (September 28), 1–5. <https://doi.org/10.1080/0142159X.2018.1497149>

- McGregor, K. J., & Peay, E. R. (1996). The choice of alternative therapy for health care: Testing some propositions. *Social Science & Medicine*, 43(9), 1317–1327.
[https://doi.org/10.1016/0277-9536\(95\)00405-X](https://doi.org/10.1016/0277-9536(95)00405-X)
- McGregor, S. (2001). Neoliberalism and health care. *International Journal of Consumer Studies*, 25(2), 82–89. doi:10.1111/j.1470-6431.2001.00183.x
- McHugh, M., Kutney-Lee, S., Cimiotti, J., Sloane, D., & Aiken, L. (2011). Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs*, 30(2), 202–219.
doi:10.1377/hlthaff.2010.0100
- McHugh, S., Tracey, M. L., Riordan, F., O'Neill, K., Mays, N., & Kearney, P. M. (2016). Evaluating the implementation of a national clinical programme for diabetes to standardise and improve services: A realist evaluation protocol. *Implementation Science*, 11(July). Article 107. <https://doi.org/10.1186/s13012-016-0464-9>
- McKenna, H., Pajnkihar, M., & Murphy, F. (2014). *Fundamentals of nursing models, Theories and practice* (2nd ed.). New York, NY: John Wiley & Sons.
- McLachlan, J. C. (2010). Integrative medicine and the point of credulity. *BMJ*, 341:c6979. doi:10.1136/bmj.c6979
- McLaughlin, K., Moutray, M., & Moore, C. (2010). Career motivation in nursing students and the perceived influence of significant others. *Journal of Advanced Nursing*, 66(2), 404–412. <https://doi.org/10.1111/j.1365-2648.2009.05147.x>
- McMaster, R. (2008). Beware those offering “gold standards”: Evidence-based medicine and the potential for institutional change in clinical-medical provision. *Journal of Economic Issues*, 42(4), 885–912.
<https://doi.org/10.1080/00213624.2008.11507195>

- Medew, J. (2012, March 14). Alternative medicine crackdown. *Sydney Morning Herald*. Retrieved from <https://www.smh.com.au/politics/federal/alternative-medicine-crackdown-20120313-1uyiw.html>
- Medical Board of Australia. (2016). *Medical specialties and specialty fields*. Retrieved from <http://www.medicalboard.gov.au/Registration/Types/Specialist-Registration/Medical-Specialties-and-Specialty-Fields.aspx>
- Mehta, N. (2011). Mind-body dualism: A critique from a health perspective. *Mens Sana Monographs*, 9(1), 202–209. <https://doi.org/10.4103/0973-1229.77436>
- Melin-Johansson, C., Palmqvist, R., & Rönnerberg, L. (2017). Clinical intuition in the nursing process and decision-making-A mixed-studies review. *Journal of Clinical Nursing*, 26(23–24), 3936–3949. <https://doi.org/10.1111/jocn.13814>
- Melnik, B., & Fineout-Overholt, E. (2011). *Evidence-based practice in nursing & healthcare*. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.
- Mero-Jaffe, I. (2011). “Is that what I said?” Interview transcript approval by participants: An aspect of ethics in qualitative research. *International Journal of Qualitative Methods*, 10(3), 231–247. doi:10.1177/160940691101000304
- Mertig, A. G., & Dunlap, R. E. (2001). Environmentalism, new social movements, and the new class: A cross-national investigation. *Rural Sociology*, 66(1), 113–136. doi:10.1111/j.1549-0831.2001.tb00057.x
- Metcalf, A., Williams, J., McChesney, J., Patten, S. B., & Jetté, N. (2010). Use of complementary and alternative medicine by those with a chronic disease and the general population—Results of a national population based survey. *BMC Complementary and Alternative Medicine*, 10(October 18), Article 58. <https://doi.org/10.1186/1472-6882-10-58>

- Meyer, J. H., & Land, R. (2003). *Threshold concepts and troublesome knowledge: Linkages to ways of thinking and practising within the disciplines*. Economic & Social Research Council. Occasional Report 4. Retrieved from <http://www.etl.tla.ed.ac.uk/publications.html>
- Mezirow, J. (1997). Transformative learning: Theory to practice. *New Directions for Adult and Continuing Education*, 1997(74), 5–12. doi:10.1002/ace.7401
- Mezirow, J. (2011). Transformative learning theory. In J. Mezirow & E. W. Taylor (Eds.), *Transformative Learning in Practice: Insights from Community, Workplace, and Higher Education* (pp. 18–31). Retrieved from <http://ebookcentral.proquest.com/lib/cqu/detail.action?docID=469114>
- Midwives and Mothers Australia. (2019). *Homeopathic labour kit*. Retrieved from <https://midwivesandmothers.com.au/product/homeopathic-labour-kit/>
- Miles, A. (2009). On a medicine of the whole person: Away from scientistic reductionism and towards the embrace of the complex in clinical practice. *Journal of Evaluation in Clinical Practice*, 15(6), 941–949. <https://doi.org/10.1111/j.1365-2753.2009.01354.x>
- Milgrom, L. R. (2008). Homeopathy and the new fundamentalism: A critique of the critics. *The Journal of Alternative and Complementary Medicine*, 14(5), 589–594. <https://doi.org/10.1089/acm.2007.0729>
- Miller, F. G., & Kaptchuk, T. J. (2008). The power of context: Reconceptualizing the placebo effect. *Journal of the Royal Society of Medicine*, 101(5), 222–225. doi:10.1258/jrsm.2008.070466
- Miller, L. R., & Miller, F. G. (2015). Understanding placebo effects: Implications for nursing practice. *Nursing Outlook*, 63(5), 601–606. doi:10.1016/j.outlook.2015.03.002

- Milton, C. L. (2018). Will nursing continue as the most trusted profession? An ethical overview. *Nursing Science Quarterly*, 31(1), 15–16.
doi:10.1177/0894318417741099
- Minkowski, W. L. (1992). Women healers of the middle ages: Selected aspects of their history. *American Journal of Public Health*, 82(2), 288–295.
<https://doi.org/10.2105/ajph.82.2.288>
- Miracle, V. A. (2008). The life and impact of Florence Nightingale. *Dimensions of Critical Care Nursing*, 27(1), 21–23.
<https://doi.org/10.1097/01.DCC.0000304670.76251.2e>
- Misselbrook, D. (2014). W is for wellbeing and the WHO definition of health. *The British Journal of General Practice*, 64(628), 582. doi:10.3399/bjgp14X682381
- Moghaddam, F. M., & Harré, R. (2010). Words, conflicts, and political processes. In F. M. Moghaddam & R. Harré (Eds.), *Words of conflict, words of war: How the language we use in political processes sparks fighting* (pp. 1–28). Santa Barbara, CA: Praeger.
- Mollart, L., Skinner, V., Adams, J., & Foureur, M. (2018). Midwives' personal use of complementary and alternative medicine (CAM) influences their recommendations to women experiencing a post-date pregnancy. *Women and Birth*, 31(1), 44–51. <https://doi.org/10.1016/j.wombi.2017.06.014>
- Montagnier, L., Aïssa, J., Ferris, S., Montagnier, J. L., & Lavallée, C. (2009). Electromagnetic signals are produced by aqueous nanostructures derived from bacterial DNA sequences. *Interdisciplinary Sciences, Computational Life Sciences*, 1(2), 81–90. <https://doi.org/10.1007/s12539-009-0036-7>

- Montagnier, L., Aissa, J., Giudice, E. D., Lavallee, C., Tedeschi, A., & Vitiello, G. (2011). DNA waves and water. *Journal of Physics: Conference Series*, 306(2011), 01200. doi:10.1088/1742-6596/306/1/012007
- Montessori Institute. (2013). *What is Montessori?* Retrieved from <http://www.mwei.edu.au/montessori-teacher-resources/what-is-montessori/>
- Montgomery, H., Grocott, M., & Mythen, M. (2017). Critical care at the end of life: Balancing technology with compassion and agreeing when to stop. *British Journal of Anaesthesia*, 119(Suppl. 1), i85–i89. doi:10.1093/bja/aex324
- Moodie, A. R. (2008). Australia: The healthiest country by 2020. *The Medical Journal of Australia*, 189(10), 588–590. doi:10.5694/j.1326-5377.2008.tb02189.x
- Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, 31(4), 662–673. <https://doi.org/10.1111/scs.12376>
- Morgan, M. S. (2014). Resituating knowledge: Generic strategies and case studies. *Philosophy of Science*, 81(5), 1012–1024. <https://doi.org/10.1086/677888>
- Morrall, P. (2008). ‘Snake oil peddling’: CAM and the occupational status of doctors and nurses. In J. Adams & P. Tovey (Eds.), *Complementary and alternative medicine in nursing and midwifery: Towards a critical science* (pp. 52–70). London: Routledge.
- Morse, J. M., Solberg, S. M., Neander, W. L., Bottorff, J. L., & Johnson, J. L. (1990). Concepts of caring and caring as a concept. *Advances in Nursing Science*, 13(1), 1--14. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/2122796>

- Motlagh, F. G., Karimi, M., & Hasanpour, M. (2012). Iranian nursing students' experiences of nursing. *Iranian Journal of Nursing and Midwifery Research*, 17(2 Suppl. 1), S107--S114. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3696962/>
- Muñoz-Sellés, E., Vallès-Segalés, A., & Goberna-Tricas, J. (2013). Use of alternative and complementary therapies in labor and delivery care: A cross-sectional study of midwives' training in Catalan hospitals accredited as centers for normal birth. *BMC Complementary and Alternative Medicine*, 13(November). Article 318. <https://doi.org/10.1186/1472-6882-13-318>
- Murgic, L., Hébert, P. C., Sovic, S., & Pavlekovic, G. (2015). Paternalism and autonomy: Views of patients and providers in a transitional (post-communist) country. *BMC Medical Ethics*, 16(1), 65. <https://dx.doi.org/10.1186%2Fs12910-015-0059-z>
- Myers Kiser, P. (2015). *The human services internship: Getting the most from your experience*. (4th ed.). Boston, MA: Cengage Learning.
- Narayanasamy, A., & Narayanasamy, M. (2006). Complementary health. Ayurvedic medicine: an introduction for nurses. *British Journal of Nursing*, 15(21), 1185--1190. <https://doi:10.12968/bjon.2006.15.21.22378>
- Natanasabapathy, P., & Maathius-Smith, S. (2018). Philosophy of being and becoming: A transformative learning approach using threshold concepts. *Educational Philosophy and Theory*, 51(4), pp. 369--379. <https://doi.org/10.1080/00131857.2018.1464439>
- National Center for Complementary and Integrative Health. (2013). *Traditional Chinese medicine: In depth*. Retrieved from <https://nccih.nih.gov/health/whatiscam/chinesemed.htm>

- National Center for Complementary and Integrative Health. (2018). *Complementary, alternative, or integrative health: What's in a name?* Retrieved from <https://nccih.nih.gov/health/integrative-health>
- National Center for Homeopathy. (2017). *Materia medica and repertory database*. Retrieved from <https://www.homeopathycenter.org/materia-medica-repertory-database>
- National Center for Interprofessional Practice and Education. (2018). *About IPE*. Retrieved from <https://nexusipe.org/informing/about-ipe>
- National Health and Medical Research Council. (2007a). *Australian code for the responsible conduct of research*. Retrieved from <https://www.nhmrc.gov.au/>
- National Health and Medical Research Council. (2007b). *National statement on ethical conduct in human research (2007)*. Retrieved from <https://www.nhmrc.gov.au/>
- National Health and Medical Research Council. (2010). *Strategic plan 2010–2012*. Retrieved from <https://www.nhmrc.gov.au/about-us/publications/nhmrc-strategic-plan-2010-2012#block-views-block-file-attachments-content-block-1>
- National Health and Medical Research Council. (2015). *NHMRC information paper: Evidence on the effectiveness of homeopathy for treating health conditions*. Retrieved from <https://www.nhmrc.gov.au/about-us/publications/homeopathy>
- National Health Portal of India. (2015). *Principles of prescribing*. Retrieved from https://www.nhp.gov.in/Principles-of-Prescribing_mtl
- National Health Portal of India. (2016a). *Homeopathy*. Retrieved from https://www.nhp.gov.in/homeopathy_mty
- National Health Portal of India. (2016b). *Homeopathy and mental health*. Retrieved from https://www.nhp.gov.in/homeopathy-and-mental-health_mtl

- National Health Portal of India. (2016c). *Second prescription*. Retrieved from https://www.nhp.gov.in/second-prescription_mtl
- National Institute of Complementary Medicine. (n.d.). Public consultation on the complementary and alternative medicine resource for clinicians. Submission to the National Health and Medical Research Council. Retrieved from https://www.westernsydney.edu.au/_data/assets/pdf_file/0003/536421/NICM_Submission_Complementary_and_Alternative_Medicine_Resource_for_Clinicians.pdf
- National Library of Australia. (n.d.). Catalogue. *The Australian Journal of Holistic Nursing*. Retrieved from <https://catalogue.nla.gov.au/Record/2679851>
- Naturopaths and Herbalists Association of Australia. (2014). *Independent review of the national registration and accreditation scheme for health professions. NHAA response*. Retrieved from https://www.nhaa.org.au/docs/Submissions/NHAA_Submission_NRAS.pdf
- Naturopaths and Herbalists Association of Australia. (n.d.). Regulation of herbalists and naturopaths in Australia. Retrieved from <https://www.nhaa.org.au/mediareleases/be-informed/regulation-of-practitioners>
- Nelson, J., Gallery, G., & Percy, M. (2010). Role of corporate governance in mitigating the selective disclosure of executive stock option information. *Accounting & Finance*, 50(3), 685–717. <https://doi.org/10.1111/j.1467-629X.2009.00339.x>
- Netherwood, M., & Derham, R. (2014). Interprofessional education: Merging nursing, midwifery and CAM. *British Journal of Nursing*, 23(13), 740–743. <https://doi.org/10.12968/bjon.2014.23.13.740>

- Neuhauser, D. (2003). Florence Nightingale gets no respect: As a statistician that is. *Quality & Safety in Health Care*, 12(4), 317–317.
<http://dx.doi.org/10.1136/qhc.12.4.317>
- Neuman, B. M., & Fawcett, J. (2011). *The Neuman systems model*. Boston: Pearson.
- New South Wales Nurses and Midwives' Association. (2018). NSWNMA policy on complementary and alternative therapies in nursing and midwifery practice.
Retrieved from <https://www.nswnma.asn.au/publications/policies-and-procedures/>
- NHS England. (2017). *Items which should not be routinely prescribed in primary care: Guidance for CCGs* [07448]. Retrieved from
<https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-guidance-for-ccgs/>
- Nicholls, P. (2005). Homoeopathy, hospitals and high society. In T. Heller, G. Lee-Treweek, J. Katz, J. Stone, & S. Spurr (Eds.), *Perspectives on complementary and alternative medicine: A reader* (pp. 201–209). Abingdon: Routledge.
- Nightingale, F. (1860). *Notes on nursing: What it is, and what it is not*. New York: D. Appleton and Company.
- Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence Based Nursing*, 18(2), 34–35. doi:10.1136/eb-2015-102054
- Nolan, J., & Nail, P. (2014). Further evidence that individuals with a high preference for consistency are more susceptible to cognitive dissonance. *Psi Chi Journal of Psychological Research*, 19(4), 214–219. <https://doi.org/10.24839/2164-8204.JN19.4.214>

- Nursing and Midwifery Board of Australia. (2010). *Retired version: Continuing professional development registration standard*. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Registration-Standards/Continuing-professional-development.aspx>
- Nursing and Midwifery Board of Australia. (2013). *Nursing practice decision flowchart*. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx>
- Nursing and Midwifery Board of Australia. (2016a). *Registration standard: Continuing professional development*. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Registration-Standards/Continuing-professional-development.aspx>
- Nursing and Midwifery Board of Australia. (2016b). *Registered nurse standards for practice*. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>
- Nursing and Midwifery Board of Australia. (2017a). *Nurse practitioner standards for practice*. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/nurse-practitioner-standards-of-practice.aspx>
- Nursing and Midwifery Board of Australia. (2017b). *Registered nurse standards*. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx>
- Nursing and Midwifery Board of Australia. (2018a). *Code of conduct for nurses*. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>

- Nursing and Midwifery Board of Australia. (2018b). *Midwife standards for practice*. Retrieved from <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/Midwife-standards-for-practice.aspx>
- Nursing and Midwifery Board of Australia. (2019). *Registration and endorsement*. Retrieved from <https://www.nursingmidwiferyboard.gov.au/registration-and-endorsement.aspx>
- Nursing and Midwifery Council of New South Wales. (2017). *Managing professional boundaries: Professional vs personal relationships*. Retrieved from <https://www.nursingandmidwiferycouncil.nsw.gov.au/managing-professional-boundaries-professional-vs-personal-relationships>
- O'Callaghan, F. V., & Jordan, N. (2003). Postmodern values, attitudes and the use of complementary medicine. *Complementary Therapies in Medicine*, 11(1), 28–32. Retrieved from <https://www.sciencedirect.com/journal/complementary-therapies-in-medicine>
- O'Keefe, M., & Coat, S. (2010). Increasing health-care options: The perspectives of parents who use complementary and alternative medicines. *Journal of Paediatrics & Child Health*, 46(6), 296–300. doi:10.1111/j.1440-1754.2010.01711.x
- Oh, Y., & Gastmans, C. (2013). Moral distress experienced by nurses: A quantitative literature review. *Nursing Ethics*, 22(1), 15–31. <https://doi.org/10.1177/0969733013502803>
- Oliver, R. L. (2010). *Satisfaction: A behavioral perspective on the consumer* (2nd ed.). London: Routledge.
- Oliver, S. J. (2013). The role of traditional medicine practice in primary health care within Aboriginal Australia: A review of the literature. *Journal of Ethnobiology and Ethnomedicine*, 9(July). Article 46. <https://doi.org/10.1186/1746-4269-9-46>

- Olshansky, E. (2011). Nursing as the most trusted profession: Why this is important. *Journal of Professional Nursing*, 27(4), 193–194.
<https://doi.org/10.1016/j.profnurs.2011.06.007>
- Olubiyi, O., Smiley, G., Luckel, H., & Melaragno, R. (2019). A qualitative case study of employee turnover in retail business. *Heliyon*, 5(6), e01796.
doi:10.1016/j.heliyon.2019.e01796
- OpenLearn. (2018). *Geometry: 2.9 similar and congruent shapes*. Retrieved from
https://www.open.edu/openlearn/search-results?as_q=Geometry
- Orfanos, C. E. (2007). From Hippocrates to modern medicine. *Journal of the European Academy of Dermatology and Venereology*, 21(6), 852–858.
<https://doi.org/10.1111/j.1468-3083.2007.02273.x>
- Ovid Technologies. (2019). *Journals –holistic nursing practice*. Retrieved from
<https://www.ovid.com/site/catalog/journals/386.jsp#horizontalTab1>
- Oxtoby, K. (2012). Blurring the roles: Where do you draw the line? *BMJ*, 344:e3105.
doi:10.1136/bmj.e3105
- Oxtoby, K. (2016). Nurse prescribing: 10 years on. *Nurse Prescribing*, 14(9), 448–449.
<https://doi.org/10.12968/npre.2016.14.9.448>
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, 42(5), 533–544. doi:10.1007/s10488-013-0528-y
- Papathanasiou, I., Sklavou, M., & Kourkouta, L. (2013). Holistic nursing care: Theories and perspectives. *American Journal of Nursing Science*, 2(1), 1–5.
<https://doi.org/10.11648/j.ajns.20130201.11>

- Paré, G., & Kitsiou, S. (2017). Chapter 9. Methods for literature reviews. In F. Lau & C. Kuziemsky (Eds.), *Handbook of eHealth Evaluation: An Evidence-based Approach [Internet]*. Victoria (BC): University of Victoria; 2017. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK481583/>
- Parry, D. C. (2008). “We wanted a birth experience, not a medical experience”: Exploring Canadian women’s use of midwifery. *Health Care for Women International*, 29(8–9), 784–806. doi:10.1080/07399330802269451
- Patashnik, E., Gerber, A., & Dowling, C. (2017). *Unhealthy politics: The battle over evidence-based medicine*. Princeton; Oxford: Princeton University Press.
- Patwardhan, B., Warude, D., Pushpangadan, P., & Bhatt, N. (2005). Ayurveda and traditional Chinese medicine: A comparative overview. *Evidence-based complementary and alternative medicine*, 2(4), 465–473. doi:10.1093/ecam/neh140
- Pearson, A. (2010). Evidence-based healthcare and qualitative research. *Journal of Research in Nursing*, 15(6), 489–493. doi:10.1177/1744987110380580
- Pearson, A., Vaughan, B., & FitzGerald, M. (2005). *Nursing Models for Practice* (3rd ed.). Edinburgh: Elsevier.
- Pelzang, R. (2010). Time to learn: Understanding patient-centred care. *British Journal of Nursing*, 19(14), 912–917. <https://doi.org/10.12968/bjon.2010.19.14.49050>
- Peplau, H. E. (1992). Interpersonal relations: A theoretical framework for application in nursing practice. *Nursing Science Quarterly*, 5(1), 13–18. doi:10.1177/089431849200500106
- Pérez-Fuillerat, N., Solano-Ruiz, M. C., & Amezcua, M. (2019). Tacit knowledge: Characteristics in nursing practice. *Gaceta Sanitaria*, 33(2), 191–196. <https://doi.org/10.1016/j.gaceta.2017.11.002>

- Permut, S. R. (2016). *AMA statement on VA proposed rule on advanced practice nurses*. Retrieved from <https://www.ama-assn.org/press-center/ama-statements/ama-statement-va-proposed-rule-advanced-practice-nurses>
- Pesce, A. (2010, September 5). *Engagement and influence*. Retrieved from <https://ama.com.au/ausmed/engagement-and-influence>
- Peters, K., McInnes, S., & Halcomb, E. (2015). Nursing students' experiences of clinical placement in community settings: A qualitative study. *Collegian*, 22(2), 175–181. <https://doi.org/10.1016/j.colegn.2015.03.001>
- Petr, C. G., & Walter, U. M. (2009). Evidence-based practice: A critical reflection. *European Journal of Social Work*, 12(2), 221–232. doi:10.1080/13691450802567523
- Pharmaceutical Society of Australia. (2018). *New medicines advice: Prescribing cascades, polypharmacy, homeopathy*. Retrieved from <https://www.psa.org.au/new-medicines-advice-prescribing-cascades-polypharmacy-homeopathy/>
- Pharmacy Board of Australia. (2014). *Code of conduct*. Retrieved from <https://www.pharmacyboard.gov.au/Codes-Guidelines/Code-of-conduct.aspx>
- Phillips, D. J., & Hayes, B. (2006). Moving towards a model of professional identity formation in midwifery through conversations and positioning theory. *Australian Journal of Adult Learning*, 46(2), 224–242. Retrieved from <https://www.ajal.net.au/>
- Pizzorno, M. C., Benozzo, A., & Carey, N. (2015). Narrating career, positioning identity and constructing gender in an Italian adolescent's personal narratives. *Journal of Vocational Behavior*, 88(June), 195–204. <https://doi.org/10.1016/j.jvb.2015.03.002>

- Pledger, M. J., Cumming, J., & Burnette, M. (2010). Health service use amongst users of complementary and alternative medicine. *The New Zealand Medical Journal*, 123(1312), 26–35. Retrieved from <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2010/vol-123-no-1312/article-pledger>
- Polanyi, M. (1966). *The tacit dimension*. Garden City, N.Y: Doubleday.
- Polit, D., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, 47(11), 1451-1458. <https://doi-org.ezproxy.cqu.edu.au/10.1016/j.ijnurstu.2010.06.004>
- Polit, D., & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice* (5th ed.). Wolters Kluwer, Philadelphia.
- Poore, J. A., Cullen, D. L., & Schaar, G. L. (2010). Simulation-based interprofessional education guided by Kolb’s experiential learning theory. *Clinical Simulation in Nursing*, 10(5), e241–e247. doi:10.1016/j.ecns.2014.01.004
- Porter, J., Morphet, J., Missen, K., & Raymond, A. (2013). Preparation for high-acuity clinical placement: Confidence levels of final-year nursing students. *Advances in Medical Education and Practice*, 4(April), 83–89. <https://doi.org/10.2147/AMEP.S42157>
- Porter, S., & O’Halloran, P. (2012). The use and limitation of realistic evaluation as a tool for evidence-based practice: A critical realist perspective. *Nursing Inquiry*, 19(1), 18–28. <https://doi.org/10.1111/j.1440-1800.2011.00551.x>
- Porzsolt, F., Rocha, N. G., Toledo-Arruda, A. C., Thomaz, T. G., Moraes, C., Bessa-Guerra, T. R., ... Weiss, C. (2015). Efficacy and effectiveness trials have different goals, use different tools, and generate different messages. *Pragmatic and Observational Research*, 6(November), 47–54. <https://dx.doi.org/10.2147%2FPOR.S89946>

- Possamai-Inesedy, A., & Cochrane, S. (2013). The consequences of integrating complementary and alternative medicine: An analysis of impacts on practice: *Health Sociology Review*, 22(1), 65–74. <https://doi.org/10.5172/hesr.2013.22.1.65>
- Power, J. J. (2017). Reductionism and nursing clinical reality. *Biomedical Journal of Scientific & Technical Research*, 1(3), 720–721. <http://dx.doi.org/10.26717/BJSTR.2017.01.000285>
- Prasad, R. (2007). Homoeopathy booming in India. *The Lancet*, 370(9600), 1679–1680. [https://doi.org/10.1016/s0140-6736\(07\)61709-7](https://doi.org/10.1016/s0140-6736(07)61709-7)
- Pratt, M. G., Rockmann, K. W., & Kaufmann, J. B. (2006). Constructing professional identity: The role of work and identity learning cycles in the customization of identity among medical residents. *The Academy of Management Journal*, 49(2), 235–262. <https://doi.org/10.2307/20159762>
- Pray, W. S. (2010). Why pharmacists should not sell homeopathic products. *Focus on Alternative and Complementary Therapies*, 15(4), 280–283. <https://doi.org/10.1111/j.2042-7166.2010.01052.x>
- Price, S. L., & McGillis Hall, L. (2014). The history of nurse imagery and the implications for recruitment: A discussion paper. *Journal of Advanced Nursing*, 70(7), 1502–1509. <https://doi.org/10.1111/jan.12289>
- Price, S. L., McGillis Hall, L. M., Angus, J. E., & Peter, E. (2013). Choosing nursing as a career: a narrative analysis of millennial nurses' career choice of virtue. *Nursing Inquiry*, 20(4), 305–316. <https://doi.org/10.1111/nin.12027>
- Prousky, J. E. (2018). Repositioning individualized homeopathy as a psychotherapeutic technique with resolvable ethical dilemmas. *Journal of Evidence-Based Integrative Medicine*, 23(January–December). <https://doi.org/10.1177/2515690X18794379>

- Pullen, R. L. J., & Mathias, T. (2010). Fostering therapeutic nurse-patient relationships. *Nursing Made Incredibly Easy*, 8(3), 4–4.
doi:10.1097/01.NME.0000371036.87494.11
- Qu, S., & Dumay, J. (2011). The qualitative research interview. *Qualitative Research in Accounting & Management*, 8(3), 238–264.
<https://doi.org/10.1108/11766091111162070>
- Queensland Health. (2017). *Ascites*. Retrieved from
<http://conditions.health.qld.gov.au/HealthCondition/condition/9/189/180/ascites>
- Queensland Health. (2018a). *Nurse Practitioners*. Retrieved from
<https://www.health.qld.gov.au/ocnmo/nursing/nurse-practitioners>
- Queensland Health. (2018b). *Nursing and midwifery: Career structure*. Retrieved from
<https://www.health.qld.gov.au/employment/work-for-us/clinical/nursing-midwifery/career-structure>
- Quinn, D. M., & Earnshaw, V. A. (2013). Concealable stigmatized identities and psychological well-being. *Social and Personality Psychology Compass*, 7(1), 40–51. <https://doi.org/10.1111/spc3.12005>
- Råheim, M., Magnussen, L. H., Sekse, R. J. T., Lunde, Å., Jacobsen, T., & Blystad, A. (2016). Researcher–researched relationship in qualitative research: Shifts in positions and researcher vulnerability. *International Journal of Qualitative Studies on Health and Well-Being*, 11(1). Article 30996.
<https://doi.org/10.3402/qhw.v11.30996>
- Ram, R. A. & Kumar, A. (2019). Biodynamic agriculture: An advance stage of organic farming. *Journal of Eco-friendly Agriculture*, 14(1), 34–37. Retrieved from
<http://www.ecoagrijournal.com/>

- Ramalho, R., Adams, P., Huggard, P., & Hoare, K. (2015). Literature review and constructivist grounded theory methodology. *Forum: Qualitative Social Research*, 16(3). <http://dx.doi.org/10.17169/fqs-16.3.2313>
- Ramos, F., Barth, P., Schneider, A., Cabral, A., & da Silva Reinaldo, J. (2016). Effects of moral distress on nurses: Integrative literature review. *Cogitare Enferm*, 21(2), 01-13. doi:[10.5380/ce.v21i2.45247](https://doi.org/10.5380/ce.v21i2.45247)
- Rao, M. L., Roy, R., Bell, I. R., & Hoover, R. (2007). The defining role of structure (including epitaxy) in the plausibility of homeopathy. *Homeopathy*, 96(3), 175--182. <https://doi.org/10.1016/j.homp.2007.03.009>
- Raza, M., Dharamshi, H. A., Ahsan, S. Z., Naqvi, Z., Naqvi, T., Mohsin Ali, A. A., & Malik Abbas, J. (2016). The future of ethics in medicine. *Iranian Red Crescent Medical Journal*, 18(6), e26900–e26900. doi:[10.5812/ircmj.26900](https://doi.org/10.5812/ircmj.26900)
- Redmond, C. (2000). The holistic nurses association of New South Wales: Our history, our present and our future. *Complementary Therapies in Nursing and Midwifery*, 6(2), 95–97. <https://doi.org/10.1054/ctnm.2000.0465>
- Reed, K. L. (2018). Creating occupational therapy: The challenges to defining a profession. *Occupational Therapy in Health Care*, 32(2), 172–193. <https://doi.org/10.1080/07380577.2018.1464238>
- Reichenberg-Ullman, J., & Ullman, R. (2010). *Healing with homeopathy: Homeopathic potency selection simplified*. Retrieved from <http://www.townsendletter.com/FebMarch2010/healhomeo0210.html>

- Reid, R., Steel, A., Wardle, J., Trubody, A., & Adams, J. (2016). Complementary medicine use by the Australian population: A critical mixed studies systematic review of utilisation, perceptions and factors associated with use. *BMC Complementary and Alternative medicine*, 16(June). Article 176.
<https://doi.org/10.1186/s12906-016-1143-8>
- Relton, C., Cooper, K., Viksveen, P., Fibert, P., & Thomas, K. (2017). Prevalence of homeopathy use by the general population worldwide: A systematic review. *Homeopathy*, 106(2), 69–78. <https://doi.org/10.1016/j.homp.2017.03.002>
- Relton, C., O’Cathain, A., & Thomas, K. J. (2008). “Homeopathy”: Untangling the debate. *Homeopathy*, 97(3), 152–155. <https://doi.org/10.1016/j.homp.2008.04.003>
- Renzaho, A., Polonsky, M., McQuilten, Z., & Waters, N. (2013). Demographic and socio-cultural correlates of medical mistrust in two Australian States: Victoria and South Australia. *Health & Place*, 24(November), 216–224.
<https://doi.org/10.1016/j.healthplace.2013.09.010>
- Revicki, D. A., & Frank, L. (1999). Pharmacoeconomic evaluation in the real world. Effectiveness versus efficacy studies. *PharmacoEconomics*, 15(5), 423–434.
<https://doi.org/10.2165/00019053-199915050-00001>
- Risman, K. L., Erickson, R. J., & Diefendorff, J. M. (2016). The impact of person-organization fit on nurse job satisfaction and patient care quality. *Applied Nursing Research*, 31, 121–125. <https://doi.org/10.1016/j.apnr.2016.01.007>
- Rivard, A. M., & Brown, C. A. (2019). Moral distress and resilience in the occupational therapy workplace. *Safety*, 5(1), 10. <https://doi.org/10.3390/safety5010010>
- Roach, Sr. M. S., & Maykut, C. (2010). Comportment: A caring attribute in the formation of an intentional practice. *International Journal for Human Caring*, 14(4), 22–26.
<https://doi.org/doi: 10.20467/1091-5710.14.4.22>

- Robert, R. R., Tilley, D. S., & Petersen, S. (2014). A power in clinical nursing practice: Concept analysis on nursing intuition. *Medsurg Nursing*, 23(5), 343–349.
Retrieved from <https://www.amsn.org/professional-development/periodicals/medsurg-nursing-journal>
- Roberts, M. J. D. (2009). The politics of professionalization: MPs, medical men, and the 1858 Medical Act. *Medical History*, 53(1), 3–56.
<https://doi.org/10.1017/S0025727300003306>
- Roberts, S. J. (1996). Breaking the cycle of oppression: Lessons for nurse practitioners? *Journal of the American Academy of Nurse Practitioners*, 8(5), 209–214.
doi:10.1111/j.1745-7599.1996.tb00648.x
- Robles, B., Upchurch, D. M., & Kuo, T. (2017). Comparing complementary and alternative medicine use with or without including prayer as a modality in a local and diverse United States jurisdiction. *Frontiers in Public Health*, 5(12). Article 56. <https://doi.org/10.3389/fpubh.2017.00056>
- Rodts, M. F. (2011). Technology changes healthcare. *Orthopaedic Nursing*, 30(5), 292--292. doi:10.1097/NOR.0b013e3182352a14
- Rogers, C. R. (1951). Client-centered therapy: Its current practice, implications and theory. Oxford: Houghton Mifflin.
- Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships: As developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A Study of a Science. Formulations of the Person and the Social Context* (Vol. 3, pp. 184–256). New York, NY: McGraw Hill.
- Rojas-Cooley, M. T., & Grant, M. (2009). Complementary and alternative medicine: Oncology nurses' knowledge and attitudes. *Oncology Nursing Forum*, 36(2), 217--224. <https://doi.org/10.1188/09.ONF.217-224>

- Rome, A. (2003). "Give Earth a chance": The environmental movement and the sixties. *Journal of American History*, 90(2), 525–554. doi:10.2307/3659443
- Rosa, W. (2017). Exploring the global applicability of holistic nursing. *Journal of Holistic Nursing*, 35(1), 7–9. <https://doi.org/10.1177/0898010117692672>
- Rosenthal, M. (2016). Qualitative research methods: Why, when, and how to conduct interviews and focus groups in pharmacy research. *Currents in Pharmacy Teaching and Learning*, 8(4), 509–516. <https://doi.org/10.1016/j.cptl.2016.03.021>
- Ross, C. L. (2009). Integral healthcare: The benefits and challenges of integrating complementary and alternative medicine with a conventional healthcare practice. *Integrative Medicine Insights*, 4(January–December), 13–20. Retrieved from <https://journals.sagepub.com/toc/imia/4>
- Ross, C., Rogers, C., & King, C. (2019). Safety culture and an invisible nursing workload. *Collegian*, 26(1), 1–7. <https://doi.org/10.1016/j.colegn.2018.02.002>
- Ross, S., Simpson, C. R., & McLay, J. S. (2006). Homoeopathic and herbal prescribing in general practice in Scotland. *British Journal of Clinical Pharmacology*, 62(6), 647–652. <https://doi.org/10.1111/j.1365-2125.2006.02702.x>
- Royal Australian College of General Practitioners. (2015). *Position statement: Homeopathy*. Retrieved from <https://www.racgp.org.au/search?q=racgp%20homeopathy>
- Royal Australian College of General Practitioners. (2016). *Nurse Practitioners in Primary Care. Position Statement –August 2016*. Retrieved from <https://www.racgp.org.au>
- Royal Australian College of General Practitioners. (2018). *General practice. Health of the nation 2018*. Retrieved from <https://www.racgp.org.au>

- Royal Australian College of General Practitioners. (2019a). *Responding to patient requests for tests not considered clinically appropriate*. Retrieved from <https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/responding-to-patient-requests-for-tests#ref-num-1>
- Royal Australian College of General Practitioners. *Letter to CAM practitioners regarding appropriate diagnostic testing*. Retrieved from <https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/responding-to-patient-requests-for-tests#ref-num-1>
- Royal Children's Hospital Melbourne. (2018). *Peripheral intravenous (IV) device management*. Retrieved from https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/peripheral_intravenous_iv_device_management/
- Rush, K. L., Kee, C. C., & Rice, M. (2005). Nurses as imperfect role models for health promotion. *Western Journal of Nursing Research*, 27(2), 166–183.
doi:10.1177/0193945904270082
- Rushton, L. (2014). What are the barriers to spiritual care in a hospital setting? *British Journal of Nursing*, 23(7), 370–374. <https://doi.org/10.12968/bjon.2014.23.7.370>
- Russell, L. M., Rubin, G. L., & Leeder, S. R. (2008). Preventive health reform: What does it mean for public health? *The Medical Journal of Australia*, 188(12), 715--719. doi:10.5694/j.1326-5377.2008.tb01853.x
- Rutten, L., Mathie, R. T., Fisher, P., Goossens, M., & van Wassenhoven, M. (2013). Plausibility and evidence: The case of homeopathy. *Medicine, Health Care, and Philosophy*, 16(3), 525–532. <https://doi.org/10.1007/s11019-012-9413-9>

- Ryan, R. M., & Deci, E. L. (2012). Multiple identities within a single self: A self-determination theory perspective on internalization within contexts and cultures. In M. R. Leary & J. P. Tangney (Eds.), *Handbook of self and identity*. (pp. 225–246). New York, NY: The Guilford Press.
- Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *BMJ*, *312*:71. <https://doi.org/10.1136/bmj.312.7023.71>
- Sage Journals. (2019). *Journal of Holistic Nursing*. Retrieved from <https://journals.sagepub.com/>
- Sakellariou, D., & Rotarou, E. S. (2017). The effects of neoliberal policies on access to healthcare for people with disabilities. *International Journal for Equity in Health*, *16*(1), 199. doi:10.1186/s12939-017-0699-3
- Saks, M. (2012). Defining a profession: The role of knowledge and expertise. *Professions and Professionalism*, *2*(1), 1–10. <https://doi.org/10.7577/pp.v2i1.151>
- Sakula, A. (1984). In search of Hippocrates: A visit to Kos. *Journal of the Royal Society of Medicine*, *77*(8), 682–688. <https://doi.org/10.1177/014107688407700814>
- Salamonsen, A., & Ahlén, R. (2018). Epistemological challenges in contemporary western healthcare systems exemplified by people's widespread use of complementary and alternative medicine. *Health*, *22*(4), 356–371. doi:10.1177/1363459317693408
- Samal, J. (2014). Indian public health standards for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy facilities: An assessment. *International Journal of Medicine and Public Health*, *4*(4), 331–335. <https://doi.org/10.4103/2230-8598.144058>

- Sampson, W. (1995). Antiscience trends in the rise of the “alternative medicine” movement. *The Annals of the New York Academy of Sciences*, 775(1), 188–197.
doi:10.1111/j.1749-6632.1996.tb23138.x
- Sampson, W., & Atwood IV., K. (2005). Propagation of the absurd: Demarcation of the absurd revisited. *Medical Journal of Australia*, 183(11), 580–581.
doi:10.5694/j.1326-5377.2005.tb00040.x
- Sargent, A. (2012). Reframing caring as discursive practice: A critical review of conceptual analyses of caring in nursing. *Nursing Inquiry*, 19(2), 134–143.
<https://doi.org/10.1111/j.1440-1800.2011.00559.x>
- Satti, J. (2005). Homeopathic drug standardization. *Seminars in Integrative Medicine*, 3(4), 113–122. <https://doi:10.1016/j.sigm.2006.04.001>
- Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., . . . Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, 52(4), 1893–1907.
<https://doi.org/10.1007/s11135-017-0574-8>
- Schlitz, M., Vieten, C., & Miller, E. (2010). Worldview transformation and the development of social consciousness. *Journal of Consciousness Studies*, 17(7-8), 18–36. Retrieved from <https://www.ingentaconnect.com/content/imp/jcs;jsessionid=ac27dis30jbca.x-ic-live-03>
- School of Homeopathy. (2017). *Minimum and single dose*. Retrieved from <https://www.homeopathyschool.com/why-study-with-us/what-is-homeopathy/minimum-single-dose/>

- Scott, A., & Schurer, S. J. (2008.). *Financial incentives, personal responsibility and prevention*. Discussion paper commissioned by the National Health and Hospitals Reform Commission. Melbourne Institute of Applied Economic and Social Research. Retrieved from <https://www.researchgate.net/publication/228798450>
- Scrimin, S., Haynes, M., Altoè, G., Bornstein, M. H., & Axia, G. (2009). Anxiety and stress in mothers and fathers in the 24h after their child's surgery. *Child Care, Health and Development*, 35(2), 227–233. doi:10.1111/j.1365-2214.2008.00920.x
- Sekonyela, T. V. (2016). Scientific basis of homeopathic medicine: A hypothesis to establish the scientific basis of homeopathy. *Journal of Traditional Medicine & Clinical Naturopathy*, 5(December). Article 185. <https://doi.org/10.4172/2573-4555.1000185>
- Selanders, L. C. (2010). Florence Nightingale. The evolution and social impact of feminist values in nursing. *Journal of Holistic Nursing*, 28(1), 227–243. <https://doi:10.1177/0898010109360256>
- Sen, S., & Chakraborty, R. (2016). Revival, modernization and integration of Indian traditional herbal medicine in clinical practice: Importance, challenges and future. *Journal of Traditional and Complementary Medicine*, 7(2), 234–244. <https://doi.org/10.1016/j.jtcme.2016.05.006>
- Sena, B. (2017). Professionalization without autonomy: The Italian case of building the nursing profession. *Professions and Professionalism*, 7(3), e1900. doi:10.7577/pp.1900
- Şenel, E. (2019). Evolution of homeopathy: A scientometric analysis of global homeopathy literature between 1975 and 2017. *Complementary Therapies in Clinical Practice*, 34(February), 165–173. <https://doi.org/10.1016/j.ctcp.2018.11.018>

- Şeşen, E. (2015). Role theory and its usefulness in public relations. *European Journal of Business and Social Sciences*, 4(1), 136–143. Retrieved from <http://www.ejbss.com/Data/Sites/1/vol4no01april2015/ejbss-1548-15-roletheoryanditsusefulnessinpublicrelations.pdf>
- Shah, H. M., & Chung, K. C. (2009). Archie Cochrane and his vision for evidence-based medicine. *Plastic and Reconstructive Surgery*, 124(3), 982–988.
doi:10.1097/PRS.0b013e3181b03928
- Shah, R. (2016). Standardization of the potentizing machine and quantification of impact of potentization. *Indian Journal of Research in Homoeopathy*, 10(2), 126–132.
doi:10.4103/0974-7168.183879
- Shang, A., Huwiler-Müntener, K., Nartey, L., Jüni, P., Dörig, S., Sterne, J. A. C., . . . Egger, M. (2005). Are the clinical effects of homoeopathy placebo effects? Comparative study of placebo-controlled trials of homoeopathy and allopathy. *The Lancet*, 366(9487), 726–732. doi:10.1016/S0140-6736(05)67177-2
- Sharma, M., & Majumdar, P. K. (2009). Occupational lifestyle diseases: An emerging issue. *Indian Journal of Occupational and Environmental Medicine*, 13(3), 109–112. doi:10.4103/0019-5278.58912
- Sharp, S., Mcallister, M., & Broadbent, M. (2018). The tension between person centred and task focused care in an acute surgical setting: A critical ethnography. *Collegian*, 25(1), 11–17. <https://doi.org/10.1016/j.colegn.2017.02.002>
- Shaw, D. M. (2010). Homeopathy is where the harm is: Five unethical effects of funding unscientific ‘remedies’. *Journal of Medical Ethics*, 36(3), 130–131.
<https://doi.org/10.1136/jme.2009.034959>

- Sheridan, D. J., & Julian, D. G. (2016). Achievements and limitations of evidence-based medicine. *Journal of the American College of Cardiology*, 68(2), 204-213.
<https://doi:10.1016/j.jacc.2016.03.600>
- Shi, J., Visschers, V. H. M., & Siegrist, M. (2015). Public perception of climate change: The importance of knowledge and cultural worldviews. *Risk Analysis*, 35(12), 2183–2201. <https://doi.org/10.1111/risa.12406>
- Shields, L. (2014). The core business of caring: A nursing oxymoron? *Collegian*, 21(3), 193--199. <https://doi.org/10.1016/j.colegn.2013.03.001>
- Shinto, L., Calabrese, C., Morris, C., Yadav, V., Griffith, D., Frank, R., . . . Bourdette, D. (2008). A randomized pilot study of naturopathic medicine in multiple sclerosis. *Journal of Alternative and Complementary Medicine*, 14(5), 489–496.
<https://doi.org/10.1089/acm.2007.0757>
- Shorofi, S. A., & Arbon, P. (2010). Nurses' knowledge, attitudes, and professional use of complementary and alternative medicine (CAM): A survey at five metropolitan hospitals in Adelaide. *Complementary Therapies in Clinical Practice*, 16(4), 229--234. <https://doi.org/10.1016/j.ctcp.2010.05.008>
- Shorofi, S. A., & Arbon, P. (2017). Complementary and alternative medicine (CAM) among Australian hospital-based nurses: Knowledge, attitude, personal and professional use, reasons for use, CAM referrals, and socio-demographic predictors of CAM users. *Complementary Therapies in Clinical Practice*, 27(May), 37–45. <https://doi.org/10.1016/j.ctcp.2017.03.001>
- Shoulders, C. W., & Myers, B. E. (2013). Teachers' use of experiential learning stages in agricultural laboratories. *Journal of Agricultural Education*, 54(3), 100–115.
doi:10.5032/jae.2013.03100

- Shuval, J. T. (2006). Nurses in alternative health care: Integrating medical paradigms. *Social Science & Medicine*, 63(7), 1784–1795.
doi:10.1016/j.socscimed.2006.05.009
- Shuval, J. T., & Gross, S. E. (2008). Midwives practice CAM: Feminism in the delivery room. *Complementary Health Practice Review*, 13(1), 46–62.
<https://doi.org/10.1177%2F1533210107311471>
- Shuval, J. T., & Mizrachi, N. (2004). Changing boundaries: Modes of coexistence of alternative and biomedicine. *Qualitative Health Research*, 14(5), 675–690.
doi:10.1177/1049732304263726
- Shuval, J. T., Mizrachi, N., & Smetannikov, E. (2004). Entering the well-guarded fortress: Alternative practitioners in hospital settings. *Social Science & Medicine*, 55(10), 1745–1755. [https://doi.org/10.1016/s0277-9536\(01\)00305-7](https://doi.org/10.1016/s0277-9536(01)00305-7)
- Siahpush, M. (1999). Postmodern attitudes about health: A population-based exploratory study. *Complementary Therapies in Medicine*, 7(3), 164–169.
[https://doi:10.1016/S0965-2299\(99\)80124-1](https://doi:10.1016/S0965-2299(99)80124-1)
- Sibbritt, D., Adams, J., Easthope, G., & Young, A. (2003). Complementary and alternative medicine (CAM) use among elderly Australian women who have cancer. *Supportive Care in Cancer*, 11(8), 548–550. <https://doi:10.1007/s00520-003-0490-4>
- Sibiya, M. N., Maharaj, L., & Bhagwan, R. (2017). Perceptions of professional nurses towards complementary and alternative modalities (CAM) in the uMgungundlovu District, KwaZulu-Natal. *International Journal of Africa Nursing Sciences*, 7(2017), 18–23. doi:10.1016/j.ijans.2017.06.001

- Singal, A. G., Higgins, P. D. R., & Waljee, A. K. (2014). A primer on effectiveness and efficacy trials. *Clinical and Translational Gastroenterology*, 5(1), e45.
<https://doi.org/10.1038/ctg.2013.13>
- Singer, J., & Adams, J. (2014). Integrating complementary and alternative medicine into mainstream healthcare services: The perspectives of health service managers. *BMC Complementary and Alternative Medicine*, 14(May). Article 167.
<https://doi.org/10.1186/1472-6882-14-167>
- Singh, S., & Estefan, A. (2018). Selecting a grounded theory approach for nursing research. *Global Qualitative Nursing Research*, 5(October). 1–9.
<https://doi.org/10.1177/2333393618799571>
- Skår, R. (2010). The meaning of autonomy in nursing practice. *Journal of Clinical Nursing*, 19(15–16), 2226–2234. doi:10.1111/j.1365-2702.2009.02804.x
- Skorikov, V. B., & Vondracek, F. W. (2011). Occupational identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity theory and research*. (pp. 693–714). New York: Springer Science + Business Media.
http://dx.doi.org/10.1007/978-1-4419-7988-9_29
- Slay, H. S., & Smith, D. A. (2011). Professional identity construction: Using narrative to understand the negotiation of professional and stigmatized cultural identities. *Human Relations*, 64(1), 85–107. <https://doi.org/10.1177/0018726710384290>
- Sleutel, M. R. (2000). Climate, culture, context, or work environment? Organizational factors that influence nursing practice. *The Journal of Nursing Administration*, 30(2), 53–58. Retrieved from <https://journals.lww.com/jonajournal/toc/2000/02000>

- Slocum-Bradley, N. (2010). The positioning diamond: A trans-disciplinary framework for discourse analysis. *Journal for the Theory of Social Behaviour*, 40(1), 79–107.
<https://doi.org/10.1111/j.1468-5914.2009.00418.x>
- Smith, K. (2012a). Homeopathy is unscientific and unethical. *Bioethics*, 26(9), 508–512.
<https://doi.org/10.1111/j.1467-8519.2011.01956.x>
- Smith, K. (2012b). Against homeopathy. A utilitarian perspective. *Bioethics*, 26(8), 398–409. <https://doi.org/10.1111/j.1467-8519.2010.01876.x>
- Sointu, E. (2006). The search for wellbeing in alternative and complementary health practices. *Sociology of Health & Illness*, 28(3), 330–349.
<https://doi.org/10.1111/j.1467-9566.2006.00495.x>
- Somani, S., Ali, F., Saeed Ali, T., & Sulaiman Lalani, N. (2014). Complementary and alternative medicine in oncology nursing. *British Journal of Nursing*, 23(1), 40–46. <https://doi.org/10.12968/bjon.2014.23.1.40>
- Song, W. J. (2016). ‘Caring’—An understanding of professional identity by first-year nursing students. *Whitireia Nursing and Health Journal*, (23), 37–44. Retrieved from search-proquest-com.exproxy.cqu.edu.au/docview/1874694895/49D38F5C79D4429BPQ/8?accountid=10016
- Sortheix, F. M., Dietrich, J., Chow, A., & Salmela-Aro, K. (2013). The role of career values for work engagement during the transition to working life. *Journal of Vocational Behavior*, 83(3), 466–475. <https://doi.org/10.1016/j.jvb.2013.07.003>
- Southern Cross University. (2013). *2014 Course enrolment guide for continuing students. School of Health and Human Sciences. Bachelor of Naturopathy*. Retrieved from https://web.archive.org/web/20170725203513/http://scu.edu.au/health-sciences/download.php?doc_id=13872

Southern School of Natural Therapies. (n.d.). *Bachelor of health science (naturopathy)*.

Subject information—electives. Retrieved from

<https://www.ssnt.edu.au/courses/naturopathy/bachelor-health-science-naturopathy>

Spence, D. S., Thompson, E. A., & Barron, S. J. (2005). Homeopathic treatment for chronic disease: A 6-year, university-hospital outpatient observational study.

Journal of Alternative & Complementary Medicine, 11(5), 793–798.

doi:10.1089/acm.2005.11.793

Spencer, C. N., Lopez, G., Cohen, L., Urbauer, D. L., Hallman, D. M., Fisch, M. J., &

Parker, P. A. (2016). Nurse and patient characteristics predict communication about complementary and alternative medicine. *Cancer*, 122(10), 1552–1559.

doi:10.1002/cncr.29819

Spiegel, A. D., & Kavalier, F. (2002). The role of Abraham Lincoln in securing a charter

for a homeopathic medical college. *Journal of Community Health*, 27(5),

357--380. <https://doi:10.1023/A:1019840711184>

Spinks, J., & Hollingsworth, B. (2012). Policy implications of complementary and alternative medicine use in Australia: Data from the national health survey.

Journal of Alternative and Complementary Medicine, 18(4), 371–378.

<https://doi.org/10.1089/acm.2010.0817>

Stratton, T. D., & McGivern-Snofsky, J. L. (2008). Toward a sociological understanding of complementary and alternative medicine use. *Journal of Alternative and*

Complementary Medicine, 14(6), 777–783.

<https://doi.org/10.1089/acm.2007.7006>

- Steel, A., Leach, M., Wardle, J., Sibbritt, D., Schloss, J., Diezel, H., & Adams, J. (2018). The Australian complementary medicine workforce: A profile of 1,306 practitioners from the PRACI study. *Journal of Alternative and Complementary Medicine*, 24(4), 385–394. <https://doi.org/10.1089/acm.2017.0206>
- Stefanovic, S., Kiss, I., Stanojevic, D., & Janjic, N. (2014). Analysis of technological process of cutting logs using Ishikawa diagram. *ACTA Tehnica Corviniensis—Bulletin of Engineering*, VII(4), 93–98. Retrieved from <http://acta.fih.upt.ro/archive.html>
- Steinbrook, R. (2006). Imposing personal responsibility for health. *New England Journal of Medicine*, 355(8), 753–756. doi:10.1056/NEJMp068141
- Steinsbekk, A., & Lüdtke, R. (2005). Patients’ assessments of the effectiveness of homeopathic care in Norway: A prospective observational multicentre outcome study. *Homeopathy*, 94(1), 10–16. Retrieved from <https://www.thieme-connect.com/products/ejournals/abstract/10.1016/j.homp.2004.11.016>
- Steinsbekk, A., Bentzen, N., Fønnebø, V., & Lewith, G. (2004). The use of simplified constitutional indications for self-prescription of homeopathic medicine. *Complementary Therapies in Medicine*, 12(2), 112–117. <https://doi.org/10.1016/j.ctim.2004.09.004>
- Stets, J., & Burke, P. (2000). Identity theory and social identity theory. *Social Psychology Quarterly*, 63(3), 224–237. Retrieved from <http://www.jstor.org/stable/2695870>
- Stevens, S., & Miretzky, D. (2014). The foundations of teaching for diversity: What teachers tell us about transferable skills. *Multicultural Education*, 22(1), 30–40. Retrieved from <https://eric.ed.gov/?id=EJ1065295>

- Stieber, J. (2005). Preventive health care in Australia: The shape of the elephant, reliance on evidence, and comparisons to U.S. Medicare. Retrieved from [http://www.health.gov.au/internet/main/publishing.nsf/Content/161E6484D0C70451CA257BF0001F52A4/\\$File/Preventative%20Health%20Care.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/161E6484D0C70451CA257BF0001F52A4/$File/Preventative%20Health%20Care.pdf)
- Stoneman, P., Sturgis, P., Allum, N., & Sibley, E. (2013). Incommensurable worldviews? Is public use of complementary and alternative medicines incompatible with support for science and conventional medicine? *PLOS ONE*, 8(1), 1–6. <https://doi.org/10.1371/journal.pone.0053174>
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Stuckey, H. L. (2013). Three types of interviews: Qualitative research methods in social health. *Journal of Social Health and Diabetes*, 01(2), 56–59. <https://doi.org/10.4103/2321-0656.115294>
- Sturgeon, D. (2008). Skills for caring: Valuing knowledge of applied science in nursing. *British Journal of Nursing*, 17(5), 322–325. <https://doi.org/10.12968/bjon.2008.17.5.28828>
- Sullivan, G. M. (2011). Getting off the “gold standard”: Randomized controlled trials and education research. *Journal of Graduate Medical Education*, 3(3), 285–289. doi:10.4300/JGME-D-11-00147.1
- Summers, S., & Summers, H. (2015, July 10). *Overcoming the ‘angel’ perception of nursing*. [Blog Post]. Retrieved from <https://blog.oup.com/2015/07/nursing-angel-perception/>

- Swayze, S., & Rich, S. (2011). Promoting safe use of medical devices, *The Online Journal of Issues in Nursing*, 17(1). doi:10.3912/OJIN.Vol17No01PPT01
- Swerissen, H., Duckett, S., & Wright, J. (2016). *Chronic failure in primary care*. Grattan Institute Report No. 2016–2, March 2016. Retrieved from <https://grattan.edu.au/report/chronic-failure-in-primary-care/>
- Symonds, V., Symonds, P., & Brown, D. H. K. (2016). Skype as a tool for qualitative research interviews. *Sociological Research Online*, 21(2), 12. <https://doi.org/10.5153/sro.3952>
- Tahir, N., Thomas, P., & Li, S. (2015). Challenges and opportunities in integrating complementary and alternative medicine into mainstream of the Malaysian healthcare system. *Tang [Humanitas Medicine]*, 5(4), 23.1–23.6. <https://doi.org/10.5667/tang.2015.0014>
- Tajfel, H. (1969). Cognitive aspects of prejudice. *The Journal of Social Issues*, 25(4), 79–97. doi:10.1111/j.1540-4560.1969.tb00620.x
- Tajfel, H., & Turner, J. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33–47). Monterey, CA: Brooks/Cole Publishing.
- Talbot, L., & Verrinder, G. (2010). *Promoting health: The primary health care approach* (4th ed.). Chatswood: Churchill Livingstone.
- Tan, J. P. I. (2015). Examining the socialisation of new teachers through the lenses of positioning theory and micropolitical theory. *Asia-Pacific Education Researcher*, 24(1), 177–188. <https://doi.org/10.1007/s40299-014-0170-9>
- Tannenbaum, C., & Tsuyuki, R. T. (2013). The expanding scope of pharmacists' practice: Implications for physicians. *Canadian Medical Association Journal*, 185(14), 1228–1232. <https://doi.org/10.1503/cmaj.121990>

- Taylor, K. (2009). Paternalism, participation and partnership—The evolution of patient centeredness in the consultation. *Patient Education and Counseling*, 74(2), 150–155. <https://doi.org/10.1016/j.pec.2008.08.017>
- Teixeira, M. Z. (2011). Scientific evidence of the homeopathic epistemological model. *International Journal of High Dilution Research*, 10(34), 46–64. Retrieved from <http://highdilution.org/index.php/ijhdr/article/view/421>
- Teixeira, M. Z., Guedes, C. H. F. F., Barreto, P. V., & Martins, M. A. (2010). The placebo effect and homeopathy. *Homeopathy*, 99(2), 119–129. doi:10.1016/j.homp.2010.02.001
- Templeman, K., & Robinson, A. (2011). Integrative medicine models in contemporary primary health care. *Complementary Therapies in Medicine*, 19(2), 84–92. <https://doi.org/10.1016/j.ctim.2011.02.003>
- ten Hoeve, Y., Jansen, G., & Roodbol, P. (2014). The nursing profession: public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing*, 70(2), 295–309. <https://doi.org/10.1111/jan.12177>
- Tessier, S. (2012). From field notes, to transcripts, to tape recordings: Evolution or combination? *International Journal of Qualitative Methods*, 11(4), 446–460. <https://doi.org/10.1177/160940691201100410>
- Therapeutic Goods Administration. (2019). *Evidence guidelines*. Retrieved from <https://www.tga.gov.au/book-page/scientific-indications-what-evidence-do-you-need-support-your-scientific-indication>
- Thomas, D. P. (2014). The demise of bloodletting. *The Journal of the Royal College of Physicians of Edinburgh*, 44(1), 72–77. <https://doi.org/10.4997/JRCPE.2014.117>

- Thomas, G., & James, D. (2006). Reinventing grounded theory: Some questions about theory, ground and discovery. *British Educational Research Journal*, 32(6), 767–795. <https://doi.org/10.1080/01411920600989412>
- Thomas, Y. (2007). The history of the memory of water. *Homeopathy*, 96(3), 151–157. <https://doi.org/10.1016/j.homp.2007.03.006>
- Thomas, Y. (2015). From high dilutions to digital biology: The physical nature of the biological signal. *Homeopathy*, 104(4), 295–300. <https://doi.org/10.1016/j.homp.2015.06.008>
- Thompson, E., Viksveen, P., & Barron, S. (2016). A patient reported outcome measure in homeopathic clinical practice for long-term conditions. *Homeopathy*, 105(4), 309–317. doi:10.1016/j.homp.2016.05.001
- Thorgaard, K. (2014). Is evidence-based medicine about democratizing medical practice? *Outlines. Critical Practice Studies*, 15(1), 49–62. Retrieved from <https://tidsskrift.dk/outlines/article/view/15827>
- Thornberg, R. (2012). Informed grounded theory. *Scandinavian Journal of Educational Research*, 56(3), 243–259, <https://doi.org/10.1080/00313831.2011.581686>
- Thornberg, R., & Charmaz, K. (2012). Grounded Theory. In S. D. Lapan, M. T. Quartaroli, & F. J. Riemer (Eds.), *Qualitative research: An introduction to methods and designs*. San Francisco, CA: Jossey-Bass.
- Timonen, V., Foley, G., & Conlon, C. (2018). Challenges when using grounded theory: A pragmatic introduction to doing GT research. *International Journal of Qualitative Methods*, 17(March), 1–10. doi:10.1177/1609406918758086
- Tippens, K., Marsman, K., & Zwickey, H. (2009). Is prayer CAM? *Journal of Alternative and Complementary Medicine*, 15(4), 435–438. doi:10.1089/acm.2008.0480

- Tirado, F., & Gálvez, A. (2007). Positioning theory and discourse analysis: Some tools for social interaction analysis. *Forum: Qualitative Social Research*, 8(2).
<https://doi.org/10.17169/fqs-8.2.248>
- Tjosvold, D. (2006). Defining conflict and making choices about its management: Lighting the dark side of organizational life. *International Journal of Conflict Management*, 17(2), 87–95. <https://doi.org/10.1108/10444060610736585>
- Toal-Sullivan, D. (2006). New graduates' experiences of learning to practise occupational therapy. *British Journal of Occupational Therapy*, 69(11), 513–524.
<https://doi.org/10.1177/030802260606901105>
- Tokeley, K. (2014). The natural health and supplementary products bill: Homeopathy, the truth and the placebo effect. *The New Zealand Universities Law Review*, 26(2), 421--440. Retrieved from <https://ssrn.com/abstract=2697277>
- Tovey, P., & Adams, J. (2003). Nostalgic and nostophobic referencing and the authentication of nurses' use of complementary therapies. *Social Science & Medicine*, 56(7), 1469–1480. [https://doi.org/10.1016/S0277-9536\(02\)00143-0](https://doi.org/10.1016/S0277-9536(02)00143-0)
- Tozer, M., Khawaja, N., & Schweitzer, R. (2018). Protective factors contributing to wellbeing among refugee youth in Australia. *Journal of Psychologists and Counsellors in Schools*, 28(1), 66–83. doi:10.1017/jgc.2016.31
- Tricco, A. C., Lillie, E., Soobiah, C., Perrier, L., & Straus, S. E. (2012). Impact of H1N1 on socially disadvantaged populations: Systematic review. *PLOS ONE*, 7(6), 1--17. doi:10.1371/journal.pone.0039437
- Turner, B. S. (1987). *Medical power and social knowledge*. London: Sage.
- Udhayam Homoeo Pharmacy. (2014). *How, what and why of homoeopathic medicines*. Retrieved from <https://pharmacy.curative-medicine.com/about-homoeopathy>

- Uggla, H. (2015). Positioning in the mind versus brand extension: The revision of Ries and Trout. *The IUP Journal of Brand Management*, 12(1), 35–44. Retrieved from <https://www.questia.com/library/p439502/iup-journal-of-brand-management>
- Ünal, B., Critchley, J. A., Fidan, D., & Capewell, S. (2005). Life-years gained from modern cardiological treatments and population risk factor changes in England and Wales, 1981–2000. *American Journal of Public Health*, 95(1), 103–108. doi:10.2105/ajph.2003.029579
- University College of London Hospitals. (n.d.). *History of the Royal London Hospital for integrated medicine*. Retrieved from <https://www.uclh.nhs.uk/OurServices/OurHospitals/RLHIM/Pages/historyofrlhim.aspx>
- University of Canberra. (2019). *Grey literature in health*. Retrieved from <https://canberra.libguides.com/c.php?g=599348&p=4148805>
- University of Newcastle. (2019). *Contemporary nursing (NURS6120)*. Retrieved from <https://www.newcastle.edu.au/course/details>
- Upshur, R. (2005). Looking for rules in a world of exceptions—Reflections on evidence-based practice. *Perspectives in Biology and Medicine*, 48(4), 477–489. doi:10.1353/pbm.2005.0098
- Urquhart, C. (2007). The evolving nature of grounded theory method: The case of the information systems discipline. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 339–359). London: Sage.
- Urquhart, C. (2013). *Grounded theory for qualitative research: A practical guide*. London: Sage.

- Urquhart, C., & Fernández, W. (2013). Using grounded theory method in information systems: The researcher as blank slate and other myths. *Journal of Information Technology*, 28(3), 224–236. doi:10.1057/jit.2012.34
- Usher, L., Fox, P., Lafarge, C., & Mitchell, K. (2013). Factors associated with complementary and alternative medicine use in irritable bowel syndrome: A literature review. *Psychology, Community & Health*, 2(3), 346–361. <http://dx.doi.org/10.5964/pch.v2i3.65>
- Ussher, J. M., Charter, R., Parton, C., & Perz, J. (2016). Constructions and experiences of motherhood in the context of an early intervention for Aboriginal mothers and their children: Mother and healthcare worker perspectives. *BMC Public Health*, 16(1), 620. <https://doi.org/10.1186/s12889-016-3312-6>
- Valencia, L. (2015). Being a mother, practicing motherhood, mothering someone: The impact of psy-knowledge and processes of subjectification. *Journal of Family Issues*, 36(9), 1233–1252. <https://doi.org/10.1177/0192513X14533542>
- Valentine, K., Ordóñez, M., & Millender, E. (2014). Transforming practice through embracing caring in nurse-managed centers. *International Journal of Human Caring*, 18(3), 52–64. <https://doi.org/10.20467/1091-5710.18.3.52>
- Valtorta, R. R., Baldissarri, C., Andrighetto, L., & Volpato, C. (2019). The dirty side of work: Biologization of physically tainted workers. *International Review of Social Psychology*, 32(1), 1–13. <http://doi.org/10.5334/irsp.213>
- van der Riet, P. (2011). Complementary therapies in health care. *Nursing and Health Sciences*, 13(1), 4–8. <https://doi.org/10.1111/j.1442-2018.2011.00587.x>

- van der Werf, E. T., Duncan, L. J., von Flotow, P., & Baars, E. W. (2018). Do NHS GP surgeries employing GPs additionally trained in integrative or complementary medicine have lower antibiotic prescribing rates? Retrospective cross-sectional analysis of national primary care prescribing data in England in 2016. *BMJ Open*, 8(3), e020488. <https://doi.org/10.1136/bmjopen-2017-020488>
- van Haselen, R. A., Cinar, S., Fisher, P., & Davidson, J. (2001). The constitutional type questionnaire: Validation in the patient population of the Royal London Homoeopathic Hospital. *British Homoeopathic Journal*, 90(3), 131–137. <https://doi.org/10.1054/homp.1999.0493>
- van Langenhove, L., & Harré, R. (1999). Introducing positioning theory. In R. T. Harré, & L. van Langenhove (Eds.), *Positioning theory. Moral contexts of intentional action* (pp. 14–31). Oxford: Blackwell.
- Vandecasteele, T., Debyser, B., Van Hecke, A., De Backer, T., Beeckman, D., & Verhaeghe, S. (2015). Patients' perceptions of transgressive behaviour in care relationships with nurses: A qualitative study. *Journal of Advanced Nursing*, 71(12), 2822–2833. <https://doi:10.1111/jan.12764>
- Vanderploeg, K., & Yi, X. (2009). Acupuncture in modern society. *Journal of Acupuncture and Meridian Studies*, 2(1), 26–33. [https://doi:10.1016/S2005-2901\(09\)60012-1](https://doi:10.1016/S2005-2901(09)60012-1)
- Varjus, S. L., Leino-Kilpi, H., & Suominen, T. (2011). Professional autonomy of nurses in hospital settings—A review of the literature. *Scandinavian Journal of Caring Sciences*, 25(1), 201–207. doi:10.1111/j.1471-6712.2010.00819.x

- Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, 18(1), 148. doi:10.1186/s12874-018-0594-7
- Veage, S., Ciarrochi, J., Deane, F. P., Anderson, R., Oades, L. G., & Crowe, T. P. (2014). Value congruence, importance and success in the workplace: Links with well-being and burnout amongst mental health practitioners. *Journal of Contextual Behavioral Science*, 3(4), 258–264. doi:10.1016/j.jcbs.2014.06.004
- Ventola, C. L. (2010). Current issues regarding complementary and alternative medicine (CAM) in the United States: Part 1: The widespread use of CAM and the need for better-informed health care professionals to provide patient counseling. *Pharmacy and Therapeutics*, 35(8), 461–468. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2935644/>
- Verhoef, M. J., & Vanderheyden, L. C. (2007). Combining qualitative methods and RCTs in CAM intervention research. In J. Adams (Ed.), *Researching complementary and alternative medicine* (pp. 72–86). New York, NY: Routledge.
- Verhoef, M. J., Mulkins, A., Carlson, L. E., Hilsden, R. J., & Kania, A. (2007). Assessing the role of evidence in patients' evaluation of complementary therapies: A quality study. *Integrative Cancer Therapies*, 6(4), 345–353. doi:10.1177/1534735407309482
- Victoria State Government. (2018). *Specialist clinics*. Retrieved from <https://www2.health.vic.gov.au/443/hospitals-and-health-services/patient-care/specialist-clinics>

- Vogel, S. (2015). Evidence, theory and variability in osteopathic practice. *International Journal of Osteopathic Medicine*, 18(1), 1–4.
<https://doi.org/10.1016/j.ijosm.2015.02.001>
- von Conrady, D., & Bonney, A. (2017). Patterns of complementary and alternative medicine use and health literacy in general practice patients in urban and regional Australia. *Australian Family Physician*, 46(5), 316–320. Retrieved from <https://www.racgp.org.au>
- Vveinhardt, J., & Gulbovaite, E. (2017). Congruence of personal and organizational values: Moving beyond practice. *Montenegrin Journal of Economics*, 13(2), 81--92. <https://doi.org/10.14254/1800-5845/2017.13-2.4>
- Wager, T. D., & Atlas, L. Y. (2015). The neuroscience of placebo effects: Connecting context, learning and health. *Nature Reviews. Neuroscience*, 16(7), 403–418.
doi:10.1038/nrn3976
- Wakely, T. (1858). London: Saturday, May 15, 1858. *The Lancet*, 71(1811), 483–485.
[https://doi.org/10.1016/S0140-6736\(02\)62607-8](https://doi.org/10.1016/S0140-6736(02)62607-8)
- Walach, H., Falkenberg, T., Fønnebø, V., Lewith, G., & Jonas, W. B. (2006). Circular instead of hierarchical: Methodological principles for the evaluation of complex interventions. *BMC Medical Research Methodology*, 6(1), 29.
<https://doi.org/10.1186/1471-2288-6-29>
- Walker, B. F., Armson, A., Hodgetts, C., Jacques, A., Chin, F. E., Kow, G., . . . Wright, A. (2017). Knowledge, attitude, influences and use of complementary and alternative medicine (CAM) among chiropractic and nursing students. *Chiropractic & Manual Therapies*, 25(October). Article 29.
<https://doi.org/10.1186/s12998-017-0160-0>

- Walker, S., Dwyer, T., Broadbent, M., Moxham, L., Sander, T., & Edwards, K. (2014). Constructing a nursing identity within the clinical environment: The student nurse experience. *Contemporary Nurse*, 49, 103–112.
<https://doi.org/10.5172/conu.2014.49.103>
- Wall, S. (2015). Transdisciplinarity and nursing education: Expanding nursing's professional identity and potential. In P. Gibbs (Ed.), *Transdisciplinary Professional Learning and Practice* (pp. 53–68). https://doi.org/10.1007/978-3-319-11590-0_5
- Wardle, J. (2010). The national registration and accreditation scheme: What would inclusion mean for naturopathy and Western herbal medicine? Part I: The legislation. *Australian Journal of Medical Herbalism*, 22(4), 113–118. Retrieved from <http://www.aronah.org/wp-content/uploads/Wardle-AJMH-Part-I.pdf>
- Wardle, J. (2011). The national registration and accreditation scheme: What would inclusion mean for naturopathy and Western herbal medicine? Part II: Practice implications. *Australian Journal of Medical Herbalism*, 23(1), 18–26. Retrieved from <http://www.aronah.org/wp-content/uploads/Wardle-AJMH-Part-II.pdf>
- Wardle, J. L., Adams, J., Lui, C. W., & Steel, A. E. (2013a). Current challenges and future directions for naturopathic medicine in Australia: A qualitative examination of perceptions and experiences from grassroots practice. *BMC Complementary and Alternative Medicine*, 13(January). Article 15.
<https://doi.org/10.1186%2F1472-6882-13-15>
- Wardle, J., Adams, J., & Sibbritt, D. (2013b). Homeopathy in rural Australian primary health care: A survey of general practitioner referral and practice in rural and regional New South Wales, Australia. *Homeopathy*, 102(3), 199–206.
<https://doi.org/10.1016/j.homp.2013.03.002>

- Wardle, J., Sibbritt, D., & Adams, J. (2014). The interface with naturopathy in rural primary health care: A survey of referral practices of general practitioners in rural and regional New South Wales, Australia. *BMC Complementary and Alternative Medicine*, 11(14). Article 238. doi:10.1186/1472-6882-14-238
- Wardle, J., Sibbritt, D., Broom, A., Steel, A., & Adams, J. (2016). Is health practitioner regulation keeping pace with the changing practitioner and health-care landscape? An Australian perspective. *Frontiers in Public Health*, 4(91).
<https://doi.org/10.3389/fpubh.2016.00091>
- Wardle, J., Steel, A., & McIntyre, E. (2013c). Independent registration for naturopaths and herbalists in Australia: The coming of age of an ancient profession in contemporary healthcare. *Australian Journal of Herbal Medicine*, 25(3), 1–7.
Retrieved from https://www.nhaa.org.au/docs/AJMH/Articles/25_3_ARONAH.pdf
- Warelow, P. J. (2013). Changing philosophies: A paradigmatic nursing shift from Nightingale. *The Australian Journal of Advanced Nursing*, 31(1), 36. Retrieved from http://www.ajan.com.au/ajan_31.1.html
- Waters, J. (2015). Snowball sampling: A cautionary tale involving a study of older drug users. *International Journal of Social Research Methodology*, 18(4), 367–380.
<https://doi.org/10.1080/13645579.2014.953316>
- Watson, J. (1985). *Nursing: Human science and human care. A theory of nursing*. Norwalk, CT: Appleton-Century-Crofts.
- Watson, J. (1997). The theory of human caring: Retrospective and prospective. *Nursing Science Quarterly*, 10(1), 49–52. <https://doi.org/10.1177/089431849701000114>
- Watson, J. (1999). *Postmodern nursing and beyond*. New York, NY: Churchill Livingstone.

- Weeks, R. E., & Newman, E. B. (2011). Behavioral factors in the placebo response. *Neurological Sciences*, 32(Suppl. 1), S3–S8. doi:10.1007/s10072-011-0555-y
- Wegman, C. (1985). *Psychoanalysis and cognitive psychology: A formalization of Freud's earliest theory*. London: Academic Press.
- Weir J. (1933). Samuel Hahnemann and his influence on medical thought. *Proceedings of the Royal Society of Medicine*, 26(6), 668–676.
<https://doi.org/10.1177%2F003591573302600603>
- Weir, M. (2016). *Australian natural therapists association submission to chair, health workforce principal committee registration of naturopathy, western herbal medicine and nutritional medicine*. Retrieved from
<http://ftp.australiannaturaltherapistsassociation.com.au/downloads/news/2016/AN%20Submission%20to%20Chair%20HWPC.pdf>
- Weir, M., Wardle, J., Marshall, B., & Archer, E. (2014). Regulation of complementary and alternative medicine: Interplay of therapeutic goods legislation consumer law. *The Bond Law Review*, 25(1), 13–34. Retrieved from
<https://blr.scholasticahq.com/article/5601>
- Weitzer, R. (2008). Legalizing prostitution: Morality politics in Western Australia. *British Journal of Criminology*, 49(1), 88–105. <https://doi.org/10.1093/bjc/azn027>
- Westman, K. F., & Blaisdell, C. (2016). Many benefits, little risk: The use of massage in nursing practice. *The American Journal of Nursing*, 116(1), 34–39.
<https://doi.org/10.1097/01.NAJ.0000476164.97929.f2>
- Whannell, R., & Whannell, P. (2015). Identity theory as a theoretical framework to understand attrition for university students in transition. *Student Success*, 6(2), 43–52. <https://doi.org/10.5204/ssj.v6i2.286>

- Whembolua, G. L. S., Conserve, D. F., & Ilunga Tshiswaka, D. (2015). Cultural identity and health promotion: Assessing a health education program targeting African immigrants in France. *The Journal of Pan African Studies*, 8(2), 23–39. Retrieved from <https://ir.uwf.edu/islandora/object/uwf:23594>
- White, A. (2009). Western medical acupuncture: A definition. *Acupuncture in Medicine*, 27(1), 33–35. <https://doi.org/10.1136/aim.2008.000372>
- White, K., & Willis, E. (2004). Evidence-based medicine and CAM. In P. Tovey, G. Easthope, & J. Adams (Eds.), *Mainstreaming Complementary and Alternative Medicine. Studies in Social Context* (1st ed., pp. 49–63).
- Whittaker, B. A., Gillum, D. R., & Kelly, J. M. (2018). Burnout, moral distress, and job turnover in critical care nurses. *International Journal of Studies in Nursing*, 3(3), 108. <https://doi.org/10.20849/ijsn.v3i3.516>
- Wieland, L. S., Manheimer, E., & Berman, B. M. (2011). Development and classification of an operational definition of complementary and alternative medicine for the Cochrane collaboration. *Alternative Therapies in Health and Medicine*, 17(2), 50–59. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196853/>
- Wilkes, L., Cowin, L., & Johnson, M. (2015). The reasons students choose to undertake a nursing degree. *Collegian*, 22(3), 259–265. <https://doi.org/10.1016/j.colegn.2014.01.003>
- Wilkes, L., Doull, M., Ng Chok, H., & Mashingaidze, G. (2016). Enjoyment in nursing---experiences from the clinical milieu. *Journal of Clinical Nursing*, 25(5--6), 656–663. <https://doi.org/10.1111/jocn.12981>
- Wilkinson, J. (1997). Developing a concept analysis of autonomy in nursing practice. *British Journal of Nursing*, 6(12), 703–707. doi:10.12968/bjon.1997.6.12.703

- Wilkinson, J. M., & Simpson, M. D. (2001). High use of complementary therapies in a New South Wales rural community. *Australian Journal of Rural Health*, 9(4), 166–171. <https://doi:10.1046/j.1038-5282.2001.00351.x>
- Willetts, G., & Clarke, D. (2014). Constructing nurses' professional identity through social identity theory. *International Journal of Nursing Practice*, 20(2), 164–169. <https://doi.org/10.1111/ijn.12108>
- Williams, M. G., & Burke, L. L. (2015). Doing learning knowing speaking: How beginning nursing students develop their identity as nurses. *Nursing Education Perspectives*, 36(1), 50–52. <https://doi.org/10.5480/12-908>
- Willis, E. (1990). Medical dominance: The division of labour in Australian health care (2nd ed.). St Leonards: Allen & Unwin.
- Willis, E. (2006). Introduction: Taking stock of medical dominance. *Health Sociology Review*, 15(5), 421–431. doi:10.5172/hesr.2006.15.5.421
- Wilson, I., Cowin, L. S., Johnson, M., & Young, H. (2013). Professional identity in medical students: Pedagogical challenges to medical education. *Teaching and Learning in Medicine*, 25(4), 369–373. <https://doi.org/10.1080/10401334.2013.827968>
- Winston, J. (1999). The faces of homeopathy: An illustrated history of the first 200 years. Wellington, NZ: Great Auk Publishing.
- Wolstenholme, D., Ross, H., Cobb, M., & Bowen, S. (2017). Participatory design facilitates person centred nursing in service improvement with older people: A secondary directed content analysis. *Journal of Clinical Nursing*, 26(9–10), 1217–1225. <https://doi.org/10.1111/jocn.13385>

- Wong, K. C. (2011). Using an Ishikawa diagram as a tool to assist memory and retrieval of relevant medical cases from the medical literature. *Journal of Medical Case Reports*, 5(1), 120. <https://doi.org/10.1186/1752-1947-5-120>
- Wong, V. C. N. (2009). Use of complementary and alternative medicine (CAM) in autism spectrum disorder (ASD): Comparison of Chinese and Western culture (Part A). *Journal of Autism & Developmental Disorders*, 39(3), 454–463.
doi:10.1007/s10803-008-0644-9
- Woo, B. F. Y., Lee, J. X. Y., & Tam, W. W. S. (2017). The impact of the advanced practice nursing role on quality of care, clinical outcomes, patient satisfaction, and cost in the emergency and critical care settings: A systematic review. *Human Resources for Health*, 15(1), 63. doi:10.1186/s12960-017-0237-9
- Woods, C., West, C., Mills, J., Park, T., Southern, J., & Usher, K. (2015). Undergraduate student nurses' self-reported preparedness for practice. *Collegian*, 22(4), 359–368.
<http://dx.doi.org/10.1016/j.colegn.2014.05.003>
- Wootton, J. C. (2005). Classifying and defining complementary and alternative medicine. *Journal of Alternative and Complementary Medicine*, 11(5), 777–778.
<https://doi.org/10.1089/acm.2005.11.777>
- Worden, J. (2019). *Baby and toddler health*. Retrieved from
<https://www.britishhomeopathic.org/charity/how-we-can-help/articles/babies-and-toddlers/baby-and-toddler-health/>
- World Health Organization. (1998). *Health promotion glossary*. Retrieved from
<https://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf>
- World Health Organization. (2001). *Legal status of traditional medicine and complementary/alternative medicine: A worldwide review*. Retrieved from
<https://apps.who.int/medicinedocs/en/d/Jh2943e/>

- World Health Organization. (2002). *WHO traditional medicine strategy 2002–2005*. Retrieved from <https://apps.who.int/medicinedocs/en/d/Js2297e/>
- World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice*. Retrieved from https://www.who.int/hrh/resources/framework_action/en/
- World Health Organization. (2015). *WHO global strategy on people-centred and integrated health services*. Retrieved from <https://www.who.int/servicedeliverysafety/areas/people-centred-care/global-strategy/en/>
- World Health Organization. (2016). *Integrated care models: An overview*. Retrieved from <http://www.euro.who.int/en/home>
- World Health Organization. (2019a). *Health workforce. Nursing and midwifery*. Retrieved from https://www.who.int/hrh/nursing_midwifery/en/
- World Health Organization. (2019b). *Traditional, Complementary and Integrative Medicine*. Retrieved from <https://www.who.int/traditional-complementary-integrative-medicine/about/en/>
- World Health Organization. (2019c). *Constitution*. Retrieved from <https://www.who.int/about/who-we-are/constitution>
- Xiong, F., & Guan, Y. S. (2017). Cautiously using natural medicine to treat liver problems. *World Journal of Gastroenterology*, 23(19), 3388. doi:10.3748/wjg.v23.i19.3388
- Xu, Y. (2004). Complementary and alternative therapies as philosophy and modalities: Implications for nursing practice, education, and research. *Home Health Care Management & Practice*, 16(6), 534–537. doi.org/10.1177/1084822304266500

- Xue, C. C. L., Zhang, A. L., Holroyd, E., & Suen, L. K. P. (2008). Personal use and professional recommendations of complementary and alternative medicine by Hong Kong registered nurses. *Hong Kong Medical Journal*, 14(2), 110–115. Retrieved from <https://www.hkmj.org/>
- Xue, C. C. L., Zhang, A. L., Lin, V., Da Costa, C., & Story, D. F. (2007). Complementary and alternative medicine use in Australia: A national population-based survey. *Journal of Alternative & Complementary Medicine*, 13(6), 643–650. <https://doi.org/10.1089/acm.2006.6355>
- Yadavendu, V. K. (2015). Health inequality and social capital: From state to community. *Global Journal of Medicine and Public Health*, 4(3). Retrieved from <http://www.gjmedph.com/archives.php>
- Yalcin, I., & Bump, R. C. (2004). The effect of previous treatment experience and incontinence severity on the placebo response of stress urinary incontinence. *American Journal of Obstetrics and Gynecology*, 191(1), 19–197. doi:10.1016/j.ajog.2004.03.089
- Yamada, Y., & Kato, Y. (2006). Images of circular time and spiral repetition: The generative life cycle model. *Culture & Psychology*, 12(2), 143–160. <https://doi.org/10.1177/1354067X06064575>
- Yang, M., Jiang, L., Wang, A., & Xu, G. (2017). Epidemiology characteristics, reporting characteristics, and methodological quality of systematic reviews and meta-analyses on traditional Chinese medicine nursing interventions published in Chinese journals. *International Journal of Nursing Practice*, 23(1), e12498. doi:10.1111/ijn.12498

- Yapijakis, C. (2009). Hippocrates of Kos, the father of clinical medicine, and Asclepiades of Bithynia, the father of molecular medicine. *In Vivo*, 23(4), 507–514. Retrieved from <http://iv.iijournals.org/content/23/4/507.full>
- Yazdannik, A., Yekta, Z. P., & Soltani, A. (2012). Nursing professional identity: An infant or one with Alzheimer. *Iranian Journal of Nursing and Midwifery Research*, 17(2 Suppl 1), S178–186.
<http://ijnmr.mui.ac.ir/index.php/ijnmr/issue/view/44>
- Young, M. T. (2018). Intuition and ineffability: Tacit knowledge and engineering design. In A. Fritzsche, & S. J. Oks (Eds.), *The Future of Engineering: Philosophical Foundations, Ethical Problems and Application Cases* (pp. 53–67).
https://doi.org/10.1007/978-3-319-91029-1_4
- Younger, C. (2011). The relationship between physical wellbeing and mental health care. *Mental Health Practice*, 15(1), 34–36.
<https://doi.org/10.7748/mhp2011.09.15.1.34.c8667>
- Yuan, H., Ma, Q., Ye, L., & Piao, G. (2016). The traditional medicine and modern medicine from natural products. *Molecules* (Basel, Switzerland), 21(5), 559.
doi:10.3390/molecules21050559
- Yun, H., Sun, L., & Mao, J. J. (2017). Growth of integrative medicine at leading cancer centers between 2009 and 2016: A systematic analysis of NCI-designated comprehensive cancer center websites. *JNCI Monographs*, 2017(52), 29–32.
<https://doi.org/10.1093/jncimonographs/lgx004>
- Zamanzadeh, V., Jasemi, M., Valizadeh, L., Keogh, B., & Taleghani, F. (2015). Effective factors in providing holistic care: A qualitative study. *Indian Journal of Palliative Care*, 21(2), 214–224. <https://doi.org/10.4103/0973-1075.156506>

- Zawiła-Niedźwiecki, J., & Olender, J. (2016). A not-so-gentle refutation of the defence of homeopathy. *Journal of Bioethical Inquiry*, 13(1), 21–25.
<https://doi.org/10.1007/s11673-015-9682-0>
- Zelle, G. (2009). *Exploring the application of positioning theory to the analysis of organisational change*. Australian and New Zealand Academy of Management Conference. Adelaide, Australia: Australian and New Zealand Academy of Management. Retrieved from <https://ro.uow.edu.au/commpapers/574/>
- Zheng Z. (2014). Acupuncture in Australia: regulation, education, practice, and research. *Integrative medicine research*, 3(3), 103–110.
<https://doi.org/10.1016/j.imr.2014.06.002>
- Zollman, C., & Vickers, A. (1999). What is complementary medicine? *BMJ*, 319(7211), 693--696. Retrieved from
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1116545/>

Appendix A Recruitment Notice



Research Participants Wanted

Participants are needed for a research project that seeks to understand what attracts registered nurses to the practice of homeopathy, and how being a both a nurse and homeopath affects the nursing practice and homeopathic practice of participants.

A willingness to undertake a private face-to-face interview in which you share your experience of becoming a homeopath is required. It is anticipated that each interview will last 60 – 90 minutes. Interviews will be held at a time and location mutually agreeable to participants and researcher.

The research is being completed as a Doctor of Philosophy at Central Queensland University. This research has been approved by Central Queensland University Human Research Ethics Committee – approval number: H12/08-165.

If you are an Australian registered nurse and homeopath, currently working in both professions, and would like to participate in this research, or would like further information, please contact:

Sandra Worsley
Phone:
Email: sandra.worsley@cqumail.edu.au

Your input into this study would be greatly appreciated

Appendix B Introductory Letter



Date

Dear

Thank you for expressing an interest in my research project titled: *“A Foot in Both Camps: A Constructivist Grounded Theory Study Exploring the Experience of Nurses who became Homeopaths.”*

Please find attached an Information Sheet that provides further information about the research and a Consent Form. If after reading the Information Sheet, you are willing to participate in the study please complete the consent form and return via email. If you would prefer a hard copy of this please advise me of your address and I will post the form out to you with a pre paid envelope for return. When this has been received I will make contact to arrange an interview.

If you have any questions, please do not hesitate to contact me.

Yours sincerely

Sandi Worsley

sandra.worsley@cqumail.com

Appendix C

Information Sheet



Project Title: *A Foot in Both Camps: A Constructivist Grounded Theory Study Exploring the Experience of Nurses who became Homeopaths*

Researcher: *Sandra Worsley*

Supervisors: *Dr Wendy Hillman*

Professor Melanie Birks

Contact Details:

Dr Wendy Hillman	Building 77/1.11 CQUniversity Bruce Highway North Rockhampton Queensland 4701 Phone: (07) 4923 2125 Email: w.hillman@cqu.edu.au
Professor Melanie Birks	School of Nursing and Midwifery CQUniversity PO Box 1128 Noosaville BC Queensland 4566 Australia Phone: (07) 54407034 Email: m.birks@cqu.edu.au

Dear

The purpose of this research is to understand what attracts registered and enrolled nurses to the practice of homeopathy, and how being both a nurse and homeopath affects their nursing and homeopathic practice.

Participation is open to anyone who is a current registered or enrolled nurse and a registered homeopath in Australia. This includes participants who work full time, part time or casual.

As a participant in this research, you will be asked to take part in an interview where you will be asked what attracted you to homeopathy, and how being a nurse and homeopath has affected your nursing and homeopathic practice. The interview will be conducted face-to-face, between you and the researcher in a mutually agreed private location that is not in the home of either the interviewer or the participant. It is anticipated that the interview will take approximately 60 to 90 minutes. The interview will be held at a time convenient to you.

The interview will be recorded onto audio tape, to be later transcribed into a manuscript for analysis. Recording of the interview is to assist the researcher in having an accurate account of your experience for analysis.

You will not receive any monetary compensation for participating in this research.

During research projects where personal information is being discussed, issues can arise that may be confronting or upsetting to participants. The following contacts are provided in the event that you need further support:

Lifeline Australia: 13 11 44 www.lifeline.org.au
beyondblue: 1300 22 4636 www.beyondblue.org.au

Every attempt will be made to safeguard your privacy. Your name and any identifying information will not appear on any of the transcripts, thesis or other publications. The consent form and any other identifying information and research data will be stored for 5 years in a secure and locked location, in accordance with Central Queensland University's Code of Conduct for Research Policy.

The research finding will be included in the researcher's Doctor of Philosophy thesis, and may also be included in journal articles, conferences, and any other publications that may result from the research.

You are free to withdraw from the research at any time up to the point of data analysis with no explanation, and without prejudice or consequences as a result of your withdrawal.

I am happy to discuss any concerns you may have about how this study will be conducted. I can be contacted on xxxx or by emailing sandra.worsley@cqu.edu.au

Should you wish to contact any of my supervisors to discuss any concerns you may have about how this study will be conducted, their contact details are:

Dr Wendy Hillman: Phone (07) 4923 2125
Email: w.hillman@cqu.edu.au
Professor Melanie Birks: Phone: (07) 5440 7034
Email: m.birks@cqu.edu.au

Should there be any concerns about the nature and/or conduct of this research project please contact:

Office of Research Building 361 Rm G.01
Central Queensland Innovation and Research Precinct (CQIRP)
CQUniversity
Ibis Avenue
Nth Rockhampton
QLD 4701
Phone: (07) 4923 2607
Email: research-enquiries@cqu.edu.au

Yours sincerely

Sandra Worsley

Appendix D Consent Form



Project Title: *A Foot in Both Camps: A Constructivist Grounded Theory Study Exploring the Experience of Nurses Who Became Homeopaths*

Researcher: Sandra Worsley

Supervisor: Dr Wendy Hillman

Contact Details:

Sandra Worsley. Phone: 0439718942. Email: sandra.worsley@cqumail.edu.au

Wendy Hillman. Phone: (07) 49232125. Email: w.hillman@cqu.edu.au

I consent to participation in this research project and agree that:

- 1) I have received an Information Sheet that I have read and understood.
- 2) I understand that participation in the research involves approximately a 60 to 90 minute individual face to face interview and that additional information may be required at a later date.
- 3) I understand that this interview will be recorded onto audio tape and will be transcribed.
- 4) I understand that being a participant in this research is voluntary.
- 5) I understand that I can withdraw from this research at any time up to the point of data analysis with no consequences as a result of this course of action.
- 6) I understand that to preserve anonymity and maintain confidentiality of participants that fictitious names may be used in publication(s).
- 7) I understand the research findings will be included in the researcher's publication(s) on the project and this may include conferences and articles

written for journals and other methods of dissemination stated in the
Information Sheet.

8) I am aware that a Plain English statement of results will be available.

9) I agree that I am providing my consent to participate in the study.

Name

Signature:..... Date

☐ Yes, I wish to have a Plain English statement of results posted to me at the address
I provide below (please tick box)

Postal Address

Appendix E

Example of early analysis using Nvivo

Nvivo capture—early analysis

Homeopathy	0	0	7/02/2013 1:40 PM	SW	15/02/2013 12:13 PM	SW
Intersecting aspects	6	18	22/01/2013 11:08 AM	SW	17/02/2013 1:04 PM	SW
Advising clients	4	13	22/01/2013 10:34 AM	SW	22/02/2013 9:44 AM	SW
allopathic knowledge helps homeopaths	1	2	4/02/2013 9:23 AM	SW	4/02/2013 9:28 AM	SW
being a health professional	1	3	4/02/2013 9:20 AM	SW	4/02/2013 9:29 AM	SW
best patient outcomes what matters	1	1	4/02/2013 9:26 AM	SW	4/02/2013 9:26 AM	SW
Differing view of health and healing	9	17	22/01/2013 10:54 AM	SW	6/03/2013 11:58 AM	SW
Health and culture	1	1	22/01/2013 3:12 PM	SW	5/02/2013 9:50 AM	SW
homeopathic nursing	4	7	4/02/2013 9:16 AM	SW	6/03/2013 12:02 PM	SW
Intersection of nursing and homeopathy	13	84	22/01/2013 10:33 AM	SW	6/03/2013 12:03 PM	SW
many forms of healing	1	1	4/02/2013 9:30 AM	SW	4/02/2013 9:31 AM	SW
merging knowledge	5	5	4/02/2013 9:29 AM	SW	22/02/2013 9:42 AM	SW
Professional identity	5	8	22/01/2013 12:06 PM	SW	22/02/2013 9:23 AM	SW
skepticism of homeopathy	1	2	4/02/2013 9:32 AM	SW	4/02/2013 9:33 AM	SW
still being a nurse	1	1	11/03/2013 11:09 AM	SW	11/03/2013 11:09 AM	SW
training nurses in homeopathy	1	3	4/02/2013 9:17 AM	SW	4/02/2013 9:18 AM	SW
understanding disease processes	1	1	4/02/2013 9:22 AM	SW	4/02/2013 9:22 AM	SW
working alongside conventional medicine	11	37	4/02/2013 9:19 AM	SW	6/03/2013 11:59 AM	SW

Appendix F

Examples of mid analysis using NVivo

NVivo capture of categories being developed

Seeing Potential	5	23	14/10/2015 2:48 PM	SW	7/08/2016 7:28 PM	SW
Seeking CAM	15	29	23/09/2015 1:18 PM	SW	30/10/2015 3:46 PM	SW
Dissatisfaction with nursing in the biomedical model of he	3	3	28/10/2015 10:42 AM	SW	17/07/2016 3:27 PM	SW
Enjoying aspects of nursing practice	2	6	9/11/2015 2:09 PM	SW	9/11/2015 2:33 PM	SW
having no autonomy	2	7	15/10/2015 12:51 PM	SW	9/11/2015 11:57 AM	SW
Lacking a holistic orientation	3	6	9/11/2015 12:13 PM	SW	9/11/2015 12:13 PM	SW
Life changes	2	4	1/05/2015 2:08 PM	SW	12/10/2015 12:48 PM	SW
Looking for career change	2	3	15/10/2015 12:51 PM	SW	9/11/2015 12:03 PM	SW
Nursing practice overmedicalised	2	3	18/10/2015 2:18 PM	SW	9/11/2015 12:03 PM	SW
Existing orientation towards holistic principles	6	12	23/09/2015 1:59 PM	SW	17/08/2016 10:00 AM	SW
Managing health concerns	9	18	23/09/2015 1:34 PM	SW	17/08/2016 10:01 AM	SW
Studying homeopathy after naturopathy	4	5	9/11/2015 2:00 PM	SW	9/11/2015 2:00 PM	SW
Wanting to Know More	13	23	25/09/2015 1:22 PM	SW	30/10/2015 2:23 PM	SW
Transforming perspectives	4	7	15/10/2015 1:03 PM	SW	30/10/2015 3:46 PM	SW
Thinking Differently	11	40	15/10/2015 1:03 PM	SW	1/05/2015 2:11 PM	SW

NVivo capture—late analysis

Intersecting Identities	0	0	9/11/2015 2:01 PM	SW	7/08/2016 7:28 PM	SW
being a homeopath	1	2	22/08/2016 9:14 AM	SW	22/08/2016 9:14 AM	SW
being a nurse	3	7	22/08/2016 9:14 AM	SW	22/08/2016 9:23 AM	SW
Navigating Conflicting Paradigms	12	44	17/07/2016 9:23 AM	SW	24/07/2016 11:12 AM	SW
professional collaboration	6	10	22/04/2016 10:20 AM	SW	17/07/2016 10:51 AM	SW
professional identity	8	24	21/05/2014 2:54 PM	SW	17/08/2016 3:48 PM	SW
Sharing Common Ground	1	1	18/04/2016 1:29 PM	SW	17/08/2016 11:27 AM	SW
nursing and homeopathy are complementary practices	4	6	17/07/2016 9:29 AM	SW	24/07/2016 9:54 PM	SW
transferring nursing knowledge into hom practice	5	21	17/07/2016 10:54 AM	SW	17/08/2016 11:52 AM	SW