A Thesis

entitled

Is Complementary and Alternative Medicine (CAM) Used to Combat Medical Costs?: A Study of Consumers, Medical Professionals, and a CAM Practitioner

by

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Rising medical costs have become a national issue in the U.S. (Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011) and medical debt and medical bankruptcy have become more common (Seifert and Rukavina 2006, Wright and Rogers 2011). Meanwhile, CAM use has increased in the U.S. (Ben-Ary et al. 2011, Ditte et al. 2011, Dolder et al. 2003, and Wetzel et al. 2003). This study used qualitative methods to identify how rising medical costs and the rise in complementary and alternative medicine (CAM) use were affecting participants. Particularly, data were collected in order to identify whether participants were utilizing CAM to combat rising medical costs. This study also explored how participant interactions and attitudes influenced their health and healing behaviors. These topics were explored from the perspective of participants with various social roles within and outside of the health care industry: consumers, physicians, nurses, and a CAM practitioner. Despite the fact that CAM is typically outside of the health care industry, which is considered the norm, most of the participants recognized the legitimacy and effectiveness of CAM. Even medical professionals, who are educated
in the dominance of the health care industry and traditional Western medicine, had positive views of CAM use. Participants also described that they, or others, were utilizing CAM as tool in order to combat negative aspects of the health care industry. The negative aspects that were described by participants were medical expenses, overmedication, somatic therapies, and difficulties in communicating. Although not every one of these issues was overtly related to costs, many responses reflected a cost component. Thus, CAM is utilized by participants as a tool to combat negative aspects of the health care industry—especially medical costs. Despite the fact that CAM can be utilized in this way, CAM is not fully integrated into the health care industry. The exclusion, or rarity, of CAM use within the industry is most likely a business decision by corporate elites in the industry to maintain control and profitability—decisions which profoundly influence the health of the population.
This thesis is dedicated to my family. I want to dedicate this to my parents, grandparents, and great-grandparents for always supporting and encouraging my education. Thank you Mom, Dad, Grandma Smith, Grandpa Smith, Grandma K, Grandpa K, Grandma Simon, and Grandpa Simon. I could not have done this without any of you. Also, a big thank you to the rest of my family for supporting me on this journey! Thank you to my best friend and partner Shawn Alkenbrack for putting up with my craziness every single day. I do not think I could have made it through without you. To the rest of my wonderful family: Thank you for putting up with my missing events, phone calls, and canceling plans due to my crazy schedule, especially my two beautiful sisters Chea and Mamie. Hopefully, you can all forgive me. This thesis is dedicated to you!
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List of Abbreviations

CAM .......................Complementary and Alternative Medicine
NCCAM..................The National Center for Complementary and Alternative Medicine
CBS ......................Culture Bound Syndrome
Chapter 1

Introduction

1.1 Aim of This Research

This study explores how participants perceive current societal and cultural trends surrounding healing and healing in the United States. It focuses on two recent trends: rising medical costs and the rise in complementary and alternative medicine use (CAM). This research explores how people are interacting with rising medical costs and how costs influence their health and healing attitudes and behaviors. This study particularly examines whether participants are using CAM to combat rising medical costs. The relationship between medical costs and CAM use was determined by analyzing data collected both on how participants are forming attitudes on these trends, their interactions with the health care industry in the past, and how they are approaching health and healing as a result. Additionally, this study explores how medical professional participants are reacting to the same social trends and how these trends influence their health and healing decisions and behaviors, both in their own lives and the lives of their patients.

1.2 Rationale for This Study

Health and healing are areas of interest because of the numerous social issues surrounding these topics in the United States today. Much of the current discussion on
health and healing centers on the formal health care industry. High medical costs, for example, have become a national issue (Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011). Over medication (Bain et al. 2008, Bushardt et al. 2008, Comer et al. 2010) and access to health care services (Ginsberg et al. 2008, Veugelers and Yip 2003) are also aspects of the health care industry which have received attention.

Universal health care has been discussed recently as a tool that will allow individuals of all socio-economic statuses access to health care services (Ginsberg et al. 2008, Veugelers and Yip 2003). However, universal health care has generated a large amount of media controversy (Manchikanti and Hirsch 2009, Wright and Rogers 2011).

This study does not and cannot focus on every issue surrounding health, healing, and the health care industry. However, this study is timely because currently much attention has been given to health care issues (Bain et al. 2008, Bushardt et al. 2008, Comer et al. 2010, Ginsberg et al. 2008, Havinghurst 2001, Hulme and Long 2005, King 2004, Seifert and Rukavina 2006, Wright and Rogers 2011, Veugelers and Yip 2003). Despite, discussion on health care issues, little discussion has centered around how these factors influence the health and healing behaviors of individuals of various roles within and outside of the health care industry. This study provides insight into how rising medical costs, one of many health care issues, are affecting the health and healing behaviors of both consumers of health care services and professionals within and outside of the health care industry.

This study gives insight into how individuals are responding to the rise in complementary and alternative medicine (CAM) use. CAM refers to a number practices that are meant to address health and healing as a whole and that satisfy health needs that
traditional Western medicine typically does not meet (Molassiotis et al. 2005). The National Center for Complementary and Alternative Medicine (NCCAM) defines most CAM practices as fitting into three categories: manipulative medicine, natural products, and mind and body medicine (nccam.nih.gov. 2012). CAM use is increasing in the U.S. (Ben-Ary et al. 2011, Ditte et al. 2011, Dolder et al. 2003, and Wetzel et al. 2003). It is a topic that appears frequently on the news, on the Internet, and in academic journals (Arikan and Gurol 2011, Hasan 2010, Koc et al 2012, Maino 2012, Mohan et al 2011, Zhang et al 2011). Despite the conversation surrounding CAM, there is much conflicting information. With its ethnographic approach, this study sheds light on how individuals view CAM, if they are familiar with CAM treatment practices, and how, or if, they are utilizing CAM in their own life. Lastly, this study attempts to identify whether individuals are reacting to rising medical costs by using CAM.

Finally, although this study has current practical relevance, it also contributes to sociological knowledge on issues such as power, authority, social roles, socialization, and the institution of health care in the U.S. This study examines the impact of two social trends in the health care industry---rising medical costs and a rise in CAM use---on participants with various social roles within and outside it: medical professionals, consumers of health care services, and a CAM practitioner.

1.3 What this study adds to health and healing research

This study adds to research on health and healing from a sociological perspective. In particular, this study will add to previously conducted qualitative research on health and healing (Cassell 2004, Cohn 2007, Frank 2000, Frank 2003, Leung et al. 2012) by exploring the influence of social trends on attitudes and behaviors. It is unique in that it
explores individuals’ attitudes on rising medical costs and the rise in alternative medicine use based on their experiences within and outside of this health care environment, and uses primary to gain insight into how these trends influence participant interactions and behaviors. This study identifies whether rising medical costs are causing individuals to utilize CAM to meet some of their health and healing needs.
Chapter 2

Literature Review

As Herbert Blumer (1969) points out, “As human beings we act singly, collectively, and societally on the basis of the meanings which things have for us (132).” Individuals in the U.S. view and approach health and healing in diverse ways based on the meaning these concepts have for them. When an individual decides how to address health and healing in their life, attitudes, interactions, and culture influence their behaviors. In this chapter, the main objectives will be to discuss the influence of culture and U.S. culture on health, to explain the predominance of traditional Western medicine in health care, and to describe two recent trends: rising medical costs and the rise in complementary and alternative medicine (CAM) use. This chapter also discusses social roles within and outside of the health care industry. The roles which are discussed are physician, nurse, consumer, and CAM practitioner. Finally, this chapter discusses other qualitative studies on health and healing, and how this study adds to that body of knowledge.

2.1 Health as a Result of Societal, Cultural, and Environmental Factors

The influence of culture and society on health is multi-faceted. This study does not attempt to describe all the ways in which culture and society influence health and
healing behaviors. However, it is important to discuss the impact culture can have on health and healing, as this study will examine how specific societal trends are influencing health and healing behaviors, and, in some cases, causing participants to deviate from the formal health care industry to the use of other healing modalities such as CAM.

Health involves more than how an individual treats his or her body: health and illness are a product of society and culture. Freund, McGuire, and Podhurst (2003) successfully explained how cultural, societal, and environmental factors influence health. The authors began their discussion with explaining how culture dictates what people view as healthy and how they approach healing. From the time individuals are born in specific culture and society their chances of survival, affect their chances of acquiring certain skills, and the probability that they will be stricken by certain illnesses or diseases.

Freund et al. (2003) explained that although it may seem like children should be or are born with a clean health slate, so to speak, from the moment a child is conceived the baby is affected by its culture. Cultural factors dictate an expectant mother’s diet, stress level, and habits. Additionally, socioeconomic status influences the newborn’s health because of the mother’s quality of diet, the sanitation of her surroundings, and a variety of other factors. Thus, by the time a baby is born, based on societal and cultural factors, the infant’s health is already greatly impacted.

Freund et al. (2003) explained that after birth, the health of individuals continues to be influenced by cultural and social values and traditions. One aspect that alters the health of an individual is social structure. Social structure refers to our social interactions and roles within society. An element of social structure is social class. Social class is an informal ranking system that divides individuals in society based on a number of factors
such as race, gender, and socioeconomic status. Social class impacts health because of access an individual has to services, education, nutrition, and living conditions.

2.2 Health Challenges in U.S. Society and Culture

Culture can and does influence health. Many of the most common illnesses afflicting current society are related to the lifestyles of the population (Adams 2009). Americans have a high amount of stress because of the amount of roles and responsibilities which they expected to participate in and fulfill. Adams (2009) points out that occupational stress can be damaging to one’s health. The amount of stress caused by a challenging workload, the current economy, and globalization causes individuals to participate in unhealthy behaviors more frequently: drinking, smoking, and overeating. Adams (2009) hypothesizes that the extra stress and responsibilities faced by Americans currently are a barrier to individuals leading healthier lives.

Currently, how Americans interact with our cultural climate is having a huge impact on health in the U.S. In 2009, it was estimated that about 75% of health conditions are related to lifestyle choices and stress (Adams 2009). In fact, the top five causes of death in the United States, according to the National Center for Health Statistics, are heart disease, cancer, chronic lower respiratory diseases, stroke, and accidents (cdc.gov 2012). Because many of these causes of death are related to lifestyle choices, social and culture factors contribute to the development of these afflictions and consequential death of the majority of Americans.

Amber Haque echoes the sentiment that culture is extremely influential in the health of individuals (2008). Health and illness are so intertwined with culture that the term culture-bound syndrome or CBS was created. The concept of CBS is illnesses or
health conditions that only occur in certain cultures, referring to illnesses that manifest out of practicing certain behaviors or cognitive processes that are culturally-specific (Balhara and Singh 2011). Conditions that are culturally-bound are of extreme interest to ethno-psychiatrists and medical anthropologists (Haque 2008, Ritenbaugh 1982, Sumathipala et al. 2004, Weller et al. 2002). However, it is important to note that there is controversy around the concept of CBS because of the various aspects that the term can connote and the disciplinary disagreements surrounding the term (Haque 2008). Despite such professional disagreement, the illnesses that exist in certain regions of the world are, no doubt, very real for the people suffering from them, and can influence their healing behaviors. Regardless of the controversy, however, the data suggests that CBS demonstrates the extent of culture’s potential influence in regards to illness.

2.3 Sociocultural values and healing

Like the diseases and health issues that develop within a culture, how society addresses such issues and views healing are also dependent on a number of socio-cultural factors. Sodi and Bojuwove (2011) discussed how cultural beliefs and practices in various parts of the world impact the way that individuals diagnose and heal disease. The authors compared three different cultures and their approaches to healing in order to demonstrate how greatly culture affects healing in three different countries of the world: England, South Africa, and India. In each of the three contexts, the authors discussed men who complained of identical symptoms. In England, the symptoms were diagnosed as depression, and it was suggested that the patient treat the depression by talking with a psychiatrist, checking himself into a hospital, or taking an extended leave from work (Sodi and Bojuwove 2011: 351). In India, a patient suffering from the same symptoms
was taken to a shaman, where it was recommended that the patient leave his current profession and enter into the shamanic practice (Sodi and Bojuwoye 2011: 351). In South Africa, a man suffering from the same symptoms was taken to a healer where he was diagnosed with a condition called ‘senyama’ (Sodi and Bojuwoye 2011: 351). The word ‘senyama’ translates to mean bad luck, and the healer suggested that the man kill a black goat to be sacrificed to his ancestors (Sodi and Bojuwoye 2011:351). These examples demonstrate how diverse health and healing approaches and practices can be viewed cross-culturally as well as the role of culture in identifying both illness and remedy within a particular context.

Cultural approaches to healing around the world are shaped by how individuals have been socialized to perceive themselves and their societal roles (Geils 2011, Shweder and Bourne 1982). Health practices in Western culture typically put little to no emphasis on an individual’s role, institutions, or power relationships with society. From above example, one can identify how diverse health philosophies are from one culture to the next. The three men with the identical symptoms were diagnosed and treated with a variety of different techniques because of their residency in three different areas of the world. As identified in the case of the English man suffering from depression, Western cultures often identify psychological issues to understand an individual’s behaviors in society (Sodi and Bojuwoye 2011). Additionally, the man’s psychological issues are viewed as the result of the individual, not of the community or larger society (Sodi and Bojuwoye 2011).

Additionally, one can identify how medically-trained professionals in Western society target where they believe the problem lies and treat that area of the body
specifically. In other societies, as identified in this example of three countries, there tends to be a more holistic approach to healing than in countries in the Western part of the world (Myers 1988). Discussion of healing in other cultural contexts is important because it provides insight into how culturally-specific healing can be.

Anthropologist Emily Martin wrote the groundbreaking book *The Woman in the Body* (1987), an ethnographical work which discussed how individuals interacted with the environment, society, and culture, and the effect it had on their health. Martin’s work primarily focused on the field work that she conducted on women’s reproductive health and the influence of American socio-cultural values. Martin discussed women’s reproductive health throughout their lives, covering topics such as menstruation, reproduction, and menopause. Her research and analysis are useful for this study, because she examined socio-cultural values and their influence on social roles, interactions, and women’s health and healing.

Martin (1987) explained that capitalism influenced the way Americans approached health. Martin wrote that disease in the U.S. was viewed in a certain way because of the values and beliefs of the nation. One of the most prominent aspects of the U.S. culture is the political and economic system of capitalism. Capitalism affects all aspects of American society; thus, it is not shocking that the values and views associated with capitalism would have an effect on health. Because capitalistic values are so ingrained in individuals’ value systems, Martin writes that health and healing are also viewed from a capitalistic perspective. In the past, the body was often viewed as a hierarchically structured (Martin 1987:44). Additionally, there was a cultural belief that people only had an allotted amount of life to expel before death, and the body was often
viewed as separate from other aspects of a human such as their mind or soul (Martin 1987: 34, 158).

These collective societal views resulted in the way Americans treat the body and the health condition which afflicts it. Martin wrote that beliefs and values of 20th century U.S. society resulted in the way we treated health conditions within the body (1987). Americans isolate areas of the body in order treat a health condition. Additionally, healing in the U.S. is often viewed as occurring as the result of “mechanical manipulations” of the area in which attention is needed (Martin 1987 p. 20). Fragmentation and isolation of different body parts further occurs because different parts of the body can be removed, replaced, and moved from person to person. Although time has passed since Emily Martin published her book, her description of how capitalistic values have influenced Western healing practices remains relevant.

2.4 A Brief history of capitalism in the U.S. and the formal health care industry

The literature reviewed demonstrates that culture is an important influence on health and healing. In the U.S., the political and economic system of capitalism has a strong influence on cultural values. Capitalism in the U.S. is unique compared to other capitalist nations, and the economic system can be described both as laissez-faire capitalism and free-market capitalism (Bradley and Donway 2010). These terms refer to U.S. capitalism which consists of open markets that are relatively free of regulation and have less governmental control than in other economically similar nations (Bradley and Donway 2010). There is no doubt that the U.S.’s unique “brand” of capitalism influences the way Americans approach healing and has impacted how the health care industry developed into what it is today.
The 1979 court case Goldfarb v. Virginia State is considered important because it changed the way the health care system in the United States progressed into its current form as a big business (Havinghurst 2001). The result of the court case was that certain professions were exempt from antitrust laws, and that anticompetitive behavior amongst professionals has a negative effect on commerce (Havinghurst 2001, Young 1975). Therefore, industry within health care began to become more competitive and thus, more profitable (Havinghurst 2001, Wright and Rogers 2011). Medicare and Medicaid, for example, increased their profits after the ruling (Havinghurst 2001).

As competition and profitability began to increase in the health care sector, the formal health care system continued to change. Paul Starr wrote about this extensively in his book, *The Social Transformation of American Medicine* (1982). Like businesses in other sectors at the time, businesses in the health care industry became a part of big business in America. The term big business refers to large firms which can reach a broad consumer base, appear frequently in the market, and mass produce goods or have the ability to offer services to an increased number of individuals (High 1985). Becoming a big business allowed for the health care industry to reach more people and become more successful financially (Starr 1982). This was a big change in the structure, considering that in the past doctors worked primarily for themselves, in independent practices, outside of the control of large corporations. The gradual shift that occurred was not without consequences. Starr (1982) wrote about the transition from independent practices to the current big business health care industry stating,

“{Americans} may prepare the way, moreover, for the acceleration of a third development, the rise of corporate enterprise in health services, which is already having a profound impact on the ethos and politics of medical care as well as its institutions (421).”
During the time period after Starr’s (1982) writing, the formal health care industry went through even more changes. As the health care industry was transitioning into big business, other changes occurred in the insurance industry, in U.S. social policies, which increased the health care industry’s profits tremendously in the late 1980’s and early 1990’s (Iriart 2011). For example, one sector of the health care industry that changed dramatically was pharmaceutical companies, which strategically changed in order to become a business and economic leader. During this time period, pharmaceutical companies lobbied for changes in drug regulations and approvals, became more involved with and in touch with patient demands, and worked to redefine health and disease to benefit their companies (Iriart 2011). This is just one example of how large corporate interests were changing in the health industry during the late 1980’s and early 1990’s. However, there were numerous other changes occurring for businesses in the health care industry in the late 20th century.

The other changes in the health care industry included increased competition, profitability, and several strategic policy and marketing changes. These allowed the industry to become extremely powerful and influential first decades of the 21rst century (Jasso-Aguilar and Waitzkin 2011). Lobbyists for companies in the industry have become extremely successful in advocating for the industry’s best interests (Iriart 2011, Jasso Aguilar and Waitzkin 2011). Consequently, smaller or less profitable companies have difficulty competing with larger industries in the health care industry which have the ability to pay lobbyists large amounts of money to fund their interests. Therefore,
capitalism in the U.S. has allowed for businesses in the health care industry to capitalize on their power and profitability.

The health care industry in the U.S. is extremely complex and involves many businesses, policy holders, and stakeholders at every level (Chen and Weir 2009). It would be extremely time consuming to discuss all the ways in which capitalism in America has influenced the health care industry to become the unique system that it is today. However, this brief discussion of the strong influence that capitalism in America has had on the health care industry shows how it has allowed for the health care industry to become extremely powerful.

2.5 Culture’s effect on health and healing behaviors

The U.S. has a unique population because it is comprised of a variety of different ethnicities and cultures. Identifying one homogenous culture in the U.S. is difficult, and can be problematic because of the extreme diversity of individuals within society (Singer 2012). Individuals can even belong to a variety of cultures at one time. From the standpoint of each of these cultural memberships, an individual interacts and can adopt identities or roles. Singer (2010) writes,

Every group of people belong to at least one culture, but in a multicultural society like the United States, each population group contemporaneously undergoes modifications and mixtures that result in cultures that are different not only from their native origins, but from similar groups across the country, and notably, individuals within each group undergo these modifications at varying rates and hold constituent elements to varying degrees (358).

Although each individual in the U.S. is influenced by American culture, there is a great deal of ethnic diversity within this culture. Therefore, while culture has an influence, the
influence does not result in identical health and healing behaviors among Americans. Therefore, health and healing behaviors can vary greatly from person to person.

2.6 Traditional Western medicine

The United States encompasses a variety of ethnicities and cultures; however, the European-American culture is dominant. In the U.S., most of the institutions are based on a European-American belief system, and the formal health care industry is no exception (Singer 2012). In the formal health care industry, the predominant line of thinking and method in regards to treatment and healing is what is termed traditional Western medicine or Western bio-medicine. Traditional Western medicine is a belief system that specifies the existence of certain illnesses, as well as certain ways to treat them, based on the principles of biology, bio-chemistry, and the natural sciences. Traditional Western medicine is typically viewed as a healing modality which provides symptomatic therapy, or treatment of symptoms. Bio-medicine has been established as the dominant healing ideology and system in the U.S. Western bio-medicine is taught in medical schools, and has a monopoly within the formal health care system. Because of Western bio-medicine’s dominant status in the U.S., it is the system by which other healing practices are viewed, measured, and judged (Shuval and Mizrach 2004).

2.7 Rising medical costs

Many nations with capitalistic economies use traditional Western medicine to address healing on a societal level. Like capitalism in the U.S., the health care industry is unique in the U.S in a variety of ways. One way that health care is unique in the U.S. is that health care is often accessed through an employer, and not on a socialized level (Seifert and Rukavina 2006, Wright and Rogers 2011). Only recently has socialized
health care become a national social policy with the recent passage of “Obamacare” (Iglehart 2010). However, the policy in its entirety not expected to take effect until 2014.

Another way that the health care industry is unique is that Americans pay more for health care than other nations do overall and in percentage of income (Wright and Rogers 2011). High medical costs could be attributed to multiple factors. One factor suggested as contributing to high medical costs is competition (Wright and Rogers 2011). American capitalism allows and encourages the market to be saturated with competition through less governmental controls and restrictions (Bradley and Donway 2010). This can be viewed as a positive, but when there is competition amongst businesses there is an incentive for each business to have the latest innovative technology. While possessing the latest medical technology can be a great marketing tool for a business, it often results in higher medical costs for consumers. Businesses may charge patients extra to cover the costs of the medical equipment or subject patients to tests that they may not necessarily need in order to use the equipment more frequently (Wright and Rogers 2011).

Another factor that has contributed to higher medical costs is the health care industry’s focus on treatment as opposed to prevention (Wright and Rogers 2011). In general, it costs less to prevent diseases or health conditions than to treat them. Because many of the most prevalent diseases and causes of death in the U.S. are lifestyle-related (McCormack and Boffetta 2011), it would be more cost-effective for individuals to change their lifestyle, in many cases, than to pay to treat the health consequences. For example, smoking tobacco is one of the most prominent risk factors for a number of different cancers (Schmidt et al. 2006). It would be more cost-effective for an individual not to smoke than to treat the various cancers that could result. Wright and Rogers (2011)
theorized that the industry’s focus on treatment is strategic. Treatments are normally more expensive than prevention.

Another factor that has caused an increase in medical costs for the public is the sale of government contracts to private firms according to Jasso-Aguilar and Waitzkin (2011). Jasso-Aguilar and Waitzkin outline how the sale of public contracts can cause an increase in medical costs for consumers. The authors discuss factors such as an added layer of bureaucracy or using expensive brand name drugs (when there are cheaper generic equivalents) as evidence that the sale of public contracts is contributing to rising medical costs.

2.8 Medical debt

Rising medical costs are multi-faceted and derive from a variety of different factors. One thing is certain: Americans are paying an extremely high amount for medical care (Ginsburg et al. 2008, Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011). The health care market is unique in that, unlike other markets, people may feel “forced” to pay the high prices and risk financial troubles, rather than risk their health or the health of their loved ones (Wright and Rogers 2011). High medical costs have resulted in many Americans accruing medical debt. In 2006, it was estimated that 29 million Americans had debt as a result of medical expenses (Seifert and Rukavina 2006). In 2011, medical debt was the leading cause of bankruptcy in the U.S. (Wright and Rogers 2011). These statistics paint a shocking picture of the severity and impact medical costs have on individuals and their families.

Medical debt can have a negative bearing on an individual’s life and health. Himmelstein et al. (2005) conducted a unique study identify the impact of medical debt
and medical bankruptcy had on individuals and their families. The authors found that in the years before filing for medical bankruptcy, many individuals with medical debt went without needed doctor or dentist appointments or filling their prescriptions. Other individuals with medical debt have reported no longer being financially able to pay bills or even, in some situations, purchase food in the years before filing. In the years after filing bankruptcy, the problems continued for individuals and their families. The blemish on credit reports can result in high insurance payments, and difficulties getting jobs, loans, or rentals. Thus, individuals are being punished for their inability to afford sometimes critical procedures and treatments.

Medical debt and medical bankruptcy have become more common for Americans. Even individuals with private health insurance, incomes of more than $40,000, and higher education have become more vulnerable to medical debt (Seifert and Rukavina 2006). With medical debt and bankruptcy becoming more severe and common, it is plausible that individuals would change their health and healing behaviors in order to avoid some of the negative consequences such as medical debt and medical bankruptcy.

2.9 Complementary and alternative medicine

Individuals may be looking for other healing modalities, such as complementary and alternative medicine (CAM), because of medical costs and the fear of medical debt or medical bankruptcy. Because traditional Western medicine is often viewed as the norm in the U.S., CAM can often be seen as oppositional (Shuval and Mizrachi 2004, Singer 2012). The opposition between the practitioners of the healing modalities has stemmed from a history of tumultuous relationships between practitioners of the different healing modalities.
Starr (1982) wrote extensively about the oppositional relationship between practitioners of traditional Western medicine and CAM. He explained that in the 1800s, physicians began to establish dominance and authority in the U.S. in regards to health and healing. During this century, medical schools began to spring up, physicians were able to earn a living practicing medicine, and the social role of physicians allowed for individuals to achieve elite social and economic statuses. Physicians during this time also began to practice traditional Western medicine.

Starr explained that homeopathy, a healing modality which consists of many natural remedies, was a popular form of medicine for the populations in the 1800s (1982), and that its popularity stemmed from its philosophical healing views: diagnosis and healing of each individual as a unique person. Although homeopaths shared many of the same beliefs as traditional doctors, they were discredited by physicians, who practiced primarily traditional Western medicine. Many traditional physicians refused to work with homeopaths in facilities, and contact with homeopaths or the purchase of homeopathic goods became a source of expulsion from the medical community.

Currently, the National Center for Complementary and Alternative Medicine (NCCAM) acknowledges that defining CAM is difficult because the term encompasses a wide variety of practices that are not always conceptualized as separate from traditional Western medicine (nccam.nih.gov. 2012). The NCCAM does, however, give some examples of broad categories of CAM such as manipulative medicine and other body-based practices, natural products, and mind and body medicine (nccam.nih.gov. 2012). The term CAM also encompasses multiple ways in which the system can be utilized, such as complementary (with traditional Western medicine), alternative (instead of
traditional Western medicine), and integrative medicine (combination of alternative medicine and traditional Western medicine) (nccam.nih.gov 2012). As indicated from the information provided by NCCAM, traditional Western medicine and CAM are often used in conjunction. Therefore, individuals do not necessarily have to make choices to utilize CAM for health conditions instead of traditional Western medicine.


2.10 Occupational roles

Occupational roles are an important component of this study. Medical professionals have had unique training, which influences how they approach health and healing in their lives and the lives of their patients. Medical schools in the U.S., as mentioned earlier, center most of their education around Western bio-medicine (Mizrachi et al. 2005). Despite this, current literature reflects that the medical community is acknowledging that more education on complementary and alternative medicine is needed among the nation’s future physicians, nurses, medical assistants, and pharmacists.
(Dolder et al. 2003, Tiralong et al. 2008, Wetzel et al. 2003). Studies have found that medical professionals have reported that they do not have sufficient knowledge of CAM practices (Dolder et al. 2003, Tiralong et al. 2008). Because medical professionals do not have extensive knowledge of CAM, they may not feel comfortable recommending practices, explaining proper dosing, or discussing side effects of CAM supplements or practices (Dolder et al. 2003, Tiralong et al. 2008). Therefore, CAM does not have a large role and is not fully integrated into the medical community currently.

2.10.1 CAM practitioners

Because CAM generally and historically has not been included in the formal health care industry, CAM practitioners are often considered to be outside of the industry as well. The term CAM practitioner can refer to a variety of roles, because the scope of CAM is so broad. One aspect that unites CAM practitioners is that they are considered outside of traditional Western medicine which is (viewed as) the practice norm (Shuval and Mizrachi 2004, Singer 2012). Because authorities on CAM are viewed as outside of the norm, these individuals do not have the same elite status and prestige as physicians or other medical professionals. However, CAM use is increasing (Ben-Ary et al. 2011, Ditte et al. 2011, Dolder et al. 2003, and Wetzel et al. 2003). Therefore, Americans may be becoming more willing to accept authorities on CAM as authorities on health and healing. All of these factors would theoretically influence how individuals view CAM practitioners and CAM, in general.

2.10.2 Physicians

Physicians are medical professionals who are considered to be highest authority on health and healing in the health care industry (Starr 1982). The social role of physician
accompanies an elite social status and prestige. The role of physician requires that individuals have higher education, which is typically science-based, and more qualifications than other medical professionals. Physician is the occupation that is often credited with curing diseases or illness in their patients (Carpenter 1995, Martin 1987). This is opposed to nurses, who are often not credited with curing disease or illness but instead with assisting the doctor or caring for patients (Carpenter 1995). Martin (1987) expressed a similar sentiment about the role of physicians and pointed out in her writing that relative to the process of giving birth physicians are often crediting with delivering the baby and rather than the mother. Thus, the role of physician is viewed as that of high responsibility and a high social reward.

2.10.3 Nurses

Nurses are medical professionals who are considered an authority on health healing; however, the social role is not usually granted as much prestige as the physician role (Fletcher 2007). Nurses must complete a certain amount of socially-sanctioned criteria in order to achieve their social position. Nurses, however, traditionally have different qualifications which they need to meet to fulfill their professional social role than do doctors. They are usually thought of as being below physicians in authority on health and healing.

There is also a gender dynamic in the social roles of nurse and physician. Nurses have traditionally been and typically are predominately female (Hesselbart 1977), and physicians have traditionally been males (Carpenter 1995). Females in U.S. society are in a social position which has less social power than males. Women often occupy occupations that earn less money or have less prestige than men (Tam 1997). In the
health care industry, nurses and are often below the doctor in rank and authority. The relationship continues to the present day, despite that men are nurses and women are physicians. The complexity of the social role of nurse can influence how an individual forms attitudes on and approaches health and healing.

2.10.4 Consumers

The social role of consumer is less homogeneous than other social roles in this study, because these individuals can have diverse knowledge, education, and experiences with health and healing. In the health care industry as well as in this study, consumers are defined as individuals who are seeking health services, advice, or products in exchange for money. Although medical professionals or authorities on complementary and alternative medicine may receive health services at some point in their lives, consumers in this study are not authorities in the health care industry nor in other healing modalities which are not traditionally associated.

The role of consumer can influence participants’ interactions with the health care industry in a complex way. The social role of consumer is present in the everyday lives of many individuals (Jenkins 2011). Therefore, the role of consumer is hard to concretely define, as every person’s experience with medical consumerism is unique. When interacting with the health care industry, however, the role of consumer does not allow individuals much power or authority, which can cause individuals to be in a vulnerable position because of rising medical costs.

As discussed previously, consumers have little authority within the health care industry. Therefore, consumers have little ability to challenge or resist high medical costs. Because of the lack of authority within the industry, consumers must pay high
medical prices or alter the ways in which they choose to receive care. When finances are a primary concern, consumers may not choose the best treatment option for their health conditions but a short term or less effective treatment that is more affordable. Additionally, a consumer’s interactions may be limited due to finances because insurance or economic resources can often dictate, not only the types of treatments that an individual uses, but where an individual can receive care. Thus, consumers’ lack of authority in the health care industry subjects them to high medical costs which can negatively impact consumers’ access to certain medical care and their health as a result.

Consumers are also at a disadvantage when interacting with the health care industry and medical professionals because they do not have as much knowledge of health and healing. Physicians and nurses have to go through educational programs, earn certain degrees, and receive specific training before they are acknowledged as fulfilling their credentialed social role. With their social role, medical professionals are expected to be an authority on health and healing. Most consumers would probably not claim that they had as much knowledge of health and healing as physicians and nurses. Therefore, many consumers may follow a doctor or nurse’s recommendations on their health, even if they do not feel that the advice is the best for them. This puts consumers at a disadvantage because they many not feel that they have enough authority or knowledge of health and healing to challenge a medical professional’s recommendations.

Another way that a consumer’s social role puts them at a disadvantage is the vulnerability that comes along with a health condition. Individuals are vulnerable when they or their loved ones are ill, because they are often at weak points physically, mentally, and emotionally (Starr 1982). When an individual is in a vulnerable position,
she or he may be willing to accrue large amounts of debt rather than risk their lives or the life of their loved one (Wright and Rogers 2011). Individuals, when in a vulnerable state, may also be less likely to pursue interactions with several health care professionals in order to make an informed decision. Treating a health condition can be a stressful time. Individuals may be unable to or have limited time to fulfill many of their other social roles when battling a health condition. In this type of a situation, individuals may not want to prolong the healing process in order to pursue the best health care option, which can result in lower quality or less successful care.

Because of the many issues surrounding health care, consumers may feel somewhat distrustful of the health care industry, in general. One of the major issues surrounding health care, on which this study focuses, is the high price of medical care (Ginsburg et al. 2008, Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011). Other issues which have received academic attention are access to care and overmedication (Bain et al. 2008, Bushardt et al. 2008, Comer et al. 2010, Ginsberg et al. 2008, Veugelers and Yip 2003). Many of the current issues in health care have caused many consumers to feel distrustful of the health care industry, in general. In a 1998 poll, most Americans reported that they did not have a lot of confidence that they would be able to receive the care they need from the health care industry (Friedman 1998).

The role of consumer in the health care industry, based all the factors mentioned above, can influence the way that individuals interact with that industry. Consumers must consider and be wary of the many issues surrounding health care when seeking health care services (Bain et al. 2008, Bushardt et al. 2008, Comer et al. 2010, Ginsburg et al. 2008, Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011,
Veugelers and Yip 2003). However, the role of consumer also requires and implies that an individual has less knowledge of health and healing (Friedman 1999), and needs the advice and services of medical professionals and the health care industry. All of these factors impact the social role of consumer to varying degrees, which can influence and cause unique inner attitudes, interactions, and health and healing behaviors.

### 2.11 How this study adds to research on health and healing

This study adds to other research on health and healing (Broom 2009, Cassell, 2004, Cohn 2007, Foote-Arah 2004, Frank 2000, Frank 2003). For example, this study adds to Jonathan Cohn’s (2007) research on the health care industry. Jonathan Cohn (2007) studied and analyzed the challenges that individuals were facing when navigating through the health care industry. Cohn collected this information through qualitative interviews, and his analysis focused on the financial challenges his participants faced in the current U.S. health care system. Although his book had many interesting points, a few of the interviews he discussed are especially revealing of the challenges individuals face today when interacting within the U.S. health care system.

Cohn presents the story of a woman who gave birth to premature twins (2007). The twins were born when the woman was only 25 weeks pregnant, and each child only weighed only one pound and thirteen ounces. The children were attached to numerous machines, but lived and eventually came home, prompting their mother to quit her job to take care of them and their health needs full time. While technology and medical care were certainly life saving for the twins, this family’s experience was not all positive. Issues arose when the family’s health insurance covered only facilities and doctors within their network, and had the ability to refuse coverage on the procedures that the twins
needed. The result was a battle between the family and their health insurance company in order to get the proper care that the twins needed.

### 2.11.1 Interactions in Cohn’s research

Cohn does not address roles and interactions extensively or overtly in his book. However, this family’s experience is a good example of how consumers interact with the health care industry and how it can impact their health and healing decisions. This study will add to Cohn’s research, and other studies like it, by identifying how interacting with the health care industry can impact health care decisions. This study extends the existing literature by identifying whether individuals are utilizing CAM out of frustration with the current health care industry.

### 2.11.2 Qualitative studies on traditional Western medicine and CAM use

This study also adds to other qualitative studies on health and healing (Broom 2009, Foote-Ardah 2004, Frank 2000, Frank 2003). Both Broom (2009) and Foote-Ardah (2004) discuss how patients make decisions on when and whether to use traditional Western medicine or CAM practices. Broom (2009) explored and discussed how patients were making decisions on treatment methods. Foote-Ardah (2004) also explored in her study what makes individuals deviate from traditional Western medicine to CAM use (2004). Although both studies explored how or why individuals may depart from traditional Western medicine use to CAM practices, the studies did not address the use of CAM practices to combat medical expenses. This study adds to this research and many other studies by discussing whether individuals are using CAM as a result of rising medical costs.
Chapter 3

Theory

Culture and capitalism have shaped the way that Americans approach health and healing. As discussed previously, health, as concept, can be both a universal and also a culturally-specific term. Maslow’s hierarchy of needs famously describes the needs that each individual must meet in order to be healthy on a variety of levels (Gorman 2010). Maslow theorized that our lowest levels of needs must be met in order to fulfill our higher needs (Zalenski and Raspa 2006 in Gorman 2010).

Health needs can be viewed using Maslow’s hierarchy of needs. All people have basic needs which allow them to be healthy, functioning human beings. These are things such as food, water, and sleep. As health needs rise to higher levels, however, they can become more culturally specific. Certain cultures view certain practices as a part of their health needs, while others may reject them. The people within the cultures are often then socialized to accept these health practices as important and needed. Although individuals are influenced by their culture, they can choose to reject their cultural practices or accept them as their own (Mead 1934).
Health and healing are extremely complex topics, which involve a variety of players with different roles, social interactions, attitudes, and values. Symbolic interactionism theory is the best theory to explain how participants in this study formed attitudes and approached health and healing in their lives, and, when it applies, the health and healing of their patients. This chapter discusses two symbolic interactionism theorists, and how their work contributes to this study: George Herbert Mead and Erving Goffman.

This chapter will also discuss how both Marxist and symbolic interactionism theories can explain the relationship between consumer participants and the health care industry. Karl Marx discussed exploitive relationships extensively throughout his career (Tucker 1978). Marx discussed his theory that, in capitalism, the bourgeois or the elite class are exploitative of the proletariat or the lower classes. Rebecca Jasso-Aguilar and Howard Waitzkin (2011) have applied Marx’s theory of exploitation to consumers’ relationship to the health care industry. This chapter discusses and defends why Marx’s theory is applicable to the relationship between consumers and the health care industry, as explained by Jasso-Aguilar and Waitzkin (2011). Last, this chapter also discusses how Goffman’s (1959) theory of teams and discrepant roles can be applied to the health care industry, and how elites work together to protect the industry’s dominance and profitability.

3.1 Individuality in behaviors

The individuality of humans is important, because this study discusses the diverse ways participants approached health and healing. Theorist George Herbert Mead (1934) discussed humans as individuals who can and do choose to think and behave in unique
ways from one another. He defended this position with comparing human behavior to animal behavior, the behavior of dogs, in particular. Mead explained that humans are socialized to act and interact in certain ways. However, humans are able to reject socialization and choose to act in ways which are not socially acceptable. This is different from dogs, Mead argued, which can be conditioned into responding in uniformed ways. Mead explained that we cannot compare humans to dogs, because humans are intelligent, rational beings who cannot be conditioned. Mead’s acknowledgement of individuality in human behaviors is important for the analysis. Although participants may all be participating in American culture to some extent, participants are not behaving in identical ways. Every participant in this study reacted to rising medical costs or other issues in health care in unique ways.

3.2 Social roles, attitudes, interactions, and behaviors

Individuals act in unique ways. However, the social roles that participants fulfill and their roles’ place within or outside of the health care industry can influence their inner attitudes, interactions, and behaviors. Social roles are a large part of this study, and both Mead (1934) and Goffman’s (1959) explanations of social roles aided in analyzing the data collected from the participants. In the U.S., health and healing involves numerous social roles: consumer or patient, nurse, physician, and many others. Mead (1934) and Goffman’s (1959) theories of role-taking helped to explain how social roles influenced each participant’s inner attitudes, interactions, and behaviors.

Mead (1934) explained that every human takes on and participates in social roles. Further, Mead explained the many ways that animals differ from humans; and one fundamental way in which the species differ is that humans take on social roles.
Assuming social roles involves fulfilling the expectations that society deems appropriate. Every human must participate in social roles when interacting, and assuming roles is unavoidable since no human can live in complete isolation. The existence of social roles, as explained by Mead, can be used to describe and explain the health and healing behaviors of participants. Social roles were utilized in this analysis, because participants act in culturally-specific ways based on their roles within or outside the health care industry.

3.2.1 Social roles and authority

Certain social roles within U.S. society have authority attached to them. Theorists Karl Marx and Friedrich Engels both wrote about authority in society (Marx and Engels in Tucker 1978). The theorists often worked in collaboration and had similar views on authority. Engels explained authority as an elite social position in which an individual could exert some control over an individual or group. Engels mainly discussed authority in his discussions of the capitalists or the bourgeois. Capitalists, due to their wealth and elite social status, were able exert authority over their workers and many aspects of society.

Marx expressed a similar view of social authority attached to individuals with wealth and property (Marx in Tucker 1978). He wrote that wealth often elevated individuals to a social position of authority and influence. In an employer and employee scenario, an example that Marx and Engels often used, the social role of employer has the power to exert his authority over his employees (Marx and Engels in Tucker 1978). The social role of employee also implies that an individual submits to the authority of their
employer; however, like any role, an individual can choose the degree to which they will participate.

Discussion of authority was important for analysis in this study. Authority is culturally determined and individually subjective. Certain roles are awarded a certain amount of authority and prestige in American culture. Physician, for example, is a social role that is given authority and prestige (Starr 1982). Conversely, CAM practitioners are not given as much, or in some cases any, prestige or authority (Shuval and Mizrachi 2004, Singer 2012, Starr 1982). Again, the lesser status of CAM practitioners is related to their exclusion from healthcare (Starr 1982). The authority associated with each participants’ respective social roles can influence how they form attitudes, interact, and behave.

3.2.2 Health care consumers and social roles

Roles within the health care industry encompass a certain amount of education, power, and authority. Social roles were discussed extensively in the literature review chapter (Carpenter 1995, Cohn 2007, Fletcher 2007, Friedman 2011, Jenkins 2011, Martin 1987, Starr 1982). However, the social roles of the participants will be briefly revisited and discussed in this chapter to demonstrate the importance of social roles in Mead’s (1934) theory of social interaction and analysis of the data collected in this study. In regard to the health care industry, each participant’s social role influences their interactions. The consumer role in the health care industry puts participants at a disadvantage and in an unequal position with medical professionals in the industry. Consumers typically do not have as much knowledge of medical practices, equipment,
health, or healing as medical professionals do (Friedman 2011). Because of this, consumers need guidance or advice from medical professionals.

3.2.3 Medical professionals and social roles

The social roles of nurse and physician have an advantage over consumers because they have studied health and healing extensively, although their bodies of knowledge may differ. However, as explained in the literature review chapter, even within medical professionals there is a hierarchy. Physicians are at the top of hierarchy, credited with healing the patient, and have the last say, over other medical professionals, on a patient’s treatment (Carpenter 1995, Martin 1987). Nurses are typically thought of as being below doctors in rank, authority, and knowledge on health and healing (Carpenter 1995, Fletcher 2007). All of these social roles influence interactions and the amount of power and authority that physicians and nurses have over their patients and their health, according to Mead’s (1934) theory of social roles.

Finally, as previously observed in the literature review, the social role of CAM practitioner is less socially-defined because CAM use is outside of what is typically considered outside of the health care industry in which traditional Western medicine is recognized system of medical authority and knowledge (Shuval and Mizrachi 2004, Singer 2012). The social role of CAM practitioner and it’s exclusion from the health care industry (Starr 1982), helped to interpret the unique ways in which the CAM practitioner participant formed inner attitudes, interacted, and approached health and healing, compared to consumer and medical professional participants. Mead (1934) emphasized the importance of social roles in interactions, and this study primarily uses social roles to interpret participant attitudes, interactions, and behaviors. This study specifically
examined how social roles influenced participants’ views on issues in health care such as rising medical costs, their views on CAM, and whether they were utilizing CAM to combat cost issues in health care.

3.3 Performances

Goffman (1959) added to Mead’s (1934) theory on social roles by comparing social roles to a performance. Mead (1934) discussed that each person is socialized into certain social roles. Goffman (1959) added that individuals are also socialized into accepting the expected performance attached to each social role. In performing social roles, individuals chose to what degree they will fulfill those roles, and this dictates the performance which they decide to give off to others. Individuals perform by highlighting the positive or socially-acceptable aspects of themselves and concealing the negative aspects, or the aspects of themselves which are not societally associated with the role they are fulfilling.

Goffman (1959) explained that individuals only perform social roles in front of other people. Goffman appropriately referred to the people watching the performance as the audience. In order for each social role to be accepted by the audience, the performer must maintain a certain degree of social distance. When there is enough social distance, audiences accept the performances given.

3.3.1 Physicians’ performance

Social role expectations can influence the performances that physicians are expected to give. Because physicians are considered the utmost authority on health and healing in the U.S., physicians may feel pressured to act as if they are in complete control
of an illness or health condition at all times. Physicians may especially act this way in front of their audience—-their patients.

Part of the physician performance is also to use traditional Western medicine. Traditional Western medicine is dominant in the health care industry and is the healing modality which is taught in medical schools (Shuval and Mizrachi 2004). Physicians have a certain comfort level using this method to treat their patients’ health conditions, because they have extensive knowledge of it. Even if a physician has knowledge of CAM or believes that CAM is useful in treating health conditions, they may not be comfortable utilizing the practices because they feel that would deviate from the performance which is traditionally associated with their role and might compromise their authority as produced in and sanctioned by the “approved” system of traditional Western medicine.

3.3.2 Nurses’ performance

Nurses’ performances are based on the many factors which make up their social role. Nurses are an authority on health and healing and have the ability to give advice to patients. However, nurses must also yield to the authority of physicians. Therefore, nurses often put on a performance in front of patients that establishes and guards the authority of the physician (Carpenter 1995). A nurse may participate in this performance even if he or she disagrees with the treatment that physicians give. Nurses may act in this manner because they feel it to be the correct performance associated with their social role.

3.4 Interactions and behaviors

Each participants’ interactions are influenced by their social role, and interactions are an important part of symbolic interactionism theory. Mead’s (1934) theory on
interactions is important for analyzing the data collected for this study. Mead explained that every person must interact with others during their lifetime, and no human is able to live without interactions. Thus, interactions are a part of every human’s reality. Mead explained that a variety of complex factors, such as social role, socialization, and culture, influence the way that individuals interact. The participants in this study have interacted with other people, medical professionals, other authorities on health and healing, CAM practitioners, and the health care industry to name a few. The variety and unique interactions which each participant had would theoretically influence their inner attitudes and behaviors, according to Mead’s theory.

Goffman (1959) also wrote extensively about interactions. It is difficult to separate discussions of social roles, interactions, attitudes, and behaviors because each aspect of human life is so intertwined. People cannot interact without participating in social roles or without performing for others. In every interaction individuals give off impressions to others, and the ways in which people interact can have specific meanings. In any interaction, humans portray themselves in a flattering light, and strategically downplay negative aspects of themselves. Interactions, like social roles, are also influenced by culture and socialization. Goffman’s explanation of interactions is useful for analyses in this study, because people must interact on a variety of levels: environmental, organizational, social, or individual (Breslow 1996). Therefore, each participant must interact with high medical costs, and this study analyzed whether participants changed their behaviors as a result of rising medical costs: a social trend.

3.5 Attitudes and behaviors
Mead’s (1934) discussions of attitudes helped to interpret how participants’ attitudes influenced their behaviors. Mead wrote that attitudes result in a variety of behaviors. However, theorist Herbert Blumer (1969) discussed that attitudes have low correlations with behaviors. This study seeks to identify participant attitudes on social trends, such as rising medical costs and alternative medicine use, and how or if the current view influences their behavior.

3.6 The I, the Me, and the Generalized Other and behaviors

Mead (1934) wrote that in any interaction, people respond out of different aspects of themselves: The I, the Me, and the Generalized Other (1934). The I is considered the part of the individual that responds in their own best interest. The Me is the socialized self of the individual, which is aware of the wants and needs of others. The Generalized Other is the social groups to which an individual belongs. Individuals consider the values and beliefs of their social groups in their behaviors. In health and healing, the Generalized Other may be the way U.S. culture believes, conceptualizes, and addresses health as a whole. Mead’s discussion of the I, the Me, and the Generalized Other aids in interpreting the many ways that individuals react to social trends, form attitudes, interact with the health care industry, and, as a result, approach health and healing.

3.7 Marxist theory and the health care industry

In the health care industry, physicians may be considered the elite authority on health and healing. However, corporate leaders have become the ultimate leaders and decision-makers in health care (Jasso-Aguilar and Waitzkin 2011, Starr 1982, Wright and Rogers 2011). This differs from the past, when physicians primarily had control of their practice and worked for themselves (Starr 1982). Therefore, even physicians, in most
cases, today do not have the last say in health care policy or even in their patient’s care, which can be often dictated by corporate leaders or institutions outside of their control such as the insurance industry or programs like Medicare and Medicaid (Cohn 2007, Starr 1982). Physicians and other health care professionals have become employees in the big business of health care with limited control over many health care decisions.

Marxist theory can be applied to the current health care industry, although not in the traditional way (Jasso-Aguilar and Waitzkin 2011). In the bulk of Marx’s writings, he wrote about class struggle within capitalistic economies (Marx in Tucker 1978). He wrote that capitalism, unlike other economic systems, creates severe economic inequalities. Two groups Marx discussed in many of his writings were the bourgeoisie and the proletariat. Marx theorized that the bourgeoisie, or the ruling class, sought to keep the proletariat, or the working classes, subordinate through exploitation.

The bourgeoisie, according to Marx, are able to keep the proletariat subordinate because of their role in industry which, the proletariat are vulnerable to the bourgeoisie for numerous reasons (Marx in Tucker 1978). One reason is that the bourgeoisie, who generally are the business owners, have more capital and control over society. The bourgeoisie are able to maintain this control over strategic manipulations on the lower classes, such as creating competition for employment which results in lower wages and class mobility. Marx theorized that such factors resulted in high profits for the elite class and make it difficult for the lower classes to fight their exploiters and overthrow them.

Marxist theory of class struggle and exploitation has been applied to the current health care industry and consumers (Jasso-Aguilar and Waitzkin 2011). Jasso-Aguilar and Waitzkin argued that Marx’s theory can be applied to many aspects of the current
U.S. health care industry, but not in the traditional way that Karl Marx described. Medical corporations have currently become powerful forces economically and politically. In the health care industry, exploitation does not necessarily involve an employer and employee relationship. The exploitation is between the industry and consumers.

Jasso-Aguilar and Waitzkin (2011) wrote that because industries in the health care sector have become so powerful, they are able to successfully lobby for their interests. This puts consumers at a disadvantage because their interests are often not being heard or considered in decision-making situations. Additionally, leaders in the health care industry have strong ties to leaders in the government, according to Jasso-Aguilar and Waitzkin. This cohesive relationship is referred to as revolving door policies. Corporate leaders often have stakes in government decisions because of the benefits the policies can bring their companies. For example, the authors discuss that George W. Bush had ties to pharmaceutical company Eli Lilly and passed legislation during his time as President that benefited drug companies. Thus, Bush passed legislation that would benefit Eli Lilly and further his own interests as well.

The relationship between government leaders and business leaders, or state elites and corporate elites, can have negative consequences for the lower class. These relationships give corporate elites immense power in the political arena (Jasso-Aguilar and Waitzkin 2011). Consequently, policies are enacted and government decisions are made which only benefit elites in the health care industry, and consequently, the lower classes are “forced” to continue to submit to the wills of government and corporate elites in the health care industry, especially if critical care from health care providers is needed. This
can include paying high medical prices and, in some situations, accruing medical debt if they cannot afford to pay with little ability to further their own interests or fight the system.

Elites in the health care industry and consumers have a similar relationship to the bourgeoisie and the proletariat in Marxist theory. The bourgeoisie are exploiting the needs of the proletariat because they need employment in order to survive and provide for their families. Additionally, the proletariat classes do not have extra time, funds, power, or the social cohesion needed to rebel and fight the system (Marx in Tucker 1978). Consumers in the health care industry are in a similar situation when seeking services from the health care industry. In seeking health care services, which can include critical care, consumers may be willing to pay high medical prices rather than risk their lives or the lives of their loved ones (Wright and Rogers 2011). The health care industry can be viewed as capitalizing on and exploiting their consumers’ vulnerability and their need for what can be live-saving care.

3.8 Goffman’s discussion of teams and the health care industry

Goffman’s theory of teams and discrepant roles also helps to explain how elites in the health care industry are able to maintain control over the public and consumers of health care services. Employers, or the bourgeoisie, are able to maintain control over their employees in an obvious way: through employment. However, the health care industry’s control is less overt, because individuals can seemingly decide when, how, and if they want to utilize health care services.

Goffman (1973) wrote that teams were formed through reciprocal relationships, and that teams must participate in a specific, socialized performance in front of their
audience. Goffman emphasized that teams must be a cohesive unit in order for the performance to be effective, and part of the effectiveness of the team is that the social actors within the team create and enforce the definition of many social situations. One could argue that this occurs in the health care industry.

Goffman’s (1973) discussion of teams can apply to the health care industry in the U.S. for many reasons. One reason is the corporate elites in that health care industry and medical professionals have the ability to work as a team to enforce social norms on health and healing. Most physicians---medical doctors in particular---are taught traditional Western medicine in medical school (Shuval and Mizrachi 2004). Therefore, it would only make sense that most physicians would use traditional Western medicine to treat their patients. Physicians also may be more likely to refer their patients to other medical professionals who practice traditional Western medicine because they have a better understanding and believe in the healing modality. Lastly, in medical facilities physicians tend to work with other physicians who have the same philosophies on healing. It would be unlikely for a medical facility employ a mix of medical doctors, authorities on ayurvedic medicine, and shamans in one building. Because of all of these aspects, one could say that physicians act as a sort of team in order to uphold their status in the facility, their elite position in the health care industry, and the dominance of traditional Western medicine by welcoming some philosophies on healing into their spaces and excluding others.

The evidence that authors Jasso-Aguilar and Waitzkin (2011) provided also demonstrate Goffman’s (1973) theory on teams. As discussed previously, Jasso-Aguilar and Waitzkin argued that corporate elites and government officials work as a team in
order to maintain the dominance of the health care industry (2011). Other individuals have provided evidence of government and corporate elites in the health care industry acting in a way that can also be described using Goffman’s (1973) teams.

Al Gore (2004) observed that government action after the terrorist attacks on September 11, 2001 resulted in higher profits for businesses in the health care industry. Friedman (2001) wrote that there is much evidence that the government encouraged fear in order to benefit wealthy elites and industry. Pharmaceutical companies profited from public fear and anxiety during this time period (Gore 2004). This can be viewed as the government performing in certain ways to benefit the health care industry in which many, as outlined previously, have a vested interest.

Terrance Samuel (2004) wrote about a similar situation which could be interpreted by Goffman’s (1973) theory of performance in interactions. As established previously, there is much evidence that government and corporate elites in the health care industry work as a team to further their mutual interests (Friedman 2001, Gore 2004, Jasso-Aguilar and Waitzkin 2011). Samuel (2004) describes a situation where the Bush administration refused to legalize the importation of prescription drugs due to safety issues. Safety is an obvious issue when it comes to pharmaceuticals, and fears surrounding safety may cause the public to feel that it is better to pay high prices for U.S. manufactured drugs, than to risk their health and or the health of their loved ones with taking unsafe drugs. Samuel (2004) argued that although the Bush administration painted that fear of importing pharmaceutical drugs as a safety issue, it does not quite make sense. Samuel pointed out that drug importation had bi-partisan support in Congress, and that many congressmen were supportive of passing of a bill which would ensure safety
for Americans. Despite this, this bill lacked support from the Bush administration. Samuel wrote that the lack of support, no doubt, had to do with the profitability of American pharmaceutical companies and their large donations to the Republican Party, which Samuel wrote was a whopping $67.5 million.

Goffman’s (1973) explanation of teams helped to interpret how individuals interact with the health care industry. The health care industry’s dominance has allowed for the industry to define social norms surrounding health and healing, what healing authorities are socially acceptable, and how health should be addressed as a nation. It would make sense that an industry would not want to push ideals or recommend treatments that are outside of the treatments that they typically provide, because it could affect their profits and status.

Because the health care industry is a business, corporate leaders may also benefit from illness. Generally, CAM is a healing philosophy that places a strong emphasis on prevention and typically has fewer invasive treatments than traditional Western medicine (NCCAM 2013). If people use CAM to stay healthy, they may rarely need to seek health care services, will seek services less often, or will decide to only use only CAM to treat health conditions. Once again, this can cut into the profitability of the health care industry. For all these reasons, and many others, individuals may be becoming distrustful of the health care industry. Individuals may feel that the health care industry, perhaps especially because of rising medical costs, does not have the consumers’ best interest at heart. Therefore, people may be seeking out CAM more because of the negative feelings and the social issues surrounding the health care industry. These issues were explored in the data collected from participants in this study.
3.9 Goffman’s discrepant roles and the health care industry

This discussion leads into Goffman’s (1973) theory on discrepant roles. Goffman explained that teams are established by their shared objectives. In order to achieve these objectives, teams must work together in order to manage their impression. This involves strategically revealing positives about the team and hiding negative aspects. The team does this by, according to Goffman, over communicating their positives to their audience. The team also must keep secrets in order for them to be able to maintain their position with their audience.

In regards to the health care industry, corporate elites may not want to highlight the health care industry’s concern with profitability to consumers. Medical prices are extremely high in the U.S. (Ginsburg et al. 2008, Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011). In fact, Americans pay about 70% more than other countries for pharmaceutical drugs (Samuel 2004), and pay more for medical services than economically similar countries both overall and in percentage of their income (Wright and Rogers 2011). Instead, high prices for health care in the U.S. are often associated with higher quality care (Garber and Skinner 2008, Wright and Rogers 2011). In reality, the health care industry has many issues with quality and effectiveness (Denney et al. 2009, Garber and Skinner 2008). Despite Americans spending much more than other countries on their health care, Americans do not have better health outcomes than many other countries (Garber and Skinner 2008). This aspect, however, seems to be under-communicated by the industry.

With medical prices so high, it is no wonder that importation of pharmaceutical drugs has been an issue that has been brought to Congress (Samuel 2004). As discussed
earlier, Congress considered allowing importation of pharmaceutical drugs in order to combat high medical prices (Samuel 2004). In the end, the issue lacked needed support from the Bush administration and Congress did not approve importation of pharmaceuticals (Samuel 2004). Safety concerns surrounding drug importation were used to ensure that the public believed that Congress and the Bush administration were acting out of the public’s best interest. Thus, this aspect was over communicated when the issue was discussed. However, others believed that Congress was keeping a “secret” which was that the issue was not passed because it would cut into the profitability of American pharmaceutical companies. Senator Dorgan of North Dakota was quoted as saying on this issue, “The question you always have to ask in politics is ‘Who do you stand with?’ The White House and Senate leadership answered it this way: ‘We are on the pharmaceutical industry’s side. We are not on the side of the American consumer (Samuel 2004 p. 1).’” Although individuals may have this opinion, this was strategically not communicated to the public, but safety issues were.

The over communication of certain aspects of the health care industry and the withholding of others allows the health care industry to manage their impression. If corporate leaders in the health care industry revealed that Americans pay a large amount of money without better health outcomes, that importation of drugs is illegal because it could affect pharmaceutical companies profits, and that other legislation has been passed which is beneficial to industry in the health care sector, Americans would justifiably be angered. This anger could influence health care profits, or inspire reform, both of which would not benefit corporate elites. Thus, it would be in the health care industry’s best
interest not to communicate these things to the public, and to work as a team to protect these “secrets.”

Although the health care industry, like any industry or person, seeks to manage its impression, Americans are not unintelligent. Americans have expressed that they are dissatisfied with the health care industry and have worries about whether they will be able to receive the care that they need (Friedman 1998, Garber and Skinner 2008). This attitude is important for this study. Social trends, undeniably, influence behaviors. Perhaps the rise in CAM use is related to rising medical costs, negative factors surrounding the health care industry, and distrust of the industry in general. Therefore it would not be unreasonable to hypothesize that participants are seeking out and utilizing CAM more often, because of these issues.

Goffman’s (1973) theory impression management is important for analyzing the data in this study. Social roles are an important part of society, and an important part of this study. Theoretically, each participant in this study should behave in certain ways based on their role within the health care industry. Understanding the importance of social roles helps to interpret why participants were acting or interacting in certain ways.

From a broader perspective, Goffman’s (1973) theory helps to understand how the health care industry could be viewed as functioning as a team, and participating in discrepant roles, in order to maintain their dominant position. The actions, or in some cases, inaction of the health care industry can then influence participants’ attitudes and behaviors. Negative aspects of the health care industry could cause individuals to reject the socialized dominance of the industry and seek alternative care modalities. All of these aspects are explored in this study.
Marx (1972), Jasso-Aguilar and Waitzkin’s (2011), Mead’s (1934), and Goffman’s (1973) discussions of social interaction, exploitation, and authority are useful for interpretation in this study. Medical costs have become a major issue in health care (Ginsburg et al. 2008, Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011), and consumers are greatly affected. These theories help explain participant behaviors as a result of medical costs, and whether participants are resisting the exploitation of the health care industry by utilizing CAM.
Chapter 4

Methods and Data

4.1 Research design

This study examined how individuals with varying knowledge of health and healing were reacting to rising medical costs. The study examined the views of general consumers, physicians, nurses, and an alternative health provider in order to provide a diverse perspective. The study focused on whether participants were using CAM as a way of offsetting medical expenses. This study also examined how individual attitudes on health and healing, interactions with the health care industry and medical professionals, and social trends influenced the behaviors of each participant.

4.2 Qualitative data collection

For this type of study, a qualitative method for data collection is the best approach. In a qualitative interview, individuals are able to tell about their experiences from own their perspective. Herbert Blumer (1969), Joan Cassell (2004), Johnathan Cohn (2007), and Arthur Frank (2000 and 2003) all express the need, and the value of, individuals telling their stories and researchers to collecting qualitative data. Arthur Frank, in particular, writes extensively about the importance of individuals’ stories regarding their experiences being an ill person, and also a patient (2000).
Frank (2000) observes,

> My methodological quandary has been and remains the limits of what can be said *about* anyone else’s story. At issue is the role of the intellectual (including physicians and medical sociologists) and contemporary suspicions of those who claim to be able to speak the truth of others’ stories better than those others can for themselves (Lemert, 1997; Said, 1994; Smith, 1987 in Frank 2000:360).

To capture the experiences, behaviors, and attitudes of each participant in this study, seventeen open-ended questions were asked. Prompts were also offered when needed in order for the researcher to better understand each participant’s answers. The questions covered topics such as health and healing, opinions on rising medical costs, and CAM use.

**4.3 Sampling methods**

For this study, fourteen individuals were interviewed: three physicians, four nurses, one CAM practitioner, and six health care consumers. Each of these participants were selected using a convenience sampling method. However, eight participants were additionally selected using a mixed-method approach: convenience and purposive. These eight participants were selected based on their occupations as doctors, nurses, and Reiki master, which is an authority on CAM and who can treat patients. The sample included six males and eight females, which ranged in age from twenty-five to seventy-three.

**4.4 Procedure**

Data were collected through open-ended interviews at a mutually-agreed-upon location with participants. There were two sets of questions for data collection: one for medical professionals and the CAM practitioner and one for consumers. Both sets of questions address health and healing behaviors, attitudes on rising medical costs, and
attitudes on the rise in CAM use. Doctors and nurses were designed to identify how they
addressed health and healing for the lives of their patients. Each participant was asked to
sign an Institutional Review Board approved informed consent form before the interview
began in order to indicate their agreement to voluntarily participate in the study. The
interviews typically lasted for about 45 minutes. Each participant was informed about the
intent of the study before beginning, and was asked if they had any questions relating to
the intent of the study, their participation, or confidentiality.

4.5 Field Site Access

The health care industry has too many sites to name. Individuals interact with
health care professionals in hospitals, physicians’ offices, and pharmacies, to name a few
sites. Individuals can consult a wide variety of physicians, depending on their health care
needs. Because of the numerous sites of the health care industry, the field site for data
collection was a mutually-agreed-upon and variable location identified by the interviewer
and the participant.

The mutually-agreed-upon location was the best for this study for a variety of
reasons. The first reason is that the method of data collection is an open-ended interview.
This study focuses on the reasoning behind the participant’s actions; therefore,
observation would not give all of the information needed for the study. This mutually-
agreed-upon location made most sense in this study, because it would be extremely time-
consuming and intrusive to follow an individual to each location at which they receive
health care services. In some instances, people may travel to multiple locations or receive
multiple treatments several times a week. While this may be useful for another study, the
time constraints for this project would not allow for this type of on-site methodology.
Time posed an issue in interviewing physicians and nurses, as well. Physicians and nurses, like most other individuals, are extremely busy individuals. It was somewhat difficult to find a physician or a nurse willing to take time out of her or his busy schedule to participate in this study. This is why a mutually-agreed-upon location was important. The interviewer in the study was able to meet with participants at a location that was convenient for them.

Additionally, the mutually-agreed-upon location had fewer barriers for accessing the participants. Hospitals, physician’s’ offices, or other health care locations have numerous gatekeepers for access to the location. Permission and participant agreement for on-site interviews would have to have gone through not only the interviewee, but also through multiple levels of administration.

4.6 Coding

The data collected from participants were coded to identify several different aspects of participants’ experiences. The data were coded for participants’ attitudes on a variety of topics; their interactions with the health care industry, medical professionals, or patients; and their health and healing behaviors. Data were organized into qualitative, thematic codes from many of the questions which overtly addressed these key themes. However, some aspects such as behaviors, specifically whether participants were using CAM to combat rising medical costs, were coded and cross-validated based on information that participants provided from their responses to other, relevant questions.
Chapter 5

Findings

5.1 Rising medical costs

Participants were asked whether they believed that rising medical costs had an effect on the treatments that an individual utilizes. Every participant expressed the belief that rising medical costs affected the treatments that individuals were using. However, participant’s responses varied when discussing the effects of medical costs. The medical professional participants were asked if medical costs affected the treatments that they recommended to their patients. Like the consumer participants, their responses varied.

5.1.1 Consumer participants and medical costs

A consumer participant expressed her belief that many people may be afraid to go to the doctor because of the potential bills attached to the visit. She stated that she believed that there was a fear amongst many people that they would accrue a massive amount of bills and would lose possessions that they have worked for all their lives. She also shared that medical costs had been an issue in her life. When the participant was in her early 20’s, she had a child who was born with health conditions, which caused her to owe a very large bill to the hospital. She explained that during that time period, which she
estimated was over 50 years ago, medical expenses were not as high as they are now. She went on to say that during that time period medical expenses could be equal to a family’s pay; however, she had two other children at the time so the costs were still high and unaffordable.

Another consumer participant relayed that he believed that medical costs allowed individuals to only get what they can pay for. After the participant was hospitalized for an infection, he accrued medical bills that he was unable to afford. Luckily for him, however, a donation to the hospital paid for a large percentage of the bill, and he was left with a manageable portion of it.

Another consumer participant articulated a similar belief on the topic. He expressed his belief that individuals are avoiding the doctor because of medical expenses by using his sons as an example. He explained that two of his sons work part time, and consequently, do not have health insurance. Because his sons would have to pay for any medical expenses, they avoided the doctor unless they felt that they had something serious. He also noted that he believed that medical expenses affect both individuals with insurance through their employers and those individuals on Medicaid and Medicare.

Three of the consumer participants mentioned health insurance. However, each participant discussed different aspects of health insurance to explain their views on treatment choices and medical expenses. One consumer participant explained that he believed that most people avoided going to the doctor or seeking out medical care, but that individuals with insurance are more likely to go to the doctor than those without it. He also added that he believed that individuals with insurance most likely do not have to
worry about medical debt, but still have to pay for medical expenses, so it effects their treatment decisions.

Another consumer participant discussed that she believed that insurance prices increased every year, and that many policies are covering less and less medical care. She concluded that individuals without insurance or with inadequate insurance were avoiding their doctors, despite the existence of a serious health condition. She also added that she believed that individuals of a low socio-economic status with free insurance were utilizing medical care more often than they needed.

Finally, one consumer participant discussed that when she was without health insurance it affected how she approached her health and healing. She discussed two points in her life when she was without health insurance and dealing with a chronic health condition. She explained that during her lapses in insurance coverage she self-treated to avoid the medical expenses that she would have incurred without health insurance coverage. Some of the treatments she used ranged from rest and relaxation to using cranberry juice for treating an infection. She even recalled using other individuals’ medication, when she felt it was safe, to treat her health conditions.

5.1.2 Nurse participants and medical costs

One of the nurse participants relayed that he believed that medical costs were definitely influencing the treatments that individuals use. He stated that he was noticing a trend that individuals were not seeking out medical care when they should. He explained that even in his own life he was not seeing the doctor as often as he should, and he admitted that he has good health insurance. He is paying for his insurance bi-weekly, but he still has significant co-pays that he feels he is unable to afford when he visits the
doctor. Thus, he believed that individuals with and without insurance were not getting adequate health care because of the cost.

The same nurse participant also identified that medical costs have become problematic for the facility where he is employed. He explained that medical costs influenced the medication that the facility chooses to prescribe to patients. When deciding between two commonly-used drugs at this facility, the decision was made on the basis of finances, and not on what was necessarily believed to be the most effective drug for the patients. He acknowledged that there were other factors coming into play in making this decision, but that finances were a big component.

Another nurse participant explained that she believed that finances had a strong influence on the treatments that an individual uses. She stated that when recommending treatments to a patient, the facility where she worked considered the financial ability of a person, although it was not the sole basis of their treatment recommendation. She added that every purchasing choice that individuals make is based on finances. However, she believed that medical professionals seem to be hesitant to discuss medical costs with patients. She stated that this went against her personal beliefs and that it is important to discuss and consider finances in health care decision-making.

Another nurse participant simply stated that medical costs affected the treatments that patients decided to use. She mentioned that recently this has become a crucial issue. However, she explained that, in her experience, she did not feel that medical costs ultimately affected the treatments that were recommended to patients.

The last nurse interviewed stated that she believed that medical expenses affected where individuals chose to receive treatments. She noticed that more patients were now
going to the emergency room when they had an illness, as opposed to waiting to go to their doctor’s office. She explained that many insurances cover emergency care and, therefore, people were going to emergency rooms to receive care even when they were suffering from a minor illness or health condition.

5.1.3 Physicians and rising medical costs

All three of the physician participants acknowledged that medical costs were influencing how patients chose to address their health conditions. However, only one of the physicians discussed that finances are a factor in all of her treatment decisions for her patients. This differed from the other physician participants who discussed that medical costs are considered in their treatment decisions for their patients, but that the expense of the treatments are more dictated by their patients’ insurances and financial ability---an issue over which they do not have much control.

One of the physician participants stated that sometimes people have no choice but to use the cheapest therapy, even if it is not the best long-term option for them. He explained that most insurance policies are designed for patients to use the cheapest means necessary for treating a health condition. He also stated that he believed that the insurance industry was responsible for shaping medical costs, and that, as a physician, he did not directly address the finances of the patients much at all.

Another physician participant explained that medical costs influenced the treatments that she recommended, but that finances were not the most important aspect. She explained that she makes recommendations based on the medical needs of the patients and her own style of caregiving; however, she also mentioned that finances must be considered. She discussed that she strives to give the patient the best treatment
possible, and that includes both meeting their needs and being within their financial means.

The last physician participant explained that medical costs come into play for patients when choosing a treatment. He went on to explain that he primarily works with cancer patients, and that most insurances cover cancer treatments. However, he did mention that he does work with patients who have large co-pays, which can cause problems for them. From his perspective; however, the treatments that he provides for patients are sometimes critical to their health and well-being.

5.1.4 CAM practitioner and medical costs

The CAM practitioner participant also expressed the belief that medical costs were affecting the treatments that an individual uses. She also pointed out that sometimes consumers have no choice in their treatment options and that this can cause them to accrue a large amount of debt. She explained that in the instance of a trauma situation, consumers are unable to make choices regarding their health. At these vulnerable points, individuals are accruing a larger bill because they don’t have the strength physically, mentally, or emotionally to make a decision or to seek out other options for care. She then shared an instance from her father’s life where he fell down the stairs, and was unable to make his own decisions regarding his health. She added that this accident was going to be extremely expensive for her and her parents, because she assisted her parents with their finances.

5.2 Rise in complementary and alternative medicine use

Every participant was also asked specifically about complementary and alternative medicine (CAM). Individuals were asked about their familiarity with CAM,
their opinions on an increase in CAM use, and whether they ever had used CAM. Most of the participants expressed that they were at least somewhat familiar with CAM, had used CAM to treat an illness, and felt that more individuals using CAM treatments could be positive. However, there was a lot of variations in these responses about CAM use.

5.2.1 Consumer participants and CAM use

One consumer participant expressed that he was somewhat familiar with CAM. He expressed that he never used CAM before, because he believed that he never had a health condition which warranted using any of these options. He explained that he would consider using CAM if it was shown to be effective; however, he explained that it is probably considered controversial. He identified, when asked about an increase in CAM use, that people have, perhaps, had negative experiences with the current health care system, and are now going outside the formal health care industry to discover all the options available to them.

Another participant expressed some hesitation when asked about CAM use. He explained that he was not familiar with alternative medicine and that he had never used an alternative method of treatment. He stated that he believed that doctors use information from previous studies when treating their patients. Therefore, he explained his belief that CAM was probably proven to be less effective than traditional Western medicine, and that is why the healing modality was not being utilized more by physicians.

Other consumer participants discussed their belief that individuals were utilizing CAM to combat over-medication, which is often associated with the health care industry (Bain et al. 2008, Bushardt et al. 2008, Comer et al. 2010). One participant stated that she
was familiar with CAM, and had successfully utilized many CAM practices in her life. She expressed her belief that individuals were using CAM more because they did not want to be over-medicated. She explained that many pills that are given to individuals which only address the symptoms of the problem and not the actual problem. She added that in her experience she felt like individuals were discussing CAM practices more frequently than they had in the past.

Another participant explained that she also felt that individuals were using CAM practices more because of the over-use of medication. She explained that she was not very familiar with CAM practices, but had utilized CAM to treat mental health issues that she had suffered in her life. From her perspective, using CAM to address her mental health was more effective than using traditional Western medicine. In her discussions of CAM, she explained that she felt that people were becoming skeptical or distrustful of traditional Western medicine and therefore were looking outside of these health practices to address their health issues.

Another participant stated that she was very familiar with home remedies. She explained that she had utilized home remedies for many of the health conditions that she had experienced in her life. She explained that a lot of people are using home remedies or other CAM practices instead of going to the doctor because they are more cost-effective.

5.2.2 Nurses and CAM use

A nurse participant reported that he was familiar with CAM and had used CAM practices in his own life. He stated that he felt vitamins had become more mainstream and more present in stores during his lifetime. He also pointed that he believed that doctors, in his experience, are utilizing CAM more frequently. He explained that he noticed more
doctors are prescribing vitamins and using more natural lotions for rashes or other types of skin irritations than they were before.

Another nurse participant explained that she was familiar with alternative medicine, and her knowledge on alternative medicine came from working closely with a physician who used both traditional Western medicine and CAM to treat patients. She reported that one technique he introduced to the facility was using organic honey on wounds. She explained that using organic honey not only helped heal the wounds, but also was safer and cheaper. She believed that it was a good thing that CAM usage was increasing; however, she did warn that even CAM can have side effects, and that individuals have to be careful with the treatments that they use and felt that the practices are best utilized when working with a physician.

One nurse participant explained that she was somewhat familiar with CAM, and that she had considered using CAM treatments in the past. However, she admitted that she did have some skepticism about CAM treatments. She explained that she was interested in acupuncture, had done some research on it, and had considered using it to help alleviate her allergies. She felt that over-medication may be a reason that people are looking to use CAM more. She added that when these people have good experiences with CAM they are more likely to tell others about their experience and, thus, more people begin using CAM practices instead of just looking to medication.

Concluding, another nurse participant explained that she didn’t feel that more people using CAM was a positive or a negative. She explained that she is not really familiar with CAM, and that it is not a topic that she finds very interesting. She added
that she was unsure as to why people were using CAM more if traditional Western medicine is still effective.

5.2.3 Physicians and CAM use

The physician participants had varying opinions on CAM use. One physician participant discussed that, while he did not know much about CAM and had never used it himself, he did not feel that more people utilizing CAM was a negative trend. He explained that some people have not been able to get well using traditional Western medicine. Therefore, people are willing to try other alternative philosophies on healing. He mentioned that he does have a lot of training in manipulative medicine, although he didn’t identify the practice as CAM. He also mentioned that he has not met many physicians who do offer CAM to their patients. However, he noted that he is newly out of residency and, thus, his lack of experience could be a factor.

Another physician participant expressed that he had familiarity with CAM. He stated that his information on the topic came from academic journals, but also from laboratory research that he has personally conducted. He explained that most of his research that utilized CAM was unsuccessful in the lab. Thus, he tried not to focus all of his time and energy on CAM. He also discussed that he had tried a supplement in order to treat a health condition of his own. Again, he felt that the supplement did not work and stopped taking it. Additionally, this physician participant added that more people are using CAM, and this had prompted him to ask his patients about CAM use. However, he felt that CAM use was not increasing in a dramatic way.

Finally, another physician participant expressed that she believed that CAM was an important part of healing and that it should be used a complement to traditional
Western medicine. She felt that it is important to address the whole person when healing, and believed that CAM allowed for that philosophy. She discussed that she had used a CAM practice before to treat her own injury, that the treatment was successful, and that she would use it again.

5.2.4 CAM practitioner and CAM use

The CAM practitioner participant was very familiar with alternative medicine, and had successfully utilized many CAM practices in her life. She discussed her belief that CAM use was increasing as a result of the costs of traditional Western medicine. She identified medications, in particular, as being excessively expensive. She expressed her belief that the healing practices of other cultures were superior to traditional Western medicine, because these practices considered the person in a holistic way. She explained that other cultures have traditionally considered the whole person, their environment, the time of the year, and their energies when addressing an illness. She added that the increase in CAM use was indicative that people would like to take more control of their health and well-being.

5.3 Interactions with the health care industry

All participants were asked about how their interactions within the health care industry, and all 14 participants had interacted with or sought care from the health care industry at some point in their lives. Consumer participants and the CAM practitioner participant were asked about their experiences in treating a health condition. Medical professional participants were asked to discuss their experiences of treating patients within the context of the health care industry. Participants were asked about the positive aspects of treating patients in the health care industry, as well as, about the negative
aspects of treating patients in the industry. These questions were meant to measure how medical professionals interact with patients based on their roles within the industry.

### 5.3.1 Consumer participants interacting with the health care industry

One of the major themes among consumer participants and their interactions with the health care industry was expenses. Two of the consumer participants reported that either they or one of their children had had a health condition that caused them to acquire medical bills that they could not afford. Another consumer participant did not discuss her medical expenses directly, but explained that, after being in a serious accident, her insurer refused to pay for her medical care. Her insurer claimed that they did not have to pay for her medical bills because she was on a motorcycle at the time of the accident. The participant then had to hire an attorney to review her insurance policy. After seeking legal help, she was found to have adequate coverage, and her insurance was forced to pay.

Another theme that emerged from the data collected was that participants had difficulties interacting with the health care industry. One consumer participant described that she had been uncomfortable communicating with many medical professionals whom she had encountered. She explained that she felt this way because many medical professionals had been dismissive of her and the health condition. Another consumer participant had a similar experience when her husband was suffering from cancer. One consumer participant expressed that he had difficulties communicating with all of the medical care professionals he encountered. He discussed instances where he would call his doctor and his nurse and leave messages. He reported that he would call and leave messages several times and would still not hear back from his doctor. Another participant
discussed that her doctor was not familiar with a method of treatment that she wanted to use, and therefore she decided to use the treatment and not consult her doctor first.

Another theme that occurred among consumer participants was that they felt that the health care professionals who worked with them cared about them. One participant noted that, while being hospitalized, he felt that the doctors and nurses genuinely cared about him and wanted him to get better. Another consumer participant can recall that the therapists that she worked with to heal injuries were encouraging and would push her to work hard for her recovery. She stated that although the therapy was painful, she felt that it was a good experience; she recovered from her injuries.

Other characteristics of the health care industry were mentioned. One consumer participant had a health condition that required him to see a specialist. When he arrived at the specialist, he noticed, because of the participant’s occupation, that the physician was using equipment that was outdated and not adequate for assessing his health condition. He felt that it was important for him to have the best equipment used on him, because his deductible would have been the same regardless of the equipment that the doctor used. Another interaction that was discussed was one participant who felt that, in his experience he was given extra tests that he felt were not needed. He felt that the extra testing was most likely due to the facilities’ fears that he would sue them if there was a problem with him not receiving the proper testing.

5.3.2 Nurses and interacting with the health care industry

All four of the nurse participants expressed that one of the positives of treating patients within the health care industry was seeing patients get well. This was the most common theme among the nurse participants. The majority of the nurse participants
directly expressed that they enjoy when they can help an individual heal, and when an individual gets better and no longer needs to receive care. Three of four nurse participants also mentioned that they found nursing to be a fulfilling and an enjoyable occupation.

Another theme that arose out of nurse participants’ interviews was that half of the nurses believed that the health care industry needed to utilize other health philosophies. One nurse participant explained that he believed using a combination of healing techniques was better for the patients. Another nurse participant expressed the belief that the health care industry needed to shift its focus from treatment to prevention.

Two of the nurse participants mentioned that finances were having a negative impact on the health care industry. One nurse participant explained that there were pressures for health care professionals to take on a large patient load, because facilities lacked the funds to hire more health care professionals. Another nurse participant expressed that she believed that the health care industry and U.S. culture had warped views surrounding death. She explained that she believed that death was not the worst possible outcome, compared to a patient living with extreme suffering. She believed, in some extreme cases, that it would be beneficial for people to let their loved ones die, rather than try to keep them alive on a variety of machines for prolonged periods of time. She explained that these types of situations are often what lead people to acquiring massive medical bills, and that many times their loved ones pass away soon after these medical efforts to prolong their life.

5.3.3 Physicians and interactions with the health care industry

Physician participants’ responses about the health care industry were extremely diverse. One theme that did emerge from the data collected in the interviews was that a
positive outcome for the doctors was changing someone’s outlook on their health. The majority of the physicians explained that the felt they have interacted with a patient in a positive way when they can change their health outlook, or when the patient takes responsibility for their own health issues. One physician participant expressed that it was important that patients did not expect a pill to deal with their health issues, but rather work hard to resolve their health problems.

Another theme that emerged from the data collected from the physicians was that they believed that they were competing with other individuals who were less skilled than they for patients care. One physician discussed that patients were able to seek care in her field from individuals who did not possess all of the medical knowledge and training that she has. She felt that individuals without her expertise should not be able to make recommendations or care for patients. Another physician participant explained that he felt that profitability sometimes comes before wellness in health care. He believed that in his field, many physicians were performing procedures that he felt they were ill-equipped to do, because they were not up-to-date on the latest techniques or education. He relayed that these physicians were performing surgeries in order to make money, and he often had to recommend and perform another surgery when these patients came to him. Therefore, physicians, who do not have the technology or training that this participant considered adequate, were performing surgeries in order to profit and not fully considering the best care option for their patients.

5.3.4 CAM practitioner and interactions with the health care industry

The CAM practitioner interacted with the health care industry in a unique way. She discussed that she had found a lump in her breast, was diagnosed with breast cancer,
and had to get a lumpectomy. She recalled deciding to have the surgery, but that she did not want to undergo any other treatment. The treatment plan that was laid out for her, she explained, was to take a drug for a five year span and to undergo radiation. Despite her family’s urging, she decided to not to follow the treatment plan. She cited her reasoning for not undergoing the planned treatments to be that she knew her immunity was down because of procedures she had had earlier in her life, and that she did not want to go through chemotherapy or radiation. She recalled that the doctors she was working with wanted to perform other procedures on her and that she refused care. She explained that, although the doctors were upset with her, she decided to spend the years after the surgery was performed building up her immunity by taking numerous supplements and following a diet and exercise program. She also explained that during that time period she removed a lot of stressors from her life.

5.4 Consumer participants and attitudes on best methods of treatment

Consumer participants were asked what they believed made one method of treatment superior to another. The answers were varied. Some of the consumer participants pointed to accuracy of the diagnosis, using treatments that did not involve seeing the doctor, and the method that had been the most researched. Another consumer participant cited that he believed that both trusting the method and your physician made one method superior to another. The last two consumer participants explained that they felt that being comfortable with your treatment and using the appropriate method of treatment for the severity of the health problems were important.
5.4.1 Nurse participants and attitudes on best methods of treatment

Nurse participants were also asked to comment on what made one method of treatment superior to another. One nurse explained that she felt that no method of treatment is superior, and that, in healing, individuals should use all methods available to them. She added that she felt that the best types of treatments allowed for individuality. One nurse participant felt that different methods of treatment worked better for different types of illnesses; for some illnesses, it might be traditional Western medicine, and for others it might be CAM. Another nurse participant echoed the same belief, and the last nurse participant felt that the amount of testing that went into a method of treatment was important.

5.4.2 Physician participants and attitudes on best methods of treatment

One physician participant felt that the best treatments had high validity, and produced the best outcomes. This participant, the best outcome would be for the patient to heal from her or his health conditions. Another physician participant explained that the best methods of treatment were those that first addressed a patient’s most critical health issues. Finally, a physician participant expressed that the best methods of treatment were effective in treating the health condition, and another physician participant expressed that the best methods of treatments were those that were effective and that people could be made accountable to follow.

5.4.3 CAM practitioner participant and attitudes on best method of treatments

The CAM practitioner participant expressed that what makes one method of treatment superior to another is how much an individual believes in the treatment. She also discussed that it is important to believe in the physicians with whom you are
working, added that she believe these mindsets can aid individuals in their healing processes.
Chapter 6

Analysis

6.1 Rising medical costs

Every participant in this study was aware of high medical costs. This reflects the literature on the severity of medical costs and its widespread influence on Americans (Ginsburg et al. 2008, Himmelstein et al. 2005, Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011). The ways in which medical costs influenced participant attitudes and behaviors differed, however.

6.1.1 Consumer Participants and Rising Medicals Costs

Discussions of medical costs’ influences on participants differed based on the participants’ social roles and relationships to the health care industry. Many of the consumer participants expressed that they, or others with whom they had relationships, had fears surrounding high medical costs. Participants discussed that they feared that medical costs would cause them to owe money or lose possessions that they had worked for all of their lives. Furthermore, a few of the consumer participants relayed that they had health conditions in their lives which needed medical treatment and costs had
become prohibitive for them. Therefore, they experienced the adverse effect of high medical costs first-hand.

Some of consumer participants discussed that medical costs have caused them, or others that they know, to alter their behavior. Many of the consumer participants discussed that they or someone they knew had changed how they approached their health and healing in order to try to avoid high medical costs. The ways in which participants described changing their behaviors included choosing more cost effective treatments which included CAM use, avoiding the doctor, and self-treating.

6.2 Consumer Participants and CAM Use

Consumer participant’s attitudes and knowledge of CAM varied. However, almost all of the consumer participants pointed out that they believed that individuals were utilizing CAM more because of negative aspects of the formal health care industry. Some of the negative aspects that consumer participants discussed were high medical costs, overmedication, difficulties in access to adequate care, and somatic therapy as opposed to healing or prevention. These issues were also discussed in the literature (Bain et al. 2008, Bushardt et al. 2008, Comer et al. 2010, Ginsburg et al. 2008, Himmelstein et al. 2005, Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011, Veugelers and Yip 2003). Some of the participants directly pointed out that they were utilizing CAM in order to avoid negative aspects of health care. Therefore, even if participants did not feel that they had extensive knowledge of CAM, they were still utilizing some of the practices in order to self-treat.

Many of the consumer participants had strong attitudes on rising medical costs or the health care industry, in general. These strong attitudes on the industry caused them to
deviate, or to believe that others have deviated, from the norm to explore other healing modalities such as CAM use. Therefore, many participants, or others they knew, were using CAM in order to combat medical costs. Although not every negative aspect of health care is overtly related to expenses, in many aspects there is a cost factor. For example, participants discussed that they did not want to be overly medicated. One participant stated, “Well I do think {complementary and alternative medicine} is increasing because I think people just don’t want to take all the medications that the doctors give you.” This participant, and other participants, may not have been discussing the expense of pharmaceuticals. However, there could be a cost component because the literature discusses that Americans pay 70% more for pharmaceuticals than other countries (Samuel 2004). Thus, a factor of not wanting to be excessively medicated may really be not wanting to pay for a variety of expensive pharmaceutical drugs.

Another consumer participant discussed that the health care industry often treats symptoms instead of addressing the problem. She stated, “If you have a certain symptom they want to give you a pill to take care of it and with some instances that’s great but other times I think it just covers it up and doesn’t take care of the problem.” This reflects the literature on traditional Western medicine which is predominately used in the health care industry (Shuval and Mizrachi 2004). The literature on health care has discussed that addressing symptoms or treating a problem is less cost-effective than prevention (Wright and Rogers 2011). Therefore, when participants discussed somatic therapies or overmedication, they may also have been referring, without directly stating, to the costs of these practices.
6.3 Consumer participants and interactions with the health care industry

Many of the consumer participants’ attitudes on the health care industry developed from the interactions that they have had with the industry. The interactions that the participants had validate why they would have fears surrounding seeking medical care. Many of the participants discussed how interactions with the health care industry in the past have caused them to accrue a large amount of medical expenses. Thus, based on their interactions many of the consumer participants formed a negative attitude on the health care industry. These negative attitudes may have contributed to participants’ decisions to choose more cost-effective treatments, self-treat, or avoid doctors or the health care industry altogether.

Other participants discussed other negative aspects of interacting with the health care industry. Some of the issues that participants discussed were difficulties in communicating with health care professionals, subjection to testing they felt was unnecessary, and a case where an insurance company was dishonest about a client’s policy. Irving Goffman (1973) explained that individuals live by inference. When individuals interact, they judge or evaluate people or institutions based on their own experiences. Based on the majority of the participants’ discussions, participants’ interactions may have caused them to form a negative attitude about the health care industry. Other studies have established that individuals are distrustful of the health care industry (Friedman 1998). Therefore, even though participants are socialized by the dominance of the health care industry and traditional Western medicine, participants were somewhat distrustful of the health care industry because of their interactions with it. In
some cases, then, participants were seeking out CAM largely as a result of those negative experiences.

6.4 Consumer participants and methods of treatment

Many of the consumer participants discussed that the superior treatments are those that patients feel comfortable with and believe in. As discussed previously, many of the participants expressed negative aspects of interacting with the health care industry, which could have caused an individual to lose trust in the health care industry. Additionally, medical costs may add an extra layer of difficulty and stress for individuals who are already battling a health condition. High medical costs and consumer skepticism may make it difficult for individuals to concentrate on their health. Therefore, consumers may be looking to use CAM or other practices outside of traditional Western medicine and the formal health care industry to ease some of these stressors and fulfill some of these needs.

6.5 Nurse participants and medical expenses

Nurse participants echoed the influence that medical expenses had on treatment choices, as reported by consumer participants. All four nurse participants expressed the view that consumers’ treatment decisions were influenced by their financial ability or other resources. Therefore, it would not be unlikely that consumers may use CAM if it was a more cost-effective treatment than traditional Western medicine.

6.6 Nurse participants and CAM use

Nurse participants overwhelmingly acknowledged that CAM was being used more often than in the past, and all but one nurse expressed the belief that this was a positive thing. Many of the nurses felt that integrating CAM into traditional Western
practices was effective in treating and comforting their patients. One nurse discussed that she believed that individuals were using CAM more because of negative issues surrounding the formal health care industry, and another nurse reported that they were using CAM at her facility because it was more cost-effective. Therefore, at least half of the nurse participants believed that consumers were using CAM to combat issues with the health care industry or medical expenses. It would then be likely that other individuals are using CAM in a similar way.

When nurse participants discussed the positives of interacting in the health care industry, all four nurse participants discussed interacting with their patients, and the positives of being a nurse. It was clear that all four nurse participants cared about their patients. Two of the nurse participants directly discussed that they found great pleasure in watching patients heal. Furthermore, all four of the nurse participants discussed that they found the nursing profession to be fulfilling.

The nurse participants also discussed many negative aspects of interacting with the health care industry. Half of the nurse participants believed that the formal health care industry needed to incorporate other healing modalities into treatment, and that solely relying on traditional Western medicine could be problematic. These participants had the viewpoint that the health of their patients could be improved by using other practices to combat health care delivery costs. Two of the nurse participants identified expenses as a large problem for the health care industry.

6.7 Nurse participants and methods of treatment

Nurse participants had an open-minded attitude toward different healing modalities. It was clear from the nurse participants’ discussion of interactions that their
patients are their top priority. Therefore, it is not surprising that many of the nurse participants had a willingness to try any healing modalities that might potentially heal or comfort their patients.

Additionally, nurse participants discussed CAM not only as a way to comfort and heal their patients, but also as a way to combat some of the negative issues surrounding health care, over-medication in particular. One nurse participant expressed that CAM could be useful for combatting overmedication. She said,

I don’t know, I think that people’s beliefs are changing about using—over using medication I think. I think that we all see that, that that is happening. So I think that some people just take it into their own hands and decide that they want to try something different. And {CAM} works for some people so, you know, if I heard from one of my friends that it worked for them and I had the same problem. And they were like, ‘It was awesome. It really helped me.’ I—I would be willing to try it. So I think that the more, as people have positive experiences, and it’s out there and we hear about it more, people are willing to try something besides taking a medication every day for their problems.

Another nurse participant suggested that CAM could be a useful alternative to medication as well. She said, “I read an article recently that meditation was as effective as Ritalin for ADD. It’s way better to meditate than it is to take Ritalin, you know. And I do wish we used more of those, I wish we incorporated things like tai chi into the day.”

Nurse participants explained that CAM could also be a way to bring individuality into the health care industry. CAM, unlike traditional Western medicine, is traditionally more focused on treating a person holistically (Starr 1982). Traditional Western medicine typically focuses on treating the symptoms of the health condition of the individual person (Martin 1987, Shuval and Mizrachi 2004). Because of this, two of the nurse participants felt that CAM, and holistic views on healing, were needed in the industry.
6.8 Physicians and medical costs

Physicians, like other study participants, discussed the influence of medical costs on health and healing. Every physician participant acknowledged that consumers are influenced by finances when choosing their treatments, and one physician explained that her own behavior in choosing treatments for patients was influenced, as well. Other physician participants explained that they felt that their patient’s insurance was responsible for medical expenses, and that the realm of insurance and expense was not part of their social role as a physician. Thus, it seems that although the literature describes physicians as the highest authority on health and healing (Carpenter 1995, Martin 1987, Starr 1982), physicians feel that they have limited control over medical expenses. Starr described physicians as once having their own practices; then this structure started to change into big business, and the health care industry formed (Starr 1982). Through this change, physicians may have lost some of their control to corporate leaders in the health care industry. Therefore, the people who have the knowledge of how to heal patients do not get the last say on treatment decisions because of their patient’s insurance or medical expenses, which their patients must consider.

6.9 Physicians and CAM use

Most physician participants had views on CAM similar to those of nurse participants. Most physician participants did not see the harm in incorporating CAM into the health care industry. Two of the physicians felt that traditional Western medicine does not work for every person, and that there is a need to look at each patient as an individual, and to utilize other healing modalities. One physician participant said, “I think there are definitely people that have failed with treatments of Western medicine. There are always
going to be people out there that are willing to try alternative medicine. Um, just typically that tends to be on the conservative side also. So less invasive.” Therefore, like nurses, physician participants---also educated in traditional Western medicine which has a monopoly on the health care industry (Martin 1987, Shuval and Mizrachi 2004, Starr 1982)---were mostly willing to look outside the traditional healing modalities to explore other options.

6.10 Physicians and interactions with the health care industry

Many of the physician participants felt that, in interacting with the health care industry, people need to take responsibility for their health problems, and work hard to stay healthy. For the majority of the physician participants, it seemed that their patients’ health was their top priority. They wanted their patients to be healthy and work hard to heal if suffering from a health condition. However, within the health care industry this may be difficult for consumers to do. The literature discusses that the health care industry focuses more on treating symptoms than on prevention (Shuval and Mizrachi 2004, Wright and Rogers 2011), and consumer participants in this study reported avoiding care from the health care industry. As a result, by the time many individuals seek care they may already have a health condition. Thus, one could argue that many consumers are not utilizing health care to receive check-ups or other preventative care when needed. This could be due to barriers within the health care industry such as medical costs. The result can make consumers ill-equipped to stay at optimal health, as medical professionals’ advice and direct care may be needed in order to adjust consumer behaviors. Friedman (1999) wrote that consumers can be knowledgeable on health and healing, but medical professionals usually have more knowledge because of education and qualifications that
they are expected to meet in order to fulfill their credentialed roles. Because of this factor, many consumers need medical professionals to advise them on how to stay healthy.

6.11 Physicians and methods of healing

All of the physician participants felt that the best methods of treatment are those that allowed patients to heal. From these answers, it is clear that physician participants in this study care about their patients’ health. Thus, it is not surprising that most of the physician participants believe that CAM practices should be integrated into traditional medical practices and that their patients should take more control over their health. What the data implies is that consumers must take some control of their health, and that CAM could be a way to do that, since even physicians and nurses now recognize its legitimacy. Therefore, recently there seems to be a shift in how medical professionals view CAM, its effectiveness, and legitimacy.

6.12 CAM practitioner and rising medical costs

The CAM practitioner participant was no different from every other participant in her belief that medical costs are excessive. She focused on medical expenses as a negative aspect of the health care industry as particularly exploitative of an individual during their time of need. Her opinions on vulnerability and illness echoed that of the literature which notes that the health care industry can be exploitative of those in need of care (Jasso-Aguilar and Waitzkin 2012, Starr 1982, Wright and Rogers 2011). She explained that individuals are not mentally, emotionally, and physically strong enough to make the best decisions when dealing with their diagnosis and health condition.
Therefore, medical expenses, according to the CAM practitioner, are exploiting individuals at their worst times.

6.13 CAM practitioner and CAM use

The CAM practitioner participant also stated that she believed that individuals are utilizing CAM because of the costs of traditional Western medicine, especially pharmaceutical costs. This was similar to ten other participants’ opinions that individuals are or should be utilizing CAM in order to combat medical expenses, overmedication, or the use of purely somatic therapies. The CAM practitioner participant, like the physician participants, had an opinion on individuals taking control of their health. She stated that she believed that individuals were using CAM to take more control of their health.

6.14 CAM practitioner and interacting with the health care industry

The CAM practitioner participant also discussed both the positive and negatives of treating a health condition in the health care industry. Like several of the consumer participants, she discussed her difficulties in communicating with medical professionals. She also communicated that she felt mistrustful of the intentions of the health care industry in general because of these barriers to communication and negative past experiences. This caused her to self-treat her health condition, which, in her case was breast cancer.

6.15 CAM practitioner and methods of treatment

Last, the CAM practitioner participant, like many other study participants, felt that it was important for individuals to believe in the treatments that they utilize. This may be another reason that individuals are utilizing CAM more, as both participants in this study and in Friedman’s (1999) study have discussed the importance of having trust
in those who are giving health advice. She explained that individuals’ mindsets can influence their health. Thus, according to this philosophy, stress brought on by medical expenses or mistrust of the health care industry or medical professionals can damage one’s healing process.
Chapter 7

Conclusion

In conclusion, a participant’s attitudes and interactions help her or him to decide when to utilize traditional Western medicine and when to deviate and use other modalities of healing such as CAM. As Mead (1934) explained, each individual acts in unique ways. However, there were many similarities in the ways that participants believed that individuals were utilizing CAM.

Each participant was socialized by the dominance of the health care industry and traditional Western medicine (Shuval and Mizrachi 2004, Starr 1982). However, due to the many negative aspects of the health care industry---medical costs, overmedication, focus on treatment as opposed to prevention (Bain et al. 2008, Bushardt et al. 2008, Comer et al. 2010, Hulme and Long 2005, Seifert and Rukavina 2006, Wright and Rogers 2011)---participants were, or believed that others were, utilizing CAM to combat these issues. Therefore, there was evidence that participants are utilizing CAM to combat issues in the health care industry.
This study specifically focused on whether individuals were utilizing CAM in order to combat medical expenses, though not every participant discussed that individuals are using CAM to specifically combat those expenses. However, many of the issues surrounding health care are related to expenses. Treatment is more expensive than prevention (Wright and Rogers 2011), and Americans pay 70% more for their medications than other countries (Samuel 2004). Therefore, when participants discuss these issues, they may be discussing finances indirectly.

Participants described having difficulties communicating with medical professionals. Similar to overmedication and somatic treatment, this issue could be related to finances. One participant described his frustration with the difficulties he faced in contacting his physician after a surgery. He stated, “I had trouble getting a hold of him afterwards because he gets paid to do the procedure. He did the procedure. Now he doesn’t get as much money for a doc-office call. It’s hard to get back in there. They’ve like a four to six week wait to get back in there.”

While medical costs have become problematic for Americans, CAM use has increased (Ben-Ary et al. 2011, Ditte et al. 2011, Dolder et al. 2003, and Wetzel et al. 2003). CAM use, according to the literature, has not only increased in recent years; but also has been recognized and accepted more by the medical community (Arikan and Gurol 2011, Ben-Ary et al. 2011, Ditte et al. 2011, Dolder et al. 2003, Hasan 2010, Koc et al. 2012, Maino 2012, Mohan et al. 2011, Wetzel et al. 2003, Zhang et al. 2011). Because the social boundaries between CAM and traditional Western medicine have become more relaxed, it has become socially acceptable for medical professionals to recognize CAM’s legitimacy, and, in some cases, the need for CAM even if they are not
extremely knowledgeable on the different healing modalities that the term encompasses. The same is true for other study participants who may also felt more comfortable talking about and utilizing CAM in their own lives.

Therefore, the behaviors of the participants in this study were reflective of the literature on CAM use (Arikan and Gurol 2011, Ben-Ary et al. 2011, Ditte et al. 2011, Dolder et al. 2003, Hasan 2010, Koc et al. 2012, Maino 212, Mohan et al. 2011, Wetzel et al. 2003, Zhang et al. 2011). Most of the participants did not question the legitimacy or effectiveness of CAM, and most had utilized CAM in some form throughout their lives. Despite these views, traditional Western medicine has remained the dominant healing modality in the U.S (Shuval and Mizrachi 2004).

Although traditional Western medicine is dominant and has a monopoly over the health care industry (Shuval and Mizrachi 2004), many people, and many of the participants in this study, have become distrustful of the industry (Friedman 1999). Even medical professional participants expressed distrust of the accountability and motives of other medical professionals in the health care industry. The general distrust of the health care industry, as well as some of the negative aspects discussed by the participants, may make individuals more willing to try CAM to address some of their health and healing needs that the health care industry does not meet.

Despite the fact that CAM is being more recognized as effective (Arikan and Gurol 2011, Ben-Ary et al. 2011, Ditte et al. 2011, Dolder et al. 2003, Hasan 2010, Koc et al 2012, Maino 212, Mohan et al 2011, Wetzel et al. 2003, Zhang et al 2011) and has been utilized by many participants in this study to combat negative aspects of the health care industry, CAM is still not fully integrated into the health care industry (Shuval and
Mizrachi 2004). The health care industry is extremely profitable, and, because of this financial power, is able to maintain and uphold the dominance of traditional Western medicine. Thus, corporate leaders in the industry have the last say on how the industry approaches health and healing. This is despite the fact that medical professionals, physicians in particular, are considered the highest authority on health and healing in the U.S. Corporate leaders have become the decisions makers when it comes to norms surrounding health and healing, although they are not necessarily physicians whose main objective is the wellness of their patients. Therefore, corporate elites are exploiting health care consumers’ need for medical care for higher profits (Jasso-Aguilar and Waitzkin 2011).

7.1 Methods

This thesis allowed for an in-depth glimpse at the unique ways that attitudes and interactions influenced behaviors of participants through qualitative methods. Qualitative interviews allowed for participants to describe their experiences and opinions from their own perspectives, which are multi-faceted. During the data collection process, every effort was made to ensure the confidentiality of the participants. The data collected were then coded for numerous themes which were explored in the findings and analysis chapters.

7.2 Implications

This thesis has practical implications for individuals within and outside of the health care industry. Consumers of health care services must deal with numerous negative aspects of the health care industry: high medical costs, overmedication, and somatic therapy, as opposed to prevention. These aspects of health care are barriers, for
many individuals, to living healthier lives. As discovered from the participants, in this study, many of the negative aspects are causing individuals to alter their behaviors, which include: using more cost effective treatments, including other healing modalities that fall under the scope of CAM, self-treating, or avoiding medical professionals or the health care industry altogether. Self-treating and avoiding utilizing health care can be problematic and even dangerous for consumers who have less knowledge, education, equipment, and authority than medical professionals. Therefore, the negative aspects of the health care industry can negatively influence the health of many individuals.

This study has practical implications for medical professionals as well. All three of the physician participants in this study wanted health care consumers to take control of their health. However, as discussed in the literature review, findings, and conclusion chapters, there is an unequal relationship between medical professionals and consumers, which puts consumers at a disadvantage for taking control of their health (Friedman 1999). Once again, high medical costs, overmedication, and somatic therapies can be barriers to individuals living at their optimal health status.

The data from this study suggest that views surrounding CAM, even from medical professionals, are generally positive. CAM was utilized by many individuals in this study, or others from their perspective, to combat negative aspects of the health care industry, which have been discussed extensively. Medical cost were a negative aspect of the industry which was discussed by participants frequently. Additionally, participants in this study generally utilized CAM in cost-effective ways: meditation as opposed to medication; cleanses and diet changes as opposed to surgery; and supplements, diet changes, and exercise as opposed to chemotherapy and radiation, to name a few.
Although a few of the medical professional participants acknowledged that CAM can be just as expensive as traditional Western medicine, the ways that participants utilized CAM were more cost-effective than traditional Western medicine. Thus, if integrated into health care, CAM could be a way for individuals to be able to treat health conditions more cost-effectively, and often times, less invasively. Because medical costs are a large barrier for many individuals to taking control of their health, CAM could be a tool for healthier living.

Despite the fact that many participants in this study and in studies described in the literature review chapter discussed the many positives of CAM (Arikan and Gurol 2011, Ben-Ary et al. 2011, Ditte et al. 2011, Dolder et al. 2003, Hasan 2010, Koc et al. 2012, Maino 212, Mohan et al. 2011, Wetzel et al. 2003, Zhang et al. 2011), CAM is very minimally used in the health care industry (Shuval and Mizrachi 2004). Health care is big business in America, and it makes sense that corporate leaders to protect the dominance of traditional Western medicine, because it is a healing modality predominantly used within the industry. If medical professionals start to teach CAM practices, or recommend patients to CAM practitioners, it could impact their profitability. Therefore, the top concern of health care elites is not the health of the public, but profitability. Many of these issues are outlined in the theory chapter.

7.3 Limitations

This thesis has obvious limitations because of the method of data collection. Qualitative data collection allows for detailed insight into the experiences of participants. However, as extensively discussed, individual experiences are unique. Thus, the experiences of the participants in this study are not necessarily representative of the U.S.
population. However, through the use of qualitative methods this study allows for individuals to tell the “stories” of their own experiences.

Another limitation of this study was that not all types of medical or health care professionals or CAM practitioners were included in this study. There are numerous types of nurses, physicians, and CAM practitioners with various levels of education, knowledge, and training. The selection of only a few of these individuals allows for but a partial glimpse into a large and varied perspective of these authorities on health and healing.

Another limitation is that participants in this study were only selected from two states in the U.S.: Ohio and Michigan. Therefore, only a small region of the U.S. was represented in this study. Additionally, many ethnicities were under-represented in this study. Although participants in this study were ethnically diverse, African Americans and many other ethnic groups were not represented in this study. The lack of ethnic diversity is an obvious limitation because ethnicity can influence participant attitudes, interactions, and behaviors.

7.4 Future research

This study extensively discussed how participant attitudes and interactions influenced their decisions to utilize traditional Western medicine or CAM. This study focused on the experiences of a small population, but with the data collected from this initial study a quantitative study could be designed, and a survey could be constructed and administered which would be able to be generalizable to the experiences of the U.S. population or the region from which the participants selected. This is an area that could be explored in the future.
Another way that this study could be expanded in the future is by exploring participant demographics’ effect on health and healing. A future study could explore how individuals of diverse social positions and statuses react to social trends and, specifically, to utilizing CAM. It would be interesting to explore in-depth into how socio-economic status, race, and gender influence participant attitudes, interactions, and decisions to utilize CAM. A study of this nature would also collect data from populations, such as a variety of minority groups, which were under-represented in this study.

7.5 Conclusion

Participants in this study utilized CAM in a variety of ways. Many of the participants expressed that they utilized CAM in order to combat the negative aspects or issues that they had encountered in the health care industry. The negative aspects or issues which were described were medical expenses, overmedication, somatic therapies, and difficulties in communicating. The fact that CAM is currently not the treatment norm in the U.S. did not seem to deter most participants, including medical professionals, from recognizing its usefulness and legitimacy. Additionally, many recent studies have discovered the usefulness and effectiveness of many CAM practices (Arikan and Gurol 2011, Hasan 2010, Koc et al. 2012, Law et al. 2010, Maino 2012, Steel 2011, Zhang 2011). Thus, the exclusion, or rarity, of CAM use within the industry can be viewed a strategy by corporate elites as a way to maintain the dominance of traditional Western medicine and the health care industry which predominantly uses the healing modality. Therefore, although CAM is useful in treating many health conditions (Arikan and Gurol 2011, Hasan 2010, Koc et al. 2012, Law et al. 2010, Maino 2012, Steel 2011, Zhang 2011), the healing modality is not typically offered to public from the health care
industry—which can profoundly affect the health of the population. For this reason, and many others, corporate elites in the health care industry can be viewed as exploiting consumers’ health in order to maintain the power and profitability of the industry.
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“Complementary and Alternative Medical Therapies: Implications for Medical


Appendix A

Interview questions for physicians, nurses, and CAM practitioner

1. What does healthy mean to you?
2. What measures do you take to stay healthy?
3. Where does your information about health come from?
4. You are a ______________. (depending on participant which is pre-selected for their occupation) How does your occupation affect your health?
5. Can I ask your age?
6. How have your attitudes on health changed throughout your life?
   a. Prompt: Did they change because of your education?
7. How do your attitudes on health effect how you treat your patients?
8. How do your attitudes on health effect how you treat your own illnesses/health conditions?
9. What makes one treatment superior to another?
10. What motivates your decision to choose one medical treatment over another?
11. What is your experience in treating patients in the health care industry?
   a. Prompt: What have been some of the positives?
   b. Prompt: What are some of the challenges?
12. Medical care in the U.S. has become increasingly more expensive and medical debt more common. Do you think these factors have had an effect on treatments that an individual uses? Please explain.
13. Do medical expenses affect the treatments that you “prescribe” patients?
14. Are you familiar with alternative medicine?
15. Where has your information on the topic come from?
16. Have you used an “alternative method” of treatment? Why?
17. I have read that alternative medicine use is increasing. What is your opinion on that?
Appendix B

Interview questions for consumer participants

1. What does healthy mean to you?
2. What measures do you take to stay healthy?
3. Where does your information about health come from?
4. Can I ask your occupation?
5. How does your occupation affect your health?
6. Can I ask your age?
7. How have your attitudes on health changed throughout your life?
8. What has been your experience with treating illness/health condition?
9. Please describe your experience with treating a health condition, using a specific example if you have one. Did this include consulting a medical professional or using a health care facility?
   a. Prompt: What were some of the challenges of navigating through the health care industry?
   b. Prompt: What were some of the positives of treating illness within the health care industry?
10. How do you regard the health care industry based on this experience?
11. What do you think makes one method of treatment more effective than another?
12. Medical care in the U.S. has become increasingly more expensive and medical debt more common, do you think these factors have an effect on treatments that an individual uses? Please explain.
13. Are you familiar with alternative medicine?
14. Have you ever used an “alternative method” of treatment? Why? This can be on your own, or you could have consulted an alternative health provider.
15. I have been reading that the use of alternative medicine is increasing. What is your opinion on that? Why?
Appendix C

Informed Consent Documentation

Informed Consent Documentation.
ADULT RESEARCH SUBJECT - INFORMED CONSENT FORM

Principal Investigator: Dr. Barbara K. Chesney, Associate Professor of Sociology  
Keri Kovacsiss, Graduate Student in Sociology, (330) 415-2884

Purpose: You are invited to participate in the research project entitled, Approaches and Attitudes on  
Health and Medical Treatments: An Ethnography of Consumer and Medical Professional Choice  
which is being conducted at the University of Toledo under the direction of Dr. Barbara Chesney. The  
purpose of this study is to explore and document how individuals look at treating and preventing health  
conditions. The study will explore how individuals feel about rising medical costs and alternative  
medicine.

Description of Procedures: This research study will take place in Toledo, OH, at a mutually agreed  
on location. You will be asked to participate in an in-depth interview with the investigator, Keri  
Kovacsiss. The interview will not last longer than one hour, and there will be one session per participant.  
You will be asked questions about how you approach health issues. You will be asked your opinion on  
health trends, as well. The answers to the questions will be recorded through note taking by the  
interviewer. Additionally, if permitted, the interview session will be audio recorded.

“Permission to record: Will you permit the research to audio record during this research procedure?”

YES ☐ NO ☐ Initial Here

After you have completed your participation, the research team will debrief you about the data, theory  
and research area under study and answer any questions you may have about the research.

Potential Risks: There are minimal risks to participation in this study, including loss of confidentiality.  
You may find that participating in this study will cause you to feel upset or anxious because of the nature  
of the topic which will be illness and financial issues. You may prefer not to answer some of the  
questions. Please know that at any time during the interview if you feel uncomfortable, you may stop the  
interview at any time.

Potential Benefits: The only direct benefit to you if you participate in this research may be that you will  
be able to describe and discuss your experiences in the health care industry. Others may benefit by  
learning about the results of this research.

University of Toledo IRB Approved  
Approval Date: 11/20/12  
Expiration Date: 11/19/13
**Confidentiality:** The researchers will make every effort to prevent anyone who is not on the research team from knowing that you provided this information, or what that information is. The consent forms with signatures will be kept separate from responses, which will not include names and which will be presented to others only when combined with other responses. Although we will make every effort to protect your confidentiality, there is a low risk that this might be breached. To guard against loss of confidentiality, the participant will be identified as "Participant #X." Additionally, all information regarding the interviews will be kept on a password-protected computer.

**Voluntary Participation:** Your refusal to participate in this study will involve no penalty or loss of benefits to which you are otherwise entitled and will not affect your relationship with The University of Toledo. In addition, you may discontinue participation at any time without any penalty or loss of benefits.

**Contact Information:** Before you decide to accept this invitation to take part in this study, you may ask any questions that you might have. If you have any questions at any time before, during or after your participation you should contact a member of the research team: Keri Kovacs at (330) 415-2884 or Dr. Barbara Chesney at (419) 530-4075. If you have questions beyond those answered by the research team or your rights as a research subject or research-related injuries, the Chairperson of the SBE Institutional Review Board may be contacted through the Office of Research on the main campus at (419) 530-2844.

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

**SIGNATURE SECTION – Please read carefully**

You are making a decision whether or not to participate in this research study. Your signature indicates that you have read the information provided above, you have had all your questions answered, and you have decided to take part in this research.

The date you sign this document to enroll in this study, that is, today’s date must fall between the dates indicated at the bottom of the page.

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This Adult Research Informed Consent document has been reviewed and approved by the University of Toledo Social, Behavioral and Educational IRB for the period of time specified in the box below.

Approved Number of Subjects: 60

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University of Toledo IRB Approved
Approval Date: 11/20/12
Expiration Date: 11/19/13

Adult Informed Consent Revised 11.05.10 Page 2 of 2

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