IDEOLOGIES OF INTEGRATION: Communicating
Philosophies, Practices, and Identities in 21st Century Medicine

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Brielle Jamie Plump
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The Undersigned Faculty Committee Approves the

Thesis of Brielle Jamie Plump:

Ideologies of Integration: Communicating Philosophies, Practices, and Identities

in 21st Century Medicine

Patricia Geist-Martin, Chair
School of Communication

Meghan Moran
School of Communication

Hala Madanat
Graduate School of Public Health

4/15/2013
Approval Date
DEDICATION

I dedicate this research to my parents, Danni and James, and Sister, Quiana, who consistently inform my scholarship and delight me with practical perspectives on life through love and laughter. Additionally, I dedicate this research to my extended network of friends and family who have taught me that illness is not a physical condition, but a state of mind. Your love motivates me to question systemic norms, and your wisdom reminds me that the answers are within.
We can trust the flow of the universe…It’s always within you.

--Thaddeus Golas
ABSTRACT OF THE THESIS

Ideologies of Integration: Communicating Philosophies, Practices, and Identities in 21st Century Medicine

by

Brielle Jamie Plump
Master of Arts in Communication
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Integrative medicine (IM) is an option in medical care that blends global healing traditions and standard biomedical models of care. Most medical care providers do not offer IM treatment for patients, yet demand for IM is growing due to the paradigm shift within medical policy and practice. Limited literature exists focusing on how providers of IM interpret their role within the changing state of medicine. This research is designed to investigate how IM providers communicate their ideological positioning within the medical paradigm shift. Data collected from interviews and ethnographic methods at the “Clinic for Care and Concern” exposes how IM providers identify structural barriers and ideological barriers when communicating about the evolving medical landscape. Conclusions from this study can assist patients, providers, and medical administrators consider the utilization of IM philosophies in standard medical training and practice. Furthermore, this research study expands conceptualizations for how narrative and ideological positioning are examined in the communication field.
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CHAPTER 1

INTRODUCTION

The United States of America prioritizes health and illness prevention for its citizens, in theory. Through the Affordable Care Act (ACA) signed on March 23, 2010 the U.S. “guarantees access to health care for all Americans, creates new incentives to change clinical practice to foster better coordination and quality, gives doctors more information to make them better clinicians, and patients more information to make them more value-conscious consumers, and changes the payment system to reward value” (Kocher, Emanuel, & DeParle, 2010, p. 536). In essence, the ACA aims to improve operations related to health maintenance and care delivery for patients, their providers, insurance companies, and other health care stakeholders. Furthermore, the bill marks a milestone along what has been unofficially referred to as a medical paradigm shift (Engel, 1977). The shift is an ongoing call to action dating at least as far back as the 70’s that asks for health care practitioners to place a stronger emphasis on prevention and patient-centered wellness (Arrow et al., 2009; Bell et al., 2002; Brill, 2013; Brownlee, 2010; Engel, 1977; Frömke & Heineman, 2012; Fuchs, 1996; Harter, Patterson, & Gerbensky-Kerber, 2010; Pellegrino, 1999). Now, three years into the implementation of the ACA, and thirty-plus years into the call to action, it is necessary for health care stakeholders to ask what practical steps should come next.

As health care stakeholders and administrators determine which changes to make next, it is important to consider how the paradigm shift has evolved and led to the development of projects campaigns, and the ACA. One feature of the shift stems from patients’ growing discontent with medical processes that are unnecessarily expensive and rarely provide patients with the tools to prevent illness (Brownlee, 2010; Snyderman & Weil, 2002). These complaints juxtapose strict health care models focused on profit, technology, and biomedicine with integrated health care models focused on quality, reliability, and a continuum of care (Arrow et al., 2009; Engel, 1977; Pellegrino, 1999). These concerns helped lead policy makers towards ACA, influenced films like Sicko (Moore & Moore, 2007) and changes within the Fifth Comprehensive Review of the Medical School Admissions Test.
Additionally, these concerns influenced the guerilla style development of other models of care (Arrow et al., 2009; Barrett, 2003; Snyderman & Weil, 2002). Gradually over the past twenty-five years, patients have sought out alternatives to the typical models of care through integrative medicine.

*Integrative Medicine* (IM) offers biomedical modalities in conjunction with other evidence based treatments and global healing traditions (Snyderman & Weil, 2002). Moreover, IM is “an approach to care that puts the patients at the center and addresses the full range of physical, emotional, mental, social, spiritual, and environmental influences that affect a person’s health” (Horrigan, Lewis, Abrams, & Pechura, 2012). Examples of IM treatments include biofeedback, herbal supplements, acupuncture, yoga, energy healing, and nutrition therapy; and patients are regaling about them all (Bell et al., 2002; Kessler et al., 2001; Nahin, Barnes, Stussman, & Bloom, 2009). Thus, IM is a model of care that is growing in popularity and has the potential to fit within the intent of both the ACA and the medical paradigm shift at large. However, IM has yet to be fully implemented in American hospital systems, apart from a few dozen care facilities (Horrigan et al., 2012). Therefore, understanding how IM providers view the ideologies of their model of care in relation to the medical paradigm shift can aid in identifying practical next steps for administrators in the medical field.

This research is designed to investigate how IM provider narratives communicate their ideological positioning in the medical paradigm shift. In the Chapter One of this thesis I contextualize how certain medical models of care facilitate or constrain communication, and the way in which physician narratives can illustrate provider ideological positioning. In the Chapter Two I explain the research site and ethnographic methods employed in this interview driven study. In Chapter Three I outline the results found within the provider narratives collected. In Chapter Four I model the conclusions that can be drawn out from the results. I also discuss the project’s theoretical implications and practical implications. Finally, I close Chapter Four by sharing some limitations within this project and prescribing directions for future research.
MODELS OF INTENDED CARE

Within all fields of practice and study there are standards as well as inconsistencies. The medical field is no different, and distinct models of care within medical practice are abundant. In America, models of care can be categorized several ways with relation to insurance carriers, or treatment options. It is a very tangled web, from Health Maintenance Organization models (HMOs), to Preferred Provider Organization (PPO) models; from primary care models, to acute care models. *Models of care* in this study will refer to the operational theories and philosophies designed to direct the flow of treatment patients receive (Engel, 1977). I will describe medical models of care as paradigms, and refer to them as systems of thought that guide how physicians approach medical issues (Arrow et al., 2009; Bell et al., 2002). The utilization of a particular philosophical model of care affects the amount, frequency, and intensity of the care patients receive, and patients rarely get to choose their model of care (Annadale, 1998). In Chapter One, first I share the main objectives and communication research of four dominant models of care in order to explain the reasons for the medical paradigm shift. Second, I discuss main objectives and communication research of two key stakeholders within health care in order to explain interaction influences on the medical paradigm shift. Lastly, I highlight the importance of provider ideological positioning on models of care in order to explain the approach I have taken in researching perspectives on the medical paradigm shift; after which I will transition into Chapter Two that describes the research methods.

Standard Models

One notion of health is the preservation of “quality of life” (Guyatt, Feeny, & Patrick, 1993; Kuyken et al., 1995), and typically refers to a person’s ability to experience a balance mentally, physically, and socially (Wang, Keh, & Bolton, 2010). This notion takes on new meaning when people are faced with illness because illness disrupts this balance and has a ripple effect on all aspects of peoples’ lives. However, not every medical care model approaches illness management or health with attention towards patients’ sense of balance; some focus on just the physical elements, or just the mental elements. Although medical care systems are responsible for navigating the path towards health for their patients (Dutta, 2008), they are imperfect and inconsistent systems that address multiple pragmatic factors in
addition to the needs of the patient. Consequently, the way in which a medical model of care operationally aids a patient severely impacts the patient’s pursuit and understanding of health. I will now discuss four major categories of medical models of care and what research says regarding their ability to address patient needs.

There are three dominant models of care that follow standardized and rigidly defined methods of health care. These models of care operate under a one-size-fits all credo (Goldsberg, 1997) but differ from one another operationally as well as philosophically. There are variations and sub-models within each care model; however when care models combine practices and functions in an inclusive manner they become Integrative Models of care discussed later in this chapter.

**Biomedical Models of Care**

First, the most common model of care is the Biomedical Model of Care, also known as Western Model of Care, Modern Medicine, and Allopathic Medicine (Engel, 1977). Biomedicine is the most standard model globally, and approaches health care strictly using hard-science (Engel, 1977; Goldsberg, 1997; Snyderman & Weil, 2002). Depending on the illness, utilizing biomedical medicine can allow for the precise measurement of an aliment and the application of finite treatment options (Annandale, 1998; Engel, 1977). Because biomedicine utilizes principles of biology, chemistry, and physics, it examines human medicine at the cellular level and relies on quantitative data and tools (Annandale, 1998). Some sub-models of Biomedicine, including Osteopathic medicine, also rely heavily on the manipulation of bone and joint structures in their practice (Harter & Krone, 2001). In essence, biomedicine aims to eliminate disease and strictly evaluates the physical elements of the body, and works to cure illness. An example of Western biomedicine is treating coronary heart disease with a coronary stent; and stents save the lives of people every day. There are quantifiable benefits that stents and other biomedical treatments offer patients, particularly within secondary care where medicine is abrupt and emergency based (Annandale, 1998; Engel, 1977). Still, many people take issue with the fact that the definitions and practices within biomedicine are so strict.

Biomedicine has been noted for shielding patients from ambiguity, providing doctors with certainty, and protecting practitioners from lawsuits; however, it does so at the expense
of quality care (Annandale, 1998). Biomedicine does not prioritize the psychological, social, or cultural aspects of health and illness (Engel, 1977), and gives no consideration to how patient life-styles affect their health challenges. Instead, biomedicine aims to treat patients and illnesses objectively through the use of cutting age technology, which many patients regard as inconsiderate, invasive, and unnecessary (Snyderman & Weil, 2002). While the technological advancements and standardization within biomedicine make care easier to cover financially and politically, patients report feeling like they have to sacrifice meaningful and respectful care as a result (Annandale, 1998; Engel, 1977; Keshet, 2009; Snyderman & Weil, 2002). Thus, at the root of most criticisms about related to biomedicine stem from concern that biomedical philosophy is more concerned with treating illness than treating people, a prioritization that disturbs doctor-patient communication.

Within the biomedical model of care, doctor-patient relationships are not privileged because scientific data and time efficiency are the priority (Annandale, 1998; Engel, 1977). Unfortunately, the dominance of science within biomedical models does not support, and in fact restricts, communication between doctors and patients (Sharf & Street, 1997). Meanwhile, countless studies have shown that patients prefer to have “collaborative” relationships with their doctors, and see communication as the vehicle for collaborative care (Ballard-Reisch, 1990; Geist-Martin, Sharf, & Jeha, 2008; Politi & Street, 2011; Sharf & Street, 1997). Without doctor-patient communication, patients have reported feelings of negligence, which has affected their perception of health and their illness recovery (Geist & Hardesty, 1990). Poor doctor-patient communication has also resulted in numerous medical mal-practice lawsuits (Levinson, Roter, Mullooly, Dull, & Frankel, 1997). Although biomedical models of care are the standard models for care in America, biomedicine is not the only medical treatment option.

**Palliative Models of Care**

A second model of care is Palliative Care. Palliative care focuses strictly on relieving patients of pain and stress (Doyle, Hanks, & Mac Donald, 1999). Palliative Care techniques aim to ease the experience of illnesses and treatment without concern for curing illness. Palliative care prioritizes communication among doctors and patients, and is particularly useful during chronic illness treatment and end of life care (Kreps, 2003; Planalp & Trost,
Examples of palliative care are pain relief medications, massage therapy, and euthanasia. Palliative care is often assumed to be non-biomedically based; however in actuality palliative care utilizes any methods of pain management available (Doyle et al., 1999). Unfortunately, the research on palliative care is somewhat limited because a large majority of patients utilize it for end of life care (Siminoff, 2010).

Some research on palliative care indicates that it is immoral and inhumane (Siminoff, 2010), and other research reports suggest that patients receiving palliative care can experience unsatisfactory communication consistent with biomedical care (Ragan, Wittenberg, & Hall, 2003). Research criticizes palliative care for placing band-aids on cancer and covering up pain through intense drug therapies that do not solve any health issues; and ultimately see it as illegitimate. Conversely, other research has asserted that palliative care enhances communication through the use of narratives, and contrasts to biomedical models of care (Ragan, Mindt, & Wittenberg-Lyles, 2005). Given that palliative care is most often utilized by patients who are in severe pain or in need of end of life care, and is strictly intended to provide comfort, it is assessed by patients and their families differently than any other model of care (Wittenberg-Lyles, 2006). Unlike biomedical models, palliative care is strict in terms of intention not method; and is opposite of biomedicine on that basis. The only model of care in strict opposition to biomedicine methodologically is Eastern Medicine.

**Eastern Medicine Models of Care**

A third model of care is Eastern medicine. Eastern medicine utilizes ancient healing traditions without the use of modern technology. Eastern medicine includes some modes consistent with palliative care, like message therapy and yoga. However, Eastern Medicine also includes healing traditions that aim to cure disease, such as acupuncture, dietary regulation, and herb therapy (Goldsberg, 1977). Eastern medicine incorporates fundamental rules that govern the human body while prioritizing the most natural procedures possible for preventing and treating illness as well as pain (Wang, & Zhu, 2011). Eastern medicine, like palliative care, considers patient comfort and balanced quality of life a priority; however it also intends to treat illness.

Eastern Medicine has been considered “treating” illness while Western medicine has been considered “attacking” illness (Goldsberg, 1977). Patients have regaled that while “the
Western practitioner goes to war; the Eastern practitioner's strategy is defensive, seeking to restore balance and harmony. It's the mighty oak versus the flexible bamboo” (Goldsberg, 1977, p. 24). Thus, patients who believe medical trends are focusing too much on diseases and not enough on disease causes, embrace Eastern medicine (Guglielmo, 1998). Furthermore, research indicates that patients are impressed with Eastern medicine because its prioritization of patient well-being and un-invasive treatments necessitate strong doctor-patient communication (Blinne, 2012; Paek, Lee, Jeong, Wang, & Dutta, 2010). This way, Eastern medicine makes up for much of what Western biomedical care models lack. Patients have reported that the communicative components within Eastern medicine practice allow them to come to a deeper understanding of the roots of their illness (Ni, Simile, & Hardy, 2002; Schreiber, 2005). However, Eastern Medicine cannot always assist patients when they are in need of acute care, which biomedicine can drastically assist with (Engel, 1977; Snyderman & Weil, 2002). Ultimately, criticisms of Eastern medicine view it as soft and outdated. A fourth model of care that is becoming increasingly popular, capitalizes on the benefits of biomedicine, palliative care, and Eastern medicine.

**INTEGRATIVE MODELS OF CARE**

A fourth care model is the Integrative Model of Care, which combines praxis from standard models of care, systematically incorporating multiple approaches to medicine without discrimination. Integrative Medicine (IM) is an overarching term used to describe health care models that utilize a wide range of modalities (including biomedicine, palliative care, Eastern medicine, and more) to both prevent illness and treat illness (Goldsberg, 1997; Horrigan et al., 2012; Snyderman & Weil, 2002; Willard, 2005). Literature engaging the concepts of IM sometimes mistakenly interchanges the terms “Eastern medicine” “integrative”, “alternative,” and “complementary”; however, in actuality IM weaves separate models of care with an inclusivity that is rapidly changing modern health care (Barnes, Powell-Griner, McFann, & Nahin, 2004; Gage et al., 2009; Goldsberg, 1997). Not only does IM utilize Western and Eastern medicine, but it is also inclusive of therapies that are rooted in Greece, India, South America, and other countries (Goldsberg, 1977; Ni et al., 2002). These features of IM position it well for patients who find biomedicine detached, palliative care illegitimate, and Eastern medicine as soft.
Instead of having a single-minded focus on a particular component of a patient, IM aims to be mindful of all aspects of a patient - physically, emotionally, psychologically, and spiritually (Barrett, 2003; Coulter & Willis, 2004; Snyderman & Weil, 2002). All IM practices aim to optimize the medicine by systematically prioritizing quality care. By customizing treatment plans to fit patient needs on a continuous basis, not just as a last resort. Thus, IM approaches health thorough a holistic lens, which necessitates provider-patient collaboration (Geist-Martin et al., 2008). Therefore, patients are drawn to IM; patient demands for IM treatment options are forcing other stakeholders within medical care to consider the benefits of IM more systematically (Bell et al., 2002; Kessler et al., 2001; Nahin et al., 2009). However, like all models of care, IM offers more than just a platter of benefits; there are systemic drawbacks related to IM practices that elicit skeptics.

Critics of IM are weary of IM in part because they see it in opposition to biomedicine. Doctors who strictly practice biomedicine are not trained to consider alternative models of care, and therefore see no benefit in blending modes of care (Keshet, 2009). Providers with differing medical training backgrounds have inconsistent foundations of knowledge, and therefore prioritize different elements of medical practice. For biomedical practitioners, hard evidence is prioritized, making it difficult for biomedical practitioners to appreciate the benefits of IM, which can be difficult to isolate and quantify (Barrett et al., 2003; Gage et al., 2009). These perspectives are shared by patients as well, who prefer to receive care within the standard model of care (Barrett, 2003). However, IM is in fact rooted in the same basic science that biomedicine utilizes (Snyderman & Weil, 2002). In order for IM to gain more systemic support from doctors, patients, policy makers, and insurance companies, more research on the practices, philosophies, and hard evidence benefits of IM are needed (Abrams, 2013; Keshet, 2009). Momentum for IM research is gaining as the popularity of IM rises in localized pockets.

**INTEGRATIVE MEDICINE’S GROWING POPULARITY**

One reason IM prevalence is projected to rise (Barrett, 2003) is due to patients’ satisfaction with IM. Patients of IM typically regard it highly because IM requires participatory communication between doctors, nurses, medical teams, and patients (Frenkel, Ben-Arye, Geva, & Klein, 2007; Geist-Martin & Bell, 2009; Harter, 2012). Also, research
indicates patients are motivated to use IM because of the sense of camaraderie and collaboration they experience with providers (Schreiber, 2005; Willard, 2005). Furthermore, IM provides space for patients to exercise self-advocacy, and to assert their needs and concerns via communication (Wang et al., 2010). IM providers take the time to engage in “biopsychosocial communication” with their patients, which all physicians could theoretically do but many claim takes too long (du Pré, 2002). Research has shown that when patients feel free to ask questions about their treatment options they learn more about how their lifestyle is affecting their health, feel more empowered to change behavior, and feel a stronger connection to their physician (du Pré, 2002; Snyderman & Weil, 2002). Overall, patients and doctors of IM are increasingly noting that the communicative components of the IM care model enable relationship building, which enhances healing. Therefore, it is no surprise that the prevalence of IM models of care is increasing.

However, IM is becoming more and more popular for reasons other than communication (Barnes et al., 2004). A second perspective on why IM is projected to increase attests that the globalization of the modern world is a vehicle for its popularity (Wang et al., 2010). Globalization brings people around the world closer together through technology (Friedman, 2005) and has made IM more accessible and therefore more utilized. Globalization has led to more access to cultural practices around the world, including medical practices (Laguerre, 1987; Wang et al., 2010). Across the board it seems, “even in countries with a dominant medical tradition, complementary and alternative medicines are increasingly available” (Wang et al., 2010, p. 80).

A third reason IM models of care are increasing is due to the growing prevalence of chronic diseases and illnesses (Bodenheimer, Wagner, & Grumbach, 2002; Gage et al., 2009). One in every two adults has a chronic illness of some kind (Strauss et al., 1984), for example, diabetes or high blood pressure. These patients want both biomedical cures and soothing treatments that ease pain, and IM is their one-stop-shop (Gage et al., 2009). Patients with chronic illness seek IM because it maximizes their treatment options, and gives them more choices for how to conduct their disease management.

Thus, a fourth reason for the rise in IM utilization is the growing desire for shared control between patients and doctors. Patients and providers are increasingly interested in exercising power during medical consultations, and are therefore attempting to rethink
standardized approaches to medicine that limit patient participation (Wang et al., 2010). Studies have shown that both patients and providers prefer care models that offer options rather than restrictions (Dutta-Bergman, 2005; Engel, 1977). Typical Western medicine practitioners do not get to control, or share control, because they are under biomedical models of care that localize patient considerations to one place on the body and use only the most precise treatment plans (Annandale, 1998). However, IM allows practitioners to broach multiple modalities to treat a person for multiple aspects of their illness; this maximizes and balances control between the provider and the patient. Having options in IM is supplemented by the provider-patient communication inherent within IM, which further allows for the co-construction of medical decision making power between providers and patients (Politi & Street, 2011). Therefore, the communication, options, and power offered through IM are in line with patient demands of the future (Engel, 1977), making IM an essential part of the medical paradigm shift.

**THE MEDICAL PARADIGM SHIFT AND IM**

The benefits IM provides patients makes it highly applicable to the future medicine because it addresses key attributes within what has been unofficially termed the *medical paradigm shift*. Essentially, the paradigm shift aims to restructure the dominant medical models of care (biomedicine) and refocus the lens through which physicians, and other medical stakeholders, approach health care (Bell et al., 2002). This shift is a call to improve, or “reform” health care that has been initiated by patients, medical practitioners, policy makers, and scholars over the past several decades through research, lawsuits, campaigns, films, and articles (Arrow et al., 2009; Bell et al., 2002; Brill, 2013; Brownlee, 2010; Engel, 1977; Frömke & Heineman, 2012; Fuchs, 1996; Harter et al., 2010; Pellegrino, 1999; Snyderman & Weil, 2002). The shift is a collective address of the contradictions and discrepancies within the dominant models of care and the health care system at large. Theoretically, it aims to prioritize the preservation of patient health, the use of efficient methods of practice, and establish a “new normal” or revised standard model of care (Arrow et al., 2009; Bell et al., 2002; Brill, 2013; Brownlee, 2010; Engel, 1977; Frömke & Heineman, 2012; Fuchs, 1996; Harter et al., 2010; Pellegrino, 1999; Snyderman & Weil, 2002). Ultimately, the shift has evolved out of ongoing discontent with the inconsistencies
noted in the above models of care, as well as others. These inconsistencies have created a medical care system that focuses on disease control more than illness prevention (Brownlee, 2010), and a system that does not take time to address all of the “biopsychsocial” needs of patients (du Pré, 2002). Some blame insurance companies; others blame doctors, the food industry, the media, and the government (Bell et al., 2002; Brill, 2013; Brownlee, 2010; Snyderman & Weil, 2002); however the call to action to improve health care, to make health care more systematically inclusive and proactive, involves each of these entities.

Currently, the driving motivations and actions within medical and health entities are inconsistent and conflicting because the actors within them have different needs as stakeholders in the medical field. In order to meet the goals of the ongoing paradigm shift many policies and practices, such as the American Affordable Care Act (ACA) of 2010, have been suggested to establish more consistent expectations among stakeholders (Kocher et al., 2010). However, what really drives the perpetuation and acceptance of the shift is the voice and outcry of dissatisfaction made by stakeholders who are fed-up with contradictions within medical practice, models of care, and their own pursuit of health. Without understanding and incorporating the perspective of stakeholders the paradigm shift will be slow moving and unproductive.

In this section I have shared the main objectives and communication research of four dominant models of care in order to explain methodological reasons for the medical paradigm shift; the paradigm shift is moving medicine towards an all-encompassing model of care with more consistency. I will now discuss main objectives and communication research of key stakeholders in order to explain interaction influences on the medical paradigm shift.

Understanding current stakeholder communication will further contextualize how the paradigm shift is discursively unfolding. Moreover, by unpacking research related to the communication practices of medical care stakeholders, the need to investigate how specifically doctors communicate about their philosophical approach to medicine arises.

**STAKEHOLDER COMMUNICATION**

All of models of care affect stakeholders throughout the medical care system differently; stakeholders are individuals, groups, and organizations that influence and are affected by decision-making (Brugha & Varvasovszky, 2000). Stakeholders in medical
practice include people (such as patients, doctors, nurses, medical assistants, and hospital administrators, medical researchers), and entities (such as medical schools, insurance companies, pharmaceutical companies, patients families, patient employers, etc.). Models of care influence the way in which local and national stakeholders communicate and collaborate with one another (Brugha & Varvasovszky, 2000), which affect the delivery of medical care. Stakeholders primarily differ based on their needs; patients need assistance and treatment, doctors need time, tools, and data, insurance companies need to uphold standards, policies and finances, etc. Moreover, these needs are interdependent. Patients cannot get treatment without doctors who cannot practice without abiding by policies. In order to pass laws, policy makers need money, which they often get from insurance companies and pharmaceutical companies (Brownlee, 2010; Fuchs, 1996). Thus, the practices, interactions, and concerns of all stakeholders in medicine are what drive decision making in the medical arena, and thus what drives the medical paradigm shift. Moreover, certain stakeholders have more influence over particular aspects of medicine. One important stakeholder throughout medicine is, of course, the patient. Patients have ongoing relationships with other stakeholders, and communicate with doctors and insurers in order to get their needs met.

A large majority of communication research asks what patients think of their health care, and asks how they benefit from particular models of care (Kreps, 1989; Zoller & Dutta, 2008). This is with good reason, because without patients there would be no need for a health care system whatsoever. Patient needs define medical care’s existence. Unfortunately, patients themselves hold very little power relative to other stakeholders (Brownlee, 2010; Fuchs, 1996). Most medical care stakeholders have to, at least in theory, look out for the patient’s needs and interests. The needs of patients shift and change in response to social contexts; including patient demographics, location, education levels, income levels, and predispositions towards illness (Cruz-Correia et al., 2007). These overlapping characteristics and circumstances affect the type of care each patient needs. However, as patients come into medical contexts with nuanced concerns (Kongstvedt, 2012), they expect to be treated as a significant priority, just like every other patient (Sharf & Street, 1997). These expectations, which are subject to change under new social conditions, greatly fuel the paradigm shift. Therefore, other stakeholders that are key to health care systems are those who work directly with patients, in particular, medical doctors.
Doctors are a second highly influential stakeholder in medical care models. The perspectives of doctors and their patterns of behavior are largely important in medical care because they implement plans of treatment for numerous patients on a daily basis (Kongstvedt, 2012). Doctors are the gatekeepers of functional medicine, and sign off on patient plans and prescriptions while adhering to policies set forth by models of care and government agencies (Beisecker, 1990; Kongstvedt, 2012; Mishra, Anderson, Angst, & Agarwal, 2012). In essence, doctors are the liaison between the patient and the model of care. Therefore, the interpersonal communication that doctors and patients engage in influences how illness is constructed and how care is perceived and managed (Flocke, Kelly, & Highland, 2009). In essence, doctor communication styles influence the interaction between doctors and patients because doctors hold the expertise that patients seek. Just as every patient is different, so is every doctor.

The performance of doctor roles are outlined by more than just professional obligations, and are subject to traits within doctors’ personal identities, backgrounds, and affiliations (Mishra et al., 2012). Doctors operate in standardized models of care that privilege objectivity, however, there is a great deal of variation from one providers’ knowledge, style, and perspective to the next. Furthermore, doctors are not lone actors, but instead behave in response to their patients. Therefore, communication research has explored some consistent behaviors performed by doctors that illustrate optimal ways doctors can work with their patients, not just for their patients. I will now share research that has uncovered some best practices of providers, as identified by communication researchers who interviewed and surveyed patients. These studies offer an understanding of how important provider communication is, which will carry over into the following section where I interrogate how providers decide what to say to their patients based off of their individual philosophies of medicine - what they themselves believe to be true of healing.

**DOCTOR PATIENT COMMUNICATION**

Doctor-patient conversations are the most basic element of communication that takes place in the medical world, and is where understanding is attempted and healing begins (Thompson, Black, & Black, 2008). As noted earlier, some models of care privilege doctor-patient communication, while others do not. Still, the way in which doctors discuss and
advise their patients ultimately comes down to that doctor (Beisecker, 1990). The more a
doctor interacts with a patient, the more their relationship can develop, which enhances the
level of quality treatment patients perceive (Flocke et al., 2009). Unfortunately, research
indicates that patients, not doctors, often initiate communication between doctors and
patients (Flocke et al., 2009). In a study of 187 adult doctor-patient interactions, researchers
found that doctors only initiated discussions of behavioral health 60% of the time, even when
patients expressed worry (Flocke et al., 2009). This finding is concerning, especially
considering that the patient is the consumer and the provider is the vendor. Patients want to
feel like they are a part of the medical process, and doctor-patient communication helps to
build rapport that enables power sharing (Dutta-Bergman, 2005). Therefore, doctors should
not only be encouraging their patient to communicate openly, but should be proactively
picking up on signals that enable them to engage with patient concerns discursively.

Even in the biomedical models of care, doctors have always been encouraged to play
an active role during consultation (Engel, 1977). However, prioritizing patient wishes and
patient understanding of treatment options has been prioritized over rapport building during
movements towards patient-centered health care (Politi & Street, 2011). Prioritizing patient
wishes and patient understanding of treatment options requires doctors to be direct and to get
down to business whenever speaking with a patient. However, building rapport requires
doctors to be indirect and to build a personal relationship with their patients based off more
than medicine. Thus, the two seemingly like ideas of rapport building and patient-centered
care can come into conflict with one another via communication. Doctors can find a balance
between having a business relationships and interpersonal relationship with their patients via
communication.

In an ideal health care model, patients are the central priority, treatment plans account
for the health of the patient as a whole, and doctors and patients can communicatively build
understanding and trust (Gamst, Haahr, Kristoffersen, & Launso, 2006). Creating this
congruency in communication is the responsibility of both the patient and the doctor as a
team (Perloff, Bonder, Ray, Ray, & Siminoff, 2006); however, doctors also need to maintain
their authoritative role as experts (Kongstvedt, 2012). In essence, it is not enough for the
doctor to be friends with their patient, nor is it enough for the doctor to take full control over
the patient’s treatments; therefore what is needed is balance (Dutta-Bergman, 2005).
Initiating this balance begins with how the doctor presents him or herself, and many communication studies have identified narratives as the window into the doctors self image.

The Role of the Doctor Narrative

Doctor narratives are fundamentally at play during one-on-one interactions with patients (Eggly, 2002; Sharf, 1990). Narratives tell a story for the purposes of convincing or explaining, and often use recounts that explain the genesis of a justification and accounts that give reason to an argument (Fisher, 1987). Convincing narratives illustrate logic and provide symbolism, adding significance to human discourse, and are natural forms of communication (Bennett & Feldman, 1981). Therefore, it is common for both patients and physicians to utilize narrative when addressing concerns and plans, as well as in everyday life (Sharf, 1990, 2009). For this reason, research in communication and medical practice has continuously explored how narratives are constructed in doctor-patient relationships, how they enrich interactions, and how they are utilized strategically.

Narratives are crucial in medical interactions in both intentional and unintentional ways. Narratives typically have a “rhetorical objective,” and both doctors and patients have objectives that are different (Sharf, 1990, p. 226). For doctors, narratives typically aim to convince patients of a course of action based on a diagnosis, especially during medical interviews (Eggly, 2002; Gray, 2009). Doctors explicate their reasoning through narrative in order to make their perspective tangible for their patient. For patients, narratives typically aim to convince their doctors that the intensity of concern needs to be evaluated in a particular way (Chatwin, 2006; Sharf & Vanderford, 2003). Thus, patients validate their experience to their doctor via story telling that narrates their struggles and symptoms. The narratives of both doctors and patients generally provide clarity in their interaction (Sharf & Vanderford, 2003). Although narratives are natural modes of communication, they are not always accidental and can be used with specific intention.

Studies have shown that narratives in health care are used as methods for healing (Harter & Bochner, 2009; Ott Anderson & Geist Martin, 2003) and increase patient satisfaction (Ellingson & Buzzanell, 1999). Narratives also convey agendas, as well as beliefs, and can be used in clinical settings to educate and inspire (Bennett & Feldman, 1981; Gray, 2009). Doctor narratives may also be used “to illustrate ethical situations, professional
dilemmas and situations, and professional identity” (Gray, 2009, p. 267). Narratives are used strategically and colloquially by doctors and other medical care stakeholders to enhance the patient experience within particular contexts, and to convey organizational intent and structural change (Geist & Hardesty, 1990; Harter et al., 2010; Martin, Feldman, Hatch, & Sitkin, 1983). Moreover, provider narratives influence the prioritization of models of care that privilege quality care and interpersonal communication (Geist & Hardesty, 1990). In essence, doctors and other stakeholders articulate their advocacy for a particular model of care through narratives. Therefore, the way in which doctors and patients respond to one another’s narratives dictates how they move forward and enrich understandings of one another, care options, and illness meanings (Sharf & Street, 1997; Sharf & Vanderford, 2003). Therefore, narratives reveal a lot about intentions and aspirations for the needs of the future medical landscape, and thus the medical paradigm shift.

The use of narratives by doctors can influence patient perceptions of the systemic models of care as inviting, equitable, and safe (Ellingson & Buzzanell, 1999). Narratives can ease patient nervousness and confusion, and offer therapeutic comfort through communication that is palpable and easy to understand (Chatwin, 2006). Thus, narratives can be used strategically to transport patients towards agreement and compliance in meaningful and beneficial ways (Green, 2006). Where they transport towards, and what they comply with, all comes down to the content of provider narratives.

**Content of Provider Narratives**

The content of provider narratives is important to consider because they typically offer “think description” of their model of care’s priorities and culture (Geertz, 1973; Geist & Hardesty, 1990). In this sense, doctor narratives shed light on their personal and symbolic interpretation of the medical profession. Thus, doctors construct their narratives based on reasoning related to the model of care they practice. Furthermore, the way in which providers construct their standpoint via narrative illustrates their standpoint on health, and more specifically their aspirations and concerns for the future of health care. These aspirations and concerns construct their ideological positioning.
Provider Ideological Positioning

The ideological positioning of a physician situates their perspective within the medical context. Where ideology is defined as an “articulation and legitimization of certain forms of social reality” within medical contexts ideology “operates as discourse when individuals express what it means to be a professional providing quality care” (Geist & Hardesty, 1990, p. 259, 261). Provider narratives offer a vehicle for these ideologies, and the ideologies reflect intentions, ideals, and perspectives valuable to understanding how doctors view their role and the model of care they operate under. Provider narratives reveal the thought processes doctors follow to legitimize their prescribed methods, techniques, and struggles (Geist & Hardesty, 1990; Mumby, 2004).

Research on organizational contexts largely discusses how narratives symbolically influence organizational practice, culture, power, and identity (Mumby, 2004; Wilkins, 1983). Narratives reveal ideological positioning within organizations as members reflect on challenges within their field, voice concerns that discredit governing perspectives (Mumby, 1987, 2004; Geist & Hardesty, 1990), and react to changing climates while projecting expectations for the future (Howard & Geist, 1995). Moreover, research investigating narratives and communication styles in health care contexts reveal physician ideological positioning as elements related to “quality care” (Geist & Hardesty, 1990), “integrity” and “identity” (Corrias, Tagliabue, & Strepparava, 2010; Geist & Gates, 1996). According to Harter and Krone (2001, p. 67) there is a gap in research regarding how providers develop these ideologies to begin with:

Early medical socialization serves as a site of identity construction cultivating particular value sets. To date, research on medical socialization has focused on mainstream Western medicine, sometimes called "allopathic" medicine and practiced by M.D.s while neglecting other ideologies of health and healing that co-exist in our medical infrastructure and that are bound to influence socialization into the health profession.

Here, it is noted that the development of ideological positioning within health care is under-researched; moreover, research addressing non-mainstream ideologies is even less researched. There has been little research investigating what narratives reveal about the development of ideological positioning for providers. Nor does research address how providers from specific models of care situate their ideological positioning within medical paradigm shift. Considering the way IM provider narratives illustrate their ideological
positioning is a necessary next step in narrative research and organizational research because it has potential to indicate what providers believe, disagree with, and desire for their practice (Geist & Hardesty, 1990) and the future of medicine as it relates to the medical paradigm shift.

Previous researchers have uncovered how communication is maintained, challenged, and fragmented within different medical models of care. In all contexts, consistent and meaningful physician-patient communication has been highlighted as a significant component of patient satisfaction. However, it is clear that the standard models of care are not addressing patient needs, or other stakeholder needs, consistently. This has led to the medical paradigm shift. Fortunately, the exchange of narratives offers key stakeholder’s opportunities to learn about one another, build rapport, and uncover health concerns. Moreover, narratives have also been found to communicate fundamental ideologies and standpoints of health care professionals, which offer insight into how they conduct their practice and envision optimal care for their patients. One area that scholars have yet to thoroughly investigate is how physician narratives expose and construct the ideological positioning of physicians through communication. In particular, what do physician narratives reveal about providers who practice within particular silos? This information would significantly aid Health Communication scholars in understanding narrative medicine, and would contribute to the advancement of the medical paradigm shift as it pertains to specific sectors of health care delivery.

Therefore, in an effort to predict where the medical paradigm shift will go next, it is valuable to explore the content of provider narratives. More specially, it is critical to learn how the ideological positioning of providers are being communicated via narrative. Therefore, this research is designed to investigate how IM providers communicate their ideological positioning in the medical paradigm shift through an exploration of within narratives.

RQ1: How do IM provider narratives communicate their ideological positioning within the medical paradigm shift?

In the next chapter I discuss how the methods for investigating providers’ ideological positioning in narratives were researched methodologically.
CHAPTER 2

METHODS

This research is designed to investigate how IM provider narratives communicate their ideological positioning within the medical paradigm shift. In Chapter One I discussed how medical models of care have been assessed in communication research, how the medical paradigm shift has evolved, and explicated the necessity for studying ideological positioning of IM providers during the medical paradigm shift. In Chapter Two I outline the methods employed at the research site of this study. First, I will begin with a narrative that sets the scene of the Clinic for Care and Concern. Figure 1 seen below illustrates the Clinic’s garden.

![Figure 1. Labyrinth image.](image)

This will be the first of five Researcher Narratives woven into the thesis, which are all derived from field notes taken during observations at the center and when analyzing data. Each narrative aims to accent the study and serve as an example of how elements of the IM modality Yoga informed this study.

After the first Research Narrative, I share more details about the research site. Second, I describe the participants in this study and how they got involved in the project. Third, I outline the data collection processes and fourth I will dissect the data analysis processes. Fifth I foreshadow the representation of data in the results section of this study. I end this section with another brief Researcher Narrative that will transition into Chapter Three, where I present the results derived from the analysis of integrative medicine practitioner narratives.
SETTING MY INTENTION: RESEARCHER REFLECTION

It is 8:15am on a Thursday morning in January, and I am already running behind schedule. The drive from my house to the Center is typically smooth, however today I am commuting during rush hour. I exit off the freeway, and head up the hill west towards the Clinic. The road, which is wide like a highway, is filled with people, students, doctors, patients, and researchers all headed to work. As I wait to take the sharp U-turn into the Clinic for Care and Concern’s (CCC) small parking lot, I catch myself frantically drumming my steering wheel. I turn down the music, and glance in the mirror. I stop to observe the blank blue sky, take a deep breath, and feel my anxious spirits lift with gratitude for what lies ahead. I set my intention: to learn more than I knew before. Oh, and to not be late for this interview.

Even in my state of anxiousness, I know that Patricia and the Clinic staff would not want me to stress behind the wheel. They would not want my car or my heart to race over being a few minutes late. Stress, as I have learned during the past 14 interviews, is what drives so many problems with lifestyle and health.

The light is still red, so I take another slow breath in and out, roll my shoulders back, and stack my vertebrae. I think about what lays ahead. It will be my fourth time meeting Morgan, my participant for today, who is a provider at the Clinic. She is about Patricia’s size – around 5’5”, in great physical shape, Caucasian, sandy blond hair, early fifties. The first time we met was – wow - over 9 months ago when Kim, another provider, introduced us during an informal tour of the Clinic. Since, she and I have exchanged several emails and casually chatted about the research project as Patricia and I have come and gone from other interviews or CCC classes. I can tell she is a compassionate and hands on caregiver, but a private individual. I recon that she is not worried because she knows I am on my way; but I hate being late.

Deep yoga breath; in through the nose, out through the nose.

LIGHT STILL RED!!

I begin to relax I start to feel like I am simply late to meet with friends, rather than research participants; I start to feel less frazzled. This is not far from the truth; the last time I saw Morgan she anxiously greeted me with a hug and asked about my classes. Each time I
see Kim it is similar, and often at the doorway to her home. Patricia and I are definitely more than a research team; I hope she will vouch for my typical timeliness.

I glance at my phone to see if Patricia has texted me; yup. She just parked in the lot of the Clinic, which is tiny and probably beginning to fill up with this morning’s visitors, patients, and fitness center members. I imagine Patricia is either in her car refreshing her lipstick, walking the CCC’s beautiful Labyrinth, or she could even be inside already chatting with Kim or Jordan, setting up our next interviews or class visits.

Another exhale. Finally, GREEN LIGHT.

I u-turn, pull into the lot, grab a parking stub, and park my car next to the portable facing the medical offices adjacent to the clinic. Now at my trunk, I frantically gather my notepad and audio recorder. I lock the car then walk a long the path way towards the Labyrinth. I gaze west and peer out at the large body of water below. As I turn left towards the modest, two story building of the CCC, I turn off my cell phone.

Exhale.

The exterior architecture of the Clinic is pretty typical; the sharp edged walls are an eggshell-white with a royal blue trim. There are two stories to the building, however access to the different facilities – the consultation offices, to the labs, the fitness center, and the multi-purpose class space – requires going outside. I pass a few nurses and peer inside the bottom floor’s rest area to look for Patricia. With no sign of her I assume she is up in the main waiting area.

I quickly bounce up the stairs towards the main check-in desk, walk the external hallway past the elevator, then slow my pace as I enter the double doors. The inside of the Clinic is atypical, and I am greeted by a bookshelf packed with IM literature and upcoming lecture brochures, and the sound of melodic waves crashing. The waiting room is softened with sandy beige walls, turquoise accents, and upholstery engraved with flowing symbols reminiscent of the waves that crash the nearby shores. The energy is slow, but people are busy at the front desks. I greet the receptionist then glance over to find Patricia, already taking notes, coffee in hand. She smiles up at me.

Exhale.

“Sorry I am late,” I say.

“It is okay. I figured I would wait here for you and we can head down together.”
She packs up her journal, we wave goodbye to the receptionist, then head back down the stairs I came up from, towards the Fitness Center.

The vibe here is much more energetic than upstairs, and patients are all over the gym being trained in floor exercises and working out on treadmills below televisions sets displaying local news. As I observe, I have to remind myself I am not at 24Hour Fitness and actually at a hospital.

We check-in and wait to begin our interview with Morgan.

**DISCOVERING THE INTEGRATIVE IDEOLOGY**

This research is designed to investigate how IM provider narratives communicate their ideological positioning in the medical paradigm shift. Ethnographic and qualitative methods were utilized to collect data within the context of a Clinic that offers IM treatments.

**The Research Site**

The Clinic for Care and Concern (CCC) (pseudonym) is located in the southwestern United States. The Clinic agreed to participate in this research study with Internal Review Board (IRB) approval, and under the supervision of one primary provider at the Clinic. The Clinic is part of a larger medical system (which will be referred to as The Hospital) that operates under a standard biomedical model of care via five campuses, a network of clinics, and over 2,600 affiliated physicians. The Clinic houses approximately twenty providers, eight of whom are medical doctors (MDs), twelve of whom are nurses, integrative medicine providers (e.g., acupuncture, nutrition, biofeedback, guided imagery, healing touch, and hypnosis, to name a few), or instructors of IM classes (yoga, meditation, vegetarian cooking, Qigong, and Tai Chi to name a few). The Clinic serves over 2,500 patients monthly, who typically access the Clinic via referrals from The Hospital.

The Clinic stands apart from The Hospital by providing care that is based on a “whole person” approach to health. The Clinic was founded through the philosophy that “healing starts from within,” and aims to “blend evidence-based complementary and alternative therapies with conventional Western medicine in a ‘best of both worlds’ approach” (Collins, 2012). People visiting the center may be seeking treatment and relief for a range of illnesses, including but not limited to cancer, diabetes, heart disease, weight management, gastro-
intestinal concerns, acute or chronic pain relief, or stress; however, the Clinic began through an effort of bring IM treatments specifically to cardiology patients (Collins, 2012).

This thesis project was born out of a larger research study still being conducted at the Clinic for Care and Concern, and offers preliminary data to be expanded upon in later publications. However, the data and analysis presented reflect my personal efforts.

**Participant Information and Recruitment**

The nine participants of the study are all providers at the Clinic, however one additional Clinic staff person and one Hospital staff person were interviewed for basic informational purposes. Of the nine participant providers, three are registered nurse practitioners and six are medical doctors (MDs). Of the MDs, four are cardiologists, and two are family medicine practitioners. Every provider participant has additional training certifying them as an Integrative Medicine Specialist, and also has individually selected interests in oncology, pain management, acupuncture, biofeedback, hypnosis, reiki therapy, and other typical IM modalities.

Including non-provider participants, six providers were female and five were male. No age or racial demographics were officially collected for this study given its intimate nature, however based on physician narratives it is clear that at least three physicians identify as non-White or Hispanic, and all physicians are between the ages of 27-65 years of age. One participant was interviewed five times, three times formally and twice informally. This participant has aided greatly in the facilitation of this project and made themselves available for informal interviews as well as email exchanges that have been instrumental to this study. Two additional participants were interviewed twice due to their availability.

Participants for this study were originally contacted via email or telephone, at which time they were told the research topic, ideas, and agenda. The first three participants (including one non-provider) assisted me in gaining access to the remainder of the Clinic and in securing Clinic IRB approval. With that approval I was permitted to conduct a fifteen-minute presentation outlining the background of the research team and goals of the study in order to recruit more participants. After, the remaining eight provider participants made themselves available via email to set up interviews. During the presentation all participants were made aware that through the IRB approval, contract interviews could be recorded.
unless otherwise requested and that provider names, and other identifying markers, would be stricken from the record. Participants were also given the option to sign consent forms during the presentation, however only two providers did so during the interview. The two providers who signed forms did so before the research was formally presented to the group, after which consent became tacitly implied through participation.

Data Collection

This research reflects data collected in interviews, as well as ethnographically. I will now explain each method separately; however, the time I spent interviewing overlaps with the data I collected ethnographically. In this section I will preview how collecting data through interviews and as an ethnographer enabled me to analyze data and answer my research question through crystallization.

Interview Data Collection

During this study I conducted eighteen face-to-face interviews ranging from thirty minutes to an hour and forty-five minutes. I chose to conduct interviews for this study because they provide opportunities for researchers to ask open ended-questions (Ellingson, 2009; Tracy, 2012) which enabled my participants to narratively account and recount their perspective on topics related to my primary research question (Fisher, 1987). The data presented here comes from thirteen specific interviews; five were excluded because they were either not conducted with an actual IM provider or because the Interview Guide did not include questions relevant to my research question. Twelve interviews were conducted on the grounds of the Clinic, three interviews took place a one provider’s home, two interviews were conducted in a coffee shop, and one interview was conducted at another medical office within The Hospital. I also participated in two lectures held by the Clinic and three IM themed classes at the Clinic. Including interviews, lectures, and classes, I have conducted over thirty hours of research at the Clinic over a twelve month period of time (see Appendix A). Given the stipulations outlined in the IRB approval for this site, and the sites relatively small staff footprint, no provider table is included in order to protect the participants identities; however a sample Interview Guide reflective of all interview questions is provided in Appendix B.
Observational field notes were hand written on site, and then typed for analysis. Interviews were audio recorded, and later transcribed then coded for data analysis. I have collected over nearly five hundred pages of data; approximately fifty-five pages are field notes, and over four hundred and forty pages of audio transcription. All non-confidential paper documents that were collected during observations and interviews are in Appendix C. During each of my visits to the Clinic I also collected documents and archived newsletters that would aid me in further understanding the research site, or allow me to access more participants. Two documents in particular proved consistently helpful: the Clinic Class Schedule and the Clinic Weekly Lecture Series Schedule. These two documents pointed me towards lectures and classes where I could make contact with providers and write observational field notes. I have provided each of these documents in Appendix A-C of this thesis. No other documents have been shared because they did not offer information relevant to my research questions, and none of their content was included in the results of this thesis.

**Ethnographic Data Collection**

The incorporation of field notes in this research study was highly ethnographic. In this sense, field notes comprised of interview content and research site observations, as well as critical reflections and perspectives of the researcher. In ethnography, the researcher is considered an instrument of investigation that is consistently navigating and negotiating through a research site (Tracy, 2012). Ethnographic researchers immerse themselves into a culture or context, sometimes for years at a time, and therefore have the privilege of making “either-or” decisions about data collection and data interpretation, on the spot and many times over (Clifford, 1988). These ongoing person-based and context-based decisions qualify the research as an expert, permitting researchers to make informed interpretations and analysis.

In this study I was a *focused participant-observer* (Tracy, 2012), and entered the CCC with a researcher with a clear agenda. My methods were “highly structured and [were] often conducted for short periods” (Tracy, 2012, p. 237) that spanned throughout the year long study. While I established myself as an observation based researcher during all interactions, I was also given access to participate in classes, discussions, and lectures interactively. I asked questions and built relationships with participants in this study that extend beyond our
interviews. Therefore, being an ethnographic researcher allowed me to obtain data through an intimate connection with the research site, which gave me powerfully subjective tools for an analysis that is deductive. In essence, ethnographic methods contribute to both data collection and data analysis.

**DATA ANALYSIS**

Phase One of data analysis for ethnographic research begins during the first visit to the research site (Tracy, 2012). Therefore, the analysis of my research data has been evolving for over one year, from the time of the very first interview. The data has been evaluated multiple times over, informally and formally, and discussed by the research team and myself on numerous occasions. Moreover, employing both interview methods and ethnographic methods allowed me to analyze data through a “framework, a methodological path that I could follow that would enable me to construct and articulate multiple lived truth, rather than force me to choose among them” (Ellingson, 2009, p.xi). Thus, my data analysis was a process of crystallization, and utilizes both my “personal narrative work and my inductive qualitative analysis” (Ellingson, 2009, p.xi). Therefore, Phase One of data analysis proliferates throughout all subsequent phases of my analysis.

During Phase Two I individually added a method of “open-coding” to my existing analysis of the data. In this phase I identified places of “thick description” within provider narratives, and looked for thematic symbols that could be consistently recognized in all interview transcripts and field notes (Tracy, 2012). For example, when looking at one specific interview transcript I highlighted sentences based on a color code scheme so I could visually trace how frequently a word, topic, or theme was expressed. After applying the same color scheme to all transcripts I was able to quantify the frequency of each expression and identify commonalities and differences among the narrative content within each interview, and the collective body of interviews.

During Phase Three, I continued to analyze the narratives using the “Methodologies to Analyze Medical Encounters” outlined by Sharf (1990). The method is as follows:

- Define the encounter in the global sense; i.e. purpose, context, dominant issues.
- Carefully examine each story; search for organizational flow, topical categories, themes, and symbols. Make an assessment of how the story evolved during the interview applying evidence from discourse.
Evaluate “goodness” and effectiveness of the story based on its coherence, style, and quality.

Assess how the communication has or has not altered the stories co-constructed in the interaction (if there is more than one person speaking in the encounter).

(Sharf, 1990, p. 228)

This directive added a formula to my analysis of data within the provider narratives. The consistency of this method further enhanced my ability to identify the patterns within the narratives. Furthermore, applying this method to my analysis highlighted the strength and depth of the provider narratives, which allowed me to more easily categorize different narratives within transcripts (and the body of transcripts) that communicated an ideological positioning.

I completed my data analysis by probing final questions that I had as a participant-observer at the site, asking the way in which provider narratives shifted and fractured based off time, space, and among different participants/characters (Scarduzio & Geist-Martin, 2008). I took more reflexive notes and asked questions of myself in order to be more mindful of my interpretation process as an ethnographer and research instrument (Tracy, 2012). For example, I reflected on how the ideological positioning of IM providers could be the same, or different, from biomedical providers. I considered how philosophies of global healing traditions trickled into the narratives, even when a specific treatment modality was not being addressed. I pondered whether providers were directly or indirectly addressing the medical paradigm shift. Finally, I looked over all of my field notes and identified trends and changes in my observations; and considered how my own ideological positioning was changing and shifting as a result of my ongoing interactions with my research site. Those final assessments led me to my chosen method for data representation.

Data Representation

To represent that data I will use gender-neutral pseudonyms for all participants, and refer to every participant as a “provider,” whether they are an MD or a nurse. Given my research question, I will represent the data using exemplarily narratives that have been categorized based on a theme I identified during data analysis. This representation allows me to display how the collection of provider narratives share specific qualities that embody consistent themes. I identify each theme as a narrative quality, because each of the themes I identified contributes to the provider narratives as whole. Unlike a narrative dimension, or
feature, these qualities enhance the vivacity of the collective provider narratives, and the
significance of each narrative communicates function holistically and characteristically,
rather than compartmentally. Therefore, the following section presents the results of this
data analysis using in vivo titles, meaning titles that are based off of the words of the
participants to categorize each set of qualities (Olson, 2011). I also break each quality into
sub-categories based on the topical nature and subject area that each narrative quality
communicated about. This format was designed to illustrate the breadth of each individual
quality, as well as the overlapping aspects of the qualities as a whole.

Additionally, I further illustrate the depth that narrative qualities can offer by sharing
five of my own Research Narratives, which are my reflections from the field, and display
thoughts I have had collecting and analyzing this data while joining a local yoga community.
Moreover, I chose to include these narratives (the first of which opens this Chapter) for three
reasons. First, my Researcher Narratives are provided as a way of illustrating the analysis
process I underwent as an ethnographer. I share my own thoughts in order to walk you
through my interpretation process. My positioning as a research instrument cannot be
separated from my analysis of this data and is offered to add texture and style to the
remainder of this paper. Second, my Researcher Narratives are intended to mimic the
narratives of the providers. I share my own thoughts in order to provide you with an
opportunity to engage in your own interpretation process of a collection of narratives, my
narratives. Third, my Researcher Narratives are meant to exemplify integrative medicine at
work. As I will cover in Chapter Four, a limit to this study is that no patient narratives were
collected; therefore, during my Researcher Narratives I place myself in the shoes of a patient
who is practicing Yoga, an IM modality, in order to reduce stress. All in all, by including my
Research Narratives I aim to display how my own narrative reflects the ideological
positioning I approached this study with and how it developed throughout the study.

In conclusion, this data was collected through a multi-layered approach incorporating
interviews and ethnography. Therefore, data analysis, and data representation are multi-
layered as well. This multi-layered approach to all facets of the study suggests that a fusion
of art forms (Minge, 2006) greatly assists narrative research.
Finding Yoga Movement: Researcher Reflection

I went on hiatus for several weeks during the month of December. I needed to rest after that busy semester, and was feeling unmotivated and sluggish from work, and teaching, and school, and research, and life! I was anxious to return to a normal sleeping pattern, to my natural state of optimism, to working out, to having color in my cheeks. Furthermore, I was heading home for the holidays, and wanted to release my mind of analytical thoughts before arriving so that I could be fully present to my friends and family. The vacation began during my drive to LA to pick up my sister and girl friend of mine. Together we would drive home to the Bay Area.

My sister was looking great! So was my friend. Immediately, the two of them radiated with high energy, and I am positive it wasn't just excitement to see me. Why couldn't I sense the exhaustion they immediately picked up on me? We all work full time and are in school; how is it that they had avoided burn out and I had not?

During the car ride we laughed, revisited secrets, got advice, and updated each other on day-to-day tid-bits of our work and love lives. They had as many complaints about schedules and obligations as I did, but posed them as "circumstances" rather than "challenges." I had to find out why these two peers of mine were not exemplifying the same fatigue I was. All three of us have histories of anemia, and my sister and I have been tested for thyroid issues; but today it seems I am the only one letting it get the best of me.

It seems the two of them had begun practicing in yoga regularly, and balanced it with their typical beach runs and bike rides to get full mind body workouts in at least 5 days a week. That type routine was in no way foreign to me, but seemed impossible with my current workload.

"Just make the choice to create time for it." They simply said. "The result is a type of strength like no other." They were getting better sleep, had energy to join activities after work and school, and were even eating less fatty foods. They hadn't been sick that whole season and weren't missing work as a result. They attributed it all to yoga.

"It must be nice," I said with envy.

"It is! Just create time for it."

I was humored by that simple suggestion, and even more so by the fact I hadn't made time for it. Here I was complaining about stress and workload knowing that the choice to be
stressed was mine and mine alone. Worst yet, all of the work and studying I was involved in were implementing and examining relationships of education, work, and health. Still worse, I had witnessed the power that a healthy body has over a healthy mind, and was raised to privilege both equally. Why was I no longer integrating natural stress relievers into my day? Stress was showing up all over my body, and I had no one to blame but myself.

Why? “No time?” That is not a very good excuse. I spent the rest of the car gazing out the window at farms and cows, shaking my head. Two weeks later I joined many other hopeful souls in making New Year’s resolutions:

1. Go to yoga once a week.
2. Stop stressing.
CHAPTER 3

RESULTS

The medical paradigm shift evolving in the American medical system is inevitable for more reasons than the just the Affordable Care Act. From mainstream documentary films like "Sicko" (Moore & Moore, 2007) and "Escape Fire: The Fight to Rescue American Health Care" (Frömke & Heineman, 2012), to call-to-action articles like "Time Magazine’s “Bitter Pill: Why Medical Bills Are Killing Us”" (Brill, 2013), Americans are becoming more aware of the inter-workings of the medical care industry and less satisfied with the limited options of their health coverage. These exposés have fanned the already burning flames of the medical paradigm shift; however, few of them include substantial accounts from providers of medicine. The voices that are heard from least are the doctors, nurses, and medical staff operationalizing the paradigm shift; a task some equate to “rearranging the chairs on the deck of the titanic” (Ari I, p. 16). After all, it is the providers who are practicing within the so-called “broken system” (Frömke & Heineman, 2012) and forging the paradigm shift on a daily basis. Those voices deserve to be heard. Table 1 offers a condensed version of results.

Table 1. Research Results Table

<table>
<thead>
<tr>
<th>Narrative</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>Reflecting</td>
<td>-</td>
</tr>
<tr>
<td>Family</td>
<td>5</td>
</tr>
<tr>
<td>Nature</td>
<td>3</td>
</tr>
<tr>
<td>Divine Intervention</td>
<td>6</td>
</tr>
<tr>
<td>Interrogating</td>
<td>-</td>
</tr>
<tr>
<td>Doctor</td>
<td>3</td>
</tr>
<tr>
<td>Patient</td>
<td>4</td>
</tr>
<tr>
<td>Pill</td>
<td>4</td>
</tr>
<tr>
<td>Visualizing</td>
<td>-</td>
</tr>
<tr>
<td>Partnership</td>
<td>4</td>
</tr>
<tr>
<td>Collaboration</td>
<td>5</td>
</tr>
<tr>
<td>Holistic System</td>
<td>6</td>
</tr>
</tbody>
</table>

This research was designed to investigate how providers of integrative medicine (IM) communicate about the medical paradigm shift through an exploration of the ideological
positioning within their narratives. In this sense, this study was designed to give physicians a voice, and to ask the providers who are already working within a progressive niche of health care how their role complicates or coincides with the evolution occurring in the health care system. The providers of the study all work in the same Clinic for Care and Concern (CCC) and therefore share many similar opinions; thus, none of the accounts were mutually exclusive from one another. Nor are the in vivo categories of the narratives, which indeed blend and fold into one another, and illustrate interwoven considerations for where medical care has been, is currently, and will be in the future. This interwoven nature of the narratives indicates that the results of the study are qualities of the way in which IM provider’s communicate about ideological positioning. Qualities, like features, or characteristics, mark components of the IM provider’s narratives that enhance their richness and provide layers of perspective. There were three qualities of narrative identified in my results; reflecting, interrogating, and visualizing.

First, I will share the quality of reflecting, which was present in all narrative and communicated the initiation of my participants ideological positioning. Second, I will discuss the quality of interrogating, which legitimized their ideological positioning. Third, I will explain the quality of visualizing, which projected way that their ideological positioning can assist medical paradigm shift. Finally, I will transition into Chapter Four through two Research Narratives.

**Reflecting on the “Foundation”**

All IM providers in this study shared reflecting narratives on their own past experiences when communicating their ideological positioning. The quality of reflecting provided texture to narratives through memorial statements, recollections, and considers for how the past influences the present (Pianko, 1979). Reflecting narratives drew on personal circumstances and specific moments from the past; providers were able to lay the “foundation” (Ari II, p. 1) for their current position within the changing medical landscape. As providers reflected on experiences, they shared interpretations of what it means to “live in a healthful way,” and recalled lessons learned when faced with illness. Rather than reflecting on science, education, or otherwise “doctory” (Danny, p. 25) elements of their profession, providers told the story of why they pursued careers in medicine. Moreover, the reflecting
narratives all expressed that the desire to work within integrative medicine in particular has been embedded within the way they see the world since childhood; becoming IM providers was something the participants in this study came to for a divine “reason” (Morgan, p. 1). I will now share narratives of the participants that reflect and reveal their ideological positioning as IM providers in terms of (a) family, (b) the universe, and (c) spirituality.

**Reflecting on Illness in the Family**

Five reflecting narratives shared stories of being ill as a child, or witnessing a family member’s illness, and were used by providers to communicate how their ideological positioning formed. Reflections on their upbringing and significant moments set up the foundation for IM providers’ current positions as ambassadors of the medical paradigm shift. Moreover, these narratives establish that being a doctor was highly personal, and intimately related to their adolescence, home life, and identity (Gray, 2009). The narratives of three providers capture this type of reflection, and each describe the connections that providers drew between their family and their approach to medicine using stories of (a) culture, (b) motivation, and (c) loss.

“**My Parents Gave Me Herbal Medicine**”

One reflecting narrative was about being sick as a child, and noted the providers’ mother and father were instrumental to the formation of her ideological positioning on health. Moreover, Kim reflected on how her cultural upbringing initiated her intent to be a provider.

You will hear it is a God thing. When I was a little girl I used to get sick fairly frequently. I mean, not any super major illnesses, but I had the German measles, and every year I had the flu, usually around the holidays and big celebrations. It was really a bummer to get sick when everybody else was celebrating. I had to eat these special foods, and I had to sit there and lie in bed and have rice soup. Because my family is from Cambodia, my parents gave me herbal medicine; they tasted awful! But, they worked. This really impressed upon me how important health is foundationally. (Kim I, p. 2)

Right away this narrative communicates her path towards IM by reflecting on her first experiences being ill, and how “bummed” she would get when illness would disrupt her life. In this way her narrative indicates her ideological positioning because tying illness into lifestyle is a definitional component of the integrative medicine. Next she reiterates how her
parents remedied her illness using cultural traditions, and connects her family’s circumstance and culture to her understanding of what it means to be healthy.

Being sick, it all comes down to behavior, and effects you, and everything that you need to do, or want to do. Even as a kid that intrigued me. So, I determined that medicine was the field that I wanted to pursue from a really early age. I grew up in a very small town outside of Dallas, and my parents immigrated, so it was an adjustment for them to get used to the different cultural ways of the US. We lived in this smaller town; therefore we had a family doctor take care of us. We would see him for our well child checks, but rarely anything else; because my parents instilled within me that good health is about the foundations of living and eating in a healthful way. My parents did not believe in using medications. (Kim I, p. 2)

The above narrative about frequently getting sick as a child reflects in order to explain what it means to live in a healthy way. As Kim shares that diet and rest (opposed to having frequent doctors visits) shaped her understanding of health, she is really reflecting on the origins of her ideological positioning. Her family upbringing taught her that in order to “do what you need to do” you cannot rely on medication; this ideological positioning is consistent with that of the medical paradigm shift. Kim’s reflection also explains that her family’s approach to healing “intrigued” her, and helped her “determine that medicine was the field [she] wanted to pursue.” This was also true for Jordan, another provider whose narrative reflected on lessons he learned through family.

“He Lost the Will to Live”

A second reflecting narrative shared the story of when a loved one experienced illness. In his narrative, Jordan reveals how his father’s diet as a diabetic was not something doctors ever acknowledged. His recognition of the need to address diet illustrates his ideological positioning development. According to his narrative it grew from an observation of a doctor who relied too heavily on medication and biomedicine, which resulted in the loss of his father.

My dad was on all the “right” pills. He was on almost 20 pills. He had had open heart surgery for valve replacement, back surgeries, and had had all of this lung cancer stuff done. He had a defibrillator and he had a pacemaker. He had all these things, it’s crazy. He was on all the right medicines, and insulin, yet he still died. I was sitting there when he died just scratching my head, like, “where did we go wrong?” The problem was that not one doctor never talked to him about the unhealthy way he eat, what he was eating, what he was not doing for exercise, about his weight problem, he was morbidly obese. Without those questions or
hearing what he could be doing other than taking drugs, he lost the will to live.
(Jordan I, p. 2)

Jordan’s reflection on how his dad struggled with diabetes, weight, and heart disease, yet never counseled on “the way he eat, about what he was eating, about what he was not doing for exercise” narrates the development of his ideological positioning. Within IM diet and exercise are essential because they create good health, and because they provide an option outside of medication. The doctors that treated Jordan’s father did not discuss diet and exercise, and gave him no options other than medications. This resulted in two things: Jordan’s father’s untimely passing, and Jordan’s ideological positioning as an IM provider.

The diabetes just slowly takes away pieces of your life, and defeats you, and for my father depression set in. I didn’t recognize it right away. You know, there’s a lot of things that, knowing what I know now – God - things would have been so different. But you know, it was just too early on in my career. Still, that’s the defining moment for me. It really made me sit down and think about what I was doing, where I was going with my life. (Jordan I, p. 2)

Jordan’s narrative reflects on how his father’s death could have been prevented, but he became depressed without being given options for treating his diabetes. Jordan’s narrative shares how his own career path was set up through this experience; moreover, his reflection demonstrates how he first began asking the questions that are fundamental to IM providers and the medical paradigm shift at large. Rather than assuming that science, procedure, or drugs were the only “right” ways to address his father’s problem, he asked questions of medicine, such as “Where did we go wrong?” He also asked questions of himself: “Where am I going with my life?” This type of reflexivity is what led him to IM. Unfortunately, this was not the only narrative that communicated that loss in the family aided in the development of an IM ideological positioning.

“What Defines a Broken Heart?”

A third reflecting narrative on loss in the family establishes the root of another providers ideological positioning. Through her brief mention of undergoing loss, Ari underlines how a very personal, and unfortunate, family experience inspired her to re-conceptualize the human biology. This type of consideration is key to IM which sees the body holistically – mentally, physical, emotional, and spiritually (Horrigan et al., 2012; Snyderman & Weil, 2002).
I’ve kind of got a lot of loss in my early life. You know, I lost my mom when I was eight, my brother when I was 10; so I realized the importance of grief. When I work with my patients I really understand, you know? Because those losses got me thinking about what defines a broken heart? I realized through those loses that it is so much more than just, “oh gee, I have high cholesterol.” (Ari II, p. 2)

This reflection narrates how an encounter with loss initiated an ideological positioning on medicine that questions the health of the body with relation to the health of the heart. This provider’s unfortunate experience catapulted her into a philosophy of health that the medical paradigm shift is catching on to, as well. Instead of simply saying, “I became a doctor because I wanted to help people who were sick,” providers like Ari connected personal experiences within their close family to their position on health care. Furthermore, narrative reflections on family to communicate how their identity contributes to their professional practice (Gray, 2009).

These narratives of reflection on family laid a foundation for the providers’ approach to health care that allows them to get personal. Through these reflecting narratives providers revealed that their ideological positioning is textured by traits and experiences that began taking shape during adolescence (Corrias et al., 2010; Gray, 2009). Furthermore, these narratives indicate that the ideological positioning of providers is not based solely on professional ideals, but on ideals learned and processed over a provider’s non-academic, pre-professional lifetime. This personalization places the ideological positioning of the providers in line with the intentions of the medical paradigm shift to make healthcare more personalized and patient-centered (Brownlee, 2010; Fuchs, 1996). Compounded with these reflections on personal and individual interpretations of health, narratives also reflected on connections they see between individual health and the entire universe to substantiate this ongoing development of an ideological positioning.

**Reflecting on a “Planetary Thing”**

A second way that three of the narratives communicated IM ideological positioning was through reflections about the universe and nature. Through this type of reflecting narrative providers told the story of how they came to IM by linking elements of science and biology to care and concern for people (Horrigan et al., 2012; Snyderman & Weil, 2002). Making this connection between all living things is another vivid component of the medical
paradigm shift; therefore, these narratives link the IM providers to the shift. The narratives of the two providers capture the essence of this type of reflection by sharing (a) acts of recycling, and (b) interests in the super-natural world.

**“Healthy Nation, Healthy Planet”**

One reflecting narrative stems from an interpretation of health that stretches beyond the human species, out into the world at large. In sum, Ari’s reflection communicates a connection between her childhood inclination towards conservation and sustainability to her practice of IM. More specifically, her reflection highlights connections between social factors, environmental factors and physical factors; bridge fundamental in IM practice (Horrigan et al., 2012; Snyderman & Weil, 2002).

Integrative medicine means different things to different people. For some people, integrative medicine means, “I have acupuncture or I have biofeedback.” For me, it’s really embedded in the philosophy. It’s a holistic philosophy that says we have to look at a whole person, how they live their lives, the community they live in, their relationship to community, their relationship to the planet. You know, healthy people, healthy nation; healthy nation, healthy planet. It all goes together. That’s really the foundation for me. (Ari II, p. 1)

Here, the narrative bridges all aspects of life - from the “person,” to the “community,” to the “planet” – all into the “foundation” of her practice. Her reflection on how her perspective that “healthy people” influence the health of a nation and the health of the environment narrates how her ideological positioning is based in a philosophy of connectedness within the universe. Next, she reflects on how understanding these connections played out in her childhood activities.

I’ve always had, even when I was very young, an inclination toward global issues. Most kids have something as a hobby; for me that something was newspaper drives, and can drives, and collecting things for recycling. I was like, you know, 8 or 9 years old. People thought I was crazy! I would fill my family’s garage with newspapers from the entire neighborhood, and then take them to recycling centers. And yes, as a kid, you got some money for doing that; but it wasn’t a money thing. It was a planetary thing. I just always thought it was good to keep things clean, and to clean up after yourself. (Ari II, p. 2)

Ari’s narrative reflects that taking care of the planet was her first step towards becoming a physician, and initiated her ideological positioning as an IM provider. Her reflection on how she sees health as “a planetary thing” helps her to segue towards an
elaboration on how considering how multiple influences factors within her patients’ environments also affect her delivery of health care.

So I grew up with all of these influences. I also recognized that social economic status impact someone’s health. How can someone cook healthy if they can’t buy fruits and vegetables for their family because you live in the Ghetto, and every other store is a liquor store with only quick food and junk food? That is what goes on, you know? Kids can’t walk to school because their afraid there’s going to be a gang shooting and their neighborhoods aren’t safe. People can’t go to the park because drugs are being dealt there, and there’s potential for problems. From this perspective I could see that the determinants of health are not cholesterol; that’s just a piece of the puzzle. It’s social economic status. It’s how people see the world, you know? I had to really think about why they were hostile. Why are they angry or depressed? Or hopeless?ccSo all of these things, and witnessing all of these things have really made me say, you know, “We need to do medicine differently. We can’t just keep putting in stents and giving people drugs.” I mean, that’s what I was doing, but what we need to do is complete the circle of care…we needed to address, “how do we keep people healthy?” Then, when you start talking to people in your office, if you dare to ask the questions, you’re going to find it’s about their relationships. It’s about the stress of their children, stress of their grandchildren, you know? Things they can’t control, like finances. All of these things; like people losing their houses. I see it all in here, and if I’m seeing it here in this small Clinic, imagine what’s going on in the rest of the country!ccSo, seeing how all of these things connect just makes you wake up and say, “Okay, what can we do differently? How can we do this differently? (Ari II, p. 2)

Ari’s reflection here illustrates the influence that nature and the social contexts of the universe have on people’s health. Her narrative expresses her ideological positioning on how biological determinants of health, like “cholesterol,” are “just a piece of the puzzle.” Furthermore, her reflection communicates an agreement with the medical paradigm shift that aims to institutionalize considerations of health from broader perspectives. Another narrated perspective was even broader, and considered how metaphysical aspects of life influence health.

“A Star Trek Mentality”

A second reflecting narrative discussed the role of the universe in health by reflecting on his interest in the “metaphysical.” In doing so, he points out that being able to practice medicine with attention for the unexplainable “ways of the universe” defines his practice. The train of thought he follows is reflective of an ideological positioning that is consistent with IM philosophy.
I was a horrendous student... I popped around and bunch of different majors, and basically I had a calling one day. I heard a voice in my head that said, “You need to go to medical school.” So I said, “Ok, I will.” I mean, I acknowledged that that was probably the path I should have always taken, but I was just a lazy student and I didn’t want to spend the time going to medical school and all that. But when it came down to it, the things that I wanted for my life were in fact practicing medicine. I mean, it was a perfect fit. I wanted something that was lifetime learning, I liked to work with people, wanted to make a good living, and wanted do something to benefit all of mankind. I was interested in bioethics and the whole health realm... I was always kind of a goofy kid with strange ideas and, you know, interested in supernatural and whatever. All this strange sci-fi stuff. So that’s the paradigm that I came into medicine with; you know, this abstract, Star Trek mentality... I was very interested in metaphysical approaches, and the power of the mind, and the ways of the universe; so I was just very abstract in my thought process. I want to use that kind of thinking in my medicine. (Danny, p. 4)

Danny’s reflection on his attraction to “abstract” thinking communicated his stance on taking a holistic approach to patient care. Instead of simply saying, “I think about medicine abstractly and from outside of the box,” he reflects on how he tends to think abstractly about everything, including why he became a doctor. His abstract thinking about the universe and “the supernatural” is what led him to medical school and an ideological positioning that considers health in both tangible and intangible ways. Thus, Danny’s ideological positioning is much more than being a hardworking student, excelling in science, or knowing procedures; it is a career path that fulfills all of his life goals. As his narrative reflects, he communicates that he is supportive of the paradigm shift by substantiating an ideological positioning that sees healing as a philosophy, not solely as a practice.

For Danny and other providers, IM narrative is a vehicle to express a unique stance on medicine (Sharf & Street, 1997). His narrative communicates a desire to practice in a model of care that considers “bioethics” and aims to “benefit all of mankind.” These considerations directly ally those of the medical paradigm shift (Brownlee, 2010; Fuchs, 1996). Additionally, Danny notes that he heard a spiritual calling towards medicine; other narratives shared reflections similar to Danny’s reflection.

“Reflecting on a Divine Reason”

Reflecting narratives from six providers shared stories of how spirituality and destiny led IM providers to their ideological positioning. As Kim said, “it’s a God thing,” (Kim I, p. 2). Danny echoed her by calling his journey to IM, “a calling” (Danny, p. 2). Jordan, too,
said that in IM most providers come to the paradigm through a “defining moment” (Jordan II, p. 1). Another provider claimed there was “a divine reason” (Morgan, p. 3) she ended up in IM. However, two specific reflecting narratives accounted for spirituality through stories about (a) religion and (b) a shared vision.

“Trying to Figure Out My Own Religion”

In reflecting on how he became a member of the medical paradigm shift, one provider narrated his journey searching for a faith that was inclusive of both his mother and his father’s cultures. His reflection conjoins ideas of religious practice and health practice and places his ideological positioning alongside the concerns pushing the medical paradigm shift, which asks for spiritual and cultural considerations in health care (Dutta, 2008).

I grew up in Iran. I was born there. My mom and dad met when my dad was an exchange student and got shipped into Chicago. So my mom is from America, he’s from Iran, and they got married. I was born in Iran, but when we came back during the revolution I did not speak any English and therefore I was struggling to learn the culture. My dad is Muslim, and my mom is Baptist, so I was continuously trying to figure out my own religion. In high school I became very interested in Eastern philosophy, and so I think that was sort of the gateway towards understanding that there are many other ways of looking at things. So, I began doing meditation, yoga and Tai Chi. (Leigh, p. 1)

Here, Leigh reflects on how his spiritual exploration got him involved first hand with the modalities in Eastern medicine (and this IM), “meditation, yoga, and Tai Chi.” Through his narrative we see that religion was a gateway towards his ideological positioning in health. Next, his narrative of reflection bridges the Eastern medical paradigm with Western medicine to further substantiate his ideological positioning.

One of my professors said, “You know, you should do a medical internship in Asia?” . . . So, I spent time with Buddhist monks learning mediation, among Tai Chi practitioners, and with acupuncturists. I was visiting hospitals in Singapore, Guangdong China, and all different parts of that area. When I came back I was trying to figure out how to fit all this into what wanted to do, and I really remember that I felt like I needed to take what I had gained and bring it into Western medicine. So, through medical school, I was always trying to see how can I use the framework of wellness and prevention, and so I start the alternative medicine interest group for the medical students, and got doctors from around the community to come and talk about this emerging trend. (Leigh, p. 1)

Like the aforementioned providers, Leigh reflected on experiences – not scientific theories, equations, or data - to tell the story of his path towards his ideological positioning.
He knew that he wanted to bring his spiritual practices “into Western medicine,” and therefore associated himself with the “emerging trend” of IM. In this sense, his narrative reveals that his ideological positioning as a provider interested in integrating medical and spiritual practices for the benefit of delivering better medicine is affiliated with the medical paradigm shift. Another narrative also used spirituality to disclose her ideological positioning.

“You Won’t Believe What I Saw.”

A second provider, Andy, who shared a reflecting narrative about spirituality, spoke about her ideological positions as part of a collective vision. Her narrative indicates that her ideological positioning was not only guided by something sacred, but that visions she saw during mediation led her directly to the Clinic. Below, Andy reflects on a specific instance where she not only saw herself practicing IM, but how she experienced that vision alongside a colleague.

Our intent was to pray and ask guidance for the work we were about to do. All of a sudden I saw this holistic center for care. It is unbelievable how much information you can get with a short meditation! But what was interesting is that my colleague saw the same thing exactly! When we opened our eyes we both looked at each other and we had tears coming from our eyes. And we were both crying, and I said, “you won’t believe it what I saw!” She said, “I saw exactly the same thing.” Of course now we were so excited. . . . It was our calling to open up an integrative facility. (Andy, p. 16)

Here, Andy narrates how meditation provided her with a calling, and thereby demonstrates her ideological positioning within integrative medicine. Furthermore, her narrative describes how her meditation and ideology literally pushed her to take part in the medical paradigm shift and open a center for holistic health. Moreover, this display of reflection really captures what narratives consistently described in their narratives of reflections; their ideological positioning on health was something they could ignore because it was something they were led to, and something “foundational” within their understanding of the world, their understanding of health, and their understanding of themselves.

Overall, narratives consistently communicated IM ideological positioning within the medical paradigm shift through the quality of reflecting by sharing intimate experiences providers had that led them to practice integrative medicine. The narratives did not rely on experiences with clinical research or learning biomedical procedures, but instead reflected on
precise instances of clarity that occurred in the private and personal – rather than public or clinical - lives of the providers (Gray, 2009; Sharf, 1990). Reflecting narratives express gratitude and provide context to the ideological positioning of my IM provider participants. Although these reflecting narratives indeed overlap and fold into one another, through the categorizations of family, nature, and spirituality, it becomes clear that the IM ideological positioning incorporates all physical and imagined elements of self – mind, body, and spirit. Furthermore, understanding the compartmentalization of all of these elements also illustrates they way in which the medical paradigm shift aims to consider the health of patients more holistically, and calls for a health care system that attends to tangible, intangible, physical, mental, emotional, and spiritual needs.

The reflecting narratives of providers described personal inclinations towards integrative medicine in order to communicate the innate and fateful draw they have for the health care ideals that are consistent within the medical paradigm shift. These narratives explain what IM providers believe, and know to be true, as well as how they have come to understand their beliefs. Furthermore, these reflecting narratives laid the foundation for providers’ approach to healing, and foreshadowed moments of ideological resistance (Geist & Hardesty, 1990). In this sense, the stories shared in reflecting narratives buttressed interrogating narratives of resistance. Thus, the reflecting narratives about what defines their ideological positioning were accentuated by interrogating narratives about what does not define their ideological positioning.

**INTERROGATING THE PATIENT THE DOCTOR AND THE PILL IN THE MIDDLE**

In conjunction with reflecting on past experiences, provider’s narratives exhibited the quality of interrogating. Interrogating narratives offered thorough investigations, critiques, or reviews of ongoing concerns (Dutta-Bergman, 2005) about standard models of care, and the different types of ideological resistance IM providers have faced. Moreover, interrogating narratives mimicked the calls-to-action that have influenced the medical paradigm shift, and further substantiate the IM ideological positioning in line with the prerogatives of the shift. Through narratives about disapproval, provider’s interrogating narratives questioned power dynamics and systemic faults (Mumby, 2004). Specifically,
interrogating narratives problematized three main roles within medicine: (a) the “doctor”, (b) the “patient”, and (c) “the pill”.

**“Interrogating the Doctor”**

Five interrogating narratives communicated that being an IM provider was not only a calling, but part of a strategic decision to heal people in a particular kind of way. Being a MD or RN who has the ability to practice medicine “beyond science” is a part of the IM ideological positioning, and was a conscious and deliberate decision for my participants. For the providers, gaining knowledge about “more humanistic” elements of health as an IM provider was the only way they would practice medicine. Interrogating narratives explained that the biomedical definitions of what a doctor should be, or how a doctor is trained, or how a doctor is expected to practice, do not coincide with their IM ideological positioning. These narratives place the IM ideological positioning in sync with the medical paradigm shift because they communicate that being a part of biomedical institutions gave them a feeling of discontentment they had to call into question. In this sense, IM narratives interrogated what doctors figuratively represent in biomedical models of care in order to legitimize themselves as IM providers. Three representative narratives explicate these interrogations well by discussing (a) medical school and training, and (b) narrow-minded biomedical departments and physicians.

**“The Indoctrination Process is all About Driving Out any Free Thought”**

One interrogating narrative about being in medical school explained that training during that “indoctrination process” was formulaic. Interestingly, despite his distaste for the restrictions of medical school, he notes that it was the “algorithmic” aspect of the medical system that pushed him to seek IM on his own.

Before Med school, I was interested in a lot of other things. I thought about going into Osteopathy, I thought about going to Naturopathic school, and about learning Acupuncture; all that kind of stuff. It all seemed really cool to me. . . . I didn’t know where medicine was going to bring me, but I knew it would give me the foundation I needed to work. But, when you go through medical school, basically, you know, the indoctrination process is all about driving out any free thought, or creative thought, or anything like that. It’s very “boom, boom, boom - these are the ways that we do things,” very algorithmic. I really resisted it at the time. But you know looking back on it, that’s kind of the only way it can be. . . . And so I
make it through the first two years and then started clinical rotations, and I still have in my head that there’s a lot of other ways that I can do things. (Danny, p. 1)

Danny’s interrogation of medical school starts off as pure criticism, however quickly shifts into a realization of “that’s how it has to be.” As he narrates, he recognizes that some strict rules are needed in the medical practice. However, his ideological positioning to think outside of the box also needed a place to express free thought to consider “other ways [he] could be doing things.” Next, his narrative explains how he continued to feel creatively and compassionately limited in the rigid system.

In Medical School that gets driven out. I mean, you’re trained to see people as humans, but you’re just trying to be very objective and not get overly involved.... There was no reward for knowing your patient. There’s no reward for taking compassionate care. I mean some doctors notice and, yeah, you get a little pat on the back; but not as much as being a good student with a fantastic list of differential diagnoses and getting the job done. There’s not a lot of time for hand holding and all that.... By the time I was in my second year of residency I was super functional; I was an awesome budding physician. I could do all sort of procedures and was very good at what I did. I was the go-to guy on the floor, and I think I took really good care of people.... Still, I started seeing again this revolving door of medicine where people come in, they tell me they’ve got something, and I tell them, “Take this, do this.” It was basically, you know, the doctor-patient-and a pill in the middle scenario, and if you can’t solve it with a pill or a surgical intervention then there’s nothing you can do. I thought, “this is ridiculous.” There’s got to be something else we can do. I mean, I know that this person has reflux because they eat like crap, they’re not exercising, they’re stressed out of their mind. To me, it just got very unsatisfying to say, “Here, take this pill.” I didn’t like the fact that there was no real connection. I mean everything went through a pill or a procedure. I also just didn’t like the revolving door. I didn’t like the fact that as soon as I let them out of the clinic, I knew that they were going to go back out there and do the same stupid stuff that got them in here in the first place. And there was no mechanism in place to address any of that really. (Danny, p. 1)

Danny’s interrogation of relying on “a pill or a procedure” during medical training left even him, a “functional” and successful student, “unsatisfied.” His interrogation of the education in the biomedical model of care was not because it was difficult for him to navigate, he interrogated it because it offered “no mechanism” for treating patients with “compassionate care.” He knew that the training he was receiving did not fit his ideological positioning on medicine, and figured “there’s got to be something else we can do.” Therefore, he next expanded on how the limited “Western” medical training system forced him to take personal initiative in exploring more “natural” ways of healing patients.
So I started really looking in earnest at other things that were out there that had
previously had my interest and that ended up being things like Acupuncture,
Osteopathic Manipulation, just basically anything other than what I was being
trained to do. Natural Medicines obviously, I was always really into Natural
Medicines and also always really into nutrition. I mean, from the beginning, to
me, that was the big thing. Nutrition and this whole world that surrounds health in
our Western culture, from advertising to what we do, to our kids, to the politics of
what goes into animal husbandry, and the making of food that is not really food.
So all of that really appealed to me. (Danny, p. 6)

For Danny, medical school’s lack of attention towards healing the whole person, and
“the whole world that surrounds health in our Western culture” forced him to seek more
“natural” healing modalities on his own. His narrative interrogates how the biomedical
training program did not support his ideological positioning, so he sought guidance outside of
it. His interrogation displays how IM providers want to consider health from multiple
perspectives, and to treat it using more than one modality. His ideological positioning of
openness and complex problem solving is communicated via narrative and aligns Danny with
the medical paradigm shift. Another narrative also communicated her ideological positioning
by interrogating biomedical training systems.

“I Just Did Not Fit in With the Pre-Med Culture”

A second interrogating narrative continued Danny’s critique by discussing the off-
putting culture that the biomedical education system creates. This culture becomes engrained
in doctors, and creates a competitive atmosphere.

When I started college I definitely knew that I wanted to pursue medicine. But
we were required to take premedical prerequisites, and instead I wanted to go for
a more humanistic, kind of, “a whole person” approach. I was in a Medical
Sociology class and that was really kind of attracted me. At first I was
testing, “Maybe I’ll major in Chemistry or Biology” or something, but it was the
culture of those departments that didn’t fit with me. I didn’t like the culture of
those departments and I also didn’t like the culture of the Chemistry majors who
were intensely pre-med; they were just very, very number oriented and kind of
like, you know, “Get out of my way” type of attitude. I just did not fit into that
ego-driven culture. (Kim I, p. 3)

In her interrogation, Kim narrates how many departments in college supplement and
expand beyond the traditional pre-med curriculum, particularly Medical Sociology.
However, most pre-meds ended up enduring the more competitive “culture” of traditional
science departments, which created an almost elitist culture. The focus on the social
implications of health that Kim believed typical biomedical departments lacked led her to study in a department that embraced her ideological positioning. Her narrative situates her in the medical paradigm shift because she communicates a desire to extend her focus on health from science to all of society. Furthermore, she insinuates that most pre-meds are hardened, competitive, and stop thinking outside of the box before they even enter medical school. Thus, her interrogation of the departments that typically begin the qualification process for MDs was also an interrogation of her peers within those departments; and the culture they sustain beyond medical education. Other narratives also interrogated provider peers, and communicated that the inability of biomedical providers to think outside the box is unappealing to them.

“People Can’t Think Outside the Numbers”

A third interrogating narrative communicates that many biomedical MDs resist IM because they do not take the time to explore IM’s benefits; and do not take them time to “understand it” foundationally.

Most Western medicine doctors scoff, and look down, and talk about, and joke about complementary alternative medicine and integrative medicine and it’s honestly because they just don’t understand it. . . . Everyone kind of turns on their nose at this stuff when you bring it up. They think it’s like voodoo. . . . When I talk about what I’m doing with integrative medicine, I just get blank stares because nobody tries to understand it. . . . I think it is an ego thing. Honestly. It’s like, those medical students and other people are just too competitive, and people can’t think outside the numbers. It’s really ego, just the people who aren’t going to like take a second look at something else because it is natural. You know, because honestly in medicine when you say “Naturopath”, when you say “integrative”, when you say any of this stuff, you know, a lot of times it is still treated just like a joke. (Loren, 3)

Loren’s narrative on doctors with pompous attitudes continues the interrogation of the all-knowing role assumed by many doctors within standard models of care. His interrogating narrative was echoed by Jordan who said, “I still get teased by all the guys. You know, oh you’re a grass pusher, you’re herbal head, oh, ‘Go get some ferns’, whatever” (Jordan I, p. 4). In these narratives we can see that the providers of IM often have to take a defensive stance to legitimize their ideological positioning (Geist & Hardesty, 1990), simply because people are unwilling to think about patients beyond what they learned gaining that MD degree. These narratives position the providers in the path of the medical paradigm shift
through their communication of discontentment with the status quo. Therefore, the provider narratives didn’t stop their interrogations with the role or doctors, and extended their interrogations to include the role of patients in strict biomedical models of care.

**Interrogating the Patient**

Four of the interrogating narratives made specific critiques of the role that patients typically play during medical consultation; interrogating narratives communicate how this typical patient role contradicts IM provider ideological positioning. Moreover, these narratives interrogated how standard medical systems, and routine medical consultations, limit the level of participation and control patients have in decision-making. *Patients* in this case are figurative, as providers did not interrogate any specific individuals. Instead, their interrogations were distinctly of patients’ roles, and the way in which patients are expected, and sometimes forced, to passively obey standards within the biomedical model of care. The interrogations of patients narrate how IM providers privilege co-constructing medical interactions with patients (Politi & Street, 2011; Sharf, 1990); in this way their ideological positioning buttressed the way in which the medical paradigm shift advocates for more patient control and more inclusion of individual patient concerns. Essentially, the narratives interrogate how strict models of care do not share power with patients, which lead them to the IM model of care in which power negotiations are more balanced. Three narratives in particular interrogated patient participation in the medical system via narratives on (a) patient hesitation, (b) assumptions placed on patients, and (c) getting patients to help themselves.

**“Patients are Hesitant to Share Their Information”**

One interrogating narrative about the role of the patient discussed the amount of information patients do not, but should, share with their provider. From the ideological positioning as an IM provider, no information is too much information within doctor-patient consultations.

When we interview patients at the CCC we are looking for information about the body, mind, spirit, and emotions. You get so much information out of it. Traditional doctors who do not exchange in dialogue with patients are missing what’s most important. The basic things in a patients life are what is usually causing their illness. . . . When this place got started we said, “Gosh, we need to do more than just this heart disease,” you know. We found out that when we were asking questions such as, “what are you taking?” patients would list only
medications. Then we would ask, “are you taking any supplements, are you going to any alternative practices?” They would kind of stop and look at you, thinking, “Is it safe for me to say, ‘I’m going to acupuncture’?” And when they felt safe they would name all these other people that they would go to for treatment, and we had no clue otherwise. . . . Patients are hesitant to share their information initially until they felt safe, which the dialogue allowed. But how else can you provide whole person care if you don’t have all this information? So we said, “we need to do even more.” I mean, here we have a high-tech fitness center, we have a medical practice, we have CT scan, we have all this technology, we have yoga, we have meditation, healing classes, you know, we have sound healing, and music therapy. . . . Having all these things educates patients. We need the patient details in order to educate and counsel patients to consider, “what is the major thing that caused my disease?” You know, a lot of time it’s not the healthcare provider who finds that cause, but it is the person themselves. (Andy, p. 24)

Andy’s narrative interrogates how traditional biomedical doctors do not create safe spaces for dialogue with their patients, which limits the ability of the patient to identify illness causes. From her ideological positioning however, when providers listen to patients, and introduce multiple modes of healing (like yoga and meditation), patients can share and learn from the ideas they express with their providers. She interrogates the typical one-way communication where doctors decide what patients should do based off their symptoms in order to explain how her ideological positioning requires communication that is two-sided. Her narrative coincides with the medical paradigm shift because it seeks patients who want to discuss their care and experience multiple ways of treating their illness, not standardization. This requires that patient to take the time to share the “details” of their lifestyle, and explore the options available. However, according to the narratives, biomedical models of care do not have the same expectations for patients. In biomedical models of care doctors call all of the shots, so patients do not get a chance to share and explore. Therefore, narratives that interrogated the role of the patient providers also interrogated why it is not good to place assumptions on patients.

“Assumptions Get You Nowhere”

A second interrogating narrative highlights how patients often have barriers or concerns about treatment that doctors are not privy to, unless patients are allowed to be proactive when receiving care. Below, Teddy interrogates the assumption that patients do whatever providers prescribe for them to do. Through her ideological positioning she
communicates that it is incorrect to make that assumption, and that IM doctors question why patients may not be able to do as prescribed.

Here, we teach: if you exercise you will get better; if you meditate you will get better. We do this rather than prescribing a lot of medicine to cover up what patients are not doing. I think IM allows us to progress from a doctor to a care taker... It is basically the idea of “self-help deficit,” which says that people do not know how to take care of themselves; thus the role of the doctor is to identify that deficit and to teach them what they needed to know so they can take care of themselves. And that’s very much what Integrative Medicine is; it teaches the patient how to care for themselves. . . . I think the majority of what we do is prevention.... So, often the physician will outline what they want the patient to do, but we always need to do the follow-up; the more motivational stuff. “What are you doing right now? What’s going to get in the way of you changing? What do you want to do?” You know? . . . . Because what typically happens is the doctor prescribes something and assumes that the patient is going to do it because they told them to. Assumptions get you nowhere because usually the patient will come back and they’ve not done any of it for a particular reason. So, in IM you can say, “Why didn’t this get done, what are the barriers?” You can work through it with them so the patient actually can take the next steps to understand their condition themselves. (Teddy, p. 3)

Here, Teddy interrogates assumptions placed on patients, and the lack of attention typically paid to patient home life, and external reasons for their illness or their inability to prevent illness. Moreover, she interrogates the role of the passive patient, and uses her ideological positioning to advocate for patients to “understand their condition themselves.” Another interrogation of the role of patients narrated a similar ideological positioning that empowers patients.

“You Can Help Yourself”

A third interrogating narrative that discussed the role of the patient communicated an ideological positioning that patients and providers should have a partnership. This narrative minimizes the role of the doctor in order to “empower” the role of the patient.

For me, integrative medicine is not just about health. It’s about keeping people healthy. It’s about giving people choice, it’s about empowering people, about educating people, about partnering with people. Right? You know, I am not here to help you, I’m not here to fix you. I’m here to serve you, so that you can help yourself. (Ari I, p.12)

Ari’s interrogation of patient roles begins with a description of what providers are doing in partnership with patients, and shifts to what patients should be doing in response to that partnership. Here, the interrogation of patients communicates a call to action, and asks
for patients to see providers as teammates rather than saviors. This call to action reflects the medical paradigm shift. However, in order for the roles of these teammates to come to fruition, the medical system at large that they operate within must also undergo interrogation. Therefore, a third way that providers used their ideological positioning to narrate interrogations was by questioning the role of the biomedical system; also referred to as the pill.

**Interrogating the Pill**

Four narratives interrogated the “pill” when communicating their ideological positioning. The standard biomedical medical care system (which includes hospitals, doctors, insurance companies, and pharmaceutical entities) is labeled a *pill* because it is a system designed to prescribed medication for treating disease, as opposed to a system designed to prevent disease. Thus, the biomedical system is like the pill it often uses to treating disease; it is a system that does very little to foresee, and prohibit, potential disease. Contrarily, integrative medical care systems practice prevention and teaching – they are behavior that should come before the pill. This, interrogating narratives discussed how “the pill” assists patients too little, too late. These interrogations also fit into the medical paradigm shift, which is essentially a reaction to the malfunctioning of the pill, and the entire health care system at large. Two specific interrogating narratives illustrate how providers spoke of the pill in order to communicate their ideological positioning.

*“Only Allopathic Medicine Focuses on Disease.”*  

Narratives interrogated “the pill” for several reasons. However, one of the most vivid criticisms narrated was that the medical system does not support prevention of disease. The below interrogating narrative articulates how frustration with the pill led to the inception of the CCC.

The vision of the Clinic is healing people and changing lives through science and compassion. We want that combination of everything evidence based plus healing through love and compassion, coming from connecting on the human level; where tech meets touch. We were extremely naive at the time of inception of the Clinic because we were talking about health and lifestyle change and wellness in a system that makes all its money on diseases; and it is still today. God willing it will change. But medicine is incentivized; physicians are incentivized for doing things for people, right? If you’re a cardiologist that practices lifestyle change versus a cardiologist that’s putting in stents, the lifestyle change cardiologist is
making maybe a third of the money, maybe less. Right? So the whole incentive is to build and to do, as opposed to prevent and to teach – which, by the way, is doctor means teacher - to teach, to educate, and to focus on health. So a lot of people in the beginning thought integrative medicine was about substituting things. You know, like, “instead of my chemotherapy, I’ll take herbs.” That’s absurd. Instead of my statin, I’ll take red yeast rice. Really, IM has got nothing to do with substituting what people need. (Ari I, p. 3)

Here, Ari interrogates how the medical system justifies inattention to preventative measures, and explains how IM attempts to fill in that gap. Her narrative communicates that IM’s ideological positioning is one of teaching and prevention, not one of substituting the acute care tactics that save lives. Next, she interrogates how the methods of prevention that exist and could better assist patients are plentiful, yet the biomedical hospital system, the “pill”, does not integrate them into routine practice.

We have to recognize that there are global healing traditions in the world, and these global healing traditions are called traditional Chinese medicine, Ayurvedic medicine, Homeopathy, Naturopathy. Then there is allopathic medicine, which is what I was trained to do in medical school. So all of these global healing traditions have value; but only allopathic medicine focuses on disease. Every other global healing tradition says prevent the disease, right? And the best physicians are the ones that prevent the disease, not wait until someone is so sick, and then you have to do all these things to stop what never had to start. So that was what initiated my involvement in IM…and slowly as it started to evolve it became very clear, right from day one, there was no money to support what IM was doing. There was no insurance company that would pay for me to teach you how to eat, or would pay for your exercise. However, if you had a heart attack or stent first, then they would pay for the cardiac rehab. . . . The hospital system, even though it says it’s a nonprofit system, does not care for prevention. (Ari, p. 4)

Ari’s interrogation of the “pill” illustrates that the ideological positioning of IM is not unique to medical practices globally, but indeed under-utilized in the “allopathic” centered system in the U.S.A. As communicated in this narrative, narratives positioned IM providers in the medical paradigm shift through their dissatisfaction with the standard biomedical system, and by utilizing all the modalities possible to treat illness without concern for cost. However, additional narratives of interrogation further legitimize their stance in the medical paradigm by commenting on biomedical physicians who do not even try to understand their IM ideological positioning until they have to experience it firsthand.
“I Do Not Want to Just Give You Pills.”

A second interrogating narrative about “the pill” told a story about an experience Jordan had helping a patient; this patient happened to be a biomedical doctor. In his narrative he juxtaposes the medical consultation flow that his biomedical colleague expected with his ideological positioning on what consultations should look like.

One of my best tools is when I get an administrator, or a physician to come and be my patient. Then they get it! . . . That’s also one of the biggest honors you can get, when another physician requests to see you. . . . About a week ago I had a neurologist call me up and she’s like, “You know, I’m having palpitations, do you mind seeing me?” So I said, “Sure, come on over.” So she comes over and I spent about an hour with her. I went through everything but her palpitations because it’s everything else that causes them. So we spent a lot of time talking. The she says, “how do you do this? You spend all this time and you not once looked at the computer or looked at your paper? You just talk to me?” And I’m like, “it’s because that what we do here. That’s listening to your patient, that’s the whole caring for the whole person, you know?” I’m like. “the palpitations are easy. I’ll get a test, I’ll get an echo, I’ll test you for that. That’s what I’ve been trained as a cardiologist to do. But it’s much harder to figure out why you’re truly in this situation, what else is going on, what else could be contributing that kind of thing. I do not want to just give you pills.” She totally walked out with this epiphany. An orthopedist who is real sports guy, very hard core, also came in. Orthopedists are typically not into this kind of stuff either, but now this guy is one of my biggest megaphones for promoting this place. Because he met me and he was totally changed. He got it. It’s interesting. Our best tool is to have other physicians experience it. (Jordan I, p. 9)

Jordan’s interrogation of “the pill” illustrates that for many biomedical providers understanding a different type of medical system, and a different way of “caring for the whole person,” requires experiencing it firsthand. According to the narratives, the entire medical system restricts the cultivation of patient-centered healing, and does not give people an opportunity to experience IM without deliberate requests. This ideological positioning aligns with the medical paradigm shift because the shift aims to standardize access to alternative options of treatment like IM. Narratives communicate that through experience other providers can learn their ideological positioning. In this sense, the interrogations made by the providers were a jumping-off point towards their recommendations for fixing “the pill.”

Like the quality of reflecting, the quality of interrogating created narratives that overlap and fold into one another. The role of the doctor is informed by the role of the
patient, and the patient role is informed by the pill, and the pill is informed by the patient and
the doctor, etc. Unlike reflecting narratives, the interrogating narratives communicate how
providers legitimize their ideological positioning through explanations of how their
perspective differs from the status quo. In this sense, the interrogating narratives parallel the
mission of the medical paradigm shift just as reflecting narratives do, but this time through an
explanation of what they do not believe or agree with. These narratives set IM providers up
to make recommendations for how to fix the standard medical model of care, which they
communicated through visualizing narratives.

**Visualizing a “New Era”**

A third quality within IM provider narratives was visualizing. Through cogitation or
articulation, visualizing narratives communicated IM providers’ desire to fulfill an intention,
or accomplish a goal (Ayres & Hopf, 1989). Therefore, visualizing narratives directly
addressed the medical paradigm shift that is evolving by offering ideas for how medical care
can be improved based off of IM ideologies. In particular, visualizing narratives
communicated a desire for a standard model of care that (1) incorporates partnerships with
patients, (2) enhances collaboration among colleagues, and (3) is managed more holistically.

**Visualization of a Partnership with Patients**

Each visualizing narrative necessitated for doctors to, “make human connections”
when healing people, and communicated an ideological positioning that prioritizes building
relational partnerships with patients. Partnerships for IM providers were more than fleeting
conversations; they provide interpersonal alliances and confidence between providers and
patients through communication – alliances providers learned to appreciate in their past, and
saw lacking in medical models of care. The opportunity to building connections with
patients is what inspired providers to pursue IM in the first place; thus, visualizing narratives
extended reflecting and interrogating narratives foreword. Three providers in particular
communicated their visualization of partnership via narratives about (a) helping patients
control their illness, (b) encouraging collective decision-making, and (c) playing as a team.
“Illness is Under Better Control Because of the Partnership”

One visualizing narrative about partnership recommended that having a human connection between doctor and patient should be a consistent expectation. By emphasizing the importance of this human connection, Ari uses her ideological positioning to communicate what she imagines for the future of medicine.

There has to be a level of expectation. You know, as a patient you’re coming in and you’re going to go see a doctor, or somebody, you believe can help you. And you come to a place that looks good. It’s a healing environment, but more importantly, you psychologically decide that this is a place that can give you your health. And then, for the relationship between physician and patient to be didactic - it’s amazing! Physicians that are perceived by the patient as being empathetic, those patients have better cholesterol levels, better blood sugar levels. For patients with diabetes, illness is under better control because of the partnership. . . . Witnessing all these things has really made me say, “you know, we all need to do medicine differently.” We can’t just keep putting in stents and giving people drugs. I mean, that is what I was doing before. But we need to complete the circle of care; which is what led me to IM. I asked, “How do I keep people healthy?” And the answer is, “by talking to people in my office to getting to know them.” If you dare to ask the questions, you’re going to find that patient illnesses are about their relationships. It’s about the stress of their children, stress of their grandchildren, you know, things they can’t control: finances, all of these things. I mean huge things. I mean people losing their houses. I mean, I see it all in here. . . because I ask. (Ari II, p.4)

Here, Ari clarifies the benefits of establishing a partnership with patients that typical strict models of care are not afforded. She explains that if more doctors asked themselves “what can I be doing differently?” building connections through a “circle of care” with patients would be the answer. Through this narrative she visualizes creating relationships in her own work so that she can learn as much as possible about her patients, and be able to communicate genuine “empathy,” which ultimately matches her ideological positioning. According to another provider, Jordan, “patients feel the benefits of conversations with their doctor and want the integrative way of practicing medicine. . . . In an ideal world, every specialty would be integrative; everybody wants to be integrative” (Jordan II, p. 4). These two narratives offer a vision of prioritizing patient needs as a way that established the IM ideological positioning within the medical paradigm shift that aims to enhance patient involvement in medical practices. However, these visualizations require both the provider
and the patient to be held accountable for the healing process, and necessitate a shared-decision making process that other narratives elaborated on.

“A System for Shared Decision Making”

A second visualizing narrative that recommended stronger partnerships between patients and providers explained how prioritizing communication can get buried unintentionally, even in an IM setting. Leigh’s visualizing narratives imagines better ways he himself can reinforce his ideological positioning by empowering patients to take action. His narrative explains that having a partnership with the patients allows everyone to feel more accountable for their role, and is the only way to address the root of a patient’s illness.

I had an instance with a patient who was being seen by a number of doctors and myself for injections, medications, fibromyalgia, and low back pain. She was in a wheeled scooter. What the instance taught me was that collaboration was failing. Everyone was doing things to her, but she wasn’t doing anything for herself, and we were enabling that. Not that it was her fault, but I remember vividly when I told the secretary to have her come back, and this was probably four months since the last visit. And by then she was morbidly obese! Her surgeon said she needed to lose 80 pounds before getting breast reduction surgery, which was causing her back pain. But she couldn’t exercise from the pain and the weight. She had all these barriers overlapping onto one another. Finally, I said we have to stop talking about the pain and start talking about your life, and your body’s metabolic workings. (Leigh, p. 8)

Here, Leigh’s discussion of a patient who was never addressed about the connection between her ailments indicates his desire to partner with patients more directly. As he explains it, all of the doctors on her case were “partnered” to help her, but she was not included in that partnership and therefore “wasn’t doing anything for herself.” His narration of an ideological positioning that wants patients to be looped into the medical process aligns with the medical paradigm shift which aims to get patients more proactive with their own health (Brownlee, 2010). As his narrative explains, including patients in partnership positively impacts their response to care.

We told that patient, “We cannot change that you’re overweight at this point, what we need to do is change your metabolism.” So, she was one of our first clients for this I-Fit model of care. She began wearing this I-Fit armband everyday. It is a body media brace on her arm that reads her caloric burn rate 24/7, tells us how well she sleeps or doesn’t sleep, and monitors all of her dietary measures. Me, the dietician, the exercise physiologist, and the behaviorist can all see data in real time no matter where she is. Through it’s technology we can give her suggestions online, too. She’s lost 50 pounds in a very short, I mean in a
rational period of time, after entire life of never been able to lose significant weight or keep it off! Today she is getting closer and closer to getting her surgery. I wouldn’t blame it all on poor collaboration, but the previous collaboration was typical. “Hey, her back is hurting, can you do an epidural?” Then, “Ok. Sure Doc.” The collaboration was: the patient is here, and the collaboration is all the way over here. We can call that integrative, but it’s actually very fragmented. Until the patient was brought back in and told that the real issue is needing to get her lifestyle back in order, and that she needs to be out of the scooter and on a treadmill - until then, nothing changed. I mean, it choking me up, but that’s where integrative medicine, I think, can sometimes become more about the modalities and less about the patient. And that’s a real fear of mine, that we have all these great tools and practitioners, who all do their great little thing for the patient, but they’re not really doing it with the patient. There has to be a system for the shared decision-making. (Leigh, p. 9)

Leigh’s narrative visualizes a medical system that maintains a partnership with patients while also collaborating with providers. He fears a system that is “more about the modalities and less about the patient.” His visualization fits into the ideological positioning of the medical paradigm shift through his critical analysis where collaboration among providers can disrupt communication with patients. As he discusses how often times, “the patient is here and the collaboration is all the way over here,” he visualizes a closer partnership between all people involved. His vision is for medicine to move away from doctors working for the patient, and “not really doing anything with the patient.” As he narrates, “until the patient [is] brought back” and made a partner in the decision-making process little healing is achieved. Another provider who narrated that doctors and patients should work as a team also visualized partnership.

“A third visualizing narrative came from Kim who hopes that the Affordable Care Act (ACA) will facilitate better relationships between providers and patients. Her narrative visualizes the ACA as a part of the medical paradigm shift that can enable teamwork.

Most physicians get 10-minute visits or 15-minute visits. That’s ludicrous to me! As someone trained in Family Medicine, where you’re supposed to be the quarterback of the patient’s team, that is just crazy to me! How are you supposed to coordinate their care, oversee their continuity of care, manage all of their chronic diseases, and take care of all their preventive needs, all with just once a year visits? You know, this is a model that is not going to be sustainable in the long run. I’m hopeful that with the ACA healthcare reform things may change, but there’s really going to be so much +backlash. It is like moving the Titanic. That’s behind the scenes, and what’s going to be very challenging, however it’s a
The Canadian healthcare system is very interested in offering integrative services and there are some major philanthropists who are trying to bring more of that model of care. People here have visited Canada to meet with the people interested in making things happen there the way we do things here. (Kim III, p.18)

Kim’s narrative indicates that she is perplexed by the time constraints on the typical medical visits in strict models of care, which leads to her visualization for the ACA enabling change. She narrates that the ACA is a “start” to getting biomedical providers in a position that is more like the “quarterback” all primary care providers are theoretically trained to be. This football analogy places the provider and the patient in a partnership. Furthermore, by noting how health care systems internationally are attempting to incorporate IM into their systems, her narrative visualizes that IM can facilitate other types of partnerships; not just with patients, not just nationally, but globally. Thus, her narrative envisions the CCC in partnership with other entities that share it’s ideological positioning on health care. This narrative imagines partnerships between doctors and patients, as well as between doctors and doctors. Other narratives also visualized this type of working partnership, and termed it collaboration.

**Visualizing Collaboration with Colleagues**

Five visualizing narratives aspired for more provider collaboration. *Collaboration* in these narratives involves having a teammate-like working relationship with other providers and stakeholders in medicine; not just with patients. Narratives visualizing collaboration are separate from partnerships with patients because they are not strictly working relationships, and would occur more regularly, and on a daily basis. Narratives visualizing collaboration communicated a desire to work alongside providers they know personally and can bounce ideas off of, with whom they can address mutual patients comfortably and consistently. Narratives acknowledged that collaboration did exist in the CCC because its primary mission is to be integrative; however, their narratives also suggested that collaboration between doctors at the CCC could happen in a more systematic way. Four providers highlight visions of collaboration via narratives about (a) referrals from the Hospital, (b) camaraderie among teammates, and (c) valuing access to multiple perspectives during problem solving.
“We Need to Send Them Over to Integrative”

First, Loren’s visualizing narrative shares what he thinks is working as far as collaboration. From his perspective, doctors outside of the Clinic do to appreciate the unique way in which the Clinic contributes to the patients; however, he admits this is not the case everywhere.

I don’t know all the ins and outs of communication between the CCC or the Hospital, but from what I see, the doctors outside of the Clinic are not like the doctors I dealt with in residency. They all know the Clinic, they all love it, and they send their patients here. We’ll joke about it, too. Like, over at the Hospital they’ll present difficult patients in a conference, and say something darned, like, “We need to send them over to integrative.” Or they’ll say, “You know we sent this guy to integrative and we were all amazed at the results.” . . . It is because here in the Clinic, we see a patient and then we say, “They need X, Y, and Z.” Well, for us X, Y, and Z is often right down stairs, or across the way; so immediately we call in the request and the patient can go get their training, or therapy. Then, if needed the doctor down there can call me, or page me, and say, “I just got this person on the treadmill and they’re not doing well.” So, instantly I can know, and can even go down there and see for myself. So there’s always this communication going on with each other. (Loren, p.11)

As Loren narrates how primary doctors in the Hospital appreciate the Clinic and collaborate with the Clinic, he establishes his ideological positioning that collaboration between medical entities is necessary within in the paradigm shift. He also narrates how providers at the Clinic collaborate with one another and discusses that, ideally, collaboration would become more widespread.

Most of the communication here is on autopilot. It’s only when there’s an issue or something is not going right that they get you involved. But they get you involved fast. Everyone is very good about communicating – even if it’s just “spitey” sense that something is a little off about somebody. Here, people are very good about getting in touch with the necessary person and letting us know that something is not right. It’s very tough to practice integrative medicine in a place that’s not integrative; not just related to the way you deal with patients and how you assist patients, but anything else regarding that communicative component that exists here I think, no matter what, you have to have an integrative team in health care. Everybody has to be on board in order for everyone to be on the same page. If I leave and go to a general cardiology practice and I’m like, “Oh, what this patients really needs is Cardiac Rehab,” well, the closest Rehab maybe like 20, 30 minutes away; somewhere what we have never had contact with, unless I go digging for it. So that’s where it gets tough. I want the type of communication model here at the CCC everywhere I work; it’s been very easy here, honestly. (Loren, p. 12)
Loren’s narrative explains that at the Clinic people can get in touch with each other on a need to know basis. Furthermore, he narrates that in order for collaboration to occur, and for patients to get the help they “really” need, all health care teams should be integrated. He narrates that the collaboration occurring at the Clinic is more than most hospitals get, and visualizes the connected communication network exemplified at the CCC being standardized. Other narratives visualized how connections internally could stand to be even stronger, and narrated that in order to match the ideological positioning of IM collaboration should occur more systemically within the Clinic.

“A Feeling of Camaraderie”

Teddy’s visualizing narrative notes a perspective similar to Loren, and expresses that many collaboration moments happen on the fly at the Clinic. She envisions collaboration happening more fluidly. According to her narrative, the biggest issue is getting the right person at the right time. As the Clinic grows, getting to that “right person” and knowing exactly who they are has become a task impeding upon camaraderie. Like Loren, Teddy feels like the Clinic collaborates smoothly ad-hoc, but she visualizes collaboration “in teams” more often.

The biggest issue is maintaining a feeling of camaraderie, enjoying being here, you now? When I first started here it was a lot of fun. People really liked each other and we had a good time. But that was a much smaller group, 15 to 30 people. That is a lot easier to deal with than now; we have like 70 to 100 people now, I think. It is just a bigger group, and the financial environment is very different as a result. Before, every week we had an hour or so staff meeting where people sat around and had a great time. We did actually get a lot of business done at the staff meeting, too because you’d say, “Okay after the meeting I want to talk to this person about this patient,” and we’d just get it done right then. Now there are so many of us you can’t just count on seeing the person you need, and not everyone makes it to the meetings. There’s so many of us now we cannot regularly meet like that. We don’t have that opportunity. . . . That’s affecting the patient care; all things boil down to that patient satisfaction, and our intention to heal. . . . I’m just now thinking, you know, maybe one way to help people get some more of that excitement and collaboration out of the workplace is to be able to have some involvement with creating the conferences and maybe participating in them. Leading a workshop would be something that would help get other members of the staff together and involved in a positive way, and then people would get recognition for their expertise, and others could get excited or involved in what they’re doing. (Teddy, p. 14)
For Teddy, collaboration in the Clinic has been reduced because “camaraderie” is reduced. She notes that “you can’t just count on seeing the person you need” because of the growth of the Clinic. Through her narrative she visualizes gaining staff members “involvement with creating the conferences” as a way to get more team members in sync. She believes that staff participation could enhance their “excitement and collaboration” which is necessary in all settings, particularly IM. Although collaboration in the Clinic happens informally every day, “in the halls” (Morgan, p. 7), and “minute by minute” (Loren, p. 10) when dealing directly with patients in distress, that it is not enough to maintain “a feeling of camaraderie.” The lack of collaboration is “affecting the patient care,” which is the top priority of IM (Horrigan et al., 2012). Thus, through her narrative we learn that Teddy visualizes streamlined collaboration, which would enable the “expertise” of providers to get “recognition” from peers. Other narratives agreed that input and feedback from peers were essential components of their ideological positioning and their vision for future medicine.

“Different Ways of Looking at the Same Problems”

The third narrative that visualized collaboration pinpointed the weekly physician meetings as a missed opportunity to make collaboration happen more interpersonally. This narrative communicates how collaboration among providers facilitates providers’ ability to approach patients holistically.

We used to dictate patient background, but now that has moved to a different kind of communication via electronic medical record system, which is required. Now we mostly just type all the information from all our visits. It takes a lot of time and doesn’t leave time for in-person chats. It’s hard enough to get all our work done, and so that system has broken down some of the previous communication opportunities in my opinion, because we are each getting a little burned out… Probably the most consistent or systematic way we would communicate with one another is by email where a lot of details are lost. Even though we all work here together, we have our different schedules, so the best way to catch each other is via the virtual space. I would like to also have a parallel track where we’re able to spend some quality time in team building on a person-to-person level, not so much as physicians or nurses or whatever. Having that type of interaction to get a more humanistic look at each other and each patient, and then having some purposeful roundtable discussions on common problems that you see or some unusual problems that we don’t all see, would be ideal. Then we can collaborate as needed, and have, not necessarily a formulaic
approach, or some sort of flow chart, but a chance to talk about different ways of looking at the same problems, by different people. (Kim I, p. 12)

For Kim, the vision of collaboration requires interpersonal staff communication “on a person-to-person level.” Within Kim’s ideological positioning, the “virtual space” communication providers are “required” to utilize would be more effective if there was a “parallel track” where providers are able to build relationships with one another. Furthermore, she envision how having time to personally chat and collaborate with one another in a “roundtable” would benefit their treatment of patients. Other narratives agreed, and envisioned how collaborating with doctors outside of the Clinic’s walls would assist their practice and their patients.

“True Believers”

The fourth visualizing narrative about collaboration came from Jordan, who imagines a system where collaboration is facilitated by educating more people, both formally and informally, about the services and benefits offered at the CCC. Education for Jordan is a part of the IM ideological positioning and occurs most effectively during shared experiences of healing with other doctors.

We want to be the site for integrative education. . . . But at the Hospital we have doctors that are true believers, and we’ve got doctors that still really battle with the concept of integrative medicine. I see it in their notes, you know, they’ll make comments. You know, like “this patient is doing these supplements which have never been proven, and I need to stop them now;” that kind of thing. So that’s been kind of a challenge; but I love the opportunity to get doctors as my patients, or doctors’ family members, because I will win them over because I’m going to give them the right medicine. For example, one of the general surgeons, her husband had a post- operational visit after heart surgery in the main Hospital. Luckily, I had the opportunity to be on call and took care of him. We had the chance to really talk about the concepts “fix” versus “cure.” His stent was the fix. But now I’ve got the guy losing weight – he’s lost 70 pounds! He is exercising daily; he’s even gotten his the surgeon to lose weight herself. Because of him she has now changed her lifestyle and she – you can’t imagine a better speaker for me. . . . So that’s one way we are trying to education. . . . Essentially the last decade has been about educating the community; today the movement has shifted to focus on educating the doctors because there’s no education, or very little education, on IM at medical schools. But the more and more and more we do, the more acceptance and collaboration we’re going to get from doctors and the community. (Jordan I, p. 14)
Above, Jordan articulates his vision for getting doctors who “really battle with the concept of integrative medicine” into the Clinic to experience IM’s benefits first hand, “as patients.” His vision for true collaboration is to work with doctors who distinguish between “fix” and “cure.” Furthermore, his visualization narrative emphasizes the importance of education as a vehicle for collaboration “there’s no education, or very little education, on IM at medical schools.” His narrative insinuates a vision of having IM as part of the standard medical curriculum. Thus his narratives indicates that, through his ideological positioning of health care, biomedical providers and IM providers should share in the same understanding and respect for their respective approaches to medicine from the beginning of their certification process. Other IM narratives shared in this vision and narrated the need for having entire medical systems that are holistically minded.

**Visualizations of Holistic System**

None of the providers of this study spoke of their philosophy of healing the whole person as a lone mission, or the duty of integrative medicinal clinics alone. Collectively, the providers visualized more patient partnerships and colleague collaborations throughout all clinics and hospitals. Six narratives visualized changing medicine from a broad perspective, beyond themselves, and beyond the Clinic. In this sense, they visualized having more holistic systems. In these narratives being holistic was not just about caring for patients mind, body, and spirit, but instead about all stakeholders in medical care working towards the same definition of health. In these narratives visions of holistic systems communicated the desire to reform all of medical care’s many entities into a less fragmented model, and envisioned ways that stakeholders from differing paradigms might prioritize similar goals. Four narratives in particular communicated that models of care need to become holistically inclined in order for the medical paradigm shift to penetrate practical changes. These narratives established ideological positioning that envisioned (a) easier communication, (b) gaining financial security, and (c) and getting involved in leadership.

**“There Should Be an Easier Way.”**

One visualizing narrative that leaps right into a recommendation for a more holistic medical system comes from Leigh. He narrates that the “easiest way” to get doctors from
different models of care involved with one another’s practice is communicating in ways that allow providers to help one another’s patients.

We do grand rounds and we do lunch and learns, but I do not have any way of knowing if that has any impact on how doctors outside of the Clinic view our work. Honestly, the best impact I think we can have is when a patient shows up here and we help transform them, even just like 2%, and then they go back to their primary doctor to spread the success. Just this last week I was emailed about a neuropathy patient who has had a lot of treatment but nothing has worked, asking if could please see them. I was like, “Wow, we have got to pick up that patient and get her in as soon as possible and make this as positive a case!” Because that’s who will go back and say, “Okay, I don’t know exactly what he did, or what the techniques are, or the herbs, but it helped; and I am better, I am safe, and nothing crazy happened.” That’s when the doctors will say, “Ok, I’m going to send more folks that way.” That’s the easiest way. . . . But it shouldn’t be that hard. There should be an easier way of saying, “Hey Dr. X, you know, have you considered us for your neuropathy patients?” (Leigh, p. 5)

Leigh’s vision for getting more patients in the door and making them “a success” is a call for more seamless ways of sharing success with other providers. His narratives suggests that having a patient get treated for the same illness in more than one way provides them with more thorough care; this vividly explicates his ideological positioning. However, Leigh narrates that this type of optimized care should not only occur when patients take initiative. Doctors across specialties should be able to say, “consider us.” In order for that type of communication to occur the a model of care that providers operated under has to expected collaboration and have a mission of providing holistic care. We learn from other narratives of visualization that the current standardized model of care does not support the needs of a holistic system.

“Support From the Bigger Entity.”

A second visualizing narrative expands the idea of a more holistic medical care system, and points to logic as the key reason for this vision. In this narrative, the ideological positioning of IM is simplified, and envisioned as something everyone should uphold.

So, there’s no question that we want to expand our services and include other kinds of specialties, but we simply don’t have the support from the bigger entity right now. We are not doing anything special here, it is just logical. We focus on lifestyle, nutrition, and exercise. We’re getting people – we’re thinking outside the acute-care box. If somebody who doesn’t want to do a stent then we’ll say, “Okay we will use supplements,” you know? I mean I guess we don’t believe this
is rocket science. We believe this is the way you should do medicine. (Jordan II, p. 21)

Here, Jordan shares his logic, his ideological positioning, on how the IM approach to healing is the way everyone “should do medicine.” His vision is for the medical paradigm shift to be about focusing on “lifestyle” and thinking, “out-side the acute-care box.” According to Jordan, in order for this to happen “the support from the bigger entity” – the medical system at large - is necessary. Thus, his narrative of visualization situates his ideological positioning within a desire to personally provide holistic health care, and to be a part of a model of health care that is systematically holistic. A third narrative also envisioned a more holistic system, and sees the CCC as a model for future systems.

“Trying to Get That Message Out”

The third visualizing narrative that recommends a holistic medical system directly addresses the “new era” of medicine. This narrative communicates a vision of incorporating all specialties into IM practices, and imagines the paradigm shift towards IM as “inevitable.”

I think that every specialty probably has its own integrative niche. You know, like for cardiology of course we focus on the vascular system and it is one of the things that half of us have to consider; statistics alone say that you and I both have a 50/50 chance of either dying of cancer or heart disease, so it’s a huge thing. I think that the IM focus within cardiology especially has really been slowing the progression of the disease because everything affects the cardiovascular system, which affects all the other body systems, as well. So, I think it’s good we do focus a lot more on the integrative cardiac medicine here; but I think that there’s definitely room for other specialties to use integrative centers. There are all sorts of people with neurology issues who do integrative functional neurology and treat MS and all these other, like, bad diseases. I think the Clinic is ushering in this inevitable paradigm shift in medicine. The ‘old time western medicine’ going slowly by the wayside and the new paradigm shift is going to be this integrative functional medicine. More and more people, and more and more insurance companies, are now paying for integrative services because they see it works. So I see the vision of the Clinic as trying to get that message out. Of course that mission is on top of the goal of being able to take some of the sickest, most complex patients, finding root causes of their diseases, and treating them in an integrative fashion - which is the whole point of medicine. . . . But what it all comes down to of course is proving our value in the money, and showing that IM really works, which is tough to do when you’re not backed by big drug companies and things like that. (Loren, p. 5)

Here, Loren states that integrative Clinics could benefit all specialties, across the board in health care concerns. His narrative notes that more stakeholders are recognizing the
paradigm shift in medicine, however stronger financial backing is needed if IM will ever be incorporated into the whole medical system. In essence, his narrative communicated a vision of all stakeholders in medical policy and practice “backing: integrative medicine. The final narrative also illustrates how IM providers need to get these other stakeholders on board, and envisions this happening via self-advocacy and leadership.

“We Need to Be at the Table with the Top Dogs”

The fourth and final visualizing narrative comes from Ari, who aspires for an entire “health transformation.” Her narrative wraps up the ultimate vision for IM, and communicates how her ideological positioning as an IM provider is rooted in a practical understanding of how medical models of care are affected by media, policy, and food production.

We need a health transformation. We cannot buy foods that have high fructose corn syrup and partially hydrogenated oils and everything laced in things, you know? So it’s about legislation, it’s about education. People don’t just buy better food because people will fear that their food will cost more, and that’s what this system as led people to believe. But what we’re doing here at the CCC, right now, is we’re rearranging the deck chairs on the titanic. Healthcare is ready to implode. We spent $310B in pharmaceutical therapies in 2010. The United States of America spent $14.6B on antipsychotics. We spent $10B on antidepressants, $13B on antacids and $13B on statin therapy. Okay? So something is not working. It is predicted that by the end of the decade we will spend $500B in pre-diabetes and diabetes alone. We are spending 16% of the gross domestic product on diseases that are preventable! And we are ranking anywhere from 37th to 50th in health outcomes. Something has to change. (Ari I, p. 16)

Here, Ari begins to build her argument for a vision of transformation by narrating the role of legislation and economics on health behavior and health care outcomes. She visualizes her role as an IM provider as “rearranging the deck chairs on the titanic,” a noble and large cause for a ship that will sink regardless, unless large-scale systemic changes occur. Next, she explains what systematic changes are required of the paradigm shift.

So now, the big question is what’s going to happen with the Affordable Care Act (ACA) because because some of the mandates for the Affordable Care Act are wellness and prevention, not just screening. Now with the Affordable Care Act, there’s going to be a full case on keeping people healthy. And that’s what people need to understand. Integrative medicine is about prevention, it is about chronic disease management, about well-being, and it’s about doing things better for everyone, with less cost. This needs to be understood from a political standpoint. From an administrative standpoint, it is all about being political..Leadership
comes from the top down, and if the senior administration doesn’t understand what integrative medicine is about - and doesn’t get that integrative medicine is about more efficient care that will cost less, focus on prevention, and chronic disease management - then IM will never go anywhere because they will not invest in it. They won’t put people in here to figure it out, which I realized, because they have got 50 other things on their plate, right? This is just one thing on their plate. So, now we need to be sitting in at all the Top Dog meetings and bringing things to their attention. We have to be at that table. Remember, if you’re not at the table, you’re on the menu. (Ari II, p. 7)

Ari concludes that the CCC’s ideological positioning on IM needs to be adopted by the larger Hospital system, which dictates medical practice. “Prevention” needs to be re-framed politically and administratively, from “the top down.” Her narrative communicates that healing individuals the IM way is not enough, but working with administrators to understand how IM heals people could penetrate real change; “if the senior administration doesn’t understand… they will not invest in it.” Ari’s narrative establishes her vision for IM advocates to get involved in the conversations taking place at the leadership table.

Visualizing narratives communicated key aspects of IM providers’ ideological positioning because they situated the practices of the Clinic into the future. The quality of visualizing created narratives that overlapped with one another, however each narrative highlights a specific component of health care acquainted with the medical paradigm shift: patient relationships, provider relationships, and systemic relationships. Furthermore, the visualizing quality echoed narratives with reflecting and interrogating qualities, and propelled those narratives into constructive ideas.

The collection of results from this study show that IM provider narratives exhibit qualities that communicate the ideological positioning of IM providers through stories about their individual lived experiences, discussion of limitations in biomedical models of care, and explanations of how IM can facilitate the delivery of improved health care. In this sense, reflecting narratives explained concerns providers would later interrogate, and interrogating narratives foreshadowed narratives that envisioned more optimal care, and visualizing narratives stemmed from the foundation of each provider’s ideological positioning. Most narratives indirectly addressed the shift; however, all narratives directly communicated an agreement that practical medicine, and the American health care system, needs to change. In the next chapter I will dissect these results and formulate conclusions that thread the qualities of the narratives together. I will also suggest implications and directions for future research.
MOVING INTO MY YOGA BODY: RESEARCHER NARRATIVE

“High plank. Lower half way. Upward facing dog. Now, tuck the toes. Downward facing dog. Relax the head, peel back the shoulders. Presssss into the floor through your palm.”

All we have done is salutation A and already sweat is dripping onto my mat. The puddles make my hands slip and my posture wobble. The instructor, a young Caucasian woman of petite size, walks slowly around the room speaking her instructors. The way she says them is much more like a guide than a teacher. Her voice is soothing; not too deep, not too fast, just loud enough to hear over the flute sounds playing out of the speakers. Her voice is like a loud whisper. As she over-annunciates each word she captivates my attention, which draws out my body movement.

“Notice those ttiiight places. Breeeeeeeath into them. Soften the knees, and alternate pressssssing your heels into the floor.”

I decide that I like her. I haven’t disliked a Yoga instructor yet. This is my seventh class and January is nowhere near over. I have not had a male instructor from Corepower yet, but my previous yoga instructor was an older Indian man, Etan, whose class I attended nearly every Saturday when I lived in LA last year. He only taught once a week, and it was free as part of a gym membership. Here in San Diego Corepower is all the rage. I had not attended their classes before because I had heard criticism of it for reasons that seem trivial now. It critiqued for being overpriced and too commercial. Other than the cost, I cannot be mad at anyone making yoga more accessible to people. As someone who recently decided to make yoga a priority, and to make myself a priority, finding a studio with a lot of class options and locations that could fit into my ridiculous schedule was the first task. So far I couldn’t be more pleased. Except for the price.

“Now, walk your feet up to your hands, and dangle. Let your body fold like a flower stem, long, firm, malleable. Now, half way lift. Back to foreword fold. Slowly rise, stacking your vertebrae one at a time. Engage your core as you slowly grow taller, your neck and head the last to rise. Now slowly grow your limbs. Stretch up towards the sky. Hips are neutral. Spread your toes and fingers out wide. Let your heart shine. Tree pose.”
More sweat dribbles down my face, and settles on my chin, waiting for enough
moister to fall. I am slightly out of breath. I feel light headed. It slowly passes. I want to
rest a bit longer, but I know it is coming-

Bring your hands to heart center, now dive down, flat back. Foreword fold."

My hamstrings already feel looser than they did three classes ago. I have always been
fairly limber and able to balance, but what difference yoga makes.

As happy as I am to be here, and as much as I try to focus on being present both
physically and mentally, I can’t help but think about the interview this morning. I need to
type my field notes! I need to send a “Thank you” email. I need to read the other
transcriptions and start analyzing data. I need more participants!

“Warrior Two.”

I am facing the sidewall, but my head stares straight out in front. My right knee is
bended foreword, knee over ankle. My right arm is sturdy, directing straight above. My left
arm is straight back over my straight left leg; which is “firm with purpose.”

“Engage your core, as if there is a long string pulling your head towards the
ceiling.”

What if I can’t meet with anyone else this month? That’s ok. I have all of February.
But, I have to lead class discussion next week! Then there is the conference... I need to write
this down; if I write these things down they will be out of my head, and then I can really start
relaxing. Right? I just need to get them out of my head.

“Pigeon Pose.”

This is one of my favorite poses; it always has been. It stretches the quads, the back,
the hips, the shoulders, and it’s on the floor. Of course “Corpse Pose” is really my favorite.
That comes last. That is when you just lay on the floor like a dead fish. Your wrists, your
hips, your legs, your arms, your toes, your tongue - all lifeless. It feels amazing. We are
over half way there; but as much as I am looking forward to Corpse, I am really looking
foreword to lunch time. I also have a lot of work to do and cannot dilly-dally once class is
over.

“Now rise up until your wrists are just below your shoulders. Rise up on your left
toes, and swing the right leg back. High plank. Lower half way. Upwards facing dog. now
tuck the toes. Downward facing dog. Relax the head, peel back the shoulders. Presssss into
the floor through your palm.”

With a strong foundation I proceed, tangled in thoughts about poses, and concerns
for life after yoga.
CHAPTER 4

DISCUSSION

RESEARCHER REFLECTION: BEING PROFESSIONAL, GETTING PERSONAL

In February 2012 I had my first interview with Kim, a physician specializing in integrative medicine at the Clinic for Care and Concern. It was the first meeting, so needless to say I had anticipated much.

In February 2012 I had my first interview with Kim, an Integrative Medicine (IM) physician within the Clinic for Care and Concern (CCC). I entered the interview expecting her to be brief, professional, and possibly even stoic. I thought I might learn about the CCC’s unique treatment options and about CCC physician and practitioner the chain of command. I hoped Kim would share her perspective on IM’s benefits for patients and give some examples of moments when collaboration took place between she and her colleagues. I was prepared to get lost in medical jargon, and was nervous about note taking on illnesses or treatments I did not understand. I was not sure if we would have time to discuss the paradigm shift in medicine, and therefore approached the appointment as an opportunity to gain basic information about the logistics of the CCC. Instead, together, Kim and I laughed, drank tea, shared childhood stories, protested standardization, and dreamt of a healthier society.

During that first interview, to my surprise and delight, I found Kim to be warm and personable. Right away she stood out as a storyteller, with her soothing voice, illustrative language, and a captivating communication style. She was not brief at all, and went into great depth as she narratively explored different ways of answering my questions. She barely discussed the hard science of IM, and dove right into critiques and suggestions for working in teams and delivering quality care to patients. I could sense her devotion to medicine immediately, as well as her aptitude for listening and guiding; equally apparent, was her dissatisfaction with unvarying approaches to problem solving in health care, and her
frustration with dysfunctional care models. She was not afraid of getting personal when justifying her professional stance on medicine.

My interview with Kim, and all providers from the CCC, aimed to discover how providers of IM communicate about their role within the medical paradigm shift. However the interviews resulted in narratives that were about identity, background, training, expectations, and optimism. With depth and enthusiasm, providers storied how being mindful of their roots, questioning the status quo, and capitalizing on opportunities, pushed them to their ideological positioning. The gravity of their narratives slowed the pace of my research, allowed me to synthesize data with patience, and careful consideration. Additionally, their narratives have presented new options for how I can question IM and other medical models of care, and enhanced my desire to do so holistically.

Chapter Three presents the results of investigating providers’ ideological positioning in the paradigm shift in medicine. We learned how providers communicated through this shift by reflecting, interrogating, and visualizing. This chapter turns our attention to a summary of these major findings. Second, I discuss two conclusions that can be drawn from the results. Third, I discuss two theoretical implications of the results. Fourth, I describe three practical implications of the study’s results. Fifth, I describe the limitations of this study and suggest possible directions for future research. Finally, I conclude the thesis with a final researcher reflection.

**Recapturing Results**

The IM providers communicated about their ideological positioning in narratives composed of three qualities: reflecting, interrogating, and visualizing. *Reflecting Narratives* communicated the background of IM providers’ ideological positioning, and contained three general subject areas: family, nature, and spirituality. Reflecting narratives that communicated about family centered on memories from childhood and in providers’ homes, and explained how IM provider definitions for health are rooted in encounters with illness and death. Reflecting narratives that communicated about nature and the environment conveyed how IM providers see the world as connected, and how believe people are reliant upon different natural systems to maintain health. Finally, reflecting narratives that communicated about spirituality and religion explained what lead providers towards IM
specialty, and highlighted how their ideological positioning as part of a “divine” path. All of these reflecting narratives mark the providers as individual, unique, and discursively aware of their specific intentions as healers. Moreover, these reflecting narratives communicate how IM provider ideological positioning happens over the course of time, through natural and innate inclinations. In essence, reflecting narratives addressed the personal background of the providers, and communicated the unique foundation for their ideological positioning.

Second, **Interrogating Narratives** communicated providers’ current concerns in medicine. In this second quality of ideological positioning, providers juxtaposed the lessons they reflected on by explaining resistance they face as IM practitioners within three subject areas: the roles of doctors, the roles of patients, and the role of “the pill.” Interrogating narratives communicated about role that doctors play in medical care as highly standardized and that medical training is more like an indoctrination process than a learning opportunity. This interrogation clarifies that providers’ belief that this standardization limits doctors’ ability to treat patients holistically. Interrogating narratives about the role of patients in clinical practice established that patients typically act (and are forced to act) passively during medical decision-making, thus limiting limits patients’ ability participate in their experience of health care. Finally, interrogating narratives about the entire system of medical care in America – “the pill” – communicated that this system puts our health in America in danger by focusing on disease rather than prevention. All of these interrogating narratives outlined how systemic inconsistencies among different service entities affect the roles that stakeholders play, the expectations they are subject to, and therefore the ability that stakeholders have in promoting health, maintaining health, and being healthy. In essence, interrogating narratives addressed the professional concerns of the providers, and communicated the ways in which their ideological positioning juxtaposes with the status quo.

Third, **Visualizing Narratives** communicated ideas for the future. In this quality, providers expressed ideas for improving medical practice in three subject areas: provider-patient partnerships, provider-provider collaborations, and integrated systems. These narratives visualized how a stronger sense of team work among providers and their patients would enhance health outcomes. These narratives also visualized how more consistent communication among providers’ colleagues would allow for more continuity in health care, and a better working environment. Finally, narratives visualized how making medical
systems more integrated could promote prevention, cut costs, and allow for more consistent leadership in hospital administration. These providers’ narratives identify opportunities for improvement, and advocate for changes that would benefit all medical care stakeholders. In essence, visualizing narratives address the professional ideals of the providers, and communicated the way in which they believe that their ideological positioning can impact future medical practices.

All three qualities of providers’ narratives thickly outlined stories, pinpointed specific contexts, and elaborated on ideals; in this sense, the qualities overlap, and inform one another. This conclusion is elaborated on in the following section where the Communicative Qualities of Ideological Positioning are explained.
CHAPTER 5

CONCLUSIONS

A wide range of conclusions can be drawn from the results of this investigation. I will focus on two of these conclusions. First, the results of this study reveal that the three qualities of providers’ narratives are interwoven consistently; providers’ communication about ideological positioning is dynamic with the qualities of reflecting, interrogating, and visualizing interweaving and influencing one another. Second, the results of this investigation can be represented visually through a model, which I have entitled The Communication Qualities of Ideological Positioning. I will now discuss the two conclusions as they relate to one another by explaining the three threads that weave the qualities together.

THREAD ONE: INTERWOVEN QUALITIES OF IDEOLOGICAL POSITIONING

IM providers communicated about their ideological positioning within the medical paradigm shift through reflecting, interrogating, and visualizing narratives that address the past, present, and future of their field. Thus, the provider narratives flow from quality to quality to communicate ideological positioning as it exists consistently, holistically, and uniformly. Furthermore, the qualities of the provider narratives are not completely separate, and bleed into one another. For example, as illustrated in the results presented in Chapter Three, providers’ reflections about experiencing death lead to interrogations of how the American health care system is designed to treat people’s illnesses rather than to teach people about prevention. These interrogations often looped back into reflections about what it means to be healthy, and the health lessons they learned in their homes and childhoods. Also, providers’ interrogations and reflections informed one another and provided substance and context to visualizations. These visualizations narrated ideas for how the medical care system can and should be improved. Furthermore, these visualizations elaborated on providers’ experiences (reflections) and questions they asked (interrogations). The three qualities are present in all of the providers’ narratives and each quality is enhanced or woven
together in relation to the other qualities. The first thread of the interwoven qualities of ideological positioning is illustrated in Figure 2.

![Figure 2. Communicative qualities of ideological positioning (thread one).](image)

**Thread Two: Interwoven Topics of Ideological Positioning**

In the Figure 1, the communicative relationship of the three qualities is illustrated. Reflecting and interrogating narratives have a communicative relationship; interrogating and visualizing narratives have a communicative relationship; visualizing and reflecting narratives also have a communicative relationship. Furthermore, these relationships can be elaborated by considering the unique topics discussed within each quality. Reflecting narratives on family, nature, and spirituality focus on providers’ personal background and have a relationship with the narratives providers offer as an interrogation of their professional concerns about the roles of the doctor, the patient, and the pill in the current biomedical model. Each of these qualities also has a relationship with providers’ visualizing narratives focused their professional ideals for provider-patient partnerships, provider-provider collaborations, and integrative systems. Thus, the weave between the narratives qualities is threaded in each qualities specific subject area. Figure 3 displays thread two of communicative ideologies of Ideological Positioning.
Thread Three: Interwoven Barriers of Ideological Positioning

Narrative qualities contain specific topics that influence the relationship between the qualities. In this sense, the IM provider narratives of reflecting, interrogating, and visualizing are woven together by the significant topics within each quality. Moreover, when adding these topics to the model another conclusion can be drawn about the way in which IM providers communicate about their ideological positioning within the medical paradigm shift; providers’ narratives reveal the structural barriers and the ideological barriers.

Structural Barriers

Providers’ narratives communicate about ideological positioning by reflecting, interrogating, and visualizing the structural barriers that the IM Clinic aims to move through and beyond. Structural barriers are systematic tensions within medical models of care that disrupt the practitioners’ ability to care for patients holistically. Throughout all of the narrative qualities and topics, providers narrated stories that focused on four overarching structural barriers: time, money, policies, and facilities. First, when providers described barriers they face with time they communicated that structural standards in medical care restrict how much time providers are able to spend communicating with patients and colleagues. Most significantly, providers narrated that the time barrier greatly affects communication. For example, providers narrated that having too little time impedes their
ability to be the “quarter-back” of their patients care (Kim III, p.18), as well as their ability to collaborate with one another and chat colloquially (Teddy, p. 14). In standard models of care, a lot of time is spent transcribing consultations, updating records, and conducting procedures. Consequently, IM providers’ narratives noted that other providers are surprised when they see how much time IM providers aim to spend helping patients (Jordan I, p. 9). The providers also narrated that in standard models of care, “there’s not a lot of time for hand holding and all that” (Danny, p. 1); thus, by having limited time, the compassionate side of medicine is lost. Providers said they wished that medical practice could, “also have a parallel track where [they are] able to spend some quality time team building on a person-to-person level” (Kim I, p. 12). In this sense, the reflecting, and interrogating in providers’ narratives communicate that structural standards place barriers on the time providers need and want to connect with patients and colleagues. However, visualizing narratives communicated that in an IM model of care, time spent with patients is prioritized.

Second, providers’ narratives focused on the barriers they face with money; moreover, they communicated that structural standards in medical care prioritize money over quality care. Most significantly, providers narrated that money creates barriers for prevention. For example, providers narrated that IM centers can be, “extremely naïve . . . because [they are] talking about health, and lifestyle change, and wellness in a system that makes all its money on diseases” (Ari I, p. 3). Providers also narrated that the success of IM all comes down to, “proving our value in the money” (Loren, p. 5). Additionally, providers narrated that the financial environment of the Clinic is shifting as a result of IM’s growth, which is a concern impeding upon their ability to maintain their collective “intention to heal” (Teddy, p. 14). Money is getting in the way of the medicine. As Jordan noted, “there’s no question that we want to expand our services and include other kinds of specialties” (Jordan II, p. 21), but that cannot happen without making money. In this sense, the reflecting and interrogating in providers’ narratives communicate that structural barriers related to finances distract providers from the real purpose of their profession, which is helping people. However, providers’ visualizing narratives communicated that making money would allow IM to gain more recognition, and ultimately help more people.

Third, providers narrated about barriers they face with facilities; moreover, they communicated that structural standards in medical care do not provide enough space for
providers to offer patients plentiful treatment options. Most significantly, providers narrated that having separate spaces for IM providers (IM based clinics, and other medical centers) creates barriers for collaboration among cross-functional providers. For example, narratives suggest that an, “easier way” (Leigh, p. 5) to collaborate with one another would come from providers on different modalities being in the, “same place at the same time” (Teddy, p. 14). Unfortunately, this is not their reality. Loren narrates that most hospital systems do not offer IM modalities in the same facility that the biomedically based MDs practice in, which makes him fearful to leave the Clinic. He says, “if I leave and go to a general cardiology practice and I’m like, ‘Oh, what this patients really needs is Cardiac Rehab,’ well, the closest Rehab maybe like 20, 30 minutes away; somewhere that we have never had contact with, unless I go digging for it. So that’s where it gets tough” (Loren, p. 12). For Loren, being in the same facility as people who can assist with Cardiac Rehab is necessary. Additionally, providers note that being in the same space does not necessitate collaboration. One narrative said, “Even though we all work here together, we have our different schedules, so the best way to catch each other is via the virtual space” (Kim I, p. 12). Here, the provider conveys that having the Clinic providers working in the same facility makes it easy to assume that they are collaborating, which is not always the case (due to time, money and other barriers). In this sense, the reflecting and interrogating qualities in provider narratives communicate that structural barriers related to space and location do one of two things. One, lack of space makes it difficult for providers to offer optimized health care. Two, if providers of multiple modalities are fortunate enough to be in one facility, then their collaboration is assumed, not necessarily actualized. However, visualizing narratives communicated that facility barriers can be overcome using technology, which allows for collaboration to occur despite providers being in separate facilities.

Fourth, providers narrated about barriers they face with policies; moreover, they communicated that structural barriers related to medical care policies over-simplify medical practice. Most significantly, providers narrated that many standardized policies create barriers for more efficient processes. From the “boom, boom, boom” policies in medical school to the “doctor-patient, and a pill in the middle scenario” (Danny, p. 1), providers narrated that policies designed to standardize medical training and medical practice limit “creative thought” (Danny, p. 1) and the humanistic elements” side of medicine (Kim I, p. 2).
Furthermore, Jordan noted that IM can only grow if policies that can uphold prevention are supported by “the bigger entity” (Jordan II, p. 21). Another narrative said that the benefits of IM need to, “be understood from a political standpoint. . . . From an administrative standpoint, it is all about being political. . . . Leadership comes from the top down, and if the senior administration doesn’t understand what integrative medicine is about. . . then IM will never go anywhere because they will not invest in it” (Ari II, p. 7). In these narratives, providers are explaining that the political arena of medical decision making creates barriers for IM; however, ironically political decision makers are the needed to help IM flourish. Providers have hope that through new policies, like the Affordable Care Act, IM practices, such as focusing on prevention, could become more systemic (Ari II, p. 7; Kim III, p. 18). In this sense, the reflecting and interrogating qualities in providers’ narratives communicate that structural standards related to policies interfere with giving patient’s access to IM. However, visualizing narratives communicated that political barriers can be overcome if leaders in health care work to facilitate IM accessibility.

Ultimately, all of the structural barriers embedded in providers’ narratives of reflecting, interrogating, and visualizing weave together and communicate about structural barriers in ways that are both limiting (reflecting and interrogating) and empowering (visualizing). The same can be said for the way in which providers communicate about ideological barriers.

**Ideological Barriers**

Providers’ narratives communicate about ideological positioning by reflecting, interrogating, and visualizing the ideological barriers that IM providers confront and grapple with in order to accomplish integrative medical care. Ideological barriers are theoretical tensions that separate opposing philosophies of care. Providers narrated stories of three overarching ideological barriers: (a) us vs. them, (b) touch vs. tech, and (c) routine vs. individualized.

First, providers narrated about barriers they face negotiating between thinking of themselves as an “us”, as IM practitioners who also have biomedical training, and thinking of themselves as a separate from “them”, the biomedical doctors. Narratives communicated that ideological standards in medical care relegate IM providers as a subculture of the biomedical
Providers narrated that they do not want to be seen separate from their colleagues, saying “we don’t believe this is rocket science” (Jordan II, p. 21), insinuating that they do not see themselves as superior to their biomedical colleagues in any way. However, providers narrated that biomedical doctors treat IM providers as inferior, and write about IM providers and practices distastefully in patient records (Jordan I, p. 14). Providers indicate that biomedical doctors “kind of turn their nose at this stuff when you bring it up. They think it’s like voodoo” (Loren, 3). Here, providers communicate that they do not like to feel separate from other MDs; indeed they want to be working in collaboration with these providers. They communicate that they want to be seen as an “us”, and no different from any other provider in the MD community.

At the same time, even in the same sentence IM provider narratives communicate ways that place biomedical providers in the “them” category. One narrative stated, “I love the opportunity to get doctors as my patients, or doctors’ family members, because I will win them over because I’m going to give them the right medicine” (Jordan I, p. 14). Here, the narrative indicates an effort to bring a biomedical provider into the fold of IM; at the same time in communicates a separation of IM providers from biomedical providers in a competitive way. In this sense, reflecting and interrogating in provider narratives communicate that ideological barriers related to titles, specialties, create an “us” vs. “them” culture, and often prohibits their ability to communicated collaboratively with other MDs. However, visualizing narratives also communicated that IM providers and biomedical MDs can learn from one another when they work together, while also acknowledging their individual skill sets.

While results indicate that IM providers construct their ideological positioning over time and in response to barriers. Their narratives expose how this construction unfolds communicatively. It is possible that providers within other silos of medicine, and within other medical models of care, communicate about their ideological positioning in a similar way. However, the data exposes how IM providers interrogate their peers and the medical system at large, making themselves separate through language that suggests an us vs. the mindset. It is possible that providers within other silos also communicate about their ideological positioning by reflecting, interrogating, and visualizing; however the barriers they identify may be entirely different. In this sense, it is unfair to assume that the
Communicative Qualities of Ideological Positioning is a model unique to IM ideological positioning. However, the topics and barriers identified may be entirely different for providers of different silos who do not openly identify with the IM philosophy of care.

Second, providers narrated what they see as barriers they face negotiating between ideological approaches to medicine that prefer “tech” or ideological approaches that prefer “touch.” Provider narratives communicate that IM must utilize the technological advancements in science and medicine while also aiming to treat patients through natural healing options, treating the whole patient. Unfortunately, providers noted that sometimes tech and touch work against each other. One provider narrated a story about a patient who was stunned by the fact he never looked at his computer, or took any tests. He replied, “It’s because that is what we do here. That’s listening to your patient, that’s the whole, caring for the whole person thing” (Jordan I, p. 9). The provider explains that of course he will run tests, which he considers easy, “but it’s much harder to figure out why you’re truly in this situation, what else is going on” (Jordan I, p. 9). In this instance, the provider is narrating that being too high tech and relying on tests doesn’t provide all of the answers; listening and being high touch helps him to understand patients’ issues much more holistically.

Still, other narratives noted how technology and touch can work together. For example, one provider noted that in their Clinic, “we have a high-tech fitness center, we have a medical practice, we have CT scan, we have all this technology, we have yoga, we have meditation, healing classes, you know, we have sound healing, and music therapy. . . . Having all these things educates patients” (Andy, p. 24). This narrative sees tech and touch in a harmonious relationship. In this sense, reflecting and interrogating in providers’ narratives communicate that ideological barriers related to tech vs. touch tend to prioritize one over the other. However, visualizing narratives communicated how IM providers can use both tech and touch in tandem.

Third, providers narrated about barriers they face negotiating between ideological approaches to medicine that that prioritize “routines” or ideological approached that prioritize the “individual.” Narratives communicate that every patient should be listened to, followed up with, and treated based on their personal needs. For example, one provider narrative explained that “what typically happens is the doctor prescribes something and assumes that the patient is going to do it because they told them to. Assumptions get you
nowhere because usually the patient will come back and they’ve not done any of it for a particular reason” (Teddy, p. 3). Here, the provider is explaining that following the routine as a doctor doesn’t fit with every patient as an individual. Other narratives agree that making assumptions based on routines prevent physicians from delivering quality care that considers the sociological factors of health (Kim I, p. 3), the economic factors of health (Ari II, p. 7), the environmental issues related to health (Ari II, p. 2) and spiritual factors of health (Leigh, p. 1). Providers’ narratives convey that although, for example, putting in stents is a routine way of treating coronary concerns, that procedure undermines the ability doctors have to talk to patients one-on-one and getting to the root of the individual coronary disease (Ari II, p. 2). Ultimately, providers narrated that “we need to do medicine differently. We can’t just keep putting in stents and giving people drugs” (Ari II, p. 2). In this sense, reflecting and interrogating narratives communicate that ideological barriers such as standard routine procedures limit the ability of providers to treat patients holistically on a consistent basis. However, narratives also visualized how IM providers can influence the holistic treatment of patients on an individual basis if IM was more systemically integrated.

Like all of the structural barriers embedded in providers’ narratives of reflecting, interrogating, and visualizing, ideological barriers interweave with one another, and communicate about ideological barriers in ways that are both limiting (reflecting and interrogating) and empowering (visualizing). Moreover, structural barriers and ideological barriers were identified throughout reflecting, interrogating, and visualizing narratives, and weave together the subject areas within each narrative quality. The interwoven relationships of the ways in which IM providers communicate about their ideological positioning within the medical paradigm shift is illustrated in this final thread of the Communication Qualities of Ideological Positioning model, as revealed in Figure 4.

The Communication Qualities of Ideological Positioning knits together the three qualities of reflecting, interrogating, and visualizing, along with the structural barriers and ideological barriers. As providers narrated their ideological positioning, their reflecting, interrogating, and visualizing communicate the personal, flawed, and evolving complexities the medical paradigm shift. Not surprisingly, these conclusions can offer a wide range of theoretical and practical implications.

The results from this study expose how providers communicated about their
ideological positions using narrative; moreover, the content within their narratives exposes how they constructed their ideological positioning: reflecting, interrogating, and visualizing. Therefore, the ideological positions of the providers were constructed through their experiences with other people, facing resistance, and theorizing about changes. In this sense, their ideological positioning was co-constructed by the influences they communicate about in their narratives. Their ideological positioning does not exist in a vacuum, and is responsive and contextualized based on ongoing communicative interactions with patients, with each others, and within the medical systems they operate under. As the model illustrates, IM ideological positioning counter acts barriers and concerns that certain health professionals identify and disagree with.

**Implications of Study**

The results and conclusions drawn from this data collection offer both theoretical and practical implications. First, the results elaborate on theoretical understandings of ideological positioning and narrative research. Second, the results of this research have can be utilized to progress practices in medical education and medical practice.

The results and conclusions offer insight into the communicative processes that participants used to communicate their ideological positioning. The next two subsections
offer’s progressive movements in the research areas of (a) ideological positioning, and (b) narrative.

**Ideological Positioning as a Result of Identity Standpoint**

Previous research on medical practitioners claims that their ideological positioning substantiates their definition of health and their techniques for care delivery (Geist & Hardesty, 1990). Furthermore, ideological positioning can give context to why a physician, or any person, negates other perspectives or resists alternative logic (Mumby, 2004; Wilkins, 1983). The present study further buttresses these claims by dissecting how provider ideological positions are communicated, and constructed, through narrative. As introduced in the Chapter Three, the providers in this study did not proclaim an ideological positioning through single statements, or with finality. Instead, providers communicated about their ideological positioning by establishing foundations, concerns, and hopes through the discussion of the structural and ideological barriers that their perspectives push against.

Through their individual reflecting, interrogating, and visualizing, the narratives revealed that the processes of forming an ideology required participants to make active evaluations of their own upbringing, their educational experiences, and situations between them and patients, other providers, and administrators within the health care industry. These topics all involve interactions the providers have had with the people around them, and the people who have raised them; circumstances that are all influenced by their identity and cultural community (Gudykunst, Ting-Toomey, & Chua, 1988; Streeck, 1994). In this sense, the results of this study indicate that the ideological positions of IM providers are marked by their identities and social demographics. Therefore, theoretical approaches to how ideological positioning is communicated must take into account identity.

What has been uncovered through this research is how ideological positioning can be studied with relation to identity theories. For example, in Standpoint Theory perspectives evolve through critical consideration of power dynamics (Wood, 2005). Consequently, researchers can extend the results of this study to consider how the ideological positioning of individuals, as well as groups, communicates embodied forms of identity. Furthermore, because this study examined ideological positioning using narratives, there are also strong
theoretical implications within the findings applicable to the study of narrative as it relates to identity.

**Narratives as a Vehicle for Distinguishing the Self**

Studying a body of narratives is particularly important when research is aiming to investigate themes or patterns among participants of a specific context (Bennett & Feldman, 1981; Gray, 2009; Sharf, 1990). The present study utilized a body of narratives to develop an understanding of IM providers who represent a subculture of medical practitioners. As an outsider, studying the narratives both individually and collectively, and examining their qualitative content longitudinally, I was transported to a place of deeper understanding of how the providers see themselves as individuals (Green; 2006; Sharf & Vanderford, 2003). This layered perspective allowed me to analyze what the data represents beyond how ideological positioning was communicated in narratives, but also how the providers defined the qualities of their ideologies as individuals.

What has been uncovered through my analysis is how narratives transport not only the researcher, but the participant, through the construction and negotiation of their identity. In their narratives, providers enacted their identities through communication (Hecht, Warren, Jung, & Krieger, 2005). Therefore, identity theories can also be applied to research examining narratives, as well as ideological positioning. For example, the Communication Theory of Identity explains how communication is comprised of “issues salient to personhood” (Hecht et al., 2005, p. 292). Communication researchers can gain further insight into their research contexts through narratives, no matter the primary research methodology, in order to more thoroughly investigate common and uncommon perspectives that influence behavior. This type of research that privileges lived and embodied negotiations and experiences would allow for a more Critical Progressive Pedagogy (Hendrix, Jackson, & Warren, 2003) to flourish in communication related to critical contexts, including: medical care, politics, and education.

Previous researchers have investigated communicative practices within different medical models of care, among physician teams, during patient consultations, in campaigns, etc. Communication research has also examined how narratives aid health care professionals communicate about their professional ideological positioning. Through this research I have
uncovered new ways to look at communication with regards to how medical professionals define themselves, and their ideological positioning, and through narrative. This information would significantly the advancement of the medical paradigm shift, and the improvement of pragmatic health care discourse. I will now discuss these practical implications at length.

Practical Implications

The results of this investigation have a range of practical implications for the CCC and the coordination of IM in medical models of care. During the interview process it was almost impossible not to strategize ways that the providers and the Clinic could implement small and specific changes, in some cases immediately. It is also clear that this research has broad applications for contexts outside of the CCC as well.

One practical implication from the results of this study is the opportunity for providers to engage in narrative exercises with their colleagues. It was clear from the IM narratives that reflecting, interrogating, and visualizing through communication and narrative is not part of providers’ daily routine. In fact, some providers were initially hesitant to share details of their experiences, or specific concerns for the medical field, only to find that once they got started they had a lot of bottled up ideas to share. As my time with each provider unfolded their descriptions deepened, and their reflections and interrogations became more vivid. If the Clinic and other medical facilities provided more time for members of their medical community to share their experiences and ideas, thereby keeping their narratives salient more consistently, then providers would be able to identify and overcome barriers more systematically. Conferences and lectures are attempting to do this, however their formality and non-medical community involvement make it difficult for providers to be critical and truthful about how what is wrong within their practice and the best way to fix it. The Clinic and other medical facilities may find that hosting their own, internal and informal opportunities for dialogic moments between providers would offer new, unexplored visualizations. Setting up an afternoon “tea-time” between patient rush hours, or an ongoing mentorship program for providers, could help them build momentum for mindful practice. Setting up routine opportunities for providers to reflect, interrogate, and visualize collectively would allow for them to uncover new motivations and opportunities for integration. Furthermore, if the providers were able to spend time communicating about barriers with one
another, the collaboration would come more naturally. Through the simple act of sharing ideas providers could identify and strategize new ways to advocate for the Clinic and find more camaraderie in their practice.

Moreover, the research suggests that the practice of sharing narratives, reflecting, interrogating, and visualizing is something medical schools should educate future providers on the use of narrative early in their careers. Furthermore, medical schools could more systematically encourage providers to think reflexively, interrogatively, and visually, about their practice and their intentions to heal. They could also encourage providers to more consistently share their narratives with one another. In doing so, medical schools could help open the minds of the providers who will be forging ahead into the medical paradigm shift, which would assist all future providers in relating to patients holistically, in relating to one another, and in collaborating more with stakeholders of different ideological positioning.

Narrative Medicine courses have been incorporated into the curriculum at some medical schools, including Colombia University and the University of California, San Francisco, but rarely are these courses required of pre-medical students. The relevance of the content of these courses would become more vivid if medical schools made these courses mandatory, setting the expectation that narratives are valuable during clinic practice, as well as among colleagues and peers.

The second practical implication from this study is that the Clinic, and other health care centers like it need to be doing more to educate the non-medical community on IM. The narratives that providers shared here are rich with knowledge about valuable and healthy trends in medicine. If more opportunities were created for providers to narrate their ideological positioning with the non-medical community, more stakeholders could contribute their support for IM and become advocates for IM from outside in the community to inside into health care systems. As of now, the Clinic providers have little time and resources to reach out to the general community. However, with more widespread campaigns that educate the public about the value of IM and the services offered by the Clinic, then IM could gain momentum through a larger fan base. One way the CCC could advertise to the general public more is by enhancing their social and mobile media presence. IM facilities like the Clinic should be advertising the educational opportunities they do have - such as classes, lectures, and conferences - through channels more readily accessible to the general public –
through their web page, Idealist, Twitter, and Facebook. In this sense, by utilizing social and mobile media IM providers can clinics can use high tech resources to influence high touch treatment. Providers claim that they want to utilize technology more, and social media holds many possibilities for them that come at a low price.

By establishing more open communication and education with the public, the Clinic and other IM facilities would be able to preach beyond the choir, and advocate for IM to people who even at this point are unaware of its presence, accessibility, and benefits. Moreover, by educating people via social and mobile media channels the CCC might be able to enlighten patients on prevention, and interfere with the development of diseases that fuel standard models of care. Ultimately, the results of this study point to two new steps that stakeholders who are influencing the medical paradigm shift can make, encouraging the use of medical narratives between providers, and utilizing social and mobile media to educate people about IM, preventative medicine, and other information that might stop a media consumer from becoming a patient in need.

LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

In all studies, researchers must accommodate and adapt to the opportunities and constraints of the research environment. For this study, the three biggest limitations were timing, site approval, and patient safety regulations. First and foremost, this research utilized interview data from eleven participants, nine of whom were providers, two of whom were administrators. Due to their demanding schedules, only three providers were available for more than one interview. Furthermore, all of the providers interviewed work for one specific clinic. Therefore, some of consistency within their narratives may be attributed to the fact that all of the participants came from one location, and were all providers of IM. Having provider participants from outside of IM, and being able to interview everyone multiple times, would have allowed for a more comprehensive understanding of the supporters and detractors of integrative medicine.

In addition to interviews, data was also collected from two informational meetings with administrators, during lectures, and during IM classes. I was unable to conduct any participant-observations of provider-patient interactions, or provider-provider conversations, due to patient safety regulations. Although patient safety is a huge priority in this research,
patient safety regulations limited the opportunities I had to conduct observation that might have offered additional evidence of the ways patients reflect, interrogate, and visualize their medical care. Observing these contexts would have significantly textured data analysis and understanding.

As mentioned in Chapter Two, this research is part of a larger project involving a team of several other researchers, and our plans to collect more observational and interview data will utilize the preliminary findings presented here. The continuing project will collect and analyze data on how the structure of the CCC and the Hospital facilitate and constrain communication and collaboration among providers. The research presented here has allowed our team to break the ice and establish rapport with the CCC, to gain understanding of the ways providers’ ideological positioning is communicated within the medical paradigm shift, and to make preliminary suggestions for CCC functioning. The continuing research at the CCC will raise new, significant questions and offer more directions for future research. However, one specific direction for future research that comes from the data thus far is that ethnographic approaches to medical contexts can truly augment research.

Future research on narrative and IM should aim to analyze the ideological positioning of other “stake holders” within the medical care system using ethnographic methods and interviews. This type of research will help identify opportunities to build shared vision and cultivate more adequate medical care models that address the barriers restricting all stakeholders. Researcher narratives, and specifically narratives from researchers and participants that are conducted in the field as decisions are being made, can greatly enhance researcher understandings of what complicates medical care and drives the medical paradigm shift. Researchers are already analyzing communication between providers and patients via conversation analysis and survey data; however, ethnography allows for in depth analysis of how communication tendencies and ideological positioning are developed in medical care contexts. More ethnographic research on stakeholder narratives can assist patients as they search for providers and care models that aim to treat them in the manner they request, whether it is biomedical care, palliative care, or integrative care. Additionally, ethnographic research on patient narratives could significantly help other stakeholders consider the underlying issues facing health behaviors and health misbehaviors.
In essence, health communication research going forward would benefit from utilizing ethnographic approaches to data collection. The methods utilized in this research enhanced the data collection and analysis, and permitted me to gain familiarity with the research site intimately. Still, the use of other qualitative and quantitative methods would allow me to learn how different stakeholders are involved in the CCC, observe trends in patient satisfaction and improved health outcomes, and open doors for more theoretical development and practical implications. With survey-questionnaire results from patients who visit the CCC and the Hospital this research would be able to make more generalizable statements about the CCC’s success and barriers, which could be used for administrators and policy makers who are involved in the medical paradigm shift. Gaining the perspectives of stakeholders, including medical students and medical school administrators, through more longitudinal studies that integrate focus groups, interviews, and surveys would also greatly assist researcher understandings of how the medical paradigm shift is being viewed by other major players. Having a mixed method approach would also allow researchers to watch the shift occur, and analyze the communicative process as it unfolds.

It is my hope that the research presented here opens the door for more studies that include the voices of physicians, future physicians, and medical administrators. While policy makers and administrators carry great power in medicine, the providers are the people you and I visit when we sense trouble. As the medical paradigm shift occurs and new trends of care popularize, it will become more and more necessary for people to get to know their doctor. The shift is “inevitable,” and will provide more choices and health care options. Therefore, it is important for all stakeholders to be mindful of what they want, why, and who to turn to for help with their health.

**MINDING MYSELF: RESEARCHER REFLECTION**


I can feel my calves working as I sniff in and out, reaching for the ceiling with my hips, pressing the earth with my hands. Breath out.
I lift my right leg high and my toes stretch for the back wall, I check to ensure my hips are still in line. Breath in. I swing my right leg forward. Breath out. I feel strong and in control. I rise up to Warrior Two. Virabhadrasana. Breathe.

"Yup." I think. "I am a warrior."

Reverse Warrior. Viparita Virabhadrasana.

My breath is slow. I spiral down back to high blank.

Breathe in.

My sweat is consistent.

Breathe out.

Focus.

Breathe in.

“Smile.” She says. I smile. I feel peaceful. I feel in control. Here, and outside. My doctor told me today that my iron has gone up; which surprised me because I am anemic, and lately I have been working out more and eating less. But my mind has been clearer. I have begun using my planner more to jot down random thoughts. I also got a journal; I can’t remember the last time I had time to keep a journal. Work is going well and I have had more consistency in my schedule; taking the time I need for me has given my whole life a more regular routine. Feeling relaxed as influenced me to spend more time alone and accomplish little tasks. I am happier when I am with friends, and feel less preoccupied.

Breathe out.

Focus.

Breathe in.

I can finally focus during yoga. I have found my intent; patience. I am motivated to keep coming, to keep improving, to keep practicing. Everything takes time. Everything worth having is worth working for.

Everything takes time.

Breathe.

Namaste; May the light in me honor the light in you.
REFERENCES


APPENDIX A

RESEARCHER ACTIVITY TABLE
<table>
<thead>
<tr>
<th>General Activity</th>
<th>Activity Location</th>
<th>Participant</th>
<th>Activity Duration</th>
<th>Transcript Pages</th>
<th>Notes Pages</th>
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<tbody>
<tr>
<td>Interview</td>
<td>CCC Conference room</td>
<td>Kim I</td>
<td>1hr</td>
<td>23 pgs</td>
<td>4 page</td>
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<td>Interview</td>
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<td>Danny</td>
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<td>29 pgs</td>
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<td>CCC Classroom</td>
<td>Instructor</td>
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<td>Kim II</td>
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<td>Healing Class</td>
<td>CCC Classroom</td>
<td>Andy</td>
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<td>N/A</td>
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<tr>
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APPENDIX B

SAMPLE INTERVIEW GUIDE
Thank you so much for meeting with ME. Would you mind if I recorded so that I can focus on the conversation, rather than taking prolific notes?

I know that you are aware that our research is focusing on the ways that providers in the Clinic communicate with one another to accomplish collaboration, coordination, and integration. Over the past 10 months have conducted many interviews with the Clinic’s staff, and learned a lot about the background of providers and the vision of the Clinic.

Today, I would like to learn more about the path that led you here, and your experiences and perspectives as a provider of what many are calling the “new normal.” I would like to begin by asking:

1. Can you tell me how you became involved in integrative medicine, focusing on some events that were instrumental in leading you down this path?
   Can you tell me more about your training, specialty, and how that fits with the Clinic?
   What do you see as the vision for the Clinic?
   What do you see as some of the most important goals for accomplishing that vision?
   Can you tell me a story of an event or incident that best represents the effective coordination of services at the Clinic or effective collaboration among the providers at the Clinic?
   Can you tell me a story of an event or incident that best represents something that complicates or impedes collaboration or coordination among providers?
   What would you describe as the single most important factor that has facilitated the existence and growth of the Clinic within the larger Hospital system? What factor has restricted the existence or growth?
   What needs to happen NOW to make IM economically viable?
   If you were to offer one piece of advice to the Director of the Clinic? Is there anything we have not asked about, that you believe is important for us to know?
   What advice would you offer me in terms of whom I should interview and what I should observe or investigate to understand communication, collaboration, and coordinating integrative medicine going forward?

I would like to set up second round interviews with all the Clinic’s physicians in the New Year; is email the best way to coordinate with you? Thank you so much for your time.
APPENDIX C

CLASS SCHEDULE
<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<td>Monitored Exercise (cardiac rehab. only)</td>
<td>Monitored Exercise (cardiac rehab. only)</td>
<td>Monitored Exercise (cardiac rehab. only)</td>
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<td>Group Support (addit. option for LC Prog. participants)</td>
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<tr>
<td>9:15-10:15AM</td>
<td>Exercise LSC Prog. and cardiac rehab.</td>
<td>Exercise LSC Prog. and cardiac rehab.</td>
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<td>Stress Mastery through Yoga and Meditation LSC Prog.</td>
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<tr>
<td>10:30-11:30AM</td>
<td>Group Support LSC Prog.</td>
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<td>Stress Mastery through Yoga and Meditation LSC Prog.</td>
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<td>11:30AM-12:30PM</td>
<td>Body-Mind &quot;Brown-Bag&quot; Lecture Series LSC Prog.</td>
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<td>Note time: 12:45pm-1:45pm Vegetarian Cooking School LSC Prog.</td>
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<td>2:45-3:45PM</td>
<td><strong>QI Gong</strong> (additional fee; class not included in LSCP)</td>
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<tr>
<td>5:15-6:15PM</td>
<td><strong>Kundalini Yoga</strong> Note time: 5:15-6:15 PM (additional fee; class not included in LSCP)</td>
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<tr>
<td>6:00-7:15PM</td>
<td><strong>Yoga and Meditation</strong> (additional fee; class not included in LSCP)</td>
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