The practice of Western Herbal Medicine in Australia

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(Signed)

Miranda Carey
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Abstract

In recent decades, complementary and alternative medicine (CAM) has gradually assumed a growing popularity and economic importance in the health care systems of Western nations including Australia. Personal expenditure on CAM now represents a significant investment by the Australian general population. During this period, various CAM professions have steadily emerged as popular, if unofficial, healthcare providers. Despite the growing popularity of CAM, little is known outside of special interest groups about most CAM practices or about the professionals who provide them. In Australia one of the most well known and popular forms of CAM is herbal medicine.

The focus of this thesis is on the professional practice of herbal medicine in Australia, specifically Western Herbal Medicine (WHM). It is estimated that practitioners of WHM conduct almost two million consultations a year representing an investment of $AUS 85 million (excluding the cost of medicines) in the Australian health economy. Typically described as a complete system of medicine, WHM boasts a comprehensive philosophy and claims to offer a unique approach to treatment, diagnosis and prescription. WHM practitioners reputedly operate within a broad range of autonomy, including some acting as primary health care professionals. Nevertheless, little is known about the Australian WHM profession: their approach to clinical practice; their use of herbal medicines; the patients and problems seen in WHM practice; or the nature of the WHM profession’s relationship with the mainstream healthcare sector.

This thesis presents a pragmatic health services inquiry that aims to provide empirical data for the purpose of stimulating reflective practice within the WHM profession and seeks to inform discussion about the role of WHM in the Australian healthcare system. The analysis employs the concept of ‘mainstreaming’ (the increasing popularity, acceptance and legitimacy of CAM
within the dominant healthcare structures) to explore the response of WHM to the changing role of CAM within mainstream healthcare. Mainstreaming is interpreted as an active social process in which the boundaries between CAM and mainstream healthcare are shifting, and is a concept that implies the dominance of the mainstream medical paradigm.

The investigation triangulates quantitative and qualitative methods to provide an in-depth account of WHM practice from the perspective of the WHM practitioner. The study population is the membership of the National Herbalists’ Association of Australia (NHAA), and the unit of analysis is the individual WHM practitioner. The research describes the clinical practice of WHM and explores the WHM profession’s developing relationship with the mainstream – including the Australian public and the mainstream healthcare professions, particularly medical practice.

A social theoretical framework is employed to examine WHM practice within its social context. The conceptual framework directs the examination of the evolving relationship between WHM and mainstreaming towards three core areas of intersection: (1) the inter-professional; (2) the intra-professional; and (3) the professional/non-professional. The inquiry consists of a mixed methods design in which an initial survey study is followed by a qualitative in-depth interview study. The rationale of adopting a mixed methods approach was threefold: firstly, to increase the scope of inquiry by selecting methods most appropriate for each inquiry component; secondly, to better understand the research problem by converging both types of data; and finally, to increase the validity of constructs and inquiry results by triangulation of data sources.

The survey study consisted of a postal questionnaire that was distributed to the membership of the NHAA. The survey was specifically designed for this study in consultation with the NHAA. A preliminary pilot study of the draft questionnaire
was conducted consisting of both a formal and informal stage of testing. The questionnaire was distributed with the association’s quarterly professional journal (*The Australian Journal of Medical Herbalism*) in December 2003 and again in March 2004. Achieving a response rate of 58% (n=378), the survey data described key aspects of the WHM profession; its approach to clinical practice, herbal prescribing and aspects of its professional relationships.

The survey results demonstrated an increased influence of medical science on WHM principles and practices including the incorporation of medical concepts, clinical procedures, technologies and language into clinical practice. Although the survey provided strong evidence of a trend towards the rationalisation of WHM clinical practice, the results showed how the prescription of herbal medicines remains a predominantly traditional practice. In terms of the WHM profession, the survey results indicate that WHM practitioners are not assuming a primary healthcare role in Australia but are predominantly providing treatments for chronic conditions. The data indicated high levels of concurrent patient care, including concurrent use of pharmaceutical and herbal medicines; thus, suggesting that WHM clientele consider WHM a complementary rather than an alternative form of medicine. The survey also showed that WHM practitioners would welcome improved inter-professional and intra-professional relationships.

The second phase of the mixed methods study consisted of a series of qualitative in-depth interviews with a sub-sample of survey respondents (n=18) resident in NSW, Australia. The objectives of the in-depth interview study were twofold: firstly, to add depth and meaning to survey data; and secondly, to understand the practice of WHM from the perspective of the WHM practitioner. To ensure flexibility and to uncover novel data from the participants the in-depth interviews were carried out on a semi-structured basis.
Building upon the survey findings, the qualitative study explored the WHM practitioners’ conceptualisations, explanations and rationalisations of their approach to WHM practice. The interview participants represented a broad range of WHM practitioners who commonly shared a holistic worldview, but who also offered a range of interpretations of the philosophical and theoretical basis of WHM. The investigation described how mainstream conceptualisations of healthcare have impacted upon the traditional model of WHM practice. The analysis identifies a number of competing sub-groups within WHM who each advocate particular approaches to WHM practice. In particular, the analysis highlights a significant degree of internal tension operating within WHM about the salience of medical science within WHM.

The analysis also revealed how the perceived subordination to, and thus distinction from, mainstream medicine is a dominant issue within the WHM practitioner’s discourse. The explanation for this emerged from the perception amongst the in-depth interview participants of the widespread appropriation of herbal medicine by the mainstream, as well as systematic discrimination towards the WHM profession. Furthermore, there was evidence of not only poor intra-professional cohesion but significant intra-professional differences regarding the apposite location of WHM in relation to mainstream healthcare.

This research provides new understandings about the clinical practice of WHM practice, but also about the role of the WHM practitioner in Australian healthcare. The thesis reveals a story of irony. Despite the increasing popularity of herbal medicines and significant concessions within WHM to the medical paradigm, the WHM profession is struggling to achieve legitimate participation within the mainstream and continues to operate on the fringe of Australian healthcare. The thesis concludes that the process of mainstreaming is challenging the authenticity of WHM herbal tradition and challenging the future viability of the WHM profession, the implications of which suggest that the WHM practitioner will continue to experience financial insecurity unless the WHM
profession can collectively move to demarcate its scope of practice and legitimate its professional role.
### Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>ALSWH</td>
<td>Australian Longitudinal Study on Women’s health</td>
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<td>ANTA</td>
<td>Australian National Therapists’ Association</td>
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<td>ATMS</td>
<td>Australian Traditional Medicine Society</td>
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<td>ATO</td>
<td>Australian Taxation Office</td>
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<td>BIA</td>
<td>Bio Impedance Analysis</td>
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<td>BHP</td>
<td>British Herbal Pharmacopoeia</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>CAM</td>
<td>Complementary and Alternative Medicine</td>
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<td>CDC</td>
<td>Centre for Disease Control</td>
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<td>DHS</td>
<td>Department of Health Services</td>
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<td>EHTPA</td>
<td>European Herbal &amp; Traditional Medicine Practitioners’ Association</td>
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<tr>
<td>FRS</td>
<td>Female Reproductive System</td>
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<tr>
<td>GST</td>
<td>Goods and Services Tax</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HRH</td>
<td>His Royal Highness</td>
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<td>MDC</td>
<td>Major Diagnostic Category</td>
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<td>MeSH</td>
<td>Medical Subject headings</td>
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<td>MRS</td>
<td>Male Reproductive System</td>
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<tr>
<td>NCCAM</td>
<td>National Centre for Complementary and Alternative Medicine</td>
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<td>NHAA</td>
<td>National Herbalists’ Association of Australia</td>
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<td>NIMH</td>
<td>National Institute of Medical Herbalists</td>
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<td>Abbreviation</td>
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<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>Quant</td>
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<td>QUAL</td>
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<td>TCM</td>
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<td>TGA</td>
<td>Therapeutic Goods Administration</td>
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<td>WHM</td>
<td>Western Herbal Medicine</td>
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<td>WHT</td>
<td>Western Herbal Therapist</td>
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Chapter 1 Introduction

“The practice of traditional knowledge within a modern healthcare environment has not been explored and is yet to be understood.”

(HRH Prince of Wales 2005)

Chapter outline

Chapter 1 introduces the broad field of complementary and alternative medicine (CAM) and then defines the focus of the research, which is the practice of Western herbal medicine (WHM) in Australia. The chapter introduces the notion of the mainstreaming of CAM as the broader social context of the research project undertaken in the thesis. It then presents the research problem to be addressed in this thesis: the need for more detailed information on the practice of WHM in order to help define and understand the evolving role of WHM in the Australian healthcare system. Subsequently, the research aim and objectives are articulated, the thesis rationale and research plan are described, and the methods used are outlined. The chapter closes with a discussion of the significance of the research.

1.1 The resurgence of CAM

Complementary or alternative medicine (CAM) has now become a significant feature of healthcare in many Western nations (Tovey et al. 2004). For the greater proportion of the twentieth century, conventional medicine enjoyed a virtual monopoly in the healthcare systems of Western nations. As chronic and degenerative diseases have become more prevalent, this authority has gradually been challenged and a range of alternatives to mainstream Western medicine have, with time, assumed more prominence (Hoffman et al. 1996; Tovey et al. 2004; Faass 2006).
The general publics in many Western nations now enjoy a broader choice in healthcare options than previous generations, with practices and products such as herbal medicine, naturopathy, homoeopathy, acupuncture, chiropractic, massage, nutritional therapies, yoga, tai chi and meditation all becoming more widely available (Eisenberg et al. 1998; Castleman 2000; MacLennan et al. 2002). Such therapies have collectively come to be referred to as complementary and alternative medicine (CAM).

Over the last two decades, global estimates of CAM consumption have indicated their growing popularity and increasing economic importance (Shenfield 1997). Earlier reports indicated that over fifty per cent (50%) of Western populations use CAM products or services, either in conjunction with or as an alternative to conventional healthcare (Eisenberg et al. 1998; Ramsay et al. 1999; MacLennan et al. 2002). More recent estimates of CAM use amongst the general population show the US at 62% (Barnes et al. 2004) and Australia as high as 70% (Xue et al. 2007).

Expenditure on CAM is worth billions of dollars, with estimates showing $US34 billion in the US (Eisenberg et al. 1998), around £4 billion in the UK (Dolan et al. 1999), and an estimated $AUS4.13 billion in Australia (Xue et al. 2007). Moreover, by the 1990s, personal CAM expenditure by the US public exceeded that for all physician services (Eisenberg et al. 1998). Quite apart from its economic impact, these studies also show the level of public interest in CAM, particularly since the reported figures generally represent out-of-pocket expenditure (Donley 1998; Xue et al. 2007).

Surveys of the general populations of Western nations have demonstrated an increased provision of healthcare by CAM practitioners (Eisenberg et al. 1998; MacLennan et al. 2002). In the UK as many as one third of the adult population were reported to have visited a CAM practitioner (Thomas et al. 2001). In the
US the estimated number of visits made to CAM practitioners exceeded visits to US primary healthcare physicians (by an estimated 243 million). Furthermore, the $US21.2 billion spent on CAM services was greater than the total personal expenditure on all US hospital care (Eisenberg et al. 1998). A recent Australian survey showed that forty-four per cent (44%) of the general population had visited a CAM practitioner in a twelve month period (Xue et al. 2007).

Despite their growing popularity, overall research about the CAM professions remains underdeveloped at present (Tovey et al. 2003; O'Sullivan 2005). Early CAM research has concentrated on consumer utilisation and the integration of CAM into medical practice (Hirschkorn et al. 2005). Consequently, there are many gaps in the literature about the various CAM professions, the various CAM therapies, CAM practitioners’ approaches to practice, and about the patients and problems seen by CAM practitioners (Cherkin et al. 2002b). As CAM has become more popular, public discussion has mounted about the form and content of CAM practice and the most appropriate role of various CAM professions (Sharma 1992; Bensoussan et al. 1996; Tovey et al. 2003).

1.1.1 The scope of CAM

The definition of CAM has changed over time and between countries and has stimulated controversial debate. The following section does not revisit this debate because it has been well developed in the literature (Pietroni 1992; Easthope 2004a; NCCAM 2006). It has been argued that the changing name is a significant indicator of the evolving relationship between CAM and mainstream medicine over time (Easthope 2004a). It is, therefore, incumbent to define how the terms CAM and mainstream will be used in this thesis.

Numerous health sociologists have described how the medical paradigm currently occupies a dominant and often exclusive monopoly over legitimate or mainstream medical care in Western societies (Saks 1995; Easthope 2004a;
Shuval et al. 2004). In the past, numerous terms have also been used to describe the many and varied CAM practices, including words such as ‘quackery’, ‘alternative’, ‘complementary’, ‘holistic’, or ‘fringe’. Each adjective has implied vastly different ideas. Historically, the terms ‘alternative’ or ‘complementary’ medicine have been used interchangeably to describe anything not taught at a conventional medical school (Pietroni 1992).

Complementary medicines are now taken to mean those used in combination with conventional medicine and alternative medicines are those used to replace conventional medicine (NCCAM, 2006). Increasingly, the term CAM has been adopted as a composite of the two and has been defined as ‘a group of diverse medical and healthcare systems, practices and products that are not presently considered to be part of conventional medicine’ (NCCAM 2006). Essentially, the term CAM acts as a collective noun for a set of heterogeneous therapeutic practices and modalities grouped together because they lie outside the bounds of conventional medicine.

There are also many labels with currency when discussing conventional Western medicine including allopathic, biomedicine, technocratic, conventional or orthodox. In general, all of these refer to the predominant form of medicine taught in Western medical schools (Shuval et al. 2004). This approach to medicine is based upon the principles of natural science and is guided by the principles of Positivism (Davis-Floyd et al. 1994; Shuval et al. 2004). In this thesis the term mainstream medicine will be used to refer to Western medicine because it is a broader term that encompasses not only medical practice but allied healthcare professionals such as pharmacists and nurses etc. It also implies that this is the dominant form of healthcare. The term medical practitioner is used to refer to medical doctors, general practitioners or physicians.
CAM and mainstream medicine emerge from two fundamentally different paradigms, or world views, which involve different perceptions about the nature of health, diseases, diagnosis and treatment approaches (Saks 1996; Coulter et al. 2004; Shuval et al. 2004). Most CAMs subscribe in varying degrees to the principles of Holism and/or Vitalism, which emphasise a holistic approach to healthcare and the recognition of an energetic principle (Coulter et al. 2004). In Traditional Chinese Medicine (TCM) this energy flow is called ‘Chi’, in Ayurvedic medicine it is ‘Ojas’, and in WHM it is referred to as ‘Vitalism’. The essential elements of holistic practice include the focus on the individual as opposed to disease states and the subsequent individuation of treatment (Mills et al. 2000).

The fundamental differences between the holistic and the positivistic medical paradigm of health have been well explored in the literature (Aakster 1986; Davis-Floyd et al. 1994; Coulter et al. 2004; Easthope 2004a). One approach has been to conceptualise mainstream medicine as a technocratic and CAM as a holistic model of healthcare (Davis-Floyd et al. 1994; Dougherty 2005). Technocratic medicine separates the mind from the body, the individual into component parts and the practice of medicine is increasingly specialised, based upon standardised treatment protocols and increasingly reliant on technology. Holism, on the other hand, moves beyond this reductionist perspective, beyond consideration of the body as a machine, and acknowledges no single explanation of diagnosis, no single treatment; problems must be addressed within the holistic context of the individual’s environment (Davis-Floyd et al. 1994; Dougherty 2005).

Many commentators have highlighted how the collection of all CAM practices under one mantle is a discriminatory process (Pietroni 1992; Baer 2004; Singer et al. 2007). CAM, as an umbrella term, includes a range of therapies based upon diverse beliefs, some with and some without an evidence base, as well as the systemised professional practices of acupuncture, chiropractic, naturopathy and herbal medicine. The British Medical Association (1993) recognised these
CAM practices as discrete clinical disciplines that have established foundations of training and differing degrees of criteria of clinical competence and professional standards. The term CAM, it is argued, does not acknowledge the marked differences between those therapies that require extensive training ‘similar to a medical undergraduate courses’ and those that require only quick courses or are self-taught (British Medical Association 1993).

It has been increasingly recognised that the scope of CAM is problematic for research (Harris et al. 2000; Bodeker et al. 2002; Coulter et al. 2004). CAM is an imprecisely defined term and, therefore, the various settings and environments of CAM practice are often misunderstood, the discrete CAM therapies often misrepresented, and the processes of CAM provision only vaguely identified or understood (Pietroni 1992; Cowper 2003; Potrata 2005). A generalised approach to CAM research potentially cloaks particular issues facing individual CAM practices and individual CAM professions.

1.1.2 Mainstreaming of CAM

The growing acceptance and consumption of CAM in the industrialised nations has been termed the mainstreaming of CAM (Tovey et al. 2004). Mainstreaming is a concept that has been applied within the sociological literature to describe the increasing popularity and acceptance of CAM within the dominant healthcare structures. From one perspective, mainstreaming is portrayed as a passive, benign process by which CAM is drawn towards the mainstream through growing public interest and resulting in increased legitimacy for CAM (Singer et al. 2007). Indeed, in recent decades various CAM professions, through public consensus, have secured a legitimate status, some in the form of statutory regulation, within mainstream healthcare structures (Baer 2007).

Alternatively, mainstreaming has been presented as a social process in which the boundaries of both CAM and the mainstream are shifting in response to
each other (Tovey et al. 2004). From this perspective, mainstreaming is an active process in which the various stakeholders, both CAM and mainstream parties, are actively engaged and, in many cases, are resistant to such developments (Tovey et al. 2004; Singer et al. 2007). From this viewpoint, too, mainstreaming implies that there will be both gains and losses for these stakeholders as the role of CAM evolves. There are, in fact, growing indications that mainstreaming is potentially operating at the expense of the CAM professions (Shuval et al. 2004; Singer et al. 2007). The analysis employs the concept of mainstreaming to explore the changing role of CAM within mainstream healthcare.

1.1.2.1 Integrative practice

Healthcare in the West has been described as a climate increasingly sympathetic to healthcare pluralism characterised by a blurring of the roles between different healthcare professions (Bensoussan et al. 1996; Baer 2004). Research has indicated growing interest in CAM across the mainstream healthcare professions, and many medical practitioners have become increasingly interested in certain aspects of CAM (Easthope 1998; Ernst 2000a; Pinn 2003; Tovey et al. 2003). For example, in England, half of all medical practices offer patients CAM (Greving et al. 1998; Dobson 2003), and some mainstream medical practitioners are now also practitioners of CAM (Wearn et al. 1998; Hall et al. 2000; Adams 2001b).

In recent decades the medical literature has initiated the use of the term integrative medicine to describe the uptake of CAM by the medical profession. Integrative medicine combines mainstream medical therapies and CAM therapies for which there is some high-quality evidence of safety and effectiveness (NCCAM 2006). The uptake of CAM by the medical profession is generally restricted to those CAM treatments for which there exists high-level evidence of safety and effectiveness. The integrative use of CAM has been
described as a tactical strategy to preserve mainstream dominance through control of the knowledge base of CAM (Singer et al. 2007).

Despite increased interest in certain aspects of CAM, there is evidence of strong resistance and continuing scepticism towards CAM practice and practitioners from within the mainstream medical profession (Eisenberg et al. 2001; Brockie 2004; Hirschkorn et al. 2005). Tovey (1997) argues that many medical practitioners remain dismissive of CAM practitioners (Tovey 1997). Shuval and Mizchari (2004) caution that the attitudes of the medical profession should be viewed against the growing threat consumer demand for CAM poses to the medical paradigm; and integrative medicine, interpreted as a defensive strategy serving the self-interest of the medical profession and particularly the medical elite (Adams 2004; Shuval et al. 2004; Singer et al. 2007).

1.1.2.2 Rationalisation of practice

Conversely, research has indicated that a key strategy of those CAM professions seeking to establish improved legitimacy as healthcare providers has been the increased adoption of medical sciences into their knowledge base (Welsh et al. 2004). For example, Boon (1996) identified within the naturopathic profession in Canada the evolution of two groups of practitioners with two different world views: the ‘holistic’ and the ‘scientific’. She defined the scientific practitioner as one who is objective, reductionist, practical, concrete, and emphasises treatment on a physical and a structural level. On the other hand there is the holistic practitioner who is subjective, spiritual, abstract, intuitive, and emphasises treatment on a mental or emotional level (Boon 1996). In this thesis the trend towards an increased influence of medical science on CAM practices including the incorporation of medical concepts, clinical procedures, technologies and language into clinical practice, is termed rationalisation.
1.1.2.3 The CAM professions

The growing public interest has stimulated growing pressure for the legitimacy of CAM within mainstream healthcare (Welsh et al. 2004; O'Sullivan 2005). As public demand for CAM increases, medical professionals, allied healthcare professionals, public authorities and the public are looking for assurances of safety and competence amongst the CAM professions (Bensoussan et al. 1996). At present, only modest details are known about how CAM professions are negotiating the transition from ‘quackery’ to complementary (Braathen 1996), and from occupation to profession (Boon et al. 2004), from peripheral to mainstream (Tovey et al. 2004). Despite their increased profile, the role of the CAM professions within the wider healthcare landscape remains empirically and theoretically under-researched.

1.1.2.3.1 Professional regulation

There has been relatively little research on the CAM professions in terms of their wider socio-economic position. There are however, indications that, despite the increasing popularity of CAM, many CAM therapists experience significant financial and professional insecurity (Boon et al. 2004; Andrews et al. 2005). Various CAM professions are striving towards achieving improved recognition of their expertise and professional legitimacy (Boon et al. 2004; Burgess 2004). A key strategy of various CAM professions aspiring towards legitimacy as healthcare providers has been to advocate for statutory regulation (Baer 2007).

Across the Western world, different CAM professions are seeking legitimate status as state sanctioned healthcare practitioners (Boon et al. 2004). For example: in the UK, a regulatory body has been proposed for WHM (White 2004); in Canada, naturopathic practitioners are seeking self-regulation (Welsh et al. 2004); and in Australia, the Federal government has recommended statutory regulation for various CAM professions including naturopathy, WHM
and acupuncture (DHA 2005). Thus, certain CAM professions are striving for professional status codified in state-sanctioned regulation, while others are advocating self-regulation (Boon et al. 2004; Ernst 2007).

Internationally, there has been intense public health debate about the relative merits of professional regulation for the CAM professions. Opponents to CAM have argued that any form of official regulation would provide CAM practitioners with a level of legitimacy that may be unwarranted (Victorian Parliament 1986; Ernst 2007). CAM advocates have counter-argued that the growth in the public use of CAM has the potential to compromise patient safety from inadequate quality control or poor advice and, therefore, statutory regulation for those who are formally trained would be in the interests of both patients and CAM practitioners (NHAA 2002; Salmond 2004; White 2004; O'Sullivan 2005).

Within the CAM professions there has also been differing opinions about official regulation. Boon et al. (2004) identified the desire for regulation amongst CAM professions as a means to prevent the co-option of their skills and knowledge by the mainstream. Conversely, opponents to codified statutory regulation perceive it as an avenue for the mainstream to limit their freedom to practice (Khoury 2003). Some sectors of the CAM community perceive registration as a mechanism the mainstream may employ to impose restrictive requirements and boundaries upon the practice of CAM. They point to the chiropractic profession, which in exchange for favourable legislation has had to accept a limited scope of practice (Boon 1996).

1.1.2.4 Scope of practice

Scope of practice is introduced here as a concept to describe the appropriate form, content and boundaries of healthcare practice. Scope of practice in its strictest sense is a legal concept that describes the parameters of professional practice and defines any profession’s operational capacity (Green 1988, in
Davis-Floyd et al. 1994). Green (1988) argued that the legal culpability of a healthcare practitioner ultimately depends upon the expectations and level of responsibility the patient presumes of the practitioner and, in turn, how a practitioner may represent himself or herself to the patient.

Hence, working within one’s scope of practice hinges upon relevant training and working within the bounds of one’s discipline (Davis-Floyd et al. 1994). For example, when a medical practitioner undertakes to prescribe herbal medicines as opposed to pharmaceutical medicines they are technically acting outside the scope of their practice, unless they are especially trained in herbal medicine. In this sense, one’s scope of practice is essentially an issue of roles, responsibilities and expectations. Scope of practice, therefore, extends beyond the activities of clinical practice and involves describing the role of the professional within the broader healthcare landscape.

Nevertheless, certain CAM practices are now routinely incorporated at will under the medical practitioners’ mantle (Davis-Floyd et al. 1994; Adams 2004; Adams 2006). Although this is commonly accepted as appropriate because they are licensed to diagnose and treat, when mainstream practitioners use CAM they are practicing within the scope of that CAM discipline, whether it is codified or recognised (Davis-Floyd et al. 1994). This has been described as a process of inter-professional co-option.

Despite their increased popularity amongst the general population of many nations, little is understood about the various CAM professions’ perceptions of their scope of practice. Although scope of practice is quite clear for medical practitioners, the concept is more fluid for CAM practitioners. This is in part
explained by the fact that in most nations medical practice has been officially codified (also known as credentialing or privileging)\(^1\) while most CAM professions remain unregulated.

1.1.2.4.1 Co-option of CAM

*Co-option* in relation to healthcare practice has been defined as the process by which one profession embraces within their scope of practice techniques or treatments that were originally developed or practiced by another profession (Boon et al. 2004). There are indications that integrative practice is potentially undermining the role of the CAM professions in healthcare (Shuval et al. 2004; Singer et al. 2007). Some CAM groups have reacted strongly to integrative medicine, using words such as ‘cherry picking’ (NHCA 2007) and ‘CAM poaching’, arguing that the intent is to diminish the role of the CAM professions (Boon et al. 2004). Accordingly, for some CAM groups, integrative medicine effectively translates into a process of co-option (Baer 2004; Turner 2004a).

Certain CAM disciplines such as homeopathy, osteopathy, herbal medicine and acupuncture have been classified as ‘complete systems’ of medicine maintaining their own distinct approaches to diagnosis and treatment structures (Pietroni 1992; British Medical Association 1993; O’Brien 2002). Many CAM practitioners have been shown to operate within a broad field of autonomy, with many acting as first contact primary healthcare professionals (Cooper et al. 

\(^1\) Credentialing as defined by the Victorian Department of Human Services is the formal process of verifying the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence and suitability to provide safe, high quality healthcare services within specific organisational environments. Defining the Scope of Clinical practice, also known as privileging, follows on from credentialing and involves delineating the scope of an individual practitioner’s clinical practice within a particular organisation. DHS (2007). Credentialling and defining the scope of clinical practice. State Government of Victoria, Department of Human Services, http://www.health.vic.gov.au/credentialling. 12/08/2007.
Presumably, primary care entails assuming responsibility for primary diagnosis and patient management, which is traditionally considered the domain of the medical practitioner. The literature has suggested medical practitioners are concerned that CAM professionals may be acting beyond their legitimate scope of practice (Cohen et al. 2005; Kerridge et al. 2004).

1.1.3 Conclusion

This background introduced the notion of the mainstreaming of CAM as the broader social context of the research project undertaken in the thesis and argued that, overall, CAM issues are complex but largely under-researched. It highlighted how concerns over professional boundaries in primary healthcare practice have become important to both CAM and mainstream providers. Notably, CAM is not a homogenous entity and, therefore, any meaningful research about CAM practice must focus on individual CAM practices. Therefore, having described this broader social context, the thesis narrows its focal point to the practice of herbal medicine within the modern era.

1.2 The mainstreaming of herbal medicine

“There is an increased use by the public of herbal products, greater cooperation between herbalists and conventional practitioners and considerable progress toward regulation … Naturally enough, this development has created a considerable amount of controversy, debate and dialogue.”

(HRH Prince of Wales 2005)

1.2.1 Popularity of herbal medicines

Herbal medicine has a history that is as old as that of mankind and it is still today the primary form of healthcare for eighty percent (80%) of the world’s
population (World Health Organisation 2003). The global market for herbal medicines is now estimated to be greater than $US60 billion and rapidly growing (World Health Organisation 2003). In the East, for example in China and India, herbal medicine has always remained a prominent feature of their respective mainstream healthcare systems. Herbalism has, however, suffered a chequered history in the West (Griggs 1997; Chevallier 2001).

With the advent of modern pharmaceutical drugs around 100 years ago, herbal medicines ceased to be the basis of mainstream therapeutics in the West (Ernst 2000a). In the UK and the US they were steadily and systematically marginalised until almost declared illegal (Saks 1996; Ernst 2000a; Winnick 2005). Over the last few decades herbal medicines have steadily returned as one of the most popular forms of CAM in the UK (Thomas et al. 2004), the US (Kennedy 2005) and Australia (Xue et al. 2007). The renewed popularity of herbal medicines in the West has witnessed a significant commercialisation of a previously ‘fringe’ market and the rationalisation of otherwise traditional systems of medicine (Collyer 2004).

1.2.1.1 Traditional Herbalism

Traditional approaches to herbal practice are commonly referred to as Herbalism. The three major traditions of Herbalism in the world are, arguably, Ayurvedic Medicine, originating from the Indian sub-continent; Traditional Chinese Medicine (TCM) from China; and WHM of Anglo-American origin (Bone 2001a). Each of these major traditions is founded upon a unique empirical basis and maintains a comprehensive philosophy that predicates a unique approach to treatment, diagnosis and prescription. Each has a deep philosophy of life, complex understanding of disease and rich knowledge of plant medicines, and subscribes in varying degrees to the principles of Holism (Bone 2001a).
Ayurvedic medicine, TCM and WHM have all been described as complete systems of medicine (British Medical Association 1993; Ody 2000; Chevallier 2001). Each of these systems has evolved over thousands of years into unique, complex, multi-dimensional and multi-faceted systems of medicine, each with a distinctive herbal materia medica and philosophy of practice (Griggs 1997). Although each has in common a holistic approach to health, each tradition teaches a different set of principles and approach to practice. For example, TCM is built upon a complex theory of Yin and Yang, the five elements, and meridian channels (Skinner 2001). Many treatises on the philosophy of WHM describe it as a holistic and individualised therapy (Mills 1993; Chevallier 2001).

Each of these traditional herbal systems preferences the use of whole raw plant preparations (termed galenicals), and yet each maintains its own distinctive materia medica and approach to prescribing. A case in point is the manner in which herbal medicines are prescribed, prepared and formulated between TCM and WHM. A good example relates to the herb *Angelica sinensis*. In TCM, a decoction of the dried root of Angelica (Dong quai) is indicated as a cardiovascular tonic. Meanwhile, from a WHM approach, a tincture of the leaves of Angelica is used predominantly for the treatment of indigestion or as a female reproductive tonic (Corrigan 2000; O'Sullivan 2005).

1.2.1.2 Commercialisation of herbal medicines

Over the last two decades, in response to consumer demand, there has been a flood of herbal supplements into the market place (Blumenthal 2003). In the US, public expenditure on herbal remedies is estimated to be worth $US5.1bn representing an increase of about 380% between 1990 and 1997 (Eisenberg et al. 1998), and the European Union herbal market is worth about £6.8bn annually (Thomas et al. 2001).
It is estimated that there are now in excess of 20,000 herbal products and related compounds being sold or used in the US alone, where sales of oral supplements increased substantially from $US8.8 million in 1994 to almost $US16 billion in 2000 (Winslow et al. 1998). In 2003, the OTC market of herbal preparations sold as dietary supplements represented $US5 billion in Europe alone (Ernst 2007).

A common feature of the mainstreaming of herbal medicines has been the tendency towards lay prescription\(^2\) with over-the-counter (OTC) herbal medicines (Barnes 2003; Collyer 2004). Kennedy (2005), based upon quantitative estimates of lay prescription from a nationally representative US sample, argued that herbal use for personal health and treatment is widespread in the US adult population. In spite of its popularity, the peer reviewed literature about use of herbal medicines by the general population remains sparse (Kennedy 2005).

It has been argued that the increasing consumption of herbal medicines is a public health issue that will increasingly require pharmacovigilance into the future (Farah et al. 2000). Contrary to popular belief, herbal remedies and dietary supplements may pose health risks because of adverse reactions or interactions with prescribed drugs (Drew et al. 1997). Ernst (2007) argues that the OTC sector is characterised by unreliable information, poor quality of the product and lack of evidence of efficacy or safety that potentially puts consumers at risk. In response, there have been increased concerns expressed

\(^2\) In the CAM literature certain writers have used the term ‘lay practitioner’ to refer to CAM practitioners (e.g. Siahpush 1999; Tovey et al. 2001). In this thesis it refers to self-prescription and self-medication by the public.
about potential toxicity of herbal medicines and potential interactions with pharmaceutical medicines (Drew et al. 1997; Barnes 2000).

Across many Western nations there have been different approaches to herbal use and subsequent responses to herbal regulation. For example, today in Germany herbal medicine plays an important role in mainstream medicine, where herbal medicine is strongly integrated into medical practice (Mills et al. 2004). In the European Union (EU), herbal medicines are licensed as pharmaceuticals and sold in pharmacies as prescription medicines (Roufogalis 2000). In the Anglo-American nations such as the United Kingdom (UK), the United States of America (USA) and Australia, WHM continues to occupy a location on the periphery of healthcare.

Although, as described above, recent figures have indicated billions of dollars of expenditure on herbal medicines by the general populations of the US, UK and Australia, herbal medicines are not regarded as a part of mainstream healthcare but as one of a range of CAMs. In the US, the largest herbal market in the world, sales are based upon the status of herbal medicines as dietary supplements (Mills 2007). Australia’s approach to herbal regulation lies somewhere in the middle of this spectrum, where herbal medicines are regulated but still classified as complementary medicines (see section 1.3.1.1).

1.2.1.3 Rationalisation of herbal medicines

Simultaneously, and perhaps as a direct consequence of their increasing commercialisation, herbal medicines have increasingly become the object of scientific enquiry (Bone et al. 1999c; Ernst 2000b). There are indications that all the major herbal systems are being progressively engaged by modern science (Bone 2001a). For example, the governments of India and China are actively funding research on their medicinal plants (Bone 2001a). However, in the west,
especially in Europe, research funds have typically originated from commercial sources (Ernst 2000a).

Bone (2001) has argued that all three traditional systems are adapting to the times without losing sight of their traditional basis. On the other hand, concerns are growing in certain CAM groups that the increasing popularity of herbal medicines is occurring at the expense of traditional systems of Herbalism (Bone 2001a; O'Sullivan 2005). There is strong evidence to suggest that herbal medicine in the West is gradually evolving into a rational system where herbs are viewed as plant-based drugs (Ernst 2000a). For example, while traditionally indicated as a ‘nervous system tonic’, *Hypericum perforatum* (St John’s Wort) has become a popular herbal medicine indicated for the treatment of mild to moderate depression. Applied this way, herbal medicines are simply replacements for pharmaceutical medicines.

These different approaches to prescribing can be understood in reference to the technocratic and the holistic model of healthcare outlined earlier (section 1.1.1). Within the technocratic model, herbal prescribing is based upon an understanding of the elemental constituents of the plant or identifying the one pharmacologically ‘active constituent’. Examples of constituents are morphine from the poppy (*Papaver somniferum*) or salicylic acid from willow bark (*Salix alba*), the derivative of aspirin (Chevallier 2001). Traditional Herbalism, on the other hand, moves beyond such a reductionist perspective and argues that the whole plant offers a synergy of action, which is lost if reduced to its constituent parts (Dougherty 2005). This has been described as the difference between simply using ‘herbs’ and the practice of ‘Herbalism’ (Khalsa 2005).

1.2.2 Impact upon Western Herbalism

WHM practitioners, across the globe, have argued that the traditional holistic foundations of WHM are not widely understood or appreciated within the
mainstream (NHAA 2004; EHTPA 2008). As a result of mainstream interest in herbal medicines there is emerging evidence of different models of WHM practice including: (1) the traditional holistic model of WHM; (2) the commercial approach of using over-the-counter (OTC) supplements that are predominantly self-prescribed (as described above); and (3) a more rational model termed ‘phytoterapy’ favoured by mainstream medicine (Corrigan 2000; Ernst 2007).

1.2.2.1 Traditional WHM model

WHM traces its roots to the Greek system of medicine and its fundamental philosophical notions to the writings of Hippocrates (Pitman 2005). WHM is based on a holistic philosophy that privileges the well-being of a whole person above the treatment of disease and a theoretical basis that extends beyond the prescription of herbal medicines to the entire structure of diagnosis and treatment (Griggs 1997; Corrigan 2000; Mason et al. 2002; O'Sullivan 2005). WHM has traditionally held that health is more than just the absence of disease and that herbs have a unique capacity to maintain and enhance the body’s capacity to well-being and health (Chevallier 2001).

It has been argued that WHM is a product of Western culture and is, therefore, more closely allied philosophically and theoretically to Western medicine than most traditions of herbal medicine. WHM is in fact based on a Western understanding of physiology and disease (Roufogalis 2000), nonetheless, the traditional herbalist aims to treat the individual and not the disease, to which end they compound different formulations of herbs for each patient on the basis of a detailed consultation (Bone 2003). Traditional herbal medicines are complex poly-pharmaceutical preparations (Roufogalis 2000). The traditional model of practice is commonly termed Western Herbalism or simply Herbalism (Khalsa 2005).
1.2.2.2 Phytotherapeutic model

The phytotherapeutic model of herbal medicine is a rational approach to herbal prescribing favouring standardised herbal treatment protocols (Corrigan 2000; Ernst 2000a). Within this model, herbal medicines are perceived as plant-based drugs (Weiss 1991; Ernst 2000a). Consequently, herbal prescribing is based on treating a particular condition/disease or managing symptoms: the medicines are chosen on an evidence basis and the herbs are administered in single preparations of standardised herbal extracts(3) (Bone et al. 1999c).

Traditional Herbalism has developed over centuries through observation and the recording of such experiential data within the pages of traditional herbal materia medica (Chevallier 2001). By contrast, phytotherapy is informed by a scientific evidence base (Ernst 2007). In recent decades evidence based monographs detailing the rational use of herbal medicines (or herbal drugs) and their combinations have been complied and published. These include the German Commission E monographs, the American Botanical Council Commission E monographs and the European Cooperative on Phytotherapy (Chrubasik 2000). These monographs now form the basis of licensing for herbal products in Europe and, generally, direct the basis of phytotherapeutic practice protocols.

1.2.2.3 Western herbal practice

In relation to the opening quote of this thesis, at present the practice of most traditional medicine within the modern healthcare environment has not yet been explored. Currently most understandings of WHM practice are inferred from textbooks of herbal prescribing. Bone (2003) has argued that such publications

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3 A standardised herbal preparation is one in which the source plant material has been chemically analysed and matched to a pre-determined chemical marker.
are based on the assumption that knowing about the properties of herbs is all that is necessary to comprehend the processes of herbal practice.

The bulk of the literature about WHM practice appears as brief reports or in editorials or letters to the editor. For example, a recent editorial argued that WHM, as practiced by herbalists, is underpinned by the ‘Humoural theory’ of medicine (Ernst 2007). The editor writes, ‘Traditional herbalists do not even think in conventional disease categories and hold beliefs abandoned by the rest of medicine 200 years ago: a ‘damp’ and ‘cold’ condition requires a ‘dry’ and ‘hot’ remedy, for example’ (Ernst, 2007, p615). Under the assumptions contained within such anecdote both the value and safety of WHM practice is questionable. Yet, as described above, WHM is in fact based on a Western understanding of physiology and disease (Roufogalis 2000).

There is evidence of a fledgling theoretical discussion about the impact of mainstreaming upon the traditional WHM practice and knowledge (Dougherty 2005; O’Sullivan 2005; Singer et al. 2007). The split between traditional Herbalism and rationally informed phytotherapy has been described as an ‘epistemological bifurcation’ (Singer et al. 2007). Singer and Fisher (2007) argue that the bifurcation of WHM knowledge is a phenomenon that warrants recognition and analysis, not only in the academic literature but in wider public health debates. Such work contributes to a small but emerging discussion in the CAM literature concerning the mainstreaming of WHM, but currently most aspects of WHM practice and knowledge remain both empirically and theoretically under-researched.

1.2.3 Conclusion

Commercialisation and rationalisation processes have arguably been central to the increasing popularity of herbal medicine in the West. A main challenge for contemporary herbal medicine, as it is mainstreamed, is whether the traditional
knowledge informing Herbalism will be valued into the future. Although there is a growing body of clinically orientated research on herbal medicines, there has been very little investigation about the practice of WHM, especially exploring the perspectives and experiences of the WHM practitioner. Currently, little is known about the modern form and content of WHM practice. In the next section the focus of the discussion is now narrowed to outline the socio-political environment of WHM practice in Australia over the last ten years.

1.3 Australian context

“CAM is a thriving sector in Australian health care although it remains largely disconnected from the health mainstream.”

(McCabe 2005a)

1.3.1 The Australian CAM landscape

The international trends surrounding CAM have been strongly reflected in Australia. Studies indicate that Australians spend approximately $AU2.3 billion on CAM each year (MacLennan et al. 2002). To place this figure in perspective, the annual expenditure by the Australian Government on the Pharmaceutical Benefits Scheme (PBS) was approximately $AU3.45 billion (MacLennan et al. 2002). As recently as 2007 a report indicated that CAM expenditure in Australia is greater than previously estimated (Xue et al. 2007). The annual out-of-pocket expense was estimated to now be at $AUS4.13 billion and accounts for almost half the total expenditure on non-subsidised healthcare products in Australia (Xue et al. 2007). Overall, these levels of CAM expenditure reflect the enormous and increasing popularity of CAM in Australia.
Recent evidence shows that significant proportions of the Australian public turn to CAM practitioners for healthcare advice (Adams et al. 2003a; Xue et al. 2007). A study published in 2002 stated that expenditure on CAM practitioners was estimated to have reached $AUS616 million representing an increase of 62% since 1993 (MacLennan et al. 2002). More recent data indicated the Australian public has made almost the same number of visits to CAM therapists as to medical practitioners. Xue et al (2007) reported an estimated 69.2 million visits annually to CAM therapists by the Australian population, which closely equates to the 69.3 million visits reported to medical practitioners.

The CAM sector in Australia is characterised by a wide range of intersecting, often competing, interests including the manufacturing sector, the health and beauty industry, private health insurance companies, Government bodies, the medical profession, the CAM professions and consumers (Easthope 2004b). Although CAM arguably makes a substantial contribution to Australian healthcare, it remains excluded from the public healthcare system. On the other hand the CAM sector currently enjoys a high degree of self-determination within the current legislative framework.

1.3.1.1 Legislative framework

Australia has an extensive publicly funded system of both medical rebates and pharmaceutical provision referred to as Medicare and the Pharmaceutical Benefits Scheme (PBS) respectively. Complementary medicines and services are currently not eligible for public subsidies under either scheme (DHA 2008; TGA 2008).

1.3.1.1.1 Complementary medicines and services

The Australian Therapeutic Goods Administration (TGA) refers to CAM products and services as complementary medicines (TGA 2008). At present,
complementary medicine products are listed on the register of Therapeutic Goods maintained by the Commonwealth Government’s TGA. Complementary medicines, unlike pharmaceutical medicines, require evidence of safety (evidence from traditional use may be accepted) and of quality according to Good Manufacturing Practice (GMP), but not of efficacy (Burton 2005). Only those complementary medicines that make claims of therapeutic efficacy must be registered by a processes similar to those undertaken for pharmaceutical goods (Roufogalis 2000; Burton 2005).

1.3.1.1.2 CAM professions

In Australia the regulation of healthcare professionals falls under the states’ jurisdictions. At present none of the states in Australia requires statutory regulation for WHM practitioners. In 1986, the Victorian Social Development Committee recommended that most CAM therapies other than chiropractic and osteopathic did not cause harm and, therefore, did not require any form of statutory regulation (Victorian Parliament 1986). In fact, the report raised concerns that registration would impart a level of unwarranted legitimacy to the CAM professions. Subsequently, statutory registration was established for the chiropractic and osteopathic professions alone. These recommendations were adopted nation-wide and have remained in place ever since.

Concerns over the levels of proficiency of CAM practitioners have periodically prompted calls for regulation of the various professions (DHA 2005). Pressure for regulation was renewed in 2003 when the Australian CAM industry faced a major crisis due to the poor manufacturing practices of the company Pan Pharmaceuticals (Burton 2003). Pan Pharmaceuticals had its licence suspended for six months and more than 1600 of its products were recalled. Dubbed the ‘Pan Crisis’, there were calls for tighter regulatory control of both CAM products and services (Burton 2003). In the aftermath, concerns were expressed that there are no mechanisms in place to ensure the quality of
complementary medicines or practice and thus ensure adequate public safety (Brockie 2004; Burton 2005).

The Australian Government’s response to the Pan crisis was to convene an expert committee to debate the regulatory requirements of CAM in the Australian healthcare system (Expert Committee on Complementary Medicines in the Health System 2003). This Commonwealth Expert Committee on Complementary Medicines recommended a move to nationally consistent statutory regulation of complementary healthcare professions, including WHM (DHA 2005). To date there have been no legislative changes implemented in response to these reports.

1.3.1.2 The CAM associations

It has been argued that, in Australia, CAM and the mainstream are being forced into a closer relationship but this is occurring in a reactive uncoordinated manner as institutions and professions respond to consumer needs for integration (McCabe 2005a). In the absence of statutory regulation, the professional associations representing CAM practitioners have provided a certain level of professional self-regulation (NHAA 2002; Khoury 2003). There are currently over twenty professional associations representing the different CAM professions in Australia (McCabe 2005a).

The status of these CAM associations is to a large extent dependent upon their ability to ensure Goods and Services Tax (GST) exemption status for their membership. In 1999 a new taxation system was assented by the Australian Commonwealth Government. The act included a provision to exempt healthcare professionals from GST for their services. Significantly, the GST only extends to CAM services; it does not exempt complementary medicines (Khoury 2003). The inclusion of naturopaths, herbalists and acupuncturists was granted only after intense lobbying to bring these services in line with those taxation
exemptions available for services of medical and allied healthcare providers (NHAA 2004). The GST exemption now arguably acts as a de facto registration system because most private health insurance companies in Australia have adopted GST exemption as the auditing requirement for granting provider status for CAM professionals.

### 1.3.2 Herbal medicine in Australia

After many years of existence on the fringe and viewed as counter-culture, herbal medicines are becoming progressively more mainstream in Australia. This assertion is supported by the following documented developments in the Australian healthcare sector:

1. Herbal medicine is one of the most popular forms of CAM used by the Australian population (MacLennan 1996; MacLennan et al. 2002; Xue et al. 2007);

2. The consumers of herbal medicine represent a broad spectrum of Australian society, including those from professional sectors and those employed in trades, services or clerical work (DHS 2005);

3. The increasing manufacture of herbal products by pharmaceutical companies and their presence not only in health food stores and pharmacies but in supermarkets (Burton 2003; Colmar Brunton 2003);

4. The changes in formal recognition status of professional herbal practitioners by the ATO granting certain taxation exemptions for their services (Khoury 2002a);

5. The provision of private health insurance rebates for the services of certain qualified herbal practitioners (NHAA 2004);

6. The increased presence of herbal medicine as a discipline in some Australian universities (Evans 2000);
7. The increased provision or recommendation of herbal medicines from within the medical profession for patients (Myers 2002; Easthope 2004a);

8. The recommendation by an Australian Government Expert Committee to implement formal registration for herbal practitioners in Australia (DHA 2005).

1.3.2.1 Western Herbalism

WHM has a long history and tradition of practice in Australia and remains today the form of herbal medicine used by most Australians (Wohlmuth et al. 2002; Xue et al. 2007). WHM based upon an Anglo-American heritage\(^4\) arrived in Australia with the early British settlers (Wohlmuth et al. 2002). This Anglo-American school of herbal medicine, later influenced by local indigenous and Asian herbal practices, reputedly forms the basis of professional WHM as predominantly practiced in contemporary Australia (Griggs 1997; Bone et al. 1999a).

Recent research has demonstrated that WHM professionals\(^5\) make a substantial contribution to the healthcare sector with an estimated 1.9 million consultations annually representing $AUS85 million (excluding the cost of medicines) in the Australian health economy (Bensoussan et al. 2004b). Increasing numbers of people are becoming involved in the professional practice of WHM in Australia (Hale 2002b; NHAA 2004). Australian WHM practitioners have been shown to operate within a broad range of autonomy with many reputedly maintaining a primary healthcare role (DHS 2005).


\(^{5}\) Herbal professionals in the referenced study included both herbal therapists and naturopaths
The professional association of WHM in Australia is the National Herbalists’ Association of Australia (NHAA). The NHAA, is in fact the oldest medical association in Australia, being incorporated in 1920, and it claims to represent an unbroken chain of knowledge to its Anglo-American herbal heritage (Bone et al. 1999a). It also claims to practice traditional WHM within the context of modern science (NHAA 2004). However, there is a lack of empirical data about the current form and content of herbal practice in Australia. In particular, little is understood about the impact the growing popularity of herbal medicines in Australia is having upon this traditional system of medicine.

The NHAA has almost 3000 members of whom approximately 1000 are registered practitioners (Cowper 2003). But in Australia WHM is also seen as an essential modality of the practice of most naturopaths (DHS 2005). The largest CAM association is the Australian Traditional Medicine Society (ATMS), a multi-modality association who reports 10,000 members, of whom 3,000 are naturopaths/herbalists (Hale 2002a). The NHAA purports to maintain higher standards of education for herbal practice than the ATMS (NHAA 2004).

In 2003 the Australian government introduced the Health Training Packages, which outlined the minimum competencies for various healthcare qualifications (NTIS 2008). In relation to herbal medicine, two qualifications were approved including the Advanced Diploma of Western Herbal Medicine and Advanced Diploma of Naturopathy (NHAA 2004). However, the implication of Australia’s CAM regulatory system is that any person, with or without qualifications,

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6 Naturopathy has its history rooted in the traditional medicine of Europe, but modern naturopathy provides a broad eclectic range of treatment modalities integrated into one practice. Defined as ‘One of the broadest systems of traditional medicine, that typically integrates several different modalities for a patient’, WHM is considered a key modality of naturopathy. Kron J (2004). “Naturopathy.” Complementary Medicine January/February: 26-30.
wishing to prescribe herbal medicines and/or calling oneself a ‘herbalist’ is at liberty to do so. Such individuals will not qualify for registration with a professional association but are, nevertheless, free to practice as a herbalist.

The introduction of the GST highlighted two important issues about the CAM professions in Australia, including the herbal and naturopathic profession. The first issue was the disparity of self-regulatory standards within the CAM professions. As described earlier there are over twenty professional CAM associations that are now formally recognised by the Australian Taxation Office (ATO). Each of these associations requires different educational requirements of its members (McCabe 2005d). Hence, even within the ranks of registered herbal practitioners who meet these minimum standards, there are significant differences in standards of professional education because of variations between the professional associations (McCabe 2005d).

Secondly, the introduction of GST also highlighted the lack of Australian studies focused upon CAM professions and their practices. The GST exemption status was conditional upon the CAM professions’ ability to meet the ATO definition of a ‘recognised professional’ (Khoury 2002a). In the absence of empirical data the professions in question (naturopaths, herbalists and acupuncturists) were unable to demonstrate they could meet this requirement. Accordingly, the Commonwealth Department of Health and Ageing (DHA) allocated $AUS0.5 million to be divided amongst several prominent professional CAM associations to conduct workforce surveys so as to collect the data they required to demonstrate they could meet such a definition (see Chapter 2 for details of findings).

1.3.2.2 Regulation debate

The last ten years in Australia have been a period characterised by an intense debate about the relative merits of self-regulation or statutory regulation for the
WHM profession (DHA 2005). The debate culminated in 2005 when the Department of Human Services (DHS) (within the State Government of Victoria) commissioned a review of naturopathy and WHM practice in Australia and the major conclusion was the recommendation of statutory regulation of these CAM professions (DHS 2005). The results of this study are discussed in the literature review (Chapter 2). No changes have as yet been made in response to this report, and WHM across all states in Australia remain an unregulated practice. The potential regulation of various CAM professions in Australia has created considerable controversy within the WHM profession (NHAA 2002; Khoury 2003).

Many WHM practitioners currently aspire to achieving professional legitimacy and improved recognition of their expertise within the mainstream healthcare sector (Burgess 2004). Proponents of statutory regulation argue that official recognition will help to protect WHM profession’s scope of practice from inter-professional co-option (Salmond 2004). Unlike medical practice, WHM has not undergone a formal process of credentialing and, therefore, the WHM scope of practice has not been ‘codified’ (DHS 2007). As a result, the WHM scope of practice is fairly ambiguous and remains potentially vulnerable to co-option through the integrative practice of herbal medicine. Conversely, the opponents to statutory regulation maintain that regulation will inevitably, as it has for other CAM professions, result in limits being placed upon the WHM scope of practice (Khoury 2003).

Statutory regulation has also been advocated as a means of protecting the livelihood of individual WHM practitioners (Baxter 2004). A common misgiving by exponents of herbal medicine is the inherent inequity in public funding excluding WHM medicines and services (Khoury 2003; Baxter 2004). The NHAA continues to lobby for the inclusion of herbal medicines on the PBS and for the services of WHM practitioners under Medicare (NHAA 2004; Salmond 2004). However, the various CAM associations have not been able to unify and
co-operate as a cohesive unit in relation to advocating their position (McCabe 2005a). For example, the NHAA and the ATMS espouse very different political positions in relation to professional regulation. The NHAA has adopted a pro-statutory regulation position and the ATMS advocates self-regulation (NHAA 2002; Khoury 2003).

The inability of the professional associations to find common ground has reputedly weakened their overall political strength and, thus, the position of the WHM profession within Australian healthcare (Khoury 2003; McCabe 2005a). In spite of the increasing popularity of herbal medicines by the general population (Bensoussan et al. 2004b; Xue et al. 2007), anecdotal evidence suggests considerable financial insecurity amongst the WHM profession in Australia (Hale 2002b; Baxter 2004). The President of the NHAA has remarked, ‘Herbalists add value to the lives of people who seek out our services, yet many herbalists struggle to maintain any sort of lifestyle without a second source of income’ (Baxter 2004). At this point, the literature seems inconsistent and very little is understood about either the impact of mainstreaming upon WHM practice or the WHM profession.

1.3.3 Conclusion

Across the globe, the popularity of CAM is unprecedented. Although aspects of CAM have been researched, both the CAM professions and practitioners have been particularly neglected. To date, most CAM research has investigated only the most basic empirical features of professional practice. The trends in CAM have been observed in Australia, where WHM is especially prominent. Despite the recognition of the potential contribution that the WHM profession makes to Australian healthcare, very little is understood about the profession’s perceptions of their scope of practice. Moving towards filling an apparent gap in the literature, this thesis presents an account of the WHM practice within the contemporary landscape of Australian healthcare from the perspective of the WHM practitioner.
1.4 The research problem

The aim of the research is to provide an account not only of the contemporary approach to clinical practice in Australia but also to consider WHM in its broader socio-political context. As Sharma (1992) reasoned: no system of medicine can be truly understood outside of its social and political context because ‘these social dimensions are as much a part of medical practice as clinical knowledge’ (Sharma 1992 p. 1). Within the current socio-political context of CAM practice, the research problem is stated as the following question:

*What is the impact of the mainstreaming of CAM on the professional practice of WHM in Australia?*

The research is concerned with investigating WHM practice and understanding the WHM profession’s location in the multi-disciplinary Australian healthcare landscape. This is an approach broadly recommended for the study of CAM (Sharma 1996; Adams et al. 2004; Potrata 2005).

1.4.1 Research objectives

The research problem is investigated from the perspective of the Western herbal therapist (WHT) as two complementary lines of inquiry, the objectives of which are:

1. *To describe the WHM system of practice in contemporary Australia;*

2. *To explore the impact of mainstreaming on the practice and provision of WHM in contemporary Australia.*
The thesis presents both a descriptive account of the clinical practice of WHM as well as an exploratory perspective of the impact of mainstreaming on the WHM practitioner and the WHM profession.

1.4.2 Study population

The focal point of this thesis is the practice of WHM by professional herbal practitioners. In the absence of statutory regulation, this thesis has adopted the definition of ‘recognised profession’ used by the Australian Taxation Office (ATO). A recognised professional is defined as a member of a professional association that has uniform national registration requirements of its members for supply of services (Khoury 2002b). Thus, professionalism was defined as those herbal practitioners eligible to receive Goods and Services Tax (GST) rebates for their services as a WHM practitioner.

The NHAA was identified as the only ATO recognised professional association in Australia that solely represents WHM practitioners. The study population was defined as those herbal professionals who were registered as full members of the NHAA at the time of the study. Both the sampling unit and sampling strategies are described in Chapter 3.

There are many labels used for practitioners of herbal medicine. In this thesis the term herbalist will be used as a generic term to denote a practitioner of traditional Herbalism. The term WHM practitioner will be used to indicate reference to the practice of WHM by a registered practitioner. Finally, the term Western herbal therapist (WHT) will be used specifically to denote the members of the study cohort only, i.e. those members of the NHAA who responded to the survey or participated in the qualitative in-depth interviews.
1.1.1 Ethics

The research was approved by the Human Ethics Committee of the University of Newcastle (Approval No. H-677-1003).

1.5 The research framework

The purpose of this thesis is for both the development and expansion of this tentative knowledge base (Greene et al. 1989). The thesis topic is an area of relative immaturity in terms of existing research and theory, and a need exists to both describe and to explore the phenomena of interest. The key motivation for the exploratory nature of this study is that little in-depth analysis of CAM practice has been conducted to date from the perspective of the CAM practitioner.

1.5.1 Mixed methods approach

This health research presents a mixed methods study that combines the results of a quantitative study with that of a qualitative study to develop and understand the current understanding about the modern approach to the practice of WHM in Australia. The notion of combining methods has gained increasing legitimacy as a research tool in health research in the last twenty years (Charmaz 2000; Lincoln et al. 2000; Teddlie et al. 2003; Johnstone 2004; Morse 2005a). In particular, mixed methods research is an increasingly accepted pragmatic approach employed to investigate healthcare services (Johnstone 2004).

1.5.2 Research design and rationale

The thesis presents the results of a two phase study in which an initial survey study was followed by a qualitative in-depth interview study. The rationale of adopting a mixed methods approach was threefold: firstly, to increase the scope of inquiry by selecting methods most appropriate for each inquiry component
(Newman et al. 2003); secondly, to better understand the research problem by converging different types of data (Creswell 2003); and finally, to increase the validity of constructs and inquiry results by triangulation of data sources (Strauss et al. 1998). Triangulation, it has been argued, is a research strategy that strengthens a study by combining both quantitative and qualitative methods and/or data (Denzin et al. 1998; Patton 2002).

In the quantitative study, descriptive data on the clinical activities of Australian WHM practitioners was systematically collected using a survey instrument tested for reliability and validity. The exploratory qualitative study consisted of a series of in-depth interviews with a smaller sample of survey respondents. To both ensure flexibility and to obtain novel data from the participants, the in-depth interviews were carried out on a semi-structured basis (Silverman 2005). In this way the mixed methods study moves to understand the differences between the reported behaviour (survey responses, and interview transcripts) between idealistic positions and the actual operational behaviours demanded by the demands of daily life in the clinic (Strauss et al. 1998).

At a practical level, due to the vast geographical distances in Australia, a postal survey was considered a key strategy to collect data from a national cohort. In-depth interviews were considered a valuable method not only to contextualise the quantitative data (Morse et al. 1995; Patton 2002) but were also a powerful tool for exploring the various processes operating within CAM practice (Broom 2005). The details of the methodological integrity of the research design and of the specific research methods are provided in Chapter 3.

In this way the current inquiry critically examines WHM practitioner's reported behaviours and explanations of clinical practice and presentations of the mainstream/CAM border in influencing their role within the Australian healthcare sector. Although both lines of inquiry are sufficient unto themselves, when
combined they function to answer in full the research problem, which is to locate the practice of WHM in Australia healthcare. The survey study results are presented in Chapter 4 and the qualitative in-depth interview results are presented in Chapters 5 and 6. The conclusions drawn from the combined research results are presented in Chapter 7.

1.5.3 Use of theory

As a mixed methods investigation, the thesis is based upon a pragmatic knowledge claim (Tashakkori et al. 1998; Maxwell et al. 2003; Morse 2003). Notwithstanding the potential incompatibilities of Positivism and Constructivism, theorists have increasingly acknowledged the value of ‘mixing’ different yet complementary data sets to not only address the practical problems of health research but to foster a broader understanding of all social science phenomena (Denscombe 2002; Patton 2002; Creswell 2003; Newman et al. 2003).

Although the motivation for the current research is essentially pragmatic, the thesis accepts the notion that the investigation must draw upon broader social theory to both identify relevant sensitising concepts with which to interpret the current research results and, thus, ultimately relate the dissertation to existing CAM research. As a health science investigation, the thesis uses a theoretical framework that is informed from a number of social theories and perspectives.

In the absence of a conceptual framework specific to WHM, several sensitising constructs have been drawn from the sociology of CAM (Tovey et al. 2002; Adams et al. 2004; Boon et al. 2004). How these have been applied in this thesis to help explain the potentially complex processes involved in the mainstreaming of WHM is described in Chapter 3. By taking this approach the thesis offers a new and practical understanding of the process of WHM practice.
1.6 Significance of the research

The thesis is essentially a pragmatic inquiry providing insights to help inform discussion about the future role of WHM practice in the Australian healthcare system. The information should be of value for public health decisions, and at an inter-professional and intra-professional level.

1.6.1 Public health significance

Herbal medicine is the subject of this thesis for two important reasons. Firstly, herbal medicine is one of the most popular forms of CAM in Australia; secondly, although generally regarded as safe, particularly in comparison to pharmaceutical medicine, as with any effective mode of treatment herbal medicines are not free of risk (Weiss 1991). Herbal medicine, unlike many other complementary therapies, involves the prescription of drugs (albeit galenicals) as part of its treatment structure. As herbal medicine consumption becomes more common there have been increasing calls for research to understand the benefits, safety and effectiveness of herbal products and services (Burton 2005). WHM is the focus because it is the most popular form of herbal medicine in Australia (Wohlmuth et al. 2002).

As consumers increasingly use CAM it is clear that the provision of safe and effective treatments is an issue of growing relevance to those involved in the planning and provision of healthcare (Kelly et al. 2005). The profile of WHM has grown internationally over the last couple of decades prompting call for regulation of its practice. There is growing recognition that the public and allied healthcare professionals want better guarantees of educational standards and professionalism (De Smet 1995; Sherwood 2000; MacLennan et al. 2002).

At the commencement of this thesis there had been no systematic study of WHM worldwide. In the meantime, studies of WHM practice have been
undertaken in the UK (O'Sullivan 2005), the US (Dougherty 2005), and several policy related studies have been conducted in Australia (Hale 2002b; Bensoussan et al. 2004b; DHS 2005). It is a mark of the significance of the thesis that the Victorian Government in Australia, with a view to statutory regulation of the profession, commissioned a review of the benefits and safety of WHM practice (DHS 2005). The results of the Australian studies are reviewed in Chapter 2.

Future public health decisions and expenditure will be informed from the data that is collected today. It is important that accurate data is collected and that unbiased research methodologies are employed. Experimental and clinical studies are necessary if herbal medicine is to be grounded on a platform of broad evidence. This research should be constructed from a core of knowledge that is informed by facts derived from the expert practice of herbal medicine. This can be achieved by acknowledging the worth of empirical data of a traditional, epidemiological and sociological basis in addition to the currently existing experimental data. Such data can be used to generate hypotheses for future clinical trials of herbal medicines.

1.6.2 Inter-professional significance

Many medical professionals have indicated they would like to know more about CAM therapies (van Haselen et al. 2004) because many patients are using CAM as a supplement rather than as replacement for conventional care (Muhajarine et al. 2000; Eisenberg et al. 2001; Thomas et al. 2001). In Australia, general practitioners (GPs) as primary contact medical practitioners are increasingly being required to play a role in coordinating and advising patients with regard to CAM (Kerridge et al. 2004). The literature has expressed increasing concern about the efficacy and safety of herbal medicines, particularly in relation to potential toxicity or potential drug-herb interactions (Drew et al. 1997). Consequently, the medical profession may require increased familiarisation with not only potential interactions of herbal medicines but also
the diagnostic, prescribing and inter-professional practises of WHM practitioners.

1.6.3 Intra-professional significance

Ultimately, it is hoped that the findings from this thesis will stimulate reflective practice within the WHM profession. It has been increasingly argued that evaluation of practice through research is central to the development of the CAM modalities into true professions and their practitioners into autonomous professionals (Abbott et al. 1998). The desirability of research focused upon CAM practice has been accentuated as the CAM professions, internationally, strive to achieve professional legitimacy (British Medical Association 1993; Abbott et al. 1998). It seems self-evident that research is essential not only for improved practice and patient safety, but also in the current socio-political climate in Australia for improved professional status.

The research presented in this thesis was undertaken with the intention of generating practical and useful knowledge for action in the custom of reflective practice (Patton 2002). Reflective practice research is defined as research designed ‘to help a group of people reflect on ways of improving what they are doing or understand it in new ways’ (Patton 2002 p.179). Patton (2002) describes the benefits of reflective practice as twofold: (1) the inquiry can yield specific insights and findings that can change practice; and (2) those who participate in the inquiry learn to think more systematically in what they are doing and their relationship to those with whom they work. Ultimately, the research provides new understandings about the role of WHM within Australian healthcare and proposes a new agenda for future research that centres on a few key research areas and opens up research in CAM to new perspectives.
1.7 Conclusion

In conclusion, Chapter 1 has established the research problem and laid strong foundations for the significance of the proposed research. The methodology was briefly described, the key definitions presented and the limitations of the research given. By following the research framework outlined above, the thesis aims to provide a unified and coherent exploration of the research problem: the impact of mainstreaming of CAM upon the practice of WHM in Australia. On this basis, the thesis can proceed with a detailed presentation of the research. The literature review is presented in the next chapter.
Chapter 2 Literature review

Chapter outline

This chapter reviews the CAM literature to determine what is currently known about the practice and provision of WHM in Australia.

2.1 Introduction

In Chapter 1 it was argued that although CAM practitioners have grown to be significant, if unofficial, providers of healthcare in many Western societies, there has been relatively little research on CAM provision. In particular, the literature that focused upon professional CAM practice remains underdeveloped. Despite the growing popularity of herbal medicine over the last decade, very few empirical studies have focussed on herbal medicine in terms of either consumption or provision. Consequently, at present little is known about herbal practitioners or their approaches to practice.

In the last few decades, as herbal medicines have become the object of scientific enquiry, most herbal research has focused on experimental studies investigating plant pharmacology or clinically orientated studies exploring their therapeutic efficacy (Ernst 2005; Mills 2007). It is not the aim of the thesis to assess the efficacy of herbal medicines and it is beyond its scope to address the enormous body of research that has focussed on the pharmacology of herbal medicines. A comprehensive systematic review of research focussed on the clinical use of herbal medicines may be found in a study published in the DHS report (Myers et al. 2005) The increasing profile of various CAM professions, including WHM, has also prompted a number of policy reviews world-wide (Bensoussan et al. 1996; Boon 2002; White 2004; DHS 2005). However, there has been limited empirical investigation about the provision of WHM from the perspective of the herbal practitioner.
This review examines the CAM literature to determine what is empirically known about the contemporary practice of WHM: specifically, what the literature shows about the Australian WHM profession and its perspective of herbal practice. Although the focus of the review is on WHM practice, the broader CAM consumption literature was also considered in order to understand the relative popularity of WHM as a form of CAM and the determinants of WHM use amongst the Australian population.

2.1.1 Literature search

The literature of interest in this review was those papers that focussed on herbal medicine: especially the consumption and provision of WHM in Australia. The following section describes how the CAM literature was searched to locate relevant studies. The literature search was undertaken in two phases that aimed to: (1) locate studies about the consumption of CAM and to identify any that included data about herbal medicine use; and (2) to identify studies that specifically focussed on WHM practice. Although a systematic approach was adopted to search the CAM literature, it does not claim to be a systematic review. As a final note, the term herbalist is commonly used in the literature reviewed here and as such this title will be used in this chapter when referring to WHM practitioners.

2.1.1.1 The CAM consumption literature

The first broad sweep of the CAM literature was undertaken adapting an established search protocol from the literature (Harris et al. 2000)\(^7\). The

\(^7\) Harris and Rees (2000) conducted a search of the electronic databases Medline and CISCOM for all years up to 1999. The search looked for all records indexed within the MeSH ‘alternative medicine’ and characterised by having ‘health care survey’ as an index term or ‘survey’ in the abstract or title. At the time of this literature search the MeSH ‘alternative medicine’ had been replaced with ‘complementary therapies’ and CISCOM was substituted with AMED.
advantages of applying this search protocol were: firstly, it was possible to estimate the growth in the CAM survey literature over the last decade; and secondly, to ensure a rigorous and systematic approach to the literature search was undertaken.

Accordingly, a search of the electronic databases Medline and AMED was conducted. In Medline the search looked for all records indexed within the MeSH ‘complementary therapies’ characterised by having ‘survey’ or ‘health care survey’ as a key word. The same search was conducted in AMED, a bibliographic database specialising in complementary and allied healthcare produced by the Health Care Information Service of the British Library (The British Library 2008). The literature search was limited to English language papers. This was not considered to introduce selection bias because WHM is indigenous to Anglo-American culture (Mills et al. 2000) and the focus of this review is Australian.

The titles and abstracts identified from the search were then individually reviewed to identify any papers that met the following inclusion criteria:

1. CAM use was measured among the general population (including sub populations e.g. women, the elderly) as opposed to a clinical population or other more narrowly defined populations;
2. The study provided data about visits to CAM therapists, including data specifically about visits to WHM therapists among these populations;
3. The study was conducted on the Australian population.

Papers were excluded if the study did not include herbal medicine in its list of CAM therapies, if it did not describe the study methods (e.g. contained only
brief reports describing publication elsewhere, letter to the journal editors) and if it was not written in English.

Harris et al. (2000) had identified a total of 638 references for the period up until 1999 (491 via Medline, another 147 via CISCOM). The updated search limited to 2000-2008 found a total of 724 references including 607 from Medline and 169 from AMED (55 duplicates were discarded). The combined searches revealed a total of 1362 CAM surveys conducted in the English literature alone. This represents a doubling in the size of this survey literature in the eight years since the original review (Harris et al. 2000). A total of 57 studies were identified that potentially met the inclusion criteria about the consumption of CAM amongst the general population (seven focussed on herbal medicine consumption). When the search was limited by the keyword ‘Australia’, ten (10) papers were identified as meeting the inclusion criteria. No additional records were identified by citation tracking.

2.1.1.2 The herbal practice literature

Subsequently, both databases were searched for all records indexed within the MeSH ‘complementary therapies’ characterised by having the terms ‘herb$’ (truncated to collect any term beginning with herb such as herbalist, herbal medicine, herbs etc.) and ‘professional practice’. The search record was then reviewed for studies that met the following inclusion criteria:

1. The study focussed on WHM practice (studies which also included data about naturopathy were included);
2. The study used either quantitative or qualitative methods.

Further attempts to locate papers about WHM were made by citation tracking and searching the University of Newcastle library catalogue (NEWCAT). In addition, a Google search of the word ‘herbalist’ and ‘naturopath’ confined to
Australia was undertaken to identify any ‘grey documents’ (literature not widely indexed, for example government reports) contained in official Australian Government web sites (either federal or state) and the CAM association websites. Further attempts to locate papers about WHM were made by contacting the key CAM professional associations that represent Western herbalists in Australia. The NHAA (National Herbalists’ Association of Australia) and the ATMS (Australian Traditional Medicine Society) and ANTA (Australian Natural Therapists’ Association) were individually contacted to identify any recent studies undertaken involving their membership.

In this phase of the literature search, five references were identified that focussed on WHM practice: two of these studies were surveys from the UK and three potentially fit the Australian inclusion criterion. Although no further papers were identified using citation tracking, one official policy document was identified by accessing official government websites (in this case the Victorian State Government of Australia). The final count of references to be reviewed totalled six (five survey studies and one public policy document). The data base search identified no qualitative studies that focussed on WHM professionals in Australia.

2.1.2 Description of the literature

In total, sixteen (16) documents about were identified that contained relevant data related to the provision of WHM. These documents were re-classified according to their study populations as either consumer-level evidence (n=10) or practitioner based evidence (n=6). The policy review document contained data fitting both categories but was classified in this review within the practitioner based category. It is these 16 studies that constitute the focus of the literature review.
2.1.2.1 Consumer level evidence

Ultimately, ten studies were identified that fit the inclusion criterion reporting data about the consumption of CAM within Australia. These studies report data about the prevalence of CAM/herbal medicine use amongst the Australian general population, including rates of visits to herbalists (MacLennan 1996; MacLennan et al. 2002; Adams et al. 2003b; Sibbritt et al. 2003; Sibbritt et al. 2004; Adams et al. 2005; MacLennan et al. 2006; Adams et al. 2007; Xue et al. 2007; Zhang et al. 2007). Table 2-1 (over page) indicates the date of survey administration, the target populations (and age groups), the therapies that were listed in the questionnaires, and the estimated prevalence of CAM use (visits to herbalists reported separately, where possible).

Only one study provided data from the national population of adult Australians; the findings from three studies were based upon the smaller South Australian population; and six of the ten papers described the prevalence of CAM use and CAM consultations within sub-populations: (1) Zhang et al. (2007) presented the findings for the elderly cohort of the national survey reported by Xue et al. (2007); and (2) the remaining five offered data about Australian women only (Adams et al. 2003b; Sibbritt et al. 2003; Sibbritt et al. 2004; Adams et al. 2005; 2007). These five papers reporting data from the Australian Longitudinal Study of Women's Health (ALSWH) (n= > 40 000 women) described a nationally representative sample of Australian women.

These ten studies reported data collected using cross-sectional surveys. In addition to profiling CAM users, several of the surveys were replicated or provided longitudinal data thus offering insight into trends in CAM consumption over time. The survey in South Australia was replicated on three occasions, providing data about trends in CAM use in Australia over the past decade (1993-2004) (MacLennan 1996; MacLennan et al. 2002; MacLennan et al. 2006). In addition, Sibbritt et al. (2004) provided a longitudinal analysis of mid-age women's use of CAM in Australia from 1996 to 1998.
### Table 2-1 CAM / herbal medicine use amongst the Australian population (grouped by populations and sub-populations)

<table>
<thead>
<tr>
<th>Authors</th>
<th>n (% response)</th>
<th>Date</th>
<th>Population</th>
<th>Age (responses)</th>
<th>Therapies listed</th>
<th>CAM use (95% CI)</th>
<th>Herbal use (95% CI)</th>
<th>% CAM therapist</th>
<th>% Herbal therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australian general population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xue et al. 2007</td>
<td>1067 (15% participation)</td>
<td>2005</td>
<td>Australia</td>
<td>≥ 18</td>
<td>As per MacLennan studies plus: Nutrition, Massage therapy, Meditation, Exercise therapy and Energy healing</td>
<td>68.9 (+/- 2.8)</td>
<td>16.3 (WHM)</td>
<td>44.1</td>
<td>29.1</td>
</tr>
<tr>
<td>Zhang et al. 2007</td>
<td>Elderly cohort above study (16.9)</td>
<td>2005</td>
<td>Elderly Australians</td>
<td>≥ 65</td>
<td>As above</td>
<td>58.8%</td>
<td>60.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>South Australian population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MacLennan et al. 1996</td>
<td>3004 (73.6)</td>
<td>1993</td>
<td>South Australia</td>
<td>≥ 15</td>
<td>Acupuncture, Aromatherapy, Chiropractic, Herbal therapy, Homeopathy, Iridology, Naturopathy, Osteopathy, Reflexology, Other</td>
<td>48.5 (+/- 1.8)</td>
<td>9.9 (WHM)</td>
<td>20.3</td>
<td>0.4</td>
</tr>
<tr>
<td>MacLennan et al. 2002</td>
<td>3027 (70.4)</td>
<td>2000</td>
<td>South Australia</td>
<td>≥ 15</td>
<td>As above</td>
<td>52.1 (+/- 1.8)</td>
<td>13.4 (WHM)</td>
<td>23.3</td>
<td>0.9</td>
</tr>
<tr>
<td>MacLennan et al. 2006</td>
<td>3015 (71.7)</td>
<td>2004</td>
<td>South Australia</td>
<td>≥ 15</td>
<td>As above</td>
<td>52.2 (+/- 1.9)</td>
<td>20.6 (WHM)</td>
<td>26.5</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Cont...
**Table 2-1** CAM / herbal medicine use amongst the Australian population (grouped by populations and sub-populations)

<table>
<thead>
<tr>
<th>Authors</th>
<th>n</th>
<th>Date</th>
<th>Population</th>
<th>Age (responses)</th>
<th>Therapies listed</th>
<th>CAM use</th>
<th>Herbal use</th>
<th>CAM therapist</th>
<th>Herbal therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams et al. 2003</td>
<td>41 817</td>
<td>1996</td>
<td>Australian women</td>
<td>18-23 (n=14698/14779) 45-50 (n=13972/14099) 70-75 (n=12662/12939)</td>
<td>Not specified CAM user defined as one visit to an alternative practitioner</td>
<td>NA</td>
<td>NA</td>
<td>19.0</td>
<td>28.0</td>
</tr>
<tr>
<td>Sibbritt et al. 2003</td>
<td>9375</td>
<td>1999</td>
<td>Australian women</td>
<td>73-78 (n=9735)</td>
<td>As above</td>
<td></td>
<td></td>
<td>14.5%</td>
<td></td>
</tr>
<tr>
<td>Sibbritt et al. 2004</td>
<td>11454</td>
<td>1996-98</td>
<td>Australian women</td>
<td>45-50</td>
<td>As above</td>
<td></td>
<td></td>
<td>During the period 1996-1998 10% of the mid-aged cohort adopted the use of CAM and 9% relinquished CAM</td>
<td></td>
</tr>
<tr>
<td>Adams et al. 2005</td>
<td>11202</td>
<td>2001</td>
<td>Australian women</td>
<td>50-55 (n=11 143)</td>
<td>Measured visits to a herbalist or naturopath</td>
<td></td>
<td></td>
<td>15.7%</td>
<td></td>
</tr>
<tr>
<td>Adams et al. 2007</td>
<td>11 202</td>
<td>2001</td>
<td>Australian women</td>
<td>50-55 (n=11 143)</td>
<td>As above</td>
<td></td>
<td></td>
<td>11.0%</td>
<td>(+/- 1.0)</td>
</tr>
</tbody>
</table>
2.1.2.2 Practice/practitioner based evidence

The research that is available about WHM practice has been mainly descriptive and quantitative based upon a limited number (n=5) of cross sectional survey studies. Two of the surveys identified are from the UK of the National Institute of Medical Herbalists (NIMH), the British equivalent to the NHAA (British Medical Association 1993; Barnes et al. 1998). These UK surveys were included in this review of Australian WHM because they were the only studies available that have focussed exclusively on herbalists, rather than on multiple CAM professions. They served as a useful point of comparison to the Australian CAM surveys.

The Australian survey populations included multiple CAM professions as represented by the ATMS, NHAA and ANTA memberships (Hale 2002a; 2003; Bensoussan et al. 2004b; Grace et al. 2006). The details of these studies including survey method/s used, response rate, CAM professions listed, and the percentage of herbalists within the study population are summarised in Table 2-2 (over page).

Data describing the Australian WHM profession are predominantly contained within two surveys commissioned by the Australian Taxation Office (ATO) and subsequently published as four papers (Hale 2002b; 2003; Bensoussan et al. 2004b; DHS 2005). In addition, the literature search identified a recent survey of the ATMS/ANTA that aimed to determine the extent to which CAM practitioners in Australia employ CAM and medical diagnostic techniques (Grace et al. 2006). The ‘Review of Naturopathic and WHM practice’ (DHS 2005) did not conduct an independent survey of WHM and naturopathic practitioners. The primary data reported was that from the Bensoussan et al. (2004b) survey.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Method</th>
<th>n (%) response</th>
<th>Date</th>
<th>Population (% responses)</th>
<th>CAM professions listed</th>
<th>Herbalists (% sample)</th>
<th>Study data</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMA 1993</td>
<td>Postal survey</td>
<td>300</td>
<td>1991</td>
<td>NIMH</td>
<td>WHM</td>
<td>British Herbalists (100%)</td>
<td>Conditions treated, inter-referral and communication patterns and concurrent treatments with medical practitioners</td>
</tr>
<tr>
<td>Barnes et al. 1998</td>
<td>Postal survey</td>
<td>317 (62, 19.6%)</td>
<td>1997</td>
<td>NIMH</td>
<td>WHM</td>
<td>British Herbalists (100%)</td>
<td>Conditions treated and herbal prescriptions for those conditions, ratings of safety and effectiveness of herbs</td>
</tr>
<tr>
<td>Hale 2003</td>
<td>Postal survey</td>
<td>9,500 (4633, 48.8%)</td>
<td>2002</td>
<td>ATMS (49%) ANTA (47%)</td>
<td>Naturopaths, Herbalists, Acupuncturists, Chinese herbalists, Massage therapists</td>
<td>Naturopaths, Herbalists &amp; Acupuncturists (2203, 23.2%)</td>
<td>Demographics data and profile of practitioners; educational qualifications, memberships with CAM associations; adverse reactions</td>
</tr>
<tr>
<td>Bensoussan et al. 2004b</td>
<td>Postal survey</td>
<td>2618 (859, 32.8%)</td>
<td>2002</td>
<td>GUHF Provider list</td>
<td>Naturopaths, Herbalists, Nutritionists, Homeopaths</td>
<td>(795/1778, 45%) Naturopaths (604, 76.0%) Herbalists (489, 61.5%)*</td>
<td>Demographic data and profile of WHM and naturopathic practitioners; diagnostic tests used; inter-professional data; Labelling of medicines and adverse reactions</td>
</tr>
<tr>
<td>Grace et al. 2007</td>
<td>Postal survey</td>
<td>2796 (617, 22%)</td>
<td>2004</td>
<td>ATMS ANTA</td>
<td>CAM therapists</td>
<td>Naturopaths, Herbalists, &amp; Nutritionists (44.5%)</td>
<td>Educational qualifications, diagnostic training and techniques used; primary contact role and referral rates</td>
</tr>
<tr>
<td>DHS 2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NIMH- National Institute of Medical Herbalists; ATMS- Australian Traditional Medicine Society; ANTA- Australian Natural Therapists’ Association; NHAA- National Herbalists’ Association of Australia; GUHF- Grand United Health Fund; * 76% of GUHF respondents had indicated more than one title to describe their practice.
The British Medical Association (BMA) study reported perhaps the earliest empirical data about the clinical activities of herbalists (British Medical Association 1993). Data with regard to organisation, practice, training and qualifications about a number of different CAM therapies including osteopathy, chiropractic, acupuncture and herbal medicine in the UK was collected. The findings about approaches to clinical practice of the various CAM practices surveyed were reported as one-page summaries for each therapy and included data about conditions treated, inter-referral and communication patterns, and concurrent treatments with medical practitioners. The second UK survey aimed to describe herbalists’ prescriptions for common clinical conditions (Barnes et al. 1998). While these data are fairly rudimentary, they remain the only surveys that focus specifically on WHM that are available.

The data collected from the ATO-funded national study of the members of the ATMS and ANTA was published as two papers (Hale 2002b; 2003). The first paper reported the results of the sub-population of 1,580 acupuncturists, herbalists and naturopaths of the ATMS (Hale 2002a). The second overlapping paper included the ATMS data combined with the ANTA data of the sub-population (n=2203) of acupuncturists, herbalists and naturopaths (Hale 2003). It is the results of this second larger paper that will be examined and discussed in this review (Hale 2003). The Bensoussan et al. (2004b) ATO-funded workforce survey, developed in conjunction with the NHAA, provided data about herbalists and naturopaths (n=795) who were listed as CAM providers by the Grand United Health Fund (GUHF). From this point onwards the ATO-funded workforce surveys will be referred to as the ATMS survey and the NHAA survey respectively.

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8 This was the nomenclature commonly used to refer to the surveys when speaking to the relevant CAM Associations.
A comparative review of these workforce surveys was less problematic than the consumer-level evidence because of the similarities in the populations, particularly the type and number of therapies examined. Additionally, a high proportion of respondents to both surveys indicated they belonged to more than one CAM association: approximately half of the respondents to the NHAA survey reported belonging to two or more CAM associations; and 45% of respondents to the ATMS survey indicated they were also members of the NHAA. As will be discussed, there was a high degree of consistency in the findings from the two workforce surveys. On the other hand, identifying any data specific to practising herbalists was problematic because the study populations consisted of multiple professions (WHM, naturopathy and acupuncture), most respondents used several titles to describe their practice, and many respondents had reported practicing multiple modalities. Nonetheless, the two workforce surveys constitute the bulk of the empirical data about WHM practice.

It must be noted that both the validity and generalisability of the findings from the practitioner surveys are problematic because of the consistently low response rates of the studies. As shown in Table 2-2 the response rates range from 19.6% to 48.8%. Although less than ideal, the response rates are not untypical of surveys of the CAM professions or the healthcare professions in general (Asch et al. 1997; Puleo et al. 2002). The literature argues that a response rate of over 50% is required to provide adequate assurance of the representativeness of a survey population (Puleo et al. 2002). Nonetheless, the question of the validity of these surveys is potentially ameliorated by the similarity in findings between the two workforce surveys.

The review of the WHM and Naturopathic professions commissioned by the State Government of Victoria was made available in 2005 (DHS 2005). The stated aim of this report, entitled “Review of naturopathy and Western Herbal Medicine”, was to identify the potential risks and benefits associated with the practice of WHM and naturopathy and to assess the need, if any, for statutory
The regulation of these professions. The focus of this document was primarily on policy related issues such as safety and efficacy of WHM and naturopathy.

This report included an extensive literature review of benefits and risks of herbal medicines (Myers et al. 2005), a survey of Australian general practitioners (GPs) and their attitudes/use of CAM (Cohen et al. 2005), a national survey of CAM educational institutions regarding their herbal/naturopathic programs (McCabe 2005d), a survey of professional associations and institutional recognition (McCabe 2005b; 2005c) and, finally, a survey plus a focus group study of consumers of naturopathy and WHM (Hill et al. 2005). The NHAA survey data as described above was replicated in the report, the review did not provide any new data related to clinical issues or on the perspectives of the WHM profession about the provision of WHM.

2.2 WHM in Australia

Drawing upon the documents identified from the literature search, the following section describes what is empirically known about WHM practice in Australia. It describes the consumption of WHM in Australia, the characteristics of the WHM profession, what is understood about their approaches to clinical practice and herbal prescribing, their clientele and their relationships with mainstream healthcare providers. The focus of the review is predominantly on the data from the ATMS and NHAA practitioner surveys, but where appropriate it compares this data to known parameters from the CAM literature, particularly as identified in Section 2.1.2.

2.2.1 The use of WHM

The consumer based literature provides strong evidence of the consumption of CAM by a large proportion of the Australian adult population. The most
commonly reported figure in the literature of CAM use in Australia is 52.2%, equalling approximately $AUS1.8 billion expenditure annually (a decrease from $AUS2.3 billion in 2000) (MacLennan et al. 2006). This estimate is derived from the South Australian population and extrapolated to the national population. A more recent study based upon a national population found that 70% of the Australian population used CAM (Xue et al. 2007). The authors estimated an annual expenditure considerably higher than previous studies of $AUS4.13 billion (Xue et al. 2007).

The substantial differences in these results may have been due to the differences in the sample population characteristics and the different type and number of therapies examined (see Table 2-1). Xue et al (2006) argue that their results indicate that CAM use by the national population is much higher than estimates extrapolated from a single Australian state. On the other hand the higher estimates may have been because the survey included more CAM therapies in its questionnaire. It is unclear if the differences resulted from true regional differences, population differences or from the type and number of therapies examined between the surveys.

Nevertheless, both of these surveys indicated similar levels of consumption of herbal medicines by the general population9. Xue et al. (2007) reported the use of herbal medicines by 16% of the adult population. MacLennan et al (2004) demonstrated a significant increase in the use of herbal medicines, with women’s use especially increasing from 17% in 2000 to 25% in 2004; males’ use of herbal medicines rose from 10% to 16% in the same time frame.

9 The distinction between Chinese and WHM was observed in both surveys
Furthermore, despite the drop in reported expenditure on CAM of the South Australian population since 2000 expenditure on herbal medicines increased.

2.2.1.1 Visits to herbalists

The annual expenditure on CAM therapists in Australia has been estimated at $AUS1.73 billion, representing a visit to a CAM therapist by 44% of the national population (Xue et al. 2007). The most recent data from South Australia was more conservative. The South Australian data estimated an annual expenditure on CAM therapists of $AUS494 million, representing 27% of the survey population (an increase of about 6% over a decade) (MacLennan et al. 2006). In general, these data indicate that CAM therapist use is widespread amongst the Australian general population. Nonetheless, the findings also suggest that this trend has not necessarily translated into large numbers of consultations with herbalists.

MacLennan et al. (2006) found that approximately 6% of South Australians consulted a naturopath and 2% consulted a herbalist. Xue et al. (2007) reported that of the 16% of the Australian population who use WHM, 29% had visited a herbalist. Despite the significant differences in estimates between these two surveys, it is evident that amongst those visiting a CAM therapist the numbers consulting herbalists/naturopaths represented only a small proportion. The reasons behind the trends in these consumption patterns were not reported. However, studies in the US have indicated that most herbal expenditure is predominantly spent on self-prescribing or self-medicating with over-the-counter medications (OTC) (Barnes et al. 2004).

It is clear that use of herbal medicine and herbalists is greater amongst women than men. Recent data from Victoria indicated that 68% of naturopathic or herbal patients are women (Hill et al. 2005). Data from South Australia specific to women indicated that 8% of women had consulted a naturopath and 2%
consulted a herbalist (MacLennan et al. 2002). This rate is double that of men, of whom 4% had consulted a naturopath and 1% consulted a herbalist. The data from the ALSWH indicated that about 11% of Australian women (mid-aged cohort) and 16% of women who also have cancer consulted a naturopath or herbalist (Adams et al. 2005; 2007). These data are also reflected in rates of visits to a naturopath or herbalist amongst US women (Upchurch et al. 2005).

Overall, the findings do not allow a definitive statement about the rates of visits to herbalists amongst the general population. Nevertheless, despite the various inconsistencies between studies, all indicated that the rates of consultation to herbal/naturopathy are only a small percentage of the overall herbal consumption by the general public in Australia. On the other hand, herbalists were the only category of CAM therapists that had experienced an ‘escalation’ of use since the earliest survey of 1993 (increase from 0.4% to 1.9%) (MacLennan et al. 2006).

2.2.1.2 Determinants of CAM use

Surveys of CAM consumption have repeatedly demonstrated strong correlations between the use of CAM and certain socio-economic indicators. The Australian studies reviewed indicated that the most common characteristics of CAM users were: female, employed, well-educated, had private health insurance coverage and higher-than-average incomes (MacLennan et al. 2006). Further data indicated that CAM is more commonly used by consumers who had poorer health (Sibbritt et al. 2004; MacLennan et al. 2006; Xue et al. 2007; Zhang et al. 2007).

The predominant factor found to be predictive of CAM use amongst Australian women was changes in health status: particularly, women suffering more illness over time are more likely to adopt CAM than those experiencing better health (Sibbritt et al. 2004). Adams et al. (2003) reported that Australian women using
CAM did not use them as a replacement of mainstream medicine but were actually high users of medical services (general practice and specialists) and hospital services. Zhang et al. (2007) found a higher proportion of elderly Australians use both CAM and conventional medical treatments (37.9%) when compared to those aged 18-34 (15.7%) and 35-64 (26.9%).

Australian consumers have indicated that they frequently do not inform their medical practitioner of CAM use: less than half of Australian users have informed their medical practitioners about their use of CAM (Xue et al. 2007); within the sub-population of elderly Australians, 24% nominated that they were not asked by their doctors and 16% considered that their doctor would disapprove of such use. Studies in Australia show that many health professionals rarely record a history of CAM use (Cohen et al. 2005).

These findings are reflected in international studies. Within the last decade numerous studies in the US and the UK have shown that consumers of CAM tend to be of mid-age, predominantly female, generally with a higher education level and perceive themselves as having poor health that has not responded to mainstream healthcare (Eisenberg et al. 1998; Landmark Healthcare 1998; Barnes et al. 2004; Thomas et al. 2004; Yu et al. 2004; Upchurch et al. 2005; Gardiner et al. 2006; Bardia et al. 2007; Gardiner et al. 2007; Upchurch et al. 2007). The international CAM literature also indicates that CAM is being used as a supplement rather than a replacement for mainstream medical care but that considerable proportions of patients using CAM do not inform their medical practitioner of such use (Thomas et al. 1991; Shenfield 1997; Muhajarine et al. 2000; Eisenberg et al. 2001; Cockayne et al. 2004).

2.2.1.3 Determinants of Herbalism/naturopathy use

Australian data was also available, which provided some evidence specifically about the determinants of visits to herbalists: firstly, women are higher users of
herbalist/naturopaths than men (MacLennan et al. 2006); secondly, people who have poorer health are more likely to use herbalist/naturopaths (Adams et al. 2005); and finally, herbal/naturopathy is used as a supplement to mainstream medicine (Adams et al. 2005; MacLennan et al. 2006; Zhang et al. 2007).

The ALSWH studies showed that women who are mid-aged and have more education and poorer health are more likely to use herbalist/naturopaths (Adams et al. 2005). Adams et al (2005) reported that mid-aged women with cancer were found to be more likely to consult a herbalist/naturopath than mid-aged women without cancer. Furthermore, herbal/naturopathy consultations appear to be utilised by these women with cancer alongside and as a supplement to conventional health services. These data indicate very similar determinants for visiting an herbalist to CAM use in general.

Recent data indicated that most herbal/naturopathic patients have already consulted and many continue to consult other healthcare practitioners, particularly medical practitioners (Adams et al. 2005; Hill et al. 2005; MacLennan et al. 2006; Zhang et al. 2007). The Victorian study of herbal/naturopathic patients confirmed these findings. The data showed 61% of patients had consulted other healthcare practitioners for the same condition, 49% had previously consulted medical practitioners, and a further 17% had consulted medical specialists. The majority of these patients were self-referred (73%) (Hill et al. 2005). The reported reasons for seeking naturopathic or herbal consultation included: seeking effective treatment for health problems, seeking treatment for chronic or serious illness or conditions, maintenance of health and wellness, and having values compatible to the philosophy and practice of WHM and naturopathy (Hill et al. 2005).

However, in contrast to the earlier CAM studies, the Victorian study indicated that herbal/naturopathy patients have a slightly different profile to CAM users in
general. The study demonstrated that herbal/naturopathy patients represented a broad range of Australians including those from the managerial or professional sectors, those employed in trades, services, industry or clerical work, and 44% with an education level of high school or less (Hill et al. 2005). The authors concluded that their results were different to CAM studies that indicated that most use is by educated middle class women, with little use by low income groups (Hill et al. 2005).

The patients in the focus group study reported in the DHS report (2005) conveyed an overall satisfaction with their practitioner but noted it was dependent upon finding a good practitioner (Hill et al. 2005). Participants reported having to consult a variety of practitioners before finding the ‘right’ one. Many were concerned about the knowledge and experience level of some practitioners. The major themes linked to reported satisfaction included the quality of the practitioner-patient relationship, time for discussion and being listened to, knowledge and skills of the practitioner and the opportunity to participate in their own healthcare. These are similar themes to those found in a study of holistic medical practitioners in the US (Davis-Floyd et al. 1994).

Thus, overall, the literature suggested that consultations with herbalist/naturopaths were undertaken by a broad spectrum of Australian society, perhaps broader than for CAM use in general. At the same time many patients continued to seek medical care. The implication is that patients are not neglecting their medical care, a primary concern expressed for those people with serious health complaints, but are rather seeking herbal medicine to fill perceived gaps in mainstream care. However, concurrent use was more likely amongst those with serious conditions and herbal use was not being routinely reported to medical practice.
2.2.2 The WHM profession

The ATMS and NHAA surveys provided key descriptive data about the Australian WHM and naturopathic workforce (see Table 2-3). Bensoussan (2004b) reported a considerable degree of overlap between the two professions because most respondents identified more than one job title to describe their practice: Hale (2003) reported 63% of naturopaths also have accreditation in WHM; and Bensoussan et al. (2004b) reported that 76% of respondents used more than one title (62% described themselves as naturopaths and 76% as herbalists). As described in Chapter 1, WHM is a modality practiced by most naturopaths in Australia but is also practiced as a stand-alone system of medicine by practitioners who identify themselves by the title herbalist.

2.2.2.1 Demographics

As shown in Table 2-3 (over page), the larger proportion of the WHM and naturopathic workforce is female (75% of the population) and of mid (range 35-45) to mature age (range 46-55). The majority reside in NSW and those from across Australia are predominantly located in metropolitan regions. The larger proportion of the respondents reported practising as solo practitioners and many work part-time.

Clinical experience as measured by years in practice was estimated to be about seven (7) years on average (6.7, SD 6.1) in the NHAA survey, and 64% of the respondents of the ATMS survey are reportedly within the first ten years of practice (39%, 1-5 years; 25% 6-10, years). The workforce surveys indicated within the herbal/naturopathic professions a wide range of education in terms of both the length (6 months to 6 years) and nature of qualifications. Most practitioners reported attaining diploma level qualifications and a small proportion have obtained bachelor degree qualifications. A smaller number of postgraduate and mainstream healthcare qualifications including mainstream medicine were also reported (11%) (Bensoussan et al. 2004b).
<table>
<thead>
<tr>
<th>Variable</th>
<th>ATMS survey</th>
<th>NHAA survey</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Category, %</td>
<td>Average (SD)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Female, 73.4</td>
<td>Female, 76.0%</td>
<td>Majority female</td>
</tr>
<tr>
<td>Age (years)</td>
<td>36-45, 30.4</td>
<td>44 (SD 10.4)</td>
<td>Majority in mid aged category</td>
</tr>
<tr>
<td></td>
<td>46-55, 29.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td>Diploma, 65.5</td>
<td>Not reported</td>
<td>Majority diploma level</td>
</tr>
<tr>
<td></td>
<td>Adv. Diploma, 15.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Degree, 10.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in training</td>
<td>≤ 2, 12</td>
<td>Average 3.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3, 28</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>≥4, 60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in practice</td>
<td>1-5, 40.4</td>
<td>6.7 (SD 6.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6-10, 22.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; 11, 37.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultations/</td>
<td>18</td>
<td>22</td>
<td>On average = 20 a week</td>
</tr>
<tr>
<td>week</td>
<td>1-45</td>
<td>1- 250</td>
<td></td>
</tr>
<tr>
<td>Total for cohort/</td>
<td>1 529 568</td>
<td>1 900 980</td>
<td>Estimated consults &gt; 1.5 million/ year</td>
</tr>
<tr>
<td>year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic</td>
<td>NSW*, 44.5</td>
<td>Graph provided</td>
<td>Majority in NSW and in metropolitan</td>
</tr>
<tr>
<td>Location</td>
<td>Victoria, 21.4</td>
<td>showing similar</td>
<td>locations</td>
</tr>
<tr>
<td></td>
<td>Queensland, 17.0</td>
<td>distribution</td>
<td></td>
</tr>
</tbody>
</table>

Source: Hale 2003; Bensoussan et al. 2004b; * NSW - New South Wales
Overall, these findings are consistent with studies overseas, which have consistently found that the length and standard of training amongst CAM professions is varied (British Medical Association 1993; Cant et al. 1996; McCabe 2005d). In the UK, studies of various CAM professions have suggested that, irrespective of the quality of their training, the clinical experience of CAM practitioners is often somewhat limited (Fulder et al. 1982; Sharma 1992; British Medical Association 1993).

2.2.2.2 Consultation rates

The data from both the ATMS and the NHAA surveys estimated large numbers of consultations conducted per year by their membership. The ATMS survey reported just over 1.5 million annually (an average of 18 per week) and the NHAA survey approximately 1.9 million annually (an average of 22 per week). Bensoussan et al. (2004b) estimated a turnover of $AUS85 million per year in combined naturopathy and WHM consultations in Australia (excluding the cost of medicines).

On the other hand most of the respondents to the ATMS survey indicated that they would prefer to have a greater number of consultations per week. Hale (2003) reported that the majority of practitioners earned less than $AUS30-50000 per annum, many were working part-time, and some of respondents had reported experiencing financial difficulties. Observations of financial insecurity amongst various CAM professions are not uncommon in the literature (Sharma 1992; Andrews et al. 2005).

Another inconsistency is that, although the ATMS population was almost three times larger than the NHAA survey cohort, it reported a lower number of consultations across its membership. It may be that the NHAA estimate has been artificially inflated because it reported a very wide range of 1 to 250 consultations per week. The high range outlier values may have skewed the
data and increased the reported mean. More specifically, potential problems associated with the workforce studies, which relied upon practitioner responses, may be those of both recall bias and/or the potential for inflated reporting of consultation rates.

Bensoussan et al. (2004b) concluded from their research that the herbal/naturopathy professions make up a large proportion of the Australian healthcare sector. This conclusion is not necessarily supported by the data from Hale (2003) or the data from the CAM consumption surveys, which suggested that herbal medicine and naturopathy was a small proportion of Australian CAM consumption (see section 2.2.1.1).

2.2.2.3 Intra-professional issues

The NHAA survey provided some rudimentary data regarding respondents’ attitudes about their professional status. The study reported that, overall, the practitioners perceived changes in professional status, standards of education, access to research infrastructure, practitioner income, postgraduate education, access to scheduled herbs and products, quality of herbs and products, and definitions of occupational boundaries to be positive. Respondents were not sure of the potential impact of the statutory regulation or medical influence on the profession or their practice (Bensoussan et al. 2004b). Hence, the study described positive perceptions but there was little further substantive detail provided.

The NHAA survey reported that a majority of herbalists/naturopaths were satisfied that their training was either adequate or good in its ability to prepare them for professional practice. However, one aspect of training reported to be unsatisfactory was in the area of inter-professional communications. The ATMS survey had reported similar levels of satisfaction with clinical training but, also, that training did not prepare practitioners to run a business.
Another issue of interest was that despite the predominantly female work force overall, men earned more than women, carried out proportionately more consultations than women, and were in clinical practice proportionately longer (Hale 2003). This is, however, similar to contemporary patterns observed throughout the Australian health workforce in general (Australian Institute of Health and Welfare 2002).

2.2.2.4 Inter-professional relationships

Bensoussan et al. (2004b) argued that the NHAA survey data points to an increasing degree of integration of WHM/naturopathy with the mainstream healthcare sector. They point out that over 30% (Hale reported 23%) practise within a multidisciplinary healthcare facility and that 11% of NHAA/ANTA members are qualified in a mainstream healthcare discipline, including general practice, medical specialty, physiotherapy, pharmacy or nursing. However, the same study had reported that, although herbalists refer to medical practitioners, they do not often receive referrals themselves: 73% of herbalists/naturopaths refer to medical practitioners on occasion, but only 8% received reciprocal referrals for half or more of their patients (Bensoussan et al. 2004b). Furthermore, about 44% of the NHAA survey respondents reported feeling inadequately prepared for inter-professional communications (Bensoussan et al. 2004b).

Australian data reporting referral rates and inter-professional communications suggested that relationships between herbalists and the medical practitioners are not well developed. In the DHS review, Australian general practitioners (GPs) were sampled to understand their attitudes towards CAM (Cohen et al. 2005). Many respondents reported concerns about adverse events related to CAM and the perception that herbal medicines could be occasionally harmful. The majority agreed that massage and acupuncture were effective and would refer for such services. However, most reported they did not consider naturopathy (71%) or homoeopathy (83%) to be effective and the common
reasons provided for such perceptions included: wrong diagnosis, allergic reactions, drug interactions and profit motive from selling products to be overriding clinical judgement. The GPs indicated observing one adverse reaction resulting from CAM therapies for every 125 GP consultations. Nonetheless, 51% of these GPs reported an interest in practising herbal medicine (53% in vitamin and mineral therapy) but that their training was limited in scope, predominantly involving introductory workshops and self-education.

These findings are consistent with UK data, which reported that concurrent treatment occurred between herbalists and medical practice; nevertheless, patients were rarely referred by GPs and patients rarely informed their GP of herbal treatment (British Medical Association 1993). The BMA (1993) also reported that, although herbalists refer to GPs, they do not often receive referral themselves. In addition, as described above, the majority of herbal/naturopathic patients (23%) from the Victorian consumer study indicated that they were self-referred (only 5% were referred by GPs) and many reported perceptions of poor inter-professional relationships (Hill et al. 2005).

Although the research reviewed has not explicitly addressed the issue, these studies seemed to suggest that inter-professional relations between medical practitioners and herbalists are not well developed. At the same time these data indicated a strong degree of interest by the medical profession in practicing herbal medicine themselves.

2.2.3 The practice of WHM

As described in Chapter 1, currently most understandings of WHM practice are inferred from textbooks of herbal prescribing. There is an extensive body of clinically orientated research on herbal medicines but there has been very little
empirical investigation about the practice of WHM, particularly from the perspective of the traditional herbalist. Essentially, the form and content of WHM practice remains undocumented.

2.2.3.1 Clinical activities

The BMA study produced, perhaps, the first indication of the clinical activities of herbalists (British Medical Association 1993). The findings as recorded in the report are reproduced in Table 2-4. As can be seen, the data is not extensive, although it does give brief information about conditions treated and an indication that inter-professional relationships are not well developed. In Australia the data about the clinical practice of WHM is not much more detailed.

<table>
<thead>
<tr>
<th>Practice</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conditions treated</strong></td>
<td>Mainly chronic, some acute</td>
</tr>
<tr>
<td></td>
<td>Typically – atopic, digestive, arthritic, gynaecological, and skin conditions; stress, migraines, etc. and chronic infections</td>
</tr>
<tr>
<td><strong>Methods</strong></td>
<td>Consultation on herbal medicine</td>
</tr>
<tr>
<td><strong>Patient’s GP informed of treatment</strong></td>
<td>Not Routinely</td>
</tr>
<tr>
<td><strong>Referral by GP</strong></td>
<td>Rarely</td>
</tr>
<tr>
<td><strong>Concurrent Treatment</strong></td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Table 2-4** National Institute of Medical Herbalists (n=300)

Source: British Medical Association (1993 p. 96)
In addition to these data, the NHAA survey indicated that herbalists/naturopaths used a wide range of diagnostic tests, both conventional and non-conventional. Grace et al. (2006) also reported high frequency of training in and use of medical diagnostic and physical examination techniques in addition to naturopathic case history taking, iris diagnosis; and face, tongue and nail diagnosis amongst the ATMS and ANTA respondents. The authors concluded that, despite the reported high frequency of training in and use in both medical and CAM diagnostic techniques, many respondents reported a lack of confidence in identifying patients requiring referral.

2.2.3.2 Herbal prescribing

The extensive literature review revealed one survey that focussed on herbal prescribing by professional herbalists (Barnes et al. 1998). Reporting a UK survey, this work aimed to determine the types of conditions that herbalists treated and the most common prescriptions for these conditions in order to establish a research agenda for clinical trials. Herbalists were asked to nominate the herb/s used by themselves for the most common conditions treated. The findings indicated that most herbalists use several herbs, often in combination, to treat a particular condition/symptom. Most herbs nominated were traditionally used and rated by herbalists as being both safe and effective. Unfortunately, the survey elicited potentially unreliable data because of a poor response rate (n=62, 19%).

The ATMS survey did not collect data regarding prescribing habits. The NHAA survey indicated that approximately half of herbalists/naturopaths dispensed herbal medicines in their own clinics using standardised source material provided by suppliers. The NHAA survey data showed that it was nutritional supplements that herbalists and naturopaths dispensed as over-the-counter supplements, while herbal medicines were predominantly individually mixed and dispensed.
2.2.3.2.1 Adverse reactions

The NHAA survey showed that practitioners report the incidence of one serious adverse reaction every 11 months (2.3 per 1000 consultations). Within the ATMS survey cohort, 17% reported adverse reactions of which a small number required a referral to a medical practitioner. Typical reactions reported included skin reactions, headaches/dizziness and nausea or digestive problems, but also included some severe symptoms such as gastrointestinal reactions, palpitations and hepatotoxicity (Hale 2003; Bensoussan et al. 2004b).

Hale (2003), after analysing the pattern of reporting adverse reactions, noted a large disproportionate number (69%) amongst the more recent graduates (previous four years) and amongst those with a Bachelor qualification. The study author concluded that more recent graduates of naturopathy or herbal medicine (particularly the sub-set of university graduates) were more likely to ‘medicalise’ client reactions. On the other hand many respondents to the ATMS survey made comments about the validity of the questions regarding adverse reactions. Hale (2003) reported comments from many respondents questioning the definition of an adverse reaction and indicating that such reactions may be interpreted as ‘detoxification’, ‘emotional releases’ or ‘a legitimate aspect of the healing process’, and that reporting is not as simple as for conventional medicine.

2.2.3.2.2 Conditions treated

The BMA (1993) reported that herbalists mainly treat chronic conditions, most typically: digestive conditions, arthritic conditions, gynaecological conditions, skin conditions, stress, migraines, and chronic infections or atopic conditions. Barnes (1998) reported the top five conditions treated by herbalists included pre-menstrual syndrome/tension, Irritable Bowel Syndrome, menopausal symptoms, eczema and arthritis. These findings are consistent with the data reported in Australia by herbal/naturopathy clientele. Hill et al. (2005) reported
that 78% of patients received treatment for chronic conditions and that people with psychological, gynaecological and endocrine disorders were the most common for seeking treatment.

### 2.3 Discussion

Within the last two decades there has been a significant growth in the volume of CAM literature. The review found that the vast majority of this literature has been descriptive, mostly cross-sectional, non-standardised survey studies with a much smaller body of qualitative analysis. The quantitative approach to CAM research has, in the main, focussed on determining the patterns of CAM consumption in localised or clinical populations. At present, most of the quantitative data about herbal medicine has been collected as an element of generalised CAM surveys.

The imprecision of the definition of CAM remains a persistent criticism of CAM survey research (Harris et al. 2000; Wootton et al. 2001; Bodeker et al. 2002; Ernst 2006). A systematic review of the international CAM consumption literature (confined to survey studies with rigorous designs: e.g. the study described survey methods or contained sufficient sample sizes to calculate prevalence estimates and confidence intervals) concluded that CAM is used by substantial proportions of the general population world-wide, but that inconsistencies in study design and various methodological limitations make it difficult to compare prevalence estimates both within and between countries (Harris et al. 2000). Thus, a general problem with the literature has been that the scope of CAM has made it difficult to compare results across the body of research.

Most Australian CAM surveys have been regionally based, focussed upon clinical populations and characterised by small sample numbers. However, a number of robust studies indicating the prevalence of CAM amongst the general
population and specifying visits to CAM therapists were identified and discussed in the review. These studies indicated that use of CAM is extensive and that herbal medicine has become increasingly popular amongst healthcare consumers. They also suggested that CAM expenditure may not necessarily have translated into high levels of visits to herbalists.

Thus, it was possible to conclude that CAM is used by a large proportion of the Australian adult population. However, a comparative review of the CAM consumption studies was problematic because of differences in the sample population characteristics and the different type and number of therapies examined (see Table 2-1). The data specific to WHM practice remains underdeveloped.

The CAM consumer literature indicated that herbal/naturopathy patients were seeking holistic healthcare, treatment of chronic conditions, mitigation of side-effects from pharmaceuticals, and maintenance of well-being. Most consumers seem to invest money in consultations with a herbalist/naturopath when they have poor health that has not responded to mainstream treatment. Given the prevalence of consultations in Australia with herbalists/naturopaths among women with cancer and amongst the elderly, the collection of data about WHM including data about herbal prescriptions and the diagnostic and inter-professional practices of herbalists assumes a greater imperative.

The importance of determining common clinical presentations and the use of herbs in order to establish a research agenda for clinical trials have been stressed (Barnes et al. 1998). Further research questions in this area that need to be addressed include those such as: What conditions are herbalists treating and what medicines are they prescribing? What do they perceive as the efficacy of their treatments? What do they perceive as the rationale for patients’ visits? How do they perceive their relationships with allied care professionals, as well
as medical practitioners? At what point does the herbalist consider it necessary to refer a patient or, alternatively, if patients are being referred to the herbalist, for what reasons and by whom?

Despite the potential for overlapping care between medical and herbal practice, the literature indicated that communication between CAM therapists and medical practitioners remains poor. It has been argued that poor relationships often appear to have their roots in misalignments over the criteria by which treatments and CAM therapies are judged to be effective (Tovey et al. 2004; Andrews et al. 2005; Hirschkorn et al. 2005). At present little of the practice of WHM is understood outside of the profession and, therefore, the criteria of judgment cannot be based upon accurate data.

If medical practitioners are increasingly being required to coordinate and advise patients with regard to herbal medicines, they may require increased familiarisation with not only potential drug-herb interactions but the diagnostic, prescribing and inter-professional practises of herbalists. Furthermore, if consumption trends continue, then both herbalists/naturopaths and GPs will increasingly require information so they can avoid potential treatment interactions and can maintain safety standards for their patients. Improved knowledge of clinical practices such as morbidity data, of professional herbalists has both intra- and inter-professional implications.

Significantly, GPs have indicated that the harmfulness of CAM was mostly related to scope of practice rather than the specific risks of the therapies themselves: for example, attempts to make a medical diagnosis that may be incorrect, delayed or inadequate (Cohen et al. 2005). What, then, do herbalists perceive as the scope of their clinical practice? The individual herbalist’s perceptions of scope of practice will influence diagnosis decisions, treatment options and prescriptions and, in turn, these perceptions will influence inter-
professional relationships and, ultimately, patient management and care. This is an area of investigation that remains under-researched.

The ATMS and NHAA surveys have provided some of the first insights about the WHM and naturopathic workforce in Australia. These workforce studies provided demographic data that indicated that the herbal/naturopathic professional reflects the profile of most CAM users: predominantly female of mid-age. These professions are diverse in terms of education and clinical experience. The high level of diploma level qualifications suggests that the education of professions in Australia continues to be largely centred outside the university system. Currently, little is known about how existing educational arrangements are preparing practitioners for clinical practice, the experiences of graduates upon moving from an educational to a clinical environment, or about their need for on-going support or training to ensure that they are able to meet the needs and demands of their patients.

The DHS (2005) review contributed an extensive review of the WHM and naturopathy professions in Australia. Within the review, however, WHM and naturopathy were not subject to fresh empirical investigation from the perspective of the herbalist. Qualitative studies were undertaken, but provided the perspective of the consumer and the medical practitioner. The herbal/naturopathic profession’s perspective was represented by the descriptive quantitative data of the NHAA survey. In this manner the review followed the general trends observed in CAM research that have predominantly focussed upon the consumer and the medical profession.

Several of the published studies acknowledged the difficulties of collecting data from herbalists/naturopaths when the research questions did not match the paradigms of herbal practice (Harris et al. 2000). Barnes et al. (1998) acknowledged that their questionnaire was unsuccessful, eliciting a low
response rate of 19.6% because of poor content validity. The survey questions were framed in terms of the mainstream medical model and did not match the Holistic paradigms of herbal practice. The authors concluded that British herbalists, unlike those in Germany, ‘have little interest in rational Phytotherapy’ (Barnes et al. 1998. p370). It is unclear from the workforce surveys as to what extent herbalists in Australia may have adopted phytotherapeutic principles. However, the increasing level of reporting of adverse events reported by Hale (2003) does seem to indicate a degree of rationalisation of WHM and naturopathic practice. Research about herbal practice undertaken from the perspective of the herbalists seems warranted.

The thesis survey (see Section 3.2) was designed to fill the gaps identified in the literature and investigate important aspects of current approaches to WHM practice. It aims to collect information about measures of clinical practice including consultation activities and diagnostic practices; about herbal medicinal use, including aspects of prescription, formulation, dispensing, and preparation forms of medicines used and dosages; details about herbal clientele, including common conditions treated and motivations for consultations; and attitudes about professional relationships.

There is also a need for further research to provide in-depth examination of WHM practice, including understanding approaches to clinical practice and herbal prescribing, and about the patients and problems seen by WHM practitioners. Furthermore, as yet the perspectives, experiences and opinions of the herbalists about their philosophy, their scope of practice, their clinical skills, and their approach to prescribing herbal medicines are not well documented in the CAM literature. Additional qualitative research with herbalists would potentially reflect the actual dynamics of clinical practice and their perceptions of the impact of mainstreaming on WHM.
It has been argued that the trend towards CAM by the general public is likely to continue into the future (Bensoussan et al. 2004a; Coulter et al. 2004). The thesis aims to provide some steps towards addressing the research gaps in this important healthcare area. It provides the first focussed examination of herbalists’ clinical practices and aims to understand the impact of the general popularity of herbal medicines on the WHM profession. The findings from this thesis will make a significant contribution to the growing body of CAM literature, reducing some core evidence gaps regarding herbal practice and providing detailed evidence about WHM practice. The significance of collecting such evidence within the context of mainstreaming lies in assessing WHM’s role in public health, in improving inter-professional relationships, and for stimulating reflective practice within the WHM profession.

2.4 Conclusion

This chapter presented a review of the literature relating to the consumption and provision of WHM in Australia. The literature search identified the enormous growth of the volume of CAM survey literature. To date, the CAM survey research has concentrated on the consumer and provided statistical data of patterns of CAM use and outlining trends concerning determinants of use. On the other hand, the literature describing CAM practice is extremely limited, with that of WHM practice consisting of a small number of survey studies. The quantitative data, as described in this review, examined the trends and patterns of WHM use and practice in Australia. This topic is one area of relative immaturity in terms of existing research and theory. In relation to the opening quote of this thesis little is now known about how the traditional practice of WHM is responding to the modern healthcare environment.

Overall, the review identified that the scope of practice of WHM is not well articulated in the literature. There has been very little investigation about the practice of WHM, especially exploring the perspectives and experiences of the
WHM practitioner. Indeed, none of these studies reviewed involved primary research whereby herbalists were interviewed regarding their opinions and behaviours. Currently, little is known about the modus operandi of WHM practice. There is currently a paucity of research focusing on the internal dynamics of WHM practice and the internal processes operating within the WHM profession. It is against this background that the thesis aims to conduct the first major study of WHM practice in Australia. In the next chapter a detailed presentation of the research methods are presented.
Chapter 3 Methodology

“Mixed methods research: a research paradigm whose time has come”

(Burke Johnson et al. 2004)

Chapter outline

Chapter 3 describes the methodology used to investigate the research problem, including details of the theoretical perspective informing both the mixed methods inquiry and the conceptual framework applied to interpret and explain the study results. The chapter then outlines the research strategy, including details of the postal survey and the in-depth interview methods employed to collect the study data. The aim of the chapter is to demonstrate that appropriate procedures were followed to ensure the methodological integrity of the research process and, thus, the validity and reliability of the research findings.

3.1 Research framework

The investigation was approached from a Pragmatic perspective applying a mixed methods research strategy. The elements of the research inquiry are summarised in Figure 3-1. The following discussion about the research framework describes the use of theory within the thesis and outlines the strategy of inquiry. The discussion does not aim to provide an exhaustive discussion of the theoretical or conceptual context that has informed the research. Only the main assumptions and the salient concepts appropriate to understanding and interpreting the thesis results are outlined.
Figure 3-1 Elements of the research inquiry

<table>
<thead>
<tr>
<th>Knowledge claim</th>
<th>Pragmatism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy of inquiry</td>
<td>Mixed methods (sequential model)</td>
</tr>
<tr>
<td>Theoretical drive</td>
<td>Descriptive</td>
</tr>
<tr>
<td>Methods</td>
<td>Postal questionnaire</td>
</tr>
<tr>
<td>Data analysis</td>
<td>Statistical analysis</td>
</tr>
<tr>
<td>Data interpretation</td>
<td>Conceptual interpretation</td>
</tr>
</tbody>
</table>

Table adapted from Creswell (2003)

3.1.1 Use of theory

The aim of the thesis was to produce practical and applied research applicable to the reflective practice of WHM (Patton 2002). Accordingly, the thesis is informed by a perspective that stresses the primacy of the research problem over methodology (Denscombe 2002; Patton 2002). Pragmatism is not a position that accords primacy to any one research paradigm but allows the researcher to select assumptions appropriate to their purpose from either quantitative or qualitative positions (Cherryholmes 1992; Denscombe 2002; Creswell 2003). Accordingly, from this perspective research methods are chosen that suit the research purpose and then the specific data-collecting techniques are specified (Patton 2002; Morse 2003). Pragmatism, it has been argued, offers an appealing philosophical grounding for mixed methods research (Burke Johnson et al. 2004).

The motivation for the current research was to investigate the practice of WHM in Australia. Many CAM scholars have asserted that CAM practice is better
understood in its broader social context (Sharma 1992; Tovey et al. 2002; Adams et al. 2004; Hirschkorn et al. 2005; Potrata 2005). Therefore, the importance of drawing upon broader health or social science theory to identify relevant sensitising concepts was recognised. In the absence of a framework specific to WHM, the thesis turned to current theoretical contributions within the study of CAM provision to facilitate the interpretation of this research, as well as to relate the dissertation to existing CAM literature.

3.1.2 Conceptual framework

As described in Chapter 1, the analysis employs the concept of mainstreaming (the increasing popularity, acceptance and legitimacy of CAM within the dominant healthcare structures) to explore the response of WHM to the changing role of CAM within mainstream healthcare. In this thesis, mainstreaming is interpreted as an active social process in which the boundaries between CAM and mainstream healthcare are shifting and is a concept that implies the dominance of the mainstream medical paradigm. In Chapter 1, the notion that mainstreaming is a complex phenomenon that is occurring at the expense of the various CAM professions was introduced.

In spite of what has been described as an ‘explosion of literature’ about CAM (Hirschkorn et al. 2005) there has been only a small amount of theoretical development for explaining the mainstreaming of CAM, particularly its impact upon the CAM professions. Most research on CAM provision has predominantly focused on the medical practitioners’ perspectives (Hirschkorn et al. 2005). Many scholars have highlighted the necessity not only to broaden the perspectives from which CAM research is conducted but also emphasised the need to develop explanatory concepts in CAM (Sharma 1992; Tovey et al. 2002; Adams et al. 2004; Hirschkorn et al. 2005).
The small body of conceptual work that has investigated the CAM professions has been predominantly informed by professionalisation theories (Saks 1995; Cant et al. 1996; Saks 1996; Cant et al. 1998; Boon et al. 2004; Welsh et al. 2004; O'Sullivan 2005). This approach has been useful for explaining the growing legitimization of certain CAM professions within mainstream healthcare structures (Boon et al. 2004; O'Sullivan 2005). For example, Boon et al. (2004) utilised the concept of *social closure* to explain this process for the naturopathic profession in Canada. Social closure ‘refers to the process by which occupational groups are able to regulate market conditions in their favour in face of competition from outsiders by limiting access to restricted groups of eligibles, enabling them to effectively monopolize available opportunities’ (Saks 1998: quoted in Boon 2004 p.124).

Conversely, social closure is potentially useful in explaining the dilemmas encountered by the Australian WHM profession in achieving similar goals of legitimacy. However, such an approach does not fully account for the broader social processes accompanying the extension of CAM mainstreaming. Tovey and Adams argue that the challenges of CAM are mediated at the level of the individual as well as the profession and offer a conceptual framework through which the broader study of mainstreaming can be streamlined (Tovey et al. 2002; Adams et al. 2004).

This thesis builds upon the Tovey and Adams work by examining the relevance of their framework to the study of the WHM profession in Australia. Importantly, the focus of this thesis was different to that of Tovey and Adams, whose research has concentrated upon healthcare professions that are part of the mainstream establishment. The work of Tovey and Adams has been directed towards understanding the integrative practice of CAM by the medical and the nursing profession. In contrast, this investigation provides the perspective of a healthcare profession which occupies a role outside of mainstream healthcare.
The Tovey and Adams framework has been employed pragmatically to focus the investigation and ensure a consistent and coherent explanation of the mixed methods results. It must be remembered that the aim of the thesis was to generate practical and applied research for the purposes of the reflective practice of WHM. The following section outlines how the framework has informed the mixed methods research and the interpretation of the data.

3.1.2.1 The social theoretical framework

The Tovey and Adams framework fundamentally draws upon Social Worlds Theory (SWT) (Tovey et al. 2001; Tovey et al. 2002; Adams et al. 2004). SWT views social boundaries as the product of ongoing struggles between different and often competing social worlds (groups, professions etc.). Within SWT the potential for intersecting social worlds, such as CAM and the mainstream, is described as either: (1) strong intersection - where worlds share a concern for similar territory and build alliances, networks and collaborative ties in order to make a new sub-world possible; or (2) weak intersection - in which a world may trespass into the domain of an associated world and adopt knowledge or practices with no intention of cooperating (Tovey et al. 2001; Tovey et al. 2002).

The Tovey and Adams framework assumes a thesis of medical dominance and, therefore, the intersection between CAM and the mainstream is an example of weak intersection. A primary process operating between CAM and the mainstream is one of appropriation. Appropriation is defined as the adoption of activities, styles and technologies that are traditionally associated with a competing social world. Tovey and Adams set out three broad themes, as well as sub-issues, upon which the study of the processes operating at the shifting intersection between the WHM profession and the mainstream may be focussed: (1) professional/non-professional; (2) inter-professional; and (3) intra-professional.
3.1.2.1.1 Professional/non-professional processes

These are the processes that are occurring at the point at which CAM professionals interact with the mainstream. The framework outlines the intersection between the professional/patient and the more formal profession/public health intersection. At the public healthcare level, Tovey and Adams highlight how the existing political agendas within prevailing healthcare structures as a result of the continuing dominance of the medical paradigm have resulted in inequality of access to CAM services. At the point of professional/patient intersection, the authors postulate that public perceptions about healthcare can potentially challenge existing professional models of practice. In particular, it describes how patients may influence a healthcare professional’s decision making in relation to how they approach clinical practice. Little is known about what the impact of such processes has been upon WHM practice or WHM practitioners in Australia.

3.1.2.1.2 Inter-professional processes

Inter-professional processes are those operating at the point of intersection between different professional groups. The primary inter-professional relationship of interest within this thesis was that between the WHM profession and the medical profession. Tovey and Adams argue that the subordination of CAM to medical practice remains a recurring theme in CAM literature and is an issue strongly impacting upon CAM processes. Tovey and Adams empirical work has described the increasing appropriation of CAM by various mainstream healthcare professions (Adams et al. 2001; Tovey et al. 2003).

In Chapter 1, appropriation of CAM through integrative practice was described using the concept of co-option. Co-option in relation to healthcare practice has been defined as the process by which one profession embraces within their scope of practice techniques or treatments that were originally developed or practiced by another profession (Boon et al. 2004). Boon et al (2004) have argued that a key strategy of the CAM professions to protect their scope of
practice from co-option by medical profession is through achieving statutory regulation. The salience of statutory regulation for the WHM profession is explored within the qualitative study.

3.1.2.1.3 Intra-professional processes

Moving beyond a simple dualism of one profession versus another, the framework contends that professions themselves are characterised by a number of competing sub-groups who advocate different perspectives, gather around particular ‘shared philosophies’ and utilise ‘particular technologies’ within clinical practice – a process is termed internal contestation (Adams et al. 2004).

The framework postulates that the predominance of any one perspective will depend upon sub-groups being able to convince others in the profession of the legitimacy of their practices through various authentication processes. Legitimacy was defined as ‘the process whereby the value and worth of objects, technologies and members in a world are constantly evaluated and revaluated’; and authentication is described as an inter-related process by which individual professionals or sub-groups advocate their particular perspective/s (Adams et al. 2004 p. 161).

The process of internal contestation provides a useful vehicle for explaining the rationale for the current approaches to WHM practice, the potential of different approaches to practice within WHM and how sub-groups within the WHM profession may be reacting to the pressures of mainstreaming. Moreover, if WHM practice is in a relationship of weak intersection with the mainstream, it is arguable that the WHM profession will also be engaged in trying to both legitimate and authenticate WHM to those outside the profession. As described in Chapter 1, a key strategy of CAM professions seeking to gain legitimate status within mainstream healthcare has been the increased adoption of
medical sciences into their knowledge base (Welsh et al. 2004). The salience of science within WHM is of key interest within the research.

3.1.2.2 Implications for research design

Tovey and Adams highlight how there is little baseline data in terms of practitioner/patient processes, but such information is fundamental to establishing a better understanding of CAM practice. Accordingly, Tovey and Adams recommend the collection of rudimentary data about the key aspects of CAM practice and recommend large statistical surveys augmented by in-depth explorations of patient and/or practitioner behaviours and perceptions.

As demonstrated in Chapter 2, there has been very little empirical investigation about the practice of WHM. The core features of the WHM model of practice, WHM practitioners’ approaches to prescribing and the patients and problems seen by WHM practitioners, remain undocumented. Therefore, the starting point of research in this thesis was broad, characterised by the collection of baseline descriptive data augmented by explorative qualitative research. In this way the investigation moved toward developing an in-depth exploratory account of WHM practice in its social context.

WHM practice was investigated by describing and exploring what WHM practitioners reported about their practice behaviours and experiences, as well as how they explain their behaviours in terms of their practice philosophy. This included first analysing their responses to a survey questionnaire, supplemented by explorative research of individual practitioner perspectives and experiences of practising WHM in Australia today. The impact of the mainstreaming of CAM on WHM practice, the WHM practitioner and the WHM profession in Australia was investigated by collecting and triangulating both statistical and qualitative data.
Tovey and Adams provide a useful core framework for research into the social processes accompanying the mainstreaming of WHM. Employing the specified framework, the examination of the impact of mainstreaming is directed to the level of the WHM profession, the WHM practitioner and the WHM model of practice. Mainstreaming is interpreted as a social process in which the WHM profession will be actively involved in defining its role as a healthcare profession. At the same time the framework highlights the dominance of the mainstream medical paradigm and, thus, suggests resistance from the mainstream to the presence of the WHM profession within mainstream healthcare structures.

A number of alternative theoretical traditions, such as conflict theory, could potentially have been employed to facilitate an explanation of WHM mainstreaming. The conceptual framework was chosen because of its currency in the sociology of CAM and because it introduces particularly useful theoretical concepts, which have direct application to the research problem at the level of both the individual practitioner and the WHM profession. The framework will be applied to facilitate a consistent explanation of the combined mixed methods data interpretation in Chapter 7.

### 3.1.3 Mixed methods strategy

In Chapter 1, an overview and rationale of the mixed methods strategy was presented. The initial quantitative phase consisted of a national postal survey, which aimed to describe the current approach to WHM practice in Australia. The subsequent qualitative phase consisted of a series of exploratory in-depth interviews with a subset of survey respondents. The data collection occurred over a two-year period.
3.1.3.1 Methodological integrity

Despite its Pragmatic basis, an awareness of the theoretical drive operating at each stage of a mixed methods project was considered important for the methodological integrity of the research (Tashakkori et al. 1998; Maxwell et al. 2003; Morse 2003). Methodological integrity has been as defined as the rigour of the project, maintained by adherence to the assumptions, strategies, data appropriateness and adequacy that are consistent with each particular method (Morse 2003). Therefore, a mixed methods study must independently exhibit methodological integrity at each different phase of the research to claim overall integrity of the research (Creswell 2003; Morse 2003; Punch 2005).

To account for the methodological integrity of the research the thesis adopted an established research model from the literature as its blue print: the sequential exploratory mixed methods model (Morse 2003). The sequential exploratory strategy (depicted in Figure 3-2) is characterised by the collection and analysis of quantitative (quant) data, followed by the collection and analysis of qualitative data; the priority is typically given to the qualitative (QUAL) data, which is noted by the use of capital letters; and the two phases are integrated during the final interpretation phase of the study (Morse 2003).

Sequential mixed methods models are arguably the most straightforward of the predominant models outlined for mixed methods research (Creswell 2003). The clear advantages of any sequential model are that the research phases fall into clear separate stages and it is, therefore, relatively straightforward to implement and manage the data collection processes. In addition, the design features provide for the potential of triangulation of the data (Creswell et al. 2003; Morse 2003). The main weakness of this design is the length of time involved in data collection, data analysis and data presentation with two separate phases (Creswell 2003; Morse 2005a).
Figure 3-2 Mixed methods model

Sequential quant-QUAL Model

<table>
<thead>
<tr>
<th>quant</th>
<th>→</th>
<th>QUAL</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>quant</td>
<td>→</td>
<td>QUAL</td>
<td>→</td>
</tr>
<tr>
<td>Data collection</td>
<td>Data Analysis</td>
<td>Data Collection</td>
<td>Data Analysis</td>
</tr>
</tbody>
</table>

| Postal survey | In-depth interviews | Conceptual analysis |

Table and notation adapted from Morse (2003)

A detailed representation of the research plan indicating the chronology of both the survey and the in-depth interviews is provided at the end of section 3.1 (see Figure 3-3). As can be seen in the figure the first year was predominantly concerned with the national survey, and in the subsequent year the research focus was on the qualitative in-depth interview data collection and analysis.

3.1.4 The sample

The study population consisted of the national membership of the NHAA. At the time of the survey the total membership of the NHAA totalled 1593 members, and of this number 844 members were registered as full members (see Table 3-1 for NHAA membership). The final sampling unit consisted of these 844 fully registered members of the NHAA. The qualitative in-depth interview study consisted of a smaller sub-sample of survey respondents (n=18).
Table 3-1 NHAA Membership at time of the national survey

<table>
<thead>
<tr>
<th>Category</th>
<th>Full</th>
<th>Student</th>
<th>Companion</th>
<th>Corporate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members</td>
<td>844</td>
<td>556</td>
<td>192</td>
<td>1</td>
<td>1593</td>
</tr>
</tbody>
</table>

Source: NHAA Secretariat (Cowper 2003)

3.1.4.1.1 Gaining access to the population

A letter was written and sent to the Board of Directors of the NHAA prior to commencement of the research project to gain permission to conduct the survey. The Board of Directors kindly agreed to allow access to their membership and offered to distribute the survey questionnaire with the association's professional journal, *The Australian Journal of Medical Herbalism* (AJMH). Included in the survey package was an invitation for respondents to participate in subsequent in-depth interviews (these documents are contained in Appendix A).

3.1.4.2 Unit of analysis

Both the quantitative and the qualitative data were framed from the perspectives of the individual WHT. The primary focus of the data collection was on the individual's experiences of WHM practice and identifying similarities and variation across the sample (Patton 2002; Creswell 2003). However, as Patton (2002) argues, an equally legitimate and not mutually exclusive unit of analysis are the shared perspectives of people with common experiences, for example the members of a particular profession such as WHM. In this study, as the data analysis progressed and evolved into categories and themes, the analytical focus shifted from individual accounts of WHM practice to exploring the relationships between WHM practitioners in terms of their shared perspectives as a professional group.
3.1.4.3 Sampling strategies

The quantitative and the qualitative studies sampled from the same population group but used different sampling methods. The survey employed complete enumeration of the population and the qualitative in-depth interview study employed purposive sampling of a sub-set of volunteer survey respondents from NSW. This purposive sampling strategy proved to be a useful pragmatic strategy for collecting data from a regionalised cohort that would represent the national membership of the NHAA. Thus, the purposive sampling offered a degree of control over the representativeness of the interview population of the broader national population.

3.1.4.3.1 Quantitative sampling

The entire sampling frame consisted of less than one thousand members (n=844) and, therefore, the survey questionnaire was mailed to 100% of the population. Duplicate listings were not an issue because the sampling list consisted of a single membership list supplied by the NHAA secretariat. The researcher was therefore confident that the sampling frame was as complete as possible, that there was no bias in the sampling frame and that the membership list was as complete and up-to-date as possible.

The main aim of sampling 100% of the study population was to achieve a representative sample of the national population of the NHAA (Kalton 1983). The literature review had identified fairly low response rates (19-45%) to previous surveys of similar populations in Australia and abroad. Therefore, a strategy of complete enumeration was adopted to maximize the eventual response rate (Denscombe 2003). Although it is often impractical to sample an entire population due to its size or potential inaccessibility, in this case it was not only practical but advantageous to include 100% of the full membership of the NHAA in the survey sample.
3.1.4.3.2 Qualitative sampling

The survey package included a letter offering NHAA members from NSW an opportunity to volunteer to participate in follow-up in-depth interviews. This sampling method, known as volunteer sampling, has been recommended as a strategy to recruit participants who fulfil the sampling criterion (Horrocks et al. 2004). It has also been recommended for application when potential informants are geographically dispersed, as is the membership of the NHAA (Rice et al. 1999).

Participants were purposively selected from this volunteer pool to participate in the in-depth interviews. Purposive sampling involves selecting cases based upon certain dimensions of interest (Appleton et al. 2002). In this case, the research was interested in ensuring participants were selected from different regional locations, both urban and rural, within NSW. The demographic analysis of the survey data had indicated the regional distribution of the NSW respondents. As recommended by Patton (2002), a few cases were selected from each regional area to ensure that the geographical variation amongst the sites was represented in the study. This approach to sampling overcame potential selection bias as the population was deliberately selected to include participants from different regional locations in NSW.

Where a number of volunteers were available in a specified region, participants were chosen to represent the mix of the WHM practitioner characteristics measured in the survey including age, gender and years of experience (Patton 2002). The purposive sampling strategy proved to be a useful pragmatic strategy for collecting data that represented the potential diversity and/or similarities within a geographically dispersed study population (Patton 2002).
3.1.4.4 Limitations and delimitations

The present study does have a number of limitations. While every effort was made to reduce bias, it is necessary to acknowledge the potential limitations inherent in examining the practice of WHM from the perspectives of the WHM practitioner. In such a case, potential personal bias may be due to personal agendas, emotions and politics (Patton 2002). Given the current socio-political CAM climate in Australia, the possibility of hidden agendas or self-serving responses was a reality. On the other hand, the in-depth exploration of individual perceptions was also considered to be a major strength of the qualitative process.

More specifically, potential problems associated with the survey study, which relied upon practitioner responses, may be those of both recall and or response bias. In addition, it is acknowledged that the in-depth interviews involved a retrospective reconstruction of events by participants who may also potentially have provided idealised accounts of their situations. However, the contrast and comparison of data between the quantitative and qualitative sources and between interview participants provided checks for internal validity.

Finally, although the data analysis of each interview participant was constantly checked against the other participants, it must be acknowledged that the themes identified in the qualitative analysis have the potential to reflect the professional background or theoretical preoccupation of the researcher (Bower et al. 2004). In section 3.3 the qualitative methods are detailed to ensure that the research process is as transparent as possible.

The current investigation was bound by certain practical delimitations. In this study the emphasis is on those CAM practitioners who consider themselves professional WHM practitioners. As described earlier, WHM is practiced by many naturopaths. This study is only concerned with WHM and does not
consider the myriad of practices incorporated into naturopathic practice, such as massage therapies, nutritional therapies, energetic healing, Bach flower remedies, aromatherapy, TCM, and Ayurvedic medicine, amongst others. The thesis makes no specific claims to generalise the results to the practice of WHM by naturopaths in Australia.

The survey was restricted to the members of the NHAA. Although the NHAA members have reported very high rate of membership of other CAM associations (Hale 2002b; Bensoussan et al. 2004b), it is unclear whether the findings can be generalised to WHM practitioners who are members of professional associations other than the NHAA. The thesis does not attempt to extend the findings of the survey research beyond the study population. No claims for significance of the survey results beyond the above delimitations will be made.

In terms of the qualitative research, the participants were selected only from those NHAA members practising in NSW. However, the strength of the mixed methods design employed ensured that the profile of the NSW sample could be matched against the data from the national population in the survey. It proved possible to establish statistically that the sub-population in the qualitative study was representative of WHTs from the other states of Australia. Thus, the results of the qualitative data can arguably be generalised to the entire study population.

3.1.5 Conclusion

By adopting this research framework the thesis aims to generate practical and useful knowledge but methodologically sound data for the reflective practice of WHM in Australia.
**Figure 3-3** Visual representation of the mixed methods research strategy

<table>
<thead>
<tr>
<th>Preliminary Phase</th>
<th>Informal in-depth interviews</th>
<th>6 key industry informants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Literature review</td>
<td>Attendance industry seminars and conferences</td>
</tr>
<tr>
<td></td>
<td>Participant observation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase 1 Quantitative</th>
<th>Year 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Instrument development</td>
<td>Identify survey questions</td>
<td>56 items including demographic, attitudinal and practice descriptor variables</td>
</tr>
<tr>
<td></td>
<td>Pilot Test: 3 stages</td>
<td>Expert panel (peer evaluation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Full members of the NHAA (n=4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Final year herbal therapies students from Newcastle University (n=15)</td>
</tr>
<tr>
<td></td>
<td>Formal Review of survey</td>
<td>Secretary of NHAA and ATMS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Board of Directors of the NHAA</td>
</tr>
<tr>
<td>2. Distribute survey</td>
<td>Administer to survey population</td>
<td>844 individuals</td>
</tr>
<tr>
<td>3. Data analysis</td>
<td>Statistical analysis using SPSS (V14)</td>
<td>Descriptive statistics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Categorical analysis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase 2 Qualitative</th>
<th>Year 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Data collection</td>
<td>Semi-structured in-depth interviews</td>
<td>Purposively selected participants practising WHM in NSW (n=18)</td>
</tr>
<tr>
<td></td>
<td>Transcription of interviews</td>
<td></td>
</tr>
<tr>
<td>2. Data analysis</td>
<td>Text analysis using QSR N-Vivo (V6 &amp; 7)</td>
<td>Coding of data; Mapping to survey data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Topic coding then thematic analysis</td>
</tr>
<tr>
<td>3. Findings</td>
<td>Development of themes from data</td>
<td>Writing results</td>
</tr>
</tbody>
</table>

**Combined data interpretation**
Corroboration of significant findings identified from survey with themes identified from interviews

**Combined analysis using a conceptual framework**

Diagram adapted from Creswell, Clark, Gutmann & Hanson (2003)
3.2 Quantitative survey methods

The objective of the postal survey was to describe the Australian WHM profession and their approach to WHM practice. This general research objective was translated into five specific research objectives:

1. To describe the characteristics of the Australian WHM profession;
2. To describe the current approach to the clinical practice of WHM;
3. To describe the characteristics of WHM prescribing;
4. To describe the clientele of the WHM profession;
5. To describe key features of the WHM profession’s inter and intra-professional relationships.

The survey collected both behavioural and attitudinal data from WHM practitioners. In addition, demographic data was necessary to describe the WHM profession, to test possible relationships within the profession, and to test the external validity of the survey data.

3.2.1 Questionnaire development

No pre-existing validated instrument that matched the survey research objective was available and it was, therefore, necessary to develop a survey questionnaire suitable for describing WHM practice in Australia. The questionnaire development was undertaken in consultation with the NHAA. At various stages in the development process the draft questionnaire was returned to NHAA for discussion and evaluation. A summary of the steps involved in developing the questionnaire are provided in Table 3-2.
Table 3-2 Checklist for developing a new questionnaire

- Define survey objectives
- Decide on data to be collected
- Search literature for existing questionnaires
- Conduct preliminary interviews with industry experts
- Compile new and existing questions in logical order
- Group questions into topics and order in a logical flow
- Decide whether to use categories or scales for replies
- Reach a consensus with colleagues and experts
- Simplify the wording and shorten as far as possible
- Decide on coding schedule
- Conduct a pilot study
- Refine the questions and the formatting as often as necessary
- Establish validity

Source: Checklist adapted from Peat (2001)

3.2.1.1 Generating questions

Informed by the five survey objectives, a list of the information requirements was generated using a number of recommended techniques including: the literature review, informal participant observation\(^\text{10}\), and a series of preliminary interviews (n=6) with herbal industry experts\(^\text{11}\) (Cartwright 1983; Jackson et al. 2000). These interviews were undertaken to help identify issues of currency and of particular relevance to the WHM community that were not apparent in the

\(^{10}\) The researcher attended numerous industry seminars or events and subscribed to various key herbal practitioner mailing lists during the period of the research development.

\(^{11}\) Interview participants included: Ann Cowper (Secretary of the NHAA); Raymond Khoury (Head of Herbal Medicine ATMS); Rod Brennan (Principle of Nature Care College of Traditional Medicine); Jody Haywood (Director of Studies Nature Care College of Traditional Medicine); Doug Stuart (Convenor Bachelor of Herbal Therapies, Newcastle University); Dennis Stewart (Director of Southern Cross School of Herbal Medicine).
literature. In addition, the initial interviewees participated at various stages of
the survey design process providing expert comment to help guarantee the
content validity of the survey. This approach is a common strategy in the initial
stages of survey development (Peat et al. 2001).

For each of the five survey objectives, a pool of survey questions larger than
ultimately needed was generated. Within each topic area the potential questions
were ordered into a logical sequence and decisions about which questions to
discard and whether to use categories or scales for replies were made. The
question wording was kept simple, where possible, but certain professional
terms were of necessity included. All such terminology was verified for clarity
and meaning during the pilot phases of the survey development. The number of
questions was continually refined through successive stages of evaluation.

The first draft of the questionnaire was submitted to a number of colleagues and
experts for appraisal of content validity, wording and potential ambiguity of the
wording of the questions. This overall process has been well documented in the
literature for the design of survey questionnaires (Roberts et al. 1998; Peat et
al. 2001; Punch 2003; Richardson 2005). Below, the specific details of the
questionnaire design and evaluation are provided.

3.2.1.2 Question structure

The survey was structured to ensure it was practical, logical and easy to use
from the respondents’ perspective. The demographic items did not solicit
sensitive data such as income. A judgment was made that ordering questions
about herbal prescribing early in the questionnaire would potentially engage the
interest of the respondents before collecting more sensitive attitudinal data
about their professional responsibilities and relationships. In addition the survey
instrument was designed to be as brief and as clear-cut as possible to minimise
potential misinterpretations of the questions, as well as data recording errors by
the respondents and, thus, reduce the number of missing data items (Peat et al. 2001).

In order to manage potential measurement error and ensure the data was easy to process and analyse, it was decided to standardise the range of responses to most of the survey questions. The majority of the survey questions were presented in a list format requiring respondents to choose one category; other questions invited respondents to select multiple categories. Most questions included the possibility to nominate ‘other’ responses if desired. The provision of a blank space was to enable respondents to provide additional rich textual data, which could provide potential hints about issues of importance to respondents (Morse et al. 1995; Roberts et al. 1998; Creswell 2003; Punch 2003).

Finally, certain rating scales were incorporated to collect attitudinal data. Measuring attitudes and opinions is arguably more complex than describing behaviours (Veal 2005). However, there are many established practices and, in addition to analysing the open ended responses, attitudes towards specific issues were measured using dichotomous scales (yes/no) and Likert scales (Punch 2003). The survey included either four- or five point scales as recommended by Punch (2003).

1. Demographic items

The demographic items included measures of age, gender and highest educational qualification in herbal medicine, whether this was obtained at a private college or university, and levels of clinical experience measured as years in practice.
2. Clinical practice behaviour and attitudinal items

A set of questions to describe the key features of WHM clinical practice, including typical length and activities of a consultation and the average number of consultations per week, were included. Further questions were asked about the clinical services offered within WHM practice including the availability of a herbal dispensary, special equipment and practice specialities, if any. Data was also collected to describe diagnostic practices and WHTs’ perceptions of their diagnostic responsibilities. Diagnostic practices were described as either medical approaches or as CAM approaches. The CAM techniques measured were identified in the preliminary interviews as commonly used diagnostic tools. These included traditional practices such as: iridology, kinesiology; face, tongue and nail diagnosis and pulse diagnosis. CAM diagnostic equipment included live blood analysis, Functional medicine tests, Hair analysis, Pulse diagnosis and Electro-dermal screening.

3. Herbal prescribing behaviour items

Questions about herbal prescribing included a pool of items about herbal formulation practices, prescription approaches, dispensing procedures, typical preparation forms of herbal medicines and herbal dosage methods. Respondents were asked about their sources of knowledge for herbal prescription and perceptions of the role of herbal medicine in healthcare.

The definitions of the dosage systems measured in the survey are as follows: firstly, the pharmaceutical dose is a modern system that refers to the recommended dosage for tablets or fluid extracts and is expressed as grams (gm) per day or millilitres (ml) per day (Mills et al. 2000); the high/medium/low dosage system is a practitioner-dosing system based upon a calculation of the total volume of each herb to be placed in a bottle of liquid herbs and is expressed as ml per 200 ml bottle (Nature Care College of Traditional Medicine 2002); the BHP dose is that as published in the 1983 edition of the British
Herbal Pharmacopoeia (BHP) (BHMA 1983); and finally, the drop dose system is a low dose approach based upon small drop doses of tinctures, usually ten drops thrice daily (Hall 1995).

4. Descriptive data and perceptions about clientele items

Measures of WHM clientele included: the nature of presenting conditions (acute or chronic); the percentage of female, male and children (of both genders) clients; and the five most common conditions/diseases/symptoms treated in each of these three categories. To assess what conditions the NHAA membership were commonly treating, a table including a column for the three categories (female, male and children) and five rows for textual responses was provided. In addition, coded items asking about WHTs’ perceptions of their client’s motivations for seeking herbal treatment were included.

5. Professional relationship items

The questionnaire included a number of questions to collect both descriptive and attitudinal data to measure professional relationships at both an intra- and inter-professional level. These questions asked respondents about their referral patterns to other health care professionals, levels of concurrent patient care, about perceptions of their role in patient management, and their relationship with both the medical community and the herbal profession.

Respondent attitudes about their inter-professional relationships were measured using five point Likert scales (excellent, very good, good, fair, poor) or four point measures of comfort (very comfortable, comfortable, uncomfortable, very uncomfortable). Specific items were included about clinical behaviours and inter-professional communication in the event of the concurrent use of herbs and pharmaceutical medicines by clientele. The main outcome measures of intra-professional relationships were reported as rating scales of perceptions of the support (very supportive, somewhat supportive, a little
supportive, not supportive) provided by the respondent’s educational institution, professional association (NHAA) and their WHM peers. NHAA members were also asked about their preferred professional nomenclature.

3.2.2 Questionnaire evaluation

The questionnaire evaluation was conducted over a four month period from April to July 2003, each stage progressively refining the survey instrument. In summary, these stages included: appraisal by an ‘expert panel’, a pre-pilot test with selected members of the NHAA, a formal pilot test, appraisal by selected experts followed by a final review by the Board of the NHAA before distribution.

3.2.2.1 Stage 1 - expert panel

The first stage of evaluation was a peer-review assessment to ensure the face validity of the questionnaire. Prior to pilot testing, the questionnaire was presented in draft form to an expert panel consisting of supervisors, colleagues and experienced health survey researchers for comment about the structure, wording and design. Comments were also sought to help improve the overall presentation and length of the survey. On the basis of the feedback, poorly worded questions were modified, questions were re-categorised; and questions were re-ordered to ensure less sensitive data, such as demographic information, preceded more potentially sensitive attitudinal questions.

3.2.2.2 Stage 2 - pilot testing

Before commencing the formal pilot testing, a pre-test to improve the internal validity of the questionnaire was conducted on a small group of volunteer members of the NHAA (n=4). This testing was undertaken on a one-to-one basis at each participant’s convenience at their individual herbal clinics and followed the steps outlined in Table 3-3. In addition, the volunteers were asked
if they considered the survey to be of relevance and interest to the members of the NHAA.

Table 3.3 Pilot study procedures

- Administer the questionnaire to the pilot subjects
- Ask for feedback to identify ambiguities and difficult questions
- Record the time taken to complete the questionnaire and decide if reasonable
- Discard all unnecessary, difficult or ambiguous questions
- Assess whether each question gives an adequate range of responses
- Check that all questions were answered
- Re-word or re-scale any questions that were not answered as expected
- Shorten, revise and pilot again (if necessary)

Source: Peat (2001)

A formal pilot study, following the same procedures outlined in Table 3-3, was then conducted with final-year herbal medicine students in a classroom at the Central Coast Campus of the University of Newcastle. This pilot test used a convenience sample (n=15) drawn from a senior class of the University of Newcastle’s Bachelor of Herbal Therapies program. These students were considered to be a group that was knowledgeable about the survey content but would not intersect with the target population. On average it took all the participants of both pilot phases 13-15 minutes to complete the questionnaire. It was agreed by all participants that 15 minutes to complete the survey was reasonable. In general, the comments were very positive and once minor revisions were made the questionnaire proceeded to the next step in the development process.
3.2.2.3 Stage 3 - formal review

The questionnaire was then subject to an expert evaluation. It was reviewed for content validity, relevance and clarity by the Head of Herbal Medicine of the ATMS and the Secretary of the NHAA. After minor changes in light of their comments, the questionnaire was reviewed by the Board of Directors of the NHAA for final approval before distribution to their members.

3.2.3 Final questionnaire

The questionnaire consisted of 56 items of self-coding boxes (with space provided for open-ended responses), which were presented to the recipients of the survey under seven discrete headings entitled:

1. Your demographic details (8 items)
2. Your herbal medicines (10 items)
3. Your clinical practice (11 items)
4. Your clients (7 items)
5. Interaction of herbs and pharmaceuticals (6 items)
6. Your relationships with fellow health care professionals (10 items)
7. Knowledge and training (4 items)

The survey questionnaire has been provided in Appendix A. The relationship between the five survey questions and the individual survey items is depicted in Table 3-4.
Table 3-4 Relationship between the survey objectives and survey items

<table>
<thead>
<tr>
<th>Survey research measures</th>
<th>Survey Item</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Characteristics of professional WHT</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Herbal practitioner demographics</td>
<td>1,2,3</td>
</tr>
<tr>
<td>▪ Education and training</td>
<td>4,5</td>
</tr>
<tr>
<td>▪ Clinical experience</td>
<td>6,9,19</td>
</tr>
<tr>
<td><strong>2. Characteristics of professional herbal clinical practice</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Case loads</td>
<td>30</td>
</tr>
<tr>
<td>▪ Consultation activities</td>
<td>7,8,20,38</td>
</tr>
<tr>
<td>▪ Diagnostic practices</td>
<td>21,22,23,24,25,26,27,28,29</td>
</tr>
<tr>
<td><strong>3. Characteristics of professional herbal prescriptions</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Sources of knowledge</td>
<td>14,39,55</td>
</tr>
<tr>
<td>▪ Preparation forms</td>
<td>11,12</td>
</tr>
<tr>
<td>▪ Formulation and dispensing</td>
<td>13,14,15,16,18</td>
</tr>
<tr>
<td>▪ Herbal dosage</td>
<td>17</td>
</tr>
<tr>
<td>▪ The role of herbs</td>
<td>34,37</td>
</tr>
<tr>
<td><strong>4. The profile of WHM clientele in Australia</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Profile of clients</td>
<td>31,32,34</td>
</tr>
<tr>
<td>▪ Clients’ motivations for consultation</td>
<td>31,34,40</td>
</tr>
<tr>
<td>▪ Morbidity of WHM practice</td>
<td>31,33</td>
</tr>
<tr>
<td><strong>5. Inter-professional relationships</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Inter-professional relationships</td>
<td></td>
</tr>
<tr>
<td>▪ referral patterns</td>
<td>43,44,45</td>
</tr>
<tr>
<td>▪ concurrent treatment</td>
<td>35,36,50,51</td>
</tr>
<tr>
<td>▪ concurrent prescriptions</td>
<td>38,39,40,41,42,49</td>
</tr>
<tr>
<td>▪ with medical profession</td>
<td>46,47,48,52</td>
</tr>
<tr>
<td>▪ Intra-professional relationships</td>
<td>53,54,56</td>
</tr>
</tbody>
</table>
3.2.3.1 Data collection and analysis

The final survey package was distributed by the NHAA secretariat to its membership with the association's quarterly professional journal, *The Australian Journal of Medical Herbalism (AJMH)*, in December 2003 and again in March 2004. The survey was closed on the 30th June 2004.

3.2.3.2 Questionnaire distribution

The survey package included the questionnaire, a covering letter with an explanation of the purpose of the survey, an invitation to NHAA members to participate in the follow-up qualitative interviews, and a stamped and addressed reply envelope. The questionnaire contained explicit instructions on how to complete the questionnaire. The survey cover page stated the estimated completion time was under 15 minutes, highlighted the confidentiality and anonymity of the surveys, and thanked the potential respondents. These documents have been reproduced in Appendix A.

Steps were taken to maximise the potential response rate. Firstly, the survey was distributed with the association's professional journal (*AJMH*). This measure was adopted to maximise the exposure of the survey and as a measure to prove the legitimacy of the source of the survey. Secondly, both a letter to the editor and an article were published in the edition of the *AJMH* that accompanied the survey package (Casey 2003). The letter to the editor explained the reasons for the survey and requested the members’ cooperation. The journal article discussed the current trends in herbal research and stressed the importance of undertaking research that considered the professional practice of WHM.
3.2.3.3 Data coding and checking

Upon receipt of a returned completed questionnaire it was assigned a sequential number and the data entry undertaken. Questionnaires were read and inspected for missing data and ambiguous or unclear responses. The decision about how to handle missing data was deferred until completion of the data entry process, when a missing values analysis could be calculated (see section 4.2.2.1). The data was initially coded and entered into Excel (2003) and subsequently exported into SPSS (version 14). Initially, a basic descriptive log was performed to check for any outliers or unusual data. Any such data were checked against the original questionnaire. After initial coding and data entry, every tenth (10th) survey was re-checked to track potential errors and then a basic descriptive log was performed again to ensure no errors remained.

3.2.3.4 Item reporting

Summary statistics were reported for each item in the questionnaire as frequencies (%) and means (see Appendix B). In the case of multiple response questions, which allowed the respondents to nominate more than one category, two sets of percentages were provided. Firstly, the ‘% responses’ column shows the percentage of the total number of responses to the survey item. Secondly, the ‘% cases’ indicates the percentage of valid cases (number of respondents to the survey item). Probabilities reported were based on two-tailed tests; however, the majority of data was categorical and, where appropriate, Pearson chi-squared tests were presented. Results of statistical tests were reported at a significant level ($\alpha = 0.05$), but the occurrence of a highly significant relationship was also indicated ($\alpha = 0.01^{**}$) (Veal 2005).

For the purpose of this study, all responses to survey item 33 (naming the top five most common conditions/diseases/symptoms that you treated in clinic) were all categorized according to the Major Diagnostic Category (MDC) of the Australian Institute of Health to which they most appropriately fit (Australian
Institute of Health and Welfare 2004). A summary of the individual qualitative responses provided from respondents within each category are listed in detail in Appendix C.

3.3 Qualitative in-depth interview methods

Subsequent to the survey, an in-depth interview study was undertaken to facilitate the second general research objective (section 1.4.1). By processing interview data and field notes, the qualitative analysis built upon the survey description and moved toward developing an in-depth exploratory account of WHM practice in its social context. The following section describes the in-depth interview method employed to collect the qualitative data and aims to demonstrate that appropriate consideration has been given to ensuring a transparent and systematic research process.

3.3.1 The in-depth interviews

The qualitative research consisted of a series of in-depth interviews with NHAA members resident in NSW. The objectives of the in-depth interviews were to help explain the various patterns found within the quantitative data, as well as to collect exploratory data from WHTs about their WHM practice. Amongst the numerous qualitative methods, each of which offer distinct advantages to health research, in-depth interviewing is well grounded as a valuable exploratory research strategy (Patton 2002; Broom 2005; Silverman 2005). In-depth interviews have been used extensively in mixed method studies, particularly, to contextualise quantitative data (Punch 2005); they are a well recognised research method used in health research (Morse et al. 1995; Broom 2005); and the many advantages of in-depth interviews in CAM research for gaining insight into the complex processes operating within clinical practice have been well established (Broom 2005; Morse 2005b).
To ensure flexibility and to facilitate the emergence of novel data, the in-depth interviews were carried out on a semi-structured basis (Patton 1990; Baker 2002; Gubrium et al. 2002; Morse et al. 2002; Broom 2005; Silverman 2005). A theme list of topics informed by the survey findings, along with prepared probes, was used to guide the interviews (see Figure 3-4 over page). The interview participants were guided during the initial stages of the interviews by the introduction of these topics for discussion. The question schedule was considered to be a guide and was used as a source of additional probes, if necessary. The interview style was flexible and encouraged participants towards open dialogue beyond the parameters of the interview schedule (Broom 2005).

The semi-structured interview schedule generated from the survey data was employed to introduce issues of interest to the interview participants. This topic list was employed in the early stages of each interview to provide an overall direction to the interviews and also to be able to compare data across the participants’ accounts. However, each interview was unique and varied in accordance with the participant’s interests (Horrocks et al. 2004).

An underlying assumption of mainstreaming is that CAM lies outside of the dominant medical structures. A key technique used to understand the principles and practice of WHM in Australia in relation to mainstream medicine was that of ‘comparison’. The technique employs the use of comparative questions. Participants were commonly asked to describe, for example, the differences between aspects of WHM and mainstream medicine, herbal medicines and pharmaceutical medicines; or professional herbal practice versus retail practices.
Figure 3-4 Schedule of content of the interviews

<table>
<thead>
<tr>
<th>1. What is WHM?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Prompt: How would you define WHM?</td>
<td></td>
</tr>
<tr>
<td>b. Prompt: How would you explain WHM to a new client?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. What are the principles of WHM practice?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Prompt: What are the traditional principles/philosophy of WHM?</td>
<td></td>
</tr>
<tr>
<td>b. Prompt: What is the role of science in WHM?</td>
<td></td>
</tr>
<tr>
<td>c. Prompt: How is WHM different to other traditions of Herbalism?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. How would you describe your approach to clinical practice and/or herbal prescription?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Prompt: Please describe to me a typical consultation.</td>
<td></td>
</tr>
<tr>
<td>b. Prompts: How do you typically approach a diagnosis, herbal formulation, treatment plans?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. What do you perceive as the role of WHM in Australian healthcare and, consequently, what are your responsibilities as a healthcare practitioner?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Prompt: What are your treatment aims, diagnostic procedures?</td>
<td></td>
</tr>
<tr>
<td>b. Prompt: How is your practice different to medical practice?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. What do you perceive to be the public’s expectations of, and attitudes towards herbal medicine?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Why do your clients seek herbal treatment?</td>
<td></td>
</tr>
<tr>
<td>b. Why do your clients seek your services as a Western herbalist?</td>
<td></td>
</tr>
<tr>
<td>c. How is professional WHM different to the public use of use of herbal medicine, e.g. herbal medicine available in health food stores, or the medical use of herbal medicines?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. What do you perceive to be the medical profession’s attitudes towards herbal medicine and, consequently, towards yourself?</th>
<th></th>
</tr>
</thead>
</table>

| 7. What do you think are the major issues/challenges/opportunities facing the WHM profession in Australia? |                                           |

The exact content and order of questioning varied according to responses
3.3.2 Interview process

All the interviews were conducted by the researcher, who travelled across NSW to the individual participant’s herbal clinic. Each interview was approximately one and a half to two hours (1½ - 2 hours), and with the participant’s permission each was audio-taped and then transcribed verbatim into Word (2003). A project research journal was kept, which recorded the physical and practical details of each interview including details of the journey to the particular clinic, the surrounding environment, details about the clinic setting and the WHT’s characteristics (attributes).

Prior to the interviews taking place, selected WHTs from the pool of survey respondents who had volunteered to participate in the interview process were sent a letter of introduction thanking them for agreeing to participate. This was followed by a telephone call to determine their availability and willingness to attend an interview. Individual appointments were scheduled at each participant’s convenience between July 2004 and February 2005. These participants were then sent a letter of confirmation for the interview date and were contacted again one month prior the actual interviews to ensure they were still willing to participate. Included in the letter was an information sheet about the research project and ethics details. Participants were given the opportunity to cancel interviews at any stage.

The emphasis in the in-depth interview was on recording the participant’s own words rather than simply allocating a response to a category. Each participant was encouraged and allowed to explore his or her own concerns and share their own perceptions to allow novel topics to spontaneously arise. As the interview process progressed, participants were encouraged to lead the interview in order to reveal new priorities and issues. At the close of each interview the researcher summarised their understanding of the interview. Participants were asked to indicate if they felt the summary was accurate and to correct or clarify any misunderstanding (Rice et al. 1999). This process of open
discovery is argued to be a major strength of in-depth interviews as a research strategy (Collis et al. 2003).

3.3.2.1 Transcription process

Each interview was transcribed verbatim into Word (2003). The accuracy of the transcription was assessed by listening to the tapes and comparing them to the transcripts. As each interview was completed, the initial step was to systematically read each transcript several times, write notes and note ideas or observations about the data (Broom 2005; Richards 2005). At this time the data passages were cleaned (ums, ahs etc were removed), ensuring retention of the tenor of the text. The transcripts were then coded by the researcher using N-Vivo (V6 and later V7). From this a profile of each interviewee was generated, recording general observations about the participant and the participant characteristics.

3.3.3 Data analysis

An interpretive grounded approach, where data was collected and analysed concurrently, was adopted for the data analysis. The analysis was conducted on an ongoing basis throughout the interview study to allow emergent themes to be synthesised into the ongoing data collection process. As described above, a semi-structured interview schedule (generated from the survey data) was employed to introduce issues of interest to the interview participants. These themes and the research problem then formed the basis of the coding strategy.

The qualitative data analysis consisted of three concurrent flows of activity including: data reduction (coding), data display, and conclusion-drawing/verification (Miles et al. 1994). As recommended by Richards (2005), the data reduction process moved progressively from simple descriptive coding (describing the participant WHT’s characteristics) to topic coding (coding}
according to the issues identified from the quantitative survey data and issues emerging from the interview process) to analytical coding (coding that resulted from interpretation and reflection on meaning). This level of coding was undertaken at the completion of each individual interview.

The objective of data analysis process was to continually explore and expand on themes from earlier interviews at successive interviews. A process of constant comparative analysis during and following data collection was adopted as patterns gradually emerged from the data (Appleton et al. 2002). Constant comparison is a process where atypical cases, conflicts and contradictions within the data are identified to ensure the complexity of the participants’ experiences are not lost due to data reduction (Ezzy 2002).

When all the interviews had been conducted and the data reduction coding phase was completed then the thematic coding process was initiated (Patton 2002; Broom 2005). As recommended by Adams (2004), the codes and analytical themes were developed in a cumulative manner, emerging from the particular claims and arguments identified within the participants’ accounts. An inductive approach, such as this, ensured that thematic analysis and codes were ‘grounded’ in the data itself, thereby providing insight into WHTs’ experiences by ensuring themes, patterns and issues emerged gradually from the participants’ explanations and descriptions throughout the interviewing process (Strauss et al. 1998; Charmaz 2000; Charmaz 2004).

Finally, having identified the emergent themes from the data, the next step of data analysis involved identification of phrases or quotations that most accurately illustrated these themes (Morse et al. 2002; Richards 2005). Direct quotations are the major source of the qualitative data and numerous quotations are presented in the results chapter (Chapters 5 and 6) as evidence in support of the thematic interpretation presented (Patton 2002).
3.3.4 Issues of rigour

It has been argued that, due to the very interpretive nature of qualitative data, its validity, reliability and generalisability can be a major issue (Gill et al. 1997). Various established techniques were used to ensure that the collection of the data and the researcher’s interpretation of the patterns emerging from the participants’ responses were analysed and encoded rigorously.

3.3.4.1 Validity

*Direct transcription* - in this study the tape recording and then direct transcription allowed for verbatim quotes to be extracted from the in-depth interviews. This process was followed to strengthen both the validity and reliability of the analysis by making the data interpretation transparent to both the participants and the ultimate reader (Bower et al. 2004). The presentation of a substantial proportion of direct quotes in the results allows for the reader to make their own evaluation of the data interpretation.

*Respondent validation* – is a common technique to establish the validity or truthfulness of qualitative research through finding agreement between the concerned parties (Gill et al. 1997). All interview participants were offered an edited version of the interview transcripts and four accepted this offer. An interview transcript, including a brief list of the major issues and themes to emerge from the data, was returned to these interview participants, who were then invited to check the edited transcript and summary. This validation step was undertaken with the four interview participants on a one-to-one basis. This method is known as respondent validation (Mays et al. 2000).

*Searching for ‘agreement’* - during data analysis, analytical accuracy was enhanced by searching for agreement in code and theme development. ‘Agreement’ in the form of repetition of key issues was sought out in the data.
Once repetition was recognized in the data, then both confirming and disconfirming accounts were identified (e.g. WHTs who practiced drop doses and those who opposed drop doses; WHTs who ran successful clinics and herbal practitioners who were less successful). This is a qualitative technique that is recognised to generally increase the rigour of the data generated (Horrocks et al. 2004).

_Triangulation_ – in order to build a coherent justification for the themes, the qualitative data was triangulated against the survey data (Creswell 2003).

3.3.4.2 Reliability

Data analysis of the interview transcripts took place concurrently with the interview process and was undertaken by the interviewing researcher using N-VIVO (initially on V6 and later V7). This approach was used to ensure that the general patterns and important issues that emerged from participants’ responses were analysed and encoded reliably.

_Intra-rating reliability_ – in order to ensure consistency in the coding, a random sample of one third of the transcripts was coded on two separate occasions (Armstrong et al 1997; Rice & Ezzy 2000).

_Audit trail_ – care was taken to document the entire research process from the initial coding until the conceptual analysis. A project research journal using N-Vivo (V6 and V7) was maintained to track the physical, practical, and analytical and methodological decisions made during the research process. With the aid of the software program the researcher was able to maintain an audit trail of the research process. This technique not only enhanced the transparency of the process but helped to ensure a level of consistency and coherence during the extended qualitative research process (Richards 2005).
3.3.4.3 Generalisation

A fundamental principle of the qualitative paradigm is the recognition of unique contexts (Lincoln et al. 2000). The focus of qualitative research is, therefore, placed upon understanding and explaining the different perspectives and experiences of the participants, and its value is related more to the ‘information richness’ of the selected cases and the conceptual analysis rather than generalisability from a large sample size (Patton 2002). The generalisability of the qualitative data rests more upon the themes emerging from the analysis and the power of the conceptual explanation than the statistical representativeness of the study sample.

However, as explained earlier, the purposive sampling strategy did ensure the interview cohort reflected the diverse group of practitioners who constitute the WHM profession. The data in the in-depth interview study are the participants’ accounts of their WHM practice. The results chapters provide numerous quotes from the interviews, which are examples representing the concepts identified within the conceptual framework. The presentation of substantial proportions of the data that has been interpreted facilitates an open and transparent process that allows the reader to judge the ultimate interpretation. This is particularly important in this study because the aim was not simply descriptive, as was the case in the survey study, but was to offer an explanation of the impact of mainstreaming upon WHM in Australia by relating the emergent themes back to the conceptual framework.

3.4 Conclusion

The chapter outlined the research framework, the conceptual framework and the research methods used to collect and interpret the results of the mixed methods inquiry. The chapter argued that the conceptual framework provides useful theoretical concepts that have direct application to this study of the WHM profession, acknowledging both contextual factors and the potential pluralism
within WHM practice. Having described the methodology and demonstrated that appropriate procedures were followed to ensure the methodological integrity of the research process, the thesis proceeds in the following chapters to present the research findings. Chapter 4 reports the data from the national survey of WHM practice, and the analysis of the in-depth interviews with selected WHM practitioners are reported in Chapters 5 and 6.
Chapter 4 Quantitative study results

Chapter outline

In this chapter, the results of the national cross-sectional survey of the NHAA are presented. The chapter opens with a review of the relevant methodological considerations of the study, and then the results of the analysis are presented. Finally, the discussion relates the study results to the broader CAM survey literature and highlights emergent issues that warrant further exploration and/or contextualisation within the subsequent qualitative in-depth interview study (Chapters 5 and 6).

4.1 Introduction

The quantitative phase of the research was undertaken to describe the current approach to the practice of professional WHM in Australia. A survey questionnaire was distributed to the national membership of the NHAA to collect baseline data about the demographic characteristics of the WHM profession and key aspects of contemporary WHM practice. The survey represents the first comprehensive charting of WHM practice in Australia providing new data about clinical behaviours and prescribing practices, as well as attitudinal data of WHM practitioners about aspects of their professional roles and relationships.

The postal survey of the NHAA was conducted between December 2003 and March 2004. The survey questionnaire was distributed to the membership of the NHAA as an inclusion with each member’s quarterly professional journal, The Australian Journal of Medical Herbalism. A postal survey was capable of collecting data from the national population of the WHM profession in Australia. The survey package is provided in Appendix A, and the summary statistics for each survey item in the order that they appear in the questionnaire are presented in Appendix B.
4.2 Methodology

This section includes a discussion of the relevant methodological considerations of the survey including response rate, sample representativeness and issues of validity. The intention of this section is to demonstrate that the survey yielded an acceptable response rate and that the results were both internally consistent and representative of the target population.

4.2.1 Response

The total membership of the NHAA at the time of survey was 1593 members. Of this number, full membership of the NHAA equalled 844. Due to the confidentiality of the survey, individual members of the NHAA could not be contacted. So, in an effort to maximise the response rate, the survey was mailed twice (December 2003 and March 2004). The response rate was 21.7% (n=183) for the first mailing and 23.1% (n=195) for the second mailing. The total response rate of members who were mailed the survey equalled 44.8% (n=378). However, the official NHAA website listed 649 practitioners as of the closure date for the survey (NHAA 2004). Assuming that all those who responded were in practice, the maximum adjusted response rate of members against this list (n=649) could be 58.2% (n=378).

4.2.1.1 Representativeness

The study sample is similar to the general Australian health workforce and WHM profession on a number of characteristics. The gender distribution (female= 82.9%) approximated that of the national health industry at the time of the survey, where females equalled 78.1% (Australian Institute of Health and Welfare 2002). There was no official gender or age information on the NHAA website; however, the baseline measures of the gender distribution and age of respondents (83% female; 43.5 years, n=376, SD=9.9) were consistent with the results reported in the workforce surveys of the NHAA/ANTA (76% female; 44 years, n=3117, SD=10.4) and the ATMS/ANTA (75% female; n=1580,
approximately 1/3 > 36-45 years) commissioned by the ATO (Hale 2002b; Bensoussan et al. 2004b).

In general, the response sample was shown to be consistent with the sampling frame characteristics and the results are considered to be generalisable to the whole NHAA membership. Postcodes of herbal clinic/s at the time of the survey were used as a measure of external validity by comparing the geographical distribution of respondents to that of the NHAA membership. The postcodes of members as listed on the NHAA official web site (n=649) were compared to the postcodes of the first clinic listed by respondents (n=372) (see Table 4-1 over page) (NHAA 2004). A test of significance indicated that there was no difference between the comparison groups ($\chi^2=7.49; \text{df}=5; p\text{-value}=0.278$). Thus it was concluded that the national distribution of the sample population is representative of the distribution of the target population across Australia.

4.2.1.2 Internal validity

A recommended mechanism was placed within the questionnaire as a test for internal validity by repeating one of the survey items (36 and 50) (Ticehurst et al. 2000). A Cronbach’s Alpha test was performed to compare each respondent’s consistency between the survey items. Nunnally (1978) suggested a Cronbach’s alpha of 0.7 an acceptable level of agreement. The results of the test show an overall score of 0.825, which indicates a high correlation of the responses between the two survey items. From this point on, survey item 36 will be used for data analysis since it was presented first.
Table 4-1 Distribution of NHAA membership by state

<table>
<thead>
<tr>
<th>State</th>
<th>Respondents (%)</th>
<th>NHAA list (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>165 (44.4)</td>
<td>302 (46.5)</td>
</tr>
<tr>
<td>Queensland</td>
<td>88 (23.7)</td>
<td>158 (24.4)</td>
</tr>
<tr>
<td>Victoria</td>
<td>68 (18.3)</td>
<td>86 (13.3)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>24 (6.5)</td>
<td>59 (9.0)</td>
</tr>
<tr>
<td>South Australia</td>
<td>15 (4.0)</td>
<td>24 (3.7)</td>
</tr>
<tr>
<td>Tasmania</td>
<td>7 (1.9)</td>
<td>10 (1.5)</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2 (0.5)</td>
<td>6 (0.9)</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>3 (0.8)</td>
<td>4 (0.6)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>372</strong></td>
<td><strong>649</strong></td>
</tr>
</tbody>
</table>

Source: Survey item 1 and NHAA Official Website (NHAA 2004)

Note: Northern territory, Tasmania and New Zealand were collapsed onto one category for the purpose of statistical comparison.

4.2.2 Data handling

In total, 378 respondents provided useable data for this analysis. Two additional surveys returned from members, one resident in the United Kingdom and one in Japan, were excluded from the data analysis because of the different regulatory environment for practice and therapeutic goods in those countries. It was decided to include two responses from New Zealand in the final sample because of the close relationship between New Zealand and Australia in terms of herbal tradition, therapeutic regulations and education.
A total of 98.9% (n=373) respondents reported that they predominantly practice WHM and not other herbal medicine traditions, such as Traditional Chinese Medicine (TCM), Ayurvedic medicine or even homoeopathy. The remaining 1.1% (n=4) reported that they predominantly practice TCM. It was decided to include the latter 4 respondents in the analysis since their data contributes to the overall picture of NHAA practises and because all WHTs registered with the NHAA are trained in and qualified to practice WHM, whether or not they continue to choose this to be their major modality in practice.

4.2.2.1 Missing data

A number of respondents did not respond to several survey questions. This number varied according to the question and was small in relation to the sample size. A Missing Values Analysis (MVA) was performed using SPSS to highlight potential issues from missing data. The results were compared to published standards, which state that if only a small amount of data is missing and that if the data is missing at random then there is no need for any imputation of the missing data (Nunnally 1978), with ‘5% or less’ being an acceptable level of missing data within a data set (Tabachnick et al. 2001). The MVA revealed a random pattern of non-response (i.e. non response was scattered randomly across survey items and between respondents) and the percentage of missing responses per question did not exceed 3.4%. Thus the survey data conform to both and Nunnally and Berstein’s (1994) and Tabachnick and Fidell’s (2001) criteria. Accordingly, in instances of missing data, non-respondents are not included in the data analysis for these items.

4.3 Profile of the WHM profession

Since 98.9% of respondents indicated WHM to be their primary practice, the data collected about the sample was used to build a professional profile of WHM in Australia. This included collecting demographic characteristics,
educational qualifications, clinical experience and caseloads, as well as issues around professional identity.

4.3.1 Demographic characteristics

Demographic measures included age, gender and geographical location by state.

4.3.1.1 Characteristics of the WHM profession

In the sample, 82.9% (n=311) of WHTs were female and 17.1% (n=64) male. The mean age of respondents was 43.5 (SD=9.9). After exclusion of the two outliers (>70 years) the mean age became 43.3 years. The two outliers (a male and a female) were excluded from any further analysis involving the variable age. An independent two-sample t-test was performed to compare mean age between gender (t= –2.31, df=371, p=0.02) and showed that the mean age of males (45.8 years) was significantly higher than that of females (42.8 years).

4.3.1.2 Geographic distribution

A total of 372 respondents provided postcodes. A few respondents (n=6) chose not to reveal their postcodes, and four of these respondents indicated on the survey form that this was for reasons of confidentiality. Table 4-1 showed that NSW has the highest percentage of herbal clinics (44.4%), followed by Queensland (23.7%) and then Victoria (18.3%). The majority of practitioners were located in metropolitan areas for all states. For example, in NSW 67.3% (n=111) of practitioners indicated metropolitan postcodes, while 32.7% (n=54) indicated a rural postcode.
4.3.1.2.1 Distribution by state

The qualitative study (Chapter 5) involved a sub-sample of respondents from the survey who reside in NSW. Statistical tests were performed on several salient demographic variables including age, gender, education and clinical experience to ensure there were no significant differences between the NSW respondents and the remaining states. Results showed that there was no significant difference in gender ratio by state ($\chi^2=1.81, df=3, p=0.613$), and that the mean ages for all states were in early to mid forties (p-value) (see Table 4-2). There were no significant differences in educational background ($\chi^2=6.017, df=3, p=0.11$) or in years of clinical experience between the states ($\chi^2=12.060, df=9, p=0.210$).

Table 4-2 Mean age by state

<table>
<thead>
<tr>
<th>State</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>165</td>
<td>42.1</td>
<td>10.2</td>
</tr>
<tr>
<td>Victoria</td>
<td>68</td>
<td>42.2</td>
<td>8.8</td>
</tr>
<tr>
<td>Queensland</td>
<td>86</td>
<td>45.9</td>
<td>9.2</td>
</tr>
<tr>
<td>Other States</td>
<td>51</td>
<td>42.7</td>
<td>8.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>370</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: analysis of survey item 1 and 2

Thus, it appears that the national membership did not vary significantly between states in terms of the personal characteristics of age, gender, educational background or years in practice. It was concluded that the NSW sub-population is representative of the NHAA membership in the other states of Australia.
4.3.1.3 Characteristics of herbal clinics

The majority of WHTs (84.4%, n=372) reported that they practiced from a single location with a small proportion of 13.4% (n=50) located in multiple sites. The vast majority of WHTs (97.3%, n=366) indicated that they operate a herbal dispensary within their herbal clinic. About one third of respondents (n=152) reported offering a range of additional services within their clinics, specifically diagnostic equipment such as Bio impedance analysis or Live blood analysis, Iridology camera or computer systems or Electro dermal testing, such as Listen or Vega machines.

4.3.2 Professional profile

Professional profile measures included data about weekly caseloads, levels of education and clinical experience, as well as attitudinal data measuring perceptions of intra-professional identity and support.

4.3.2.1 Education

The results showed a total of 287 (76.1%) of professional qualifications in herbal medicine that are either a diploma or advanced diploma. A smaller percentage (23.6%, n=89) held bachelor degrees. One individual (0.3%) reported holding a ‘grandfather’ qualification. This individual is obviously a unique case and was excluded from the remainder of the analysis in this section. Most respondents (88.0%, n=332) had obtained their qualification in WHM at a college rather than from a university (3.5%, n=13). A small percentage of 8.5% (n=32) reported having studied at both types of institutions. These 32 respondents were considered university graduates for any remaining data analysis.
Respondents were also asked to indicate on a rating scale how well they perceived their training to have prepared them for clinical practice (1-excellent, 2-very good, 3-average, 4-poor). The majority of WHTs (71.6%, n=268) reported a positive attitude (excellent or very good) towards the quality of their training in preparing them for clinical practice. Only a small minority of 2.7% (n=10) showed they had received ‘poor’ training. The mean satisfaction rating equalled 2.0 (SD=0.817) indicating that, on average, respondents rated their educational training as preparation for clinical practice as above average or ‘very good’. There was no significant difference in attitudinal ratings between university and college graduates ($\chi^2=6.017$, df=3, p=0.111).

4.3.2.2 Caseloads and clinical experience

The average number of consultations per week amongst the sample group was 19.2 (n=365, SD=18.13, median=15). After excluding outliers (over 50 consultations per week), the mean number of consultations per week was 15.6 (n=342, SD=10.15, median=15.0). On average, male WHTs conducted 6.8 more consultations per week than females. Although males constitute only 17.1% of the respondents, they carry a significantly higher caseload per week ($t=-2.68$, df=361, p=0.008). Using the adjusted mean, an estimate of the total number of consultations carried out by the sample group (n=378) per week was 5897. Assuming 48 working weeks per annum per practitioner, the respondents carried out 283,046 consultations per year. This extrapolates to approximately 485,971 consultations per year for the NHAA membership (n=649).

Nearly one half of respondents (46.2%, n=174) were within their first five years of practice, compared with the one third of the cohort that fell into the most experienced category (>10 years; 36.3%, n=137). The data, as evidenced by the age range (23-59 years) in the least experienced category, indicated that people of all ages have entered the WHM profession in the last five years.
4.3.2.3 Intra-professional support

Figure 4-1 indicates the responses to the question, ‘How do you rate the support you received as a new graduate when beginning clinical practice from your training institution, your professional association (in this case the NHAA) and from other practitioners?’ The figure shows that the greater proportion (74.8%; n=279, a little and not supportive) of all respondents perceived their training institution to be unsupportive.

**Figure 4-1** Perceptions of levels of professional support for WHTs

There were no significant differences in attitudes about support provided from their training institute by either university or college graduates ($\chi^2=2.75$; df=3; $p=0.43$). Levels of satisfaction with the professional association (the NHAA) were reported around the mid-range responses (63.9%, n=235, somewhat and a little supportive). In contrast, the majority of WHTs (65.6%, n=244) reported a
positive perception of support (either very supportive or somewhat supportive) from other practitioners.

4.3.2.4 Preferred terms for WHM practice

The respondents signified a range of terms they preferred to describe the type of medicine they practice. ‘Natural Medicine’ (34%, n=122), followed by ‘Complementary Medicine’ (30.4%, n=109) and ‘Holistic Medicine’ (23.7%, n=85) were reported as the top three preferences. Additional terms selected included Traditional medicine, Alternative medicine, Non-orthodox medicine and Non-conventional Medicine. Finally, various open-ended responses were reported including: ‘a combination’ of the above’ (n=33), Allied Health (n=2), Functional Medicine (n=1), Herbal Medicine (n=2), Integrative Medicine (n=1), Naturopathy (n=2), Unified (n=1) and Vitalistic Medicine (n=1).

4.3.3 Summary

The results indicate a reasonable degree of homogeneity in membership characteristics of the NHAA across Australia. The majority of WHTs in Australia are female (over 80%), in their early to mid forties and are educated in the college system, holding diploma levels qualifications as opposed to degrees. The national distribution (by state) is not significantly different in terms of personal characteristics of age, gender or years in practice. The survey data indicated that the majority of WHTs concentrate their clinical practice in one location and operate their own herbal dispensary. There is evidence of larger numbers of new entrants into the profession than experienced practitioners. While most WHTs signified they were satisfied with their education in preparing them for practice, most reported a perception of inadequate professional support available to them.
4.4 Approaches to clinical practice

The respondents provided data on a range of aspects of their clinical practice including consultation activities, length of consultations, therapeutic services offered, diagnostic practices and examination procedures used. WHTs were also questioned about their role in patient management. This involved perceptions of primary care responsibility for making a medical diagnosis, types of conditions treated, understanding of herb/drug interactions, and referral patterns.

4.4.1 Consultation characteristics

Table 4-3 shows that most (95.5%, n=361) initial consultations are longer than 30 minutes, with over half (53.7%, n=203) of those over an hour long. Follow-up consultations are generally 30-60 minutes in length (97.3%, ‘0-30mins’ n=165, ‘31-60mins’ n=203).

**Table 4-3** Length of consultations

<table>
<thead>
<tr>
<th>Consultations</th>
<th>0-30 mins (%)</th>
<th>31-60 mins (%)</th>
<th>&gt; 60 mins (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>17 (4.5)</td>
<td>158 (41.8)</td>
<td>203 (53.7)</td>
</tr>
<tr>
<td>Follow up</td>
<td>165 (43.7)</td>
<td>203 (53.7)</td>
<td>10 (2.7)</td>
</tr>
</tbody>
</table>

Source: Survey items 6 and 7

Respondents recorded a broad number of activities involved in an initial consultation including case history taking (98.9%, n=373), dietary history (92.6%, n=349), nutritional advice (90.2%, n=340), herbal formulation (87.8 %, n=331), herbal dispensing (84.9%, n=320), formulation of treatment program (80.4%, n=303), physical examinations (69.5%, n=262), diagnosis (57.8%,...
n=218) and counselling (51.2%, n=193%). A substantially smaller proportion (27.3%, n=103) reported preparation for pathology tests as a normal activity.

4.4.2 Clinical specialties

Table 4-4 summarises the different clinical specialties of WHTs (a detailed list of individual responses are contained in Appendix B). It shows that less than one-third (30.2%, n=114) of the respondents indicated having a clinical specialty, and half of this number (50%, n=57) specialised in the treatment of the Female Reproductive System (FRS).

Table 4-4 Clinical speciality

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female reproductive</td>
<td>57</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Diet/lifestyle</td>
<td>17</td>
<td>14.9</td>
<td>64.9</td>
</tr>
<tr>
<td>Immune conditions</td>
<td>8</td>
<td>7.0</td>
<td>71.9</td>
</tr>
<tr>
<td>Other modalities</td>
<td>7</td>
<td>6.1</td>
<td>78.0</td>
</tr>
<tr>
<td>Chronic Fatigue Syndrome</td>
<td>6</td>
<td>5.3</td>
<td>83.3</td>
</tr>
<tr>
<td>GIT Disorders</td>
<td>6</td>
<td>5.3</td>
<td>88.6</td>
</tr>
<tr>
<td>Children</td>
<td>5</td>
<td>4.4</td>
<td>93.0</td>
</tr>
<tr>
<td>Muscular skeletal</td>
<td>3</td>
<td>2.6</td>
<td>95.6</td>
</tr>
<tr>
<td>Other: cancer support, mental health, skin conditions</td>
<td>5</td>
<td>4.4</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Survey item 19
Clinical speciality was tested to see if it was an indicator of clinical experience. There was no statistically significant association between clinical speciality and years in practice ($\chi^2=1.539$, df=3, p=0.673), or clinical speciality and gender ($\chi^2=0.043$, df=1, p=0.835). Thus, clinical speciality does not appear to be a marker of clinical experience.

4.4.3 Diagnostic practises

The survey items collectively measured key features of diagnostic practises including patient examination styles, use of patient examination instruments, and types of diagnostic tools or medical pathology tests utilised. Respondents were also questioned about perceptions of their responsibilities relating to diagnosis. Related data about WHTs’ interactions with the medical community in terms of concurrent management of patients is addressed in section 4-7.

4.4.3.1 Patient Examination Styles

WHTs reported using a combination of medical and CAM techniques to examine patients. The data indicates that while WHTs routinely perform medical-style physical examinations, such as reading blood pressure, they are simultaneously using CAM examination techniques, such as iridology torches. Respondents reported a regular use of the following medical equipment: sphygmomanometer (n=279), stethoscope (n=229), otoscope (n=107) and thermometers (n=75). CAM patient examination styles reported include iridology (n=284); face, nails and tongue examination (n=280); pulse examination (n=52), mainstream medical physical examinations (n=214) and kinesiology (n=27).

4.4.3.2 Diagnostic Testing

More than half the respondents (55.7%, n=209) signified that they used medical pathology testing on a regular basis to inform treatment decisions. In general, most of such pathology tests (63.6%, n=222) are requested via a general
practitioner (GP). Only 4% (n=14) indicated that they referred patients directly to pathology laboratories for testing. By considering the five most commonly used medical and CAM tests, it is evident that there is a more frequent use of medical pathology testing than CAM procedures. This relationship is illustrated in Figure 4-2.

**Figure 4-2** Comparison between medical and CAM diagnostic test use

![Bar chart showing comparison between medical and CAM diagnostic tests](image)

<table>
<thead>
<tr>
<th>Tests</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAM</td>
<td>Functional Medicine Tests</td>
<td>Hair Analysis</td>
<td>Live Blood Analysis</td>
<td>Pulse Diagnosis</td>
<td>Electro Dermal Screening</td>
</tr>
<tr>
<td>Medical</td>
<td>Blood Tests</td>
<td>Hormone profiles</td>
<td>Liver Function Tests</td>
<td>Urine Samples</td>
<td>x-rays</td>
</tr>
</tbody>
</table>

Source: Survey items 22 and 25; respondents could tick more than one box

4.4.3.3 Diagnostic responsibilities

Most (95.2%, n=359) WHTs reported that they accepted the importance of a medical diagnosis when providing herbal treatment. However, most (85.9%, n=324) also signified that they did not consider it their responsibility to make a medical diagnosis. Instead, they (82.6%, n=309) considered that it was their responsibility to recognise the signs and symptoms of an underlying disease (in mainstream medical terms) in order to refer for medical treatment if necessary.
4.4.4 Summary

Although the data indicated some variation in clinical practice styles between respondents, the survey described the general patterns of practice of WHM in Australia. Respondents recorded a wide range of consultation activities involved in relation to herbal prescription as case history taking, formulation of treatment programs, individual herbal formulation and herbal dispensing. Not surprisingly, considering the range of activities, initial consultations were typically in excess of one hour. The results indicate that WHTs integrate many aspects of mainstream medical practice into their approach to clinical practice, but also use CAM examination techniques such as iridology. The data clearly indicated that WHTs do not, for the most part, function as primary diagnosticians.

4.5 Approaches to herbal prescribing

The respondents were invited to provide data on a range of key aspects of their herbal prescribing including herbal formulation and dispensing, typical preparation forms of herbal medicines dispensed, herbal dosage and the authoritative sources of knowledge for herbal materia medica. Measures were taken to explore patterns of concurrent prescription of herbal and pharmaceutical medicines are addressed in Section 4-6.

4.5.1 Herbal Tradition

As indicated previously, a total of 98.9% (n=373) respondents reported that they predominantly practice WHM and not other herbal medicine traditions such as Traditional Chinese Medicine (TCM, 1.1% n=4), Ayurvedic medicine or even homoeopathy.
4.5.1.1 Sources of knowledge

When asked to nominate which pharmacopoeia they considered to be the authoritative source of WHM prescribing, 61.3% (n=214) nominated the BHP (British Herbal Pharmacopoeia). This was followed by the materia medica notes provided by their educational institution (37.2%, n=130), then the German Commission E Monographs (21.8%, n=76), information from traditional sources (16.9%, n=59) and, finally, the ESCOP (European Scientific Cooperative on Phytotherapy) (10.3%, n=36). It is of interest that 18.1% (n=63) of respondents, unprompted, nominated key industry spokesman Kerry Bone in the ‘other’ category.

4.5.2 Herbal formulation and prescription

WHTs were questioned about certain principles of herbal prescribing including construction of herbal formulae, whether they prescribed single herbs or mixtures of herbs, and if herbal formulae used are individualised for each patient or pre-constructed (meaning the formulae are from an authoritative source).

4.5.2.1 Formulation practices

The vast majority (96.3%, n=363) of respondents reported that they predominantly construct individual formulae for each client. Only a small number (3.5%, n=13) noted a preference for the use of pre-constructed formulae. In addition, WHTs also reported the prescription of pre-formulated tablets/capsules from manufacturers (40.7%, n=153), their own ‘tried and tested’ formulae for specific conditions (19.1%, n=72) and formulae received

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12 Kerry Bone is the founder and Managing Director of Mediherb Pty Ltd., an Australian herbal manufacturing company. He has written many books about herbal medicine. A selection of these is listed within the thesis reference list.
from other WHTs (5.3%, n=20). Respondents indicated that initial formulation decisions were made predominantly upon consideration of the underlying cause of the problem (43.6%, n=164) or the signs/symptoms of the patient (42.0%, n=158). Less than 6% (5.9%, n=22) of WHTs initially consider the diagnosed disease or condition, alone, when formulating herbal prescriptions. The majority reported that the predominant consideration in the choice of herbal medicines for formulae were the pharmacological actions of the plant (59.3%, n=223), as opposed to the indications of the herb (14.4% n=54). A small minority reported the chemical constituents of the plant as being a primary factor (0.8%, n=3).

4.5.2.2 Preparation forms of herbal medicines

The greater majority (84.7%, n=320) indicated that they normally dispense herbals after initial consultation. As indicated in Table 4-5 (over page), liquid herbal extracts are the preferred form of preparation for 90.1% (n=336) of WHTs with the most highly concentrated extracts of 1:1 or 1:2\(^{13}\) strength (referred to as fluid extracts) used in preference to more traditional tinctures (usually a strength of 1:10). Teas are the next most popular herbal preparation type, followed by tablets/capsules, tinctures and, finally, powders.

Figure 4-3 (over page) illustrates how WHTs are incorporating tablets/capsules into practice and that they continue to dispense traditional forms of herbal preparations such as topical creams, pessaries or douches, gargles, eyebaths, teas and poultices. However, these traditional preparations are not as commonly used as liquid extracts.

\(^{13}\) The ratios refer to the concentration of liquid preparations. 1:1 means equal parts herb: fluid; 1:2 equals 1 part herb: 2 parts fluid; 1:5 equals 1 part herb: 5 parts fluid etc. Fluids are generally mixtures of water and ethanol.
Table 4-5 Preferred forms of herbal preparations

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluid extracts</td>
<td>336</td>
<td>90.1</td>
<td>90.1</td>
</tr>
<tr>
<td>Teas/dried herbs</td>
<td>16</td>
<td>4.2</td>
<td>94.3</td>
</tr>
<tr>
<td>Tablets or capsules</td>
<td>14</td>
<td>3.8</td>
<td>98.1</td>
</tr>
<tr>
<td>Tinctures</td>
<td>4</td>
<td>1.1</td>
<td>99.2</td>
</tr>
<tr>
<td>Powders</td>
<td>3</td>
<td>0.8</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>373</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Survey item 11

Figure 4-3 Traditional herbal preparations dispensed

Source: Survey item 12; respondents could tick more than one box
4.5.3 Herbal dosage

The survey showed that dosages administered varied between respondents but that the predominant system used by the WHM profession is that of pharmacologically active doses of highly concentrated fluid extracts. Table 4-6 indicates that just over half the respondents (54.1%, n=204) prescribe the pharmaceutical doses of individual herbs (based on doses of each herb required per day or week); a quarter (24.7%, n=93) employ the high/medium/low dosage system (based on a calculation of amounts of herb per 200ml bottle); 11.9% (n=45) refer to the BHP for amounts of herb; and 8.2% (n=31) prescribe drop doses. The remaining 1.1% (n=4) adopts different systems such as TCM or Kinesiology upon which to base their dosage calculations.

<table>
<thead>
<tr>
<th>Dosage</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceutical</td>
<td>204</td>
<td>54.1</td>
<td>54.1</td>
</tr>
<tr>
<td>H/M/L</td>
<td>93</td>
<td>24.7</td>
<td>78.8</td>
</tr>
<tr>
<td>BHP</td>
<td>45</td>
<td>11.9</td>
<td>90.7</td>
</tr>
<tr>
<td>Drop</td>
<td>31</td>
<td>8.2</td>
<td>98.9</td>
</tr>
<tr>
<td>Other*</td>
<td>4</td>
<td>1.1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>377</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Source: Survey item 17
4.5.4 Summary

Respondents indicated that herbal treatment decisions are initially made upon consideration of the underlying cause of the problem or the signs/symptoms of the patient. The implication of this is that the diagnosed disease of the patient plays a secondary role in the formulation of treatment decisions. The predominant considerations in the choice of herbal medicines were the pharmacological actions of the plant, as opposed to the indications of the herb. The chemical constituents of the plant were not reported as a significant factor in prescribing decisions. The data collected provides strong evidence that WHTs are perpetuating a traditional approach to the prescription of herbal medicines rather than adopting the phytotherapeutic model of practice.

4.6 The clientele of WHM

The following section provides a profile of the clients who consult WHTs and the nature of their conditions. WHTs were also asked to estimate the percentage of clients concurrently under medical supervision, percentages of those being prescribed herbal medicines while on pharmaceutical medication, and questions about case history taking in regard to concurrent treatment. Respondents were also asked to help establish the personal motivations for clients seeking herbal treatment.

4.6.1 The profile of WHM clientele

The overwhelming majority of herbal patients are adult females (70.1%), while men constitute 18.4% and children (of both genders) constitute 11.7%. As displayed in Figure 4-4, WHTs report high proportions of their clients have already consulted a medical doctor and have a diagnosis, are concurrently under medical care and are combining herbal and pharmaceutical medications.
WHTs’ perceptions of clients’ motivations for taking herbal medicines concurrent to pharmaceutical medicines included a combination of the adverse side effects of pharmaceuticals (81.1%, n=300), patients were seeking a natural alternative (77.3%, n=286) or that the pharmaceutical medications were no longer effective (41.9%, n=155). Additional questions were asked about WHTs’ treatment responses and rates of concurrent treatment and prescription with medical practitioners or pharmaceutical medicines (see 4.7.2).

**Figure 4-4** Concurrent WHM and medical treatment

Legend:

- Diagnosis= have consulted a medical practitioner prior to herbal consultation
- Consultations= concurrently consulting a medical practitioner
- Pharmaceuticals= concurrently using pharmaceuticals and herbal medicines

Source: Survey items 35, 36 and 41
A list of the common reasons reported for requests of herbal treatment included a combination of dissatisfaction with mainstream medicine (85.5%, n=323), a growing concern about the effectiveness or side effects of drugs (78.0%, n=295), clients seeking a more holistic approach to health (74.6%, n=282), the chronic nature of their disease or condition (71.7%, n=271), a desire for preventative medicine (47.4%, n=179), seeking greater control over one’s health (38.4%, n=145) and, finally, for philosophical or spiritual reasons (13.2%, n=50).

Notably, this survey item (No 34) elicited more open comment than most other items and they are, thus, worth noting here. They included curiosity (n=1), lack of faith in mainstream medicine (n=1), wishing to address underlying cause (n=1), belief or philosophy (n=3), no artificial chemicals (n=1), concern about long-term use of pharmaceuticals (n=1), cultural preference (n=1), concern about needing pharmaceuticals indefinitely with no cure (n=2), fear of addiction (n=1), fear overuse of pharmaceuticals (n=1), getting sicker or not improving on drugs (n=2), drugs ineffective or dissatisfaction (n=2), no medical treatment available (n=3), patients want both for better effect (n=1), want cure not symptom management (n=1) and want more concern from doctors (n=1).

4.6.2 Morbidity of WHM practice

Measures were taken of the nature of presenting conditions (acute or chronic); the percentage of women, men and children (of both genders) clientele; and the top five most common conditions/diseases/symptoms treated in each of these three categories. The specific responses reported by the respondents ranged from general descriptions of body systems being treated to naming very specific diseases/conditions. For the purpose of this study, responses were all categorised according to the Major Diagnostic Category (MDC) of the Australian Institute of Health to which they most appropriately fit (DHA 2004).
Most respondents (86%, n=324) indicated clients were requesting herbal medicine for the treatment of chronic conditions. The top five conditions most frequently treated in herbal clinics for women, men and children are summarised in Table 4-7. The range of open responses provided by respondents listed under the MDC category to which they were assigned is provided in Appendix C (Table C-1).

**Table 4-7 Summary of top five categories of conditions treated**

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRS conditions</td>
<td>Health status</td>
<td>Skin conditions</td>
</tr>
<tr>
<td>Mental health</td>
<td>Mental conditions</td>
<td>Digestive conditions</td>
</tr>
<tr>
<td>Health status</td>
<td>MRS conditions</td>
<td>Immune conditions</td>
</tr>
<tr>
<td>Digestive system</td>
<td>Digestive conditions</td>
<td>Mental conditions</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Musculoskeletal</td>
<td>ENT conditions</td>
</tr>
</tbody>
</table>

Source: Survey item 33

Note: FRS (female reproductive system); MRS (male reproductive system); ENT (ear, nose, throat)

Overall, the top five categories of conditions for which clients seek herbal medicine included endocrine and reproductive conditions, especially of the female reproductive system (FRS); factors effecting health status, mental conditions, digestive conditions, and skin conditions. It is noteworthy that reports of neoplastic disease (cancer), serious virulent infections, acute trauma such as burns or injuries, and alcohol or drug related conditions were not significant. The relative frequency of conditions treated in each MDC for
women, men and children are provided in Appendix C (see Tables C-2, C-3, C-4 respectively).

For women, the predominant conditions treated included hormonal conditions as well as those related to an emotional or nervous aetiology. Many women clients appear to seek herbal medicine for the treatment of conditions related to the FRS (MDC 13) including infertility, menstrual problems, menopausal symptoms, and more chronic conditions such as endometriosis, polycystic ovarian syndrome and uterine fibroids. Further hormonal problems reported included some of an endocrine, nutritional and metabolic aetiology including hypothyroid problems, diabetes (NIDDM), insulin resistance, Syndrome X, and metabolic conditions such as obesity and food intolerances (MDC 10).

Both men and women seek herbal medicines for the management of conditions such as stress, anxiety, depression and sleep disorders (categorised under MDC 19 as mental conditions), as well as preventative healthcare including lifestyle or nutritional advice, weight management advice and detoxification programs (MDC 23). Of interest is the relatively common reporting of the treatment of benign prostatic hypertrophy (BPH) for men (MDC 12). In addition to these top five categories, men frequently requested herbal treatment for cardio-vascular related conditions, which may also be understood as related to lifestyle, including hypertension, hypercholesterolemia and stroke recovery/prevention (MDC 5). A category of commonly treated conditions common for both adults and children, alike, were digestive complaints such as poor appetite, chronic constipation, bloating and flatulence, and food sensitivities (MDC 6).

Thus, the majority of clients are seeking herbal medicines for chronic conditions. The notable exception to this factor is the relatively high reporting of the treatment of common acute immune based conditions in children. Featuring
foremost amongst the conditions reported for children are common acute infections including upper respiratory tract infections (e.g. colds or Otitis media; MDC 3, 4) and inflammatory conditions of the skin, especially eczema (MDC 9). Of note, respondents did not report treating serious virulent infections such as measles, mumps, rubella etc. The most commonly reported chronic respiratory condition was the various types of asthma. In addition, behavioural issues (ADD, ADHD, hyperactivity) and learning disorders were commonly reported (MDC 19).

4.6.3 Summary

The majority of the WHM client base is female. Most clients of WHM tend to seek care for chronic conditions, have undertaken a medical diagnosis, continue to consult a medical practitioner and concurrently take pharmaceutical medicines with their herbal medicines. The exception was the relatively high reporting of the treatment of common acute immune based conditions in children. The results suggest that people seek WHM treatment for conditions that may not have responded to mainstream treatment, or by clients who are concerned about the effects of pharmaceutical medicines. They also indicate that clients consult a WHT for preventative and for conditions that may have resulted as a result of lifestyle choices.

4.7 Inter-professional relationships

Finally, WHTs were questioned about their relationships, interactions and communications with the medical profession.

4.7.1 Concurrent patient care

As reported in Section 4.6.1, there are very high levels of concurrent herbal/mainstream utilisation by herbal clientele, and the majority of WHTs perceived the role of herbal medicines to be complementary rather than a
replacement for most mainstream medicines. The following section describes WHTs concurrent patient management approaches.

4.7.1.1 The role of herbal medicines

The majority of respondents (53.0%, n=195) signified that they considered herbal medicines as a complementary treatment rather than a replacement of pharmaceutical medicines (22.3%, n=82). The remainder of respondents (24.7%, n=91) placed herbal medicines in both of these roles.

4.7.1.2 Referral patterns

Survey item 44 showed the rates of referrals to other healthcare practitioners by WHTs. Almost all respondents (98.9% n=373) indicated that they referred patients to other healthcare professionals, with 93% of WHTs (n=348) reporting referral to medical practitioners on a regular basis. In contrast, a significantly smaller proportion of respondents (54.3%, n=204) reported having received referrals from medical practitioners. The most common reason reported for referral to medical practice was to request pathology tests (90.8%, n=336). Other common referrals were to chiropractor/osteopaths (79.1%, n=296), counsellors (71.4%, n=267), acupuncturists (53.2, n=199) and other natural medicine practitioners (54%, n=202).

About half the respondents indicated they used pathology testing on a regular basis to inform treatment decisions, and most pathology tests are requested via a GP rather than referring patients directly to pathology laboratories. WHTs also reported referring their clients to GPs for medical treatments or for pharmaceutical prescriptions, if necessary (61.1%, n=226); obtaining (55.9%, n=207) or confirmation of a medical diagnosis (47.8%, n=177), and treatment of acute infectious diseases (35.7%, n=132).
4.7.1.3 Co-ordinating herbal and pharmaceutical use

The majority of respondents (94.4%, n=354) noted encouraging clients to inform their medical practitioner of their herbal prescriptions and 99.7% (n=376) of WHTs routinely ask patients if they are taking pharmaceutical medications during initial case history. Table 4-8 indicates how confident respondents felt in treating patients taking pharmaceuticals.

Table 4-8 Confidence treating clients on pharmaceutical medications

<table>
<thead>
<tr>
<th>Confidence</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident</td>
<td>117</td>
<td>31.5</td>
<td>31.5</td>
</tr>
<tr>
<td>Confident</td>
<td>227</td>
<td>61.2</td>
<td>92.7</td>
</tr>
<tr>
<td>A little confident</td>
<td>21</td>
<td>5.7</td>
<td>98.4</td>
</tr>
<tr>
<td>Not at all confident</td>
<td>6</td>
<td>1.6</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>371</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Survey item 42

Although 92.7% (n=344) reported feeling confident to very confident treating those clients taking pharmaceuticals, when asked if they believed there was sufficient information available about the interactions of herbs and drugs, 68.8% (n=256) reported ‘no’. These data are noteworthy because three-quarters of all respondents (n=320) dispense herbal medicines to patients after the initial consultation.
4.7.2 Relationships with the medical community

Table 4-9 indicates WHTs’ perceptions of their working relationship with the medical community and perceptions of attitudes from the medical community towards themselves. It shows two-thirds (66%, n=244) did not rate attitudes towards themselves as good (a rating of fair to poor); however, at least one-third (34.4%, n=128) reported a positive perception (a rating of good, very good or excellent) (see Table 4-9).

Table 4-9 Ratings of inter-professional relationships and attitudes

<table>
<thead>
<tr>
<th>N (%)</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working relationships</td>
<td>51 (13.7)</td>
<td>96 (25.7)</td>
<td>139 (37.3)</td>
<td>68 (18.2)</td>
<td>19 (5.1)</td>
</tr>
<tr>
<td>Medical attitudes</td>
<td>89 (24)</td>
<td>156 (42.1)</td>
<td>75 (20.2)</td>
<td>45 (12.1)</td>
<td>6 (1.6)</td>
</tr>
</tbody>
</table>

Source: Survey items 46 and 47

Nevertheless, a considerable percentage (73.2%, n=276) reported feeling comfortable communicating with the medical community and 60.8% (n=226) felt they had a good to excellent working relationship with the medical community. The greater majority (96.8%, n=364) signified that they would like to see closer collaboration and co-operation with the medical community in the future.

4.7.3 Summary

The findings indicate that a large proportion of WHM clientele are concurrently receiving medical and WHM treatment and taking herbal and pharmaceutical medicines. WHTs reported a high referral rate to medical practitioners for medical diagnosis, treatment and/or prescription. The majority of WHTs confirmed that they routinely include a pharmaceutical case history as part of
their consultations, and clients are encouraged to tell GPs of herbal prescriptions. WHTs' referral rates to medical practitioners were significantly higher than reciprocal levels from medical practitioners. The majority of WHTs reported a perception of poor inter-professional relationships and indicated a desire for closer collaboration and cooperation with the medical community in the future.

4.8 Discussion

This survey represents the first comprehensive charting of WHM practice in Australia including providing new data about clinical behaviours, prescribing practices and WHTs' attitudes about their professional roles and relationships. The survey data provided strong evidence of the rationalisation of clinical practice, but that WHM retains a traditional approach to herbal prescribing. The survey findings confirmed that WHM, as per CAM practice in general, is utilised by the Australian public as a form of complementary rather than primary healthcare practice. The survey highlighted some unique understandings about WHM not evident when WHM was examined as one of several CAM professions.

The following discussion relates the survey results to the CAM survey literature reviewed in Chapter 2 and highlights the salient issues arising from the quantitative study warranting further exploration and/or contextualisation within the subsequent qualitative in-depth interview study.

4.8.1 Representativeness

The NHAA is the oldest medical association in Australia, being incorporated in 1920, and it claims to represent an unbroken chain of knowledge to its traditional Anglo-American herbal heritage (Bone et al. 1999b). The NHAA repute to maintain the highest educational and practice standards for WHM in
Australia (NHAA 2004). Furthermore the NHAA is the only CAM professional association in Australia representing WHM alone. The NHAA was thus considered an ideal population to represent the practices of WHTs in Australia and represented a sampling unit that would reduce any confounding variables.

The response rate to this study was 58%, providing data from a national population that would have otherwise been inaccessible, but non-response bias was acknowledged as a potential threat to external validity. However, the response rate was consistent with that typical for health professionals (Asch et al. 1997), was higher than response to earlier studies of similar Australian populations (Bensoussan et al. 1996; Barnes et al. 1998; Hale 2002b; Bensoussan et al. 2004b; Grace et al. 2006), and higher than previous surveys of herbalists in the UK (Barnes et al. 1998). Given the high level of correlation between the sample and the sampling frame in terms of population profile (see section 4.1.1), non-response bias was considered to be minimal. Indeed, the relatively good response rate to this survey was the strength of this study.

The present study does also have certain limitations. In the first instance, while every effort was made to reduce bias, it is necessary to accept the potential limitations inherent in all survey work. The method of participant recruitment meant that participants were self-selecting. More specifically, potential problems associated with the study, which relied upon individual’s responses, may be those of both recall and/or response bias. The potential for incorrect responses must be recognised due to recall bias and for over- or under-reporting on certain issues by respondents.

The responses to survey item 33, about common conditions that WHTs treated, were categorised according to the MDC (Major Diagnostic Category) by body system (Australian Institute of Health and Welfare 2004). The conditions specified by respondents did not necessarily fit the original intention of the MDC.
data codes, which are used to track hospital data. However, the MDC codes were seen as a starting point to classify the morbidity of herbal practice in Australia and as a contextual framework with which to relate this data to existing medical morbidity data.

Finally, no pre-tested survey instruments were available for adoption in the research project. Previous authors have acknowledged the difficulties of collecting data from CAM practitioners if survey questions do not reflect the paradigms of the respondents (Kenner 1997; Barnes et al. 1998; Mason et al. 2002; Hale 2003). In the next chapter, qualitative in-depth interviews are used to explore the practice features of WHM from the perspective of the WHTs and thus add further depth, detail and meaning to the quantitative analyses.

4.8.2 The WHM profession

The survey allowed a generalised picture of the characteristics of WHTs to be drawn. The findings indicated that the majority of WHTs in Australia are female (over 80%), in their early to mid forties and practice from a single location. Most of the WHM profession are educated in the college system and hold diploma levels qualifications, as opposed to degrees. The survey supports earlier findings that, despite the predominantly female workforce, overall, the male practitioners carried out proportionately more consultations and were in clinical practice proportionately longer than women (Hale 2003). While gender issues are clearly important, warranting further research, they are not the focus of this thesis.

The survey highlighted some unique findings that are not evident when WHM is examined as one of several CAM professions. Bensoussan et al. (2004b) assert a considerable degree of utilisation of WHM and naturopathic practitioners by the general public and that these professions make a significant contribution to Australian healthcare. However, the overall number of consultations reported in
this study indicated a comparatively low rate of visits to WHM practice annually, particularly compared to naturopathy. The findings from this survey are more consistent with the CAM consumption surveys reporting low rates of consultation to WHTs by the general public in Australia (MacLennan et al. 2002; MacLennan et al. 2006; Xue et al. 2007). WHTs’ perceptions of the use of herbal medicines by the public and the WHM profession’s contribution to healthcare will be explored in the in-depth interview study (Chapter 5).

Although the membership of the NHAA has a significant cohort of experienced practitioners, over half of the membership was relatively inexperienced, falling within their first five years of practice. The data demonstrated that there is no clear association between age and experience and that people of all ages enter the profession (the ages of new practitioners ranged from the early twenties to late fifties). These findings were consistent with the workforce surveys of the WHM and naturopathic professions in Australia (Hale 2003; Bensoussan et al. 2004b). The motivations for people entering the WHM profession will be explored in the qualitative study (Chapter 5).

Bensoussan et al. (2004b) reported that the majority of WHM and naturopathic practitioners were satisfied that their clinical training was sufficient for preparing them for professional practice. Earlier research by the ATMS had reported similar levels of satisfaction with clinical training, but that such training did not prepare CAM practitioners to run a business (Hale 2002b) or for interprofessional communications (Bensoussan et al. 2004b). This survey confirmed a general level of satisfaction by NHAA members with their training in preparing them for clinical practice and introduced data relating to prevailing levels of satisfaction with support structures available once in clinical practice.

In summary, the majority of respondents reported being unsatisfied with postgraduate opportunities for ongoing clinical training and support. Reports of
levels of professional support available to them from their training institution were less positive than their assessment of the quality of their education. At present, avenues of support appear to be on an informal basis, practitioner-to-practitioner, as opposed to the availability of any formal structures. A nationally significant finding of this research is the apparent need for an expansion of formalised support structures available for WHTs in their herbal clinics. The issue of ongoing professional development, the levels of clinical experience in the profession and the impact of insufficient support for individual practitioners is explored in greater depth in the qualitative study.

4.8.3 WHM practice

The survey provided strong evidence of the rationalisation of WHM clinical practice. In Chapter 1 the increasing influence of medical science on CAM practices, including the incorporation of medical concepts, clinical procedures, technologies and language into clinical practice, was termed rationalisation. On the other hand, the data also demonstrated that the WHTs in Australia perpetuate a traditional approach to the prescribing of herbal medicine.

4.8.3.1 Clinical practice

The survey respondents recorded a wide range of consultation activities including case history taking, formulation of treatment program, individual herbal formulation and herbal dispensing. Not surprisingly, the average initial consultation was in excess of one hour; follow-up consultations were shorter in length, generally between 31-60 minutes. Lengthy consultations have been noted as a characteristic CAM practice (Cherkin et al. 2002a; Hale 2003). It has been argued that patients are attracted to CAM because of the time taken in consultations (Ernst et al. 2000; White et al. 2000; Adams 2001a). The salience of extended consultations in WHM practice is explored in Chapter 5.
Although WHM is a complete system of medicine with its own diagnostic framework (British Medical Association 1993), evidence was provided of the integration of medical science in clinical practice, particularly for the purposes of diagnosis. In addition to case history taking, the respondents reported a frequent use of medical diagnostic and physical examination techniques. These data are consistent with the findings reported by Grace et al. (2006). Of note, the data showed greater utilisation rates of medical diagnostic equipment and medical pathology tests than CAM techniques (i.e. iris diagnosis; and face, tongue, and nail diagnosis).

Nonetheless, the survey data showed that most WHTs do not perceive the diagnosis of medical conditions to be their responsibility and indicated a high referral rate to medical practitioners for diagnosis, treatment and/or prescription. How WHTs accommodate both WHM and medical diagnosis within the WHM framework is explored in the in-depth interviews.

4.8.3.2 Herbal prescribing

Although the results provided strong evidence of a rationalisation of WHM, the data also show that in Australia WHTs perpetuate the traditional principles and practices of herbal prescribing. According to this survey, WHM is characterised by the prescription of mixtures of liquid herbal medicines, which are individually formulated for each patient after an in-depth consultation.

This survey confirms that in Australia most WHTs are preparing individualised medicinal formulae for patients from dispensaries in their clinics in the form of concentrated liquid extracts. Furthermore, the respondents indicated that the predominant considerations in the choice of herbal medicines were the traditional actions of the plant (i.e. how the plant effects the body), as opposed to the indications of the herb (i.e. the disease or condition). In the face of modern trends in herbal medicine, where the plant preparations are being used
simply as replacement for conventional drugs to treat specific symptoms of diseases, the survey data strongly suggests that WHTs in Australia today continue a tradition of individuation in prescription.

It has been reported that British herbalists, unlike those in Germany, have not adopted a phytotherapeutic model of practice (Barnes et al. 1998). As described in Chapter 1, within the phytotherapeutic model herbal prescribing is based on symptoms or a particular condition, the medicines are chosen on an evidence basis, and the herbs are administered in single preparations of standardised herbal extracts\(^{14}\) (Bone et al. 1999d). The findings from the survey study showed that in Australia WHTs are perpetuating a traditional model of practice, in preference to the phytotherapeutic model.

Further evidence of traditionalism is that the British Herbal Pharmacopoeia (BHP) appears to still be regarded as the premier authoritative source of materia medica rather than the phytotherapeutic monographs (German Commission E and ESCOP). Respondents indicated that herbal formulation decisions are based upon consideration of the underlying cause of the problem or the signs/symptoms of the patient, rather than a medical diagnosis. The chemical constituents of the plant were not reported as a significant factor in prescribing decisions. Additionally, the BHP Specific Indication (BHP SI) is no longer commonly adopted to inform prescribing decisions. The implication is that the diagnosed disease of the patient plays a secondary role in the formulation of treatment decisions.

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\(^{14}\) A standardised herbal preparation is one in which the source material has been chemically analysed and matched to a pre-determined chemical marker.
A point of divergence from more traditional herbal preparations used was the strength or concentration of the medicines being used now. The survey shows that WHTs predominantly dispense highly concentrated liquid extracts. Traditional liquid extracts of herbal medicines were usually prepared as macerations in wine or brandy, commonly in strengths of 1:10 (plant to liquid) (Blumenthal 2003; Bone 2003). Modern liquid extractions are more commonly made with ethanol or glycerol, and most fluid extracts are of highly concentrated ratios of 1:1 or 1:2 fluid extracts (Bone 2001b; 2003). The survey data support anecdotal observations that modern herbalists are increasingly favouring liquid extracts and abandoning the use of more traditional forms of herbal preparations (Zeylstra 1995).

The WHT does continue to compound traditional topical applications in the forms of topical creams, pessaries or douches, gargles, eye baths, teas and poultices. These types of preparations are not, however, reported as primary therapeutic tools, but rather incorporated into treatment programs as a complementary or secondary choice. These observations are consistent with earlier findings. Bensoussan et al. (2004b) reported that it was nutritional supplements that herbalists and naturopaths dispensed as over-the-counter (OTC) supplements, while herbal medicines were predominantly individually mixed and dispensed.

The survey highlighted how the respondents used a range of dosage systems. The notable aspect of these variances is that the utilised doses can range from a few drops up to 10 ml or more for the same herb between different prescriptions. The purpose of this thesis is not to debate the merits or describe the nuances of the various systems; suffice to say, the pharmaceutical, high/medium/low and BHP systems are grounded on pharmacologically active dosage amounts, whereas the drop dose system is one based upon the energetic properties perceived in the plants (Hall 1995; Mills et al. 2000).
Although a cumulative total of 90.2% of respondents adhere to a pharmacologically active dosage regime, the diversity of dosing within the WHM profession is an issue that requires further investigation. It is reasonable to suggest that individual WHTs would probably not continue to use a dosage system if it did not produce the desired results for their patients and that each would be able to refer to appropriate sources of evidence, be it scientific or traditional, to support their opinion on philosophy of dosage. However, those outside the WHM profession may question these differences, and the issue of dosage warrants further in-depth exploration.

4.8.4 Scope of practice

This survey has not only mapped WHM practice but provided some insights into the WHM profession’s scope of practice. *Scope of practice* was defined earlier as a concept to describe the appropriate form, content and boundaries of healthcare practice.

Studies have shown CAM therapists to be operating within a broad scope of practice, with many acting as first contact primary professionals (Cooper et al. 1998). In contrast, the survey data showed that WHTs are generally acting in a complementary rather than an alternative role to mainstream medicine. These findings are supported by previous studies indicating that most CAM patients have already undertaken and many continue to undertake concurrent consultation with other practitioners, particularly medical practitioners (Adams et al. 2005; Hill et al. 2005; MacLennan et al. 2006; Zhang et al. 2007).

In practical terms, the results suggested that most clients are seeking WHM for conditions that have not responded to mainstream treatment. While a portion of WHM caseloads are devoted to the management of what may be termed lifestyle and preventative healthcare, the majority of clients seek care for chronic conditions, have undertaken a medical diagnosis, continue to consult a
doctor and many concurrently consume pharmaceutical medicines. These results are consistent with the general determinants of CAM consumption discussed in Chapter 2 (Sibbritt et al. 2004; MacLennan et al. 2006; Xue et al. 2007; Zhang et al. 2007).

A significant public health issue highlighted by the survey data was the large proportion of WHM clients concurrently taking herbal and pharmaceutical medicines. The survey indicated that WHM clients are questioned about all aspects of their current medical care, the majority routinely include a pharmaceutical case history as part of consultation, and patients are encouraged to tell medical practitioners of herbal prescriptions. Yet, the data also revealed that WHTs recognise the potential implications and would welcome improved levels of information about potential drug-herb interactions.

The survey indicated a perception of poor inter-professional relationships with the medical profession. While most survey respondents reported high referral rates to medical practitioners, they also noted significantly less reciprocation. The majority of respondents do not perceive a positive attitude from the medical profession towards the WHM profession, but reported a desire for closer collaboration and cooperation with the medical community in the future. The WHTs' perceptions of their role, responsibilities and their relationships, particularly in relation to medical practice, will be explored in further depth the interview study (Chapter 5).

4.9 Conclusion

The survey was undertaken to collect baseline empirical data about the current approach to the practice of WHM and provided the first comprehensive record of WHM practice in Australia. The survey data confirmed the notion that the clinical practice of WHM has been significantly rationalised but it does not support the notion that WHM has adopted the phytotherapeutic model of
practice. On the contrary, the survey analysis demonstrated that WHTs in Australia continue to perpetuate a traditional approach to the prescribing of herbal medicine. The survey results indicated that WHM is an eclectic blend of both medical science and traditional Herbalism.

Even though WHM has integrated medical science into its model of practice, WHTs are not functioning as primary practitioners. The survey data confirmed that WHM is used as a form of complementary healthcare practice by the Australian public. WHM is providing herbal medicines for the management of chronic conditions that have not responded to mainstream medical care. Despite high levels of concurrent patient management with the medical profession, the results also suggest inter-professional relationships are not strong; significantly, neither were the levels of perceived intra-professional support.

The survey has provided a broad generalisable description of contemporary WHM practice, but the aim of the thesis is broader. There is a need for further exploratory analysis of these initial findings, especially given the lack of research on this topic in Australia. Additional qualitative research with WHTs reflecting the actual dynamics of clinical practice and their perceptions of the impact of mainstreaming on WHM are presented in the next two chapters. In this way, the thesis provides both a generalisable and an exploratory account of WHM practice.
Chapter 5 Qualitative study results – Part 1

‘The modern herbalist may utilise medicinal plants from all over the world, in the context of a health philosophy incorporating modern and traditional concepts and knowledge.’ (NHAA 2004)

Chapter outline

Chapter 5 is the first of two chapters that explore, with a sub-set of survey respondents, their explanations, perceptions and experiences of practising WHM in Australia. This chapter examines the various dimensions of clinical practice from the perspective of the WHM practitioner. In Chapter 6 the analytical focus is broadened to consider the socio-political context of WHM provision in contemporary Australia.

5.1 Introduction

The survey study presented in Chapter 4 provided the first comprehensive record of the form and content of WHM practice in Australia. The survey data described how the WHM profession approaches the clinical practice of WHM, the prescription of herbal medicines, WHM clientele and data about certain aspects of WHTs’ inter- and intra-professional relationships. As per the opening quote, the survey results demonstrated that WHM is an eclectic blend of both medical science and traditional Herbalism. In addition, the survey provided some insights into WHTs’ attitudes about their clinical role, responsibilities and both inter and intra-professional relationships.

The survey contributed generalisable data about the WHM profession and practice in Australia. In the process, it raised a number of intriguing questions about the processes operating within WHM such as: How do WHM practitioners
conceptualise the philosophical and theoretical basis of WHM? How do they explain and rationalise their approach to clinical practice and herbal prescription? How do they accommodate both rational and traditional principles of practice in the WHM framework? What do they perceive as their role in healthcare and, consequently, their responsibilities as healthcare practitioners? How do WHM practitioners locate their practice in response to the general public's expectations of and attitudes towards herbal medicine? Why do they characterise their relationship with the mainstream healthcare sector as unsatisfactory?

To both contextualise the survey findings and investigate these issues, an exploratory study examining WHM practice from the perspective of the WHM practitioner was undertaken. As described in Chapter 3, a series of qualitative in-depth interviews were conducted with a sub-set of survey respondents. This chapter reports on one aspect of the findings from the in-depth interview study. The analysis presented in this chapter focuses upon clinically related issues. Subsequently, in Chapter 6 the analysis is broadened to consider the social context of WHM practice.

5.1.1 Participants

From the survey sample, 58 respondents agreed to participate in the in-depth interview study. A total of 18 in-depth interviews were eventually conducted with WHTs working in private herbal clinics in different regional locations in NSW, Australia. The interview participants were purposively selected as described previously (Section 3.1.4). The sample size was not predetermined; rather, successive interviews were undertaken until the list of themes on the semi-structured interview schedule had been explored sufficiently and no new themes emerged from continued data collection and analysis (thematic saturation).
The participants interviewed came from a wide variety of backgrounds, both urban (n=11) and rural (n=7), and practiced in a variety of clinical settings.\textsuperscript{15} Of the 18 interview participants (aged between 24 and 62), seven participants practiced from their home, four operated a clinic on their own, two worked from premises within a health food store and the remaining five practiced in a multi-disciplinary clinic. Of these last five, one WHT shared with a GP and the remaining four shared with other CAM therapists. Eleven of the participants were also qualified Naturopaths. Fifteen of the interview participants were female. Table 5-1 summarises the interview participant attributes and indicates how the interview cohort represented the characteristics of the survey respondent sample.\textsuperscript{16}

The range of clinical experience amongst the interview participants ranged from recent graduates to those with many years of clinical practice. Nine WHTs were within the first five years of practice (two in their first two years): six with approximately ten years of experience and three with over twenty years of practice. For all but two participants, WHM was a second career. The WHTs reported a high incidence of self-employment and incomes being supplemented by part-time employment, some in unrelated industries. Only five participants considered clinical practice a full-time occupation. Nine of the participants, in addition to their clinical practice, were employed part-time in the CAM industry working in either retail (pharmacy or health food store) or in education (teaching herbal medicine) or involved as consultants for herbal manufacturing

\textsuperscript{15} The interviews were undertaken in Sydney [Northern suburbs (n=2), Western suburbs (n=2), Southern suburbs (n=2) and inner city (n=2)], the Blue Mountains (n=1), the Central Coast (n=2), Hunter region (n=2), Northern NSW Coast (n=1), Wollongong (n=1), South Coast (n=1) and regional country (n=2) areas.

\textsuperscript{16} Note: a list of individual participant attributes cannot be provided because of confidentiality issues. Individuals could be potentially identified from such a list by cross matching locations to the NHAA website referral list.
companies. Three of the participants were sitting members on the board of directors of the NHAA.

Table 5-1 Characteristics of the interview study participants

<table>
<thead>
<tr>
<th>Attributes</th>
<th>% interview participants n=18 (%)</th>
<th>% survey respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3 (17%)</td>
<td>17%</td>
</tr>
<tr>
<td>Female</td>
<td>15 (83%)</td>
<td>83%</td>
</tr>
<tr>
<td>Age range</td>
<td>24-62 years</td>
<td></td>
</tr>
<tr>
<td>Mean age</td>
<td>37.5 years</td>
<td>42.1 (NSW)</td>
</tr>
<tr>
<td>Metropolitan practice</td>
<td>11 (61%)</td>
<td>67% (NSW)</td>
</tr>
<tr>
<td>Regional/rural practice</td>
<td>7 (39%)</td>
<td>33% (NSW)</td>
</tr>
<tr>
<td>Experience range</td>
<td>2 - &gt;30 years in practice</td>
<td></td>
</tr>
<tr>
<td>Practice full time occupation</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>WHM second career</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Director NHAA</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

As indicated in Table 5-1, the interview participants for this study closely reflected the age range, experience levels and gender ratio of the national survey cohort. Thus, the purposive sampling offered a degree of control over the representativeness of the interview population of the broader national population.
5.1.2 Themes

The analysis in this chapter considers how WHM is being mediated as an entity by those within the profession – the WHTs. The interview participants represented a broad range of WHTs who commonly shared a holistic worldview, but who also offered a range of interpretations of the philosophical and theoretical basis of WHM. For some of the participants the traditions of WHM were central, while others stressed the scientific basis of WHM. The results of the analysis are divided into two sections. The first, entitled ‘WHM: Holistic practice’, outlines the themes common across all accounts of WHM practice; the section also considers how herbal clientele potentially impact upon WHTs’ decision making about practice and herbal prescribing. The second section, ‘Rationalisation of practice’, focuses on the salience of science in the participants’ accounts of the contemporary practice of WHM. The analysis revealed the existence of a number of competing sub-groups within WHM over philosophy and/or approaches to WHM practice.

5.2 WHM: Holistic practice

Holism predicated every account of WHM practice. The following analysis explores how the participants’ conceptualisation of WHM as ‘holistic’ has shaped both clinical practice and approaches to herbal prescribing. The closing sub-section, entitled ‘Pursuing Holism’, considers the participants’ perceptions of how and why WHM is being used by their clients. The qualitative data suggested that the WHTs’ conceptualisations of WHM were to a certain extent an idealised account of practice. Consistent with the Tovey and Adams framework, the analysis indicated that the distinction from mainstream medicine was a dominant issue within the WHM practitioners’ discourse; secondly, that the WHTs’ conceptualisations of their model of practice has been challenged by their clients’ existing conceptualisations of healthcare.
5.2.1 Clinical practice

WHT 2: Holism is the key here. Holism involves the physical, the mental, the emotional, the environmental and the spiritual aspects of people.

The central and unifying theme to emerge from the data was Holism. When asked to define WHM, the participants did not make references to the use of plants as medicines; instead, Holism predicated every description of WHM practice. For example:

WHT 7: What is Herbalism? It is looking at the whole body instead of just going to the doctor for ten minutes. It is a holistic understanding and approach to treatment, not just suppressing symptoms.

As demonstrated in the following statements, WHM was conceptualised as a broad therapeutic system that honours the spiritual, mental, emotional and physical aspects of health.

WHT 5: I’m very much holistic in terms of how I see the person … I suppose in saying that, I don’t really see that herbalists treat diseases, we treat individuals; that is, we actually treat people who have compromised health.

WHT 10: The mind, the body, the spirit, everything is inter-connected, and real healing is effected upon a whole person. Herbalism is a holistic approach to medicine. It’s integrating everything, which is where I think orthodox medicine has gone wrong.

Implicit in the selection of quotes above are a number of assertions: firstly, holistic practice is patient-centred, meaning the focus of the practitioner is on the person not simply the disease process and, therefore, treatment is an individualised process that extends beyond the suppression of symptoms; secondly, that such patient-centred practice requires time to pursue; and notably, WHM is being distinguished from medical practice. The distinction of
WHM from mainstream medicine was a dominant issue within the WHM practitioners’ talk. Indeed, without comparative reference to medical practice, many of the participants would have found it difficult to meaningfully convey their understandings of WHM practice. But the participants’ talk suggested much more – it suggested that WHM is the ‘natural’ and, thus, legitimate approach to medicine and, as such, enjoys an inherent advantage over medical practice. For example:

  WHT 17: What I love about the idea of our sort of natural medicine is it doesn’t matter what the name of a disease is. All patients are individuals. So, by spending time and individualising the treatment specifically targeted at the person … then you’ve got just such a greater chance of success (than medical practice). I mean, you almost can't fail.

As suggested in this quote, WHM is perceived to be underpinned by the laws of nature, itself – to work with the forces of nature, not against them – and is, therefore, an almost ‘fail-proof’ system of medicine. The WHTs’ rhetoric implied that the ultimate legitimacy and authority of WHM comes from nature, itself. These themes are explored in greater detail below.

5.2.1.1 Focussing on the individual

The participants’ rhetoric of WHM as a patient-centred model of practice emerged as two closely linked and interwoven sub-themes of Holism: the centrality of the individual and the importance of taking time to understand the person.

  WHT 2: When a person comes to see me as an herbalist I’m not just interested in their disease, I’m interested in them as a person. A consultation is about taking all factors into consideration … the full context – where they live, who they live with, what they eat, what they drink – and it takes an hour to do a basic consult with a new client.
WHT 8: I’m looking at the whole picture. I’m looking for a picture of what the individual person’s life is like. I’m looking for where things are out of balance. That takes time.

A common idiom used by the participants to reinforce the patient-centred focus of WHM practice was ‘we treat people, not diseases.’ This phrase was used repeatedly by the participants and essentially conveyed an understanding that within WHM the focus of the WHT is on understanding the individual, rather than diagnosing the disease.

WHT 17: When we diagnose, we consider lifestyle issues causing the medical problem. So, I suppose we’re looking at broader contributing factors. Perhaps there’s also lifestyle and emotional aspects in our diagnosis. We treat people, not diseases.

As suggested in the next quote, from the WHM perspective disease is considered to be the product of ‘imbalance’ between any of the various aspects of an individual’s life. Therefore, if any one aspect of a person’s life assumes too much dominance or is not accorded enough significance, the resulting imbalance may cause ill health.

WHT 2: Holism … is about taking into account what affects people in their daily life … In Holism the disease can be considered to be an expression of imbalance of what’s going on in the individual’s life, rather than a disease of the body.

Consequently, physical symptoms or diseases are considered to be the ultimate expression by the body of an existing imbalance. As an example, in the following excerpt the WHT describes how emotional problems can manifest as physical symptoms because everything is inter-connected:

WHT 9: Sometimes the causes (of illness) are emotional and this will affect the physical. If someone is not happy, then that has to manifest in their body in
some way, shape or form. It is all inter-connected. You must discover the root of the problem.

Accordingly, the WHT aims to understand the full ‘picture’ of a client’s ‘life’ in order to identify the ‘root cause’ of the imbalance. The clinical implication is that within WHM the diagnostic emphasis is placed upon identifying the underlying cause, rather than focussing on the physical symptoms or the diagnosed disease. All the participants commonly affirmed that the aim of a WHM case history was to identify the ‘underlying causes’ of the individual’s condition:

WHT 17: When we talk about diagnosis, I’m not talking about the names of an illness; I’m talking about the holistic understanding of a health or illness pattern. It doesn’t really matter if you have a name of a disease because a name of a disease isn’t going to make you feel better. I look for the underlying causes.

WHT 12: I think my main focus is to find out the underlying causes … so that would be what my main aim, to find out the underlying cause.

WHT 10: Yeah, herbal treatment – it’s really getting in, on a causal level, to what is the absolute root cause of a person’s problems.

As the following quotes demonstrate, the possible underlying causes can potentially include diet, nutritional deficiencies, emotional problems, environmental toxins, lack of exercise, alcohol, cigarettes or drugs (sometime including pharmaceutical medicines) etc:

WHT 7: The cause may be dietary, emotional, environmental, physical trauma, spiritual, infection etc. You must remove or treat the underlying cause; otherwise the problem will keep returning.
WHT 5: Sometimes it doesn't matter what herb you give them because the underlying problem is still there: for example, if it is caused by the side effect from a drug.

Therefore, within WHM the client’s medical history is evaluated within the context of a holistic case history, which in turn is an extensive in-depth one that considers the individual’s family history, medical history, lifestyle choices, diet and environmental context. For these reasons, the case history emerged as an important clinical tool within WHM practice. As an illustration, in the following extract the WHT emphasises the importance of the case history over and above all other types of physical and pathology examinations:

WHT 5: You must get a good patient history. Everything else is a dead loss. You can have all the iridology tools, all the pathology testing; if you haven’t got a good history, you can forget it. Tests can’t tell you the person’s background. I investigate their diet, lifestyle, social life, environment etc., as well as their medical history.

Consequently, the WHT then considers all of the information obtained from the case history in order to make decisions about the client’s treatment plan, which incorporates lifestyle and dietary advice, as well as herbal remedies. Ultimately, as the next quotation outlines, the prescription of herbs is based on this holistic assessment:

WHT 2: And then in prescribing I’ll take all those details into account and formulate an individualised treatment. This includes dietary advice, lifestyle advice, as well as herbal medicines and nutritional supplements.

Thus, WHM practice means working out a new individualised treatment strategy for each and every person who books a consultation. WHTs described developing a new treatment protocol for clients in terms such as ‘starting every case with a clean slate’, a ‘fresh canvas’ and ‘new story’. The holistic approach to herbal prescribing is explored in greater depth below (see Section 5.2.2).
5.2.1.1 The role of medical diagnosis

As described in the analysis above, herbal treatments are prescribed without the need for a definitive medical diagnosis because, by observing the patterns of symptoms and identifying the underlying cause, the value of labelling a disease becomes secondary. Nonetheless, the thesis survey had clearly indicated a predisposition towards medical diagnosis by the survey respondents. This was indicated by both a high rate of referral to medical practitioners and use of medical diagnostic equipment and examination techniques by WHTs, themselves. How, then, do WHTs account for the use of medical diagnostic procedures and technologies as reported in the survey? As demonstrated by the answers to the following question, the medical diagnosis is recognised as a key tactic to ensure quality care and patient safety:

Interviewer: What is the role of the orthodox medical diagnosis? Is it important to you for case management?

WHT 14: It can be if it is a really complex, dangerous problem.

WHT 5: A medical diagnosis is very important. I mean, it’s crucial to how you set up your treatment program

WHT 17: A medical diagnosis provides useful information about the underlying pathology. It is also very important to know if the patient needs medical attention, you know, for diabetes or something like that.

The participants had explained that a medical treatment and diagnosis was an important aspect of case management and patient safety, particularly if the condition was ‘really complex’ or a ‘dangerous problem’ or a condition such as diabetes that needed medical treatment. Confirming the thesis survey findings, the interview participants reported that they did not consider medical diagnosis to be their primary responsibility but routinely referred to medical practice when necessary. For example:
WHT 5: … but if they need pathology I say, ‘You need to go back to your doctor and ask for this or ask for that.’

WHT 11: We have been trained to understand a medical diagnosis, but it is not my job to make a diagnosis. That is the doctor’s role. They are really good at diagnosis … they have all the training.

As indicated in these quotes, the WHTs emphasised the need to recognise the limits of their expertise and need for vigilance when working with a medical diagnosis. Nonetheless, despite recognising its worth, the absolute value of a medical diagnosis was routinely qualified by the participants. As the subsequent citations indicate, WHTs perceived medical pathology tests to have a number of shortcomings. For instance, obtaining a medical diagnosis can be an extended and/or expensive process that did not necessarily mean a solution to the client’s problems:

WHT 4: Fabulous. All for it (medical diagnosis); indispensable in some instances, particularly if the condition is serious, but other times it is a cost and expense that doesn’t need to be borne.

WHT 5: I figure if people have been to 25 different specialists, had 700 blood tests, body scans, all those sorts of things, and the doctors are still saying we don’t know what is wrong with you, does diagnosis matter? Does it matter if you have a name of a disease or not?

The WHTs argued that mainstream medicine is pre-occupied with diagnosing specific pathologies but is short on providing effective treatments. Furthermore, the participants seemed reluctant to be confused by their clientele with a medical practitioner by relying too much on medical diagnosis.

WHT 3: I don’t want patients to look at me as a doctor who’s going to focus on their symptoms and push them into a standardised diagnosis.
Thus, medical diagnosis was typically described as an important aspect of case management. Most of the WHTs expressed a general willingness to accommodate aspects of medical science within their clinical practice, if it proved useful to clients. However, the value of medical diagnosis was routinely tempered by individual participants who argued that the WHT does not focus on specific diseases but aims to identify the underlying causes of each individual’s problems. Finally, the WHTs also stressed the need for caution, arguing that they recognised the limits of their own competence when working with a medical diagnosis.

5.2.1.2 A time and space to heal

A second inter-related theme to emerge from the WHTs’ accounts of their patient-centred practice was the importance of time – for both practical and therapeutic reasons. In the first place, a WHM consultation was longer than a standard medical consultation simply because of the detailed case history.

WHT 11: The consultation hour, you’re joking, I take two hours for a consultation. Yesterday I took three hours for a complicated person ... I went through everything I could see, checking his eyes, his fingernails, his tongue, his eyelids, his hair, his skin, his urine and questioning, questioning, questioning. I found some of the causes and then had to explain to him what was happening.

Although most participants were not at liberty to spend quite this length of time with clients (the thesis survey indicated the average is one hour), the extensive nature of the holistic case history was well illustrated by this quote. Also evident in this extract is the notion that involving the client, explaining the causes of their problems, is an essential part of the consultation. As demonstrated in the next examples, the time spent interacting with the client was perceived as an important element of the consultation:
WHT 9: I understand, too, that just listening to someone, spending an hour with someone, talking and listening, certainly goes a long way in helping them heal.

WHT 3: In a consultation, by saying ‘how can I help’ I’m opening up the whole spectrum of physical, emotional, mental and spiritual. I’m opening up the idea that I’m concerned.

These quotes were interpreted to mean that within WHM the value of a consultation extends beyond the medicines; the WHT aims to facilitate an ambience of trust in the therapeutic relationship. This concept was often reflected in the physical environment of the herbal clinic.

WHT 10: I give people the time and space to explore more comprehensively what’s going on and I am a very supportive, nurturing sort of person, so that’s a plus. I think the environment at my clinic lends itself to people who really like being here – they don’t even mind hanging about the waiting room, reading some of my funny books.

Most of the clinics visited during the interview process generally offered a relaxing and nurturing environment. The importance of spending time with people and developing a therapeutic relationship was commonly reinforced by comparison to the short consultations offered within medical practice.

WHT 2: I’ve heard from many clients that it is a seven-minute consultation with a traditional doctor, orthodox doctor. It’s very hard to fit everything into seven minutes.

By default, since the typical medical consultation is short, it cannot provide the same level of patient-centred, individualised care. A parallel rhetoric employed throughout the WHTs’ accounts was how medical practice, by contrast to WHM, was not patient-centred and offered the patient neither ‘care’ nor ‘time’.

WHT 4: One difference to orthodox medicine is a straight philosophy of care.
WHT 13: I think time is probably the big difference to orthodox medicine.

In fact, medical practice was portrayed as a restrictive system of medicine in which the medical practitioners’ ability to engage with their patients was limited.

WHT 10: I have great sympathy for the doctor. I think they have a terrible job … They’ve got a ten-minute turn around to process everybody – they’ve got no time to listen to them and so they just prescribe drugs.

WHT 8: If you want someone to take a long time to totally understand you as a person, then go and see an herbalist, don’t go and see a doctor.

The secondary implication of such arguments is that medical practitioners have an unsatisfactory working life in which they are prevented from providing personalised attention for their patients. As these statements suggest, the WHTs perceived the structural constraints of working within mainstream healthcare to be impacting upon medical practitioner’s freedom to inter-relate with their patients. The phrases, ‘I have great sympathy’ and ‘they have a terrible job’ demonstrate a perception that medical practitioners are constrained by the system in which they work. In the next quote, the participant uses the strong imagery of a ‘sausage factory’ to emphasise the structural differences between WHM and mainstream medicine:

WHT 5: That’s why I didn’t want to do that medicine (mainstream). I don’t want to be a sausage factory. I’m happy to spend the time with people and educate people. Personally, I spend a lot of time explaining to people about their illness or explaining to people about their physiology. This is one of the reasons I think people are seeing our practitioners.

Here, the term ‘sausage factory’ functions as a metaphor to imply that within medical practice patients are minced together, pushed in one end and pumped out the other with minimal recognition of the individual. The patient is viewed as
a ‘piece of meat’, rather than a person who requires personalised care and attention in order to understand their illness. Recalling the idiom identified earlier, WHTs often claim ‘we treat people, not diseases.’ At another level, the term ‘sausage factory’ also worked as an allegory to what was described in Chapter 1 as the technocratic model of mainstream medicine. Within this model the body is considered to be a biological machine for which standardised treatments are used to fix the problem. The statements, ‘This is one of the reasons I think people are seeing our practitioners’ and ‘then go and see a herbalist, don’t go and see a doctor’ suggest that the WHTs were positioning themselves as an alternative form of healthcare to mainstream medicine.

5.2.1.3 Support not suppression

WHT 4: The orthodox approach is suppressive. A ten-minute consultation is very little time to address causative factors, so they prescribe medications that suppress symptoms … I’m the other pole of that, looking at supporting the body’s natural ability to heal; and the herbs play a wonderful role in doing just that.

The argument that WHM was a supportive rather than a suppressive form of therapy was consistent in the WHTs’ talk. The term ‘support’ appeared repeatedly within the participants’ explanations of their herbal prescribing, intimating that herbal medicines are considered to work by stimulating the body’s natural healing ability to ‘strengthen the whole person’.

WHT 1: The underlying (traditional) principles are … supporting the body through using herbs … not just treating a particular disease or illness that might be presenting, but supporting the body to heal.

WHT 4: Herbal medicines essentially aid your body to heal itself … Herbs support your body’s own ability to correct an imbalance.
Thus, from the traditional WHM perspective, medicines are not used to override human physiology but to gently ‘support’ the body, restore ‘balance’ and gently stimulate the body to heal itself. This may involve working internally with medicines, but also necessitates removing exogenous causes of ill health. In the following extract, one WHT explains this idea of supporting the body’s natural healing responses using fever as an example:

WHT 4: In the orthodox approach, if you have a symptom they take the symptom away. They use a pharmaceutical to suppress the symptom … I use herbal medicines to support the body and its natural ability to heal itself. A fever is a good example … to suppress a fever you suppress the body’s attempt to deal with an immune challenge. A GP will bring the fever down with a suppressive medication … therefore blocking and suppressing the body’s expression of that disease process. The herbal perspective is to support the body in its fever to dispel or burn off the challenge.

This argument that the medical approach is suppressive while the focus of herbal treatment is not to override human physiology but use herbs to stimulate the body to heal itself and, thus, to help restore the body’s natural ‘balance’ was a common theme within the WHTs accounts. It was explained how the suppression of the body’s natural responses may ease symptoms in the short term but will inevitably lead to further health problems in the future:

WHT 9: By focussing on the symptoms, all you are doing is applying a Band-Aid. The problem will manifest again at some point.

In the following quotes, the participants cited inflammation as an example of the concept of supporting the body’s natural responses to injury rather than suppressing these responses:

WHT 11: An anti-inflammatory is fine in the short-term to ease pain but not for long-term use, absolutely not! If you take an anti-inflammatory and you have back injury … the anti-inflammatory will inhibit repair (of the injury) strongly.
WHT 2: The doctor recommended cortisol creams for his eczema … Steroidal creams relieve the symptoms short-term, but I knew he would be in dire straights down the track.

The WHTs’ accounts contained many similar examples, such as using an expectorant for a cough to dispel mucous, rather than using an anti-tussive; using an immune stimulant for an infection, rather than an anti-microbial; using a digestive stimulant for reflux and normalising digestion, rather than an antacid; not inhibiting diarrhoea with an anti-diarrhoeal, since this was the body’s response to eliminate a gastric infection. On the other hand, the WHTs argued that mainstream medicine focuses upon suppressing symptoms, most saliently, by using pharmaceutical medicines.

WHT 5: Well, a doctor is naming one or two specific illnesses and treating that illness with a pharmaceutical preparation.

WHT 8: They (mainstream medicine) have a drug for a named disease. I have no drug. I have only a traditional remedy for a set of symptoms, which supports the body to heal itself and varies from person to person.

As indicated in this quote, the WHTs constantly compared WHM prescriptions to medical prescriptions. While medical prescriptions are standardised – the same medicine for everyone with the same diagnosis – WHM prescriptions vary between people, even if they happen to have the same medical diagnosis. WHM prescriptions are matched to the individual rather than the disease.

WHT 9: It’s important to see the person as an individual, not as a set of symptoms and not just treat the symptoms. Although herbal medicines can certainly treat symptoms while working on the underlying cause, the symptoms should not be the focus.
In the next quote, the WHT, using a cough as an example, explains how the underlying causes of problems are always different for different people and so the herbal remedy will be different between people with the same symptom.

WHT 1: One person with a cough is going to be different to another person who comes in with a cough. Usually the cause of the cough will be different, their vitality might be different, their environment might be different … everybody deserves to be treated as an individual, so having the flexibility to create what each person might need to help them get better is wonderful.

The WHTs’ talk indicated that they were aware that their emphasis upon the individual, particularly in prescribing, was a prominent reason why many medical practitioners were often sceptical about WHM. For instance:

WHT 18: I think that conventional medicine can’t quite understand why an herb that you would give, say for instance sarsaparilla for arthritis, you would also give for menopause and for skin conditions. How can you give one herb for all these diverse-type things?

The WHTs repeatedly highlighted the potential dangers of the suppressive approach including numerous side effects and/or the adverse reactions:

WHT 5: I am always very cautious about issues to do with pharmaceuticals. I never say to someone ‘stop taking that drug; its killing you’, but I might tell them about the side effects and that all their health problems are actually caused by the drug … you need to go back to your doctor … maybe there is an alternative … a safer alternative such as a herbal medicine

As evident in this extract, WHTs questioned why pharmaceutical medicines were commonly used as the first choice of medicines, when the more ‘natural’ and safer herbal medicines were available. Even so, as per medical diagnosis, the participants routinely qualified their criticism of pharmaceutical medicines, acknowledging their potential value in certain circumstances. The role of
pharmaceutical medicine in acute conditions, particularly virulent infections, was well recognised by WHTs.

WHT 2: Modern medicine works well with acute diseases. If you have got a life-threatening infection, then intravenous antibiotics are very good to deal with that. Whereas natural medicines, once the crisis is over, can facilitate the convalescence of the body rather than the palliation of the symptoms.

WHT 11: I also think the medical model has virtue, everything has virtue … sometimes allopathic medicine is the right approach, for example to kill an infection. Kill it! Remove it! Stop it! So I think medical as well.

Despite conceding to the judicious use of pharmaceutical medicines, the WHTs questioned why pharmaceutical medicines had become the mainstream’s default option rather than reserved for cases of necessity. The WHTs appeared cognisant of the value of medical science but routinely qualified its value and role. This theme of accommodating medical science within WHM is explored in greater depth below (see section 5.3).

5.2.2 Holistic prescribing

The notion of Holism was reflected in not only how the medicines were prescribed but how the herbs were prepared and dispensed as individually constructed liquid formulae. Thus, the sub-theme of individualism described above was also inter-woven into the WHTs’ accounts of herbal prescribing.

5.2.2.1 Holism: Synergy and complexity

Firstly, the participants described their preference for the use of ‘whole plant’ preparations, referred to as galenicals (i.e. the crude unrefined preparation such as a fluid extract), rather than refined extracts popularly found in commercially
available preparations. The underlying rationale for emphasising galenical preparations was centred on the complexity of the herbal chemistry within the whole plant – a concept described a ‘synergy’.

WHT 11: In the whole herb there is synergy. Synergy is where the action of several different agents in the herbs is greater than the sum of the parts.

Synergy was usually explicated by the participants through referencing the idiom, ‘the whole is greater than the sum of its parts.’ As the next quotation explains, plants contain a complex chemical mix and, therefore, the ‘whole herb’ will have a broad range of physiological actions.

WHT 5: The complex chemistry of the herb is such that herbs usually have more than six, ten, twenty different actions in the body.

The WHTs explained how this was different to pharmaceutical medicines, which usually contain a single chemical and therefore have a much narrower therapeutic range.

WHT 11: So, compared to a pharmaceutical drug, an herb encompasses many modes of action. What we know is that they support health but they can inhibit disease, they can actually shift bio-chemistry, they can act as tonics …

WHT 17: A pharmaceutical drug disrupts a very specific bio-chemical function in the body chemistry – that’s how it works – whereas a herb may or may not disrupt a specific function. Very often a herb will inhibit one function, support another, tonify another or provide raw materials, such as vitamins or minerals, and a whole host of other unknown actions.

Hence, while pharmaceutical medicines aim to achieve a specific pharmacological action, herbal medicines are valued because they offer a broad range of actions. In the following reference, the WHT explicated this
concept by describing the multiple pharmacological actions of the popular herb St John’s Wort (*Hypericum perforatum*):

WHT 11: St. John’s Wort is a very good example. We know that it supports the nervous system as a whole, it is a tonic; we know that it protects nerve cells where there is inflammation, for example a spinal injury; we know that it reduces pain, especially nerve pain; and we also know that it raises serotonin levels without stuffing up the other neurotransmitters.

Reinforcing an earlier theme, the term ‘support’ appeared repeatedly within the participants’ explanations of how herbal medicines work, suggesting that herbal medicines are considered to work by stimulating the body’s natural healing ability to ‘strengthen the whole person.’ In this context, the term ‘tonic’ was frequently used to describe how herbal medicines support the body. Many participants argued that using the whole plant preparation not only enhanced the efficacy of the treatment, but reduced the incidence of adverse reactions.

WHT 13: Herbs work really, really well. Each plant has its own plant chemicals that work just as effectively, if not more effectively, than synthetics (pharmaceuticals). It is just staggering how well the herbs actually work. I love hearing back from clients how much better they feel from having been on their mix of herbs. They don’t do as much damage as pharmaceuticals and they don’t have as many side effects or adverse reactions. In fact, if prescribed properly they should have no side effects. The only side effect you will get is that you will get better!

Thus, herbal medicines were prized by the WHTs because their broad therapeutic range of actions means they function ‘without stuffing up’ or disturbing the body’s normal metabolic processes. Herein lay the logic, common amongst the WHTs, as to why herbal medicines were generally believed to be much safer medicines than pharmaceuticals. But the complexity of WHM prescribing extended beyond the pharmacological complexity of the whole plants to another level when the WHT mixed different herbs together in a formula. The participants explained how WHM herbs are dispensed as complex
herbal formulae, rather than as single herbs, in order to match the herbal mix to a client’s specific needs. In the next quote, the WHT emphasises the complexity involved in constructing an individual formula tailored specifically to match the individual:

WHT 17: Making the individual formula, it’s a really complex thing. I suppose this is really the crux of what we do. It’s very hard trying to explain how complex what we do is.

One WHT, using the treatment of stress as an example, elucidated on how herbal formulae address the ‘underlying cause’ of the individual’s problem:

WHT 11: My treatment approach acts on many levels. If the underlying cause is the patient’s stress, I will give the patient herbs to support stress; if the patient is in pain, I will give herbal tonics to strengthen the whole person; if their digestion is very poor, I will provide a tonic to increase digestion; if they can’t sleep, a sleeping herb etcetera.

The idiom ‘we treat people, not diseases’ re-occurred frequently when the participants described their approach to herbal formulary. Many of the WHTs provided details of how they prepared formulae. In the next extracts, two examples are presented – one of preparing a formula for a person who presented with a stomach ulcer, and one with a thyroid problem:

WHT 16: So, for example, if I have a patient with a stomach ulcer I can choose an herb which promotes rapid healing of the mucosal lining of the stomach. But I also have herbs that treat the underlying stress. I also have herbs that will reduce the acidity and buffer the stomach lining against normal digestive juices, acid and enzymes. So I have got at least three actions there, which together will have a far greater effect.

WHT 2: We treat people with diseases, not diseases. Suppose someone presents with a Thyroid disorder, there’s probably about three or four herbs that
you would include in the mix. But the remainder of the mix would be made up of herbs that would treat the person as a whole.

Of interest in these examples is how the WHTs distance themselves from the practice of treating diseases but simultaneously employ medical terminology. As the WHTs talked, they had provided an insight into the complex process of holistic herbal prescribing and how they build herbal formulae. The WHTs had emphasised the therapeutic benefits of using whole plant preparations and capitalising on the multiple therapeutic actions achieved by mixing different herbs together into a single formula. Thus, the practical aspect of competently formulating and dispensing an herbal mix was, it appeared, an art in itself.

5.2.2.2 Individualism: Therapeutic flexibility

WHT 12: I don’t think I’ve ever made up the same formula twice, even for the same person; it usually varies from visit to visit. You can use herbs which will complement each other … you can use herbs to balance a formula … depending on the person, it’s really very individualised.

As described earlier, the individualism of WHM implied working out a new treatment strategy for each and every person booking a consultation. The WHTs emphasised how each and every client is considered as an individual and, therefore, requires a unique herbal formula. The WHTs described how liquid herbal preparations were vital to their practice because they offered the WHT the therapeutic flexibility needed to individualise herbal formulations.

WHT 15: I don’t reject the use of pre-formulated tablets. I use some in my practice. However, I am a Western herbalist. The patient-centred approach to medicine is at the core of my philosophy and, as such, I employ liquid herbal medicines as the cornerstone of my practice.
Similarly, another WHT explained that herbal liquids are used primarily because they allow the practitioner to tailor make prescriptions and adjust doses to individual needs:

WHT 14: Liquid herbs are used by professional herbalists because you can individualise the treatment.

The idea that liquid preparations offered both therapeutic flexibility and control over their prescriptions was commonly expressed. Indeed, all of the interview participants indicated that they preferred liquid herbs over solid dose preparations (i.e. tablets or capsules) because the individualised nature of many herbal formulae necessitated a preparation form that can be mixed and blended by the dispensing WHT.

WHT 13: The liquid has a lot of advantages. The first advantage is because it’s liquid you can mix up any amount of any combination to individualise the formula … I just love that and the fact that you can vary and change the formula according to a person’s response, individual tailor made – you can’t go past that.

WHT 15: What else offers the same degree of therapeutic flexibility? Therapeutic flexibility is necessary if we want to live up to our claim of being holistic practitioners who look at the whole patient.

WHT 1: I have more control over the liquids in terms of dosage and flexibility, and there’s not as much flexibility in tablets as in the formulas that I would like to use for that person.

The thesis survey had indicated that over 97% of WHTs operate their own herbal dispensary. The qualitative findings confirmed the survey data, which had indicated that practically every WHT in Australia manages a herbal dispensary as a part of their herbal clinic from which herbs are dispensed as individualised herbal formulae, rather than as single herbs, and liquid extracts in
preference to solid dose preparations. Each and every WHT interviewed managed a herbal dispensary and stressed the advantages of having it as a part of their herbal clinic. As the next extract indicates, the herbal dispensary was perceived to be an ‘indispensable’ (no pun intended) part of the herbal clinic:

WHT 5: My dispensary is in the clinic, which I think is an advantage for several reasons. First up, when clients walk in and they see all the herbs … then they see you actually mixing up the herbs. I explain I’m tailor making this medicine for you, no one else, just you, and as your health response changes we can change the formula.

This ability to control the herbal prescription by using liquids emerged as one of the most important reasons for WHTs maintaining a herbal dispensary. In addition, the herbal dispensary was described as a part of the ‘mysticism’, the ‘psychological advantage’, even the ‘magic’, of visiting a WHT.

Thus, the interview participants described liquid extracts as a cornerstone of their practices because the holistic principles of WHM predicated individualised formulations that were tailored to suit the needs of each and every client. It appeared that the WHTs considered the power of the herbal medicines lay in the expert choice of the remedy or mix of remedies made by the practitioner, rather than the simple pharmacological effects of the medicines. The ‘expert’ use of liquid extracts and preparing individualised formulations, rather than using tablets, emerged as a core feature of the WHTs’ professional identity.

5.2.3 Pursuing Holism

The qualitative analysis confirmed that the modern practice of WHM in Australia continues to subscribe to the principles of Holism. Subsequently, the analysis switched focus towards the WHTs’ experiences of practising WHM in their own herbal clinic. WHTs were asked about their perceptions of their role as
healthcare practitioners and their perceptions of clients’ motivations and/or expectations from WHM treatment. As the WHTs described their experiences, it became evident that they were compromising upon their idealised model of practice in response to their clients’ expectations of WHM treatment.

5.2.3.1 The role of the WHT: ‘filling a gap’

A prevailing theme to emerge from the WHTs’ accounts of their role in healthcare was of ‘filling a gap’ in mainstream healthcare. The analysis suggested that people’s motivations for seeking WHM were essentially practical in nature and that WHM clientele are utilising WHM as a complementary form of healthcare. In the first instance, the WHTs confirmed the survey findings that most people were not relying on WHM as their primary healthcare choice. During the interview process, WHTs were directly questioned about whether or not they were working as a primary healthcare practitioner. Responses were predominantly negative:

WHT 2: Most of my clients have visited a GP. They come to see me because they are still unwell. So, generally, they have already got a diagnosis; most are taking drugs (i.e. pharmaceutical medicines).

WHT 13: Probably not. Probably not. Most clients would have been to consult a GP (general practitioner) first.

WHT 18: Most of my clients have already consulted a doctor … and most are already taking a pharmaceutical medicine.

As these statements indicated, the majority of WHM clientele have already undertaken a medical diagnosis and many take pharmaceutical medicines. As indicated in the next quote, although some people seek WHM for philosophical reasons or as a form of preventative healthcare, the WHTs perceived a large
proportion of clientele seek herbal treatment because mainstream medicine has ‘failed’ to provide a solution.

WHT 11: Some people stress natural medicine, so they’ll come to me first, but mostly my patients are people for who the medical profession has failed.

The WHTs listed a number of reasons as to why they perceived people to be seeking WHM treatment – these motivations, it appeared, were predominantly practical in nature. Firstly, the interview participants explained their perception of the growing frustration among their clientele with mainstream medicine:

WHT 7: They come for herbal medicine because of frustration with orthodox medicine. They come to see me because they haven’t got or found any answers elsewhere.

WHT 4: Why are patients coming to see me? Ah, for the most part I get to see them after they’ve tried everything else with regard to the orthodox system. They come in with a bag full of pharmaceuticals and say ‘what can you do?’ Yeah, they’ve tried everything else: ‘what can you do?’

All of the participants stressed how a large majority of their clientele were seeking herbal treatment for conditions that had not responded to medical treatment. Indeed, some participants argued that herbal medicines were often sought as a ‘last resort’ by people with long-term chronic problems:

WHT 3: A lot of people I’ve seen say, ‘I’m fed up with doctors. I’m fed up with getting nowhere. I’ve had this problem for so long and all they’ve done is give me medication or give me antibiotics and tell me that they can’t help me. And so I’m here. You’re my last chance.’ I love that line, I really love that line.

WHT 13: They’ve got to a point where they have tried everything; they’ve knocked on every other door they could possibly knock on and they just happen
to either get my card from wherever and they just ring and go, ‘can you help me?’

WHT 17: … sometimes I'll have people come or they'll ring up and say, ‘do you treat chronic fatigue?’ They want me to treat all these chronic or un-diagnosable diseases … which orthodox medicine can’t treat.

Implicit in these quotes is the suggestion that the WHTs have heard these and similar queries/sentiments expressed by their clientele on many occasions. The qualitative data provided confirmatory evidence to support the survey findings, which had indicated that a major determinant for herbal consultation centred upon dissatisfaction with pharmaceutical medicines, particularly a growing concern about the effectiveness or side effects of drugs.

WHT 5: I think because a lot of people aren’t getting results with pharmaceuticals and they aren’t happy about taking pharmaceuticals: they’re unhappy with either the results or the side effects of the poly pharmacy.

WHT 12: They’ve been through the medical system and they’d like to explore other options, mainly because of side effects of their medicines.

Another, smaller group of participants argued that their clients were increasingly disillusioned with the poor inter-personal features of mainstream healthcare and were thus looking for different sources for healthcare.

WHT 11: … people who have got really, really insulted by their doctor’s treatment: not listening, telling them they’re lying when they’re actually in pain. They (doctors) don’t actually say ‘you’re lying’, but they say it a different way … You know, that’s inexcusable in this day and age to say that kind of thing to somebody. It’s all in your mind – well excuse me!
The WHTs’ accounts had suggested the prevailing motivation for using WHM was dissatisfaction with mainstream healthcare. The WHTs confirmed they were predominantly treating chronic conditions that had not responded to pharmaceutical medicines. The WHTs had indicated that overall their clientele were predominantly seeking herbal treatment for practical reasons related to poor health rather than ideological or philosophical or spiritual beliefs.

5.2.3.2 Compromises and concessions

The theme of ‘Holism’ was central to the participants’ conceptualisations of WHM practice. Further analysis revealed that the public held a number of ‘misconceptions’ about the form and content of WHM and, thus, the nature of the treatment they would receive as a result of seeking a WHM consultation. The following analysis suggested that WHTs are frequently compelled to compromise upon their basic holistic principles to meet their client’s expectations.

5.2.3.2.1 ‘Re-inventing the wheel’

A commonly expressed concern amongst the WHTs was the generalised lack of knowledge about WHM practice coupled with a lack of understanding and appreciation for herbal medicines amongst their clientele. Apparently many clients were unaware of what to expect from a consultation and treatment; thus, an initial consultation typically involved explaining the basic principles and practices of WHM.

WHT 4: Explaining Herbalism every time someone walks in the door is interesting. There is just such a lack of exposure to, and experience with, herbal medicine – in this part of the world, anyway.

The prerequisite to explain the basic principles of WHM to clientele was described as ‘re-inventing the wheel every time someone walks in the door’, as
‘time consuming’, as ‘can be mundane’ and, even, that it potentially became ‘quite boring’. To overcome this issue, many WHTs had prepared brochures for their patients to read describing the fundamental principles of WHM and what to expect from a consultation. Nonetheless, it seemed common practice to explain the broad scope of the holistic consultation, case history and ultimate treatment outcomes to clients in order to circumvent any potential misunderstandings.

WHT 2: To put them at ease, I tell them what I do, what we’re going to do. Because even if they’ve come to see me about their skin, I want them to be aware that I’ll ask them questions about their bowel habits and things like that. Which may not, in their minds, be linked to what they’ve come to see me about. So I explain what I do. That it (Herbalism) is about taking everything into consideration, not just their skin.

As the WHTs talked about their interactions with their clientele, a list of concessions made to their ideal approach to practice emerged from the data. These included providing symptomatic treatments, shortening the length of consultations, reducing treatment periods, as well as offering tablets instead of liquid herbs. In the first place, it was a common perception amongst the WHTs that many clients perceived herbal medicines to be ‘natural drugs’ to be used as safer substitutes for pharmaceutical medicines.

WHT 9: Most people think it’s natural, so it’s got to be better; it’s natural, so it can’t hurt you; and then, on the other side, it’s they’ve had bad experiences with orthodox medicine and they’re looking for an alternative.

WHT 10: Most people actually want a natural alternative to the pharmaceuticals. I think there’s a general perception in the community that drugs have side effects that they don’t want and, rightly or wrongly, the word ‘natural’ has positive connotations.

These statements suggest that people were motivated to use herbal medicines because they are considered to be ‘natural’, and thus considered ‘safer’ than
pharmaceutical medicines. As implied by the term ‘rightly or wrongly’, the WHTs argued that this was an oversimplified perspective about herbal medicines. It was explained that some herbal medicines do contain powerful phyto-chemicals and have potential to provide quick symptomatic relief:

WHT 2: Some herbs are very powerful … but saying that it is safe just because it’s natural is wrong. There are many things that can go wrong with natural medicines if they are used incorrectly. Most of the adverse reactions occur with self-prescribing.

Recalling an earlier theme (see Section 5.2.1.3), the WHTs had made a point of stressing that the ideal aim of the WHT was to support nature to allow the body to heal itself. The WHTs reinforced the contention that herbal medicines are ‘safe’ if they are prescribed within the WHM philosophy: that is to say herbal medicines are safer when they are used as supportive therapeutic agents not as suppressive agents.

WHT 11: I don’t heal, the body heals itself or, rather, nature heals. My job as an herbalist is twofold: to support the body to heal; and remove all impediments to heal, as well. What the doctor does, his philosophy, is simply to attack the problem.

WHT 12: Allowing the body to heal takes longer (than symptomatic treatment) and a lot more effort from the patient. Herbalists are not just aiming to treat the symptoms but we are looking at balancing the whole system.

The participants explained that allowing natural healing to occur is generally a slow and gentle process. Therefore, the effects of herbal medicines, being supportive remedies, are usually much more subtle than pharmaceutical prescriptions. The common rule of thumb for herbal prognosis was described as ‘one month of treatment for each year’ that the condition had been present. This was a concept not generally understood by WHM clients and generally needed to be explained in a consultation.
WHT 14: I also explain that they may not get an immediate result. I explain to people that a disease process builds up over time, so that it then takes time to treat and they have to take medicines for longer than a drug that is going to suppress a symptom.

Nonetheless, the WHTs described their perception that the public had expectations of a ‘quick fix’ and described the pressures they felt to produce ‘quick results.’ As described earlier, in addition to taking herbal medicines, holistic treatment requires personal changes to be made by the client, such as diet or lifestyle. The WHTs considered many of the public simply wanted a quick fix – they did not necessarily want to make any lifestyle or dietary changes. For example, as WHT 8 indicated, ‘I have a patient at the moment that is very difficult; she doesn’t want to change anything (referring to diet, lifestyle).’ As a consequence many WHTs admitted to offering symptomatic treatments. As the next quotes show, symptomatic prescribing without the option to extend the treatment to address the underlying causes was considered to be a significant compromise on their holistic principles:

WHT 17: I think the general population want a quick result. They want some immediate impact right now! ‘I want to feel better now.’ Even though where they are now might have taken twenty years to develop. ‘I want something to change in the next week’. So, I do treat symptomatically, initially, to make people feel better.

WHT 13: People do want results immediately. So, unfortunately, we do treat symptomatically but with the understanding that we’re going to go beyond that if they will allow that.

WHT 1: Well, the treatment aim is to get the person feeling well. So, if there are any specific conditions, I would use symptomatic relief to help that person feel better, obviously, and then later address the underlying cause of why that person is feeling that way.
Another issue of compromise was related to the preference expressed by many clients for herbal medicines in tablet form. As indicated in the survey, herbal tablets and capsules are now commonly incorporated into a WHT's dispensary and are regularly prescribed. The qualitative data indicated that this is a response to patient expectations. In the next quote, the WHT explains how the mainstream public wanted herbal medicines but they want them to be in the same form as pharmaceuticals:

WHT 16: They seem to want pills. They just want to swallow a tablet. I think they are used to just popping pills. Everything comes in a blister pack now.

It appeared, from the WHTs’ accounts, that clients could make an appointment seeking herbal treatment but were actually reluctant to take the herbal preparations. For example:

WHT 17: I had a patient who returned their herbal mix for a refund. They said ‘it’s got green bits floating in it’. I laughed inside and with a straight face said, ‘yes, that would be the herbs’. Fancy that, plants in an herbal mix!

In addition, the taste of liquid herbals emerged as a significant obstacle to patient compliance. Many WHTs described the strong aversion of some clients to the often bitter taste of liquid herbs. In the following quotes, the participants describe their strategies to overcome the problem:

WHT 2: I always tell clients that my herbs taste terrible – that it will be the worst thing they ever taste – and then they generally come back and say, ‘it wasn’t as bad as you said’ (laughs). I think it works on reverse psychology.

WHT 1: I might have a mother that wants herbs for their child. So I prescribe some herbs. I explain about the bad taste and I explain it may not be easy to get the child to take them. So we talk about that, but she doesn’t have any success at all, comes back and is really upset. That affects me too.
As indicated in these quotes, WHTs are well aware of the potential constraint of the taste of herbal medicines upon the client’s compliance. In some cases the strategy of proactively warning the client works but, as illustrated from the example of prescribing for a child, taste is a significant issue that can negatively impact both the client and the practitioner. As argued previously, the WHTs perceived liquid herbs to be the cornerstone of their practice but it appeared that some clientele have different expectations about the preparation form of their medicines.

5.2.3.3 Financial considerations

WHT 7: They hate it; they hate it (the cost). They’ll comment, like, ‘so much?’ or their faces fall … and I’ve had elderly people who say ‘oh no’ and ask for old age pension discounts and this and that. I’ve given it a couple of times and I know perfectly well they’ve got far more money than I do!

Perhaps, as highlighted in this quote, one of the most significant constraints upon WHM practice was financial considerations – for both the client and the WHT. Many of the WHTs underlined the frequently negative reactions they received at the time of asking for payment over the cost of WHM treatment. Cost was highlighted as an obstacle to people booking an initial consultation because ‘it is difficult … making people understand … that it is worth spending the money on in the first place (WHT 3)’, as well as limiting the client’s willingness to return for repeat consultations.

WHT 12: I’ve refined consultations down. For most people it’s only one, two or three visits and that is not long enough for any true healing to take place, so my results have not been amazing.

The extracts suggested that practitioners are aware that their goal of pursuing holistic treatment is dependent upon the willingness or, indeed, financial ability of an individual to pay out of their own pocket for WHM treatment. A direct
consequence of the cost of undertaking WHM treatment was that many clients
do not pursue treatment long enough to achieve ‘true healing’. As the following
quote indicated, the demand for ‘quick fixes’ may be strongly linked to the
potential cost of pursuing holistic treatment:

WHT 14: People want a quick fix; they want something for nothing. They don’t
truly value your time, your experience.

This quote also reflects a common misgiving by the WHTs that many clients did
not understand the level of expertise required to competently formulate an
individualised treatment plan. Nevertheless, many of the participants described
the significant internal conflict they experienced asking for remuneration for their
services and/or the herbal medicines they dispensed. One WHT explained how
difficult it was to ask for money after a consultation because it impinged upon
the client-practitioner relationship:

WHT 7: I’m very happy, and the only trouble with spending an hour and a half in
a consultation is then you get really fond of them and you really want to help
them. And then it’s terrible to ask them for some money.

In a similar vein, a fairly inexperienced WHT described her process of
reconciling her ‘desire to help everyone’ against the need to be more business
orientated. She described how her ‘bubble had been burst’ when she realised
that people will actually try to take advantage of her disposition:

WHT 8: Oh, by gosh, you learn that painfully, though, don’t you … I think that’s
one of the enormous lessons that you learn when you come out of college with
all this new knowledge bubbling around a big desire to help everybody and do it
for nothing. And then, on the other hand, you get certain people who just try and
bleed you dry. Well, you have to be able to handle both. And you handle the
bleed-you-dry by saying, ‘Look, I can’t do justice to you with half a consultation:
you ring up and book a consultation.’
What was also evident in this quote is the reality of moving from the nurturing
confines of college, where everyone is ‘bursting with enthusiasm’, to the
practical realities of life as a clinician. Balancing the demands of paying the bills
with honouring one’s holistic principles emerged as a substantial challenge
facing many WHTs. Further questioning with more experienced participants
indicated that this dilemma was common amongst all the WHTs, no matter what
their level of experience.

WHT 8: Well, I take a lot shorter consultations now, I can tell you. I used to give
too much. I think I used to try and do too much. And I realise, now, that you just
confuse people by trying to do too much and you sell yourself short giving too
much.

This WHT, a very experienced clinician, explained the importance of becoming
more efficient in order to reduce the length of consultations, in order to reduce
client costs, and in order for her to increase her volume of clients. One very
experienced WHT explained her particular strategy to streamline her herbal
formulary:

WHT 18: I actually start from scratch in each case, but I have a staple of
recipes, ready to be adjusted … some recipes have worked spectacularly well,
and I immediately think of them in a similar situation because it simply makes it
easier than starting from scratch. But I’m more than capable of starting from
scratch, and I do it on about 50 percent of people.

As demonstrated above, some experienced WHTs have developed a staple of
recipes that could be adapted quickly with confidence to different cases, yet
allowed individual ‘tweaking’ of the formulae – a compromise between holism
and pragmatism. Overall, the analysis indicated that both the general public’s
expectations and financial considerations place significant constraints upon
holistic practice. The participants had described a delicate balancing act
between their holistic deals and accommodating the demands of their clients’
expectations. Although the interviewees articulated an idealised concept of
WHM as holistic healthcare practice, they also described the reality of practice as a process of constant negotiation between competing interests and conflicting demands.

5.3 Rationalisation of practice

The analysis revealed that Holism was central to the WHTs’ accounts of clinical practice. Furthermore, the analysis demonstrated how the rhetoric of Holism was employed as a tactic by the WHTs to distance WHM from medical practice. On the other hand, the survey had indicated a significant degree of rationalisation of WHM in Australia. How then do WHTs accommodate medical science within the WHM framework? The qualitative data indicated how the WHTs employ a number of rhetorical devices to accommodate science within WHM; but a significant degree of internal tension is evident within WHM in relation to the role of medical science within WHM practice.

5.3.1 Accommodating science within WHM

The qualitative analysis revealed three rhetorical devices used by WHTs to accommodate science within the WHM conceptual framework. Firstly, the participants frequently used historical references to legitimate WHM tradition; secondly, the participants described WHM tradition as an eclectic one – meaning that WHM is a system that had evolved over time by blending different knowledge claims into its framework. Finally, the qualitative analysis suggested that the conceptual framework of WHM is broad and, therefore,

17 The term ‘knowledge claim’ is used here as defined by Creswell (2003), to mean the philosophical assumptions or claims about what is knowledge (ontology) and the processes for studying it (methodology).
interpretively flexible. As a result, while all the WHTs perceive themselves to be holistic, different sub-groups appear to have adopted different interpretations of the basic tenets of WHM and opinions regarding the salience of medical science within WHM practice.

5.3.1.1 An ancient and eclectic tradition

The legitimacy of WHM tradition was commonly reinforced by reference to its ancient historical lineage. It was explained that the foundations of WHM could be traced back for centuries to the ancient Greeks. In fact, the basic tenets of WHM had originated from the work of the father of medicine himself: Hippocrates.

WHT 11: My wonderful herbal text books, which, you know, are distilled from 5000 years of wisdom, empirical observation.

WHT 2: Western herbal medicine has its roots way back with the Greeks, with Hippocrates and Dioscorides. WHM has a tradition of some twenty-five hundred years.

The idea that WHM is not a fixed body of knowledge but rather one that has evolved and changed in response to prevailing ideas was widespread throughout the participants’ accounts.

WHT 18: Herbal tradition is built upon mankind’s shared experience when faced with human suffering to devise creative new ways of applying herbs and foods. Over thousands of years these novel approaches have enormously increased our ability to alleviate people’s suffering. In this way we have evolved our materia medica.

In a similar fashion, many of the participants stressed that the WHM knowledge of plants has evolved gradually over a long period of time by observation. The participants suggested that WHM is not a purist tradition but one that has
always, throughout history, been open to accepting knowledge from different cultures.

WHT 2: Western herbalists have never restricted themselves to using European materia medica. A lot of the knowledge of the European herbalists came from Egypt and the Middle East and from India. It is called Western herbal medicine, but a lineage on its own is not true; it's an eclectic collection of practices and herbs.

The WHTs described the evolution of the WHM materia medica. For example, in Australia, the modern materia medica has been influenced by Asian herbal medicine:

WHT 13: We (Australian WHTs) use Ayurvedic or Chinese herbs but we tend to use them in our prescribing methods, not in their prescribing methods.

Hence, WHM was conceptualised as a ‘flexible system of herbal medicine’ that has continually adapted over time by incorporating a wide range of ideas, concepts and observations into its knowledge base. As evident in the next citation, the term eclectic was introduced to describe this ‘flexibility’:

WHT 11: Now, the ancient tradition that has become modern Western Herbalism is an eclectic philosophy: it means the tradition that we use has accepted many traditions into itself and taken the best of each, including what became modern science.

The WHTs’ accounts revealed that WHM has over time integrated many different types of knowledge into its framework. The term ‘empirical’ was used by the participants to describe historical knowledge. As described in the following statements, the WHM knowledge of herbal prescribing has evolved out of thousands of years of observation of the therapeutic or toxic effects of plants in the human body:
WHT 14: Well, there is empirical evidence that has built up over time, and now we are getting the evidence that is coming from clinical trials and modern scientific research.

WHT 2: Western herbal medicine … has been modified through the ages, and nowadays we take on more and more scientific information, which, interestingly, is proving what we’ve already known on an empirical level; but it’s nice to have it confirmed.

Illustrated in these statements is how the participants considered the traditional ‘empirical’ knowledge base of WHM to have been validated by scientific evidence. Also evident within the participants’ talk was how they constantly debated the relative merits of empirical traditional knowledge versus modern scientific knowledge of herbal medicines. For example:

WHT 8: I think that empiricism has an important role to play: it is not scientific, but it’s certainly qualitative evidence. I think that is very important.

WHT 17: There is a place for science in terms of understanding more about herbs … scientifically investigating the chemistry of herbs. But you could spend a lot of time and money and still not understand how they work … science doesn’t really prove or disprove anything.

Notably, in both quotes the WHTs accepted the value of both types of knowledge claims – the empirical and the scientific. These data suggested that from the WHT’s perspective the traditional (empirical) knowledge of WHM has not been discredited, but actually vindicated, by science. As described in the next quotes, the WHTs reflected upon how their own clinical experience had reinforced their confidence in the traditional indications of herbal medicines:

WHT 13: Getting good results in clinic keeps reinforcing that herbal medicine is not just a fairy tale; it has been working for centuries and centuries and that reinforces your own confidence in your own practice.
Nonetheless, phrases such as ‘not just a fairy tale’ and ‘I know they will work because …’ indicated that the WHTs are consciously and actively advocating the validity of their traditional knowledge.

Thus, both traditional knowledge and modern science were accommodated within the eclectic WHM framework. The qualitative data suggested that within modern WHM traditional empirical data is referenced to substantiate the claims for the reliability of the materia medica. However, scientific evidence is considered to offer confirmation of the validity of the traditional use of herbal medicines. In this way, the analysis explained how WHM is a traditional system of medicine, but one that has accommodated science.

5.3.1.2 Interpretive flexibility of Holism

Holism had emerged as a defining feature of WHM practice and was a common rhetoric in which all the WHTs shared. Nonetheless, as the qualitative analysis proceeded, individual participants offered varied interpretations of Holism. Some of the interview participants stressed the spirit, mind connection. These WHTs emphasised the ‘energetic’ aspects of Holism in their accounts and this translated into making an assessment of the ‘vitality’ of the client.

WHT 1: Herbalism is supporting the body through using herbs to increase vitality; not just looking at a particular disease or illness, but supporting the body’s own innate intelligence to heal … its vital force, if you will.

WHT 2: Herbal medicine is about aiming for balance, supporting the vital force, the body’s ability to heal itself. The vital force has been described variously as light force, energy field etc. It’s an indefinable quality in a person.
In these quotes, Holism is linked to ‘Vitalism’ - the traditional philosophical concept that translated into supporting the individual’s ‘energy’, ‘essence’, ‘light force’, ‘subtle body’ or ‘vital force’. Words such as ‘suppress’ or ‘force’ indicated that the function of herbal medicine is not to override human physiology, but to gently support the Vitality and thus stimulate the body to heal itself. Alternatively, others emphasised the opposite end of the holistic spectrum, stressing the importance of identifying and treating the underlying physiological cause:

WHT 12: I think my main focus is to find out the underlying causes, which are usually the basic physiological functions like digestion. From an herbalist’s point of view, my main aim is to find out the underlying physical cause.

As demonstrated in the next citation, while some WHTs advocated the Vitalistic elements of WHM tradition, other participants openly questioned the currency and validity of this particular aspect of traditional philosophy:

WHT 15: The reason I advocate the scientific model is the evidence that supports it; although I appreciate it as a concept I'm still waiting to see any evidence in support of the actual existence of a vital force.

These participants, who promoted the more physical aspects of the holistic spectrum, stressed the importance of harnessing the pharmacological properties of herbal medicines for therapeutic benefit. In the next quote, the WHT alludes to the disagreement operating within WHM between those adopting a Vitalistic perspective and those advocating a more ‘physical’ explanation of how herbal medicines actually work:

WHT 8: Well, people adhere to different theories about what doses to use. Some people adopt theories that it’s not the constituents of herb working; it is the energetics of herbs. That is possibly true but it’s not something I hold with, myself. I bring change about on a physical level using a larger dose. The herbs have a physiological effect.
These data suggested that WHM offers a broad interpretive framework and that there are a number of internal tensions operating with WHM, particularly in relation to the salience of tradition within modern WHM practice. The qualitative data indicated that WHM practitioners are in a constant process of negotiation between traditional and scientific world views.

5.3.2 ‘Medicalisation’ of practice

As described in the opening section, the WHTs’ talk continually contrasted WHM to mainstream medicine. However, the thesis survey had indicated a high use of medical science within clinical practice. This process in which medical sciences are being increasingly incorporated into clinical practice was referred to by the participants as the medicalisation of WHM. The analysis indicated that the medicalisation of WHM is an issue in which the WHM profession is currently and consciously engaged in debate, and is a contentious and divisive process operating within the WHM profession.

Two broad indigenous categories of WHTs emerged from the analysis: firstly, the medical herbalists (n=10) who emphasised the importance of medical science within modern WHM; and secondly, a sub-group of interviewees (n=8) who advocated the maintenance of a traditional approach to WHM practice. The analysis indicated that the process of medicalisation is an issue that touches upon the very essence of what WHM is, and what it means to be a WHT.

5.3.2.1 Medical herbalists

In general, the medical herbalists argued for the importance of an approach to clinical practice firmly underpinned by medical science. The medical herbalists seemed to not only advocate the importance of, but also seemed comfortable with, medical science.
WHT 7: Both, both, both (science and tradition). Why not use the best of all? We’d be foolish not to use the best of both.

WHT 13: Diagnosis and treatment decisions require a scientific basis – it helps with understanding the disease process.

As these quotes indicate, the medical herbalists advocated the value in utilising both medical science and WHM tradition. Furthermore, the medical herbalists did not seem to perceive the medicalisation of clinical practice to represent a significant compromise on their holistic practice. A very experienced WHT explained that, although her practice had increasingly become ‘medicalised’ over time, it had not required her to compromise on her qualitative approach to practice; it had not changed the fundamental way she practiced:

WHT 5: The core way I practice hasn’t changed in terms of taking a solid case history and looking at the underlying patterns and layers and then prescribing an herbal formula. I still practice holistically.

The medical herbalists stressed the value of medical science, how it constituted a valuable adjunct to modern WHM practice, but also stressed that they were still holistic practitioners. The data also indicated that the integration of medical sciences into the WHM knowledge base was a key strategy to establish improved status for WHM as a form of healthcare. In the next statement, the WHT highlights the direct relationship between science and mainstream ‘acceptance’ of WHM:

WHT 3: I have come to realise that we need scientific validation, if we want to be accepted by the community as a whole, if we want to be accepted by the medical profession. We want our medicines to be taken seriously. They will not be taken seriously while we have airy-fairy, intuitive new age people. That’s the wrong way.
A tactic running through the medical herbalists’ talk was to distinguish WHM from more traditional or ‘arcane’ practices. Instead of referencing their past, the medical herbalists actually distanced themselves from certain aspects of their tradition and advocated the need to ‘move with the times’, ‘to validate practices,’ to ‘move into the new century’.

WHT 18: This is the twenty-first century; this is not 1940 or 1950. With the amount of litigation around and with the emphasis that the medical profession has on science, without scientific evidence litigation is a real fear.

As suggested by the reference to ‘litigation’, the medical herbalists were concerned about establishing the legitimacy of WHM within the modern era. Apparent in the above quote, by the use of the terms ‘airy-fairy’ and ‘intuitive’, is how science is used as a strategy to actively distance herbal medicine from less scientific, esoteric practises. An example of this is clearly articulated in the next quote:

WHT 5: I’ve always been careful; sometimes herbal medicine is mixed up with tarot card reading sort of stuff … so I’ve always adopted a more medicalised practise of herbal medicine.

Other fairly deprecating terms that appeared in the medical herbalists’ accounts for non-medically based practice were, for example, ‘mumbo-jumbo’, ‘folklore’, ‘fortune telling’ or ‘crystal waving nonsense.’ From the medical herbalists’ perceptive, medical science was an extremely important aspect of modern WHM, particularly for ensuring patient safety. To this end, the medical herbalists seemed keen to stress how WHM practitioners are now educated in medical science. As one WHT stated:

WHT 8: ... students are being trained to understand conditions and to understand the physiological and the pathological basis to conditions.
The perspective especially common amongst this group was that teaching medical sciences to herbal students was an increasingly important professional responsibility, especially in terms of quality of care and public safety. One medical herbalist echoed this argument, calling for the minimum qualification level to be improved and upgraded to a degree:

WHT 3: Students are far better educated now and I’m one of the people that advocate a Bachelor degree as a minimum qualification … because people put their health in our hands and I treat that seriously.

As this quote intimated, within WHM there is an ongoing debate about the requisite form and content of education and the minimum level of qualifications needed to become a registered WHM practitioner. Thus, the medicalisation of clinical practice appears to be a key strategy within WHM for securing the legitimacy of WHM within the mainstream.

5.3.2.2 Traditional herbalists

On the other hand, the more traditionally orientated WHTs were concerned about the increasing medicalisation of WHM practice. The growing imperative to be qualified in medical sciences was seen as a concern for these practitioners, who explained how they felt reluctant to conform to the pressure to embrace medical science because it was too much of a compromise of their traditional principles. The traditional herbalists were concerned that WHM tradition and philosophy was being compromised and could potentially be pushed aside in favour of the ‘medical paradigm.’ For instance:

WHT 2: Medical science can help to enhance our practice, but what concerns me is that it will overtake the tradition associated with the prescribing of herbal medicines.

WHT 14: The way herbal medicine is been taught now, the traditional philosophy is really rushed over and the medical paradigm is taking over.
As shown in these statements, of central concern within this group’s talk was that WHM was in danger of being overshadowed by the medical paradigm. In comparison to the medical herbalists, the traditionalists argued that the growing emphasis on medical sciences was operating at the expense of WHM and its unique characteristics. As an example, in the next extract the WHT expresses concern about the incongruity between the philosophies of WHM and mainstream medicine:

WHT 17: … medical professionals are coming from a completely different philosophy, they’re coming from a completely different diagnostic framework and their treatments are completely different. Some of the ideas and skills are transferable to practice but not all. See what I mean?

As another illustration, one traditionalist argued that WHTs seem to have lost their affinity with the earth and have lost contact with plants. The participant, a practitioner with about ten year’s experience, described how ‘living plants’ seemed to have very little to do these days with the study of herbal medicine:

WHT 4: We seemed to have divorced ourselves pretty much entirely from nature in the Western world at the moment … Like, even to the degree in my training, there was no herbal garden. All you saw was something dried or liquid in a bottle. I’m sure there’s something missing there!

Indeed, as described earlier, very few of the interview participants had referenced plants when they were asked to define herbal medicine at the commencement of each interview. The traditionalists argued that the medicalisation of clinical practice was blurring the line between WHM and the medical profession. In the following extract, the WHT thoughtfully reflects upon the implications of the increasing influence of the medical paradigm upon the WHM profession:

WHT 16: … it seems we are becoming preoccupied with treating the disease, rather than assisting the body to cure itself. Does it come from our need to compete with the medical profession? Are we abandoning the most distinctive
difference between our profession and the medical and even the naturopathic profession? I would be interested to know whether this change of emphasis (towards medical science) is common to our profession worldwide.

A dominant concern amongst this group was that the new generation of practitioners was operating as ‘mini-doctors’ rather than herbalists, overly concerned with medical diagnosis and, as reflected in the earlier quote above, ‘becoming preoccupied with treating the disease.’ The group of traditionalists all followed a similar line of logic, maintaining that the WHM profession should be emphasising their difference to medical practice, not trying to compete with the medical profession. One traditionalist stressed that the medical profession is, and has always been, antagonistic towards WHM. Therefore, the best way forward for WHM was to emphasise its differences to mainstream medicine, not blur the lines.

WHT 16: Well, I think that the challenge is to have what we do respected; we are never going to be understood. I feel that doctors couldn’t give a stuff about us. I think this silly idea we’ve got, that if only we could show them how clever we are then they’d understand, is just a futile ambition … we need to stop being such wimpy apologists.

The traditional herbalists seemed to be comfortable with the empirical evidence base of their materia medica and while not dismissing, qualified the necessity for medical science within WHM. Overall, the traditionalist preferred ‘a live and let live’ approach, noting that it was the patients’ choice to seek their services and that WHM was sought because it was so different from the mainstream approach. Significantly, many of this group were well established with a viable client base and were comfortable with their approach to practice. Most of this group had started practice when herbal medicine was well and truly considered an alternative practice, and training was a less formalised process.
5.3.3 The dosage debate

The quantitative data demonstrated that within WHM there exist different approaches to dosage. The qualitative analysis indicated that the topic of herbal dosage is actually a complex and contentious issue. Dosage was a topic worthy of specific exploration because it reflected and contextualised a number of the earlier themes in this chapter. The question of herbal dosage provided a good example of how the intra-professional debates about the authentic approach to practice are being mediated within the profession. It is important to highlight here that not all of the WHTs who were identified as traditional herbalists advocated drop dosing and indeed one medical herbalist even supported the drop dose system.

5.3.3.1 ‘Material’ or ‘drop’ doses

The survey indicated that the predominant approach to herbal dosing within WHM is based upon prescribing pharmacologically active doses of highly concentrated fluid extracts. However, a small band of WHTs prescribed very small ‘drop doses’. The interview participants explained that within WHM a standard dose generally consisted of a standard teaspoon of an herbal formula taken three times a day (5mls TDS).

WHT 8: I’m a bit more of a high dose person … that means that in a two hundred ml bottle I could easily use five herbs. The client takes about 5mls three times a day.

However, a dose of medicine could be as small as taking a few drops throughout the day:

WHT 9: I give a number of herbs. Technically, I would use six herbs in a mixture and then dosage is generally fifteen drops, three times a day. I guess I use a type of Herbalism that’s a little bit different to the mainstream and most herbalists. I use drop doses.
The indigenous terms used amongst the interview participants to distinguish the different approaches to dosing were either ‘material’ or ‘pharmacological’ for the larger doses, and ‘drop dosing’ for the smaller. In both of these quotes, the phrases ‘I’m a bit more of a high dose person’ and ‘a little bit different’ suggested that the participant is sensitive to the fact that using drop doses is not considered mainstream, even within WHM. The dosage debate provided an example of how the earlier theme of the interpretive flexibility of Holism is expressed in practice. As described in the next extract, drop dosing is an expression of the Vitalistic conceptualisation of health; on the other hand, the material approach to dosing is heavily influenced by a more grounded and physical conceptualisation of health.

WHT 9: Okay, so with the drop doses it’s basically using the smallest effective amount to assist the body to find its balance. So, rather than using a high dose that works physically, giving the smallest minimum dose stimulates the vital force.

In summary, small doses are perceived to act energetically upon the subtle energy patterns of the body, mind and spirit to stimulate the body’s natural physiologic responses. However, as the herbal dosage increases, the effects of the medicine become more physical and the chemical constituents of the plant produce a pharmacological effect. The question about whether herbal medicines work at an energetic or at a physical level and how each practitioner answers is, it appeared, central to how individual WHTs ultimately prescribe herbal medicines. The qualitative analysis provided a number of key indications that the drop dose perspective is one that is being increasingly challenged from within modern WHM.

5.3.3.2 The case against drop dosing

The efficacy of drop doses is a contentious issue within WHM. Firstly, the practice of drop dosing was confined to a small number of the interview participants (n=4). The case against drop dosing revolved around one simple
argument: i.e. small doses are sub-therapeutic, meaning they are pharmacologically inactive and, therefore, not effective medicines.

WHT 13: Low doses don’t get any results because the dosages are not even pharmaceutically active.

WHT 8: I like to get the maximum oomph out of what I’m doing. I don’t like the drop dose idea at all … I’m always trying to get something therapeutic happening.

As another WHT argued, using a common pharmaceutical to carry her point, drop dosing was in effect the same as ‘under dosing’:

WHT 5: It’s like taking a quarter of an aspirin for a migraine. It is not going to work. You take a quarter of an aspirin if you want to prevent a DVT (deep vein thrombosis); you probably take four aspirin for a migraine.

As these quotes indicated, drop dosing was subject to criticism within WHM from WHTs who advocated material doses. Indeed, the majority of the participants reacted quickly to distance themselves from the practice of drop dosing. The material dosers argued that their approach of using higher doses was based upon a solid evidence base. In the next quote, the participant references both types of knowledge claims – traditional and scientific – to substantiate the material dose perspective:

WHT 14: The therapeutic doses are based on both empirical evidence and modern research.

WHT 1: I am sceptical about drop-dosing. All the scientific and empirical evidence is based on larger doses.
However, for some practitioners the concern was not that drop doses had no efficacy at all, but that herbal medicines simply took too long to work when used in such small doses.

   WHT 2: What’s amazing is that it doesn’t really matter what method of dosage you use, the results still seem to turn up. I personally use a high, medium, low dose.

In the next quote, the WHT references her own clinical experience to explain that higher doses are much more effective than small doses and capable of producing the desired therapeutic result much more quickly:

   WHT 13: Using drop doses, people were eventually getting better but it was taking a long time; and the bigger the doses I started to give people, the quicker it (results) started to happen.

Similarly, another practitioner originally trained in drop dosing described how she learned from ‘bitter’ practical experience that such small doses were less effective than higher doses:

   WHT 3: I was trained in drop doses and when I started work of my own my struggle started. I started to really question what I was doing. People start to feel better within three or four days with bigger doses, whereas it could take weeks before people start to feel better when they are on drop doses.

Statements such as these reflected straightforward clinical considerations. The use of phrases such as ‘I started to really question’ and ‘my struggle started’ were indicative of the dilemma experienced by some practitioners for whom drop dosing had not produced successful clinical results. With hindsight and the benefit of having used both approaches, the WHT questioned not only the efficacy of small doses but also raised the concerns about the ethics of ‘drop dosing’.
WHT 3: I was taught to give ten drops, which is not even close to a therapeutic dose. I was really questioning the ethics behind that sort of practice and that sort of philosophy. It calls into question the value of herbal medicine.

As suggested in this analysis, the question of dosage reflected more than a disagreement about clinical practice but also reflected broader professional issues related to the validity of herbal prescribing and the legitimacy of WHM.

5.3.3.3 The case for drop doses

In response to such criticism, the drop dosers provided many examples from their clinical practice of how well clients had responded to drop dosing. For example:

WHT 9: Fantastic results, really good results. I usually find within two weeks they start to feel the herbs kicking in. It’s very, very, very rare for someone to come back and not feel the difference in their system and heading in the right direction.

The evidence base supporting the drop dosers seemed to be predominantly built upon anecdotal evidence derived from the individual’s clinical experience. The next quotes provide examples of how the drop dose advocates strengthened their case by referencing positive reactions from some medical practitioners with whom they shared mutual clients:

WHT 9: One lady in particular has such good results that she sung the praises of herbal medicine to her specialist, and he was so impressed with her results he rang me to find out what I had done.

WHT 10: Well, in the past twelve months I’ve actually had a doctor make time to come and talk to me, to see if she could refer some clients to me.
The drop dosers de-emphasised the importance of scientific evidence, arguing that science can’t explain how herbal medicines work, anyway. Instead of scientific evidence, they emphasised their traditional empirical knowledge:

WHT 13: The body is a system of subtle energies and the fact is that the way our medicines work is unexplainable scientifically in most cases. But if you have enough people, over time, using herbal medicines, that demonstrates their effectiveness.

But also apparent in this quote is how, for this group of practitioners, the ultimate authority behind the legitimacy of their approach was philosophical. As evident in the next few citations, drop dosing is informed by the traditional philosophical concept of Vitalism:

WHT 4: Herbal medicines aid your body’s own ability to heal itself. I wouldn’t suppress or force my will on your body. Herbs support your body’s own ability to correct an imbalance. Herbs support your vitality.

WHT 10: The mind, the body, the spirit, everything is connected, and real healing is on the whole person … herbal medicines stimulate the body to heal itself, stimulates its vital force.

However, the drop dosers emphasised how the role of herbal medicines is to gently support the body and gently stimulate the body to heal itself, not to override human physiology using strong medicines. They emphasised the non-physical aspects of healing. Many terms, such as ‘energetic’ or ‘spiritual’ or ‘etheric’, were used by the drop dosing advocates to rationalise their approach. Within this sub-group of interview participants, the validity of intuition as a part of the process in choosing herbs for clients was proposed:

WHT 4: Well, I prescribe intuitively … it is a skill that I have developed over time. It’s very useful because you’re not sitting in the consultation wondering what needs to be prescribed … you can just sit there and be with the person, be present. I go across to the shelf; a particular herb will tell me it is required.
WHT 9: Sometimes, when I am working out a formula, it’s just a thought that pops into my head. It’s a herb knocking on the door and saying, ‘I need to go in as well’. I stand by my dispensary and sometimes my hand just reaches for one. Just sitting listening to someone goes a long way to helping them heal.

Both of these statements describe a very similar process of how the prescribing process is an interaction between the practitioners, the clients and the herbal medicines. In both statements the emphasis is placed upon spending time with the client because it is considered to be a powerful force in the overall process of healing. The quotes provide another insight into why, for the WHT, it is important to maintain their own dispensary in their clinic. The drop dosers acknowledged that a common criticism of drop dosing was that such treatments were simply placebos. One way in which the drop dosers counteracted this criticism was by actually claiming the placebo effect to be a legitimate component of their holistic strategy, arguing that the placebo effect is a natural and powerful healing process and harnessed within by the holistic practitioner.

WHT 13: It doesn’t matter what medicine you use, what dose you use, they’re all just props … to stimulate the body’s healing vitality.

WHT 9: I understand that the mind plays a big part. I like that, because if someone believes something is going to work, then it has a greater chance of success.

In addition to these esoteric arguments, the drop dosers also provided a number of practical reasons to support their case. Firstly, it was argued that drop dosing is not only effective and reliable but better tolerated by clients:

WHT 13: There are much less side effects with drop doses. People don’t notice the taste and they don’t report adverse reactions to the herbs.
Another drop dose advocate argued that the risk of drug-herb interactions and/or an adverse reaction is almost completely removed when small doses are used:

WHT 9: I think too any people are taking medications these days. Who really knows what the impact of the interactions between their medications and with herbal medicine? So, in one way that is why it is good using drop doses because at least I know I can’t harm anyone.

Furthermore, drop dosing overcomes many of the compliance issues associated with the taste of fluid extracts:

WHT 13: Clients can disguise the taste in a glass of juice if they are only taking a few drops. So, I find people will keep taking their herbs. That is not always the case when they have to take a whole teaspoon full.

Finally, drop doses were promoted as a cost effective approach to using herbal medicines:

WHT 4: People do not need to take large doses and so it is cheaper for them to use herbs. That is important if you want people to use herbal medicine.

It was explained that with the standard doses a 200ml bottle of herbs lasts only two weeks while a smaller bottle of herbs with a dropper lasts much longer, up to a month in many instances. For example:

WHT 9: After an initial consultation I might see someone again in four weeks time so the, the remedy I give them lasts them four weeks.

Recalling an earlier finding, WHTs had reported a negative response amongst their clientele about the cost of herbal treatment. Drop dosing provided a potentially powerful strategy to overcome compliance and financial barriers to using herbal medicines.
5.4 Summary discussion

As described in Chapter 1, many treatises on the philosophy of WHM describe it as a holistic and individualised therapy, and these themes dominated the WHTs’ accounts of the provision and practice of WHM. The theme of Holism emerged as central to not only how the participants approached clinical practice but also to their interpretations of their professional role. The analysis presented in this chapter indicated how WHTs’ explanations of their holistic practice guide their approach to both clinical practice and herbal prescribing, but also described how individual interpretations of these holistic principles feed into ongoing issues relating to the salience of science within WHM.

The qualitative data indicated that across the WHM profession there is a jointly held identity of being holistic healthcare practitioners. Embedded in the WHTs’ discourse were descriptions of how the meaningful aspects of WHM practice are not simply the acts of identifying a disease or the dispensing of a medicine, although these are clearly important. Instead, the WHTs highlighted how the interaction between the client and practitioner, signalled to the client that they are not just a patient, a sick person, but an individual with emotional needs. WHTs perceived themselves to be concerned with the complex underlying causes of ill-health including social, lifestyle, emotional, spiritual and physical problems or ‘imbalances’ and, therefore, offering a quality of care often missing in medical practice.

The analysis also suggested that the rhetoric of Holism is somewhat an idealised professional discourse. Firstly, as revealed by the theme of concessions and compromises, the examination indicated that client expectations, as well as financial considerations, are significant constraints upon holistic practice. The qualitative data indicated that WHTs perceive many of their clientele to have preconceived expectations about herbal medicine. These included perceptions of herbal medicines to be replacements for pharmaceutical medicines and, therefore, expectations of receiving herbal
medicines in pill form, offering a quick fix and suppression of symptoms. Furthermore, the attitudes and financial considerations of clients can have a significant effect in dictating the time available to the WHM practitioner: time in terms of the length of the consultation, as well as the total length of the herbal treatment and prognosis.

Secondly, the qualitative data revealed a significant degree of internal tension operating within WHM about the salience of science over WHM tradition. Although the survey provided strong evidence of a trend towards the rationalisation of the clinical practice, the results indicated that the prescription of herbal medicines remains a predominantly traditional practice. While most of the interview participants perceived the integration of medical science into WHM to be a necessary pre-cursor for legitimate participation in mainstream healthcare, a smaller group of WHTs, those with a traditional perspective, advocated for the continuation of their traditional practices and promoted a role for WHM as an alternative to mainstream healthcare.

Thus, the qualitative analysis revealed how the dominant medical paradigm has impacted upon WHM and helped to explain the growing influence of medical science upon WHM practice, as described in the survey study. The interview study confirms, in reference to the opening quote, that WHM is indeed a complex mix of tradition and medical science. The qualitative analysis also revealed a significant degree of intra-professional divergence over the salience of tradition versus medical sciences within the modern clinical practice of WHM. The exploration of the drop dose debate, for example, highlighted some of the strategies used within WHM by the sub-groups to legitimate their particular perspective.

Many of the findings from this analysis support Tovey and Adams’ conclusions, as outlined in Chapter 3. Firstly, that the subordination to, and thus distinction
from, mainstream medicine was a dominant issue within the WHTs’ discourse. The participants essentially positioned WHM as what was described in Chapter 1, a ‘holistic’ model, and medical practice as a ‘technocratic’ model of medicine. Secondly, the investigation revealed how pre-conceived notions of healthcare held by WHM clientele have impacted upon the existing model of WHM practice. Finally, the analysis identified a number of competing sub-groups within WHM who each advocated particular interpretations of WHM philosophy and, thus, adopted different approaches to WHM practice. These findings are explored in greater depth in the concluding discussion presented in Chapter 7.

As outlined in Chapter 1, the strategy of inquiry was organised around two broad research objectives, which were to both describe WHM practice and explore the social context of WHM provision in Australia. The next chapter builds upon these findings about clinical issues with further exploratory data investigating the context of WHM provision.
Chapter 6 Qualitative study results – Part 2

“... any system of medicine is practised within a social and political context and involves inter-personal transactions of a more or less institutionalised nature. These social dimensions are as much a part of medical practice as clinical knowledge.”

(Sharma 1992)

Chapter outline

In this chapter an exploratory account of WHM practice within its social context is presented. Chapter 6 broadens the focus of the qualitative analysis from clinically related issues towards the interview participants’ perspectives and experiences of practising WHM within the current environment of Australian healthcare.

6.1 Introduction

In Chapter 1 it was argued that mainstreaming has been potentially operating at the expense of the CAM professions because of the continuing dominance of the medical profession (Shuval et al. 2004; Tovey et al. 2004; Singer et al. 2007). In this chapter, part two of the qualitative study is presented, and the unit of analysis shifts from the individual participant’s accounts of their clinical practice to exploring their shared perspectives and experiences as a professional group. The analysis suggests that the WHM profession is, indeed, struggling to negotiate a role within mainstream Australian healthcare and reveals a number of strategies used by the WHM profession to legitimate the practice of WHM. At the same time, a number of divergent views emerged from within WHM on whether and/or how the WHM profession can improve its position vis-à-vis the mainstream.
6.1.1 Themes

The WHTs involved in the in-depth interview study were all at various stages of their herbal careers, some with many years of clinical experience and busy herbal clinics; while others were in the first few years of practice, some struggling to attract clientele. Nevertheless, a general concern within the WHTs’ discourse centred upon the barriers to legitimate participation of the WHM profession with mainstream Australian healthcare. In this chapter, results of the analysis are divided into two sections. The first, entitled ‘Professional struggle’, outlines the predominant theme common across all the accounts of practising WHM: it considers the many challenges confronting the WHM profession as it progressively engages with the mainstream. The second section, ‘Locating WHM within the mainstream’, focuses on different perspectives within WHM about the role of the WHM practitioner in healthcare and the salience of professional regulation as a stratagem to secure legitimate status for the WHM profession within the mainstream.

6.2 Professional struggle

WHT 18: It’s intriguing to me that when you look at recent publications that $13 billion in Australia and billions more in America is being spent on herbal medicines, alone. In Australia, I think a survey showed expenditure (on CAM) was four times what’s being spent on the PBS (Pharmaceutical Benefits Scheme) and that’s money out of people’s own pockets. But the truth is that herbal practitioners are struggling!

Professional struggle emerged as an umbrella theme spanning all of the in-depth interviews. Despite the increasing expenditure by the public on CAM, the participants’ talk centred upon their experiences of the financial insecurity of working as a WHT, owning a herbal clinic and of the difficulties of attracting clientele systemic within the WHM profession. A few of the WHTs participating in the interviews were very well established, successful practitioners with extensive client lists; nevertheless, all of the participants collectively highlighted
substantial doubts and their uncertainties related to the viability of WHM as a career in general.

WHT 3: There are very experienced people who are fed up with not earning any money.

WHT 12: I am struggling to attract clientele. I came out of college recently quite confident and really quite passionate about the industry, but that feeling just been really squashed.

As these quotes demonstrate, the privation of clientele has threatened the enthusiasm for practising WHM of both new and experienced WHTs. The participants cited many examples of the financial strains experienced by themselves and their peers, citing how ‘too many people are working for very little return’ (WHT 11). As an illustration, in the next quote the WHT described the patience required to persevere in light of the difficulties associated with building a successful herbal practice:

WHT 9: I guess when you initially start out it probably takes a good five years to actually build up a number of a client base to pay even your rent. So, in those initial times it’s, like, is this worth it? Am I going to make enough money from this to make this a career?

This quote reflected the common doubts expressed amongst the WHTs of the financial viability of herbal practice. Similarly, in the next citation another WHT talks of her necessity to rely on family to sponsor her practice:

WHT 10: But if you haven’t got a partner who is earning an income and can support you then there’s no way you’re going to make money out of herbal medicine as a career.

Many of the WHTs explained how they maintained a second job to ensure a steady income stream. A widely held source of part-time work often involved
working as a massage therapist or working in a pharmacy or health food store giving ‘free’ herbal advice.

WHT 9: I did a massage course first because you can always make money on the side massaging people while you try and build up your clientele.

WHT 8 Well I have been in practice a very long time. But I’ve always done other things. You couldn’t survive just in practice.

WHT 4: I work in a health food store and also have the massage clinic part-time.

Across the board, it was explained how WHM was a career choice that required significant personal, emotional, intellectual and financial investment – an investment that in many cases did not show large financial returns. Reflecting on the cost of a herbal education versus potential income earning capacity, one very experienced participant commented pragmatically that ‘perhaps people are wising up … it’s around seven thousand-odd a year to train and all you’re going to do at the end of it is flog things in a pharmacy’. This WHT argued that the idea of WHM as a feasible career was now questionable:

WHT 8: Now I think a kind of consciousness is creeping through, and as a career choice people are being a lot more cold-hearted and clinical and looking at what it’s going to cost and what can I expect in return and, perhaps, seeing the ratio doesn’t quite work.

The same participant, involved in education of WHTs for almost thirty years, explained how the significant hardships of making a living were becoming a significant obstacle to the future growth of the WHM profession. She emphasised her case with the observation that after an initial peak of interest in the 1980’s the numbers of new students enrolling to study WHM had declined significantly in more recent times:
WHT 8: We’ve seen two peak periods. In about the early eighties there was a real peak of student numbers and then that peak came again about ten years later, but interest (in studying herbal medicine) has died away again.

So, ongoing discussion about financial issues had uncovered concerns amongst the WHTs about the future viability of the WHM profession, itself. Emerging from exploration of the theme of professional struggle were three primary causes for the profession’s dilemma: firstly, *discriminatory policy* towards WHM within Australian healthcare structures; secondly, perceptions of growing *competition* over the supply of herbal medicines to the Australian public; and finally, experiences of professional *isolation* within the WHM profession. The analysis revealed that the WHTs perceived these processes to be actively impacting upon the viability of the WHM profession, particularly in terms of the individual WHT’s ability to attract and build a strong client base. These themes are explored below.

### 6.2.1 Professional discrimination

WHT 10: I am against the whole public healthcare system, where pharmaceutical drugs are subsidised but natural medicines are not. I also worry about the plethora of herbs out there in the marketplace, people self-diagnosing and doctors prescribing and getting it wrong. I think sometimes there’s a sort of grand master conspiracy happening.

In this quote the WHT joked acerbically about ‘a conspiracy’, but the quote was reflective of a general perception amongst the WHTs of systemic discrimination within the public healthcare structures that favoured the medical profession at the expense of WHM. The quote highlighted how the WHTs considered the discrimination they were experiencing to be an ongoing and active process and one formalised in legislation. Phrases such as ‘an uneven playing field’ or ‘the decks are stacked against us’ littered the participants’ accounts of the difficulties of practising WHM in the current inequitable healthcare system. The analysis
revealed three pre-eminent sources of discrimination: inequity of public healthcare, public prejudices and professional censure.

6.2.1.1 Systematic inequity

A common theme amongst the WHTs was of the negative impact upon the WHM profession of the inequitable healthcare policies in Australia, which excluded WHM from the public healthcare system.

  WHT 18: … until we get government funding and until we get Medicare behind us, I think that within the next ten years we are going to see a lot of people drop out (of practice), including a lot of experienced people drop out. I don’t know what’s going to happen about the new students. The profession is struggling.

In this particular instance, the WHT explained how the WHM profession’s ‘struggle’ was directly related to discriminatory governmental policies that have excluded WHM from Medicare. Clichés such as ‘no win situation’, ‘underdogs’ and ‘the little guy’ littered the WHTs’ accounts of their current socio-political position. Several WHTs explained how the public may want to seek a WHM consultation but were not necessarily willing to pay for such healthcare because of access to subsidised medical care:

  WHT 3: People can walk into the doctors, they can hand over their Medicare card and they can get the money back … We charge more but can’t get Medicare; patients can’t claim. We can’t afford pension discounts because none of us earn enough money and we don’t get any benefits from the government.

  WHT 13: They can get a herbal mix from a doctor and not have to pay GST and walk out fifteen minutes later. Now, we keep them for an hour … and they (herbal patients) resist payment.
In particular, the WHTs highlighted a perceived resistance amongst the public to pay out-of-pocket for a herbal consultation. In the previous chapter the significant difficulties of attracting clients because of the cost of treatment, both the consultation and the cost of herbal medicines, was described. In the following citation, the WHT stresses the additional burden of substantiating the costs of a consultation when medical practice is publically subsidised:

WHT 14: Yes, I do love it (Herbalism) even though it is difficult. I guess the biggest frustration is making people understand the differences between herbal medicine and orthodox medicine and that it works and the positive impact it can have on your health and that it is worth spending the money on.

These quotes are straightforward claims of inequity linking the financial insecurity being experienced by many within the WHM profession to a discriminatory public funding policy. Some of the participants argued that the existing public healthcare system discriminated against those members of the public who wished to access herbal medicine. In the next extract, the WHT contends that public healthcare policies were creating a situation, in which WHM was becoming the domain of the wealthy, the 'very lucky elite':

WHT 11: I think the government is failing people … unless you're one of the very lucky elite. Now, a hell of a lot of people, without any fault on their part, really can't afford to come to us and that is a problem. I don't actually believe the government is ever going to put us on Medicare.

This quote reflects the scepticism, common amongst the participants, about the likelihood of an equitable re-distribution of public subsidies. Also apparent in the WHTs’ talk was a cynicism about the form and content of mainstream healthcare provision. Many of the participants expressed incredulity that in this day and age, when public healthcare funding was such a major political and economic issue, that mainstream healthcare perpetuated the expensive and often invasive treatments before considering the simpler, safer and cheaper natural alternatives.
WHT 10: What I would like to see happen is that community attitudes and government attitudes change and be more positive because I really think the health system is in such disarray: it is falling apart at the seams and as we all get older and health funding will become an issue. I wish governments would get the message that if they encourage people to take preventative health steps by supporting us (herbalists) in the same way they do as doctors, they could save the community a fortune.

WHT 18: The mind, body, spirit, everything is interconnected, which is where I think the orthodox medicine has gone wrong … Why do people, when they can’t conceive a child, think the first port of call is to go to the IVF clinic? They spend a fortune, all that embarrassment, pain and emotional destructiveness. No doctor says to them, look, have you thought about how your diet affects you? It’s that simple.

The participants’ accounts suggested that, while schooled in medical sciences, the WHTs held a deep-seated antipathy towards the current approaches to healthcare and the public healthcare model. The WHTs explained how the current discrimination potentially threatened the future of the WHM profession:

WHT 13: … well, constantly feeling under threat because of not being recognised and feeling like, at any point now, we could disappear as a profession!

WHT 12: Well, there’s no government support. We’re trying to be professionals, act in a professional role, but the government as yet doesn’t recognise us as professionals. We’re at the mercy of the government.

The WHTs frequently employed a rhetoric of vulnerability represented by the repeated use of phrases such as ‘at the mercy of the government’, ‘we could disappear as a profession’, ‘we are invisible’, ‘our position is precarious’ and ‘constantly feeling under threat’. The WHTs questioned why, despite being
highly qualified, the WHM profession continued to be sidelined or marginalised from public healthcare, as if they were invisible. For example:

        WHT 17: We have so much to offer. We are highly trained. Are we invisible?

Thus, the analysis suggested that, despite the increasing popularity of herbal medicines in Australia, the WHM profession continues to be marginalised and thus occupies a role on the fringe of healthcare.

6.2.1.2 Public prejudices

        WHT 8: Well, I think one of the big struggles is that we as practitioners know that we were well educated but we came up against such personal bias from doctors and from members of the public.

Another prominent sub-theme of professional struggle centred upon a perception of prejudice towards WHM from the general public. The WHTs outlined their experiences of discriminatory behaviour towards themselves from both the public and the medical profession. As illustrated in the next quote, many WHTs felt this discrimination stemmed from personal bias rather than informed opinion:

        WHT 15: It is staggering the amount of ignorance that exists among the public and even other health professionals about what we do.

        WHT 8: The people who don’t like natural therapies (due to) what they believe about us is not evidence based or fact based, it is merely an expression of their personal bias, their ignorance.

Most of the WHTs conceded that attitudes towards herbal medicines were changing slowly but they argued that prejudice, perhaps as a legacy of the past, persisted.
WHT 2: There is greater acceptability within the general public of herbal medicines. Once upon a time everybody thought it was rubbish. Nowadays, everybody you speak to will say 'oh I believe in natural remedies', which is fine, but there's also a lot of misinformation about herbal remedies out there in the public.

As described in the next quotes, the WHTs considered some of the public to associate herbal medicine with an element of mysticism, magic and, therefore, the herbalist with the occult:

WHT 10: Many in the public are sceptical, very sceptical, about herbalists. I am sure some of them think I was a witch in a past life or something.

WHT 12: The general public does not understand herbal medicine. Some people, I think, see herbal medicine as a bit cultish and a bit obscure. I had one comment from a patient … that people will think he's joined a cult or something because he tried to eat more wholesome foods.

Indeed, some of the participants openly used the word ‘ignorance’ to describe the public’s prejudice. On the other hand, one WHT sympathising with the public perspective pointed out that prior to studying herbal medicine she, too, had very little understanding about WHM:

WHT 18: I don’t think the general public knows much about herbal medicine and, thinking back to my impressions of it before I studied it, I didn’t know anything either.

Other participants highlighted the importance of the WHM profession actively working on redressing misconceptions about herbal medicines and re-educating the mainstream about the expertise and educational qualifications of the WHM profession:
WHT 5: There are lots of challenges, in terms of promoting an understanding in the Australian public, of the level of education of registered herbalists and the potential value of herbal medicines.

WHT 16: I think there are a lot of people out there who still think it is quite wishy-washy. They don’t realise how much study is involved and that there is a lot of science and that it is actually quite complicated. I spoke to someone not long ago who was really surprised that I had done a degree.

Thus, the WHTs accepted the importance of changing public perceptions about the level of knowledge, skills and training of the WHM profession, as well as the potential of herbal medicines as effective medicines to secure a legitimate role within Australian healthcare.

6.2.1.3 Inter-professional censure

WHT 8: Well, I think that the challenge we have is to have what we do respected by the medical profession.

Implicit throughout the WHTs’ accounts was the perception of the subordination of WHM to the medical profession. Indicative of this was how the WHTs’ accounts centred upon the perception of discrimination towards themselves from the medical profession, which translated into experiences of inter-professional censure. Indeed, this was a persistent theme, as the next few quotes indicate:

WHT 18: There is a lot of negativity out there towards what we do from the medical profession.

WHT 2: There are sectors of the medical profession who are totally anti natural therapies for whatever reason and have, in my opinion, very closed minds to natural therapies.
The survey study had indicated a considerable degree of intersection between WHM and the mainstream medical profession. Despite the increasing levels of concurrent patient care most of the interview participants reported the continuing resistance to their presence in healthcare, particularly by the medical profession. Considering, as evidenced in the survey, that many WHM clients are seeking herbal medicine treatments because of dissatisfaction with pharmaceutical medicine, it is not unreasonable to hypothesise that there may be a fair degree of antagonism engendered between the two camps. The majority of WHTs reported that their professional advice was routinely dismissed by the medical profession.

WHT 9: Most doctors are very negative. They'll tell their patients to stop taking any herbal remedy.

The WHTs explained how the medical profession also routinely questioned the efficacy and validity of herbal medicines and provided many examples of the misinformation and misconceptions about herbal medicine held by the medical profession. For instance, as the next WHT described, the medical profession commonly described herbal medicines as simple placebos:

WHT 2: Herbal medicines are often ‘poo-pooed’ by doctors as only being placebo. And I think, well, if it is placebo it’s pretty powerful medicine because people get well and stay well.

At the same time it was reportedly common practice for the medical profession to argue that herbal medicines were dangerous and toxic:

WHT 6: Although people have been using herbs for eons, doctors seem to think they are all going to cause allergic reactions or liver failure.

Similarly, in the following quote, the WHT provided an example of a doctor who perceived herbal medicines to be contaminated:
WHT 15: A patient of mine was asked this week by her doctor if any of the herbal medicines I have prescribed contain steroids!

The participants highlighted their perceptions of the inconsistency of logic within the medical profession’s arguments against herbal medicines. As one WHT (11) argued, ‘either herbs are innocuous, or they are poisonous – you can’t have it both ways, boys!’ Some WHTs also argued, with a fair degree of cynicism, that the medical profession was actively pursuing a monopoly over healthcare:

WHT 10: The AMA (Australian Medical Association) is very blinkered. I think, really, what they want is to be the soul purveyors of health.

WHT 17: I think we should all write to our local politician because the message isn’t going to be delivered by the AMA. They want the opposite; they would like us all to be sort of run off into a cupboard and burnt at the stake or something.

Evident in such quotes is that WHTs are conscious of the poor relationship with the medical profession and corresponding poor levels of inter-professional respect. Such data clearly account for the survey finding, which reported high referral rates from WHTs to medical practitioners but a significantly lesser degree of reciprocation. Such statements suggest that the WHTs perceive stronger political forces, such as the medical profession, to be actively working to disadvantage them and exclude them from participation within mainstream healthcare. In particular, these extracts reflected an awareness of the differential in political power between WHM and the medical profession. These phrases suggested a deeply rooted antipathy that passed both ways between the two professions, but most of the participants expressed a desire for improved inter-professional relations:

WHT 17: It’s just a matter of both herbalists not being so doctor-phobic and the doctors not being so naturopathic-phobic.
A common notion raised amongst the WHTs was of the existence of deep philosophical and paradigmatic tensions between the two professions. In the next extracts, the WHTs explained how finding common ground between what was described in Chapter 1 as the ‘holistic’ and ‘technocratic’ paradigms is a significant source of tension between WHM and medical practice:

WHT 4: How do you explain to someone who believes the world’s flat that it’s actually round? For the most parts, they have no real understanding of what we do. It’s just the difference in philosophy of care, pretty much. If you do a degree that teaches nothing exists other than what they understand or perceive to exist, then nothing else exists.

WHT 2: Medical doctors have a different perspective on disease and health and so we’re challenging paradigms. I am not sure if there is common ground.

The WHTs recognised the dominance of the medical profession but they nevertheless expressed a desire for some degree of inter-professional respect from the medical profession.

WHT 16: I don’t think that they (medical practitioners) give me as much respect as I do them.

WHT 14: I guess a more equal relationship would be good. But I don’t know, I still feel like it’s very much doctors are up there and we are down here.

Thus, both the survey and interviews indicate that WHTs desire a closer working relationship with the medical community; however, at present, inter-professional relationships remain poor. The inter-relationship between WHM and the medical profession remains one of medical dominance characterised by censure towards the WHM profession.
6.2.2 Professional competition

The second sub-theme that featured strongly in the WHTs’ accounts centred on the growing level of competition from the mainstream over the supply of herbal medicines. In particular, the WHTs focussed on the commercialisation of herbal medicines and the trend towards the integrative practice of herbal medicine by the medical profession. In response, the WHTs frequently used a rhetoric of being the best qualified to provide herbal medicine and of offering expertise, safety and quality of practice to the public.

6.2.2.1 Competition from the medical profession

WHT 2: Greatest challenge! I think the level of interest that doctors are showing in natural therapies … because they get the best of both worlds. You can go and see a doctor and, although he's not supposed to, get a Medicare rebate for the consultation in which they prescribe natural medicines.

The integrative practice of herbal medicine by the medical profession was commonly highlighted as an issue of concern to the WHTs. Most participants conveyed a message of feeling a deep sense of injustice when reacting to this notion. To this end, strong emotive terms such as ‘hijacking’, ‘theft’, ‘pilfering’ and even ‘turf war’ were scattered through their accounts when referring to the prescription of herbal medicines by the medical profession. Similar sentiments were offered in one form or another by nearly all the participants:

WHT 16: It is a sad day when things like that start to happen. It is hard enough as it is, trying to help the community when people have to fork out their own money to see us. Now, if doctors start to use herbs and supplements, where does it leave us? Disappointed again!

The use of phrases such as ‘herbs belong with us, they do not belong to the doctors’ suggested that the WHTs perceived the prescription of herbal medicines by the medical profession to be an act of co-option (as defined in
Chapter 1). Further examples of terms frequently used by the WHTs to describe the co-option of herbal medicines into medical practice included ‘poaching’ or ‘cherry picking’ and even ‘theft’. Mirrored in the next extract is the idea that the integrative practice of herbal medicines is yet another obstacle on top of all the other obstacles for the WHT to overcome in their quest to practice WHM. Here, the WHT explains how the medical profession’s interest will inevitably challenge traditional Herbalism:

WHT 15: The entry of the medical profession onto our patch will mean (herbal manufacturing) companies will increasingly formulate products tailored to the medical model. Our approach might disappear.

As discussed in Chapter 1, there is now emerging evidence of a progressive rationalisation of herbal medicines in the West. In reaction, it was a common tactic for the WHTs to attack the medical practitioners’ prerogative, with little or no training, to prescribe herbal medicines. For example:

WHT 3: No. Doctors don’t know anything about them. They belong with us, with the people who know what they’re doing, not people who do not take it seriously.

WHT 11: Doctors are more likely to cause harm because they’re allowed to use toxic herbs that I’m not allowed to use (referring to S4 scheduled herbs). They don’t always have the philosophical training to understand when it’s harmful and why.

WHT 17: Now, the doctor who practises herbal medicine ... There are the doctors who do totally inadequate courses and because they’re doctors they’re legally allowed to prescribe anything they want, including herbal medicine, but they don’t really know what they’re doing.

In these comments, the WHTs not only advocated their credentials but actually questioned the medical practitioners’ competency to safely prescribe herbal
medicines. This theme of safe practice by observing one’s professional scope of practice was a common one amongst the WHTs.

WHT 5: Well you certainly aren’t going to do anything outside the realm of anything in your training. I’ve always been very conscious of that whole professional issue of not crossing boundaries in terms of not telling people to stop taking their medicines, ‘throw away your pharmaceuticals’. I believe you don’t work outside your area of expertise, your training. That’s safe practice.

WHT 17: If we are expected to observe medical scope of practice then, by rights, medical practitioners should likewise reciprocate and not start prescribing herbal medicines.

Also reflected in these quotes is the notion that observing scope of practice is a professional courtesy, but one rarely extended to WHM from the medical profession. Recalling, in the previous chapter, the WHTs had argued that their use of medical science was tempered by the recognition of the limits of their professional competence and, indeed, the survey data had indicated a high rate of referral of WHM clientele to medical practice for diagnosis and treatment. Another WHT outlined similar concerns about the competency of ‘doctors practicing herbal medicine’:

WHT 11: I have very mixed feelings about the doctors practicing herbal medicine. I would rather see good doctors refer to good herbalists and in exactly the same way good herbalists refer to good doctors. That’s a much better way; every one does a really good job and refers. I don’t want my patients being treated by a doctor who’s done six weeks in herbal medicine. They can make mistakes that I would never make.

Once again this extract reflected a concern amongst the participants with observing safe practice, professional expertise, respecting another profession’s scope of practice and patient safety. Also contained in this quote is evidence of an earlier theme of the WHTs’ perceptions of the medical profession’s seeming
lack of inter-professional respect. At the core of the participants’ rhetoric to defend their scope of practice from the medical profession was a tactic to demarcate the WHM professional as the best qualified to prescribe herbs.

6.2.2.2 Commercialisation of herbal medicines

WHT 3: The story that I’m getting at is that herbal medicine practitioners are struggling. All that money’s being spent in health food shops, pharmacies and supermarkets … That is where the money is being spent; it’s not being spent on practitioners.

WHT 10: My theory is that as herbal medicine is commercialised, for instance lots of Hypericum sold in lieu of the anti-depressant … practising as a full time herbalist may not be viable for a lot of people. I mean there might be a few who manage it, but not many.

A major concern for WHTs, principally because of its direct impact upon the financial success of their herbal clinics, was the increasing commercialisation of herbal medicines coupled with the public trend towards self-prescribing with OTC products. The participants’ talk centred upon the difficulties of attracting clientele to their clinics when herbal medicines were readily available, without the cost of a consultation, from many retail outlets.

WHT 11: A lot of herbal medicine is in pharmacies, health food shops and supermarkets, and there is a role for this because a lot of people cannot afford a full consultation with a natural therapist; but part of this is also the Medicare problem.

In reaction, the commercial herbal sector was characterised as a source of unreliable information, poor quality of the product and lacking guarantees of safety. Firstly, it was a common tactic to argue that the herbal products available in health foods stores were of an inferior quality, as compared to the
herbal medicines offered in a WHT’s herbal clinic. In the next extract, the WHT describes the difference between retail and ‘practitioner’ products in terms of raw ingredients and strength of the herbal medicines:

WHT 14: People are paying good money and it is not cheap buying in a health food store. There is no guarantee that they are going to get a result and they don’t know the appropriate treatment, dosage or the quality of what they are buying.

WHT 11: There is the strength of the doses. Doses are often a lot lower in the health food store. The retail products tend to be a lot lower doses, which is why I am surprised that some of them work.

The participants advocated professional herbal preparations over commercially sourced products by questioning the efficacy of OTC products. Also highlighted were the potential safety issues associated with non-professionally prescribed herbal medicines, in particular the increased risk of adverse reactions and/or drug-herb interactions likely to accompany self-prescribing.

WHT 2: … there are things that can go very wrong with herbal medicines if they’re used incorrectly. And most of the adverse reactions, I think, occur with self-prescribing.

In this case, the WHT argued that the open sale of herbal medicines in retail outlets presented a potential safety issue for the public. In a comparable fashion concerns were expressed about how, in the event of adverse reactions, the difference between an ‘expert’ and a lay prescription was usually not acknowledged. As the next WHTs argued, this circumstance had in the past, and may again in the future, result in the generalised restriction of access to herbal medicines:
WHT 10: People abuse and misuse herbal medicines and, eventually, officials will make a case because of herb-drug interactions to say the herb should be unscheduled (i.e. removed from the prescribing schedule).

WHT 2: Self prescribing is a problem. I mean herb-drug interactions have caused several herbs to be removed from the market over recent years.

Evident in these quotes is not only a concern for the perceived ‘misuse’ of herbal medicines, but that the WHTs were conscious of an irony: OTC supplements were often less effective than professional herbal formulations; potentially poor results or adverse reactions challenged public perceptions of herbal medicines and this, in turn, unfairly reflected back upon professional WHM.

WHT 10: But we are shooting ourselves in the foot by allowing it to flow into supermarkets and health food stores run by shop keepers who don’t know anything. Yeah, it’s a tricky one that – it is freedom of choice versus safety for the public.

The WHTs seemed to find it quite difficult to balance their desire to promote herbal medicines against their professional imperative to guard their financial interests. A common dilemma amid the WHTs was the apparent conflict between wanting people to use herbal medicines rather than pharmaceutical medicines, but at the same time having concerns over self-prescribing:

WHT 1: In terms of herbal medicine, how it fits into the community is tricky. Half of me believes that it’s best to be prescribed by a practitioner with knowledge; however, if people have the choice of going into a chemist and taking a drug of the shelf or some herbs, I’d much rather they take the herbal medicine. But then that gets back to self-prescribing versus seeing a practitioner. I’m not sure what the answer to that is, I would like the general public to have more availability to have herbal medicine as a choice, but then if they were able to see practitioners …
The passage above is a fairly lengthy one, but it was included because it was representative of the ambivalence in many of the WHTs’ talk about the use of herbal medicines by the public. Accordingly, some of the participants called for tighter regulatory control of herbal medicines. These WHTs argued for the establishment of a register of herbal medicines and restricting access of certain herbal medicines/products to ‘trained herbalists:

WHT 2: We could have a separate schedule set up for some herbs deemed to be too unsafe for general consumption but prescribed by appropriately trained people: a special schedule of herbs to which only professional herbalists have access. I see this as a way of protecting our profession.

WHT 3: The TGA (Therapeutic Goods Administration) have not listed any herbs at all and I think they need to be separated between practitioners and retail. Every single herb we have access to is allowed to be put on the shelves at the supermarket. Now that’s crazy; it is absolutely crazy. It is downright dangerous and it’s absolutely crazy. I believe there should be two tiers, one purely for practitioners of the stronger herbs.

So, the participants’ accounts suggested a degree of ambivalence over the increasing popularity of herbal medicines. The participants’ talk contained conflicted messages about the increased popularity of herbal medicines amongst the general public as they weighed the advantages of increased public awareness and consumption of herbal medicines against the impact of the commercialisation of herbal medicines upon the WHM profession. A potential solution to this dilemma, advocated by most of the participants, was of restrictions on the commercial sale of herbal medicines coupled with recognition of the expertise of the WHM profession to offer safe and effective prescriptions.
6.2.2.3 In-store consultants

WHT 3: People know they can walk into a pharmacy, they can walk into a health food store, they can get professional advice and they can walk out with something and they haven’t had to pay for consultation. That is impacting on all of us in our clinics.

Another issue of concern to many of the participants was the ease with which the public could walk into a retail outlet and avail themselves of a ‘free consultation’ with a qualified practitioner – often a naturopath or herbalist. Although the OTC market was a significant source of competition for the WHM profession, it was also the major source of employment for WHM practitioners. As described earlier, working as an in-store consultant was just one of the many strategies that WHM graduates often employed to secure a living from herbal medicine. Those interview participants who were employed as in-store consultants explained their dilemma of finding a balance between the need to supplement their income and maintaining their professionalism. This trend of WHTs providing free in-store consultations was of concern to many of the participants. As one WHT (6) asked, ‘Why would you pay for my services when you can a walk into a health food store and see an herbalist or naturopath for free?’ Demonstrated in the next quote is how the WHTs employed a rhetoric of ‘expertise, quality and safety’ to distinguish between a professional consultation and an in-store consultation:

WHT 11: There are a number of reasons why people should come to professional herbalists. One, it (the herbs) might not have worked because they don’t know what or how to use them. They may not understand there is a difference in quality between what is on the shelf and what their herbalist can give them. They may want a proper consultation rather than the advice standing up over the counter, which is not much safer or better than what a doctor does, really. We offer a different approach and a different degree of training.
Also evident in this extract is that the medical profession is also considered to be ‘unqualified’ to prescribe herbal medicines. In addition, the WHTs invoked the earlier themes of patient-centred care as a tactic to validate the cost of a ‘full’ consultation with a WHT in preference to an in-store consultation.

WHT 14: Those people who don’t have money, sometimes even people who do, think that if they go to the health food store they can get that free advice. They don’t understand what is involved in a full consultation and the individualised treatment. They miss out on a lot in stores – they can’t cover everything.

WHT 3: The only thing I say to people is that at least by coming and seeing me, or any other herbalist, you get the time spent to really go into things.

The WHTs strengthened their case against in-store consultations using adjectival phrases such as ‘quick’, ‘at the counter’, ‘in the middle of the shop’, ‘with people listening in’, ‘no privacy’ and ‘it is symptomatic prescribing’ to emphasise the shortfalls of the in-store consultation. Another response to justify the cost of a ‘full’ herbal consultation was to compare prescribing strategies, specifically standardised OTC products versus the individualised formulae:

WHT 1: There’s the herbal medicine from health food store and there’s herbal medicine that we prescribe as practitioners. Herbal medicines at the health food stores, for example, are tablets and so are the same formula, the same dosages. Whereas, at least with a practitioner there’s scope for changing formulas to individualise to the dosages as well as the herbs going into the formula.

The ‘expert’ use of liquid extracts, preparing individualised formulations rather than using tablets, emerged as a central tactic to differentiate professional WHM from lay practice. As described in Chapter 5, WHTs do use herbal tablets but this is a small part of their practice, a concession perhaps, but essentially liquid herbal preparation remains the fundamental tool of trade for the WHM.
profession. The current analysis suggested that the use of liquids, despite the patient compliance issues identified in the previous chapter, is more than a philosophical issue, it is also pragmatic one. The WHTs actively tried to professionalise WHM from the ‘unqualified’ commercial sector. Ironically, however, by working in retail outlets many WHTs have effectively became their own professional competition.

6.2.3 Professional isolation

Another theme to emerge from the exploration of the social context of WHM practice was that of professional isolation. The WHTs talked of the sense of isolation they experienced working as a clinician: isolation from both other WHM practitioners and from other healthcare professionals. The participants called for improved professional relationships and professional solidarity to assist individual practitioners to meet the challenges of practising in the modern socio-political context.

6.2.3.1 Poor intra-professional support

WHT 18: I feel the more support we are to each other the more we will take our medicine into the future as a respectable form of medicine.

The theme of professional isolation resonated through many accounts, particularly those who worked from home and by the newer practitioners. Most of the participants in the in-depth interviews worked in relative isolation from other healthcare professionals. In fact, all but five of the participants practiced as the sole practitioner in their own herbal clinics, seven of whom worked alone from their homes. Working from home, it appeared, was a commonly adopted compromise to reduce the many expenses associated with managing a herbal clinic.
WHT 17: I’m working from home. I guess I’d probably prefer to be working with other practitioners and enjoy that support with other partitioners, that would be good. But working from home is easier; you don’t have the overheads but then there’s no exposure, so it’s overall but it’s probably a disadvantage at this stage.

WHT 12: When I finished college, I thought that it would be ideal to work form home – not having to pay rent and things like that – but it’s very difficult. I advertised in the local paper which goes to quite a few areas, and did letter box dropping and nothing, absolutely nothing. I put some cards in local cafes and got one person from that, and it’s just been though word of mouth that I’ve got a few people, so it’s been very slow. Now I’ve started in retail at a pharmacy and worked there for almost a year and now I have just started at a practice just a couple of suburbs away.

Thus, the data suggested that the decision about where to locate their herbal clinic was made as a compromise for practical and financial reasons. As suggested in these passages, working from home is often not the most advantageous solution – it removes the WHT from interaction with potential clientele as well as from the mutual support of other practitioners. This issue was not insignificant given that over one-third of the interview participants worked from home (n=7). This theme of isolation emerged most noticeably from the accounts of the less experienced interview participants. The newer graduates within the interview cohort noted that there was no help available to them from within the WHM profession after they graduated: ‘No, you’re kind of left on your own’. In the next quotes, the WHTs describe their sense of the ‘overwhelming’ difficulties of moving from the confines of herbal college into herbal practice:

WHT 1: I don’t know where to begin, the difficulties of going out into practice. It’s very overwhelming, especially being on your own.
WHT 12: I think I came out of college very confident and hyped up about what herbal medicine could do and it all seemed very simple and clear, but in the real world it’s been such a challenge. I think feeling unsupported, that’s been the main thing. I’ve always sort of looked for a mentor, too; I’ve never had a good solid mentor.

As indicated in the second extract, the many challenges associated with starting clinical practice were, it seemed, being compounded by the absence of any form of guidance or support in times of need. Similarly, an experienced WHT with in excess of 15 years clinical practice described how the absence of intra-professional support for new members of the profession was perennial. She remembered her first few years in practice:

WHT 18: I remember when I first went into practice, trying to find support on issues I had not experienced and found none. If anything, the experienced practitioners either did not have time to assist me or did not want to.

Many of the WHTs indicated their desire to have had access to a mentor in the early stages of their career, particularly because of the complexity involved in holistic practice. For instance:

WHT 13: I definitely wanted to try and work alongside other practitioners with experience, either in a clinic or to have some sort of mentor that you can easily refer to and communicate with.

WHT 8: Holistic practice is difficult. Learning to formulate an individual treatment for every new client is challenging. You only learn by experience but there is no help when you first start to practice. So I learned a lot by my mistakes.

In the next extract, the WHT explains how inexperience amongst new practitioners could potentially result in poor, undifferentiated and untargeted
prescribing as the practitioner, in deference to the holistic framework of WHM, tries to treat ‘everything’:

WHT 14: If you get told you have all these systems in your body, which don’t work, that your emotions are a mess and the only way to fix it all is to take this herbal liquid, this herbal tablet, these nutritional supplements, these celloids, Bach flowers, make dietary changes and start a meditation program. There goes the patient’s food budget for the week and they are left feeling like their presenting complaint has been largely forgotten, ignored, rendered obsolete. They dubiously try half of the program for a week find little or no improvement and, so, don’t return.

This tendency towards over-prescribing was referred to as a ‘scattergun approach’ by several of the participants. The fact that it had been given a label by the WHTs indicated that it was not an uncommon intra-professional issue. WHT 14 explained how the cost of a consultation plus the cost of the medicines, particularly from ‘scattergun’ prescribing, often resulted in dissatisfaction amongst herbal clientele. Dissatisfaction amongst clientele then translated into low client numbers, particularly low return consultation rates, which in turn limited a practitioner’s capacity to gain clinical experience. She concluded by saying:

WHT 14: I think one of the most important answers to the low patient numbers problem is patient satisfaction. Our new members need support when they begin to practice … particularly dealing with tricky cases.

The WHTs’ talk suggested that the WHM profession was, itself, actively contributing to its own dilemmas by not supporting the new generation of practitioners. These data suggest that many WHTs are aware of the imperative for WHM to improve the levels of intra-professional support, particularly for the newer members of the profession. In the absence of intra-professional support, WHTs may continue to struggle to become more experienced and successful practitioners. The quality of ongoing professional support for its members was
highlighted by the participants as an issue of importance to the continued strength and growth of the profession.

6.2.3.2 Poor inter-professional communications

The survey respondents had reported feeling ‘comfortable’ communicating with the medical community. A large proportion of respondents indicated a ‘good to excellent’ working relationship with the medical community. In support of these findings, one interview participant described her experience of interacting with the local doctor in positive terms:

WHT 9: He (local doctor) said he was happy for clients to use herbal remedies; he was impressed that the people who were taking herbs were improving and he was happy to recommend anything that helped the clients improve … I don’t think he realised how many clients we had in common …

Another indicated the perception amongst the WHTs of a range of attitudes within the medical profession based upon individual inter-personal relationships:

WHT 13: It seems to be very personal. There’s either this absolute abhorrence of herbal medicine, which I think comes out of ignorance, or they’re open to it. I think the majority of doctors fall somewhere in-between.

In general, however, the qualitative data revealed a very different story. The interview data suggested few WHTs were at ease communicating with the medical profession and few were enjoying a positive working relationship with medical practitioners. Most WHTs emphasised how their attempts to create communication pathways with the medical profession had, in general, received disappointing responses:

WHT 7: I try and keep in touch and I try very hard with all the local doctors. We had a big party earlier in the year and we invited absolutely everybody – every health professional in the area, every doctor – and can you believe not one of them turned up, not one … We had a lovely party (sarcasm).
WHT 4: Some don’t even speak to me and are not interested in what I do. Others, who see the results their patients have using herbs, express a passing interest; but then it becomes all too hard for most because it’s very difficult to fit into the system structure they work under. Horrible system; when I’m looking into their system, I wouldn’t be happy working in that one.

The general perception amongst WHTs was of a negative attitude from the medical profession. As the last statement above suggested, some WHTs conceded that many medical practitioners were restricted in their ability to have open communication with their patients because of the constraints of the formalised healthcare system in which they operated. At a personal level, some of the participants admitted that they felt intimidated by the medical profession, describing inter-professional communication as a particularly challenging aspect of their role as a healthcare practitioner:

WHT 14: Yes, I would like to be able to write a letter to a doctor and say that these are my concerns and can they be investigated? But I am hesitant because I do not know what type of reaction I will get.

Another fairly inexperienced WHT rationalized how her communication with the medical profession was compromised because she, herself, had not understood the protocols surrounding inter-professional communications:

WHT 12: I had one patient who wanted me to access some of her information from the doctor or talk to the doctor and I didn’t even realise you have to get their permission before you ask for medical tests. I really blundered my way through.

The analysis revealed that less experienced WHTs could feel ‘anxious’ and ‘intimidated’ about communicating with the medical profession. One WHT explained that she believed this feeling was actually very common within the profession and described one of her inter-professional communications:
WHT 14: I have had to write a letter recently to a GP for one of my patients and ask her to revise one of her medications and it’s kind of hard. I don’t want to sound like I am telling her how she needs to treat her patients, so I had to be really sensitive in the way I wrote. I think many of us (WHTs) feel the same … you know, uncomfortable, unsure.

As a result, a fairly common tactic appeared to be to indirect communication via the patient. Interviewees described how, due to poor responses from the medical profession and feeling intimidated, many WHTs resorted to communication through the mutual client:

WHT 9: So, these days, I educate the clients. I always tell them that it’s good for them to tell their doctor what they’re taking because if doctors become more aware of having people who are taking herbal medicines, then they’ll have to think about it a little bit more.

Indeed, the survey data had indicated that patients consulting WHTs are encouraged to inform their GPs of herbal prescription, but the qualitative data indicated that this responsibility remains with the client. Another WHT described how she provided the client with strategies to use with their medical practitioner if their use of herbal medicines was challenged:

WHT 9: I tell them, ‘your doctor is going to tell you to stop’ … probably tell you about interactions between the two substances … So, I tell the client to ask the doctor what those reactions will be. Usually that stumps the doctor because he doesn’t know. So that makes the client a little bit more aware that the doctors just saying ‘no’, not out of knowledge but sometimes just because they can’t be bothered.

Thus, in accordance with the survey, the greater majority of interview participants indicated that they would like to see closer collaboration and co-operation with the medical profession in the future. Nonetheless, the interviews revealed a perception that such change was quite unlikely to transpire; as
indicated in the analysis, the relationship between WHM and medical practice is quite competitive and antagonistic. The analysis indicated that, at present, the coordination of patient care and communication between medical practitioners and WHTs remains a significant public health issue.

6.2.3.3 Poor professional solidarity

WHT 18: At a public health level, considering the political climate, the political environment in terms of our ability to continue to practice in Australia … we, as herbalists, as natural healthcare practitioners, need to be stirred up a bit and to get ourselves politically organised. If we don’t, well, then that will be our own fault.

A parallel theme to emerge from the discussions of professional isolation was how the WHM profession was contributing to its own ‘struggles’ because of poor professional solidarity and political acumen. As reflected in the next quote, the participants suggested that as a group WHTs were not politically savvy:

WHT 5: Well, there is power in the politics, I suppose. I think the people power is there … but we’re not very good at politics.

Similarly, another participant emphasised the WHM profession’s political impotence by juxtaposition against the organisational structure of the medical profession, noting that ‘we desperately need to pick up our game’:

WHT 15: I just want to make it clear I am not starting an ‘us’ and ‘them’ debate. Without denigrating the doctors, it is a matter pointing out that we desperately need to pick up our game. Yes, the medical profession has a greater and more lucrative infrastructure and there is no way that this is a level playing field but we have to begin by using the resources we have more effectively.
The WHTs’ talk described the apparent inability of the WHM profession to capitalise to their advantage on the public's interest in herbal medicines. Some WHTs spoke about the necessity of the WHM profession to mobilise itself and begin to take charge of its own destiny:

WHT 15: We, as a profession, need to take some responsibility for our own invisibility.

WHT 16: I don't think there are any easy answers to our problems but I do think that the more of us that are out there speaking to the public the better. We need to help ourselves.

Thus, taking active steps to improve public relations, elevating their professional status and defending their scope of practice had emerged as prominent issues within the WHTs’ talk. Nonetheless, the data suggested that WHTs did not consider the WHM profession to be a very cohesive and strong political unit, particularly in comparison to the dominant medical profession.

### 6.3 Locating WHM within the mainstream

The analysis to this point suggests that WHM professionals are struggling to compete in the mainstream as healthcare professionals. Further exploration suggested that most WHTs aspired to improved status as healthcare providers and recognition of their expertise within the mainstream. While there was broad agreement amongst the interview participants about the need to secure legitimacy for the WHM profession, substantial intra-professional disagreement emerged from the in-depth interviews about how this process should be managed.
6.3.1 WHM practice: complementary or alternative?

A significant debate to emerge from the qualitative data centred upon whether WHM should occupy a complementary or an alternative role in Australian healthcare. For the purposes of this analysis, *complementary* is taken to mean the legitimate use of WHM within mainstream healthcare structures in combination with mainstream medicine; and *alternative* to be the practice of WHM as a complete system of medicine, which is used to replace mainstream medicine.

The earlier qualitative analysis presented in Chapter 5 had revealed that WHTs frequently used the rhetoric of Holism to position WHM as an alternative to medical practice; nonetheless, both the quantitative and the qualitative data indicated that WHM is predominantly used by the public as complementary medicine. The theme of ‘working side-by-side’ with the medical profession emerged from some of the WHTs’ accounts. Although, as described earlier, most interview participants perceived a philosophical incongruity between WHM and mainstream medicine, they nonetheless spoke hypothetically of a scenario in which both systems of medicine were valued within mainstream healthcare.

WHT 1: Both herbalists and doctors should work hand-in-hand because when you have got the patient’s best interest at heart it may be orthodox medicine they need and it may be herbs and often it is a combination …

WHT 4: Actually, the doctors have wonderful diagnostic skills … you know, diagnostics, blood tests etc. The two (WHTs and doctors) should really work side by side. Herbal medicines work so well for many chronic problems.

Both of these are idealised statements in which the WHTs highlight the potential healthcare benefits of capitalising upon the strengths inherent in both medical practice and WHM practice. Indeed, after ‘natural medicine’, the name ‘complementary medicine’ was reported by the survey respondents as their
preferential choice to describe the type of medicine they practiced. A popular tactic to achieve legitimate participation within Australian healthcare was through gaining statutory regulation. This is illustrated in the next citation, as the WHT directly links the importance of official ‘recognition’ for securing a legitimate role within mainstream healthcare:

WHT 2: I think recognition is one of the important things that we need to pursue as professional herbalists. We need to be recognised in order to offer people a viable, not alternative, but something that’s viable to stand alongside orthodox medicine. The recognition needs to come from governmental sources.

By calling for improved recognition and legitimacy as complementary healthcare practitioners, the WHT was implicitly acknowledging the dominance of the medical profession. Most of the WHTs participating in the in-depth interviews perceived the ideal role of WHM to be a complementary one. On the other hand, a smaller group of WHTs preferred to perpetuate their traditionally alternative role:

WHT 17: I believe that there is always going to be the orthodox medical path and our traditional path … There’s always going to be the two approaches. I don’t like the term complementary … I look at us as being alternative.

Recalling an earlier theme explored in Chapter 5, some WHTs questioned whether the philosophical differences between the medical profession and the WHM professions could be bridged without significant compromise of the fundamental principles of WHM. As one WHT had asked, ‘Does it come from our need to compete with the medical profession? Are we abandoning the most distinctive difference between our profession and the medical?’ In the following quote, the WHT uses the hypothetical scenario of ‘being on Medicare’ to argue against WHM entering mainstream healthcare structures:

WHT 10: I have thought about that (being on Medicare) a lot. I mean, it may encourage patients to come but then I think you are going on bulk billing. I couldn’t bear it. I mean, I love the luxury of time that I have with patients. I like
to spend an hour and I would hate to have to surrender that because I think that would really diminish the quality of practice. It would become just like the pharmacists dispensing over the counter.

Eventually, after serious consideration of the pros and cons, this WHT had concluded that being eligible for Medicare benefits would require too great a compromise on her WHM practice. In this quote, the WHT evoked all the earlier themes of WHM being a holistic, patient-centred model of care. In many ways this debate over a complementary or an alternative role reflected the debate over the medicalisation of WHM practice. As the data presented in the previous chapter suggested, the medicalisation of clinical practice is a key strategy for securing the legitimacy of WHM within the mainstream. The majority of WHTs considered medical sciences to be a valuable adjunct to modern WHM practice. Nonetheless, some WHTs perceived the medicalisation of clinical practice to represent a significant compromise on their holistic practice. A cross-check of the individual transcripts indicated that most of those WHTs who belonged to the sub-group of traditional herbalists were advocates of maintaining an alternative role to mainstream healthcare.

6.3.2 The regulation debate

The analysis revealed that the majority of interview participants advocated greater public legitimacy and a complementary role for the WHM profession within mainstream healthcare; but a smaller sub-group preferred to preserve the status quo and function outside the mainstream as alternative healthcare providers. Nonetheless, all of the participants in the in-depth interviews recognised the value of tightening the restrictions upon who could and who could not legitimately practice WHM. Most, but not all, of the WHTs (n=12) supported statutory recognition of the WHM profession and statutory regulation of certain herbal medicines as defined in Chapter 1: professional status codified in state-sanctioned regulation. Consistent with their perspective of WHM being alternative, a smaller number advocated the less official self-regulation (n=6).
The majority of interview participants signalled their support for statutory regulation by using clear-cut terms such as ‘definitely’, ‘it’s vital’ and ‘it’s essential’ to establish their case. The dominant argument within these accounts was that while the WHM profession remained unregulated, herbal medicines were vulnerable to appropriation, in particular by the commercial sector offering OTC products and from the medical profession through integrative practice. This concern was explored earlier (section 6.2.2.1), where the analysis revealed how WHTs perceive medical practitioners who prescribed herbal medicines to be moving into their scope of practice, and how the co-option of herbal medicines by the medical profession was perceived as the major threat to the future of the WHM profession. A number of other arguments were proposed in favour of statutory regulation. In the first instance, the notion of regulation being a public guarantee of professional competency was introduced:

WHT 5: Okay, registration is a public system of acknowledgement and endorsement of a practitioner’s professional competency.

WHT 14: I think that registration is pretty positive because if we have minimum standards set then patients can be guaranteed of a certain level of service and we can be understood by the medical profession and politicians. There wouldn’t be so much grey and confusion about what we actually do.

As demonstrated earlier, the WHTs frequently employed a rhetoric aimed at signalling to the mainstream that WHM practitioners have extensive expertise and are highly qualified healthcare practitioners. Here, statutory regulation emerged as a key policy to legitimise the safety and competence of the WHM profession and improve relations with the mainstream at a professional and structural level. A related strand to this argument was the exigency to demarcate professional WHM from unqualified ‘lay’ sectors of ‘alternative’ medicine:
WHT 14: There are a lot of short courses around now, and untrained people set up practice because without regulation there is no stopping them; anybody can hang a sign on the door and call themselves an herbalist.

The idea that unqualified people were practicing herbal medicine generally evoked strong emotional reactions. Use of expressions in the WHTs’ talk such as ‘they make my blood boil’, ‘I get very angry’ and ‘it’s ridiculous’ revealed a deep-seated antagonism towards those who practiced herbal medicine without appropriate herbal qualifications. The WHTs quickly distanced themselves from the ‘untrained’ or the ‘unqualified’ by recourse to strong evocative terms like ‘quacks’, ‘charlatans’, ‘shonks’, ‘psychics’ and ‘witches’, but many recognised the value of more formalised regulatory control over herbal practice:

WHT 3: I think registration is vital. We have to get the shonks out. I mean, I look in the back of magazines and you can do an herbal medicine course through the back of a magazine, you know, in six months. To me they’re shonks!

While there was agreement about the need to control lay practice, there was not unanimity about how this process should be managed. Some questioned the value of formal regulation of the profession and argued that market forces would provide adequate quality control.

WHT 8: Registration won’t keep the shonks out! There are shonks in every field who work outside of the checks and balances … This idea that everybody’s going out unqualified and operating as an herbalist with no qualifications whatsoever is ridiculous. It’s hard enough to get patients when you’re wonderfully trained; where do these people get them? I don’t believe it is really needed because there’s the lure of the marketplace.

In this passage, the earlier theme of professional struggle is highlighted again. The participant, a very experienced WHT who had witnessed the evolution of CAM over the last thirty years, introduced a powerful argument against statutory regulation – preserving freedom of practice. The participant described how
WHM practitioners in Australia have enjoyed ‘the most glorious and wonderful privilege of being able to practice completely unfettered’ and highlighted the potential restrictions that could be placed upon WHM practice as a result of regulation. She argued that the idea of registration emerged from ‘a deep sense of inferiority’, a feeling she regretted was ‘endemic in the herbal profession’, and concluded with the contention that statutory regulation would not ‘protect’ the profession and would not ‘solve all the problems’ being experienced by the profession.

In the final analysis, most of the WHTs pragmatically conceded that within the current socio-political climate the odds of political change and legitimisation of WHM within the mainstream were remote. For many, the debate over regulation was a moot point. When the WHTs were asked if they expected to be included under Medicare or herbal medicines to be schedule on the PBS, all responses included matter-of-fact replies such as ‘not likely’ and ‘no, I don’t expect so’ to more some more cynical, such as ‘not in my life-time’, ‘are you kidding’, ‘don’t be ridiculous’ and ‘when pigs fly’.

### 6.3.3 WHM practice: an individual pursuit?

The dominant theme throughout this analysis was of the struggle within the WHM profession. Why then, in the face of such seemingly overwhelming odds and financial insecurity, do the WHTs pursue their role as a herbal clinician? The participants were asked about their personal motivations for practising WHM. Aside from one individual who had inherited her interest from her mother and another who had drifted towards WHM through curiosity, all participants described how they had originally been attracted to WHM through personal experiences. Many told stories about how they had originally been attracted to WHM through personal experiences. Many told stories about how they had originally turned to herbal medicines because of personal a health crisis or health problems of a loved one and described the remarkable successes achieved:

WHT18: I got to a sort of crisis point in my mid thirties.
WHT 10: Oh, right, I got sick, the usually story. CMV it ended up being labelled. That was in the mid eighties – I was in my mid thirties.

WHT 8: Well, I chose it as a profession because when I was much younger I’d been in a really terrible car accident … I had to have a lot of medical things done to me that were very wrong.

WHT 12: It helped me with my own health. I’d been quite a bad asthmatic as a child and a young adult. The orthodox medicine kept me alive and breathing, but it wasn’t until I explored other avenues that I actually got better.

WHT 2: Ah, that goes back to my son. He was born with eczema and asthma … only the herbs helped …

Evident in these quotes is that for most WHTs the decision to practice WHM was personal and founded upon a sincere sense of loyalty and personal zeal for herbal medicines. Most of the participants described the profound satisfaction that work as a WHT had brought into their lives. The sense of personal commitment and passion for WHM was continually built across the interviews by the participants’ use of evocative positive language. This is demonstrated by the similar answers provided by many to the following question:

I: So what are your motivations for continuing to practice WHM?

WHT 2: Oh, it’s so satisfying. There’s a great feeling of satisfaction.

WHT 8: Just the absolute pleasure in doing something that helps another person to recover the joy in their life.

WHT 13: Oh, because I love it. I love it and I see the benefit – I see the benefit for the people who do come.
WHT 14: Oh, I feel like I really help people, I really do. I feel like a really big difference to their lives.

Despite experiencing financial difficulties, the analysis indicated that the WHTs’ personal experiences with using herbal medicines (upon themselves, their family and clientele) continually reinforced their belief in the value of the herbal medicines.

WHT 14: I had absolute faith in the medicines. No, it was just the practice and that I wouldn’t get patients. It is just slow.

WHT 12: I am confident working with patients and about the herbs, but I’m really finding it hard to promote my business and, I guess, sell it to people and get the people through the door.

In fact, none of the participants ever, in any context across all the interviews, ever questioned the therapeutic power, validity, and efficacy of herbs as medicines. A persistent line of reasoning throughout the WHTs’ talk was the inevitable power of the attraction of herbs as therapeutic agents for mankind:

WHT 17: Mankind’s suffering has always led them to search for new ways of treatment, but the use of herbal medicines has remained consistent throughout our history.

Some WHTs argued that mankind always had and will continue to turn to herbal medicines simply because they ‘helped to alleviate mankind’s suffering’. Contained within the participants’ accounts were numerous stories and numerous references to successful case studies providing anecdotal evidence of their experiences of the efficacy of herbal medicines. One experienced WHT joked sardonically that it was, in fact, the very effectiveness of herbal medicines that contributed to her financial difficulties. She explained, tongue-in-cheek, how
herbal medicines worked so well that her clients actually got better and so she continually needed to source new clients:

WHT 17: There’re a lot of herbalists that are very good at what they do and they’re very passionate and very knowledgeable, but the sad thing about our business is that people actually get well (laughs). So you’ve just lost you’re income stream. The way you build a big practice and good practice is by getting people well but, unfortunately, you have to keep getting more sick people to come to you. So, it takes a long time to get that critical mass of people; so, in the meantime, you can starve to death yourself. (Laughs)

Although financial concerns seemed to be an ongoing issue associated with working as a herbal clinician, all of the participants (except for one who indicated considering returning to their previous occupation) indicated an acceptance of their situation because of the personal rewards and satisfaction of practising WHM. This is illustrated in the next quote:

WHT 10: It’s a great job. When I sit back and think about it, what I am doing fills me with joy and happiness and the positives of what I am doing outweigh the negatives.

For most of the practitioners, their motivations for practising WHM were centred upon deep-seated personal reasons rather than for financial incentives. A common adaptive reaction to the competitive and often discriminatory socio-political context of practice was to focus their energy within their herbal clinics, upon their own smaller sphere of influence, and work on an ‘individual level’. This is illustrated in the next quotes:

WHT 13: My influence is always on an individual level rather than broader exposure to the community in general. At the moment, I work in a small clinic and am dealing with individuals, so I make a difference for an individual.
WHT 8: If you want to pay to go the doctor and get your drug prescribed in the standard two and a half minutes – go for it. See, I can’t convince anyone; that’s not my role in life. I just care what people believe. People can choose to come to me or my sort, or not come. I’m not on a crusade to persuade them. I want them to arrive at their own decisions.

The interview participants had signalled a tacit resignation towards their situation because of the personal rewards and satisfaction they experienced from practising herbal medicine. Individual WHM practitioners reported cognisance of the potential difficulties in establishing a strong client base but were resigned, if not pleased, with allowing their practice to build over time. The data suggested that most WHM practitioners continue herbal practice for personal reasons, such as a passion for the art of herbal medicine, rather than financial motivations.

Many had argued that WHM should not be competing with the mainstream but attracting those members of the public who were seeking an alternative to the mainstream approach, not simply a natural alternative to pharmaceutical medicines. The analysis also suggested that many WHTs had resigned to the fact that there was no point fighting for a place within a healthcare system – particularly one in which they seemed unwelcome. As the final quote indicated, in the end, when all is said and done, healthcare is an individual choice and WHM practice is an individual pursuit. There was not unanimity in opinion amongst the WHTs about the future direction of the WHM profession, but in the end they all were united in their passion for WHM.
6.4 Summary discussion

The themes emerging from this study revealed how WHTs perceive themselves to be subject to substantial discrimination from the mainstream. The analysis indicated that many WHTs consider themselves to be marginalised, misunderstood and disregarded as legitimate healthcare practitioners and revealed a number of intra-professional perspectives about the ideal location of WHM in Australian healthcare. The analysis presented in this chapter revealed a number of strategies employed within WHM to legitimate, define and defend its position within Australian healthcare.

In the first instance, the analysis revealed how the systemic inequity within current healthcare structures is perceived by the WHTs as a serious constraint to the future viability of the WHM profession. Secondly, the analysis suggested the WHTs perceived the increasing commercialisation of herbal medicines to be a significant challenge to the financial viability of their WHM practice and revealed a number of rhetorical devices used to counteract this source of competition. Thirdly, the analysis demonstrated how the increasing interest in herbal medicines by the medical profession is perceived by the WHTs as a threat to their professional scope of practice. Overall, the results suggested a significant degree of antipathy amongst the participants about the perceived inequalities in Australian healthcare.

Nonetheless, the data indicated that the individual WHM practitioner continues clinical practice because of a personal sense of commitment and a passion for the art of herbal medicine. Many individuals reported cognisance of the potential difficulties in establishing a strong client base but were resigned, if not pleased, with allowing their practice to build over time. Although most WHTs expressed disappointment that they – the WHM practitioner, the healthcare professional best qualified to deliver the benefits of herbal medicines – had been excluded from the herbal medicine chain of supply; they emphasised the personal satisfaction they gained by their role as a WHM professional.
The qualitative study offered the opportunity to both contextualise the survey data and to interpret the data from the perspective of the WHT. The qualitative investigation has provided new data about WHM practice in Australia. In particular, the behaviours, perspectives, experiences and opinions of WHM practitioners about their philosophy, perceptions of their scope of practice, their clinical skills and relationships with their patients or medical professionals. Such data has not previously been documented in the mainstream literature. In the concluding chapter, these emergent themes are related back to the conceptual framework to provide an explanation of the impact of the processes identified in this chapter upon WHM in Australia.
Chapter 7 Conclusions and implications

“The history of medicine is one of the most curious anomalies in the world … to encounter the prejudice and ignorance of the people on the one hand, and the interests of a legalised monopoly on the other, is a task of no ordinary kind.”

From Medical Botany: A series of lectures in Sussex

(Dr Albert Issiah Coffin 1850)

Chapter outline

This chapter draws together the findings from the mixed methods inquiry. The research findings regarding the practice and provision of WHM in Australia are discussed in relation to the broader CAM literature and the thesis’s overall theoretical framework. The chapter highlights the distinct contribution of the research towards the reflective practice of WHM and concludes by offering suggestions for future research.

7.1 Introduction

In Chapter 1, the increasing consumption of CAM was related to the social process observed in many Western nations termed ‘mainstreaming’ of CAM. This thesis employs the concept of mainstreaming to explore the response of WHM to the changing role of CAM within mainstream healthcare. Chapter 1 highlighted the underdeveloped nature of the research about the practice and provision of CAM. It also underlined the problems with the definition of CAM and questioned the value of conflating all the various CAM therapies into a single entity; particularly CAMs, such as WHM, which are complete systems of medicine.
Chapter 2 identified the substantial gaps in the literature about the use and practice of WHM in Australia. The literature review highlighted the need to broaden the perspectives employed in CAM research and Chapter 3 identified salient sociological concepts capable of increasing understanding of the processes within and external to CAM provision. Chapter 3 described the overall research framework and the mixed methods research strategy used to study WHM practice. Drawing on Social Worlds Theory, the framework outlined in Chapter 3 employs concepts such as appropriation, authentication and internal contestation in analysing contemporary WHM practice.

Chapter 4 presented the results of a national survey of the peak body representing WHM practitioners in Australia (the NHAA). The response rate to this study was 58%, providing data generalisable about the form and content of WHM practice across Australia. WHM emerged as a complex mixture of traditional herbal and modern medical scientific knowledge and practices. The survey results suggested that the WHM profession fills a complementary role in Australian healthcare and is predominantly utilised to manage chronic diseases. The chapter concluded with a comprehensive discussion relating the survey results to the existing WHM literature (as reviewed in Chapter 2) and highlighting the unique contribution of the survey to the substantive topic of WHM practice.

Chapters 5 and 6 presented the findings of in-depth interviews with WHM practitioners. The qualitative analysis revealed the many personal and professional challenges facing Australian WHM practitioners. Chapter 5 described how the practice of WHM is being influenced by the expectations and attitudes of mainstream medical science and practice. The findings indicate the extent to which WHM practice has accommodated the dominant medical paradigm resulting in an eclectic, often uneasy, mix of the traditional holistic and medical scientific approaches. Chapter 6 moved beyond clinical issues to uncover WHM practitioners’ experiences of marginalisation and systematic
discrimination from the mainstream Australian healthcare sector. The results also suggested a lack of intra-professional cohesion and revealed significant differences among practitioners regarding the most appropriate and achievable role for WHM in the broader health system.

The concluding section utilises the conceptual framework outlined in Chapter 3 to derive a pragmatic, consistent and coherent explanation of WHM mainstreaming in Australia.

### 7.2 WHM and the mainstreaming process

The increasing use of CAM in Australia is a social phenomenon argued to be neither well understood nor well researched (Coulter et al. 2004). The literature describes how herbal medicines have re-emerged within the consciousness of Western society (Ernst 2000a) and have progressively returned as a popular form of healthcare for many Australians (Xue et al. 2007). The research for this thesis suggests that what has occurred with this ‘mainstreaming’ is an increased social acceptance of herbal medicines, but that this is a development that has not been accompanied by increased legitimacy for the WHM profession.

In reference to the opening quote, the mainstreaming of herbal medicine for WHM practitioners largely represents a continuity of past discrimination. From the practitioners’ perspective mainstreaming represents a process of appropriation that involves the rationalisation of herbal knowledge, the commercialisation of herbal medicines and the co-option of herbal practices. Ironically, the growing popularity of herbal medicines presents a challenge to traditional WHM practice, the financial security of the WHM practitioner and the viability of the WHM profession in Australian healthcare.
7.2.1 WHM practice

The findings from this thesis suggest that the increasing popularity of herbal medicines is potentially undermining the authenticity of WHM tradition. WHM practice is evolving into a complex synthesis of medical and traditional knowledge. This synthesis, however, is not without tensions: the most prominent source of intra-professional tension evident in the data was the significance of the rationalisation of traditional herbal knowledge and the appropriateness of the resulting medicalisation of practice.

The literature has described the trend towards the rationalisation of herbal medicine. This is partly evident in the extensive clinical research on herbal medicines that has been undertaken in recent decades (Myers et al. 2005). It is also evident in the ways herbal medicines are adopted into medical practice, their use being similar to the prescription of conventional pharmaceuticals, a model of herbal practice defined earlier as phytotherapy (Corrigan 2000). The research provided strong evidence that mainstreaming has been associated with significant rationalisation of WHM practice in Australia.

The research offers detailed empirical findings about the clinical and prescribing practices of contemporary WHM practitioners in Australia. Results demonstrated an increased influence of medical science on WHM including the incorporation of medical concepts, clinical procedures, technologies and language into clinical practice. The study provided details of how both medical science and traditional practices have been accommodated within the modern practice of WHM. The WHM practitioners interviewed described how clinical practises are now informed by medical science, the efficacy of herbal medicine is being validated by science, which is investigating the pharmacology of plants but, importantly, they also routinely emphasised that herbal prescribing remains a traditionally informed practice.
Boon (1996) argued that naturopathic practitioners have reacted to the dominant paradigm in two different ways: by adopting either a scientific or a holistic interpretation of the naturopathic paradigm. Similarly, WHM practitioners in Australia have made concessions to the dominant healthcare paradigm; however, the profession continues to define itself as philosophically different to mainstream medicine. Within this investigation the WHM practitioners interviewed employed scientific discourse to describe their clinical practice but simultaneously each and every practitioner commonly identified themselves as ‘holistic’. The theme of Holism emerged from the qualitative data as central to not only how WHM practitioners approach clinical practice, but also to their interpretations of their professional role.

The findings illustrate that WHM maintains a strong allegiance to its historical legacy and honours its traditional identity as a form of holistic healthcare. The interview data confirmed the survey findings about how WHM remains an individualised practice based upon traditional, holistic principles and that WHM practitioners consider traditional fluid extracts to be the cornerstone of their practices. In contrast, the WHM practitioner's explanations of their use of medical practises are directed towards concerns directly related to the legitimacy of WHM within mainstream healthcare.

The first distinctive feature of holistic practice emphasised was not only the extensive length of a typical consultation (on average an hour), but also the range of activities involved in a consultation. The interview participants explained that the individualised focus of WHM necessitated an extended consultation in order to undertake a holistic diagnosis and formulate an individualised treatment. The consultation process was described as an important time between therapist and the individual clientele for facilitating the healing process. This finding is reflective of earlier CAM research which has explored the appeal of CAM for the public (Davis-Floyd et al. 1994; Coulter et al. 2004; Easthope 2004b)
Secondly, the qualitative data contextualising the survey describes how herbal treatment decisions are initially made upon consideration of the underlying cause of the problem or the signs/symptoms of the patient. From the WHM perspective, disease is described as the physical expression by the body of an existing ‘imbalance’ in an individual’s life. Accordingly, the aim of WHM treatment is to help ‘support’ the body to re-gain health and/or vitality rather than using medicines to suppress symptoms. Consequently, herbal treatments and prescriptions may vary substantially between individual clients ostensibly presenting with the same condition or disease.

The research describes how within WHM the medical paradigm has challenged traditional knowledge claims. In addition a number of findings from the research suggest client expectations have influenced practitioner decision-making in relation to how they approach clinical practice; for example the incorporation of solid dose preparations (tablets or capsules) into herbal dispensaries. The interview data suggests that the public have pre-conceived expectations of WHM treatment including the expectation of receiving a pill, a quick fix and suppression of symptoms. Furthermore, the attitudes and financial considerations of clients can have a significant effect in dictating the time available to the WHM practitioner: time, in terms of the length of the consultation, as well as the total length of the herbal treatment and prognosis. These findings provide general support for Tovey and Adams’ (2004) argument that the existing dominant medical paradigm will challenge existing models of CAM practice.

The interview participants confirmed that the underlying rationale for incorporating medical science into WHM practice is related to issues of professionalism including ensuring client safety, improved diagnosis and the ability to communicate with the mainstream medical profession. Although a medical diagnosis was typically perceived to be important by the WHM practitioners, it did not assume the central focus of a WHM consultation. These
findings are consistent with previous work which has explained the incorporation of medical sciences into CAM practice as a strategy to gain legitimacy as healthcare providers within mainstream healthcare structures (Welsh et al. 2004).

Overall, the results suggest that WHM practitioners have adopted a pragmatic flexible response to mainstream expectations. The qualitative analysis revealed a number of rhetorical strategies used within WHM to accommodate medical science while simultaneously authenticating their traditional holistic practice. These included citing historical precedence, highlighting the eclectic knowledge claims of WHM and the interpretive flexibility offered by the holistic framework of WHM. The examples identified centred upon the Vitalistic and the physical interpretations of philosophy, the medical and the traditional approaches to practice, the pharmacological and the drop based dosing, and adopting a complementary or an alternative role in healthcare. All these tensions highlight how the WHM profession is actively negotiating the divide between traditional knowledge and mainstream knowledge claims.

This pragmatism suggests that the medicalisation of WHM practice is a concession towards the mainstream, motivated by a desire for a legitimate role within mainstream healthcare, but simultaneously reflecting the WHM profession’s desire for recognition and acceptance of WHM as a valid system of medicine. The adherence to traditional holistic prescribing is interpreted here as a professional strategy to differentiate WHM from the mainstream. At the same time, although rationalisation poses a potential challenge to their traditional knowledge, the medicalisation of practice emerges as a dominant professional strategy to secure the legitimacy of the WHM profession.

Previous research has observed the emergence of distinct groups within CAM professions who advocate different conceptualisations of practice (Boon 1996;
The study indicated that the WHM framework is broad and accommodates a range of interpretations of the basic tenets of Holism. As a consequence there was also evidence of a strong degree of internal contestation within WHM over the authenticity of different approaches to WHM practice. Although each individual practitioner interviewed described their practice as ‘holistic’, the interview study highlighted the internal tensions between those practitioners actively advocating the medicalisation of WHM practice and those resisting this mainstreaming process.

Tovey and Adams (2004) argue that in any healthcare profession there will be competing sub-groups, each comprised of individuals sharing particular philosophies and advocating particular approaches to practice. Furthermore, the predominant approach will depend upon advocates being able to convince others in the profession of the legitimacy of their practices through various authentication processes. The interviews revealed the various authentication processes employed by the sub-groups within WHM who identified themselves as either medical or traditional herbalists. There are a number of findings from the interview study which provide evidence to support Tovey and Adams’ conceptual perspective.

The qualitative analysis identified two distinct sub-groups within WHM. Firstly, there were the medical herbalists who promoted the scientific paradigm as a strategy to secure legitimacy for WHM within mainstream healthcare. By contrast, those with a traditional perspective positioned WHM as a viable alternative to mainstream healthcare. The traditionalists preferred the continuation of WHM practices that honoured their traditional perspective above that of medical science. It is these intra-professional differences that help to explain the variations in clinical practice styles observed within the survey cohort: for example, the practice of drop dosing as opposed to higher doses and the use of pathology tests in preference to iridology. According to both the
quantitative and qualitative data, the perspective of the medical herbalists is currently assuming dominance.

Resistance to the ‘medicalisation’ of WHM practice was interpreted by subgroups of medical herbalists as being reactive and ignoring the changing social context of practice. In some instances traditional knowledge and those who perpetuated certain practices, for example the extension of the concept of Vitalism to diagnosis and the practice of drop-dosing, were subject to derision for ‘non-rational’ or ‘arcane’ practice. For this group the notion of eclecticism was employed to authenticate the blending of science and Holism within the single framework. In contrast, the traditional herbalists emphasised WHM tradition and history to authenticate their approach to practice. Amongst the traditional herbalists science provided confirmation of herbal efficacy, but the effectiveness of herbal medicines was predominantly informed by the strength of traditional empirical data. These contrasting rhetorical styles have been described as nostophobic and nostalgic referencing, respectively (Tovey et al. 2003).

Overall, the evidence gathered for the thesis builds a picture of WHM practice evolving pragmatically and flexibly to accommodate the dominant medical paradigm within its framework. The WHM model of practice has evolved into a complex mixture of traditional Herbalism and the medical paradigm. The survey and interview data support the NHAA assertion that modern WHM utilises medicinal plants ‘in the context of a health philosophy incorporating modern and traditional concepts and knowledge’ (NHAA 2004). WHM practice can be interpreted as a negotiation between the demands of the mainstream paradigm and traditional principles of practice.
7.2.2 WHM practitioner

There is growing evidence that mainstreaming has resulted in a significant commercialisation of herbal medicines to capitalise upon the general demand for herbal products (Collyer 2004). The results of this investigation suggest the increasing expenditure on herbal medicines by the general population has not necessarily flowed onto the WHM practitioner. On the contrary, evidence was presented that the commercialisation of herbal medicines poses a significant challenge to the financial viability of many WHM practitioners.

This study suggests that the WHM profession makes a relatively small contribution to the overall use of CAM by the Australian public. The survey showed a fairly low number of consultations conducted per week by WHM practitioners (averaging between 15 and 17). Furthermore, many interview participants described the endemic struggle within the WHM profession to build a viable client base and earn a reasonable income from the practice of WHM. These findings are consistent with earlier international studies in which various CAM professions have been shown to be experiencing significant financial insecurity (Sharma 1992; Cherkin et al. 2002b; Andrews et al. 2005).

In Australia, herbal medicines are readily available from retail outlets, including pharmacies, health food stores and supermarkets, without the expense of a consultation. Australian research has indicated that most of the increased consumption of herbal medicines has been predominantly on OTC supplements sourced from retail outlets (MacLennan et al. 2006; Xue et al. 2007). The WHM practitioners interviewed described the considerable difficulties experienced in competing with the commercial sector; citing in particular their perceptions of high levels of self-prescribing or self-medicating of herbal medicines by the Australian public.
As argued by Adams and Tovey (2002) to successfully compete with existing healthcare CAM must be able to convince ‘outsiders’ of the legitimacy of their practices. The qualitative analysis revealed a number of rhetorical devices used by WHM practitioners when advocating the value of WHM. Firstly the commercial sector was characterised as a source of unreliable information, poor quality of the product, and unable to provide guarantees of safety to the consumer. WHM practitioners emphasise the advantages of traditional herbal preparations over OTC products and where possible, to prescribe galenical preparations, and dispense mixtures of liquid herbal medicines in preference to herbal tablets.

In addition WHM practitioners argue that herbal medicines are safer when prescribed by qualified herbal practitioners who have been trained in the appropriate use of herbal medicines. The practitioners routinely emphasised how the preparation of liquid mixtures requires extensive training and expertise to formulate competently, thereby excluding practice by those not adequately trained in WHM. Thus the use of liquid herbal medicines is a key strategy to distinguish professional WHM prescriptions from the commercial competition. The practitioners emphasise how they mix individualised herbal formulations for their patients which are not only more effective than OTC supplements but are safer because they that are dispensed only after extensive consultation.

WHM practitioners actively distance their professional practice of herbal medicine from non-qualified lay therapy. The rhetoric used included strong evocative terms like ‘quacks’, ‘charlatans’, ‘shonks’, ‘psychics’ and ‘witches’; as well as fairly aggressive attacks upon non-scientifically based practice such as, for example, ‘mumbo-jumbo’, ‘folklore’, ‘fortune telling’ or ‘crystal waving nonsense’. Ironically, such language is reminiscent of the type of vernacular traditionally used by the mainstream to attack WHM (Easthope 2004a; Winnick 2005). Despite such strategies the WHM practitioners reported poor public
perceptions and a generalised lack of appreciation of knowledge, skills and training of WHM practitioners by the public.

The concept of social closure has been applied overseas to explain the successes of certain CAM professions operating within mainstream healthcare (Boon et al 2002): social closure refers to the process by which occupational groups regulate market conditions in order to limit competition by ‘outsiders’. Regulation of herbal medicines emerged as a potential mechanism to restrict access to herbal medicines to qualified practitioners and limit access by the ‘unqualified’, including both lay therapists and medical practitioners. Many of the interview participants signalled their desire for the introduction of a tighter regulatory system in Australia for herbal products. However the current analysis clearly indicates that the WHM profession has been unable ‘to regulate market conditions in their favour’ or limit competition from the mainstream.

WHM practitioners continue to experience the impact of growing sources of competition for the supply of herbal medicines. As a consequence many WHM practitioners highlighted the need to manage every aspect of the business themselves and reported a high incidence of part-time employment, self-employment and supplementing their incomes in unrelated employment. Ironically, a major source of income for many WHM practitioners is within the retail sector, where they are providing ‘free consultations’ to promote the sale of commercial preparations of herbal medicines. This irony was not lost on many of the interview participants, who argued that this practice essentially devalued the WHM consultation, potentially undermined the practitioner’s professional integrity and compromised their identity as healthcare professionals. Nonetheless, the WHM practitioners explained the need to continue in this form of employment because of the difficulties in attracting clients.
Although aware of the manifold obstacles confronting the profession, most WHM practitioners seemed to distinguish between their personal experiences and the broader situation of the WHM profession. This is, however, strongly contingent upon the individual persisting through the very tough early years in practice. Most of the practitioners interviewed experienced significant difficulties establishing their herbal business but described the high degree of satisfaction they experienced in their work at the practitioner/client level. Ultimately, many WHM practitioners continue herbal practice for personal reasons, such as a passion for the art of herbal medicine, rather than financial motivations.

Paradoxically, this research suggests that rather than improving opportunities for business in Australia, WHM practice is actually being constrained by the enormous market viability of herbal medicines. Mainstreaming, unfolding as commercialisation of herbal medicines, is negatively impacting upon the WHM practitioner’s ability to sustain a living from the practice of WHM. The analysis demonstrated that as WHM moves towards the mainstream, individual practitioners must find a way to negotiate their business prerogatives with their needs to define what they do as holistic healthcare providers.

7.2.3 The WHM profession

The findings from this thesis suggest that the mainstreaming of herbal medicines is potentially undermining the viability of the WHM profession. The qualitative analysis described the perceptions of discrimination and continuing experiences of marginalisation within the WHM profession. The organisational inequity present within the structure of mainstream healthcare in Australia appears to be effectively limiting the role of the WHM profession in Australian healthcare. Significantly, the research identified an important divergence within WHM over the apposite location of WHM in respect to mainstream healthcare.
7.2.3.1 Public health processes

Historically, WHM has existed on the ‘fringe’ of healthcare and until the end of the last century WHM was predominantly and systematically excluded from mainstream healthcare. Mainstreaming of CAM, it is argued, has witnessed a re-orientation of thinking and a shift of awareness towards accepting healthcare pluralism marked by a promised change in public attitudes and a flow-on change in public policy (Carlton et al. 2002; Baer 2007). In contrast to this, but consistent with Tovey and Adams’ contentions, the study describes WHM practitioners’ experiences of marginalisation and discrimination from the mainstream Australian healthcare sector. The ongoing inequity within existing healthcare structures towards WHM is perceived by some within WHM to be a serious constraint upon the future of the WHM profession.

The literature has described the increasing legitimacy being enjoyed by various CAM professions in Australia (Baer 2006). In particular, the professions of naturopathy and WHM have been identified as offering significant contributions to Australian healthcare (Bensoussan et al. 2004b), leading to a parliamentary report focussed on safety and efficacy (DHS 2005). Ostensible indications of the growing legitimacy of the WHM profession include improved educational standards (McCabe 2005d), an increasing presence in the University sector (Evans 2000), inclusion of WHM services under the GST for tax exemption (Khoury 2002a), provision of private health insurance rebates (NHAA 2004) and a certain degree of participation in mainstream healthcare practices (Baer 2007; Grace et al. 2006).

At present the WHM profession has not been granted any form of official recognition within public healthcare in any political jurisdiction in Australia (Baer 2006). In recent decades the minimum standards for registration as a WHM practitioner have become more stringent (McCabe 2005d). The WHM practitioners in this study viewed their profession as a highly qualified workforce well versed in the medical paradigm; nevertheless, they continue to experience
significant professional censure and be excluded from legitimate participation in public healthcare. Ironically, while remaining excluded from public healthcare structures, the mainstream is imposing increasing demands on the profession to provide guarantees of professionalism (De Smet 1995; Sherwood 2000; MacLennan et al. 2002).

In section 7.2.1 the discussion described the various authentication strategies employed within the profession to legitimate WHM practice. Referencing Tovey and Adams (2001, 2002, 2004) such strategies highlight the model of intersection occurring between WHM and the mainstream healthcare sector. The study of the WHM practice provides an example of 'weak intersection' where the traditional activities and tools of WHM are being adopted by the mainstream yet access of the WHM practitioners to healthcare structures continues to be restricted or denied.

Therefore the results provided in this investigation indicate that the WHM profession continues to occupy a marginal role in mainstream healthcare. The interview participants perceived WHM to be ‘filling a gap’ in Australian healthcare left by the preoccupation of mainstream medicine with diagnosing pathology and prescribing pharmaceutical medicines at the neglect of the ‘whole person’. Both the survey and interview study provide evidence that the WHM profession performs a niche role in Australian healthcare providing medicines for people with chronic conditions who are dissatisfied with outcomes of their mainstream healthcare.

It was a common contention amongst the interviewed practitioners that herbal medicine presents a potentially valuable but neglected aspect of Australian healthcare. Many within WHM argue that that exclusion from public healthcare significantly limits the general public’s access to WHM services and thus potentially compromises patient safety. The WHM practitioners argued that
herbal medicine, like all medical treatments, requires knowledge and skill to identify the appropriate treatments for each patient. In particular the expense of a WHM consultation particularly when medical care is by contrast publically subsidised, seems to be a notable constraint upon the public seeking professional herbal treatment.

In spite of the increasing popularity of herbal medicines, despite significant concessions within WHM to the medical paradigm, the WHM profession is struggling to participate on an equal footing within the mainstream and continues to operate on the fringe of Australian healthcare. This research indicates that many WHM practitioners consider themselves to be misunderstood and disregarded as legitimate healthcare practitioners.

7.2.3.2 Inter-professional processes

Previous work has explained that the entry of CAM into existing healthcare structures will be interpreted as a threat to the medical establishment, which will react to maintain its monopoly over healthcare (Shuval et al. 2004). Significantly, the results of this study indicated that the medical profession is integrating herbal medicine into medical practice rather than forming alliances with the WHM profession. The WHM practitioners reported perceptions of the systematic co-option of herbal medicines by the medical profession. The mixed methods study indicates that the subordination of WHM to mainstream medical practice is an issue strongly impacting upon WHM practice.

Consistent with Tovey and Adams (2001, 2004), the analysis identified how the subordination to, and thus distinction from, mainstream medicine was a dominant concern colouring the WHM practitioners’ discourse. As described in Chapter 1, concerns over professional boundaries in healthcare practice have become important to both CAM and mainstream healthcare providers (Bensoussan et al. 1996; Adams 2004; Shuval et al. 2004; Turner 2004b;
Hirschkorn et al. 2005). Research has indicated that the medical profession is not concerned with establishing professional networks or cooperating with those outside of the medical establishment (Adams 2000). The medical profession is excluding others from the primary care setting and is opting for integrated practice of CAM rather than complementary practice (Adams 2001b; 2004; Shuval et al. 2004).

Tovey and Adams (2004) conceptualise professional groups as constantly competing with each other (sometimes initiating division, other times forming new collaborations) over limited resources and often appropriating such resources. The integrative practice of CAM has been viewed as an adaptive strategy used by the medical profession to meet the challenges of mainstreaming (Adams 2004; Shuval et al. 2004). Shuval and Mizrachi (2004), reflecting the earlier work of Saks (1995), conclude from their research that integrative practice of CAM by the medical profession can be understood as a defensive strategy to preserve their dominance over existing healthcare provision.

Many of the WHM practitioners perceive integrative practice to be disingenuous; merely a concession by the mainstream medical profession to the popular support for herbal medicines. This research identified the reactions within the WHM profession regarding integrative practice and revealed the strategies employed by WHM practitioners to retain control over the prescription of herbal medicines, in other words to defend their traditional scope of practice. WHM practitioners employ both philosophical and practical strategies to demarcate their WHM scope of practice.

Firstly, in order to defend their scope of practice the WHM profession has maintained a strong conceptual identity through a shared repertoire informed by Holism and strengthened by highlighting the contrasts between WHM and
medical models of practice. In earlier research Adams and Tovey (2004) demonstrated how nurses establish professional distance from medicine by explicitly contrasting nursing practice to the reductionism of medical practice. Similarly, as described above, the WHM profession emphasises the difference between what has been described as the holistic WHM model and technocratic models of medicine (Davis-Floyd 1996).

Section 7.2.1 of this chapter described how the WHM profession accommodate both medical science and Holism simultaneously. Conversely, the trend towards ‘medicalisation’ of WHM practice may itself be perceived as an appropriation of medical knowledge. The literature has suggested medical practitioners are concerned that CAM professionals may be acting beyond the scope of practice. However, within the WHM profession the use of medical sciences was justified as a concession towards the medical paradigm.

The WHM practitioners interviewed demonstrated that WHM presents itself as distinct from medicine not only through philosophical perspectives but through practice differences. As a prime example, the WHM profession highlights the distinctive herbal formulary principles of traditional WHM. As described earlier the research indicates that traditional herbal principles and practices clearly remain the vanguard of professional WHM practice. Secondly, individualised prescribing requires time with the client – a luxury generally not available in medical practice (Adams 2001a). Ironically, the unique advantages of holistic practice such as time, individualised treatments and therapeutic flexibility seem to have actually contributed to its marginalisation simply because of the expense required to provide patient-centred care, particularly without any public healthcare subsidisation. WHM practitioners report difficulties justifying the cost of a consultation when the public has access to subsidised medical care, particularly if their medical practitioner prescribes herbal medicines.
Thus, consistent with the literature cited above, WHM practitioners perceive the intent of integrative practice to be to diminish the role of the WHM profession. The research indicates that uptake of herbal medicines into integrative practice coupled with the simultaneous exclusion of WHM from public healthcare, particularly public subsidies, have collectively had a negative impact upon the ability of WHM to compete with the medical profession for clientele.

7.2.3.3 Intra-professional processes

Of fundamental importance to this study of WHM practice were the interactions and dynamics between the members of the WHM profession, itself (Sharma 1992; Tovey et al. 2001). The inquiry reveals the WHM profession to be one actively engaged in attempts to legitimate WHM to those outside the profession (the mainstream), as well as being occupied in inter-professional debate about the authentic practice of WHM and the appropriate role of WHM practice within the mainstream.

The profession is divided between advocates for complementary status and those practitioners who wish to perpetuate their alternative role. Recalling from Chapter 1, alternative medicines are those used in place of mainstream medicine, complementary medicines are those used in conjunction with mainstream medicine and integrative medicines have been subsumed under the mainstream medical model. The interviews reflected a significant level of internal contestation over the relative merits of self-regulation or statutory regulation for the WHM profession.

Boon et al. (2004) have argued that a prime strategy by CAM professions to legitimate their profession has been to secure statutory regulation. The dominant perspective currently within the NHAA, are those who advocate for statutory regulation rather than self-regulation. The proponents of statutory regulation reasoned that WHM profession has been unable to effectively protect
its professional boundaries from ongoing appropriation. Therefore, the WHM profession will continue to experience appropriation unless it can legitimate its professional role and demarcate its scope of practice.

A smaller group of practitioners argued that statutory regulation may compromise the autonomy and independence of the WHM profession. Those within this group cherish their independence as ‘alternative’ healthcare professionals because it allows self determination; they fear restrictions upon their autonomy will accompany any integration into mainstream healthcare. They argued that statutory regulation will not restrict appropriation but actually limit the WHM profession’s scope of practice. Furthermore, despite the significant concessions already made to accommodate the mainstream, which had significantly compromised the authenticity of traditional WHM, the profession still remained on the fringe of healthcare.

It has been argued that the inability of the CAM professions to find common ground has reputedly weakened their overall political strength within Australian healthcare (Khoury 2003; McCabe 2005a). The results from this study suggest that the WHM profession’s lack of solidarity has significantly contributed to its weakened political position vis-à-vis the mainstream. On the positive side, the results from this study have suggested that, despite the dominance of the medical paradigm, the WHM profession has maintained a very strong traditional holistic worldview. Ironically, perhaps as a direct result of its ongoing marginalisation, the WHM profession has been largely free to determine its own model of practice.

### 7.3 Implications for reflective practice

The aim of this thesis was to generate practical and useful knowledge about the practice of WHM in Australia. The findings from the investigation provide practical data for informing future directions in clinical research and practitioner
education; public health decisions about the CAM professions, particularly considering the currency of this debate in Australia; and improving inter-professional relationships. Above all, the research offers specific insights into current approaches to practice that can help the WHM profession to facilitate reflective practice.

7.3.1 Public health issues

The survey study provided a generalised description of key aspects of the WHM profession, WHM clinical practice, WHM prescribing, WHM clientele and aspects of its inter-professional and intra-professional relationships across Australia. These data have useful applications for public health decision making in relation to the role of herbal medicines within Australian healthcare. Together, the mixed methods data suggests that WHM occupies a complementary rather than an alternative form of healthcare in Australia.

The investigation offered valuable public health data about the patients and conditions treated by the WHM profession in Australia. The results indicated that most WHM clients predominantly seek WHM treatments for chronic conditions, which have not responded to medical treatments or to which pharmaceutical medicines have caused undesirable side effects. The majority of WHM clientele have undertaken a medical diagnosis and continue to consult a medical practitioner. WHM practitioners do not predominantly assume the primary healthcare role in Australia and therefore claims, as outlined in Chapter 2, that the public are turning to WHM for serious acute conditions or forsaking medical treatments do not appear to be warranted.

The growth in the herbal market has raised potential issues about the therapeutic efficacy, safety and quality of herbal preparations. This investigation also documented key aspects of clinical practice and herbal prescribing within a professional WHM consultation. The results highlighted the significant
difference between traditional herbal prescribing as used in professional practice and commercial herbal preparations. In preference to the commercial trend where most products available are tablets or capsules, which by their nature are pre-packaged and are pre-formulated to treat specific conditions, WHM practitioners in Australia are predominantly individualising herbal mixtures for each patient which are dispensed after an in-depth consultation.

Significantly, the results in this thesis highlighted the issue of the variance between doses used within WHM, ranging from large pharmacologically active doses to small drop doses – a system based upon the energetic properties perceived in the plants. The different doses ranged from a few drops up to ten millilitres or more for the same herb between different prescriptions. Those outside and, indeed, many inside the WHM profession may question these differences and ask whether all the systems contain merit, or whether some prescriptions are in unnecessarily high doses or others in sub-therapeutic doses.

In Australia, claims of safety and, indeed, therapeutic regulation for herbal medicines are based upon empirical data derived from such traditional individualised use of herbs (TGA 2008). However, while the clinical application of the fluid extract used by professional herbalists is quite well documented in the literature many commercial preparations on the herbal market contain increasingly concentrated doses of herbal medicines and, increasingly, contain extracts that are refined and standardised (Bone 2003). Therefore questions should be asked about how modern preparations differ from the traditional preparation forms upon which much of the historical knowledge of the medicines is based.

A number of factors make the assessment of herbal medicines more complex than for pharmaceuticals. As described in Chapter 1, herbal medicines are
complex poly-pharmaceuticals. In addition, the herbal medicines prescribed by WHM practitioners are not extracts of a single herb but an individualised mixture of several herbal medicines. Furthermore, as Drew and Myers (2002) stress, the different methods of processing of plant into a finished herbal medicine carried out by a manufacturer, CAM practitioner or the patient is a major determinant of the pharmacological activity of the finished product. Future research comparing traditional knowledge about herbal preparations with laboratory, clinical and/or epidemiological research documenting the modern applications, preparation and doses of herbal medicines seems warranted.

7.3.2 Inter-professional issues

In Australia the coordination of patient care when provided by more than one health professional is raising significant safety issues as well as legal and ethical debate (Kerridge et al. 2004). Currently, the medical literature is replete with warnings about the potential toxicity of herbal medicines as well as their possible interactions with pharmaceutical medicines (Barnes 2003; Ernst 2007). The potential interactions of drugs and herbal medicines has been described as a major concern for medical professionals (Drew et al. 1997).

This study confirmed that a large proportion of WHM clients are concurrently taking pharmaceutical and herbal and medicines. Consistent with this data, the interview participants suggested that WHM clients are predominantly receiving herbal treatment for the management of chronic conditions that have not responded to mainstream medical care or to which pharmaceutical medicines have caused undesirable side effects.

The practical implication is that all healthcare professionals are increasingly requiring information regarding herbal medicines so they can avoid potential treatment interactions and can maintain safety standards for their patients.
Significantly, the survey highlighted a perception amongst the WHM profession of a lack of available research about drug-herb interactions. This thesis provided some steps towards addressing the research gap about this important inter-professional healthcare issue. It is hoped that the results from this thesis about what conditions WHM practitioners are treating will provide focus for future research by identifying the most likely adverse reactions and potential drug-herb interactions.

As discussed in Chapter 2, many consumers of herbal medicines do not inform their medical practitioner of their use of herbal medicines. Many WHM practitioners perceive the medical profession to be openly antagonist towards herbal medicine. Significantly, interview participants described their experiences of inter-professional censure and resulting poor inter-professional communications. As a result the qualitative data identified a lack of confidence amongst WHM practitioners in communicating with the medical profession, leading to various avoidance tactics. Such behaviours could compromise patient safety and the effectiveness of treatments. The majority of survey respondents reported a desire for closer collaboration and cooperation with the medical community in the future.

Significantly, concerns amongst medical practitioners, as raised in Chapter 2, about the harmfulness of CAM related to scope of practice seem unnecessary. The qualitative study indicated that WHM practitioners are conscious of not trespassing upon the medical profession’s scope of practice. Importantly, most WHM practitioners do not perceive primary diagnosis of medical conditions to fall within their scope of practice, but report a high referral rate to medical practitioners for diagnosis or treatment when it is considered necessary; however, WHM practitioners reported a significantly lower degree of reciprocation.
Thus, an important finding of this research is that, at present, concurrent patient care between medical practitioners and WHM practitioners appears to be rarely coordinated due to poor inter-professional communication. Ironically, WHM, unlike other traditions of herbal medicine, integrates many aspects of medical science into its practice, providing a platform for common dialogue with the medical profession. If WHM practitioners feel ill-equipped to communicate with medical practitioners, then future education is required to develop improved communication skills with the medical profession.

7.3.3 Intra-professional issues

In consideration of the amount of money involved in the herbal medicine industry and the issues related to its integration within the Australian health care system, there has been a paucity of information on how prepared WHM professionals are when they enter clinical practice. WHM professionals in Australia appear satisfied with their clinical education. However, the research indicated that WHM practitioners practice in relative isolation and that intra-professional support appears to be reliant on the formation of ad hoc inter-personal relationships as opposed to any formalised intra-professional support structures.

The data provided about the form and content of clinical practice, client expectations from treatment and the publics motivations for seeking herbal treatment should help inform future WHM curriculum development. In particular, the data about WHM patients and problems treated should help to identify those areas of practice warranting extra emphasis in clinical training programs, for example the treatment of female healthcare issues and diseases.

While most practitioners were satisfied with their education in preparing them for practice, most reported a perception of inadequate professional support available to them. The interview analysis confirmed that the lack of professional
support, particularly mentoring in the early years of practice, is an issue of significant concern within the profession. As a direct result many WHM practitioners, particularly those in the early years of practice, were experiencing a significant degree of isolation. A significant finding of this research is the apparent need for an expansion of professional support structures available for WHM practitioners once in clinical practice.

Both the quality of professional training and ongoing professional support are issues of importance for ensuring the continued strength and growth of a profession. Any healthcare profession must be able to ensure training programs that deliver competent and safe healthcare professionals who are able to communicate with both their patients and other healthcare providers. It seems that the educational institutions involved in the education of WHM practitioners, as well as their professional associations, have responsibilities for providing support not only to their graduates/members and their future patients but also to the healthcare system and to society at large.

The thesis also raises pertinent issues relating to the structural discrimination towards the WHM profession in Australia. As described in Chapter 1, the Australian population reputedly spends more money on CAM than is provided by the PBS. Nevertheless, medicines classified as complementary by the TGA are excluded from public healthcare subsidies (TGA 2008). The research described how the WHM profession is struggling to compete with powerful mainstream influences, particularly in light of formalised inequity within existing public healthcare.

The research indicates that the WHM profession constitutes a healthcare workforce conversant in medical science, which functions in a complementary capacity to medical practice. The data presented highlights a potential role for herbal medicines and the WHM practitioner in public healthcare, particularly in
the management of chronic conditions for which there are currently no medical alternatives. The thesis offers a case for the statutory regulation of the WHM profession.

This research contributes pertinent data to inform any discussion about the potential regulation of the WHM profession, offering in particular specific insight into the WHM profession’s scope of practice. Such data are particularly useful for the credentialing process. The understanding of WHM practice and of the characteristics and attitudes of WHM practitioners provided in thesis may be useful in any future assessment of the need for regulation of the WHM profession. The thesis demonstrates that within the WHM profession there are divergent views on whether, and how, WHM can improve its position within the mainstream.

As defined in Chapter 1, statutory regulation involves the credentialing of healthcare professions; in other words, it is a process of formally defining a profession’s scope of practice. While some WHM practitioners perceive statutory regulation to limit scope of practice, it seems that mainstreaming is already compromising the viability of the WHM profession by intruding into its professional boundaries. Statutory regulation will lead to credentialing which effectively equates to a defined scope of practice. In addition, defining the WHM scope of practice would be advantageous for patient safety and also as a means of boosting cross-professional understanding in multi-disciplinary patient care. Statutory registration would also help regulate education, post-graduate development and continuing education requirements.

Whether the profession chooses to pursue statutory self-regulation or state controlled statutory registration is a matter for the WHM profession to decide. However, statutory regulation does not appear to be a realistic prospect within the current healthcare environment and is one compromised by numerous intra-
professional tensions and poor professional solidarity. Whether WHM ultimately occupies an alternative role or a complementary role within mainstream healthcare, at present the WHM profession appears to lack the cohesion and solidarity required to effectively counteract the increasing appropriation of herbal medicines by the mainstream.

7.4 Conclusion

The thesis describes the salient features of WHM in Australia at this point in time and indicates how it has evolved in relation to the modern context of healthcare. The advantages of using a mixed methods approach to investigate the complex research problem are evident in the variety and depth of the data collected. The thesis shows that WHM practice is a synthesis of the complex inter-play of social processes, historical influences, philosophical ideas, political ideology and practical considerations.

WHM practice is described as an eclectic practice of traditional Herbalism and Phytotherapy, supplemented by the judicious use of OTC supplements. The WHM profession continues to preference traditional herbal prescribing practices and principles. On the other hand, the results clearly indicated the influence of the dominant medical paradigm upon WHM clinical practice. WHM may be conceptualised as a negotiation between traditional ideals and concessions to mainstream expectations.

The analysis employed a conceptual framework to provide a coherent understanding of the complex processes characterising the mainstreaming of WHM and is a vehicle to explain the detailed and sometimes discrepant mixed methods results. A significant contribution of this investigation, which is an area not previously explored within the literature, is the understanding of how the appropriation of herbal medicines is impacting upon WHM practice, the WHM practitioner and the standing the WHM as a legitimate healthcare profession.
Many of the findings from this analysis support Tovey and Adams' conclusions, as outlined in Chapter 3. Firstly, it revealed that the subordination to, and thus distinction from, mainstream medicine was a dominant issue within the WHM profession’s discourse. Secondly, mainstream expectations of healthcare have altered the traditional WHM model of practice. Finally, the analysis identified a number of competing sub-groups within WHM who each advocated particular interpretations of WHM philosophy and, thus, adopted different approaches to WHM practice.

Importantly, the focus of this thesis was different to that of Tovey and Adams, whose research has concentrated upon healthcare professions that are part of the mainstream establishment. To date the majority of social research has been concerned with strong intersection between different mainstream healthcare professions. In contrast, this investigation offers the perspective of a healthcare profession that occupies a role outside of mainstream healthcare. The thesis provides an example of ‘weak intersection’ where activities are adopted from elsewhere yet contact with ‘other’ practitioners is restricted or denied. The research provides strong evidence that, while the mainstream has shown an increasing interest in the utilisation of herbal medicines rather than collaborating with the WHM profession, it has increasingly imposed its own requirements (commercialisation and rationalisation) while simultaneously restricting WHM practitioners from legitimate participation within the mainstream healthcare system (co-option).

The inquiry reveals the WHM profession to be one actively engaged in attempts to legitimate WHM to those outside the profession (the mainstream), as well as being pre-occupied in inter-professional debate about the authentic role of WHM practice within the mainstream. Finally, the analysis identified a number of competing sub-groups within WHM, namely the medical and traditional herbalists, who advocated different interpretations of WHM philosophy and,
thus, approach WHM practice differently. The thesis portrays a professional group currently seeking a legitimate entry into Australian healthcare but is a profession divided between advocates of complementary status and those who wish to perpetuate their alternative role.

This research provides new understandings about both the practice of WHM and the location of the WHM profession in Australian healthcare. The study suggests the WHM profession is engaged in a constant process of negotiation between competing interests and conflicting demands. Ironically, despite the increasing popularity of herbal medicines and significant concessions within WHM to the medical paradigm, the WHM profession is struggling for legitimacy and continues to operate on the fringe of Australian healthcare. Mainstreaming is operating at the expense of the WHM practitioner, challenging the authenticity of WHM herbal tradition and the future viability of the WHM profession. The thesis reveals a story of the continuity of past marginalisation rather than substantial change for the WHM profession.

7.4.1 Limitations and further research

The research has a number of limitations. Although considerable effort was made to reduce bias, the potential for recall and response bias remain. In particular, the interviews involved a retrospective reconstruction of events by participants who may have provided idealised (or self-serving) accounts of their practices. Additionally, the methods of recruitment meant that participants were self-selecting. Nonetheless, the consistency of the findings across both studies offers reassurance of the validity of interpretation of the qualitative data.

The fact that the survey was undertaken as the first component to be completed could be seen as a limitation by traditional methodologists. However, the preliminary survey data was instrumental in identifying the broad themes upon which the qualitative analysis was based. The in-depth exploration of individual
perceptions was also considered to be a major strength of the research process.

Another potential limitation was that the qualitative analysis was conducted by one researcher. It is, therefore, possible that the interpretation may have been influenced by the personal biases or theoretical preoccupation of the researcher (Bower et al. 2004). Negative case testing was applied to the qualitative data and any case of deviation from the major thematic arguments was highlighted. The claims for validity of the interpretation were strengthened through the study design. The methodology ensured the contrast and comparison of data between the quantitative and qualitative sources and between interview participants. Nevertheless, it must be acknowledged that bias in the themes identified in the analysis cannot be completely eliminated. An opportunity to work with other researchers on the coding and thematic analysis may have been extremely beneficial.

In addition, the themes identified are illustrative of the potential offered by an analysis of mainstreaming but not a definitive account of it. Further research could examine data from other sources, including WHM practitioners from states other than NSW, or members of other relevant professional bodies. Future research employing more extensive qualitative methods, such as ethnography, would be useful to deepen understanding of the clinical practice of WHM. Ethnographic study involving patients would be particularly useful in establishing the behaviours and actions that take place in the consultation, rather than relying only on the descriptions and explanations of practitioners.

The thesis provided the first comprehensive charting of WHM practice in Australia. The national data from this thesis about how, when and why WHM practitioners prescribe herbs could help inform hypotheses for future herbal medicine research, including clinical trials of efficacy and safety. For example,
the thesis data could be valuable for identifying the most likely drug-herb interactions due to concurrent herbal and pharmaceutical use by the general public. Significantly, the majority of both WHM practitioners and WHM clientele in Australia are women. It is important to consider CAM issues within the context of women’s conceptualisations of healthcare and health needs as well as the motivations of women, themselves, for both seeking WHM treatment and choosing CAM as a career. Exploration of gender related issues was an underdeveloped aspect of this thesis and clearly warrants further investigation.

It is anticipated that these findings may raise awareness among mainstream health professionals about the form and content WHM. Research has shown that, where medical practitioners have knowledge about CAM, their referral to CAM practitioners for both treatment and diagnostic activities increases (Hirschkorn et al. 2007; Grace et al. 2008). Future research is also needed to explore the interactions between WHM and medical practitioners in more detail. Additional questions that merit investigation include issues such as identifying exactly which conditions WHM practitioners refer to medical practice, WHM practitioners’ perceptions of the efficacy of WHM treatments versus those of medical practice and, of course, how to improve inter-professional communications.

Finally, research in the area of CAM practice has not yet been substantially explored using a critical social science analysis. Future research with the application of different social theoretical perspectives may expand the development of underlying theory and concepts to adequately conceptualise the broader social, cultural, political and economic contexts of WHM practice. In consideration of the underlying theme of discrimination emerging from the data, future research employing a social justice or transformative framework to give voice to the perspectives of this marginalised group with less power and privilege than those inside the mainstream seems warranted.
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Appendices

Appendix A – the survey questionnaire package

Appendix B – the survey summary statistics

Appendix C – responses to survey item 33 reporting morbidity of WHM practice
December 2003

Dear NHAA Member

An invitation to participate
National Survey of Herbal Medicine Practitioners

The Centre for Clinical Epidemiology and Biostatistics (CCEB) of the University of Newcastle is extremely privileged to be able to join the NHAA and conduct a national survey of herbal medicine practitioners.

The survey is being mailed to all herbal medicine practitioners and naturopaths (who practice herbal medicine) registered with the NHAA. The membership of the NHAA has been chosen for this important research because the association is one of the most well respected traditional medicine associations in Australia.

The information that is to be gathered from this survey is hopefully of fundamental importance to the continued growth and strength of your profession. The survey aims to collect data in order to facilitate public understanding of the professional practice of herbal medicine in Australia.

We would like to invite you to join in this project by completing the attached survey. It should take no more than 20 minutes. Once completed please return the survey in the enclosed pre-paid envelope by the end of January 2004. The survey is anonymous.

You will also find attached an invitation to join a follow up study of in-depth interviews about herbal medicine practice. Please read the information sheet and return the consent form by fax if you are interested in participating in an interview.

A detailed information form is attached to the survey. If you have any further queries please feel free to contact me at the CCEB on (02) 4923 6302.

Thank you for your co-operation.

Yours sincerely

Mavoureen Casey
CCEB, Newcastle University
This Survey is Anonymous
Please do not write your name on this questionnaire

It should only take between 15-20 minutes to complete
Please return the questionnaire in the reply paid envelope before
the end of January 2004.

A detailed information form is attached

THE SURVEY
Please place a cross in the appropriate box(es)
Please use a black or blue pen

Your demographic details

1. What is the postcode of your clinic(s)? ☐ ☐ ☐ ☐ , ☐ ☐ ☐ ☐ , ☐ ☐ ☐ ☐

2. What is your age (in years)? ☐ ☐

3. What is your gender? ☐ Female ☐ Male

4. What is the highest level of qualification in herbal medicine that you hold?
   ☐ Diploma ☐ Advanced Diploma ☐ Bachelor Degree

5. At which type of the educational institution were you trained in herbal medicine? (you may tick more than one box)
   ☐ Private College ☐ University

6. How many years of experience do you have in clinical practice?
   ☐ 1 - 2 years ☐ 3 - 5 years
   ☐ 6 -10 years ☐ More than 10 years

7. What is the average length of an initial consultation?
   ☐ 0-30 mins ☐ 31-60 mins ☐ 60+ mins

8. What is the average length of a follow up consultation?
   ☐ 0-30 mins ☐ 31-60 mins ☐ 60+ mins

Questions are printed on both sides of pages
Your herbal medicines

9. Which herbal medicine tradition do you predominantly practice? (tick one box only)
   - Western Herbal Medicine
   - Traditional Chinese Herbal Medicine
   - Ayurvedic Herbal Medicine
   - Other ____________________

10. Does your clinic operate its own herbal dispensary?  
    - Yes  
    - No

11. Which form of herbal medicines do you prescribe most often? (tick one box only)
    - Fluid extracts (1:1 or 1:2)  
    - Tinctures (1:5 or 1:10)  
    - Other ____________________
    - Teas / dried herb  
    - Powders  
    - Tablets or capsules

12. Other than liquid formulae, what other types of herbal preparations do you regularly prescribe? (you may tick more than one box)
    - Topical creams  
    - Pessaries or douches  
    - Gargles  
    - Other ____________________
    - Teas  
    - Tablets or capsules  
    - Poultices or topical washes

13. Do you predominantly prescribe individualised herbal formulae for each patient?  
    - Yes  
    - No

14. Do you often prescribe a single herb based upon its specific indication in the British Herbal Pharmacopoeia (BHP)?  
    - Yes  
    - No

15. Which do you predominantly consider when constructing herbal formulae?
    - The actions of the herb  
    - The indications of the herb  
    - Other ____________________
    - The specific indication of the herb  
    - The chemical constituents of the herb

16. What do you initially consider when formulating herbal formulae? (tick one box only)
    - The diagnosed disease or condition  
    - The signs / symptoms of the patient  
    - The underlying cause  
    - Other ____________________

17. Which dosage system of herbal medicine do you generally use? (tick one box only)
    - Drop dosages  
    - The pharmaceutical doses as recommended on each bottle  
    - British Herbal Pharmacopoeia (BHP) dosages  
    - High, medium, low dose ranges  
    - Other ____________________

18. What types of formulae do you prescribe most often? (you may tick more than one box)
    - Individualised formulae for each patient  
    - Pre-formulated tablets or capsules from manufacturers  
    - Precisely constructed / authoritative formulae  
    - Your own tried and tested formulae for specific conditions  
    - Formulae from other herbalists

Your clinical practice

19. Do you specialise in any area of treatment or practice?  
    - Yes  
    - No
    If yes what is it? ____________________
20. Which of the following activities do you normally conduct in an initial consultation? (you may tick more than one box)
   - Case history
   - Dietary history
   - Physical examinations (as per q.21)
   - Diagnosis
   - Formulation of treatment program
   - Nutritional and herbal advice
   - Preparation for pathology tests
   - Herbal formulation
   - Herbal dispensing
   - Counselling

21. Which types of patient examination styles do you commonly use? (you may tick more than one box)
   - Iridology
   - Kinesiology
   - Face, nails, tongue diagnosis
   - Pulse diagnosis
   - Conventional physical examination techniques

22. Which diagnostic tests do you use on a regular basis? (you may tick more than one box)
   - Live blood analysis
   - Functional medicine tests
   - Hair analysis
   - Pulse diagnosis
   - Electro-dermal screening (Listen, Vega etc.)

23. Does your clinic operate any of the following diagnostic equipment? (you may tick more than one box)
   - Bio impedance testing
   - Live blood analysis
   - Iridology camera or computer system
   - Electro-dermal testing equipment (Listen or Vega etc.)

24. Which of the following do you use regularly during patient examinations?
   - Sphygmomanometer
   - Otoscope
   - Stethoscope
   - Thermometer

25. Do you use medical pathology tests on a regular basis?  
   - Yes  
   - No

   If yes, which tests do you request on a regular basis?
   - Blood tests
   - Hormone profiles
   - Liver function tests
   - X-rays
   - Urine samples

26. How do you request pathology tests when needed?
   - Refer the patient directly to pathology laboratory
   - Refer the patient to a General Practitioner
   - Ask the patient to request the tests from a General Practitioner
   - Other

27. How important is it to you to understand a patient’s orthodox medical diagnosis when providing herbal therapy?
   - Extremely Important
   - Somewhat Important
   - A little important
   - Not important

28. Do you consider it your responsibility to be able to make an orthodox medical diagnosis for your patients?  
   - Yes  
   - No

29. Do you consider it your responsibility to be able to recognize the signs and symptoms of an underlying disease but rely on a medical practitioner for a diagnosis?  
   - Yes  
   - No
Your clients

30. What is the average number of patients booked in for consultation with you per week? ☐ ☐ ☐

31. What do the majority of your patients request herbal medicine treatment for? (tick one box only)
   ☐ Management of acute conditions
   ☐ Management of chronic conditions

32. Approximately what percentage of your patients fall into the following 3 categories?
   Women __________%  Men __________%  Children __________%

33. What are the **TOP 5 most common** conditions/diseases/symptoms that you treat in your clinic?

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34. What are the **most common** reasons that patients give to you for seeking herbal medicine treatment?
   (you may tick more than one box)
   ☐ Seeking a more holistic approach to health
   ☐ A desire for preventative medicine
   ☐ The chronic nature of their disease / condition
   ☐ A growing concern about effectiveness / side effects of drugs
   ☐ Greater control over their health
   ☐ Philosophical or spiritual reasons
   ☐ Dissatisfaction with orthodox medicine
   ☐ Other__________________________________________

35. What percentage of your patients have already seen a medical doctor to understand their conditions?
   ☐ 0-20%  ☐ 21-40%  ☐ 41-60%  ☐ 61-80%  ☐ 81-100%

36. What percentage of your patients concurrently consult you and a medical doctor for treatment?
   ☐ 0-20%  ☐ 21-40%  ☐ 41-60%  ☐ 61-80%  ☐ 81-100%

**Interaction of herbs and pharmaceuticals**

37. Do you see the role of herbal medicine as a -
   ☐ Replacement for most conventional medicine or drug therapies
   ☐ A complementary treatment to most conventional medicine or drug therapies
   ☐ Other__________________________________________

38. During case history taking, do you routinely ask your patients if they are taking pharmaceuticals?
   ☐ Yes  ☐ No
39. Do you believe there is sufficient information available about the interaction of drugs and herbs? □ Yes □ No

40. What are the most common reasons patients who are taking medications give for seeking herbal medicine treatment?
   □ Their medication is no longer effective
   □ Unwelcome side effects of medication
   □ Seeking a ‘natural alternative’
   □ Other ______________________

41. What percentage of your patients are concurrently taking prescribed medication as well as herbal medicines?
   □ 0-20%    □ 21-40%    □ 41-60%    □ 61-80%    □ 81-100%

42. How confident do you feel to treat patients who are also taking prescribed medications?
   □ Very confident □ Confident □ A little confident □ Not at all confident

**Your relationship with fellow health care professionals**

43. Do you receive referrals from medical practitioners? □ Yes □ No

44. Do you refer your patients to other health care practitioners? □ Yes □ No

   If yes, to whom? (you may tick more than one box)
   □ General Practitioners □ Acupuncturists
   □ Chiropractor / Osteopaths □ Other Natural Medicine Practitioners
   □ Counsellors □ Other ______________________

45. For what reasons do you refer patients to medical practitioners? (you may tick more than one box)
   □ To request pathology tests
   □ To confirm a medical diagnosis
   □ To obtain a medical diagnosis
   □ For treatment or prescription when necessary

46. How would you rate your working relationship with the medical community?
   □ Excellent □ Very good □ Good □ Fair □ Poor

47. How do you rate the medical community’s attitudes towards yourself as a herbalist?
   □ Excellent □ Very good □ Good □ Fair □ Poor

48. How comfortable do you feel in communicating with the medical community?
   □ Very Comfortable □ Comfortable □ Uncomfortable □ Very Uncomfortable

49. Do you encourage your patients to tell their doctors they are taking herbal medicine? □ Yes □ No

50. What percentage of your patients are concurrently consulting a medical practitioner?
   □ 0-20%    □ 21-40%    □ 41-60%    □ 61-80%    □ 81-100%

51. What percentage of your patients perceive you as their primary health care practitioner?
   □ 0-20%    □ 21-40%    □ 41-60%    □ 61-80%    □ 81-100%

52. Do you see closer collaboration and co-operation with the medical community as a desirable situation for the future? □ Yes □ No
Knowledge and training

53. How would you rate the training you had with regard to preparing you for work as a professional herbalist in clinical practice?
- Excellent
- Very good
- Average
- Poor

54. Which of the following commonly used terms do you feel most accurately describes the type of medicine you practice? (tick one)
- Natural Medicine
- Complementary Medicine
- Alternative Medicine
- Traditional Medicine
- Non-orthodox medicine
- Holistic Medicine
- Non-Conventional Medicine

55. With regard to Western Herbal Medicine what do you consider to be the authoritative source of Materia Medica reference?
- British Herbal Pharmacopoeia and Compendium
- German Commission E Monographs
- ESCOP or American Monographs
- Traditional Sources e.g. Culpeper, Morrison’s etc
- Your College or University Materia Medica
- Other

56. How would you rate the support you received as a new graduate when beginning clinical practice from the following sources?

a. Your training institution
- Very supportive
- Somewhat supportive
- A little supportive
- Not supportive

b. Your professional association
- Very supportive
- Somewhat supportive
- A little supportive
- Not supportive

c. Experienced practitioners
- Very supportive
- Somewhat supportive
- A little supportive
- Not supportive

Please place the survey in the reply paid envelope and return it by end of January 2004

IN – DEPTH INTERVIEWS

We intend to conduct some in-depth interviews about herbal medicines and professional herbal practice in Australia. If you practice in NSW and are interested in participating in an interview, please complete the attached consent form and return by fax to:-

(02) 4349 4565

Thank you for your time and for helping us with this important research
INFORMATION FORM

The Professional Practice of Western Herbal Medicine in Australia
The project is being conducted by the CCEB, Newcastle University

THE INVESTIGATORS

Dr J Adams, CCEB, Faculty of Health, University of Newcastle
Dr D Sibbritt, CCEB, Faculty of Health, University of Newcastle
Ms M Casey, CCEB, Faculty of Health, University of Newcastle

AN INVITATION

You are invited to participate in this research project which explores issues currently pertinent to the clinical practice of herbal medicine in Australia, for which fundamental data is currently unavailable. In assessing and describing herbal medicine in Australia, it is important that the perspective and experiences of those health professionals involved in clinical practice are examined and considered. This project is being undertaken with the co-operation of the National Herbalists Association of Australia (NHAA).

Your participation includes the completion of the attached survey and if you live in NSW the possibility of an in-depth interview. The interview questions will be informed by the survey responses which is why specific content cannot be given at this time. However the focus of the interviews will be the perspectives, experiences and opinions of herbal therapists about their philosophy, scope of practice and clinical experiences. These interviews will be conducted in a few months’ time.

Why is this research being done?

It is important that unbiased and rigorous data about the clinical practice of natural medicine in Australia by registered and qualified practitioners be collected and published for general and targeted readership. This research will address the gap that currently exists in locating professional complementary medicine within the Australian health care system. It is also one of the first academic ventures in Australia which aims to raise natural medicine practice issues and policy issues, and place them firmly on the scientific agenda. It is envisaged that results will form the basis of future research in diverse areas which encompass philosophical issues, educational strategies, issues of professionalisation, governmental policy, funding, and research methodologies.

What do you need to do to participate?

Please read the Information Form and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have any questions, contact the researchers.

1. Please complete and return the questionnaire in the reply paid envelope by the end of January 2004.

2. If you live in NSW and would like to participate in the interviews, please complete the separate consent form, return it via fax and a member of the research team will contact you to arrange an interview appointment. The consent form is returned separately form the survey to ensure your anonymity.

Centre for Clinical Epidemiology and Biostatistics
Faculty of Health, University of Newcastle, Level 3 DMB, Royal Newcastle Hospital, Newcastle NSW 2330
Who can participate in this research?
This invitation to participate is being extended to all those members of the NHAA who are registered to practice Western Herbal Medicine.

What would you be asked to do?
1. We are asking all members of the NHAA who are registered to practice herbal medicine to complete and return the included survey.
2. We are also seeking herbal therapists and/or naturopaths (who practice herbal medicine) and who practice in NSW to take part in an in-depth interview. If you agree to participate in the interview, you will be asked to attend an interview, at a time to suit you, to be held at your clinic address. The interviews will run for between 1-1 ½ hours and will be facilitated by Ms Mavourneen Casey.

What choice do you have?
Participation in the research project is entirely your choice. The survey is constructed to ensure complete anonymity. Only those people who give informed consent will be included in the interview process. Whether or not you decide to participate, your decision will not disadvantage you in any way.

If you decide to participate in an interview, you may withdraw from the project at any time without giving a reason.

How will your privacy be protected?
All information you give as part of the research will be treated in the strictest confidence. All surveys are anonymous and if you participate in an interview, any identifiable features of your discussion will not be transcribed. Any information which might identify you will not be disclosed without your consent. Steps will be taken to honour your privacy and autonomy throughout the research. Interview participants will be able to review, edit or erase the tape recording and/or transcripts of interviews for those who consent to participate in that phase.

Only the research team listed in this information form will have access to the data collected. All information will be transcribed from tape and will be stored in password protected computer files. The information will be stored for seven years and then destroyed following University of Newcastle procedures.

Practitioners who consent to participate in the interview are being asked to return the consent form by fax which will be separated from their survey to ensure their responses to the survey remain anonymous.

How will the information collected be used?
This work will be the first movement towards addressing the gap in research upon the contemporary location of professional herbal medicine in the Australian health care system. The findings will be of interest and use to all those involved in the education, clinical practice, provision and planning of natural health care services in Australia. This includes grassroots stakeholders (natural therapists, general practitioners, nurses, etc) formal representative bodies and institutions (professional associations, health consumer representative groups, universities, colleges etc) and policy makers and planners.

The data and its analysis will be reported in academic and professional journals on completion of the research. There will be a time lag between completion and publication of approximately 6-9 months. A professional development seminar outlining findings will also be held at a time and place to be arranged by the NHAA. Results will also be submitted for publication in the Australasian Journal of Medical Herbalism. Individual participants will not be identified in any reports or papers arising from the project – all effort will be undertaken to ensure participants are guaranteed confidentiality and anonymity throughout the research.

Footnote:
Mavourneen Casey is conducting this research as part of her Doctor of Philosophy (PhD) under the supervision of Dr Jon Adams and Dr David Sibbritt from the School of Medical Practice and Population Health, University of Newcastle

This project has been approved by the University of Newcastle Human Research Ethics Committee:
Approval No. H-(677-1003).

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308. Telephone: (02) 49216333. Email: Human-Ethics@newcastle.edu.au

For further information regarding this project please contact:

Mavourneen Casey, CCEB, Phone: (02) 49236302 Fax: (02) 4349 4565
Dr Jon Adams, CCEB, Phone: (02) 49236466 Fax: (02) 49236148
# Appendix B

## National Survey of Herbal Medicine Practitioners

### Your demographic details

1. What is the postcode of your clinic(s)?

<table>
<thead>
<tr>
<th>Postcode</th>
<th>Freq.</th>
</tr>
</thead>
<tbody>
<tr>
<td>clinic 1</td>
<td>372</td>
</tr>
<tr>
<td>clinic 2</td>
<td>50</td>
</tr>
<tr>
<td>clinic 3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>425</strong></td>
</tr>
</tbody>
</table>

2. What is your age (in years)?

<table>
<thead>
<tr>
<th>Age</th>
<th>Obs</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Median</th>
<th>IQR</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>376</td>
<td>43.49</td>
<td>9.86</td>
<td>45</td>
<td>15</td>
<td>23</td>
<td>77</td>
</tr>
</tbody>
</table>

3. What is your gender?

<table>
<thead>
<tr>
<th>Gender</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>female</td>
<td>311</td>
<td>82.9</td>
<td>82.9</td>
</tr>
<tr>
<td>male</td>
<td>64</td>
<td>17.1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>375</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

4. What is the highest level of qualification in herbal medicine that you hold?

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>diploma</td>
<td>170</td>
<td>45.1</td>
<td>45.1</td>
</tr>
<tr>
<td>advanced diploma</td>
<td>117</td>
<td>31.0</td>
<td>76.1</td>
</tr>
<tr>
<td>degree</td>
<td>89</td>
<td>23.6</td>
<td>99.7</td>
</tr>
<tr>
<td>grandfather*</td>
<td>1</td>
<td>0.3</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>377</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. At which type of the educational institution were you trained in herbal medicine? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Education</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>college</td>
<td>332</td>
<td>88.0</td>
<td>88.0</td>
</tr>
<tr>
<td>university</td>
<td>13</td>
<td>3.5</td>
<td>91.5</td>
</tr>
<tr>
<td>both</td>
<td>32</td>
<td>8.5</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>377</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

* Other indicates responses reported in addition to primary choice by respondents
6. How many years of experience do you have in clinical practice?

<table>
<thead>
<tr>
<th>Years</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 years</td>
<td>82</td>
<td>21.8</td>
<td>21.8</td>
</tr>
<tr>
<td>3-5 years</td>
<td>92</td>
<td>24.4</td>
<td>46.2</td>
</tr>
<tr>
<td>6-10 years</td>
<td>66</td>
<td>17.5</td>
<td>63.7</td>
</tr>
<tr>
<td>&gt; 10 years</td>
<td>137</td>
<td>36.3</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>377</td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

7. What is the average length of an initial consultation?

<table>
<thead>
<tr>
<th>Initial</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-30 mins</td>
<td>17</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>31-60 mins</td>
<td>158</td>
<td>41.8</td>
<td>46.3</td>
</tr>
<tr>
<td>60+ mins</td>
<td>203</td>
<td>53.7</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>378</td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

8. What is the average length of a follow up consultation?

<table>
<thead>
<tr>
<th>Follow up</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-30 mins</td>
<td>165</td>
<td>43.7</td>
<td>43.7</td>
</tr>
<tr>
<td>31-60 mins</td>
<td>203</td>
<td>53.7</td>
<td>97.4</td>
</tr>
<tr>
<td>60+ mins</td>
<td>10</td>
<td>2.6</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>378</td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Your herbal medicines**

9. Which herbal medicine tradition do you predominantly practice? (tick one box only)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Western herbal medicine</td>
<td>373</td>
<td>98.9</td>
<td>98.9</td>
</tr>
<tr>
<td>Traditional Chinese medicine</td>
<td>4</td>
<td>1.1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>377</td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Other responses included Ayurveda (n=2), TCM (n=6), Homeopathy (n=1), Physiomedical (n=1).

10. Does your clinic operate its own herbal dispensary?

<table>
<thead>
<tr>
<th>Dispensary</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>366</td>
<td>97.3</td>
<td>97.3</td>
</tr>
<tr>
<td>no</td>
<td>10</td>
<td>2.7</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>376</td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>
11. Which form of herbal medicines do you prescribe most often? (tick one box only)

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>fluid extracts</td>
<td>336</td>
<td>90.1</td>
<td>90.1</td>
</tr>
<tr>
<td>teas/dried herbs</td>
<td>16</td>
<td>4.3</td>
<td>94.4</td>
</tr>
<tr>
<td>tinctures</td>
<td>4</td>
<td>1.0</td>
<td>95.4</td>
</tr>
<tr>
<td>powders</td>
<td>3</td>
<td>0.8</td>
<td>96.2</td>
</tr>
<tr>
<td>tablets or capsules</td>
<td>14</td>
<td>3.8</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>373</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

*Other responses included various combinations of the above (n=13), Homeo-botanicals (n=2), essential oils (n=2).

12. Other than liquid formulae, what other types of herbal preparations do you regularly prescribe? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Preparations</th>
<th>Obs</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>topical creams</td>
<td>255</td>
<td>21.6</td>
<td>68.5</td>
</tr>
<tr>
<td>pessaries or douches</td>
<td>79</td>
<td>6.7</td>
<td>21.2</td>
</tr>
<tr>
<td>gargles</td>
<td>134</td>
<td>11.3</td>
<td>36.0</td>
</tr>
<tr>
<td>eyebaths</td>
<td>90</td>
<td>7.6</td>
<td>24.2</td>
</tr>
<tr>
<td>teas</td>
<td>228</td>
<td>19.3</td>
<td>61.3</td>
</tr>
<tr>
<td>tablets or capsules</td>
<td>322</td>
<td>27.2</td>
<td>86.6</td>
</tr>
<tr>
<td>poultices or topical washes</td>
<td>74</td>
<td>6.3</td>
<td>19.9</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>1182</td>
<td>100.0</td>
<td>317.7</td>
</tr>
</tbody>
</table>

6 missing cases; 372 valid cases

*Other responses included baths (n=2), culinary herbs (n=1), inhalations (n=1), essential oils (n=4), powders (n=1).

13. Do you predominantly prescribe individualised herbal formulae for each patient?

<table>
<thead>
<tr>
<th>Formulae</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>363</td>
<td>96.3</td>
<td>96.3</td>
</tr>
<tr>
<td>no</td>
<td>14</td>
<td>3.7</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>377</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

14. Do you often prescribe a single herb based upon its specific indication in the British Herbal Pharmacopoeia (BHP)?

<table>
<thead>
<tr>
<th>BHP</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>67</td>
<td>17.9</td>
<td>17.9</td>
</tr>
<tr>
<td>no</td>
<td>307</td>
<td>82.1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>374</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
15. Which do you **predominantly** consider when constructing herbal formulae?

<table>
<thead>
<tr>
<th>Formulae</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>the actions of the herb</td>
<td>223</td>
<td>59.3</td>
<td>59.3</td>
</tr>
<tr>
<td>the specific indication of the herb</td>
<td>27</td>
<td>7.2</td>
<td>66.5</td>
</tr>
<tr>
<td>the indications of the herb</td>
<td>27</td>
<td>7.2</td>
<td>73.7</td>
</tr>
<tr>
<td>the chemical constituent of the herb</td>
<td>3</td>
<td>0.8</td>
<td>74.5</td>
</tr>
<tr>
<td>combinations of above</td>
<td>96</td>
<td>25.5</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>376</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Other responses included intuition (n=1), TCM (n=2), patient’s constitution (n=6), energetics (n=5), kinesiology (n=1), patient’s medications (n=1), synergy (n=2) and therapeutic goal (n=1).

16. What do you **initially** consider when formulating herbal formulae? (tick one box only)

<table>
<thead>
<tr>
<th>Initial</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>diagnosed disease or condition</td>
<td>22</td>
<td>5.9</td>
<td>5.9</td>
</tr>
<tr>
<td>underlying cause</td>
<td>164</td>
<td>43.6</td>
<td>49.5</td>
</tr>
<tr>
<td>signs/symptoms of the patient</td>
<td>158</td>
<td>42.0</td>
<td>91.5</td>
</tr>
<tr>
<td>combinations of above*</td>
<td>32</td>
<td>8.5</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>376</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

*Indicated as “all of above” in other or multiple ticks in boxes by one respondent. Other responses included holistic (n=4), TCM diagnosis (n=1), eliminatory systems (n=1) and acute or chronic condition (n=1).

17. Which dosage system of herbal medicine do you generally use? (tick one box only)

<table>
<thead>
<tr>
<th>Dosage</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>drop</td>
<td>31</td>
<td>8.2</td>
<td>8.2</td>
</tr>
<tr>
<td>pharmaceutical</td>
<td>204</td>
<td>54.1</td>
<td>62.3</td>
</tr>
<tr>
<td>BHP</td>
<td>45</td>
<td>11.9</td>
<td>74.2</td>
</tr>
<tr>
<td>H/M/L</td>
<td>93</td>
<td>24.7</td>
<td>98.9</td>
</tr>
<tr>
<td>Other*</td>
<td>4</td>
<td>1.1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>377</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

*Other responses included TCM doses (n=2), kinesiology (n=1) and sprays (n=1).

18. What types of formulae do you prescribe most often? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Formulae</th>
<th>Obs</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>individualised formulae for each patient</td>
<td>359</td>
<td>58.2</td>
<td>95.5</td>
</tr>
<tr>
<td>pre-formulated tablets or capsules from manufacturers</td>
<td>153</td>
<td>24.2</td>
<td>40.7</td>
</tr>
<tr>
<td>precisely constructed / authoritative formulae</td>
<td>13</td>
<td>2.1</td>
<td>3.5</td>
</tr>
<tr>
<td>your own tried and tested formulae for specific conditions</td>
<td>72</td>
<td>11.7</td>
<td>19.1</td>
</tr>
<tr>
<td>formulae from other herbalists</td>
<td>20</td>
<td>3.2</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>617</td>
<td>100.0</td>
<td>164.1</td>
</tr>
</tbody>
</table>

2 missing cases; 376 valid cases
19. Do you specialise in any area of treatment or practice?

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>114</td>
<td>30.2</td>
<td>30.2</td>
</tr>
<tr>
<td>no</td>
<td>263</td>
<td>69.8</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>377</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

If yes what is it? _________________________________

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female reproductive</td>
<td>57</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Children</td>
<td>5</td>
<td>4.4</td>
<td>54.4</td>
</tr>
<tr>
<td>Diet/lifestyle</td>
<td>17</td>
<td>14.9</td>
<td>69.3</td>
</tr>
<tr>
<td>CFS</td>
<td>6</td>
<td>5.3</td>
<td>74.6</td>
</tr>
<tr>
<td>GIT Disorders</td>
<td>6</td>
<td>5.3</td>
<td>79.9</td>
</tr>
<tr>
<td>Other modalities</td>
<td>7</td>
<td>6.1</td>
<td>85.9</td>
</tr>
<tr>
<td>Mental health</td>
<td>2</td>
<td>1.8</td>
<td>87.7</td>
</tr>
<tr>
<td>Cancer support</td>
<td>2</td>
<td>1.8</td>
<td>89.5</td>
</tr>
<tr>
<td>Skin conditions</td>
<td>1</td>
<td>0.9</td>
<td>90.4</td>
</tr>
<tr>
<td>Immune conditions</td>
<td>8</td>
<td>7.0</td>
<td>97.4</td>
</tr>
<tr>
<td>Muscular skeletal</td>
<td>3</td>
<td>2.6</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>114</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Specific details reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female reproductive</td>
<td>hormonal disturbances, pre-conception, infertility, endometriosis, menopause</td>
</tr>
<tr>
<td>Children</td>
<td>asthma</td>
</tr>
<tr>
<td>Diet/lifestyle</td>
<td>weight management, anti-aging, preventative, athletes, detoxification</td>
</tr>
<tr>
<td>CFS</td>
<td>Fibromyalgia, chronic fatigue</td>
</tr>
<tr>
<td>GIT</td>
<td>Hepatitis, dysbiosis, indigestion, parasites</td>
</tr>
<tr>
<td>Other modalities</td>
<td>Pharmacy, homeopathy, acupuncture, radiesthesia, kinesiology, osteopath</td>
</tr>
<tr>
<td>Mental health</td>
<td>Emotional, depression, stress</td>
</tr>
<tr>
<td>Cancer support</td>
<td></td>
</tr>
<tr>
<td>Skin conditions</td>
<td></td>
</tr>
<tr>
<td>Immune conditions</td>
<td>auto-immune, allergies, chronic inflammation</td>
</tr>
<tr>
<td>Muscular skeletal</td>
<td>Neuromuscular, neurological, arthritis</td>
</tr>
</tbody>
</table>
20. Which of the following activities do you normally conduct in an initial consultation? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Consultation Activities</th>
<th>Obs.</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>case history</td>
<td>373</td>
<td>13.4</td>
<td>98.9</td>
</tr>
<tr>
<td>dietary history</td>
<td>349</td>
<td>12.5</td>
<td>92.6</td>
</tr>
<tr>
<td>physical examinations (as per q.21)</td>
<td>262</td>
<td>9.4</td>
<td>69.5</td>
</tr>
<tr>
<td>diagnosis</td>
<td>218</td>
<td>7.8</td>
<td>57.8</td>
</tr>
<tr>
<td>formulation of treatment program</td>
<td>303</td>
<td>10.9</td>
<td>80.4</td>
</tr>
<tr>
<td>nutritional and herbal advice</td>
<td>340</td>
<td>12.2</td>
<td>90.2</td>
</tr>
<tr>
<td>preparation for pathology tests</td>
<td>103</td>
<td>3.7</td>
<td>27.3</td>
</tr>
<tr>
<td>herbal formulation</td>
<td>331</td>
<td>11.9</td>
<td>87.8</td>
</tr>
<tr>
<td>herbal dispensing</td>
<td>320</td>
<td>11.5</td>
<td>84.9</td>
</tr>
<tr>
<td>counselling</td>
<td>193</td>
<td>5.9</td>
<td>51.2</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>2792</td>
<td>100.0</td>
<td>740.6</td>
</tr>
</tbody>
</table>

1 missing cases; 377 valid cases

* Other responses included BIA (n=2), acupuncture (n=1), astrology (n=2), dowsing (n=1), food preparation education (n=1), kinesiology (n=1), exercise (n=1), osteopathy (n=1), patient questionnaires (n=1) and referrals (n=3).

21. Which types of patient examination styles do you commonly use? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Examination</th>
<th>Obs</th>
<th>% Respondents</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>iridology</td>
<td>284</td>
<td>33.1</td>
<td>77.6</td>
</tr>
<tr>
<td>kinesiology</td>
<td>27</td>
<td>3.2</td>
<td>7.4</td>
</tr>
<tr>
<td>face, nails, tongue</td>
<td>280</td>
<td>32.7</td>
<td>76.5</td>
</tr>
<tr>
<td>pulse</td>
<td>52</td>
<td>6.1</td>
<td>14.2</td>
</tr>
<tr>
<td>conventional physical examination</td>
<td>214</td>
<td>25.0</td>
<td>58.5</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>857</td>
<td>100.0</td>
<td>234.2</td>
</tr>
</tbody>
</table>

12 missing cases; 366 valid cases

*Other responses included BIA (n=4), colour, smell (n=2), heamaview (n=1), posture/ body motion (n=2), GP (n=1), phenolics (n=1), radiesthesia (n=1), reflexology (n=1), tissue analysis (n=1), urine analysis including urinary indicans (n=12), blood group typing (n=3), Vega (n=2) and zinc tally testing (n=5).

22. Which diagnostic tests do you use on a regular basis? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Diagnostic tests</th>
<th>Obs</th>
<th>% Respondents</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live blood analysis</td>
<td>52</td>
<td>17.0</td>
<td>26.3</td>
</tr>
<tr>
<td>Functional medicine tests</td>
<td>126</td>
<td>41.2</td>
<td>63.6</td>
</tr>
<tr>
<td>Hair analysis</td>
<td>65</td>
<td>21.2</td>
<td>32.8</td>
</tr>
<tr>
<td>Pulse diagnosis</td>
<td>37</td>
<td>12.1</td>
<td>18.7</td>
</tr>
<tr>
<td>Electro-dermal screening (Listen, Vega etc.)</td>
<td>26</td>
<td>8.5</td>
<td>13.1</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>306</td>
<td>100.0</td>
<td>154.5</td>
</tr>
</tbody>
</table>

180 missing cases; 198 valid cases

* Other responses included clot retraction test (CRT) (n=2), thermography (n=1), tongue (n=1), cytotoxic allergy test (n=1), food intolerance tests (n=1), medical pathology (n=2) and saliva testing (n=4)
23. Does your clinic operate any of the following diagnostic equipment? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Clinic equipment</th>
<th>Obs.</th>
<th>% Respondents</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bio impedance testing</td>
<td>41</td>
<td>27.0</td>
<td>39.0</td>
</tr>
<tr>
<td>Live Blood Analysis</td>
<td>27</td>
<td>17.8</td>
<td>25.7</td>
</tr>
<tr>
<td>Iridology camera or computer system</td>
<td>61</td>
<td>41.1</td>
<td>58.1</td>
</tr>
<tr>
<td>Electro-dermal testing equipment (Listen or Vega etc.)</td>
<td>23</td>
<td>15.1</td>
<td>21.9</td>
</tr>
<tr>
<td>Total responses</td>
<td>152</td>
<td>100.0</td>
<td>144.8</td>
</tr>
</tbody>
</table>

273 missing cases; 105 valid cases

*other responses included functional medicine (FM), including intestinal permeability) (n=2), biofeedback (n=1) and magnagraph (n=3).

24. Which of the following do you use regularly during patient examinations?

<table>
<thead>
<tr>
<th>Examination tools</th>
<th>Obs.</th>
<th>% Respondents</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sphygmomanometer</td>
<td>279</td>
<td>40.4</td>
<td>95.5</td>
</tr>
<tr>
<td>Otoscope</td>
<td>107</td>
<td>15.5</td>
<td>36.6</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>229</td>
<td>33.2</td>
<td>78.4</td>
</tr>
<tr>
<td>Thermometer</td>
<td>75</td>
<td>10.9</td>
<td>25.7</td>
</tr>
<tr>
<td>Total responses</td>
<td>690</td>
<td>100.0</td>
<td>236.3</td>
</tr>
</tbody>
</table>

86 missing cases; 292 valid cases

*Other responses included ophthalmoscope (n=2), blood glucose meter (n=3), iris torch (n=4), callipers (n=1), palpation (n=1), peak flow meter (n=1), urine strips (n=2), vaginal speculum (n=1)

25. Do you use medical pathology tests on a regular basis?

<table>
<thead>
<tr>
<th>Pathology tests</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>209</td>
<td>55.7</td>
<td>55.7</td>
</tr>
<tr>
<td>No</td>
<td>166</td>
<td>44.3</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>375</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

If yes, which tests do you request on a regular basis?

<table>
<thead>
<tr>
<th>Pathology tests</th>
<th>Obs.</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood tests</td>
<td>205</td>
<td>32.6</td>
<td>95.8</td>
</tr>
<tr>
<td>Hormone profiles</td>
<td>144</td>
<td>22.9</td>
<td>67.3</td>
</tr>
<tr>
<td>Liver function tests</td>
<td>157</td>
<td>25.0</td>
<td>73.4</td>
</tr>
<tr>
<td>X-rays</td>
<td>40</td>
<td>6.4</td>
<td>18.7</td>
</tr>
<tr>
<td>Urine samples</td>
<td>83</td>
<td>13.2</td>
<td>38.8</td>
</tr>
<tr>
<td>Total responses</td>
<td>629</td>
<td>100.0</td>
<td>293.9</td>
</tr>
</tbody>
</table>

164 missing cases; 214 valid cases

* Other responses included ECG, EEG (n=2), lung function (n=2), BGM (n=2), saliva assays (n=3), allergy tests (n=2), cervical swabs, semen analysis, ultrasound (n=3), CT scans (n=1) and vaginal swabs (n=1),
26. How do you request pathology tests when needed?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>refer the patient directly to pathology laboratory</td>
<td>14</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>refer the patient to a General Practitioner</td>
<td>79</td>
<td>22.6</td>
<td>26.6</td>
</tr>
<tr>
<td>ask the patient to request the tests from a General Practitioner</td>
<td>143</td>
<td>41.0</td>
<td>67.6</td>
</tr>
<tr>
<td>a combination of above</td>
<td>113</td>
<td>32.4</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>349</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

Other responses included self performed GP (n=3), patient already has tests from doctor (n=2), to a GP to get Medicare rebate (n=1), depends upon patients preference (n=1).

27. How important is it to you to understand a patient’s orthodox medical diagnosis when providing herbal therapy?

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>extremely important</td>
<td>219</td>
<td>58.1</td>
<td>58.1</td>
</tr>
<tr>
<td>somewhat important</td>
<td>140</td>
<td>37.1</td>
<td>95.2</td>
</tr>
<tr>
<td>a little important</td>
<td>11</td>
<td>2.9</td>
<td>98.1</td>
</tr>
<tr>
<td>not important</td>
<td>7</td>
<td>1.9</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>377</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

28. Do you consider it your responsibility to be able to make an orthodox medical diagnosis for your patients?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>53</td>
<td>14.1</td>
<td>14.1</td>
</tr>
<tr>
<td>no</td>
<td>324</td>
<td>85.9</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>377</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

29. Do you consider it your responsibility to be able to recognize the signs and symptoms of an underlying disease but rely on a medical practitioner for a diagnosis?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>309</td>
<td>82.6</td>
<td>82.6</td>
</tr>
<tr>
<td>no</td>
<td>65</td>
<td>17.4</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>374</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

Your clients

30. What is the average number of patients booked in for consultation with you per week?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Obs</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Median</th>
<th>IQR</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>365</td>
<td>19.19452</td>
<td>18.13254</td>
<td>15</td>
<td>1</td>
<td>130</td>
<td></td>
</tr>
</tbody>
</table>
31. What do the **majority** of your patients request herbal medicine treatment for? (tick one box only)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>acute conditions</td>
<td>45</td>
<td>12.0</td>
<td>12.0</td>
</tr>
<tr>
<td>chronic conditions</td>
<td>323</td>
<td>86.4</td>
<td>98.4</td>
</tr>
<tr>
<td>both</td>
<td>6</td>
<td>1.6</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>374</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

32. Approximately what percentage of your patients fall into the following 3 categories?

<table>
<thead>
<tr>
<th>Patients</th>
<th>Women %</th>
<th>Men %</th>
<th>Children %</th>
</tr>
</thead>
<tbody>
<tr>
<td>women</td>
<td>70.04533</td>
<td>15.3025</td>
<td>70</td>
</tr>
<tr>
<td>men</td>
<td>18.43484</td>
<td>12.00663</td>
<td>19</td>
</tr>
<tr>
<td>children</td>
<td>11.7008</td>
<td>10.26828</td>
<td>10</td>
</tr>
</tbody>
</table>

33. What are the **TOP 5 most common** conditions/diseases/symptoms that you treat in your clinic?

<table>
<thead>
<tr>
<th>Women by MDC</th>
<th>Men by MDC</th>
<th>Children by MDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. FRS conditions</td>
<td>Mental conditions</td>
<td>Skin conditions</td>
</tr>
<tr>
<td>2. Endocrine conditions</td>
<td>Digestive conditions</td>
<td>Mental conditions</td>
</tr>
<tr>
<td>3. Mental conditions</td>
<td>MRS conditions</td>
<td>Blood/immune conditions</td>
</tr>
<tr>
<td>4. Health Status</td>
<td>Musculo-skeletal conditions</td>
<td>Digestive conditions</td>
</tr>
<tr>
<td>5. Digestive conditions</td>
<td>Respiratory conditions</td>
<td>ENT conditions</td>
</tr>
</tbody>
</table>

See Appendix C for frequencies table of each category and for specific responses provided in each category

34. What are the **most common** reasons that patients give to you for seeking herbal medicine treatment? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Reasons for herbal treatment</th>
<th>Obs.</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>seeking a more holistic approach to health</td>
<td>282</td>
<td>18.3</td>
<td>74.8</td>
</tr>
<tr>
<td>a desire for preventative medicine</td>
<td>179</td>
<td>11.6</td>
<td>47.5</td>
</tr>
<tr>
<td>the chronic nature of their disease / condition</td>
<td>271</td>
<td>17.5</td>
<td>71.9</td>
</tr>
<tr>
<td>a growing concern about effectiveness / side effects of drugs</td>
<td>295</td>
<td>19.1</td>
<td>78.2</td>
</tr>
<tr>
<td>greater control over their health</td>
<td>145</td>
<td>9.4</td>
<td>38.5</td>
</tr>
<tr>
<td>philosophical or spiritual reasons</td>
<td>50</td>
<td>3.2</td>
<td>13.3</td>
</tr>
<tr>
<td>dissatisfaction with orthodox medicine</td>
<td>323</td>
<td>20.9</td>
<td>85.7</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>1545</td>
<td>100.0</td>
<td>409.8</td>
</tr>
</tbody>
</table>

1 missing cases; 377 valid cases

* Other responses included a safer option (n=3), time/attention in consultation (n=5), previous bad experience with orthodox medicine (n=3), a complementary approach (n=6), a last resort (n=1), referral / reputation (n=5).
35. What percentage of your patients have already seen a medical doctor to understand their conditions?

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Freq.</th>
<th>Precent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20%</td>
<td>5</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>21-40%</td>
<td>32</td>
<td>8.5</td>
<td>9.8</td>
</tr>
<tr>
<td>41-60%</td>
<td>67</td>
<td>17.8</td>
<td>27.6</td>
</tr>
<tr>
<td>61-80%</td>
<td>156</td>
<td>41.5</td>
<td>69.1</td>
</tr>
<tr>
<td>81-100%</td>
<td>116</td>
<td>30.9</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>376</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

36. What percentage of your patients concurrently consult you and a medical doctor for treatment?

<table>
<thead>
<tr>
<th>Concurrent</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20%</td>
<td>32</td>
<td>8.5</td>
<td>8.5</td>
</tr>
<tr>
<td>21-40%</td>
<td>98</td>
<td>26.1</td>
<td>34.6</td>
</tr>
<tr>
<td>41-60%</td>
<td>101</td>
<td>26.9</td>
<td>61.5</td>
</tr>
<tr>
<td>61-80%</td>
<td>103</td>
<td>27.6</td>
<td>89.1</td>
</tr>
<tr>
<td>81-100%</td>
<td>41</td>
<td>10.9</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>375</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Interaction of herbs and pharmaceuticals**

37. Do you see the role of herbal medicine as a –

<table>
<thead>
<tr>
<th>Role</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>replacement for most conventional medicines</td>
<td>82</td>
<td>22.3</td>
<td>22.3</td>
</tr>
<tr>
<td>a complementary treatment for most conventional medicines</td>
<td>195</td>
<td>53.0</td>
<td>75.3</td>
</tr>
<tr>
<td>both</td>
<td>91</td>
<td>24.7</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>368</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Other responses included preventative medicine (n=3), patients choice / preference (n=5), complementary initially then replacement in future (n=2), effective medicine leading to cure (n=2), a medicine in its own right (n=2), empowerment (n=1), non acute disease management (n=1), protection while on pharmaceuticals (n=1).

38. During case history taking, do you routinely ask your patients if they are taking pharmaceuticals?

<table>
<thead>
<tr>
<th>Pharmaceuticals</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>376</td>
<td>99.7</td>
<td>99.7</td>
</tr>
<tr>
<td>no</td>
<td>1</td>
<td>0.3</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>377</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>
39. Do you believe there is sufficient information available about the interaction of drugs and herbs?

<table>
<thead>
<tr>
<th>Information</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>116</td>
<td>31.2</td>
<td>31.2</td>
</tr>
<tr>
<td>no</td>
<td>256</td>
<td>68.8</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>372</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

40. What are the most common reasons patients who are taking medications give for seeking herbal medicine treatment?

<table>
<thead>
<tr>
<th>Reasons for herbs</th>
<th>Obs</th>
<th>% responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>medications no longer effective</td>
<td>155</td>
<td>20.9</td>
<td>41.9</td>
</tr>
<tr>
<td>unwelcome side effects of medications</td>
<td>300</td>
<td>40.5</td>
<td>81.1</td>
</tr>
<tr>
<td>seeking a natural alternative</td>
<td>286</td>
<td>38.6</td>
<td>77.3</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>741</td>
<td>100.0</td>
<td>200.3</td>
</tr>
</tbody>
</table>

8 missing cases; 370 valid cases

* Other responses included curiosity (n=1), lack of faith in orthodox medicine (n=1), address underlying cause (n=1), belief /philosophy (n=3), no artificial chemicals (n=1), concern about long term use of pharmaceuticals (n=1), cultural preference (n=1), concern about needing pharmaceuticals indefinitely with no cure (n=2), fear of addiction (n=1), fear overuse of pharmaceuticals (n=1), getting sicker (n=1), drugs ineffective / dissatisfaction (n=2), no medical treatment available (n=3), not getting better on drugs (n=1), patients want both for better effect (n=1), want cure not symptom management (n=1), want more concern from doctors (n=1).

41. What percentage of your patients are concurrently taking prescribed medication as well as herbal medicines?

<table>
<thead>
<tr>
<th>Concurrent</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20%</td>
<td>57</td>
<td>15.2</td>
<td>15.2</td>
</tr>
<tr>
<td>21-40%</td>
<td>132</td>
<td>35.1</td>
<td>50.3</td>
</tr>
<tr>
<td>41-60%</td>
<td>123</td>
<td>32.7</td>
<td>83.0</td>
</tr>
<tr>
<td>61-80%</td>
<td>61</td>
<td>16.2</td>
<td>99.2</td>
</tr>
<tr>
<td>81-100%</td>
<td>3</td>
<td>0.8</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>376</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

42. How confident do you feel to treat patients who are also taking prescribed medications?

<table>
<thead>
<tr>
<th>Confidence</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>very confident</td>
<td>117</td>
<td>31.5</td>
<td>31.5</td>
</tr>
<tr>
<td>confident</td>
<td>227</td>
<td>61.2</td>
<td>92.7</td>
</tr>
<tr>
<td>a little confident</td>
<td>21</td>
<td>5.7</td>
<td>98.4</td>
</tr>
<tr>
<td>not at all confident</td>
<td>6</td>
<td>1.6</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>371</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
Your relationship with fellow health care professionals

43. Do you receive referrals from medical practitioners?

<table>
<thead>
<tr>
<th>Referrals in</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>204</td>
<td>54.3</td>
<td>54.3</td>
</tr>
<tr>
<td>no</td>
<td>172</td>
<td>45.7</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>376</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

44. Do you refer your patients to other health care practitioners?

<table>
<thead>
<tr>
<th>Referrals out</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>373</td>
<td>98.9</td>
<td>98.9</td>
</tr>
<tr>
<td>no</td>
<td>4</td>
<td>1.1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>377</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

If yes, to whom? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>Obs.</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioners</td>
<td>348</td>
<td>26.5</td>
<td>93.0</td>
</tr>
<tr>
<td>Chiropractor / Osteopaths</td>
<td>296</td>
<td>22.6</td>
<td>79.1</td>
</tr>
<tr>
<td>Counsellors</td>
<td>267</td>
<td>20.4</td>
<td>71.4</td>
</tr>
<tr>
<td>Acupuncturists</td>
<td>199</td>
<td>15.2</td>
<td>53.2</td>
</tr>
<tr>
<td>Other Natural Medicine Practitioners</td>
<td>202</td>
<td>15.4</td>
<td>54.0</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>1312</td>
<td>100.0</td>
<td>350.8</td>
</tr>
</tbody>
</table>

4 missing cases; 374 valid cases

*Other responses included LBA practitioner (n=1), Alexander technique (n=1), bodywork (n=6), yoga (n=3), Tai chi (n=1), Bowen therapy (n=3), holographic re-patterning (n=1), community workers (n=1), energetic healers (n=3), holistic dentists (n=3), homeopaths (n=1), kinesiologists (n=4), listen practitioner (n=1), lymphatic drainage (n=2), medical specialists (n=11), gynaecologists (n=3), physiotherapists (n=6), podiatrists (n=1), psychologists (n=1), veterinarians (n=1).

45. For what reasons do you refer patients to medical practitioners? (you may tick more than one box)

<table>
<thead>
<tr>
<th>Referral</th>
<th>Obs.</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>to request pathology tests</td>
<td>336</td>
<td>31.2</td>
<td>90.8</td>
</tr>
<tr>
<td>to confirm a medical diagnosis</td>
<td>177</td>
<td>16.4</td>
<td>47.8</td>
</tr>
<tr>
<td>to obtain a medical diagnosis</td>
<td>207</td>
<td>19.2</td>
<td>55.9</td>
</tr>
<tr>
<td>acute infectious diseases</td>
<td>132</td>
<td>12.2</td>
<td>35.7</td>
</tr>
<tr>
<td>for treatment or prescription when necessary</td>
<td>226</td>
<td>21.0</td>
<td>61.1</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>1078</td>
<td>100.0</td>
<td>291.4</td>
</tr>
</tbody>
</table>

8 missing cases; 370 valid cases

*Each response reported for “other” (n=11) fitted into one of the above categories
46. How would you rate your working relationship with the medical community?

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>excellent</td>
<td>19</td>
<td>5.1</td>
<td>5.1</td>
</tr>
<tr>
<td>very good</td>
<td>68</td>
<td>18.2</td>
<td>23.3</td>
</tr>
<tr>
<td>good</td>
<td>139</td>
<td>37.3</td>
<td>60.6</td>
</tr>
<tr>
<td>fair</td>
<td>96</td>
<td>25.7</td>
<td>86.3</td>
</tr>
<tr>
<td>poor</td>
<td>51</td>
<td>13.7</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>373</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

47. How do you rate the medical community’s attitudes towards yourself as a herbalist?

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>excellent</td>
<td>6</td>
<td>1.6</td>
<td>1.6</td>
</tr>
<tr>
<td>very good</td>
<td>45</td>
<td>12.1</td>
<td>13.7</td>
</tr>
<tr>
<td>good</td>
<td>75</td>
<td>20.2</td>
<td>33.9</td>
</tr>
<tr>
<td>fair</td>
<td>156</td>
<td>42.1</td>
<td>76.0</td>
</tr>
<tr>
<td>poor</td>
<td>89</td>
<td>24.0</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>371</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

48. How comfortable do you feel in communicating with the medical community?

<table>
<thead>
<tr>
<th>Communication</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>very comfortable</td>
<td>61</td>
<td>16.2</td>
<td>16.2</td>
</tr>
<tr>
<td>comfortable</td>
<td>213</td>
<td>56.5</td>
<td>72.7</td>
</tr>
<tr>
<td>uncomfortable</td>
<td>96</td>
<td>25.5</td>
<td>98.2</td>
</tr>
<tr>
<td>very uncomfortable</td>
<td>7</td>
<td>1.8</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>377</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

49. Do you encourage your patients to tell their doctors they are taking herbal medicine?

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>355</td>
<td>94.7</td>
<td>94.7</td>
</tr>
<tr>
<td>no</td>
<td>20</td>
<td>5.3</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>375</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
50. What percentage of your patients are concurrently consulting a medical practitioner?

<table>
<thead>
<tr>
<th>Concurrent</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20%</td>
<td>36</td>
<td>9.6</td>
<td>9.6</td>
</tr>
<tr>
<td>21-40%</td>
<td>112</td>
<td>29.9</td>
<td>39.5</td>
</tr>
<tr>
<td>41-60%</td>
<td>102</td>
<td>27.2</td>
<td>66.7</td>
</tr>
<tr>
<td>61-80%</td>
<td>94</td>
<td>25.1</td>
<td>91.8</td>
</tr>
<tr>
<td>81-100%</td>
<td>31</td>
<td>8.2</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>375</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

51. What percentage of your patients perceive you as their primary health care practitioner?

<table>
<thead>
<tr>
<th>Primary</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20%</td>
<td>64</td>
<td>17.0</td>
<td>17.0</td>
</tr>
<tr>
<td>21-40%</td>
<td>101</td>
<td>26.9</td>
<td>43.9</td>
</tr>
<tr>
<td>41-60%</td>
<td>111</td>
<td>29.5</td>
<td>73.4</td>
</tr>
<tr>
<td>61-80%</td>
<td>83</td>
<td>22.1</td>
<td>95.5</td>
</tr>
<tr>
<td>81-100%</td>
<td>17</td>
<td>4.5</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>376</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

52. Do you see closer collaboration and co-operation with the medical community as a desirable situation for the future?

<table>
<thead>
<tr>
<th>collaboration</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>364</td>
<td>96.8</td>
<td>96.8</td>
</tr>
<tr>
<td>no</td>
<td>12</td>
<td>3.2</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>376</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

---

**Knowledge and Training**

53. How would you rate the training you had with regard to preparing you for work as a professional herbalist in clinical practice?

<table>
<thead>
<tr>
<th>Training</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>excellent</td>
<td>113</td>
<td>30.2</td>
<td>30.2</td>
</tr>
<tr>
<td>very good</td>
<td>155</td>
<td>41.4</td>
<td>71.6</td>
</tr>
<tr>
<td>average</td>
<td>96</td>
<td>25.7</td>
<td>97.3</td>
</tr>
<tr>
<td>poor</td>
<td>10</td>
<td>2.7</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>374</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
54. Which of the following commonly used terms do you feel most accurately describes the type of medicine you practice? (tick one)

<table>
<thead>
<tr>
<th>Preferred name</th>
<th>Freq.</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural medicine</td>
<td>122</td>
<td>34.0</td>
<td>34.0</td>
</tr>
<tr>
<td>Complementary medicine</td>
<td>109</td>
<td>30.4</td>
<td>64.4</td>
</tr>
<tr>
<td>Alternative medicine</td>
<td>13</td>
<td>3.6</td>
<td>68.0</td>
</tr>
<tr>
<td>Traditional medicine</td>
<td>27</td>
<td>7.5</td>
<td>75.5</td>
</tr>
<tr>
<td>Non-orthodox medicine</td>
<td>2</td>
<td>0.6</td>
<td>76.1</td>
</tr>
<tr>
<td>Holistic medicine</td>
<td>85</td>
<td>23.7</td>
<td>99.8</td>
</tr>
<tr>
<td>Non-conventional Medicine</td>
<td>1</td>
<td>0.2</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>359</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

*Other responses included a combination of the above (n=33), Allied Health (n=2), Functional Medicine (n=1), Herbal Medicine (n=2), Integrative Medicine (n=1), Naturopathy (n=2), Unified Healthcare (n=1), Vitalistic Medicine (n=1).

55. With regard to Western Herbal Medicine what do you consider to be the authoritative source of Materia Medica reference?

<table>
<thead>
<tr>
<th>Sources of Knowledge</th>
<th>Obs</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHP</td>
<td>214</td>
<td>37.0</td>
<td>61.3</td>
</tr>
<tr>
<td>German Commission E Monographs</td>
<td>76</td>
<td>13.1</td>
<td>21.8</td>
</tr>
<tr>
<td>ESCOP</td>
<td>36</td>
<td>6.2</td>
<td>10.3</td>
</tr>
<tr>
<td>traditional Sources</td>
<td>59</td>
<td>10.2</td>
<td>16.9</td>
</tr>
<tr>
<td>college materia medica</td>
<td>130</td>
<td>22.5</td>
<td>37.2</td>
</tr>
<tr>
<td>Kerry Bone</td>
<td>63</td>
<td>10.9</td>
<td>18.1</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td>578</td>
<td>100.0</td>
<td>165.6</td>
</tr>
</tbody>
</table>

29 missing cases; 349 valid cases

56. How would you rate the support you received as a new graduate when beginning clinical practice from the following sources?

<table>
<thead>
<tr>
<th>Source of Support</th>
<th>Very supportive</th>
<th>Somewhat supportive</th>
<th>A little supportive</th>
<th>Not supportive</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Institute</td>
<td>8.3 (n=31)</td>
<td>16.9 (n=63)</td>
<td>23.9 (n=89)</td>
<td>50.9 (n=190)</td>
<td>100 (n=373)</td>
</tr>
<tr>
<td>Professional Association</td>
<td>22.5 (n=83)</td>
<td>34.2 (n=126)</td>
<td>29.5 (n=109)</td>
<td>13.8 (n=51)</td>
<td>100 (n=369)</td>
</tr>
<tr>
<td>Other Practitioners</td>
<td>33.3 (n=124)</td>
<td>32.3 (n=120)</td>
<td>22.8 (n=85)</td>
<td>11.6 (n=43)</td>
<td>100 (n=372)</td>
</tr>
</tbody>
</table>
### Table C-1 Common conditions reported within each MDC category

<table>
<thead>
<tr>
<th>No.</th>
<th>Category name</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Nervous system</td>
<td>Insomnia, migraine, neuralgia</td>
</tr>
<tr>
<td>2.</td>
<td>Ear, nose, mouth, throat</td>
<td>Otitis media (frequently reported as glue ear), Upper respiratory tract infections (URTI), URTI allergies</td>
</tr>
<tr>
<td>3.</td>
<td>Respiratory system</td>
<td>Asthma, especially allergic, Bronchitis, infections</td>
</tr>
<tr>
<td>4.</td>
<td>Circulatory system</td>
<td>Hypertension, hypercholesterolemia, varicose veins, stroke recovery</td>
</tr>
<tr>
<td>5.</td>
<td>Digestive system</td>
<td>Bloating, flatulence, reflux, heartburn, Indigestion, constipation, diarrhea, Irritable Bowel Syndrome (IBS), ulcerative colitis</td>
</tr>
<tr>
<td>6.</td>
<td>The hepatobiliary system and pancreas</td>
<td>Liver detoxification problems, hepatitis, toxin exposures</td>
</tr>
<tr>
<td>7.</td>
<td>Muskuloskeletal &amp; connective tissue system</td>
<td>Arthritis (osteo- and rheumatoid), fibromyalgia, Chronic Fatigue Syndrome (CFS), back pain, neck pain, muscle tension, tension headaches Both acute and chronic forms of arthritis; sporting injuries, back pain etc.</td>
</tr>
<tr>
<td>8.</td>
<td>Skin &amp; subcutaneous tissues</td>
<td>Skin rashes (including cradle cap), psoriasis, acne, dermatitis, eczema</td>
</tr>
<tr>
<td>9.</td>
<td>Endocrine, nutritional &amp; metabolic disorders</td>
<td>Hormonal problems including to those of the thyroid, diabetes (NIDDM), insulin resistance, Syndrome X; Nutritional and metabolic conditions such as obesity and food intolerances</td>
</tr>
</tbody>
</table>

Cont …
<table>
<thead>
<tr>
<th>No.</th>
<th>Category</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>Male reproductive system</td>
<td>Benign Prostatic Hypertrophy (BPH) and Infertility problems</td>
</tr>
<tr>
<td>12.</td>
<td>Female reproductive system</td>
<td>Premenstrual syndrome (PMS), Menstrual problems, dysmenorrhea, preconception Care, Polycystic ovarian syndrome (PCOS), fibroids, endometriosis, vaginal infections, infertility problems</td>
</tr>
<tr>
<td>13.</td>
<td>Pregnancy, childbirth and the puerperium</td>
<td>Pregnancy support</td>
</tr>
<tr>
<td>14.</td>
<td>Newborns &amp; other neonates</td>
<td>Breast feeding problems, colic, weening, sleeping problems</td>
</tr>
<tr>
<td>15.</td>
<td>Blood and immunology</td>
<td>Immune, autoimmune conditions, anaemia, lymphatic congestion, allergies, chronic inflammation; but not serious virulent infections such as measles, mumps, rubella etc, allergies (including food sensitivities)</td>
</tr>
<tr>
<td>16.</td>
<td>Neoplastic</td>
<td>Cancer support, Breast cancer support</td>
</tr>
<tr>
<td>17.</td>
<td>Infectious &amp; parasitic diseases</td>
<td>Colds, influenza, Acute viral, Candida, parasites</td>
</tr>
<tr>
<td>18.</td>
<td>Mental diseases &amp; disorders</td>
<td>Stress, anxiety, depression, sleep disorders, memory problems; for children also included behavioural issues (ADD, ADHD, hyperactivity) and learning disorders</td>
</tr>
<tr>
<td>19.</td>
<td>Factors effecting health status</td>
<td>Preventative health care, lifestyle and nutritional advice, dietary advice, weight management and detoxification programs, fatigue, “below par”, headaches</td>
</tr>
</tbody>
</table>

No responses were provided to MDC categories 2 (the eye), 12 (Male reproductive system), 13 (female reproductive system), 20 (alcohol/drug use), 21 (injuries, poisoning and toxic effects of drugs), 22 (burns)
### Appendix C

Table C-2 Women: conditions treated by MDC

<table>
<thead>
<tr>
<th>MDC</th>
<th>Category label</th>
<th>Count</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nervous system</td>
<td>42</td>
<td>2.5</td>
<td>11.7</td>
</tr>
<tr>
<td>3</td>
<td>Ear, nose, mouth, throat</td>
<td>11</td>
<td>0.6</td>
<td>3.1</td>
</tr>
<tr>
<td>4</td>
<td>Respiratory system</td>
<td>27</td>
<td>1.6</td>
<td>7.5</td>
</tr>
<tr>
<td>5</td>
<td>Circulatory system</td>
<td>19</td>
<td>1.1</td>
<td>5.3</td>
</tr>
<tr>
<td>6</td>
<td>Digestive system</td>
<td>179</td>
<td>10.5</td>
<td>49.7</td>
</tr>
<tr>
<td>7</td>
<td>The hepatobiliary system and pancreas</td>
<td>7</td>
<td>0.4</td>
<td>1.9</td>
</tr>
<tr>
<td>8</td>
<td>Muskuloskeletal &amp; connective tissue system</td>
<td>69</td>
<td>4</td>
<td>19.2</td>
</tr>
<tr>
<td>9</td>
<td>Skin &amp; subcutaneous tissues</td>
<td>69</td>
<td>4</td>
<td>19.2</td>
</tr>
<tr>
<td>10</td>
<td>Endocrine, nutritional &amp; metabolic disorders</td>
<td>150</td>
<td>8.8</td>
<td>41.7</td>
</tr>
<tr>
<td>11</td>
<td>Kidney &amp; urinary tract</td>
<td>18</td>
<td>1.1</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>Female reproductive system</td>
<td>426</td>
<td>24.9</td>
<td>118.3</td>
</tr>
<tr>
<td>14</td>
<td>Pregnancy, childbirth and the puerperium</td>
<td>19</td>
<td>1.1</td>
<td>5.3</td>
</tr>
<tr>
<td>16</td>
<td>The blood, blood forming organs and immunological</td>
<td>82</td>
<td>4.8</td>
<td>22.8</td>
</tr>
<tr>
<td>17</td>
<td>Neoplastic (haemotological and solid neoplasm)</td>
<td>17</td>
<td>1</td>
<td>4.7</td>
</tr>
<tr>
<td>18</td>
<td>Infectious &amp; parasitic diseases</td>
<td>47</td>
<td>2.7</td>
<td>13.1</td>
</tr>
<tr>
<td>19</td>
<td>Mental diseases &amp; disorders</td>
<td>218</td>
<td>12.7</td>
<td>60.6</td>
</tr>
<tr>
<td>23</td>
<td>Factors effecting health status</td>
<td>310</td>
<td>18.1</td>
<td>86.1</td>
</tr>
</tbody>
</table>

**Total responses** | **1710** | **100** | **475**

Source: survey item 33; multiple response item; 16 missing cases; 360 valid cases
Appendix C

Table C-3 Men: conditions treated by MDC

<table>
<thead>
<tr>
<th>MDC</th>
<th>Category label</th>
<th>Count</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nervous system</td>
<td>37</td>
<td>2.5</td>
<td>10.2</td>
</tr>
<tr>
<td>3</td>
<td>Ear, nose, mouth, throat</td>
<td>54</td>
<td>3.7</td>
<td>14.8</td>
</tr>
<tr>
<td>4</td>
<td>Respiratory system</td>
<td>31</td>
<td>2.1</td>
<td>8.5</td>
</tr>
<tr>
<td>5</td>
<td>Circulatory system</td>
<td>122</td>
<td>8.4</td>
<td>33.5</td>
</tr>
<tr>
<td>6</td>
<td>Digestive system</td>
<td>162</td>
<td>11.2</td>
<td>44.5</td>
</tr>
<tr>
<td>7</td>
<td>The hepatobiliary system and pancreas</td>
<td>43</td>
<td>3</td>
<td>11.8</td>
</tr>
<tr>
<td>8</td>
<td>Muskuloskeletal &amp; connective tissue system</td>
<td>134</td>
<td>9.2</td>
<td>36.8</td>
</tr>
<tr>
<td>9</td>
<td>Skin &amp; subcutaneous tissues</td>
<td>90</td>
<td>6.2</td>
<td>24.7</td>
</tr>
<tr>
<td>10</td>
<td>Endocrine, nutritional &amp; metabolic disorders</td>
<td>52</td>
<td>3.6</td>
<td>14.3</td>
</tr>
<tr>
<td>11</td>
<td>Kidney &amp; urinary tract</td>
<td>12</td>
<td>0.8</td>
<td>3.3</td>
</tr>
<tr>
<td>12</td>
<td>Male reproductive system</td>
<td>168</td>
<td>11.6</td>
<td>46.2</td>
</tr>
<tr>
<td>16</td>
<td>The blood, blood forming organs and immunological</td>
<td>75</td>
<td>5.2</td>
<td>20.6</td>
</tr>
<tr>
<td>17</td>
<td>Neoplastic (haemotological and solid neoplasm)</td>
<td>24</td>
<td>1.7</td>
<td>6.6</td>
</tr>
<tr>
<td>18</td>
<td>Infectious &amp; parasitic diseases</td>
<td>36</td>
<td>2.5</td>
<td>9.9</td>
</tr>
<tr>
<td>19</td>
<td>Mental diseases &amp; disorders</td>
<td>190</td>
<td>13.1</td>
<td>52.2</td>
</tr>
<tr>
<td>23</td>
<td>Factors effecting health status</td>
<td>222</td>
<td>15.3</td>
<td>61.6</td>
</tr>
<tr>
<td></td>
<td><strong>Total responses</strong></td>
<td><strong>1452</strong></td>
<td><strong>100</strong></td>
<td><strong>398.9</strong></td>
</tr>
</tbody>
</table>

Source: survey item 33; multiple response item; 12 missing cases; 364 valid cases
### Table C-4 Children: conditions treated by MDC

<table>
<thead>
<tr>
<th>MDC</th>
<th>Category Label</th>
<th>Count</th>
<th>% Responses</th>
<th>% Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nervous system</td>
<td>106</td>
<td>8.3</td>
<td>33.1</td>
</tr>
<tr>
<td>3</td>
<td>Ear, nose, mouth, throat</td>
<td>130</td>
<td>10.2</td>
<td>40.6</td>
</tr>
<tr>
<td>4</td>
<td>Respiratory system</td>
<td>114</td>
<td>8.9</td>
<td>35.6</td>
</tr>
<tr>
<td>5</td>
<td>Circulatory system</td>
<td>2</td>
<td>0.2</td>
<td>0.6</td>
</tr>
<tr>
<td>6</td>
<td>Digestive system</td>
<td>198</td>
<td>15.5</td>
<td>61.9</td>
</tr>
<tr>
<td>8</td>
<td>Muskuloskeletal &amp; connective tissue system</td>
<td>8</td>
<td>0.6</td>
<td>2.5</td>
</tr>
<tr>
<td>9</td>
<td>Skin &amp; subcutaneous tissues</td>
<td>203</td>
<td>15.9</td>
<td>63.4</td>
</tr>
<tr>
<td>10</td>
<td>Endocrine, nutritional &amp; metabolic disorders</td>
<td>6</td>
<td>0.5</td>
<td>1.9</td>
</tr>
<tr>
<td>11</td>
<td>Kidney &amp; urinary tract</td>
<td>15</td>
<td>1.2</td>
<td>4.7</td>
</tr>
<tr>
<td>15</td>
<td>Newborns &amp; neonates</td>
<td>1</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>16</td>
<td>The blood, blood forming organs and immunological</td>
<td>157</td>
<td>12.3</td>
<td>49.1</td>
</tr>
<tr>
<td>17</td>
<td>Neoplastic (haematological and solid neoplasm)</td>
<td>5</td>
<td>0.4</td>
<td>1.6</td>
</tr>
<tr>
<td>18</td>
<td>Infectious &amp; parasitic diseases</td>
<td>124</td>
<td>9.7</td>
<td>38.8</td>
</tr>
<tr>
<td>19</td>
<td>Mental diseases &amp; disorders</td>
<td>137</td>
<td>10.8</td>
<td>42.8</td>
</tr>
<tr>
<td>23</td>
<td>Factors effecting health status</td>
<td>68</td>
<td>5.3</td>
<td>21.3</td>
</tr>
<tr>
<td></td>
<td><strong>Total responses</strong></td>
<td><strong>1274</strong></td>
<td><strong>100</strong></td>
<td><strong>398.1</strong></td>
</tr>
</tbody>
</table>

Source: survey item 33; multiple response item; 56 missing cases; 320 valid cases