



# Identity in a medicine cabinet: Discursive positions of Andean migrants towards their use of herbal remedies in the United Kingdom



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## ABSTRACT

This study explores different rationales for using herbal remedies among people from Andean descent in the United Kingdom, using positioning theory as a conceptual framework. By analysing processes of positioning in narratives about healthcare choices conducted with 40 Bolivian and Peruvian migrants in London (between 2005 and 2009), we examine in which ways talking about personal preferences for herbal medicine can be constitutive of one's health identity. The results reveal three distinct discursive repertoires that frame the use of herbal remedies either as a tradition, a health-conscious consumer choice, or as a coping strategy, each allowing specific health identity outcomes. An enhanced understanding of how people make sense of their use of traditional, plant-based medicines enables healthcare professionals to better assist patients in making meaningful decisions about their health. Through illustrating how treatment choices are discursively linked with identity, the present results debunk the tendency to perceive patients with a migration background as one homogenous group and thus urge for a patient centred approach.

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## 1. Introduction

The use of herbal remedies -i.e. plant-based medicinal preparations-is a common healthcare seeking strategy among diverse migrant communities in western urban areas (Pieroni and Vandebroek, 2007; Muniz de Medeiros et al., 2012; Vandebroek and Balick, 2012; Quave et al., 2012; Pieroni and Privitera, 2014). Likewise, people from Andean descent who live in the United Kingdom continue to use a wide variety of herbal and natural remedies known from their country of origin, especially for minor ailments and preventive care (Ceuterick et al., 2011), although no statistically representative data exist.

Health choices are often identity-infused habits (Oyserman et al., 2007). Like dietary choices, consuming herbal remedies can be a conscious action that contributes reflexively to a sense-of-self (Fox and Ward, 2008a). The choice for one or multiple treatment options within pluralistic healthcare systems reflects degrees of negotiation among different forces, including financial and physical

access, availability of healthcare, gravity of illness, knowledge of home treatments, cultural beliefs about health, perceived effectiveness, faith in a certain treatment, but also the expression of identity (Young and Young-Garro, 1982; Miles and Leatherman, 2003; Ceuterick et al., 2007; de Pribyl, 2013).

For migrants, multiple medical realities exist, ranging from traditional over complementary and alternative to biomedical healthcare facilities in different locations. Traditional medicine is based on health related knowledge indigenous to a certain culture; complementary and alternative medicine includes treatments that fall outside of mainstream biomedical healthcare (WHO, 2000). As such, diverse pre- and post-migratory bodies of health knowledge form a wide variety of treatment options. Besides the use of herbal home remedies, a range of alternative healthcare seeking strategies has been documented among Latin-American communities in London, such as informal care from unregulated alternative providers (naturopaths), private healthcare from Spanish-speaking doctors, self-medication with over-the-counter or imported pharmaceuticals and transnational biomedical care (accessed during visits to the country of origin) (McIlwaine et al., 2011; Gideon, 2013). In a migration context, the use of traditional herbal medicine can be a deliberate strategy to strengthen and affirm an ethnic

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identity (Gervais and Jovchelovitch, 1998; Pieroni and Vandebroek, 2007; Jeffery and Rotter, 2016). Herbal remedies can be subtle symbolic vehicles for different forms of identity, including social, ethnic, or class identity (Crandon-Malamud, 1983; van der Geest and Reynolds Whyte, 1989). When seeking healthcare, people produce and reproduce narratives that act as metaphors for their position in the social world (Gold and Clapp, 2011). As such, medication narratives (accounts of medication use) are useful tools in illuminating one's identity (Bissell et al., 2007).

In this article, we borrow the concept of health identities that emerge from health related practices (Fox and Ward, 2006, 2008b). Specific aspects of embodiment, such as the consumption of herbal medicine, are embedded in a web of associations from which health identities are constructed (Fox and Ward, 2008b). Health identities are emergent identifications that are created actively, in relation to available discourses (Davies and Harré, 1990). Health identities are not static, and can be equally congruent with both medicalised conceptions of health and illness, and resistance to biomedicine (Fox and Ward, 2006).

Generally, patients are not prone to spontaneously disclose non-biomedical uses to health professionals (Stevenson et al., 2003; Howell et al., 2006; Vickers et al., 2006; Chao et al., 2008; Shelley et al., 2009; Posadzki et al., 2013). Most practitioners in the United Kingdom only occasionally ask about the use of herbal medicine when planning or reviewing a patient's drug therapy (Thomas and Coleman, 2004; DTB, 2010), despite an average prevalence rate of herbal medicine use of 37% (Posadzki et al., 2013). This lack of communication has potential negative outcomes, such as an interference with proper utilization of biomedical care, non-adherence to prescribed biomedical treatments, or undesired interactions between different types of medicines (Stevenson et al., 2003; Vandebroek, 2013). As such, awareness about patients' treatment preferences can help to improve healthcare delivery. Knowing why and in which circumstances people choose to rely on herbal remedies can improve the quality of care and advise policies aimed at enhancing patient safety and patient centred care.

This article uses a discourse analysis to understand the choice for herbal medicine, and the meaning of those remedies in Andean people's lives in London. In health research, discourse analysis is commonly employed to examine how language is used to create and enact identities and health activities (Lupton, 1992; Starks and Brown Trinidad, 2007). By focusing on medication and healthcare-seeking narratives, we describe the symbolic associations of herbal medicines in people's lives and the role these remedies play in shaping health identities. Using positioning theory, we explain how people originating from Andean countries position themselves with respect to their use of herbal remedies, and what underlying identity needs these choices represent. The two central questions that this article seeks to address are: (1) *How do Andean migrants explain their use of herbal remedies in the United Kingdom?* and (2) *How is language about their preference for herbal remedies used to discursively construct identity?*

## 2. Materials and methods

### 2.1. Theoretical framework

Positioning theory assumes that identities emerge through social interaction and are reflexively (re)constituted in discursive practices and narratives (Davies and Harré, 1990; Benwell and Stokoe, 2006). Following these theoretical assumptions, identity is defined as a subject position in relation to social representations—condensed in interpretative repertoires—as people make sense of themselves and their actions by drawing on and reconstructing

those social representations (Fox and Ward, 2006; Andreouli, 2010). A subject position is both who the speaker is to be seen by others, and the perspective from which (s/he) sees the world. To construct a subject position or identity, people draw on, resist, or (re)negotiate interpretative repertoires (Davies and Harré, 1990; Charlebois, 2008). A socially defined interpretative repertoire is a patterned and recognisable routine of descriptions, arguments and evaluations that can be distinguished by recurrent themes, metaphors and characterisations (Wetherell, 1998). Interpretative repertoires are culturally familiar, habitual lines of argumentation, from which accusations or justifications can be launched, without having to spell out an entire argumentation. Apart from adopting positions, speakers also assign certain positions to other people, including the interviewer and non-present others (Charlebois, 2008). Interpretative repertoires can be used to construct positions for one's self, and for others. Hence, the notion of positioning clarifies the relational, dynamic and contextual character of identity. Interviews provide an ideal arena for discursive practices, and for participants to draw on discursive resources (Potter, 2004).

### 2.2. Data collection

A total of 40 in-depth, semi-structured interviews were conducted between 2005 and 2009, with equal numbers of Peruvian and Bolivian migrants in London, as part of a larger study on the use and perception of traditional medicine among Latin-American migrants in the United Kingdom (Leverhulme Research Project Grant F00235D, PI: Andrea Pieroni). This study was granted ethical approval by the University of Bradford Ethics Committee. Data saturation (based on knowledge and preference of herbal remedies) occurred after approximately 12–15 interviews in each group. Participants were recruited through purposive sampling (Tongco, 2007). Prior consent was obtained verbally before each interview. Interviews lasted between one and three hours, were conducted in Spanish by the first author, recorded and then fully transcribed in a cut-down form of Silverman's guidelines (2001). Relevant quotes were translated into English afterwards.

Table 1 shows that participants had been living in the United Kingdom between one and 30 years. All Peruvian interviewees originated from the capital, Lima, except for one person from Arequipa. All Bolivians previously lived in the city of Cochabamba. Although a third had also lived in La Paz and/or Santa Cruz reflecting internal mobility before migrating abroad. Slightly more women were interviewed (ratio 23:17). Participants differed in age between 19 and 75 years. To the best of our knowledge, none of them had obtained British citizenship through nationalisation. The majority of interviewees claimed to have migrated to pursue better economic circumstances. One third of the interviewees worked in the cleaning industry. Forty percent of all participants held master degrees from institutions in their countries of origin (in medicine, dentistry, nursing, veterinary medicine, law, engineering and economics) and were over-qualified for their jobs in the United Kingdom. The remaining participants did not specify their educational background. A minority of 15% held positions that matched their educational background. Usually they had been living in the United Kingdom for longer, or they had initial long-term perspectives to stay in the United Kingdom (because of work, marriage or family reunification). Three people were unemployed at the time of the interview. Two were studying. One woman identified as a fulltime housewife. Four persons were retired. Other demographics are set out in Table 1. Participants who did not confirm registration with a general practitioner, were either unsure or claimed they planned on registering or did not provide an answer to the question. Such ambiguous answers could be related to taboos on legal status.

**Table 1**  
Demographics of study participants.

	Bolivians	Peruvians
Female	n = 8	n = 15
Male	n = 12	n = 5
Total participants	20	20
Average age	32 (stdev 9.7)	44 (stdev 14.6)
Age range (years)	19–60	19–75
Length of residence in the UK varies between (years)	1–10 (average: 3)	1–30 (average: 8)
Participants with children (living at home in the UK)	n = 2	n = 2
Registered with a general practitioner or medical centre	Yes: 11 No: 3 Unanswered: 6	Yes: 12 No: 3 Unanswered: 5

### 2.3. Data analysis

Interview transcripts were coded with Nvivo10, computer-assisted qualitative data analysis software. Following Hall (1997), data were scrutinized for recurrent themes and elements, including: 1) statements about traditional herbal medicine that offer insight into how treatment choices relate to identity; 2) tacit rules of inclusion and exclusion which prescribe what can be said and thought in relation to the use of herbal remedies; 3) topics that personify a discursive strand; 4) explanations of how knowledge about the use of herbal remedies acquires authority; and 5) the emergence of opposing argumentations. Specific attention was paid to the different levels of identity construction outlined by De Fina et al. (2006), i.e. relationships between the speaker and what is being said; relationships between self and other, or speaker and hearer; and relationships to mainstream ideologies, widespread social practices or underlying power structures. Subsequently, transcripts were scrutinized for patterns of argumentation and rhetorical tools, including the organisation of talk around contrasts, repetition of words and grammatical structures, metaphors, analogies and lists (see Roberts and Sarangi, 2005) to identify interpretative repertoires. No new themes emerged after about half of the interviews. Finally, interview excerpts were selected to illustrate the observed patterns. For privacy reasons, quotes in this article have been anonymised.

## 3. Results

### 3.1. Interpretative repertoires on herbal remedies

Three distinct repertoires were identified, framing the use of herbs respectively as: (1) tradition-bound, part of an ethnic background, a habit and a way to feel at home, (2) a health-conscious consumer choice and (3) a coping strategy. Table 2 summarises these interpretative repertoires. They constitute the discursive terrain of traditional herbal medicine use in a migration context for this particular sample of people from Andean descent.

The majority of Bolivians (more than half) and only a few Peruvians used the tradition-bound repertoire. About a quarter of Bolivians and almost all Peruvians relied on the health-conscious

consumer repertoire. No Peruvians and only a few Bolivians relied entirely on the coping strategy repertoire.

These three repertoires were built on the basic juxtaposition of herbal medicine with biomedicine or pharmaceuticals. There existed consensus among interviewees that medicinal plant use in their countries of origin was -and often still is- considered a symbol of poverty, implicitly adding negative stigmatising connotations and prejudices. Interviewees explained that within this dominant discourse the use of pharmaceutical products was considered modern and an indirect proof of education, sophistication, economic prosperity, urban residency and even moral superiority, while relying on plants for personal health was equalled to a lack of education, ignorance, superstition, rural residency and having little physical and financial access to biomedical healthcare facilities.

“Sometimes, there is a bit of prejudice as well, about the fact that you use medicinal plants. If you use medicinal plants it is considered stupid. Only the people that have a high socio-economic status say: ‘no, I do not like plants, a chemical medicine is better, herbal remedies are stupid, for poor people, people who cannot buy medicines’ (...) What happens to a language, also happens with plants, because people suffer from discrimination, they stop practicing a lot of things they know. ‘I do not know anything about plants’ they would say, ‘I do not use plants’, because they are afraid that other people would make fun of them.” (LoP4, man, 32, Peru)

“Nowadays, the Peruvians, most of all those from Lima, have learnt to appreciate natural products, because for a long time, we, the people from Lima, we were very prejudiced, you see, about things that came from the countryside. Above all the elite, not in my case, but the people with better economic resources in Lima, Lima’s high classes.” (LoP12, woman, 37, Peru)

Participants knew and repeated these dominant perceptions from the societies they lived in before moving to the United Kingdom and positioned themselves towards these negative views on a continuum from subtle rejection and renegotiation to nuanced acceptance. In order to overcome negative connotations, different discursive strategies were employed to obtain a positive health identity outcome.

**Table 2**  
Summary of different repertoires: (1) tradition-bound; (2) health-conscious consumer choice; (3) coping strategy.

	Repertoire 1	Repertoire 2	Repertoire 3
Motives	Internal. Tradition, family, rootedness in historical use and ethnic culture	Internal. Health benefits, natural and thus healthier Scientific proof (excludes magico-ritual uses)	External. No other option
Framed as	Faith	Choice (informed by proven effectiveness, science and personal judgement)	Coping strategy
Identity outcome	Focus on ethnicity: member of (imagined) community, still Andean	Focus on healthiness: health-conscious consumer	Focus on socio-economic position: survivor, struggling migrant

### 3.1.1. Tradition-bound use of herbal remedies

“Because of our culture, our tradition, we prefer to use herbal remedies before we visit a doctor.” (LoB8, man, 25, Bolivia)

“I believe that sometimes there are people who fall back on their own culture as they remember it, once they go abroad.” (LoB19, man, 47, Bolivia)

In the first interpretive repertoire, using herbal remedies was framed as an essential, valuable and intrinsic part of the speaker's Andean culture, tradition and practice, as the above quotes illustrate.

The associated vocabulary on knowing about herbal remedies encompassed words like *costumbre* (“custom”, “habit”), *rutina* (“routine”), *cultura* (“culture”), *tradición* (“tradition”), *conocimientos de la abuelita* (“grandmother's knowledge”), *familia* (“family”) and *acostumbrarse* (“to get used to”).

Validity of use was sought explicitly in tradition itself. The effectiveness of herbal remedies was considered proven by their long existence in family traditions and to a broader extent in Andean culture. Practices handed down through generations were deemed to hold legitimacy.

“If a grandmother passes it on to her daughter, that daughter to her daughter, and if it goes on like that for generations in a row, then it must have an effect. They tell this to you for a reason.” (LoB17, man, 37, Bolivia)

Users of this repertoire considered inheritance to be a testimony of effectiveness of herbal remedies, whereas scientific proof was not explicitly used as an argument to validate their use of herbal remedies. In line with the argumentation of rootedness, having faith in plants, to believe (*tener fe en las plantas, creer*) was sometimes raised as a valuable argument to endorse their personal use of herbal remedies.

Some participants that relied on this repertoire, underlined the importance of herbal remedies for their personal wellbeing and emphasised how they struggled with their new situation after migration, in which low accessibility of herbal remedies was just one of the many difficult changes. Nonetheless, biomedicine was generally depicted as a last resort, only used in case of severe diseases or emergencies. For many interviewees herbal remedies became a symbol of home.

“I love my garden, as I was born in the mountains, in the countryside, I would not be able to live in an apartment or in a place without plants.” (LoP8, woman, 70, Peru)

“A lot of people leave for different reasons. Fifty percent of all those people that leave their country of origin do so for economic reasons. Unfortunately, South-America has a huge economic problem. And a lot of people, like me, who are in university, once we leave university, we have to migrate and once we are abroad we have to do something else ... I clean. So, you leave a lot of things in your country. You leave your house, your family, your habits ... you leave your medicine. Here, I cannot use what I used back there. Sometimes, I feel bad and I have to wait or ask my mom to send them [herbal remedies] to me.” (LoP5, woman, 24, Peru)

This repertoire also contained negative comments on peers who stopped using herbal remedies and who allegedly had forgotten about their country or “had become British”.

Furthermore, a possible equation of using herbal remedies with

inferior attributes such as a lack of education or economic resources, was subtly renegotiated in this repertoire. To manage the renunciation of a potential membership in the troubled category of “poor and uneducated”, three discursive strategies were used. By using these three strategies of reframing, speakers warded off a possible interpretation and judgement (by the interviewer) of herbal plant use as a personal deficit.

First, the “lack of education” stereotype was generally neutralised by making a subtle distinction between magico-ritual uses and medicinal uses for mere physical problems. Without exception, participants who drew on this repertoire, distanced themselves from using plants for magical or ritual purposes. This distancing was marked by a common differentiation between traditional medicine personified by natural healers (*naturistas*), who work on the physical level and cure with herbal remedies, and other healers (*curanderos*), who work on a spiritual level employing forms of magic and witchcraft (*brujería*). Oftentimes, the linguistic act of distancing (to distance from what is depicted) was used through the passive voice and third person.

“People over there read *coca* [*Erythroxylum coca* Lam.] leaves for good luck. The indigenous people, the people from the countryside, maintain this practice. I have seen that they toss *coca* leaves. From that they predict your future, they see how your business will go. Until today, a lot of people believe in that. Supposedly, permission is asked to *Pachamama* or Mother Earth, to tell you how things will go. Listen, I do not think much of that.” (LoB13, woman, 19, Bolivia)

Second, possible stereotypes generally associated with rural residency were neutralised and overruled with the virtue of physical strength. In this repertoire physical vigour was directly linked with health as a result of a traditional rural way of life that includes using natural products and herbal remedies.

Third, the common association of using herbal remedies with a lack of economic resources (regardless of residency) was counterbalanced by stating that “things have always been this way”, including a lack of money. This acceptance contained no negative undertone and thus implicitly normalized the use of herbal medicine.

Linguistic mechanisms that marked this repertoire were: a general descriptive tone, active voice, first person (including the possessives “ours” and “mine”), resulting in an overall grammatical identification with the subject of herbal remedies. As such, this repertoire displays a pride in traditions, free of inferiority complexes.

### 3.1.2. Using herbs as a health-conscious consumer choice

In the second repertoire, using herbal remedies was framed as a choice driven by health concerns, rather than by tradition. People who drew on this repertoire claimed that they used herbal remedies because they considered these to be healthier than biomedical pharmaceutical products, natural, more effective and better in general. Recognising that herbs are healthier was even considered a sign of (moral) progressiveness.

“I think, as time goes by, the majority of the population realises that anything natural is just better.” (LoP12, woman, 37, Peru)

The vocabulary associated with knowledge about herbal remedies encompassed words as *saludable* (“healthy”), *natural* (“natural”), *efectivo* (“effective”), *comprobado* (“proven”), *preferir* (“to prefer”), *confiar* (“to trust”). Within this repertoire, arguments for choosing herbal remedies focussed on health motives instead of on

the expression of an underlying ethnic identity. Herbal remedies were believed to be more natural and therefore better than synthetic drugs (*productos farmacéuticos*), which were criticised for contaminating the body with chemicals. By chemicals, speakers referred to synthetic or artificial compounds. A frequently formulated idea was that herbal remedies “do not contain any chemicals”.

“In my family, we use a lot of natural medicines, plants. I do not like drugs too much. The truth is that they contain a lot of chemicals. I prefer natural medicine, because I believe it is more effective, faster, and it does not contaminate the body. They put a lot of chemicals in drugs.” (LoP1, man, 28, Peru)

“I never or hardly ever use chemical remedies. On top of that, I am allergic to analgesic substances, so I prefer natural remedies. I rarely use something a doctor prescribes.” (LoP11, woman, 31, Peru)

A perceived absence of side-effects was considered another valid reason for using herbal remedies.

“The truth is that I generally do not use that much medicine. If I have a headache, I just let it pass, because I believe that if you use a lot of medicine, you become resistant and in the end nothing will happen.” (LoB14, man, 26, Bolivia)

In addition to the subjective argument of herbs being “natural” and “healthier”, this repertoire was supplemented with other validity claims and two different acts of discursive distancing.

First, as a user of herbal remedies, the risk of being identified as “uneducated” was countered by a rational positioning towards the use of herbal remedies. People relying on this repertoire corroborated their personal use of herbal remedies by stating that they only used plants with a scientifically confirmed therapeutic effect and advocated a scientific evidence-based approach. Biomedical concepts were used to discursively assess non-biomedical practices. The choice for herbal remedies was further rationalized by a more idiosyncratic assertion of effective treatments, based on experiential knowledge.

“We use both. Sometimes natural products are more effective, better than pharmaceutical products. When natural products no longer work, then we use pharmaceutical products, or the other way around as well. If you take a drug and you feel that it does not help to improve, then you will use natural products.” (LoB15, man, 38, Bolivia)

This illustrates how some interviewees framed their preference for particular herbal remedies as a sort of shopping behaviour, which allowed portraying their use of herbal remedies as a health-conscious consumer choice.

Second, users of this repertoire shunned away from mere belief or faith in herbal remedies based on tradition. This repertoire was characterised by a deliberate distancing from those who claimed to use herbs out of mere compliance with tradition. By doing so users of this repertoire, accepted negative connotations related to a lack of education. People who use herbal remedies for the sake of tradition without considering the actual effectiveness of active compounds were viewed as uncritical, and to a broader extent uninformed and uneducated, depending on traditions and social conditions.

“I studied, I have an academic education, I have a scientific background, so I believe more in science. I do not discard or reject medicinal plants either, you see? Medicinal plants are the

foundations of medicine, and I am open, I am open-minded about medicinal plants if they have a proven curative power. I have my doubts about the ones that are not confirmed, I do not trust those. I use what has an effect. Cat’s claw for example, I am convinced that this plant has anti-inflammatory properties, and I only use it for that reason. If it has a scientific base, it is clear to me. For my stomach I use chamomile or aniseed. I use eucalyptus for colds. Those uses are confirmed, those are recognised as medicines. I try to see the scientific panorama and I always question my own habits as well. I would not have done that without my studies. You know that at university you always have to question things.” (LoP3, man, 32, Peru)

Accordingly, ritual plant uses were clearly associated with superstition, which was considered a sign of misinformation. A strong dissociation from charlatany and notions of witchcraft further characterised this repertoire.

In addition, other users of this repertoire underlined their socio-economic position to avert negative connotations. A few Peruvians who drew on this repertoire explicitly stated that, while growing up in a city, they had learned to use herbal remedies from nannies or housekeepers. They never explicitly stated they originated from upper class families themselves, yet by indicating from whom they had learned, they subtly dissociated from the common negative stereotypes linked with traditional plant knowledge.

“My grandfather was a medical doctor, so he ignored those things. My grandmother raised me. She did not give us any traditional medicine. On the contrary, western medicine, full stop. Our nanny, the person who took care of me, her parents were from the mountains, they were migrants. The people who work in the house, they let you [use herbal remedies]. If you are a child and you grow up, if you have a sore throat you have to drink garlic, or if your stomach hurts, you have to drink your cinnamon tea. Although my grandfather was a doctor, she was in charge of us. The children who grow up with nannies have another relation [with herbal medicine] ... the people always pass on certain knowledge. My grandmother was a pharmacist, so we grew up surrounded by [pharmaceutical] medicines. That has not stopped us from learning, and you explore more traditional things, which I believe are more effective.” (LoP11, woman, 31, Peru)

This quote also reaffirms the underlying idea of shopping for herbal remedies.

Furthermore, these health-conscious users acknowledged a current revitalization of often hybridized traditional and alternative medical practices across Europe stemming from concerns about the health risks of pharmaceuticals. The growing appeal of non-biomedical medicine highlights the importance of consumers’ self-responsibility and personal empowerment. However, consumers who typically use these products often lack both access to the raw plant material and the knowledge necessary for their collection and preparation, which restricts their use to those therapies that are accessible through commercial markets. Users of the second repertoire were well aware of this and stressed their personal first-hand knowledge as a person of Andean descent, as illustrated by the following quote:

“It is interesting to see that herbs with a traditional use have become fashionable, after the whole revival of herbal medicine. So, it is a bit like they are selling you your own tradition.” (LoP11, woman, 31, Peru)

### 3.1.3. Using herbs as a coping strategy

In the last repertoire, the personal use of herbal remedies was framed as a coping strategy that resulted from a perceived lack of acceptable healthcare options. As such, possible stigmatisation was countered by the affirmation that there are no other viable options (*no tenemos de donde escoger*). Related vocabulary included the verb *tener que* (“having to”). Their use of herbal remedies was explained by blaming an alleged lack of qualitative healthcare in the United Kingdom.

This argument was not exclusively used by people without legal permission to stay in the country (who refrain from seeking official help based on the ill-conceived fear of being reported), nor by people who might believe they are not entitled to healthcare all together. On the contrary, most people who relied on this repertoire had at some point sought medical help through the National Health Service, yet refrained from doing so after disappointing experiences. Reported negative experiences with the National Health Service in our study included language barriers, difficulties in understanding procedures to make an appointment, and long waiting times. Several interviewees claimed to have received wrong prescriptions or treatments, which might have to do with a mutual inability to clearly communicate about symptoms and expectations (by both healthcare professionals and patients). The most frequently expressed criticism on British healthcare framed the prescription of a generic painkiller as a metaphor for disappointing experiences in the form of supposedly impersonal and thus inadequate treatments.

“I suffered from bone pain. I went to the doctor to prescribe me a medicine. It took two weeks. First they had to do an analysis, then I had to go back and afterwards they just gave me the same painkiller that I already had at home. I was working as a dishwasher. I had a lot of pain in my bones, rheumatism you know, pain in my bones. So I wanted something that would relieve the pain. They examined me and afterwards I had to go back to the doctor, just to tell me that the solution was quitting my job. He gave me the painkiller, and I changed jobs. That is the worst experience I have had here.” (LoB15, man, 38, Bolivia)

“It is always paracetamol, for everything. It probably helps, but I just do not take it anymore, because one person goes to a doctor with a certain ailment and gets a prescription for paracetamol, another person with another ailment will have to take paracetamol as well. I just do not have a lot of faith anymore.” (LoB9, woman, 25, Bolivia)

These quotes illustrate the often heard idea that general practitioners do not listen adequately to patients' complaints and therefore prescribe one solution for all. For some, this impression had resulted in a complete lack of trust in healthcare professionals.

“I do not trust doctors in London. I do not, and that is the opinion of most Latinos here. Nobody trusts doctors here.” (Researcher: “And why is that, in your case?”) “Because, one day I went to a general practitioner and it seemed like the doctor who was seeing me, just put the persistent symptoms in a computer and gave me possible causes of my disease. I have recurrent backaches every two years, it is a terrible backache. Over there, [in Bolivia] I used to treat it with a mixture of garlic, aloe and lemon that my mother gave me. That is a way to relieve the pain. Here, they cure everything with paracetamol, that is why I do not trust them anymore (laughs) You are not a doctor, are you?” (LoB4, man, 33, Bolivia)

This quote also shows how identity is a constantly negotiated

performance. In an encounter with a researcher this person is willing to perform the identity position of a coping migrant. In front of a general practitioner, there seems no willingness to openly demonstrate doubts about the prescribed remedy, or address differences in expectations about medical treatment. The identity position of a disappointed patient is one that is only shared in interaction with a more impartial researcher.

Generally, participants who relied on the coping repertoire perceived their health as poor, unlike users of the other repertoires. For the former, retreating to non-biomedical care did not always solve their health problems. The coping repertoire also contained an envisioned temporality of migration, as these Bolivian interviewees who considered their stay in the United Kingdom to be short-term, felt less urgency to return to a general practitioner or invest in efforts to improve that experience.

Overall, in this repertoire, few arguments were discerned to overcome possible negative stereotypes related to the use of herbal remedies, as the argument of “having no other choice” overruled.

## 4. Discussion

### 4.1. Health identity outcomes

To the best of our knowledge, this is the first study to directly analyse health identity patterns in relation to traditional herbal medicine use among migrant communities. While the described identity outcomes are directly linked to participants' migration background and Andean origin, multiple argumentations discerned in the three repertoires are not specific to this group of participants and have been found in other studies among users of herbal remedies.

As in many other post-colonial contexts, biomedicine and pharmaceutical remedies have become an implicit metonym for modernity in Peru and Bolivia –both former colonies of Spain (Reynolds Whyte et al., 2002; Wayland, 2004). The basic juxtaposition of herbal medicine with biomedicine and the related ethnocentric and negative imagery perceived in all three repertoires, has been described in literature on traditional Andean medicine (Greenway, 1998; Miles and Leatherman, 2003; Bussmann, 2013; de Pribyl, 2013). Participants employed different discursive strategies to overcome negative health identity outcomes resulting from their personal use of herbal remedies.

For people adhering to the tradition-bound repertoire medicinal plants symbolically embody a (lost) sense of belonging. For them, herbal remedies generate positive connotations and sensorial memories of a previous home, and thus become emblematic of a partially lost cultural identity. Their choice for herbal remedies is a positive one, inspired by personal/family traditions. This is a line of argumentation that can be found in several studies on herbal medicine use amongst different migrant communities in Europe (Ceuterick et al., 2008, 2011; Gervais and Jovchelovitch, 1998; Mata Codesal, 2008; van Anandel and Westers, 2010; Cooper, 2014; Jeffery and Rotter, 2016). For these tradition-bound users, herbal remedies have become a means to sustain a sense of continuity in their health identity, which confluences with their ethnic identity. Bolivian interviewees that relied on this repertoire openly talked about their Quechua-speaking, working-class background. The fact that more Bolivian participants in this study relied on the tradition-bound repertoire can be seen in light of an influential indigenous movement in Bolivia (Thorp et al., 2006) and a commercial resurgence of herbal medicine inspired by governmental pro-indigenous policies in which pride in an Andean ethnicity takes centre stage (Sikkink, 2010). At the time of our fieldwork, the number of people who self-identified as “indigenous” was higher in Bolivia (60–70%) than in Peru (38–40%) (Thorp et al., 2006).

In contrast, the health-conscious consumer repertoire seeks a discursive escape from adopting tradition too uncritically. Arguments of naturalness, purity, efficacy and fewer side-effects characteristic to this repertoire are typically also found in discourses of herbal medicine users in the West, such as British, white upper-class women (Aakster, 1986; Vickers et al., 2006). These resisting, health-aware and sceptical consumers fabricate a health identity around lay experiential models of health and frame herbal remedies as part of a healthy lifestyle (Astin, 1998; Reynolds Whyte et al., 2002; Greenhalgh and Wessely, 2004; Fox and Ward, 2006; Andrews et al., 2009). Similar health identity outcomes are sought after by users of the health-conscious consumer repertoire of Andean migrants who depict themselves as health-aware individuals. This repertoire was used most often by Peruvian interviewees, regardless of gender. While the emphasis in this repertoire lies on making health-conscious choices, there is a socio-economic identity outcome that moves beyond that of a health-conscious consumer. Users of this repertoire implicitly aimed at positioning as belonging to middle or even upper classes, an act that was strengthened through the discursive alliance with critical herb users in the west. At the same time, users of this repertoire morally distanced themselves from western healthism consumers by claiming to possess an authentic, first-hand Andean knowledge of herbal remedies. This apparent duality is exemplary of the Peruvian context, a country that is still coming to terms with its cultural and ethnomedical diversity (de Pribyl, 2013). Compared to Bolivia, there has been a relative failure of an indigenous movement to emerge in the twentieth century, and “there seems to be a deep-seated lack of an indigenous identity, despite a significant indigenous population and severe horizontal inequalities” (Thorp et al., 2006: 465). Moreover, the struggle for official recognition of traditional medicine in Peru has been met with much political hesitation (Bussmann, 2013; de Pribyl, 2013).

The tradition-bound and health-conscious consumer repertoires do not necessarily evaluate experiences with the British healthcare system as negative. The coping repertoire on the other hand, embodies the health identity of a resilient self-carer who manages to cope despite negative experiences with the British healthcare system. This is a more explicit socio-economically focussed identity position that is maintained mainly by (often highly educated) Bolivian men who ended up in low-wage jobs in the cleaning or catering industry. As such, their choice for using herbal remedies is not necessarily a positive personal choice (unlike in the other repertoires), but can be seen as a symbolical act that contains a moral commentary on the shortcomings of life as a migrant in the United Kingdom. Latin Americans are not recognised as an official ethnic group in Britain and are as such underserved by health measures directed at ethnic minorities (McIlwaine et al., 2011). Generally, the British healthcare system seems to struggle to meet needs of culturally diverse populations (George et al., 2015). The coping strategy repertoire contains elements, such as the paracetamol metaphor, that can become part of a narrative of anyone who has ever had negative experiences with, or felt marginalised by, the biomedical healthcare system, regardless of ethnic origin or migration background. Lack of trust in biomedical care is a general complaint among users of alternative health strategies (Pound et al., 2005). Agency, as well as a degree of control over one's own health through the use of herbal remedies, has been described as one of the main reasons why the general public seeks alternative treatments (Doel and Segrott, 2003; Thomson et al., 2014). Similar arguments were part of a self-help repertoire used by elderly respondents to emphasize their personal choices in medical care, sometimes against biomedical advice (Lumme-Sandt et al., 2000). Additional barriers for people with a Latin-American background seem to exacerbate the tendency to retreat to

traditional medicine (McIlwaine et al., 2011). One in five Latin-Americans in London has never visited a general practitioner, and only 77% of Bolivians residing in the British capital has sought medical help through the National Health Service (McIlwaine et al., 2011). A lack of trust in physicians has also been shown to drive Latino or Hispanic patients in the United States towards using more traditional herbal remedies (Howell et al., 2006).

#### 4.2. Implications for culturally-sensitive care

The process of health identity construction is neither straightforward, nor uniform. Speakers can strategically utilize interpretive repertoires to suit the rhetorical demands of the interactional context, such as an interview setting or a medical consult. Likewise, patients can shift between repertoires, depending on the position they want to take on during a biomedical encounter. In order not to be perceived as conservative, unintelligent, or uneducated, people might deliberately omit mentioning their previous use of, or preference for, herbal remedies. This would be hardly surprising in a British context, where the majority of mainstream practitioners think that the general public is poorly informed and has a misplaced faith in herbal medicines (DTB, 2010) and where, accordingly, the acceptance of the professional legitimacy of alternative medicine is low (Tovey, 1997). Some repertoires include a degree of taboo around talking about herbal remedies in a biomedical encounter and an inhibition to reveal a personal preference for this type of medicine out of anticipation of a negative response. Hence, the present results inform healthcare professionals to be sensitive to underreported self-treatment when seeking medical care, or even to the simultaneous use of herbs and pharmaceuticals. As such, our results support the recommendation of Posadzki et al. (2013) that a full medical history should include some questions about herbal medicine usage. Most models on culturally-sensitive care and (inter)cultural competency encourage the strategy to inquire about herbal medicine use by asking open-ended questions in a respectful, friendly, matter-of-factly and non-judgmental way when asking for treatment history and preferences (Berlin and Fowkes, 1983; Teal and Street, 2009; Epner and Baile, 2012; Vandebroek, 2013; Sias et al., 2014). Our data show that patients with a similar migration background use herbal remedies for different reasons. This underlines the importance to understand the needs of each individual patient and to address these with sufficient cultural sensitivity (Epner and Baile, 2012). Healthcare providers can draw upon the different interpretive repertoires and the related discursive elements that we encountered, in order to gain trust and personalise their communication style in accordance with a patient's performed health identity. Not only when probing for a patient's preferences, but also to provide non-patronizing, professional advice on clinically effective herbal remedies, herb-drug interactions, and on the potential consequences of non-compliance.

#### 5. Conclusion

Andean migrants in London negotiated their health identity in subtle and indirect ways, using three interpretive repertoires that explained their use of herbal remedies. These repertoires open up a range of overlapping subject positions and identity choices which cover allegiance to tradition, a health-conscious consumer choice and refuge. The first repertoire is focused on ethnicity (being Andean), the second on belonging to a subculture of healthy, educated consumers, and the third on being a struggling yet coping migrant. In a plural and highly hybrid medical context, where multiple treatment options are available, choosing for a certain type of treatment is part of one's personal politics and identification.

Among patients with a migration background, such as the Andeans in this study, these identity-infused choices are not always rooted in traditions.

The present results illustrate that multiple stances or positions are possible in regard to the use of herbal remedies and accordingly help to debunk the tendency to see patients with an Andean background as one homogenous group of migrants with similar health needs and identities. While some arguments found in our study are similar to findings on interactions among non-migrant patients and healthcare providers in general, the current analysis is original in that being a migrant is shown to play an often explicit role in the act of positioning, and in the formation of health identities surrounding the use of herbal remedies. For some people, their marginalised position as a migrant defines their positioning (third repertoire); for some, the longing for the familiar (first repertoire) is decisive; and for others, the need to be seen as an educated health consumer in their new environment dominates (second repertoire). Our data recommend a sensitive approach to distinguish these subtle differences in reasoning for using herbal remedies, and thus argue for an individualised, patient centred approach.

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