

Intuition, Subjectivity, and Le Bricoleur: Cancer Patients' Accounts of Negotiating a Plurality of Therapeutic Options

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Cancer patients are now combining complementary and alternative medicine (CAM) with biomedical cancer treatments, reflecting an increasingly pluralistic health care environment. However, there has been little research done on the ways in which cancer patients juggle multiplicity in claims to expertise, models of disease, and therapeutic practice. Drawing on the accounts of cancer patients who use CAM, in this article I develop a conceptualization of therapeutic decision making, utilizing the notion of bricolage as a key point of departure. The patient accounts illustrate the “piecing together” (or bricolage) of therapeutic trajectories, drawing on intuitive, embodied knowledge, as well as formalized “objective” scientific expertise. Le bricoleur, as characterized here, actively mediates, rather than accepts or rejects CAM or biomedicine, and utilizes a combination of scientific expertise, embodied physicality, and social knowledge to make decisions and assess therapeutic effectiveness. Although these “border crossings” are potentially subversive of established biomedical expertise, the analysis also illustrates the structural constraints (and penalties) associated with bricolage, and furthermore, the interplay of a repositioning of responsibility with neoliberal forms of self-governance.

Keywords: *cancer; complementary methods; decision making; interviews; sociology*

The last two decades have seen a rather dramatic shift in the prominence of complementary and alternative medicine (CAM; Bakx, 1991; Eastwood, 2000; Tovey, Easthope, & Adams, 2003). Particularly among cancer patients, CAM is hugely popular (Cassileth & Vickers, 2005; Girgis, Adams, & Sibbritt, 2005; Goldstein, 2003; Miller et al., 1998), and biomedical cancer services in Australia and internationally are coming under increasing pressure to pursue a more holistic and patient-centered approach to patient care (Tovey, Chatwin, & Broom, 2007). Although state-provided care is still dominated by biomedical cancer services, a demand-based, privately-funded cancer care sector is surging in popularity (Adams, Sibbritt, & Young, 2005; Miller et al., 1998; Salminen, Bishop, Poussa, Drummond, & Salminen, 2004). Lack of any interaction or dialogue between these sectors has led to a recent senate enquiry which criticized the division in Australian cancer care between biomedical and CAM cancer services (National

Health and Medical Research Council, 2005; Senate Community Affairs References Committee, 2005). However, although professional distancing and boundary work persist in Australian cancer care, patients themselves are increasingly embarking on (self-funded) “border crossing” within their therapeutic trajectories (Adams et al., 2005).

For sociologists, this proliferation of CAM has raised complex questions regarding processes of demedicalization and the movement away from the centrality of “scientific” medicine. Among other things, this emergent therapeutic pluralism has been viewed as reflecting a cultural turn of sorts toward a focus on narrativity, subjectivities, and therapeutic embodiment (Eastwood, 2000; Lowenberg & Davis, 1994; Sered & Agigian, 2008; Siahpush, 1998; Sointu, 2006a, 2006b). Such processes, it has been posited, are situated within a broader waning in public deference to biomedical expertise and scientific knowledge, and an increasingly individualized and subjectified cultural (and health care) landscape (Low, 2004; Tovey, Atkin, & Milewa, 2001), characterized by reflexivity (Beck, 1992; Giddens, 1991) and skepticism toward expert knowledge (Lupton & Tulloch, 2002). However,

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despite significant theoretical work within sociology regarding recent sociocultural shifts, there is a paucity of research examining actual patient accounts of therapeutic decision making and sense-making practices within pluralistic health care environments.

In practice, most cancer patients juggle a multitude of claims to expertise and ideological standpoints in their illness journeys (e.g., holism vs. positivism; healing vs. cure; abstraction vs. individuation; Girgis et al., 2005; Miller et al., 1998). Even if they do not actively consider—or indeed use—a range of therapeutic approaches, at the very least exposure to diverse therapeutic modalities is highly likely (i.e., through support groups or the Internet), and presents important challenges within decision making (Broom and Tovey, 2007a; 2008b). As such, awareness of multiplicity is a feature of the contemporary experience of being a cancer patient (Broom & Tovey, 2008a). The question of how individuals make sense of diverse therapeutic practices remains a key question for sociologists. In this article I attempt to begin to fill this gap in knowledge by exploring the lived experiences of 20 Australian cancer patients.

Background

Although the various issues surrounding the definition of CAM have been addressed extensively elsewhere in the social science literature (e.g., Tovey et al., 2007), some mention of categorization is useful. CAM is generally used to refer to therapeutic modalities such as aromatherapy, naturopathy, herbalism, homeopathy, mindfulness-based stress reduction, reiki, acupuncture, spiritual healing, and so forth. While acknowledging the dynamic nature of what constitutes CAM, there are certain parallels we can draw between therapeutic practices. What largely characterizes CAM is, first, a lack of integration into Western health care systems and, second, a tendency to espouse models of care that incorporate physical and metaphysical elements in treatment processes. There is also some merit in distinguishing between whole-systems approaches such as naturopathy, traditional Chinese medicine, or homeopathy, and the less ideologically driven healing approaches such as reiki, aromatherapy, massage, mindfulness-based stress reduction, or healing touch (Tovey et al., 2007).

Although only a relatively new field, the sociology of CAM has produced a wide range of theoretical ideas and a diverse literature base (e.g., Baer, Hays, McClendon, McGoldrick, & Vespucci, 1998; Bakx,

1991; Bishop & Yardley, 2004; Broom & Tovey, 2007a, 2007b, 2008a; Freidin & Timmermans, 2008; Hirschhorn & Bourgeault, 2005; Kelner, Wellman, Boon, & Welsh, 2004; McClean, 2005; Mizrachi, Shuval, & Gross, 2005; Shuval & Mizrachi, 2004; Siahpush, 1998; Tovey & Adams, 2001; Tovey & Broom, 2007a, 2007b). However, until relatively recently, most sociological work in this area has examined inter- and intraprofessional issues, and only limited work—none in Australia—has been done on conceptualizing individual sense making and subjectivities within treatment decision making (Bishop & Yardley, 2004; Broom & Tovey, 2008a; Daykin, McClean, & Bunt, 2007; McClean, 2005; Sered & Agigian, 2008; Sointu, 2006a, 2006b). As such, boundaries between professions have been a central focus, but the boundary-crossing and sense-making practices of patients have been given little attention.

A key concern in the broader sociological literature, but also in recent work on CAM, is increased individualization in contemporary cultural practices. Indeed, in the area of cancer care there has been emerging commentary around individuation and reflexive practice (e.g., Bishop & Yardley, 2004; Daykin et al., 2007; McClean, 2005; Sered & Agigian, 2008). With a perceived waning in public deference to scientific knowledge and expertise, the individual is increasingly conceptualized as an active mediator of therapeutic options rather than merely the recipient of expertise (Nettleton & Burrows, 2003; Tovey et al., 2001), and patient engagement with CAM is positioned as one facet of this cultural shift toward individuation (Tovey et al., 2007). Indeed, there seems to be a degree of shift occurring in the range of therapeutic alternatives entering the realm of possibility for most cancer patients (Adams et al., 2005). Informal networks, community advocacy groups, and the advent of the Internet have each, albeit differentially, contributed to the proliferation of knowledge about diverse therapeutic options (Broom, 2005a, 2005b; Ernst & Schmidt, 2002; Goldstein, 2004; Hardey, 1999). Furthermore, recent work suggests that some patients are assessing practices based on subjective, embodied judgments, or those practices that “work for me” and “make me feel well,” rather than merely those legitimized by formalized “objective” expertise (Bishop & Yardley, 2004; McClean, 2005; Sointu, 2005, 2006a, 2006b). Although such subjectivities have always played some part in patient decision making, their importance compared to abstracted clinical efficacy might be increasing. Although self-help and the use of intuitive, embodied knowledge is

not a new phenomenon (Katz, 1981), individuals are, it would seem, increasingly piecing together often disparate therapeutic practices in line with their needs and (sometimes shifting) ideological standpoints. These shifts might have wide-ranging implications for patients and health professionals and, it is argued here, also demand the development of new theoretical frameworks to help make sense of contemporary approaches to therapeutic decision making.

In this article individual engagement with a multiplicity of therapeutic options is framed as a site of bricolage (Lévi-Strauss, 1968; see also Hess, 1997; Hester, 2005), an iterative process whereby individuals actively collect together varying forms of expertise, practices, and technologies in an attempt to create a subjectified, individualized, and embodied therapeutic trajectory. The conventional definition of le bricoleur is someone who is a “handyman or jack-of-all-trades” (Hess, 1997). Bricolage applied in this context refers to a process of individuals actively seeking different forms of therapeutic practice (biomedical and CAM-derived therapeutic models), and in doing so, is viewed as a form of expertise. Although for some this might engender a postmodern or relativist stance on therapeutic engagement, this is not the meaning of bricolage as employed in this article (Hester, 2005). Rather than engendering the loss of metastructures and pursuit of pure individuation, bricolage is intended to engender individual agency/action within competing structures of health knowledge and the activity of pragmatic (but structurally constrained) individuation. Such an approach is necessary to emphasize both structural constraint and sites of subversion and resistance within contemporary therapeutic landscapes.

Methods

After ethics approval was secured, two oncology departments in a state capital city in Australia were approached regarding recruitment. When access was negotiated with appropriate members of staff, patients were recruited via posters placed in oncology wards. Forty patients responded to the invitation to participate in the study and 20 were purposively selected from those who offered to participate. The final sample consisted of 20 medical oncology outpatients with a range of cancer types (including lung, brain, breast, bowel, non-Hodgkin’s lymphoma, melanoma, myeloma, intestinal, and cervical) and stages of disease (ranging from confined

to metastatic to advanced/palliative-care). All of the participants were relatively intensive CAM users. For example, perhaps instead of using aromatherapy every now and then, they drew together multiple and often intensive CAM therapies to pursue their healing processes. The recruitment strategy was designed to provide in-depth insight into the lived experience of negotiating multiplicity in therapeutic options, rather than the occasional user of therapies such as reiki or healing touch, for example. Of the final sample, 6 were male and 14 female, with a range of ages from 30 to 70 years. Given the high proportion of female CAM users reported in previous studies, it was expected that a great number of females would take part.

All the respondents were interviewed in their own homes for between 1 and 2 hours. As an experienced sociologist who had no involvement in the care given to the patients, I conducted all interviews. The interviews were semistructured, exploring such things as what constitutes a legitimate form of knowledge/expertise; the ways in which various sources and forms of knowledge and practice are accessed, utilized, and/or transformed within disease and treatment processes; and the implications of utilizing different health practices for interactions with various actors (e.g., health professionals). The interviews were structured around these broad themes but the specific questions asked to promote dialogue were adapted as appropriate to the context of the individual participant. With the permission of each participant, the interviews were digitally recorded and subsequently fully transcribed.

Analysis

The methodology for this study drew on the interpretive traditions within qualitative research, focusing on establishing an in-depth understanding of the experiences of the respondents. This involved taking an in-depth exploratory approach to data collection, aimed at documenting the subjective and complex experiences of the respondents rather than merely reflecting on such things as types of treatments used or perceived physiological effects. Data analysis was based on four questions adapted from Charmaz’s (1990) approach to social analysis: What is the basis of a particular experience, action, belief, relationship, or structure? What do these assume implicitly or explicitly about particular subjects and relationships? Of what larger process is this action/belief, etc., a part? What are the implications of such

actions/beliefs for particular actors/institutional forms? The aim was to achieve a detailed understanding of the varying positions adhered to, and to locate these within an appreciation of broader underlying beliefs and/or agendas. The approach used was developmental in that knowledge generated in the early interviews was challenged, compared with, and built upon by later ones.

The process of analysis began during data collection. This provided an opportunity to establish initial themes and look for deviant or negative cases, complicating initial observations and retaining the complexity of the data. The analysis initially involved the author systematically reading through each transcript several times, writing notes, discussing ideas with colleagues, and noting emerging patterns within the data collected. Within this process, the focus was on retaining the complexity of the respondents' experiences, and documenting atypical cases, conflicts, and contradictions within the data. Following this initial analysis, I looked back through these notes in the margins of the interviews to establish themes emerging across the interviews. Within this process, once a theme was identified, a search would be done through the other interviews for related comments, employing constant comparison to develop or complicate these themes further. Using this process meant that events initially viewed as unrelated could be grouped together as their interconnectedness became apparent. The final step involved revisiting the literature and seeking out conceptual tools that could be used to make sense of the patterns that had emerged from the data.

Results

Intuition, Belief, and Embodied Knowledge

A key topic addressed in the interviews was how the participants went about making decisions regarding the legitimacy of ideas, expertise, treatments, and regimens in the context of their cancer. Given their exposure to a wide range of modalities, the aim was to try and disentangle the ways in which they negotiated this pluralistic environment, and the basis for their decisions and assessments:

Making a decision about what treatment to go for is a combination of belief, what you feel in your own body, and whether others have had success. That's

what drives me . . . if you rely on one doctor, or whoever, you only get part of the picture. In the end only you can bring all the elements necessary together to make a decision. [female, breast cancer]

Well, I think to make decisions [on a treatment] you have to have . . . I feel like I've got a bit of an intuitive sense. I think it is you just have to have a faith! Yeah, faith in yourself. [female, non-Hodgkin's lymphoma]

Yeah . . . to me it's . . . it's how I feel. For me it's really about how I feel. I do believe that given the right . . . circumstances our bodies can heal ourselves . . . for me what my body says is more important than the evidence. . . . It is a healing thing. Sometimes I don't know why something is working but it doesn't worry me, as long as it is working. Does that make sense? [female, breast cancer]

Personal experience [matters] more than anything for me. Like acupuncture, I believe in it because it has worked. Before I went in there, hey, sticking needles in your ears and stuff like that is going to help? I don't think so. But you know, from personal experience I know what works. Ah . . . so I go more on that than anything. [male, non-Hodgkin's lymphoma]

Intuitive and embodied knowledges were repeatedly held as critical sources of knowledge of therapeutic benefit. In the participants' talk about effectiveness it was consistently posited that knowledge was actually produced through their bodies (through their physicality) and augmented with biomedically derived expertise. A recursive process was evident whereby individual subjectivities and embodied knowledges were used to contextualize statistical knowledge, and statistical probabilities were drawn on to contextualize intuitive, subjective knowledges. It was evident in their accounts that practices (biomedical or CAM) were not entirely rejected or accepted. Rather, seemingly disparate models of disease and therapeutic approaches were interrogated, sometimes precariously incorporated into the treatment regimen, and then discontinued or reconfigured at a later point in time.

Lay Knowledge Networks, Bricolage, and "Piecing it Together"

A second key theme that emerged from the interviews was the participants acting as active collectors and assessors of expertise; what is described here as a process of bricolage. Rather than rejecting or accepting one form of expertise (i.e., oncological or naturopathic), there emerged an iterative process

of collecting together different practices and models of care:

You try something and if it doesn't work you move on. If you commit to something, one-eyed, you get nowhere and that goes for medical things as well. Also, you can take bits and pieces of different things. Like, I might not accept all of what traditional Chinese medicine has to say about treating cancer, but that doesn't mean I won't use one herb or one idea. [male, melanoma]

[How do you decide what treatments are going to be effective and which ones aren't?] At first I had the belief that Herceptin was going to fix me but after reading about it, it doesn't . . . so you put different things together, as you see fit. . . . I'll look into things; I have to have a feel about it first and to have a bit of a read about it, talk to people who have either used it and to suss out [figure out] the safety of it. I don't accept everything about something, like why it works, but may still use it on and off. [female, breast cancer]

After the diagnosis I thought, I'll go more into the natural stuff. Do whatever I can! B17 [laetrile], which you're also not allowed to eat, but I eat apricot kernels like they're going out of fashion and lots of other antioxidants. I'm on quite a program. . . . I have used a lot of products. Multivitamins, all the Bs, chlorophyll for your body cleansing system, etc. . . . I made a learned decision. . . . If things stop working I'll reassess and change, look for other options I guess. [female, melanoma]

A key feature of these participants' accounts was a willingness to engage with a wide range of ideas about the body and disease. Rather than rejecting the biomedical model or fully embracing an alternative conception of health or disease, they engaged in a pragmatic quest that drew on localized and community beliefs, complex modality-specific therapeutic systems, as well as broader (and often biomedically derived) notions of evidence and effectiveness. A process of bricolage was evident whereby the participants pragmatically collated together disparate practices, often translating them in accordance with their own needs and subjective experiences of disease.

The Limitations of Science and the Utility of Rumor and Social Knowledge

A pattern across all the interviewees' accounts was the usefulness of "scientific" medicine, but also the fallacies of statistical probabilities in predicting what

would happen to the individual. None dismissed probabilities and scientific knowledge; rather, this knowledge was put in its place beside other forms of knowledge and expertise:

Well . . . I don't mind statistics. Sometimes I look at who developed them and I think well, that's a bit limited—that's all. It depends on who created the statistics and how they formed them and where they created them . . . they [the oncologists] said to me, I wouldn't live for more than 18 months. But now that we're going through the process [treatment], some of the top people are thinking there's a chance that I could completely survive what's going on. In a way it's great but then you wonder about the science of it in the first place. [male, brain tumor]

They said to me three to six years [life expectancy] but they've had patients who've . . . one lady was in remission for ten years before she needed treatment. There are always the exceptions to the rule as you know . . . my immediate thought was, now, I know you can't be told how long you're going to live. You could walk outside tomorrow and drop dead of a heart attack. How can these people say three to six years? [female, myelodysplastic syndrome]

Skepticism toward both biomedicine and CAM practices was evident in the participants' accounts with critiques of both "scientific" expertise and holistic or natural approaches to treatment (e.g., herbal or naturopathic approaches). There emerged an interesting pragmatic process whereby models of healing and actual practices were drawn together and different forms of knowledge drawn on concurrently to assess progress. The interviews highlighted an iterative process of embodied assessment of therapeutic effectiveness, which involved notions of "making sense to me," "doing better than other patients," and "feeling right in my body." However, this embodied physicality as a means of therapeutic assessment emerged as intertwined with social knowledges produced through group interactions. A dialectical tension was evident between individual vs. group subjectivities and the collective mediation of "effectiveness" in the midst of therapeutic uncertainty. Specifically, the participants recounted regular informal communications in oncology wards and shared subjective interpretations regarding relative "success":

Even though I wasn't allowed, I was taking them [naturopathic treatments] right through chemo. There were a lot of people when I had chemo, they would

ask me questions, “Oh, have you been to hospital?” “No,” I would say. “Have you had ulcers in your mouth?” “No.” “Well what do you take to prevent the ulcers? Have you had this cough?” “No.” “Well what do you have to prevent that?” So I could see that there was something that I was doing right. [female, non-Hodgkin’s lymphoma]

You can’t help but look around and ask how others are doing. It gives you a sense of whether what you are doing is right. Check up on the others if you know what I mean. “Gee, isn’t she doing well,” we will say. [female, breast cancer]

The nurses would quietly say to me when I came in, “You are doing so well. Most people don’t do this well you know.” “The other things [alternative treatments] must be helping” they [nurses] would say. That made me feel really good. [female, breast cancer]

Rumor and hearsay played crucial roles in these participants’ assessments of how well they were doing compared to other patients in the oncology ward, and their assessments of the effectiveness of their “piecing together” of different CAM and biomedical treatments. Anthropologists have been fascinated by the utilities of rumor, hearsay, and gossip (Kroeger, 2003), and likewise, they emerged here as important for individuals in gauging therapeutic legitimacy.¹ Conversations in waiting rooms were reported to involve comparing side effects and informal reflections of “whether it’s working” and the role of CAMs therein. Gossip and rumor emerged as key sense-making strategies through which the participants were able to maintain their sense of solidarity with other patients but also arrive at explanations for and responses to ambiguous events (Kroeger, 2003), including periods of treatment in which progress had not been formally assessed (i.e., through CT scans or other biomedical technologies).

The subjective sense of “how I am doing compared to others” was also critical to the tenability of the participants’ therapeutic trajectories (i.e., whether they continued following The Gerson Diet² or using traditional Chinese medicine). They would initially energetically utilize particular combinations of CAM and biomedicine but then shift their approach depending on a range of factors including “objective” physiological response (i.e., reduction or increase in tumor size/metastases) and subjective, informal assessments (i.e., comments from nurses/doctors about how well they were doing compared to other patients). Seemingly insignificant, off-the-cuff comments from nurses

(“You must be doing something right,” or “Whatever it is, keep it up”) were key to driving their motivation. This relates back to the increasingly critical role of cancer nurses as influencing and at times promoting patient CAM use (Tovey & Broom, 2007a). As such, although subjectivities and intuitive, embodied knowledges emerged as playing key roles in supporting and legitimizing their therapeutic trajectories, the need to “do better than others” and “be an exception to the rule” remain strong within these participants’ accounts. Subjective assessments were thus situated, in part, within a biomedical frame of being “better than the average” or a statistical exception. It is here that we begin to see the tension between shifts toward individuality/subjectivities and institutionalized medicine and the centrality of objectivity/measurable success. Moreover, doctor–patient interactions in clinical contexts further complicated the capacity to innovate and embrace multiplicity.

Challenging Medicine and the Penalties of Innovation

In employing the notion of bricolage, it is not suggested that the cancer patient now becomes pure innovator, transcending structural constraint and absorbing power/agency previously held by the health professional. In practice, the uses toward which patients put particular therapies (naturopathy, herbs, acupuncture, meditation, spiritual healing, and so forth) are limited, at least in part, by the previous uses to which they have been put (see Hatton, 1989). Furthermore, as an approach to therapeutic decision making, bricolage can be met by significant resistance from clinicians. In the current study, for example, the benefits gained from drawing on multiple sources of expertise and therapeutic practice were significant, but so, too, were the implications. Whereas bricolage might be viewed as a form of innovation, inevitably, when boundaries are contested and established expertise decentered, there remains the distinct possibility of interpersonal conflict:

Interviewer [I]: Tell me how your doctors have responded to your [use of CAM].

Participant [P]: They didn’t.

I: What do you mean by “didn’t”?

P: He said that they will kill me and I said, “No faster than what your medication will” [laughs]. Not too happy they weren’t. [female, non-Hodgkin’s lymphoma]

I said to the oncologist, “Do you think that the Taxol and the other chemo could have reduced these lumps that significantly in that time?” “No,” he said. I said, “Well I’ve been on Chinese herbs.” [He said], “Get off them, get off them, you can’t mix the two together.” He was angry. [female, breast cancer]

My doctor responded [to my use of complementary medicine], well, basically saying, “Get off it, it’s interfering with the medical treatment you’re getting.” [female, breast cancer]

I don’t think they [oncologists] were terribly encouraging. I suppose . . . I know complementary medicines work, but I had this horrible thing with my diet I was doing with nuts and fruit. When I told him what I was doing all my doctor said to me was, “What do monkeys eat?” [male, melanoma]

Although negative reactions from oncologists regarding patients extending beyond biomedicine is not particularly surprising (Gray, Fitch, & Greenberg, 1998; Roberts et al., 2005; Tovey & Broom, 2007a), what is interesting here are the conceptual implications of the interplay of *le bricoleur* and the reassertion of biomedical authority in clinical contexts. In talking about bricolage, Rao, Monin, and Durand (2005) suggest that the practice of “borrowing” (i.e., practices, rhetoric, ideology) and “piecing together” potentially weakens the sharpness and resonance of the boundaries of the opposed category pair (in this case CAM and biomedicine; expert and patient; science and quackery). They also point toward the penalties for violating them and the structural limitations of “innovation” by the individual. Such ideas are pertinent to the accounts presented here. Although there seems an emergent form of active engagement with a multiplicity of therapeutic options, and a process involving some degree of therapeutic innovation and transformation, such processes must be viewed as embedded in a context of ongoing and heavy reliance on biomedical practice and expertise. As such, and perhaps unsurprisingly, there might be a price to pay for digression from the “rules of play,” a disciplining of the subject and reassertion of the influence of certain forms of expertise.

Discussion

In this article, drawing on the accounts of a select group of Australian cancer patients who used CAM, I have attempted to disentangle the ways in which some individuals negotiated multiplicity in therapeutic

options. First, it should be noted that this was a relatively small sample of intensive CAM users, and as such, the results are not presented as indicative of the experiences of cancer patients in general, nor of those who use CAM. Rather, the results of this study should be seen as providing a set of indications as to the possible experiences of those patients attempting to draw together a range of different therapeutic options.

As evident in their accounts, the participants used their own embodied, subjective experiences as tools for making sense of the legitimacy of different therapeutic options. Embodied knowledges (intuitive, subjective sense making), social networks (rumor, hearsay, and collective/comparative sense making), and scientific “objective” expertise (probabilities and biomedical technologies) are combined to assess the legitimacy of their therapeutic trajectories, each forming a part of the decision-making “tool box.” The accounts presented here are indicative of an approach to therapeutic decision making as concurrently embodied (i.e., knowledge is drawn from the body’s response to different approaches), and analytical (i.e., knowledge is drawn from “fact” and probabilities), illustrating a potentially transformatory form of contemporary expertise—that of bricolage (Derrida, 1978; Hatton, 1989; Hester, 2005; Lévi-Strauss, 1968; Rao et al., 2005). Practices are brought together, parts of ideologies combined, and elements of regimens put aside, to create the “right mix.” The notion of bricolage, from a poststructuralist perspective, engenders a decentering of “reference to a center, to a subject, to a privileged reference, to an origin” (Derrida, 1978). Although a relativist position of therapeutic knowledge is not espoused here, the accounts presented do raise interesting questions regarding the (shifting) locus of control within treatment decision making, and the innovative conflation of, and experimentation with, divergent practices in the context of contemporary cancer care. The practice of bricolage also presents challenges for established biomedical expertise and the autonomy of its practitioners.

Biomedical power has traditionally relied heavily on the centrality of its practitioners in shaping therapeutic trajectories; with the entrance of *le bricoleur*, the collector (rather than mere recipient) of expertise potentially shifts the character of the lay–expert interface (Hester, 2005; Turkle & Papert, 1990), and even treatment outcomes. A historical deference to biomedical expertise is thus transformed (albeit to differing degrees depending on the individual patient) into a tentative and often iterative engagement with a

multitude of therapeutic models and possibilities (Broom & Tovey, 2007a). However, as we saw in the accounts provided, moves to innovate inevitably result in attempts by other actors to re-establish order and to reaffirm boundaries (Rao et al., 2005). This was shown clearly in the participants' accounts of their specialists' responses to their attempts to "innovate."

Bricolage is not presented here as a simplistic challenge to oncological expertise or as engendering a reduction in the influence or power of the oncology practitioner. In fact, the emergence of le bricoleur might actually result in the deployment of disciplinary devices on the part of biomedical clinicians (i.e., changes to deployment of risk discourse/advice giving/support practices). In saying this, there still remains a potentially subversive element to this form of patient action. Specifically, the use of embodied and intuitive knowledges might, at least in part, decenter scientific expertise and formalized, "objective" measures of therapeutic legitimacy. It also seems likely that the sanctions resulting from border crossing, evident in the accounts presented here, are likely to decline as borrowing/piecing together by cancer patients becomes more common (Rao et al., 2005).

It is important to emphasize that embodied and intuitive knowledges also reinforce biomedical legitimacy and expertise. As such, what the bricoleur does shift is the centrality of the health professional as key to legitimizing knowledge rather than the actual kinds of knowledge considered legitimate. What it does not do is increase the likelihood of individuals either choosing nonbiomedical options or waning in their support for biomedicine. Furthermore, it is worth noting that the decentering of the health professional in decisions about legitimacy/effectiveness should be situated within the emergence of neoliberal forms of government and in the wider context of the promotion of the "entrepreneurial self." Indeed, new forms of governmentality have been ascribed to such cultural shifts, with the espousal of individual (rather than state) responsibility for health and the centrality of "acts of choice" (Rose, 1992, 1999; see also Emmison, 2003). As such, bricolage could be construed as an organizationally and politically desirable outcome. Although potentially challenging traditional oncological (and biomedical) expertise, it also recenters responsibility for health (and in this context cancer care) onto the individual. The bricoleur is thus at once an emerging form of potentially transformative expertise but also part of a broader strategic repositioning of responsibility. This emergent

contradiction between individuation and responsibility is a key issue for future investigation.

Notes

1. Observational research of patient-patient interactions in oncology waiting rooms and inpatient wards would be valuable to further explore this process.

2. Dr. Max Gerson (1881-1959) developed a so called "cancer therapy" that mainly involves a rigorous and expensive restrictive diet (no meat, sugar, or dairy), plus daily caffeine enemas and supplements. It is highly controversial among the medical community but very popular among cancer patients. There has been no evidence produced of its effectiveness in the treatment of cancer.

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