

**Title:** Cancer self-health programmes: An ethos for negotiating multiplicities of healthcare

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**Abstract**

Cancer self-health programmes are a popular form of healthcare in the UK, Australia and North America. This article explores how they bring together heterogeneous and possibly incommensurable modes of healthcare (including complementary and alternative medicine, self-help, psychotherapy, and systems theory from bioscience) to form programmes of self-health. Through a discourse analysis of four programmes – The Bristol Approach; Health Creation Programme; CANCERactive; and, The Healing Journey – this article explore how these programmes promote: (1) Strategies to delineate spheres of living, such as mind, body, and spirit; (2) Relational practices such as, holism, connectedness, listening, and healing; (3) Empirically pragmatic attitudes that individualise techniques and practices; and, (4) Purposes to life that emphasise a dialogical movement between dichotomised positions. Significantly, through these strategies, techniques and practices cancer self-health programmes are able to promote an ethos that seeks to affect the user, without determining an individual's specific needs or choices.

**Keywords** Complementary and alternative medicine, self-help, psychotherapy, cancer, systems biomedicine, sociology.

A prominent part of healthcare policy in the UK, North America and Australia in the last decade has been to increase choice of mainstream healthcare providers (Tritter et al 2009). Related to this area of growth in the health economy is an increased interest and focus upon personal health, which is popularly understood as the individual taking responsibility for their wellbeing in an environment frequently framed as a healthcare market (Illouz 2008). Understood like this, one choice up to 40 percent of people with cancer will exercise is to include some form of complementary and / or alternative medicine (CAM) in their healthcare (Horneber et al 2012).

Developing and promoting this interest are cancer support centres, which have become an increasingly acceptable healthcare provider for many people with cancer (Seers et al 2009; Shneerson et al 2013). These centres emphasise programmes of self-health and have become ‘a key informative and pragmatic resource in the provision of CAM services to patients’ (Chatwin and Tovey 2004: 210). Formed as charities, third sector or private organisations they frequently have financial revenues into the millions, funded through donations and commercial activities (PBCC 2012; CANCERactive 2012). They therefore have been able to grow outside the institutional reach of mainstream healthcare and mitigate some of the factors that could be used to marginalise them (cf Coulter et al 2010; Wahlberg 2007).

While significant consideration has been given to the experiences of various CAM modalities by people with cancer (Broom 2009 a and b; Chatwin and Tovey 2004; Horneber et al 2012; McClean 2005; Shneerson et al 2013; Smithson et al 2010; Stacey 1997) and differing CAM modalities relationship with biomedicine (Bendelow 2009; Broom and Adams 2009; Cant and Sharma; 1998; Coulter 2004; Coulter et al

2010; Gale 2014; Kuhlmann 2009; Possamai-Inesedy and Cochrane 2013; Saks 2003; Seers et al 2009), there has been less consideration of the specific self-health programmes provided by the centres themselves. The first aim of this article is therefore to explore how the cancer self-health programmes are able to draw together divergent treatments, therapies and practices in a way that they assert users will find useful. The second aim is to explore how the programmes cancer support centres offer might provide novel understandings of cancer healthcare provision in contexts where there are multiple providers.

*Complex negotiations: Bringing CAM and biomedicine together*

CAM can refer heterogeneous field of practices, treatments and therapies including the psychological, nutritional, body-work, psychic and spiritual, as well as ‘alternative’ healing systems (Bendelow 2009). Within this diverse range of modalities are ‘whole system’ approaches like homeopathy and ‘less ideological’ practices like reiki (Broom and Tovey 2008: 8). What frequently characterises a CAM modality is, first, a lack of integration into the biomedical or ‘Western’ healthcare model; and, second, it is frequently an approach that includes some degree of physical and metaphysical elements (Broom and Tovey 2008). Therefore, given the range of different modalities available, the coming together of CAM with biomedicine – itself a diverse field with a range (and history) of approaches to the body, health and care (Mol and Berg 1998) – is a relationship characterised by a complex array of problems epistemologically, systemically and at the level of individual healthcare.

Most notably, the relationship between CAM and biomedicine has been defined by a long history of mutual distrust and conflict (Saks 2003) and has frequently been viewed through simplified binary oppositions (Gale 2014) (e.g. scientific/quack;

reductionist/holistic; cure/care etc.). While more recent commentaries have focused on the lack of efficacy for many CAM modalities and provided a vocal critique of the dangers of using unproven treatments and therapies (e.g. Goldacre 2008; Singh and Ernst 2009), others have been able to emphasise the importance of historical, social and cultural factors related to the ongoing use of CAM (Bivins 2007; Gale 2014; MacArtney and Wahlberg 2014; Saks 2003; Sointu 2012; Wahlberg 2007). This literature highlights how epistemological conflicts about what constitutes acceptable modes of healthcare are frequently juxtaposed against a person with cancer's desire (or obligation) to do the best they can, at that time, for their health and wellbeing (Broom 2009 a and b; McClean 2005).

Despite this problematic history, several CAM modalities have also sought different ways to work with, or at least coexist alongside, biomedical healthcare (Possamai-Inesedy and Cochrane 2013; Tyreman 2011). At a systemic level, CAM practitioners have traditionally had more freedom to operate at the level of primary care, which has resulted in the development of an entrepreneurial attitude in the provision of many CAM modalities (Weeks 2001). This involved developing networks not only within a particular CAM discipline, but also across CAM modalities, insurance schemes, and with some biomedical practitioners (Coulter 2004). This more pluralist approach (Cant and Sharma 1998), however, was not without its problems. Many CAM practices have been relegated to position in a hierarchy determined by a complex array of political, economic and regulatory forces, as well as being left exposed to 'a kind of normalization or disciplining of practice' (Wahlberg 2007: 2314). In such circumstances the boundaries between CAM modalities are often reinforced and

solidified as they compete to define and regulate themselves, contrary to much of the rationale behind cooperation and integration.

Part of the problem of bringing CAM modalities and biomedicine together is that the aim or outcome of that integration has not always clearly defined (Coulter et al 2010), or that their coming together is too frequently based on an asymmetric understanding (in favour of biomedicine) (Gale 2014). As a consequence the degree of success to which CAM modality might be integrated with biomedicine has often depended upon a complex array of factors, including the CAM discipline involved and its receptiveness to being subsumed within the biomedical framework (Coulter et al 2010; Tyreman 2011). Even where there is more potential for mutual transformation (Gale 2014) the success or otherwise has come down to individual preferences of those (in biomedicine) charged with implementing the policy (Broom and Adams 2009; Smithson et al 2010). As a result, while there have been successful attempts to integrate some CAM modalities and biomedicine, there is little evidence to suggest that these successes should not be treated as localised or marginalised, rather than a model that could be generalised.

#### *An emerging ethos of self-health*

Against this background of epistemological and systemic conflict, many people with cancer have been observed finding ways to combine different CAM modalities (e.g. Hok et al 2007), as well as using one or more CAM modality alongside their biomedical treatments (Horneber et al 2012). Using CAM in this way is part of a wider self-help phenomenon, whereby people are encouraged to take individual responsibility and become experts of themselves in all manner of ways, drawing on

resources from both CAM modalities and biomedicine, in both commercial and public fields of healthcare (Stacey 1997).

This ontological shift (towards the user) in who defines what is an appropriate healthcare practice (and how its relationship to other health modalities should be described) also has implications for how success is gauged, as understandings become broadened to engage experiences that promote autonomy, wellbeing, self-fulfilment, and authenticity (Broom 2009a; McClean 2005; Sointu 2006; 2011; 2012; 2013; Stacey 1997). However, such engagement is not without its costs as users of some CAM modalities have reported feeling overly responsible for matters they experienced as beyond their control (Broom 2009 a and b; McClean 2005; Sered and Agigian, 2008); becoming exasperated by discourses of positivity (Ehrenreich 2009); and, disheartened by the social capital barriers to entry and ongoing intellectual effort to achieve their aims (Broom et al. 2014 a and b). In particular, the loss of externally provided coherence, when moving across multiple systems of knowledge (Broom et al. 2014a), appears to be a particular casualty of an individuated, self-responsible conception of healthcare. That is, despite the well-publicised successes of using some CAM modalities as part of an individuated programme of self-health, many others find it a difficult and complex field of healthcare to negotiate.

Furthermore, the development of a new self-health attitude to healthcare, derived from knowledge and experiences from CAM modalities, has not been without its detractors. By proposing particular ways that person with cancer should approach and think about their healthcare, it has been argued that many CAM modalities tap into a neoliberal ethos to healthcare (Broom et al 2014a; cf Rimke 2000). That is, cancer

self-health can be understood as an approach emerging from a field of healthcare that emphasises practices of self-improvement and self-modification, based on the values of autonomy, individuality, responsibility, choice, and freedom in healthcare (Bauman 2007; Foucault 1973; Giddens 1991; Rose 1999). Accordingly, the values and discourses that pose as an alternative to the mainstream biomedical values, might be found to contain cultural artefacts that constrained their emancipatory promise (Philip 2009; Sointu 2011; Stacey 1997).

In contrast to these potential critiques, however, there is also a growing literature that questions whether there are opportunities within some CAM modalities and self-health for the individual to move ‘beyond’ previously construed neoliberal boundaries that instigated the user’s care for their health (Broom 2009b; Fullagar 2002; Kuhlmann 2009; Meurk et al 2013). That is, if the ‘persistence of controversy is often not a natural consequence of imperfect knowledge but a political consequence of conflicting interests and structural apathies’ (Proctor 1995: 8), then the tensions within and between CAM and biomedicine in advanced liberal society might therefore form a productive backdrop that opens up a possible space for things – self, health and life – to be different.

One way of approaching this is to ask if programmes of self-health *open-up* possibilities and resources for the user to work out for their self what is needed (cf Frank 2010). If cancer self-health programmes open-up possibilities then the dialogue they instigate might be argued to facilitate ways that individuals could think differently about their health and wellbeing (cf Frank 2010). As such, the critiques that focus on the neoliberal normativity of such programmes (or the CAM modalities



within) could be tempered by the *ethical* difference these programmes make to the ways users understand their healthcare. In order to consider this, this article explores how the strategies, techniques, practices and aims of cancer self-health programmes are proffered to the user as one way of managing the multiplicity of tensions in self-healthcare.

## Method

The following four cancer self-health programmes<sup>1</sup> were selected for analysis following a review of recommended self-health approaches by users of a cancer support centre in London, UK, canvassed as part of a wider ethnography into people's experiences of cancer self-health. The selected programmes represent a sub-field of complementary healthcare that is attempting to bring together CAM modalities, self-help, psychotherapy and systems biomedicine into one overall approach. These cancer self-health programmes were:

- Penny Brohn Cancer Care's 'The Bristol Approach'<sup>2</sup> (Cooke 2003).
- Rosy Daniel's 'Health Creation Programme' (Daniel 2005).
- Chris Woollams' 'CANCERactive' (Woollams 2005, 2008).

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<sup>1</sup> While the founders or users of these programmes may not specifically use the label 'cancer self-health', I do not believe the conceptualisation would be one either alien to them or construed as necessarily problematic.

<sup>2</sup> Cooke wrote most of the book on The Bristol Approach, however it introduces an approach inspired by Penny Brohn and Pat Pilkington (the founders) (PBCC 2013) and that was the product of years of collaboration from numerous CAM and biomedical practitioners at the Bristol center.

- Alistair J. Cunningham's 'The Healing Journey' (Cunningham 2000, 2004a, 2004b).

The books that were selected from each programme represent the core texts for each approach, introducing the main ideas, attitudes and practices to the (potential) user.

The programmes themselves extend much further than these books, offering websites, newsletters, blogs, DVDs and podcasts, as well as courses and retreats. However, in order to focus on the central messages of the programmes these were excluded from this analysis.

The field of cancer self-health is an international and multi-million dollar enterprise and so other programmes were considered for analysis. For example, Lawrence LeShan's ([1989] 1994) *Cancer as a Turning Point*, Louise Hay's (2004) *You Can Heal Your Life* and Jane Plant's ([2000] 2007) *Your Life in Your Hands*. However, unlike the other four programmes, which seek to bring together a heterogeneous mix of treatments, therapies and practices, these approaches emphasise one discipline to the exclusion of others. LeShan and Hay primarily focus on the psychological aspects of illness, while Plant is mainly concerned with the environment and biochemistry of diet. These programmes were excluded from this analysis as they were not attempting to bring CAM modalities and biomedicine together, preferring to offer alternative or additional emphasis to what the user is already doing.

The practices and techniques drawn from discourse analysis were used to start the analysis, involving in-depth reading and note taking from each of the main books associated with the programmes. Throughout this process notes were made of key concepts, practices, techniques and aims of the programmes, with similarities and

differences highlighted. This would also involve a degree of interpretative work, whereby I would also note my reflections and thoughts, as well as provide any necessary contextual information. These initial categorisations were further developed through application of an analytical framework that drew on Foucault's four ethical dimensions used to explore the care of the self as described in *The History of Sexuality Vol 1* ([1979] 1998). As Rose (2007) summarizes, these dimensions can be understood as a set of analytical strategies that: (i) identified an aspect of the person to be worked upon; (ii) problematised it in certain ways; (iii) elaborated a set of techniques for managing it; and, (iv) set certain objectives or forms of life that are to be aimed for. A similar framework was also used by Blackman (2001) to analyse the practices and techniques of members of the Hearing Voices Network. In this study, by taking a loose interpretation of each dimension, it was possible to frame an analysis that enabled a multilevel consideration of the ethos that cancer self-health programmes advocated. In practice, as the analysis progressed, these categorisations were refined so that the Foucauldian dimensions were subsumed within an analysis that held more resonance with the field of enquiry. This was an iterative process, which entailed my reading and re-reading significant sections of text so that new forms of connections, relations and phrasing could be highlighted. The sociological literature was then returned to in order to explore some of the key discourses and concepts that had emerged from the analysis.

## **Results**

Cancer self-health programmes are orientated towards providing the user with individualised tools through which the user can come to make better decisions for his or her self, health and life. In this sense cancer self-health programmes can be seen as

merely a collection of information, guidance and advice that the user is free to take up at their discretion. But in providing this information cancer support centres are aware that cancer self-health programmes can have a significant effect on the user's life. They consequently seek to undertake this role without enforcing limits or decisions upon users. What arises from managing this tension, of affecting without directing (cf Rose 2007), is an ensemble of properties in cancer self-health programmes that have hitherto not been used together. The ethos of cancer self-health programmes can be seen to comprise of ontological strategies to assist the user in distinguishing spheres of their life; themes through which to develop new ways of relating to their self; the formation of an epistemological attitude that assists the user in evaluating what information and knowledge is useful to their health; and, the renewal of purposeful living when faced with a serious illness like cancer.

### *Reconceptualising life*

Each cancer self-health programme identifies several spheres that the user might wish to attend to as part of an ontological strategy to reshape their life. The Bristol Approach says that,

the more complete picture is central to our approach. It allows us to tease out the path that will allow each individual to find his or her way forward with a strengthened and well-functioning immune system, so that the whole person - mind, body and spirit - is primed for recovery and well-being (Beales 2003: 23-24).

While increasing the user's awareness is an established technique in many CAM modalities, self-health approaches and psychotherapy (cf Sointu 2013), each of the cancer self-health programmes provides a different emphasis or suggests fewer or greater numbers of spheres for the user to consider. For example, while Daniel is very clear about the four spheres of mind, body, spirit and environment (each with three sub-spheres) to which the user should attend, Cunningham provides several loosely defined labels (body, conscious mind, deeper mind, social, and spiritual) that the user is free to amend to suit their life and culture. Nonetheless, for all the programmes, developing an attentive attitude to oneself and one's environment is a significant part of the cancer self-health approach as it allows the user to become aware of what exists in their world and how they should understand its affects upon them.

Cancer self-health programmes therefore draw on various antecedents (from CAM, self-help, psychotherapy and bioscience) to provide the rough contours of the object to which the user is to bring their attention to. However, cancer self-health programmes limit themselves by not committing to a full operationalisation of the content of each sphere. For example, The Bristol Approach identifies seven 'core human needs', but says 'these take a particular form in each person's own life and circumstances' (Cooke 2003: 26). So while it is possible to provide a description of the popular features of each sphere, a methodological warning is needed about reading-in meaning that is left open in the texts (cf Blackman 2004). The use of the descriptor 'spheres' therefore reminds us that the explanation provided in the programme is necessary, but not sufficient, in appreciating how it is the user understands and experiences these spheres. Instead of this being a failure that demonstrates cancer self-health programmes's fuzziness, this is a productive strategy

that allows both users and the cancer self-health approaches to be open to new developments in forming each sphere. In practice the advantage of this strategy is that cancer self-health programmes will describe popular features of a sphere, while it leaves open the core of the sphere for the user to find if ‘... it work[s] for me in my life’ (Broom et al 2014b: 348).

### *Developing new ways of relating*

As well as identifying spheres of life that the user might wish to bring their attention to, cancer self-health programmes also seek to suggest new ways the user can relate to these spheres to encourage new or better ways of being. Through various exercises – such as listing relationships to be developed or nurtured and those that are to be ‘left behind’ – and via contact with new ways of relating to oneself – in meditation, visualisation, support groups, individual psychotherapy, spiritual and energy treatments etc – the user is exposed to ways of relating to their newly identified spheres of living that they might not have previously considered.

Without providing a typology, it is possible to highlight some of the indicative ways in which the user is encouraged to relate to their self, health and life. For example, users are encouraged to explore ways of being holistic ‘in the sense that it recognises the unity and interdependence of body, mind and spirit within each individual’ (Cooke 2003: 2). This is a relationship that seeks to develop an awareness of how *all* of the different aspects of living interrelate, in a symbiotic and systematic approach. Holism contrasts to ideas of ‘connectedness’ (Cunningham 2004a: 22; Daniel 2005: 14), which draws the user to approach the relations between spheres of living in twos or threes, and is more about the flow and influence between particular spheres, rather

than seeking to form a totalised (holistic) mode of association (cf Woodhead and Sointu 2008). Another example is the ways users are encouraged to ‘listen to yourself’ (Cooke 2003: 33); a practice that at first is an aural experience, but which is quickly generalised so that the user also comes to ‘listen’ to how things *feel*. Or finally, developing ways of ‘healing’, which focuses on improving the user’s experience of their illness, rather than curing it, so that the user can be ‘healed’ in ways that avoid the scrutiny from biomedical concerns with curing (cf Sointu 2006).

*Forming a new attitude to ways of knowing*

A third feature of cancer self-health programmes is the way through which they seek to form an epistemological attitude that the user can apply to any situation. Cancer self-health programmes draw on the diversity of available healthcare disciplines including the diverse practices of CAM; self-help’s attitude of empowerment; generalisations of psychotherapeutic principles; and, bioscience’s empirical authority. Cancer self-health programmes attempt to bring these multiple, supposedly incommensurate, disciplines and practices together in a meta-approach that is empirical and pragmatic, while being generalisable and subjective.

It is possible to briefly highlight particular influences of each antecedent as an example of what it contributes to the ethos of each cancer self-health programme. The prominence of CAM is perhaps the most obvious feature of the programmes. CAM use is frequently framed by an attitude of personal exploration and experimentation, which leads to reflections upon what worked and what did not in creating the ‘right mix’ (Broom 2009b: 1056). For example, Woollams (2005) draws on his daughter’s diagnosis of a brain tumour, which led him to the conclusion that – after much

research – there is a diverse literature on preventing and curing cancer, but he argues scientists are failing to pass this on to doctors, and doctors on to their patients. As a consequence of their personal experiences each founder started to produce resources that others could utilise. Exploring these databases and archives is an important step for the user in forming an empirically pragmatic approach to their healthcare.

Therefore, while cancer self-health programmes provide this information, it is for the user to choose the best intervention ‘within a framework of support’ (Cooke 2003: 59). What this means is that each user must reflect for their self what it is that they need to do, using the practices and techniques learnt in cancer self-health programmes. As such cancer self-health programmes stress particular aspects of self-help over others (Stewart 1990) to focus on individual responsibility, a desire for change, developing coping mechanisms, and self-esteem work, in forming ways in which the approach can advise the user, without explicitly directing them. In this it draws on a further influence from the non-directive component of psychotherapy (i.e. as used in Carl Rogers’ client-centred approach). This non-directive support allows cancer self-health programmes to be detached from being complicit in individual decision-making, yet at the same time it can be a source of comfort for the user by providing an ethos through which decisions come to be made. By distancing the approach and generalising therapeutic imperatives cancer self-health programmes provide the user with practices and techniques that help the user to decide how to manage the problems they face, without the approach first having to know the specific details of the user’s problem.



The final influence on cancer self-health programmes' epistemological attitude is bioscience. Again the founders use of a biographical approach is, at first, used to help overcome the mutually antagonistic relationship biomedicine and CAM have held to each other in the past (Saks 2003). That is, Woollams forefronts his MA in biochemistry; Cunningham draws on his PhD in cell biology; Daniel's approach is as a general medical practitioner; and, while the founders of The Bristol Approach may not have had a background in bioscience, biomedical practitioners were significant contributors to developing the approach and writing the book. However, while this initial biographical experimentation and integration under the rubric of what worked is used to dissolve boundaries, the future integration is premised upon the theories and evidence from systems bioscience; namely, psychoneuroimmunology (PNI). As Daniel says (2005: 172), 'PNI has now given us irrefutable evidence that improving our state of mind and calming our nervous systems can have a profound effect on our ability to resist disease, and survive it if we do fall ill'.

Therefore, while individual studies from PNI are frequently cited to legitimise the use of certain treatments, therapies or practices, it is the *theory* of PNI that provides a rationale for the ongoing use of a diverse range of healthcare practices. This provides a framework for users, who frequently cannot wait for the conclusive evidence based meta-analysis, to test for themselves if a treatment, therapy or practice works for them. That is, if there is some perception of benefit, then an awareness of PNI allows the user to recognise this as a *physical* improvement. This is because PNI provides a model that links all spheres of life, through the interplay of hormones, the immune system and the environment. The material body is therefore related to holistic ideas

providing a systemic conceptualisation of health and healthcare that the user is able to individualise to their particular circumstances (cf Broom 2009b; Sointu 2006).

Drawing the four antecedents together, an epistemological attitude emerges that cannot be reduced to any one discipline or influence (cf Broom 2009b). Through a non-directive framework of support cancer self-health programmes are able to inform the user without telling them exactly what they should do. That is, the empirical pragmatism and emphasis of supporting one's self do not tell us, or the user, what the outcome of those deliberations will be, as they seek to find 'what works, for me'.

### *Finding purpose in life*

Doctrines of meaning and final causes do not, and cannot, come from biomedicine alone (Kleinman 1989). This is not a matter overlooked by cancer self-health programmes, which engage the person with cancer in thinking about the timing of their illness and how this affects meaning and purpose in their life. This can be described as a dialogical approach, as cancer self-health programmes oscillate between the concrete and the abstract, the singular and the generalizable, and the immediate and transcendent (cf Foucault 2005). For example, Cunningham (2004b) moves between the effects of the immediate physical factors the user experiences to reflecting on the 'higher levels' that can be taken into account in the meaning of illness. The Bristol Approach's 'living life in the here and now' (Cooke 2003: 90), is juxtaposed with other 'metaphysical' perspectives, such as the feeling of unconditional love or there being a 'higher power'. For the cancer self-health programmes, the movement between dichotomous positions is posed as a powerful technique that aims to profoundly alter users' perspectives.

This is part of an ongoing programme, towards what The Bristol Approach calls a ‘healing way of life’ (Cooke 2003: 90), which engages a step-wise long-term approach. Therefore, the use of cancer self-health techniques or therapies can continue over months and years and the impact of their affects can shift (cf Sointu 2006). This can mean that the reasons for engaging a particular healthcare practice or exercise can also develop (Broom et al 2014b; Broom and Tovey 2008), as what is found to be the right for the user in one situation might not necessarily be the same for a later, similar, experience.

## **Discussion**

Cancer self-health centres self-health programmes provide an easily accessible framework through which users can bring CAM modalities and biomedical healthcare together. This analysis provides two important insights for understanding how cancer self-health programmes do this: first, the cancer self-health programmes that cancer self-health centres promote allow them to frame themselves as arms-length entrepreneurial providers in a pluralist healthcare market; and second, bringing together heterogeneous healthcare practices will be most successful if defined and implemented at the level of the user, rather than at the level of disciplines or institutions.

For the user, a consequence of engaging a cancer self-health programme is that they will be provided with more options than they previously had; it therefore opens up possibilities, rather than closes them down (Frank 2010). This is a noteworthy distinction from previous considerations of CAM modalities and self-health

approaches. This is because unlike some other conceptualisations of CAM or self-health, where the user was limited in their understanding by being directed towards bounded discourses (e.g. Fries 2008; Philip 2009; Stacey 1997), cancer self-health programmes sought to open-up opportunities for interpretation and experience beyond a singular interpretive framework.

Cancer self-health programmes therefore entailed something quite unique. The cancer self-health centres have found a way to take the individualised forms of integration (cf Broom 2009b) and organised a programme around them to provide an overall approach to bringing CAM modalities and biomedicine together. Cancer self-health centres were able to do this by drawing together a plethora of resources that are in many ways incommensurate with each other and then locate the user within a milieu that is found to no longer have a singular voice. These findings therefore contribute to arguments that have noted how by locating evaluations of efficacy with the individual, various CAM modalities are contributing to wider trends of self-trialling and self-care (Broom et al 2014a). What this analysis has supplied is a description of how cancer self-health programmes were able to do this, through providing the user with: the conceptual apparatus with which to orientate the user; practices and techniques with which to relate to these (new) objects in the user's life; an approach through which the value of things can be established; and, goals and possible reasons for undertaking new ways of living. The end result is an ethos that will affect the user, but not necessarily direct them in any pre-given way.

Cancer self-health programmes therefore do not use the difficulties of integration, along with the ambiguities and controversies within the field of cancer healthcare, to

close down or limit what could or should be used (cf Frank 2010). Instead, where there is a lack of definitive knowledge or there are problems of integration, these are framed as a productive space for the user to individualise their self-health. Each programme engages this strategy of ‘strategic ignorance’ (McGoey 2007) to a different degree. Further, how cynical this agnotological (Proctor 1995) (the social and cultural production of ignorance) positioning is by the programmes is questionable and in need of further research. But what is clear is that by providing the user with an ethos through which to approach the problems of contemporary cancer healthcare, cancer self-health programmes are better understood as a response to the *ethical* imperative of self-health to be individually responsible for one’s healthcare. Indeed, these findings build on previous research that found users of some CAM modalities and self-health were able to manage competing bodies of knowledge, often in an attempt to open-up previously established normative constructions of their self, health and life (Broom 2009b; Meurk et al 2013; Segar 2012; Sointu 2013).

Furthermore, by dislocating the cancer self-health programme from the outcome for the individual user, these programmes are able to claim an innovative new model of healthcare that provides a way to both recognise the wider normative forces in healthcare, whilst honouring the distinctive contribution and experiences of the user. As a *model* of healthcare, cancer self-health programmes therefore hold the potential to provide a significant challenge to mainstream healthcare as it seeks to legitimise esoteric practices and alternative approaches through an embodied subjectivity of the user (cf Kuhlmann 2009; Sointu 2006, 2013). Yet as the *practice* of cancer self-health programmes is located at an individual level, it does not appear to offer the consistent or coordinated critique necessary to threaten systemic change. Indeed, the cancer self-

health programmes' ethos is not certain to remain distinctive. Previous analysis have stressed how, as self-help groups formalise and focus on service delivery, they become more bound to the strategic aims of the state and lose their capacity to provide an alternative perspective (Chaudary et al 2011).

In sum, the growing popularity and significance of cancer self-health programmes reflects the (increasing) use around the world of discourses that value of autonomy, individuality, responsibility, choice, and freedom as the basis for their healthcare systems (Bauman 2007; Foucault 1973; Giddens 1991; Rose 1999; Tritter et al 2009). As such, cancer self-health programmes represent one example of what happens when these values are allowed to flourish: rather than endorsing one therapy, treatment or practice over another, cancer self-health programmes displace authority from disciplines and practitioners and locates the user at the locus of a heterogeneous healthcare system (cf Broom 2009b). Although further analysis will be needed to see how users take-up the specific strategies, practices techniques and aims offered by these programmes, and what the implications for mainstream healthcare programmes will be, what this analysis of the cancer self-health programmes has found is that they are providing users with a novel ethos with which to negotiate the complexities of contemporary cancer healthcare.

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