A CLINICAL AUDIT OF REGISTERED HOMOEOPATHIC PRACTITIONERS IN KWAZULU NATAL

by:

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I, Marianne Bernadette Verhoogt, declare that this mini-dissertation represents my own work both in conception and execution.

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DEDICATION

I dedicate this dissertation to my parents Wim and Thea Verhoogt and the rest of my family, for all their love, support and wisdom.

To my friends and fellow great homeopaths, Hayley, Heather, and Bruce, who have walked this path with me and given it meaning.

To friends close to my heart, who make life brilliant and who inspire unique expression.

To all homeopaths:

"If the time comes when you have lost the spirit behind your service at the clinics and it becomes just work – stop it. It is no longer service. But a drop of love for the patient from the healer will help the patient and the healer too."

Swami Venkatesananda

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ABSTRACT

From the world wide sales of homeopathic products for 1997, which were estimated to be $1.15 billion homeopathy is growing and becoming an important aspect of healthcare. In South Africa homeopathy is relatively new and there seems to be limited awareness of homeopathy amongst the public and healthcare authorities. A collection of basic data on treatment and prescribing patterns is urgently needed. A clinical audit, namely, practice based clinical research that allows the effectiveness of homeopathy to be evaluated under "real-life" circumstances, is required.

A clinical audit includes three areas, quality assurance, treatment outcomes and economic outcomes. The study addressed the first two of these areas. Quality assurance includes documenting practitioner and practice demographics, procedures of diagnosis, care and treatment. The treatment outcomes were assessed by the practitioner and the patient. Patients also gave feedback on consumer satisfaction.

The study was carried out by using the survey method and the measuring tool was a series of six questionnaires. The sample of practitioners (n = 30) was drawn from registered homeopathic practitioners of Kwazulu Natal (KZN). Data from 158 patients was collected.

The study was completed in 5 stages. Stage 1, was a telephonic contact of all registered homeopaths by the researcher. In Stage 2, a face to face interview of participating practitioners was conducted by the researcher. Stage 3 was the initial consultation, where both the practitioner and patient completed questionnaires. Stage 4 consisted of a follow-up consultation where again the practitioner and patient completed post treatment questionnaires. Stage 5 was the exit questionnaire administered to drop out patients by the researcher telephonically.

The data was analysed by means of descriptive statistics using frequency tables and bar charts. The Pearson's Chi-square test and the Wilcoxon Signed Ranks Test were used on selected data.

On analysing the results it can be seen that the demographics of practitioners have been influenced by the political-legal and training history of homeopathy in South Africa. The largest influence has been the closure of the register for 10 years in 1974 till 1985. The homeopaths are thus split into two main age groups the 20-34 year olds and over 65 year olds. The majority are male. Homeopathy is largely an urban based "white peoples" medicine, as both the practitioners and patients are mostly white living in cities or towns.

The majority of homeopaths who participated in the study were graduates of the Durban Institute of Technology (DIT), who had had less than ten years experience. Few KZN homeopaths are trained as medical general practitioners. However, many are trained in and practice phytotherapy, acupuncture or naturopathy, whilst the black practitioners also practice as traditional healers. Homeopathy is the main form of treatment with two thirds of the practitioners practicing homeopathy more than 75% of the time.

In general very poor ongoing education seemed to be undertaken, as few practitioners subscribe to homeopathic journals, and conference attendance is limited to those that are held in Durban, Kwazulu Natal.

The number of patients seen per week varied from 4 to 75. KZN practitioners estimated that they spend on average of 56 minutes on an initial consultation and 36 minutes on the follow-up, with fees averaging R117.30 and R91.37 respectively. The cost of consultation is more expensive in Durban than the Greater KZN area.

The majority of patients who see homeopaths are white, English speaking females between the ages of 26-50 years. They are mostly employed, housewives or pensioners. More than half the patients belonged to a medical aid scheme however the majority of medical aid schemes only provide partial payment of the consultation. The patients had complaints that were largely of a chronic nature. The most common complaints were sinusitis/allergic rhinitis and depression.

The practitioners focused on an oral history taking. Physical examinations consisted largely of taking blood pressure and pulse, and in general corresponded to the main area of complaint. Very few special investigative tests were performed, with blood tests ordered for less than 10% of the patients.

The primary aid used by practitioners was a repertory, with one third having computer repertorising programmes. Practitioners felt that most patients were from self referrals, and referrals from other practitioners were limited. However, the practitioners themselves made referrals to chiropractors, general practitioners, psychologists, gynaecologists and colleague homeopaths.

Homeopathic medicines were prescribed for 96% of the patients, with more than half the patients receiving additional non-homeopathic medicine and treatment (mainly herbal supplements, minerals, vitamins and acupuncture). From the nature of the prescriptions it is evident that the majority of practitioners practiced pluralist homeopathy. Seventy percent of the patients were prescribed a complex or more than one medicine (either in combination or alternating). The majority of single or combination prescriptions were for polychrests, with Natrum muriaticum the most frequently prescribed medicine.

The practitioners, by means of the Glasgow Homoeopathic Hospital Outcome Scale, rated 44% of the patients as showing major improvements or cure. Despite the variety of treatment approaches, it was statistically established that

the results of treatment outcomes did not vary across the practitioners (Pearson's Chi Square Tests, P-value = .744). From the patients perspective, 74.1% rated their outcomes of healthcare as good or excellent. No association was found between the duration of consultation and the patients perceived outcome of healthcare (P-value = .151). Patients rated homeopathic treatment as holistic and showed improvements in all areas. Consumer satisfaction with all aspects of the treatment was very high.

The study raised a few areas of concern, firstly the lack of exposure and presence of homeopathy in the black market, meaning that homeopathy plays a limited role in the broader healthcare system in South Africa. Further, the limited number of registered practitioners actually practicing homeopathy fulltime in Kwazulu Natal raises questions that need to be addressed in a further study. Of specific concern is the economic viability of practicing homeopathy in KZN. Of relevance here is the problem of medical aid scheme coverage. The study shows that the medical aid scheme rates that have been set by the Board of Healthcare Funders are set lower than the required time spent per patient and the average cost per consultation.

Quality assurance questions are raised regarding the limited ongoing education of practitioners. It is suggested that the Allied Health Professions Council of South Africa enforce the Continued Professional Development ruling. Further quality assurance is questioned regarding the high use of complexes.

From this study one can conclude that homeopathy as it is practised by this sample of homeopaths in KZN, is an effective form of medical treatment. The findings will be very encouraging to the homeopathic community, but can also play a role in communicating the clinical effectiveness of homeopathy to the medical establishment and the general public. Finally, this study is a significant contribution to the international movement for the collection of homeopathic data, and will be forwarded to the Data Collection Group (DCG).

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DEFINITION OF TERMS

Homeopathy

"Homeopathy is a therapeutic method which clinically applies the law of similars and which uses medicinal substances in weak or infinitesimal doses. The law of similars.... [is the] similarity between the toxicological action of a substance and its therapeutic action....The same things which cause the disease cure it."
(Jouanny, 1993:11-12)

Please note: historically homeopathy was spelled homoeopathy. However, modern day practice is to drop the first 'o' (Fisher, 1999).

Homeopathic practitioner

For the purpose of this study, "homeopathic practitioner" will refer to homeopaths registered with the Allied Health Professions Council of South Africa.

Clinical audit

The process of "systematically looking at the procedures used for diagnosis, care and treatment, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient" (Van Haselen and Fisher, 1994).

Acute disease

A pathological process, which may vary in intensity, but which has a limited duration. Ending in resolution, either spontaneous or in response to treatment, or in death (Swayne, 2000:1-2). In this research, acute disease was noted as a complaint of less than one week duration.

Chronic disease

A disease whose onset is usually gradual, which progresses slowly and whose course is of long duration with no likelihood of recovery; may consist of recurrent

acute episodes or exacerbations; often involves more than one body system (Swayne, 2000:40). In this research, chronic disease was noted as a complaint of longer than three months duration.

Repertory

Systematic cross reference of symptoms and disorders to the homeopathic medicines in whose therapeutic repertoire (materia medica) they occur. The strength or degree of the association between the two is indicated by the type in which the medicine name is printed (Swayne, 2000:183).

Miasmatic treatment

The medicine prescribed to treat the miasmatic taint. Miasms can be seen as a trait within a society, family or individual making them susceptible to a particular pattern of morbidity (Swayne, 2000:135).

Totality of symptoms

The complete clinical picture of the patient during the illness, comprising all the mental symptoms, general symptoms and local (particular) symptoms and signs, and test findings if appropriate. Resulting in a complete pattern from which the simillimum must be found (Swayne, 2000:215-216).

Constitutional treatment

The medicine prescribed is the individual's constitutional medicine. The constitutional medicine for a person is determined by the homeopath who uncovers certain fundamental truths about the person and then repertorises that symptomology or examines that typology in order to uncover the patient's nature or constitution, and the corresponding medicine (Yasgur, 1998:56).

Keynote treatment

A leading symptom that is so apparent, so clear, that it suggests a small group of medicines or even a single medicine. Keynotes are actually peculiar symptoms which have taken on a highly characteristic flavour and tend to point directly to the medicine (Yasgur, 1998:250).

LIST OF ABBREVIATIONS

AHPCSA = Allied Health Professions Council of South Africa

CAM = Complementary and Alternative Medicine

DCG = Data Collection Group

DIT = Durban Institute of Technology

GHHOS = Glasgow Homoeopathic Hospital Outcome Scale

IIRS = Illness Intrusiveness Rating Scale

KZN = Kwazulu Natal

TN = Technikon Natal

VAS = Visual Analogue Scale

CHAPTER 1

INTRODUCTION

The World Health Organisation's Traditional Medicine Programme (WHO, Fact Sheet N134, 1996), reports that there has been a growing interest in traditional and alternative systems of medicine in many developed countries over the past decade. In the Netherlands and Belgium, 60% of the public and 74% in the United Kingdom are in favour of complementary medicine being available within the framework of the National Health Service. This growth can be seen in the retail sales of homeopathic medicines in the United States which increased from $100 million in 1988 to $250 million in 1996 (Jacobs *et al.*, 1998:537). The world wide sales of homeopathic products for 1997 were estimated to be $1.15 billion (Information Access Company, Market letter, 1996 quoted in Jacobs *et al.*, 1998).

Part of this growth can be attributed to the development of physics and growth of scientific research around homeopathy. As Thomas (2001:103) states, "From the 1960's onwards homeopathy has undergone a revival. No longer is homeopathy on the wane in the USA. Modern physics has come forward in an attempt to explain the effect of homeopathic medicines on man and animals. Nuclear magnetic resonance spectroscopy has shown that there is a difference between a dilution and a dilution succussed to homeopathic methods. Well planned clinical trials have shown how effective these are in certain diseases." Thus it would appear that despite being established for over two hundred years it is only in the last thirty years of "modern medicine" that homeopathy has emerged as an important complement to orthodox medical treatment.

In South Africa homeopathy has had a difficult time gaining formal recognition, and still plays rather a peripheral role in the medical health structure. Caldis (2000) gives a synopsis of the legal history of homeopathy. In 1974 a window period of six months was granted during which time registration under the

Chiropractors, Homoeopaths, Naturopaths, Osteopaths and Herbalists Act (Act 52) was possible. At the end of this period the register was officially closed, meaning that existing practitioners remained registered but no new registration was possible. The register was reopened in 1985, the year in which the homeopathic profession was granted the right to train and register new practitioners under The SA Associated Health Service Professions Act (Act 63 of 1982), now termed the Allied Health Professions Act 63 of 1982. In 2000 parliament passed the Chiropractors, Homoeopaths and Allied Health Service Professions Council Amendment Bill 2000. Homeopathy now falls under one of the four professional boards of the Allied Health Professions Council of South Africa (AHPCSA) together with Naturopathy and Phytotherapy. In order to practice their profession, practitioners need to register with the Council.

Training began at Technikon Natal in 1989 and Technikon Witwatersrand in 1993. (Technikon Natal (TN) changed its name to the Durban Institute of Technology (DIT) in 2002, and will be referred to as such in this dissertation). DIT had its first set of graduates in 1994. The structure of the course has changed over the last 13 years. At present 5th year students have a practical component and see patients in the afternoon at the DIT Homoeopathic Day Clinic. The Clinic provides homeopathic services to the public at a reduced rate.

Besides the DIT and Technikon Witwatersrand courses, The Faculty of Homeopathy (United Kingdom) provides post graduate training for dental surgeons, doctors, nurses, midwives, pharmacists, podiatrists, veterinary surgeons and other statutorily registered healthcare professionals.

A pilot study on Complementary Medicine in South Africa was undertaken by The Complementary Medicine Trust (Caldis, 2000). The study serves as a description of the status of complementary medicine in South Africa. Caldis interviewed relevant people in the field, and reported that at that time there were 500 homoeopaths registered with the AHPCSA, 50 of whom had dual registration as

medical doctors (2000:15). Fees for an initial consultation varied from R100 to R360 or more. There was also great variation in prices of homeopathic medicines ranging from R20 to R100, sometimes for the same medicine. The Caldis study highlights the diversity of how homoeopaths practice and what is available to the consumer. Another important issue highlighted by the study is that of inadequate coverage by medical aid schemes for homeopathic treatment. For example schemes fail to cover the long consultation time required in the practice of homeopathy and are unable to verify the appropriateness of homeopathic medicines for particular clinical conditions. The problem seems to be due to their lack of knowledge and understanding of how homoeopaths operate. Caldis recommends a postal census of all registered practitioners as a means of collecting accurate data for future reference.

The lack of data on how homoeopaths practice is not limited to South Africa. In the 2001 Homint R&D Newsletter it is stated that the collection of basic data on treatment and prescribing patterns is urgently needed. These are required as the basis for discussion with authorities and decision makers in healthcare (Haidvogl, 2001). Therefore, from the point of view of the medical aid schemes, the public and the medical community there is a need to document how homoeopaths are practising.

Historically, randomised controlled trials have been the primary tool for scientific evaluations of homeopathy. However a recent trend is to employ practice based clinical research such as prospective data collection in order to evaluate the effectiveness of homeopathy under "real-life" circumstances (Steinsbekk *et al.*, 1999). One of the forms of this type of research is the clinical audit. This is defined by the British National Health Service as "systematically looking at the procedures used for diagnosis, care and treatment, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient" (in Van Haselen and Fisher, 1994:136).

In recognition of the value and need for this type of research within the homeopathic field, an international group called The Data Collection Group (DCG) has been established (Steinsbekk *et al.*, 1999). The first task of the DCG was to develop an international standard for data collection in homeopathic practice. After various drafts a "final" document was published (Steinsbekk *et al.*, 1999).

The DCG categorised the type of data to be collected into three broad areas;

1. Quality Assurance.

This is defined by the DCG as "systematically looking at the procedures used for diagnosis, care and treatment, investigating the effect care has on the outcomes as assessed by the practitioner, as well as recording the qualifications and experiences of the practitioner" (Steinsbekk *et al.*, 1999:4).

2. Treatment Outcomes.

This includes practitioner effectiveness; patient assessed effectiveness; utility and quality of life; as well as the assessment of adverse events including aggravations.

3. Economic outcomes.

This is related to resource use and the cost of caring for the patient.

The primary goal of the DCG is to develop ongoing data collection, by means of a multinational mega database with at least 10000 patients per country, with each practitioner utilising a 10-item data set to document each new patient (see Appendix A). The intention of the DCG is to develop a valid and systematic database that creates maximum synergy and harmonisation between different data collection projects, while maintaining the flexibility to tailor individual projects to local needs and objectives

At present no homeopathic clinical audit has been undertaken in South Africa and very little basic information on South African homeopaths exists. The current study aimed to provide demographic data on homoeopaths and information on how they practice. The guidelines that have been outlined by the DCG formed the basis for this study. The focus of this research was on assessing quality assurance and treatment outcomes, and was based on the 10-item data set developed by the DCG.

The findings of this study can be used as the basis of discussion with authorities and decision makers in healthcare.

CHAPTER 2

REVIEW OF THE RELATED LITERATURE

2.1 Homeopathic methods

Debats (1997), states that when trying to define homeopathy as a method, we are confronted with practical, historical and theoretical problems. The method was developed by a German medical doctor, Samuel Hahnemann, (1755 – 1843). Hahnemann himself experimented with many different techniques. Prior to his death he completed the 6th and final edition of his major work, The Organon (O'Reilly, 1996), containing important revisions on his method of treatment. However, this final version was not published till 1921 (Swayne, 2000: 150). After his death, homeopathy grew and established itself in many countries without these revisions. In addition homeopaths have added to the original philosophy over the years. This has lead to many theoretical debates amongst homeopaths and various types of homeopathy. The philosophies differ in case taking techniques, case analysis, therapeutic prescriptions and on the outcome measures. Classical homeopathy, Pluralist homeopathy, Clinical homeopathy and Complex homeopathy all claim to be valuable methods and they all report successes (Debats, 1997).

2.1.1 Classical homeopathy

Classical homeopathy claims to be based on strict Hahnemannian principles (Swayne, 2000:42). This claim is problematic as there is continued debate about Hahnemann's principles and methods, and some interpretations of classical homeopathy refer to concepts originated by Kent rather than Hahnemann. It is most often associated with the Unicist School of homeopathy, i.e. the therapeutic method of using a single medicine in a single prescription at one time and waiting for its effect to be exhausted before prescribing another (Colin, 2000). Debat

(1997) states that an accurate classical homeopathic diagnosis consists of a methodological screening of all hierarchical levels of the patient as an acting, feeling, willing and spiritual organism and detecting the disturbance that is situated at the highest level of this hierarchy. Cure is not reported unless there is improvement in the existential well-being of the patient.

2.1.2 Pluralist homeopathy

In this type of homeopathy, between two and five medicines are prescribed in alternation - mostly polychrests and nosodes for chronic disease, and complementary medicines for acute disease (Colin, 2000). Thus more than one homeopathic medicine representing different aspects of the illness are given in a single prescription. The instructions usually require that the different medicines are taken at different times. For example, a homeopath may prescribe one main deep acting chronic medicine in high potency and another in low potency for so-called "drainage purposes". The drainage medicine is intended to produce a discharge and create an outlet for the exodus of the disease (De Schepper, 2001:32).

2.1.3 Clinical Homeopathy

This type of homeopathy is based mainly on guiding symptoms and on the predominant correspondence to somatic symptoms, organ affinity, etiological prescribing and specifics (Swayne, 2000:44). Clinical homeopaths base the prescription on the medical diagnosis. Success is monitored by the removal of symptoms and the decreased need to prescribe allopathic medicine (Debats, 1997). Generally combination/complex homeopathy falls under clinical homeopathy. Medicines are prescribed in low to middle potency's.

2.1.4 Combination/Complex homeopathy

Included under this therapeutic methodology is polypharmacy, where several different medicines are administered at the same time through giving a number of single medicines or giving a combination homeopathic products (Yasgur, 1998:53). The latter may be termed a complex, where as many as ten medicines can be administered to a patient at the same time. Complexes may have developed as a response to the need for quicker prescribing methods. This is evident, for instance in the Handbook on Healing written by Swami Narayani and Swami Ananda (1987). The authors (1987:21) have discovered that although combinations are not the Hahnemann method, they produce wonderful results. Their observation is that when using classical homeopathy, it is not possible to treat more than three patients a day. They say: "[we] have seen many people, declaring themselves to be true followers of the Hahnemann method, choosing one remedy in a matter of fifteen minutes. This is not possible. They are bluffing themselves." (1987:11)

2.2 Surveys and their importance

Mitchell and Jolley (1992:451-452) state that surveys are a research tool using systematic and structured questions with which one can gather information from a large sample of people with less effort and expense than most other data-gathering techniques. Further, they state that surveys are used most often to assess people's beliefs, attitudes, and self-reported behaviours. Researchers use surveys to describe behaviour and to develop causal hypotheses that can be tested in experiments. However, surveys cannot, by themselves, establish causality.

The main advantages of surveys are that they can be used to investigate problems in realistic settings, and allow researchers to examine a large number of variables which can be analysed with the help of multivariate statistics.

The main disadvantages of surveys are that independent variables cannot be manipulated as in experimental research, and reliability and validity are not always easy to ensure. Cooper and Schindler (2001:295) state that the major weakness with surveys is that the quality and quantity of information secured depends heavily on the ability and willingness of respondents to cooperate. There are many reasons for lack of cooperation, including that the respondents may fail to see the value in participation, fear the interview experience for some personal reason or view the interview as intrusive. An area of weakness specific to paper surveys, is that respondents may interpret the question differently from what was intended by the researcher. Also, in answering the questions, they may intentionally mislead the researcher by giving false information. Thus, survey responses should be accepted for what they are – statements by others that reflect varying degrees of truth (Cooper and Schindler, 2001:295).

When designing the questionnaire care must be taken to make sure that it is the right length, that the questions are clear, unambiguous and that the questions are not leading (Doman *et al.*, 1993:70). This is important so as to avoid respondent fatigue, biased answers, and vague responses.

In the health field, surveys can contribute to the identification or description and measurement or analysis of: (1) health and illness; (2) the nature of disease; (3) needs for different sorts of care; (4) factors associated with the use of services; (5) the effects of care; (6) acceptability of care; (7) the organisation of care (Aday 1989, cited in Drews, 1994).

A recent development is the acknowledgement that an evaluation of therapies of complementary and alternative medicine (CAM) may have to ask different questions than those asked in orthodox medical assessment (Long *et* al., 2000). The scientific medical model is based on a reductionism paradigm, as opposed to one based on holism. Measures like the Illness Intrusiveness Scales (Lorig *et al.*, 1996) address dimensions of health, i.e. physical, mental, social and spiritual

areas, rather than the philosophy and practice of health and healing. Long *et al.* (2000:27) describes it as follows; "left unmeasured are key features of the interaction between therapist and therapy user, and the underlying philosophy of health and healing of CAM. Indeed, survey evidence suggests this is an important factor in the reasons why users come to complementary therapists for treatment."

Golovatiouk *et al.* (2001), state that the upsurge in the use of homeopathic treatment options is due largely to the increasing dissatisfaction with conventional treatment. However, the desire for natural therapies with as few side effects as possible, and the hope for better, more trusting communication with homeopathic physicians also plays a role. Luff and Thomas (2000) examined patient satisfaction with complementary and alternative medicine (CAM) by means of face to face interviews, within the National Health Service (UK). A total of 49 patients received one of the following treatments within a primary care centre; osteopathy, acupuncture, homeopathy, chiropractic or massage. The study focused on patient satisfaction, and the results show that predominantly positive experiences were expressed. Patients felt that the treatments were effective, and that they were 'getting somewhere'. Some claimed miracle cures. The results of these positive experiences - specifically the practitioner-patient relationship - resulted in an increasing commitment by the patients to CAM. The patients perceived complementary practitioners as being caring, and the treatments as being calming. Further, they valued the development of a therapeutic relationship within which they were encouraged to take an active part in looking after their health. This aspect of patient satisfaction is often missing in research that compares the efficacy of CAM using an orthodox medical paradigm.

Long *et al.* (2000) published an article entitled "Developing a tool to measure holistic practice: a missing dimension in outcomes measurement within complementary therapies." The authors state that the choice of outcome criteria,

namely, whose criteria are given priority and how these are measured, may make a substantial difference to conclusions as to whether a particular intervention or therapy is effective or not. Their view is that while complementary researchers have paid heed to the importance of measuring the subjective experience of the therapy, they have left unmeasured the notion of holism, particularly the effect of the interaction between therapist and therapy user, and its underlying philosophy of health and healing. They undertook a one year exploratory study interviewing complementary practitioners, and users of these modalities. Based on the results of this study, the first steps in the process of introducing a measurement of holism have been made, in the form of a series of questions. Some of the questions developed by Long *et al.* were used in the current study.

2.3 Homeopathic studies

Over the past 10-15 years practice based clinical research as a means for scientific evaluations of homeopathy have been undertaken. In the following section, reference will be made to surveys that cover areas relating to the demographic data of patients (i.e. who see homeopaths), the range of conditions treated by homeopaths, prescriptions selected by homeopaths, and outcome of homeopathic treatment.

The formation of the Data Collection Group (DCG) in 1995 highlights the importance the homeopathic community places on the development of clinical audits that assess quality assurance and treatment outcomes in homeopathy. Quality assurance is defined by the DCG as "systematically looking at the procedures used for diagnosis, care and treatment, investigating the effect care has on the outcomes as assessed by the practitioner, as well as recording the qualifications and experiences of the practitioner" (Steinsbekk *et al.*, 1999:4). "Treatment outcomes" includes practitioner effectiveness; patient assessed effectiveness; utility and quality of life; as well as the assessment of adverse

events including aggravations. Until now South African research has focused primarily on patient perceptions of the efficacy of homeopathy.

2.3.1 Studies around patient demographics, consultation and treatment characteristics

Jacobs and Crothers (1991) did a study of patient characteristics in a homeopathic family practice. Over a five year period information on 2500 patients was collected and compared to results from the National Ambulatory Medical Care Survey (UK). The authors concluded that homeopaths were more likely to be consulted for chronic illness, for cases that are difficult to treat by conventional means and for cases related to psychological and/or with ill defined signs and symptoms.

Jansen and Koster (1995) report on a survey that not only gave insight into what type of disease homeopaths treat but also included prescription data. For one week 58 homeopaths in the Netherlands registered the complaints and diagnosis of their first 30 patients who were given exclusively homeopathic treatment. The results showed that the main complaints were conditions of the respiratory tract, followed by psychological and skin conditions. In terms of frequency of prescriptions polychrests scored highest. With regards to posology, centesimal potencies were prescribed at a rate of 85.4%, quinquagenimillesimal (LM) prescriptions at 9.8% and decimal potencies at 4.5% of the prescriptions. The group prescribed almost exclusively one homeopathic medicine at a time.

Kayne and Beattie (1998) report on a retrospective study conducted at the Glasgow Homeopathic Hospital, where the prescriptions of four years (1994-1998) of winter month's consultations at the outpatient department were analysed. The results show that in all four years Natrum muriaticum was the most frequently prescribed medicine, followed by Pulsatilla and Rhus toxicodendron. The most frequent dilution prescribed was 200c.

Bernard (2000) conducted a survey of 300 homeopaths on potency prescribing with the aim of establishing practitioner methodologies, specifically how and why these methodologies were applied. Respondents were from the United States, Canada, India and New Zealand for whom homeopathy comprises 60-100% of their practices. They had many differing opinions on the various homeopathic potencies and how to apply potency in practice. However there were some consistent practices and beliefs. The majority of practitioners began treatment with a single dose of 200c potency, those with 21-25 years in practice doing this most frequently (67% of the time). LM potencies were prescribed mainly by practitioners with 6-15 years experience. The majority of practitioners reported a follow-up time of 4-6 weeks after the first visit. Many of the respondents commented on the fact that homeopathic prescribing was very individualistic for each patient and therefore found it difficult to state general trends.

In 1990 Dempsey and Swayne published a paper titled 'Thinking what we are doing'. They acknowledged that there is diversity in practice methodology but stated that as homeopaths "we must begin with a clear statement of what we are doing, and to what extent we differ in how we do it. We can then go on to ask why these differences exist, how we justify them and whether they affect the outcomes of what we do. These are not merely academic questions. If we are to submit homeopathic treatments to tests of efficacy it matters a great deal that we know what strategies and regimes are likely to yield best results in particular clinical contexts" (Dempsey and Swayne,1990:82). They set out to investigate the following:

- Description – who does what;
- Audit – detailed accounting of therapeutic activity;
- Analysis – of this therapeutic activity;
- Outcome – uncontrolled but systemic recording of clinical judgement.

They conducted two surveys of homeopathic doctors the first in 1987, which had 73 respondents and the second in 1988, which had 46 respondents. The respondents were asked to record all consultations undertaken in one working week. A multitude of data was collected. Here are some examples:

- On a scale of 1-10, none of the doctors estimated their skill level to be as great as 8;
- They found that respiratory complaints were the most frequent;
- They list the top 48 medicines prescribed, and show the frequency with which the top 20 medicines were prescribed in different morbidity groups;
- They analysed the prescribing habits of doctors in respect of potency, with the 30c potency predominating, however this varied depending on the diagnostic group.

This study did not survey outcome.

In 1992 Jacobs, Chapman and Crothers conducted a survey (Jacobs *et al.*, 1998) to establish practice patterns as well as patient characteristics. A letter was sent to all 102 active members of the American Institute of Homeopathy (AIH), asking them to record data on all patient visits for a one week period. Twenty seven members agreed to participate, and recorded information on the following: demographic information on the practitioner and patient, payment sources, principle diagnosis, medication therapy, and the duration of visit. The survey was modeled on and compared to the 1990 National Ambulatory Medical Care Survey (NAMCS) of general and family physicians. The results were similar to their 1991 survey in that they found that AIH physicians were more likely to be consulted by patients with chronic illnesses and psychological symptoms. In the 1992 survey the AIH and NAMCS physicians had roughly the same age (average 46 years) and sex (81.5% men) demographics. However, major differences in geographical distribution were found, which affected the patient characteristics. The majority of AIH practitioners were located mainly in western America which has a high Asian population, whereas the NAMCS practitioners were located mainly in southern America, which has a high black and Hispanic population.

They found that the AIH physicians were more likely to see woman, children younger than 15 and young to middle aged adults. A higher number of patients with private medical insurance suggested to the researchers that the AIH patients were more affluent.

This study goes on to give some practice management information. Homeopathic physicians spent more than twice as much time with their patients, which the researchers concluded was a reflection of the complexity of the homeopathic case history taking and prescribing process. The AIH physicians ordered fewer laboratory tests than the NAMCS practitioners which could relate to the longer consultation time, i.e. more in depth case history taking and physical examination. It also could be due to the fact that extensive testing had already been done by other physicians. The AIH physicians prescribed predominantly homeopathic medicine, exclusively in most cases. However, in almost 28% of cases conventional pharmaceutical drugs were also prescribed. The researchers suggested that further studies comparing clinical outcomes, costs and patient satisfaction needed to be done to increase understanding of the role of homeopathy in the healthcare system.

Colin (2000) analysed 2148 of his consultations, specifically to document the reason for the consultation and the patient characteristics (age and occupation). Colin practices in south-west France, where patients are accustomed to pluralist homeopathy, thus this study documents pluralist homeopathy. He is known as a general practitioner who prescribes almost exclusively homeopathic medicines. He states that his homeopathic practice is mostly pluralist and in 5-10% of cases he will prescribe classically. Further, he states that pluralist treatment has advantages over classical treatment because prescribing is simpler, leading to shorter consultations, and shorter waiting periods.

He found that the main indications for homeopathy were mental, respiratory infections and rheumatological problems. When compared to general practice he

encountered more respiratory infections and mental illnesses and less cardiovascular and metabolic illnesses. Other illnesses (dermatological, gynaegological and genitourinary) were roughly equally prevalent. The French pluralist treatment was compared to British homeopathy (the Dempsey and Swayne 1990 study). The more 'classical' British homeopaths saw fewer respiratory infections and mental cases, and more rheumatoid cases.

2.3.2 Studies with treatment outcome

In 1992 Van Haselen and Fisher tried to formalise the study of outcome assessment by testing a new method which they named Systematic Outcome Correlation. In this method, outcome, as measured by standard clinical assessment, is correlated with prescription. They used standard clinical parameters to estimate the progress of rheumatoid disease: 'duration of morning stiffness', 'pain intensity scale', London Articular Index and 'grip strength'. Of the 64 patients that met the inclusion criteria, 59% showed an improvement. The researchers found the most favourable prognosis in single medicine prescription cases. Further they state that subjective clinical assessment is vital to developing validity and reliability of prescribing indications.

Downey (1996) a General Practitioner in the UK who is trained in homeopathy undertook an audit of homeopathic prescribing style and outcome in his general practice. In a six-month period, 9.7% of all consultations received homeopathic prescriptions only. He found that the range of conditions treated represented the full spectrum of work in general practice. The lack of time dictated a reliance on keynotes, with constitutional prescribing in only 20% of the cases. Downey admits to the limitations of this approach, and thus states that he refers out when cases are considered complicated. There was a predominant use of low potency prescriptions. Patients used a subjective rating scale (unsourced) to assess their improvement (0 = No improvement, 1 = slight improvement, 2 = mild improvement, 3 = moderate improvement, 4 = great improvement, 5 = complete

removal of all symptoms). He found that 80% of patients had experienced some improvement in symptoms.

Sever (2000) also undertook a clinical audit in his own private practice, based on 829 consecutive patients over a period of 7 years. Details of the patients name, age, sex, main diagnosis, medicine prescribed, potency, posology and outcomes were recorded. He stated that outcome measures can be assessed in the following ways:

- Clinically - the doctors notes on assessment of the patient. He rates the outcome on the Glasgow Homoeopathic Hospital Outcome Scale (GHHOS);
- Patient reported response;
- Objective indices - results of blood tests, x-rays;
- Visual Analogue scale;
- Follow-up questionnaire.

Using the GHHOS, he found that 503 (61%) patients benefited from homeopathic treatment. Of these, 357 patients (43%) had an excellent response, scoring +2 on the GHHOS, and 146 patients (18%) had a good response scoring a +1. Six patients (0.8%) became worse, and 233 patients (28%) were lost to follow up.

Richardson (2001) reports on an Outcome Survey carried out at the Liverpool Regional Department of Homoeopathic Medicine over a 12-month period. Only patients who had completed at least two courses of homeopathic treatment were included. Most patients suffered from chronic disease, and had tried conventional medicine, often for long periods of time before coming to homeopathy. The department felt that a minimum of three visits was necessary to give a fair picture of the benefits of homeopathic treatment. Using self assessment by the GHHOS, 76.6% of patients reported an improvement in their conditions since starting homeopathic treatment. The study looked at which conditions showed the greatest improvement results. Homeopathic treatment produced excellent results for patients with premenstrual syndrome (PMS) and patients with recurrent upper

respiratory tract infections. Sinusitis, catarrh, rhinitis and headaches also showed excellent improvement. Patients with psoriasis did less well than those with eczema. Fifty-two percent of patients reduced their conventional medicine.

An International project to investigate the effectiveness of homeopathy in medical primary care IIPCOS-01 (Heger *et al.*, 2001), showed how effective homeopathic treatment can be in these settings. A total of 348 patients suffering from upper and lower respiratory tract complaints in Germany, Austria, Switzerland and USA were documented. Three quarters of the patients were treated with just 14 medications; the most commonly used were Pulsatilla, Lycopodium and Sulphur. Nearly half the patients received adjunctive therapies, mainly herbal medicines but also conventional medicines. Two thirds of the consultation times were less than 16 minutes, with most prescriptions being made based on "key notes" and "totality of symptoms". The treatment was most successful amongst children between 2-11 years. Over 90% of patients were very satisfied or satisfied with treatment. Adverse drug events arose in 3.4% of patients.

A survey conducted by Golovatiouk *et al.* (2001) was designed along the DCG guidelines, specifically to gauge:

- the extent of collection of patient data amongst homeopathic physicians;
- conditions for constructing a documentation system;
- country-specific differences.

The survey also included a personal profile of the physicians (age, gender and training), and their confidence levels in their own prescribing abilities and that of their colleagues. They state that the systemic collection of data offers an opportunity for an extensive overview of the effectiveness of homeopathic treatment, contributes to quality assurance and permits national and international exchange of data.

Golovatiouk *et al.* (2001) distributed a total of 6,685 questionnaires in 5 European countries (Germany, the Netherlands, Norway, Russia, and Ukraine), resulting in a 17% response rate. The highest response rates came from Russia and the Ukraine. The physicians were mostly female (70%) aged between 40-49 years (40%). The majority (80%) of the German, Russian and Ukrainian physicians had less than 10 years experience as a homeopath. Overall, 75% of physicians had enough confidence in their homeopathic prescribing to communicate with others, with a correlation to their age and experience. The advantages of documentation were recognized by the physicians, with 79% believing that data collection offered them the possibility of evaluating their own prescribing results. However, only 67% of the physicians actually collected patient data, while only a third of these used a computer to collect patient data. The authors felt that the current situation for data collection in homeopathic practice is unsatisfactory. They found that there is little interest in data collection *per se,* particularly amongst the countries where homeopathy is well established. The situation was different for countries where homeopathy is still in a developmental phase, where they found that the motivation for data collection was high but the nature and methods did not correspond with the international standard.

The largest clinical audit study (in line with the DCG guidelines) called the International Study of Homeopathy (ISH-10) is currently underway. The aim is to create a valid and systematic multi-national database for clinical cases. The data is collected online over the internet. At present more than 250 practitioners from 10 countries are participating, and approximately 14 000 patients have been included so far (Haidvogl, 2001)

2.4 Related surveys in other fields

Assendelft *et al.* (1995) conducted a comprehensive study of chiropractic practitioner demographics and practice methods. A survey was sent to all members of the Netherlands Chiropractors Association (n = 59). The survey had

an 88% response rate and contained questions on education, practice management, diagnostics, treatment, inter-professional co-operation and referral. They found that fifteen chiropractors had additional postgraduate training. Most worked in a solo practice, with a median number of hours per week of 36. Full physical examination techniques taught by colleges were not always used. Self-referral was the largest source of patients. Most chiropractors seldom referred patients to other forms of therapists.

2.5 South African surveys

Research on homeopathy in South Africa has centered on public or patient perceptions of homeopathy. The Opinion Survey Centre (OSC) of the Human Sciences Research Council (Steenekamp, 1985) conducted a study in 1983 investigating the South African public attitude, knowledge and experience of the chiropractic and homeopathic professions. A mail survey to a sample of 3000 people on the voters roll (only white people) was used to collect the data. It was found that in the 12 months preceeding the survey, 12.9% of respondents had consulted a homeopath. Almost half (49.4%) had been completely cured, or helped very much, while 21.6% stated that the treatment did not help at all. The most common reasons for consulting an alternative practitioner were because 'medical practitioners could no longer help' (27.9%) or because the patient felt 'desperate' (30.3%).

Ferrucci (1994) conducted a survey on patients regarding their demographic data, clinical conditions, treatment and clinical methods employed by homeopathic private practitioners as compared to senior homeopathic students practicing in the Clinic at Technikon Natal Homoeopathic Day Clinic, Durban (now DIT Homoeopathic Day Clinic). The total sample size was 300, with 160 patients of private practitioners, and 140 patients of the Day Clinic. Ferrucci found that more females consulted both practitioner groups, and that patients in general seem to suffer more from chronic complaints, with a high incidence of

vague or psychological complaints. The age of the patients varied between the two groups, with the private practitioner sample falling largely in the 26-35 (20%), 36-45 (21%) and 46-55(21%) age groups. The Day Clinic group was younger, with a large group of patients in the 18-25 (29%) age group. With regards to employment, 33% of the private practice patients were business people, and 29% were unemployed. In the Clinic 36% of patients were students. With regards to education the majority of respondents in both groups indicated that they had an education level higher than grade twelve.

The normal fee for a first consultation with a private practitioner was R70, with R60 for a follow-up, and 61 % of private practice respondents belonged to a medical aid scheme. The Day Clinic fee was R25 per consultation, and 57% of patients belonged to a medical aid scheme.

The treatment outcome evaluation was by means of patient perception. 62% of patients from the private practitioner group rated that the treatment programme had improved their symptoms a great deal. This is compared the Day Clinic group, of whom only 29% felt that their symptoms had improved a great deal. The Mann-Whitney test was used to establish that there is a statistical difference between the two samples outcome. However, the study does not provide pre- and post-treatment evaluations, which have been statistically tested to see if the treatment outcome is significant. This is a weakness of the Ferrucci study which the current study addresses.

30% of patients reported that the private homeopathic practitioners they had consulted used treatment modalities other than homeopathy. The study however does not provide information on clinical methods. Again this is an area addressed in the current study.

A third South African study (Moys, 1998) focused on the perceptions of residents of two affluent communities toward homeopathy (n = 1000). These two areas are

racially very diverse, namely Westville, a predominantly white residential area, and Reservoir Hills, a predominantly Indian residential area. Moys states that overall, the respondents perceived that chronic conditions such as headaches, arthritis, skin problems and blood pressure would respond to homeopathic treatment. The Westville group reported more experience of homeopathy, i.e. 39% had consulted a homeopath as opposed to 18.2% of the Reservoir Hills group. Of the respondents who had consulted a homeopath, the majority reported that their treatment had been effective to varying degrees. Very few people chose a homeopath as their usual care provider, but among the Westville group it was found that homeopathic patients gave higher scores to their homeopath than general practitioner patients gave to their doctor regarding the following items: for finding out what was wrong with them, the efficacy of the medication and for listening to what the patient had to say about their illness.

CHAPTER 3

MATERIALS AND METHODS

The framework of the study is based on the guidelines set by the international Data Collection Group (DCG) (Steinsbekk *et al.*, 1999). Appendix A gives details of the DCG's 10 item set, and also provides a table that outlines this study's questionnaires and how they relate to the DCG's 10-item data set.

3.1 Study population

All practising homeopaths registered with the Allied Health Practitioners Council of South Africa in Kwazulu Natal (KZN) were invited to participate (n = 79).

3.1.1 Inclusion criteria

Practitioners had to be registered with the Allied Health Practitioners Council of South Africa and be based in Kwazulu Natal (KZN). They had to be actually practising homeopathy, consulting both new and follow-up patients.

3.1.2 Exclusion criteria

Practitioners who were not practising homeopathy or only treating follow-up patients were not included.

3.2 Study sample

All the practitioners who responded positively fitted the inclusion and exclusion criteria, and were included in the study (n = 30). Only seventeen practitioners completed all the stages required of them by the study (see 3.3.3-4). Each participating homeopath was to have completed data for 10 consecutive new patients. Not all the practitioners completed data for all ten patients, thus the number of patients totalled 158.

3.3 Methodology

The data collection took place from September 2001 to May 2002. The study involved five stages. Six questionnaires (Appendices D1-D6) were used to gain the data.

3.3.1 Stage 1 – Initial contact

The researcher contacted the registered practitioners by telephone and asked them to participate. The phone call was followed by a fax or email detailing the nature of the study, with a fax reply slip included. Letters were sent to those practitioners who could not be reached telephonically. From the positive responses the study sample was formed. The demographics of age, sex, race and area of practice were noted by the researcher of all contactable registered practitioners.

3.3.2 Stage 2 – Practitioner interview

Questionnaire 1 was administered by the researcher in face to face interviews with the practitioners. Questions pertained to practitioner demographics, practice information, continued education, and referrals. The question on referrals was taken from the Assendelft study (1995)

3.3.3 Stage 3 - initial consultation

Each practitioner enrolled 10 consecutive new patients to participate in the study, after gaining their consent (see Appendices B3 and B4). Participants completed Questionnaire 3 (Appendix D3) before going in for the appointment. The Questionnaire covered items 2, 4 and 5 of the 10-item data list, relating to patient's complaints and quality of life. A self sealing envelope was provided for the patient to place the completed form in. The questions for item 2 were based on The Illness Intrusiveness Ratings Scale (Lorig *et al.*, 1996). Items 4 and 5 on general well being and 'life-state' assessment respectively were assessed via Visual Analogue Scales (Lorig *et al.*, 1996). The practitioners completed Questionnaire 2 (Appendix D2) for these 10 new patients. The questionnaire covered items 1,3,6,7 and 10 of the 10-item data list. The follow-up appointments were made at the end of the initial consultations.

3.3.4 Stage 4 - follow-up consultation

Stage 4 dealt with the treatment outcome whereby patients and the practitioners completed a follow-up questionnaire.

Patients completed Questionnaire 5 (Appendix D5) which included a repeat of the Illness Intrusiveness Ratings Scale and Visual Analogue Scales on general well being and "life-state" today. The questionnaire also included questions regarding the level of patient satisfaction or dissatisfaction with the treatment methodology, and was based on the Group Health Association of America Consumer Satisfaction Survey (Lorig *et al.*, 1996). Section 5 contained questions based on an Holistic Practice Questionnaire developed as a means of measuring holistic practice outcomes (Long *et al.*, 2000).

Practitioners completed Questionnaire 4 (Appendix D4), based on item 8 and 9 of the 10-item data list. Item 8 was assessed using the Glasgow Homeopathic Hospital Outcome Scale (GHHOS) (Steinsbekk *et al.*, 1999).

3.3.5 Stage 5 - drop out patients

If a patient did not arrive for the follow-up appointment the receptionist was instructed to contact them telephonically and reschedule the appointment. In cases where they did not arrive for this second scheduled follow-up the patients contact details were forwarded to the researcher. An exit questionnaire (Questionnaire 6) was then administered telephonically by the researcher to the drop out patients. The questionnaire included the GHHOS, as well as the Group Health Association of America Consumer Satisfaction Survey and the questions regarding holistic practice outcomes.

3.4 Data analysis

SPSS Version 9 was used to analyse the data. The Pearson's Chi-Square test was used to test the association between various factors in the questionnaires at the 5% level of significance. The Wilcoxon Signed Ranks Test was conducted on the pre- and post-treatment results of the Illness Intrusiveness Rating Scale and Visual Analogue Scales (VAS) completed by the patient.

3.4.1 Hypotheses tests

The following hypotheses were tested:

3.4.1.1 The association between type of homeopathy practiced and training.

H_0 = Type of homeopathic treatment and type of training are independent.
H_1 = Type of homeopathic treatment and type of training are dependent.

3.4.1.2 The association between type of homeopathy practiced and outcome

H_0 = Type of homeopathic treatment and outcome are independent.
H_1 = Type of homeopathic treatment and outcome are dependent.

3.4.1.3 The association between age of patient and outcome.

H_0 = age of patient and outcome are independent.
H_1 = age of patient and outcome are dependent.

3.4.1.4 The association between duration of complaint and outcome.

H_0 = Duration of complaint and outcome are independent.
H_1 = Duration of complaint and outcome are dependent.

3.4.1.5 The difference between pre- and post-treatment results of the Illness Intrusiveness Rating Scale

H_0 = there is no difference between pre- and post-treatment results.
H_1 = there is a difference between pre- and post-treatment results.

3.4.1.6 The difference between pre- and post-treatment VAS results

H_0 = there is no difference between VAS, pre- and post-treatment.
H_1 = There is a difference between VAS, pre- and post-treatment.

3.4.1.7 The association between duration of the initial consultation and the consumer satisfaction of outcome of healthcare (how much you were helped?)

H_0 = there is no relationship between the duration of the initial consultation and the patients perception of outcomes of healthcare.
H_1 = there is a relationship between the duration of the initial consultation and the patients perception of outcomes of healthcare.

3.4.2 Decision rule

At $\alpha = 0.05$ level of significance, the null hypothesis is rejected if $P < \alpha$ where P is the observed significance level or probability value. Otherwise the null hypothesis is accepted at the same level of significance.
If $P < 0.05$ reject H_0
If $P \geq 0.05$ accept H_0

3.5 Materials

See appendices for copies of the following documents:

Appendix B1:	Letter to practitioners containing information sheet and instructions regarding the research;
Appendix B2:	Practitioner Informed Consent Document;
Appendix B3:	Information Sheet for the patient;
Appendix B4:	Patient Informed Consent Document;
Appendix C:	Guidelines to the receptionist;
Appendix D1:	Questionnaire 1 – practitioner demographics;
Appendix D2:	Questionnaire 2 – initial consultation (practitioner);
Appendix D3:	Questionnaire 3 – initial consultation (patient);
Appendix D4:	Questionnaire 4 – follow-up consultation (practitioner);
Appendix D5:	Questionnaire 5 – follow-up consultation (patient);
Appendix D6:	Questionnaire 6 – exit survey;
Appendix D7:	Zulu translation of the patient information sheet, consent form and Questionnaires 3 and 5;

CHAPTER 4

RESULTS

The researcher attempted to contact all the practitioners residing in KZN whom were registered with the Allied Health Professions Council of South Africa as at September 2001. Of the 79 listed, 9 were not contactable - either the telephone numbers were incorrect, or no reply was made to a mailed invitation letter. Of the remaining 70 contactable practitioners, four had left South Africa, seven had moved out of KZN, thus reducing the target population to 59. Of these only 45 said they were practising. The balance of contactable homeopaths were not practising homeopathy for various reasons. Six had retired or were ill, two were on maternity leave and two worked for homeopharmaceutical companies (industry). Four said they were not practicing at present because of other personal reasons. See Figure 1.

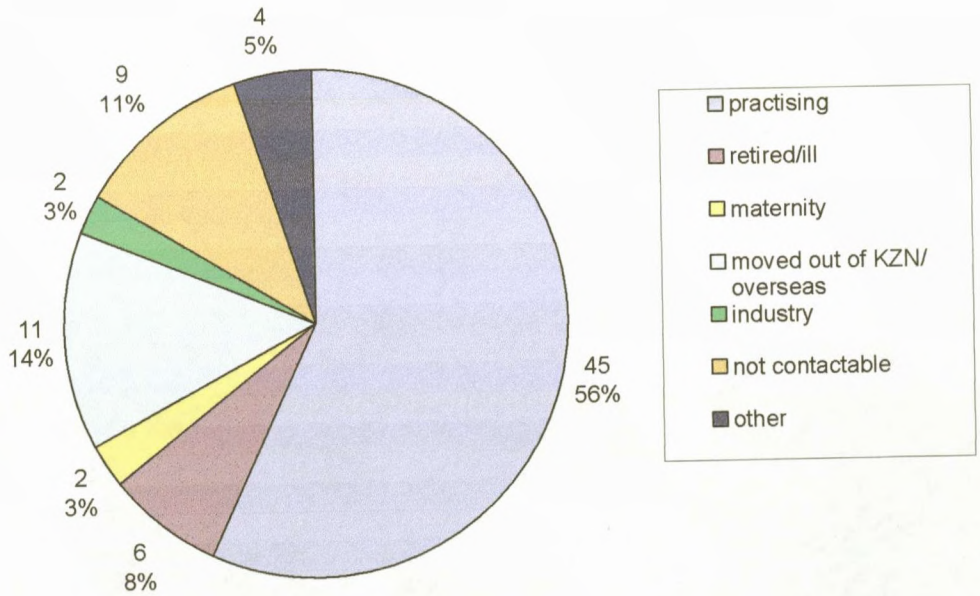

Figure 1. Practice status of registered homeopaths in KZN.

Of the 45 practising homeopaths, three were excluded from the study because they were considered to be too closely involved in the study. Nine practitioners were not willing to participate, because they felt they were too busy. A further three practitioners were not willing to participate because of difficulties experienced previously with surveys that required patients to fill in questionnaires. Two of these practitioners felt that patients do not want to fill in forms and thus thought it was a waste of time. One black practitioner from a small town in KZN, with a largely rural based practice felt that he would have difficulty in getting patients to partake in a "white" research project. A final total of 30 registered practicing homeopathic practitioners agreed to take part in the study. This amounted to 67% of the total number of practising registered homeopaths.

4.1 Practitioner demographic data

4.1.1 Demographic comparisons of the study sample and the total contactable population

The demographics of the study sample (n = 30) was compared to the total contactable study population (n = 59) in order to highlight any bias in the study sample (see Figures 2-5).

4.1.1.1. Age distribution

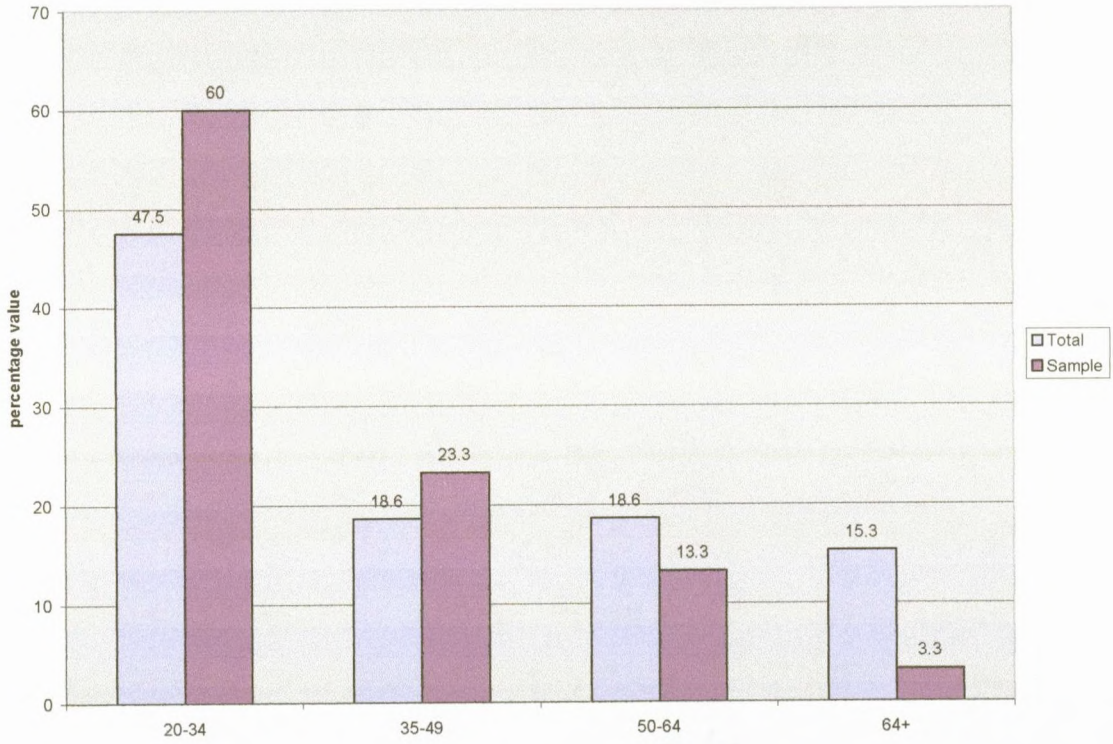

Figure 2. Age distribution of practicing homeopaths.

As can be seen from Figure 2, the study sample population is generally younger than the total population i.e. 60% fall between the ages of 20-34, as opposed to 47.5% of the total contactable population falling in this age group. Within the +65 age group, the total contactable population was 15.3% compared to a mere 3.3% in the study sample.

4.1.1.2. Gender distribution

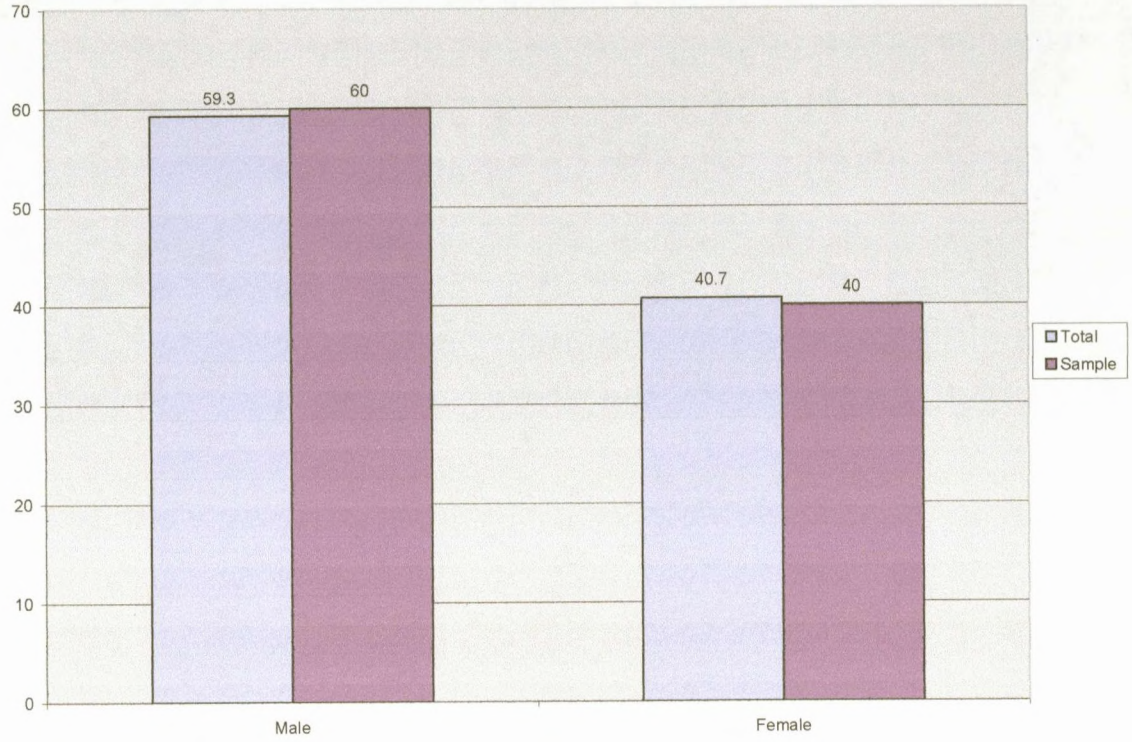

Figure 3. Gender distribution of practicing homeopaths.

As can be seen in Figure 3, the gender split for both groups is fairly consistent, with the majority of respondents being male - 60% for the study sample and 59.3% for the total population.

4.1.1.3. Race distribution

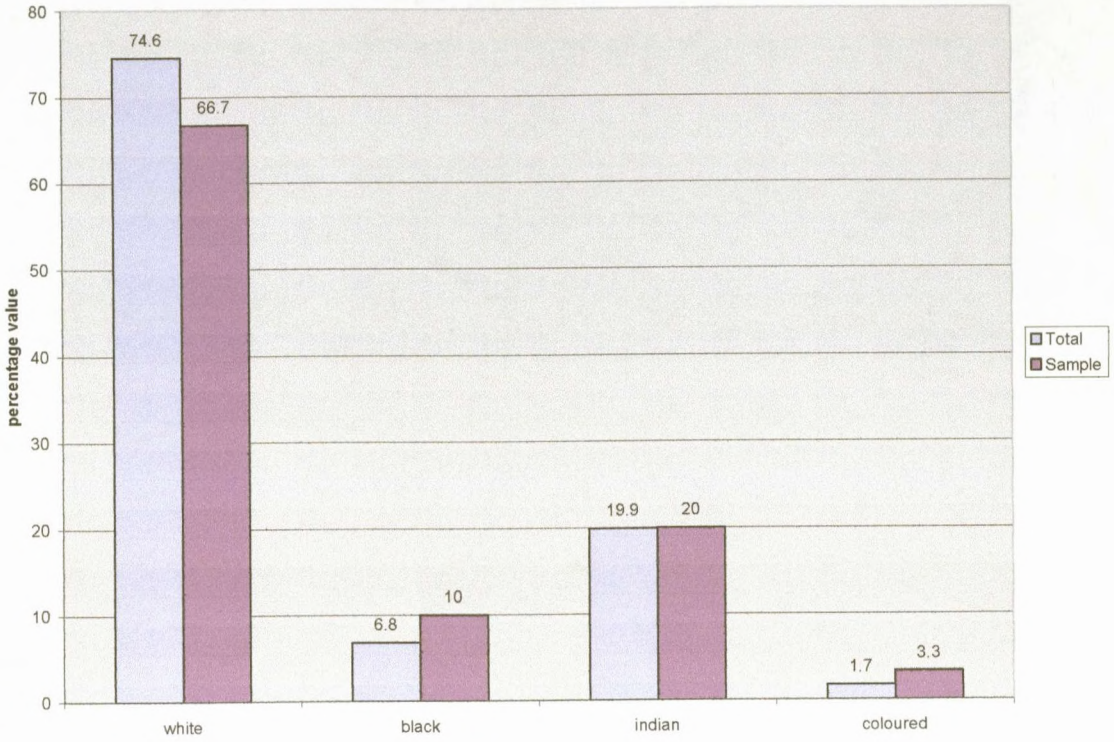

Figure 4. Race distribution of practicing homeopaths.

Race is included as a variable in light of the history of South Africa. From Figure 4 it is clear that both populations are predominantly white at 74.6% of the total population and 66.7 % of the study sample.

4.1.1.4. Distribution by area

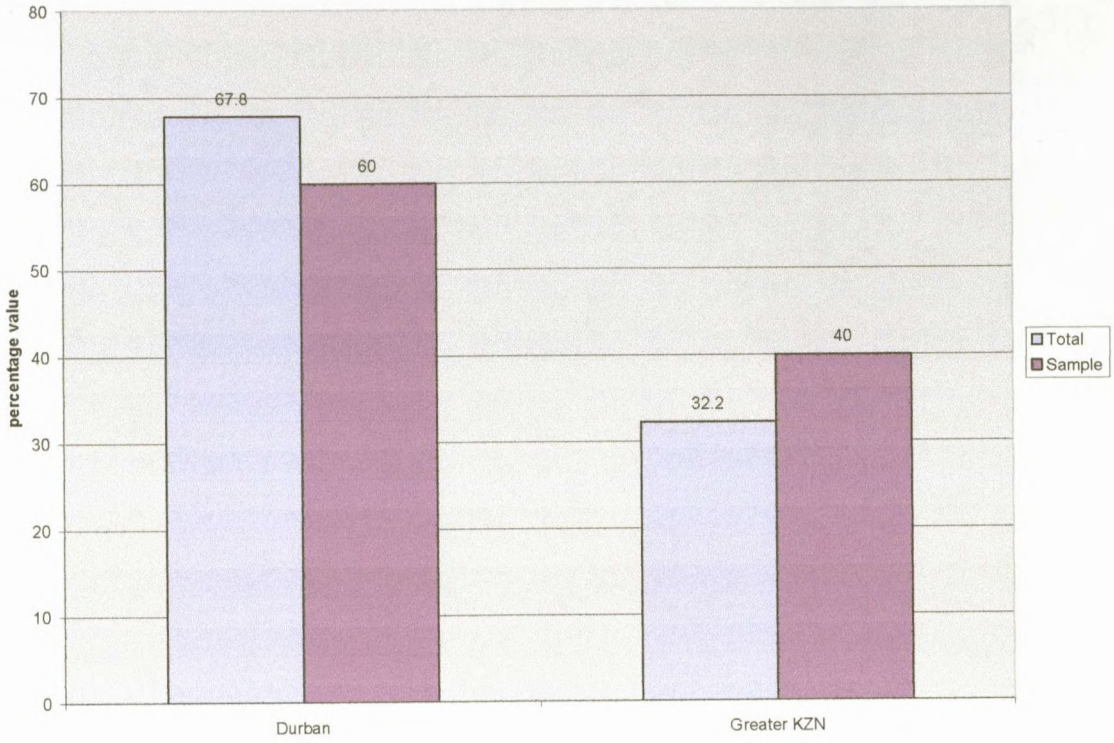

Figure 5. Durban vs Greater KZN.

Figure 5 demonstrates that over 67% of total practitioners reside in the Durban area. However, the study sample contained a higher proportion (40%) of practitioners residing in Greater KZN than the total population (32.2%). Thus, practitioners living outside of Durban were more agreeable to participating in the study.

4.1.1.5. Summary

The study sample is younger, less white, and more highly represented in the Greater KZN areas than the total contactable population.

4.1.2 Data related to Questionnaire 1 - study sample practitioner demographics, practice characteristics and practice methodologies

4.1.2.1 Number of years/months practicing homeopathy (re: Q1.1.8)

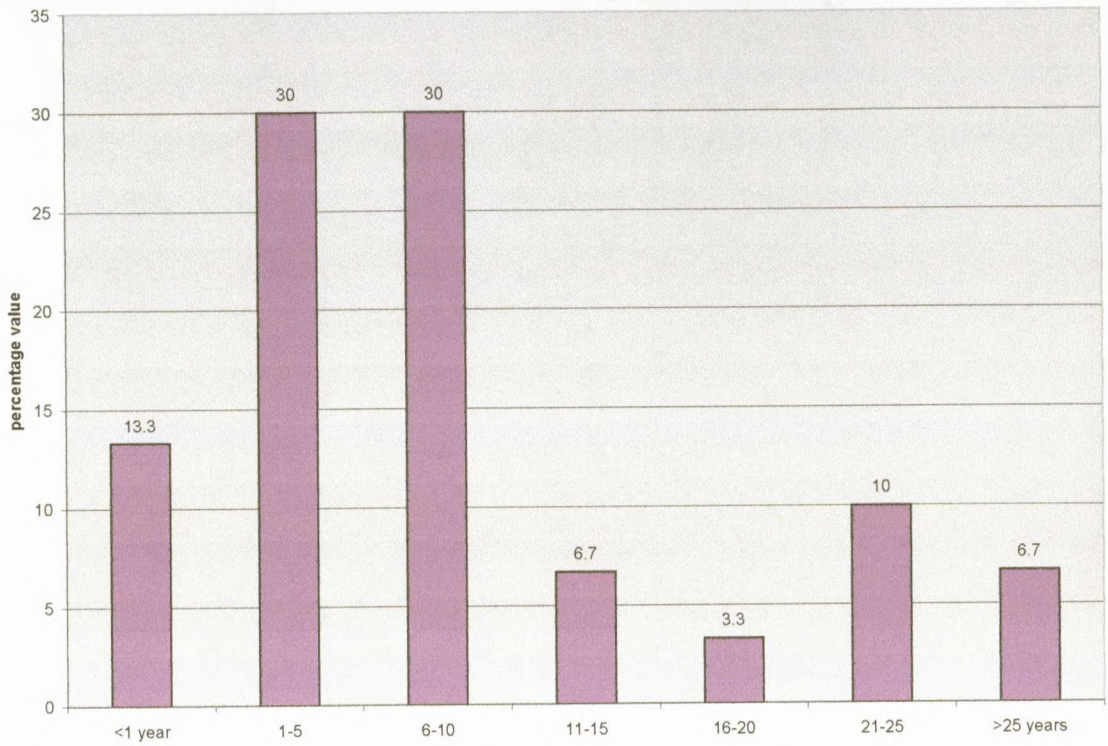

Figure 6. Years of experience in practicing homeopathy.

Figure 6 gives a breakdown of the number of years of practicing homeopathy. 73.3% have been practicing for less than 10 years, with 13.3% only having practiced for less than one year. Over 16.7% have practiced for more than 20 years.

4.1.2.2. Homeopathic qualification and other qualification (re: Q1.1.5-7)

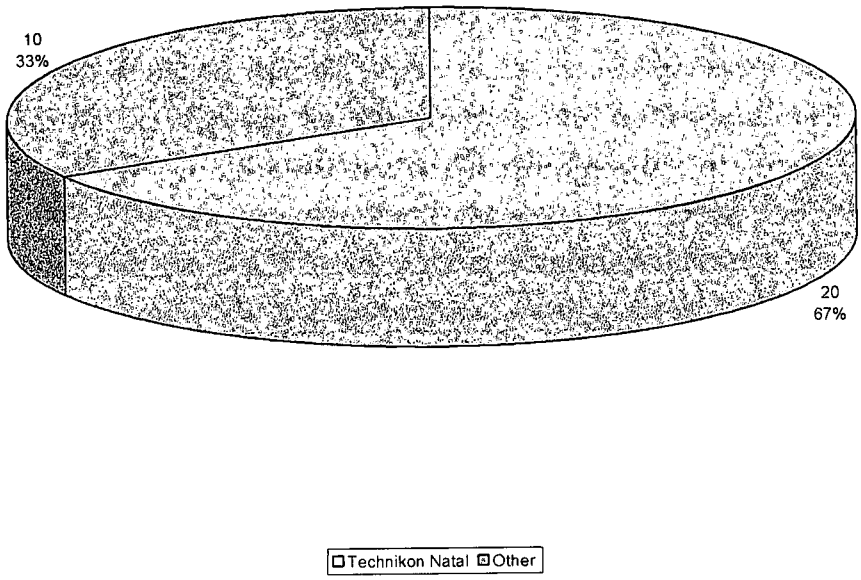

Figure 7. Qualification from Technikon Natal vs other.

Two thirds (66.7%) of the practitioners held a Master of Technology (Homeopathy) diploma or Masters of Technology (Homeopathy) degree from Technikon Natal, depending on the year of graduation. The qualification changed to a Masters of Technology in 1997. The remaining third held a Diploma in Homeopathy from a variety of schools, as listed below:

- APPCSA
- Bainstride College
- Delhi Homeopathic School
- Royal London Homeopathic Hospital
- Academy of Science (UK) – 2 practitioners
- College of Arts and Science
- Brindridge Forest School (UK)
- Other (2)

Seven practitioners held other professional degrees/ diplomas;

- Mb.Bch (Medical Doctor)
- B.Com (Law), BA Honours
- BA (Communication)
- B.Sc
- B.Sc (Agriculture)
- Dip. Technical Nursing
- Dip. Pharmacy

4.1.2.3 Other disciplines practiced alongside homeopathy (re: Q1.1.10)

Table 1 lists the other disciplines practised by the practitioners and the number of practitioners who practice these disciplines. Phytotherapy, naturopathy and acupuncture were the most common additional disciplines practised by the practitioners. Three out of the four black practitioners who participated in the study noted that they also practiced as traditional healers. Only one practitioner practised allopathic medicine, one chiropractic, one osteopathy and one ayurvedic medicine.

Table 1. Additional disciplines employed by the practitioner.

Discipline employed	**No. of practitioners**
Phytotherapy	21
Naturopathy	18
Acupuncture	16
Iridology	3
Reflexology	3
Traditional healer	3
Aromatherapy	2
Ayurvedic medicine	1
Allopathic medicine	1
Chiropractic	1
Healer	1
Osteopathy	1

4.1.2.4 Percentage of practice which is homeopathic (re: Q1.1.11)

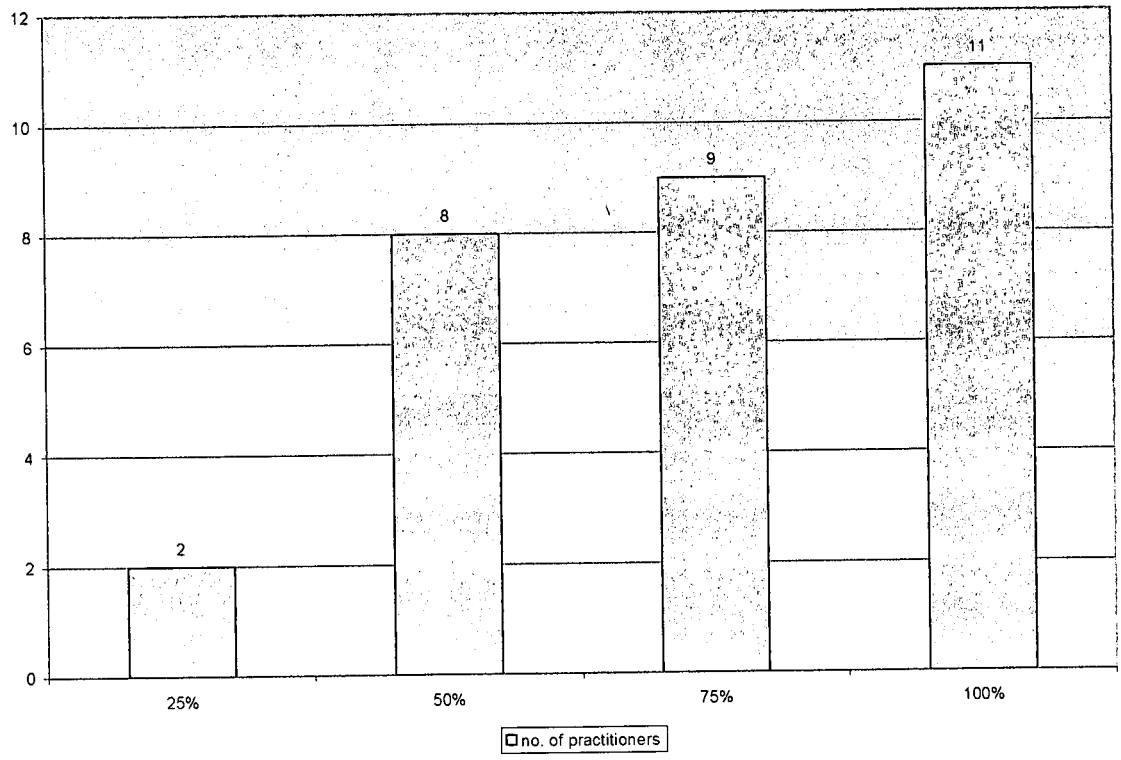

Figure 8. Practice breakdown by percentage of homeopathy practiced.

Twenty practitioners (66.7%) indicated that over 75% of their practice is homeopathy, eight practitioners indicated that the percentage of homeopathy practised was at 50%, and two practitioners at 25%. See Figure 8.

4.1.2.5 Type of practice (re: Q1.1.9)

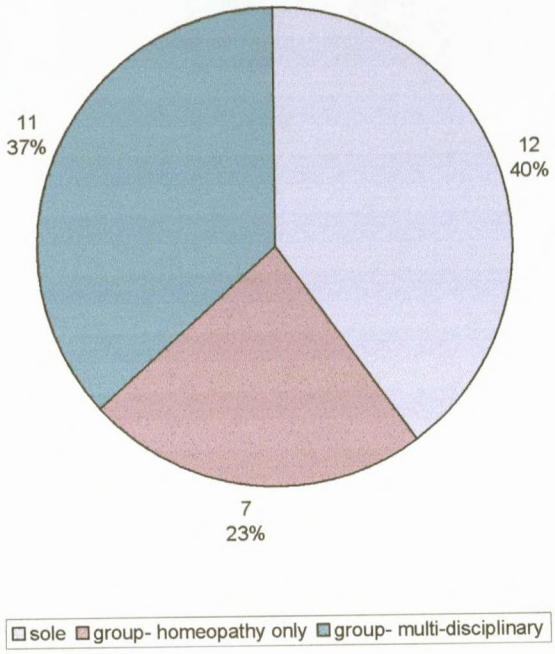

Figure 9.Type of practice.

In Figure 9, it can be seen that 40% of practitioners had solo practices, i.e. they practiced alone. 23.3% practiced with other homeopaths, this included three practitioners who practiced at the DIT Homoeopathic Day Clinic. 36.7% were part of a multi-disciplinary practice, which included other medical and complementary disciplines, namely General Practitioners, nurses, psychologists, physiotherapists, chiropractors, aromatherapists, and massage therapists.

4.1.2.6 Average patient load per week (re: Q1.1.12)

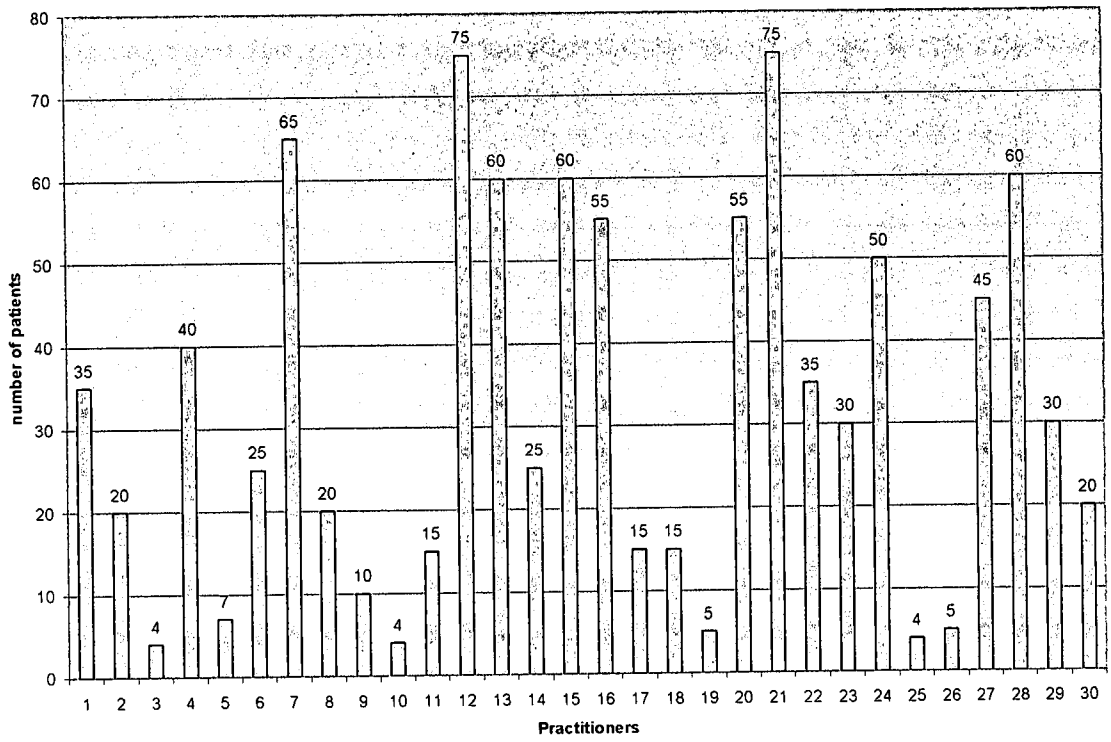

Figure 10. The average number of patients seen per week.

Figure 10 shows the average number of patients that are seen per week by each practitioner. The maximum is 75, and the minimum is 4. These results are dependent on the number of hours spent in the practice. Seven practitioners do not run a full time practice for the following reasons:

- Three practitioners are lecturers, and thus only practice 2-3 days per week;
- One practitioner works as a clinician in the Technikon Natal Homeopathic Day Clinic two afternoons per week;
- Two practitioners run a morning practice only;
- One practitioner works only one day per week.

4.1.2.7 Estimated average time for an initial and follow-up homeopathic consultation (re: Q1.1.13-14)

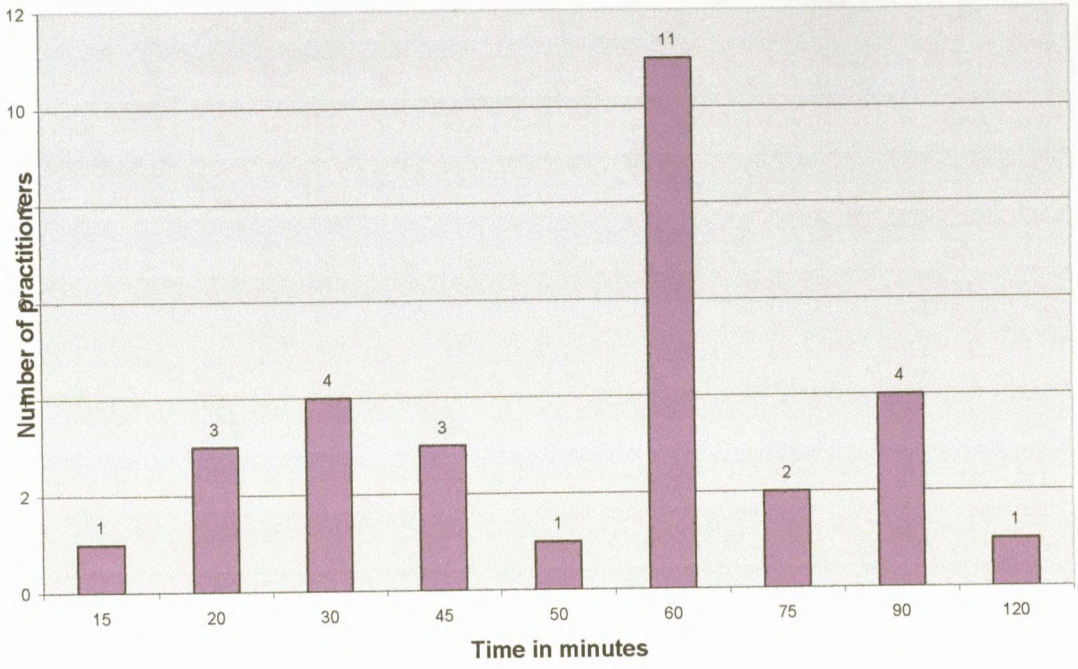

Figure 11. Duration of first consultation.

The average duration of the first consultation estimated by practitioners was 56 minutes. The estimated durations varied between practitioners from 15 minutes to 120 minutes for a first consult. 11 practitioners (36%) estimated that they spent 60 minutes on the first consultation. See Figure 11.

The average duration estimated by practitioners for the follow-up consultation was 36 minutes. In the follow-up consultation detailed in Figure 12, the estimated durations varied between practitioners from 10 minutes to 90 minutes. Eight practitioners (27%) estimated that they spent 45 minutes on the follow-up consultation.

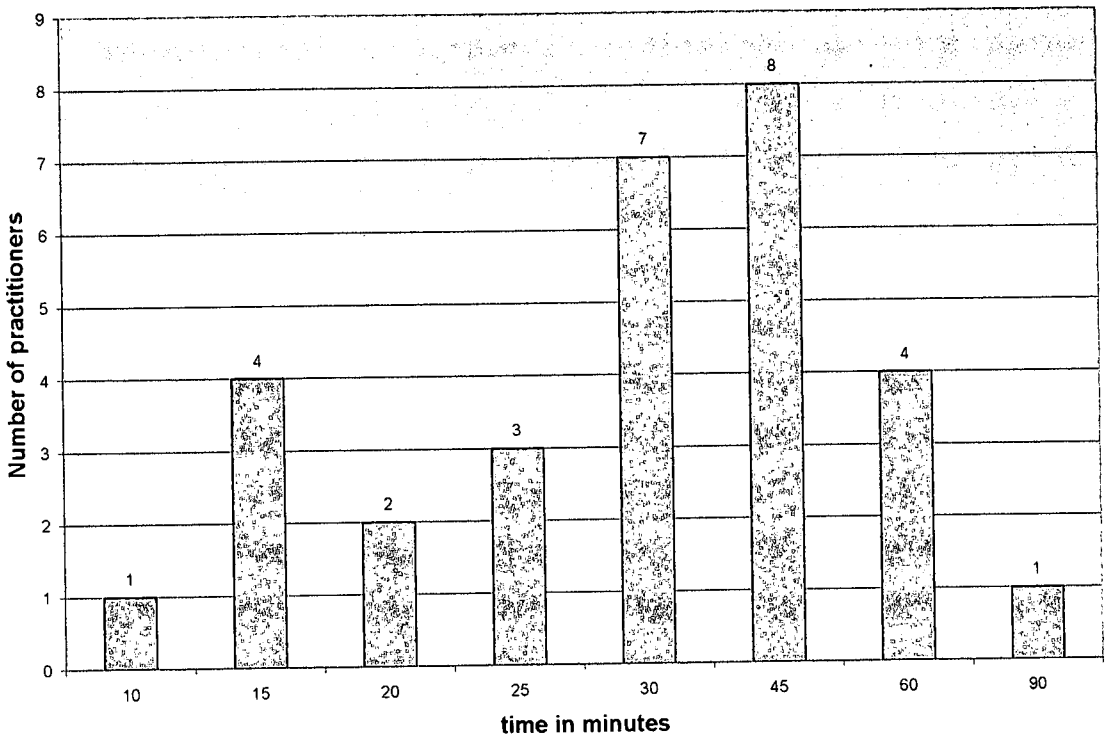

Figure 12. Duration of follow-up consultation.

4.1.2.8 Consultation fees (re: Q1.1.15-16)

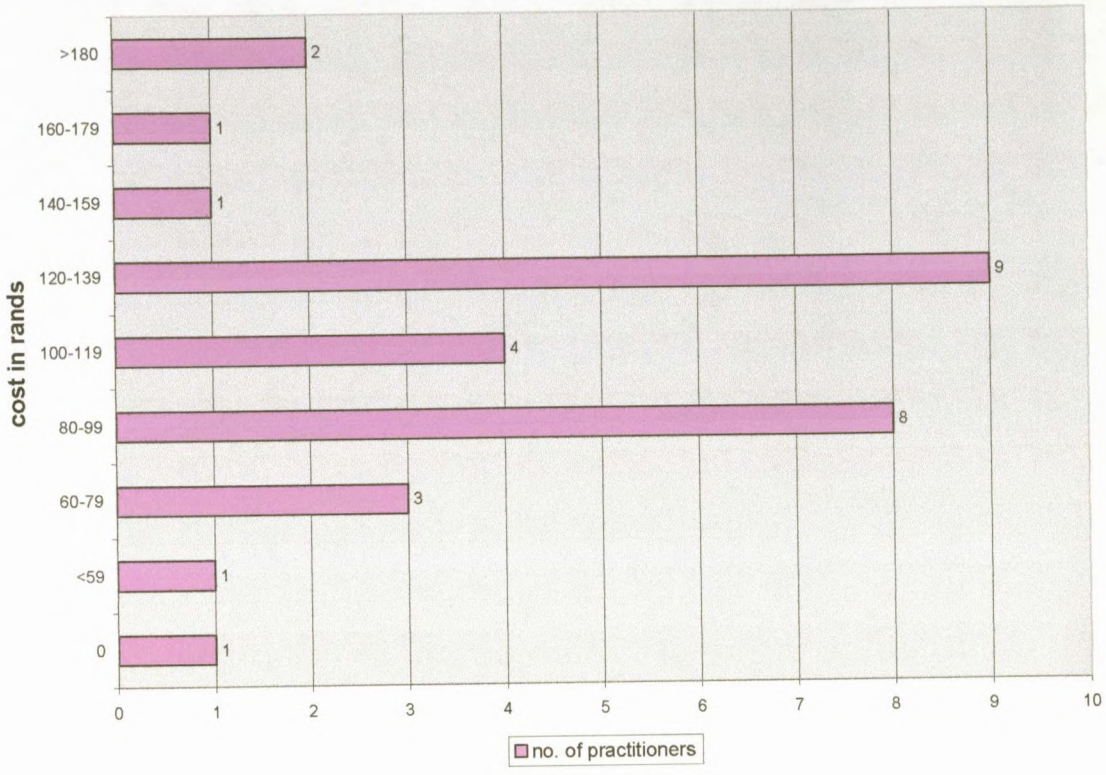

Figure 13. First consultation fee.

Figure 13 shows the range of first consultation fees, against the number of practitioners. The lowest cost was R56 and R375 was the highest. The average cost was R121.35. The average cost was based on 29 practitioners because one practitioner works at The Health Awareness Clinic[1], which operates on a donation basis.

[1] The Health Awareness Clinic is a volunteer clinic that provides homeopathic treatment to the public on a donation basis. The clinic was started by Swami Naryani and Swami Ananda in the early sixties in Durban. By 1968 the clinic work became full-time and with a mobile clinic they travelled throughout KZN. In the eighties the clinic was established as the Soham Sanctuary in Atlasville. The clinic is currently located in central Durban, as the Health Awareness Clinic.

The average fee for a follow-up consultation was R94.52. Figure 14 shows the range of follow-up consultation fees, against the number of practitioners. The most expensive follow-up consultations were R375.00. These were for the Quantum Xeriod Consciousness Interface (QXCI) [1] treatments.

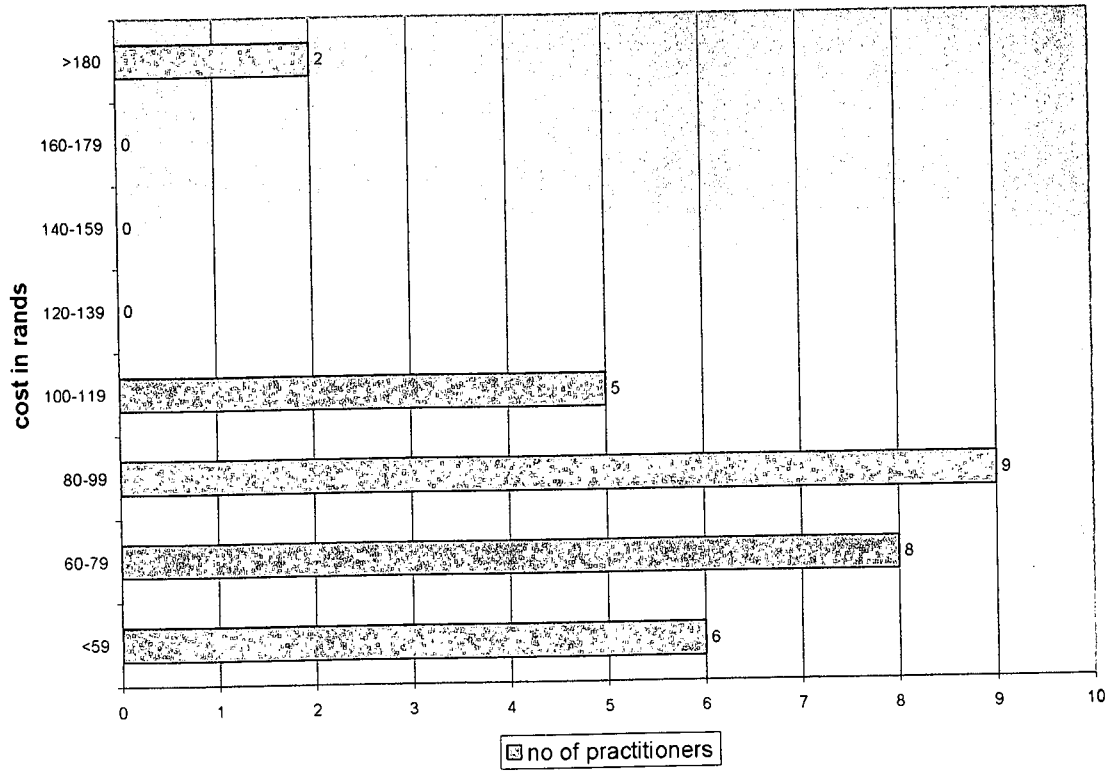

Figure 14. Follow-up consultation fee.

[1] See Footnote on page 48.

The consultation fees have been crosstabulated against area in Table 2. Practitioners in Durban were more expensive, charging an average of R140.35 per first consultation, whilst the average in Greater KZN was R94.42.

Table 2. The number of practitioners per area crosstabulated with first consultation fee.

Cost in rands	**Durban**	**Greater KZN**	**Total**
56	1		1
75	2	1	3
80	1	5	6
90		1	1
95		1	1
100	3		3
110		1	1
120	4	2	6
123		1	1
130	2		2
145	1		1
165	1		1
375	2		2
Average	R140.35	R94.42	29

4.1.2.9 Diagnostic and prescription aids (re: Q1.1.17-18)

The practitioners were asked if they used a repertory, pendulum, radionics or any other device or technique to aid their diagnosis and/or prescription. Nearly one third of the practitioners used a computer repertorising programme. Four practitioners said that they did not use any device to assist them. Two practitioners used the QXCI[1] and one practitioner used the Vegatest device[2]. Table 3 gives the results.

Table 3. Diagnostic and/or prescription aids (More than one answer was permissible).

Device or technique	**Number of practitioners**
Repertory	26
Computer repertorising programme	9
Pendulum	2
QXCI	2
Vegatest device	1
Pulse	1
Blood	1
Iridology	3
None	4

[1] This is a biofeedback device used for medical diagnosis and treatment Sensors are attached to the patient, by wires to the ankles, wrists and forehead that measure and feed resonsance information between the QXCI and the patient. The patients body is scanned for viruses, defiencies weaknesses, allergies, and food sensitivities, it reports on the biological reactivity and resonance in the patients body and indicates needs, dysfunctions and vulnerabilies. The system not only detects but provides therapies like the acupuncture, chakra, color, spiritual healing, detoxification, NLP, metabolic repair, and pain treatment to mention just a few. The promoters state that the QXCI far surpasses single parameter probe systems (Energetic-medicine, 2003).

[2] The Vegatest device is described as electroacupuncture. The organism's response to the appropriate test information is queried at a single skin measurement point. Practitioners first perform an energy screening to evaluate the patients regulatory and energy situation. Areas of evaluation, which include allergies, symptoms, organ weakness, heavymetal intoxification and dietry intolerance are then traced and prioritized. The Veagtest can also be used to ascertain compatable, effective prescriptions. Thus the Vegatest is promoted as simplyfying diagnosis and optimising therapy (Techmed, 2003).

4.1.2.10 Dispensary (re: Q1.1.19)

Table 4 gives details on the practitioners' dispensary status. Almost the entire study sample of practitioners dispensed their own medicine.

Table 4. Dispensary details.

	YES	NO	SOMETIMES
Do you dispense your own medicines?	29		1

4.1.2.11 Sources of new patients and referrals to other healthcare providers (re: Q1.1.23-24)

From Table 5 one can see that the majority of homeopaths felt that they gained most new patients from "self referral" i.e. where the patient may have heard about the doctor or taken the advice of a significant other who has seen the doctor. The only strong inter-referral relationship seemed to exist with chiropractors. The referrals from General Practitioners were fairly high but homeopaths tended to refer out to General Practitioners more often than they received referrals. 63% of the sample referred out to psychologists and gynaecologists sometimes, often or always. Most referrals by homeopaths were to chiropractors, General Practitioners, psychologists, gynaecologists or colleague homeopaths.

There were very few referrals to naturopaths and acupuncturists. This is probably because over 50% of practitioners practice these modalities themselves.

The "other" option includes referrals from health shops, pharmacists, reflexologists, aromatherapists, nursing staff and specialists.

Most practitioners mentioned specialists in the 'other' option as referral practitioners, these included surgeons, ENT specialists, cardiologists, urologists.

Table 5. Source of new patients and referrals to other healthcare providers.

	Source of patients			Referral of patients		
	Seldom or never	**Some-times**	**Often or always**	**Seldom or never**	**Some-times**	**Often or always**
Self referral/ advice of significant other	1	4	25			
Naturopath	28	1	1	27	2	1
Chiropractor	12	16	2	12	11	7
Physiotherapist	24	4	2	18	10	2
Acupuncturist	29	1		27	3	
Colleague homoeopath	17	9	4	13	16	1
General practitioner	15	12	3	10	20	
Psychologist	19	6	5	11	17	2
Paediatrician	25	3	2	16	12	2
Gynaecologist	23	4	3	9	17	4
Other						

4.1.2.12 Ongoing education (re: Q1.1.20-22)

4.1.2.12.1 Journal subscription

16 practitioners responded that they did not subscribe to any medical or homeopathic journals. The three practitioners, who practice from the DIT Homoeopathic Day Clinic, have access to journals via the DIT library.
Table 6 gives details of which journals are subscribed to.

Table 6. Journal subscription (More than one answer was permissible).

Journal	**Number of practitioners**
Homeopathic Links	5
British Homeopathic Journal	2
Health and Homeopathy	1
S.A journal of complementary therapy	3
Update	3
S.A. Medical journal	2
Modern Medicine	2
Medical chronicle	1
Biological therapy	1
Vegatest device	1

4.1.2.12.2 Attendance at homeopathic conferences in the last 12 month period

Table 7 Conference attendance (More than one answer was permissible).

Conference name	**No. of practitioners**
SACMA	12
-Heel Seminar	5
Snakes and spiders	2
The Alchemy of potentisation	1
David Lilly	1

53% (16) had attended homeopathic conferences over the past 12 months. Table 7 gives details of which were attended. The South African Complementary

Medicines Association (SACMA) conference was most popular, with 12 practitioners attending.

4.1.2.12.3 Areas for further education

Although Continuing Professional Development (CPD) points are not yet compulsory, the system is being set up by the AHPCSA. The areas that the practitioners felt they would like to see covered in order to earn CPD points are listed in Table 8.

Table 8. Areas of interest that practitioners would like to learn more on.

Area	**No. of practitioners**
Emergency procedures	16
Materia Medica	14
Homeopharmaceutics	13
Pathology	13
Diagnostics	12

Other areas listed were; paediatrics, iridology, ayurvedic, nutrition and life skills.

4.2 Data related to Questionnaire 3 – Study sample patient (n = 158) demographics

4.2.1 Gender, age, race and home language (re: Q3.1.2-3, Q3.1.5-6)

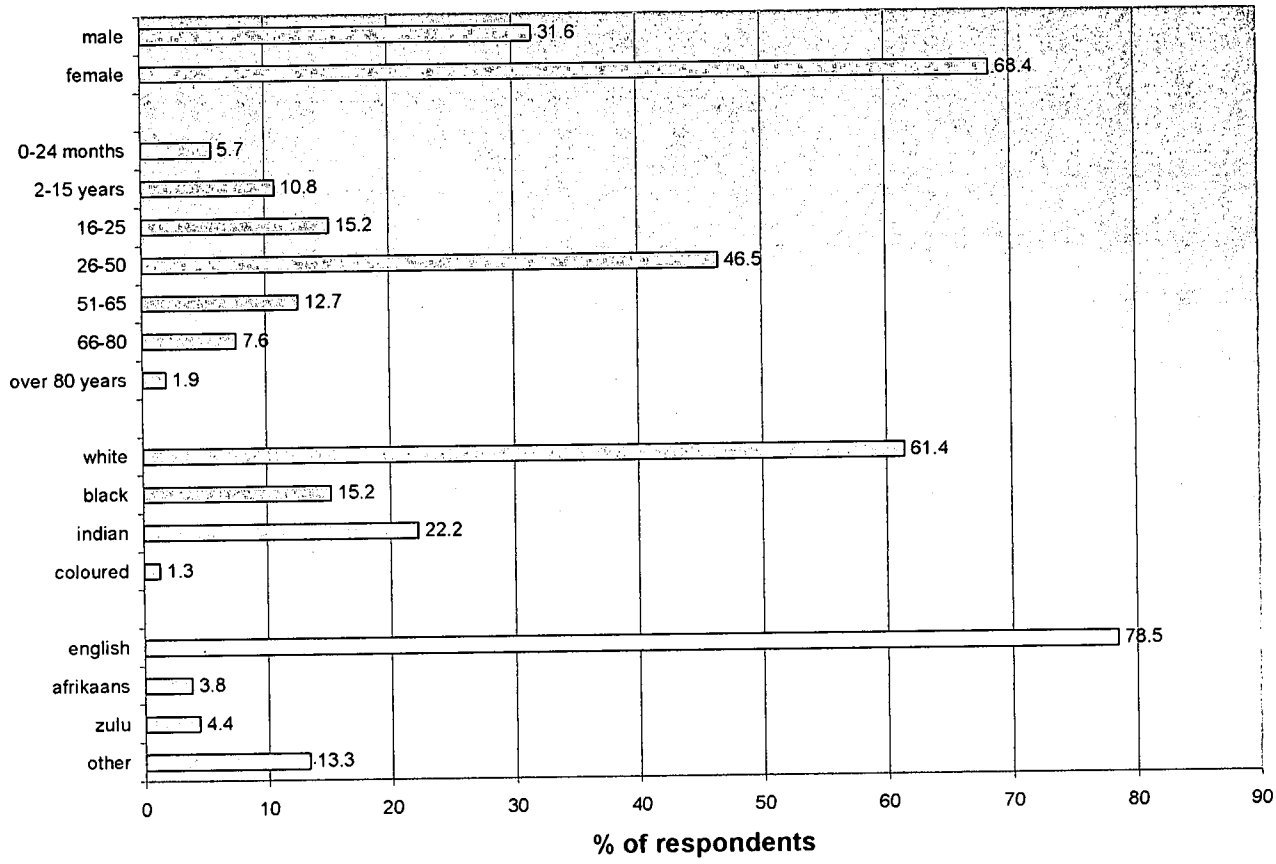

Figure 15. Gender, age, race and home language of patients.

As can be seen from Figure 15 the majority of patients consulting the homeopaths covered in this study were white, English speaking females between the ages of 26-50 years.

4.2.2 Occupation (re: Q3.1.4)

Table 9. Patient occupation.

Occupation	Frequency	Percentage
Housewife	22	13.9
Student	17	10.8
Infant	16	10.1
Clerical	15	9.5
Professionals	15	9.5
Teacher	13	8.2
Pensioner	13	8.2
Scholar	10	6.3
Managers	6	3.8
Artisan/tradesman	6	3.8
Self employed	5	3.2
Therapists	4	2.5
Marketing & sales	4	2.5
Designer & decorators	4	2.5
Unemployed	3	1.9
Farmer	2	1.3
Information Technology	2	1.3
Industrial	1	.6
	158	100

The patients covered a large variety of occupations as listed in Table 9. Clerks, teachers and professionals formed the largest remuneratively employed groups. Less than 2% were unemployed. Housewives made up 13.9% and pensioners 8.2% of the survey population. A large portion of the study population were infants and children (16.4%). Students also filled a substantial group with 10.8%.

4.2.3 Medical aid scheme membership and reimbursement (re: Q3.1.7-8)

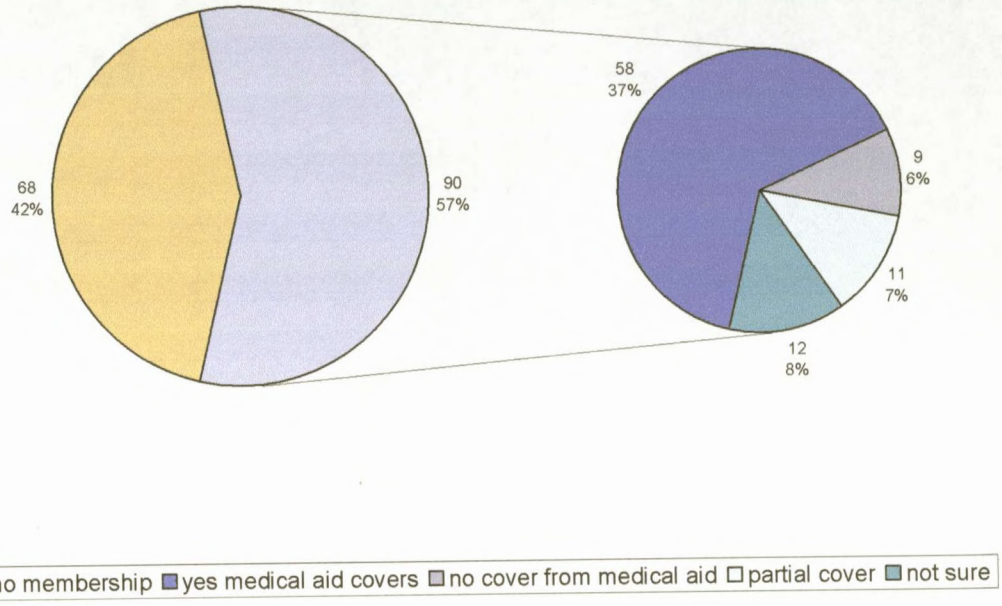

Figure 16. Medical aid scheme membership and cover.

More than half of the respondents (57%) belong to a medical aid scheme. Of these, the majority (58) stated that homeopathic consultations are covered by their medical aid. Nine responded that their medical aids did not cover, and eleven are partially covered. See Figure 16.

4.2.4. Main complaints

4.2.4.1 Duration of complaint (re: Q3.1.10)

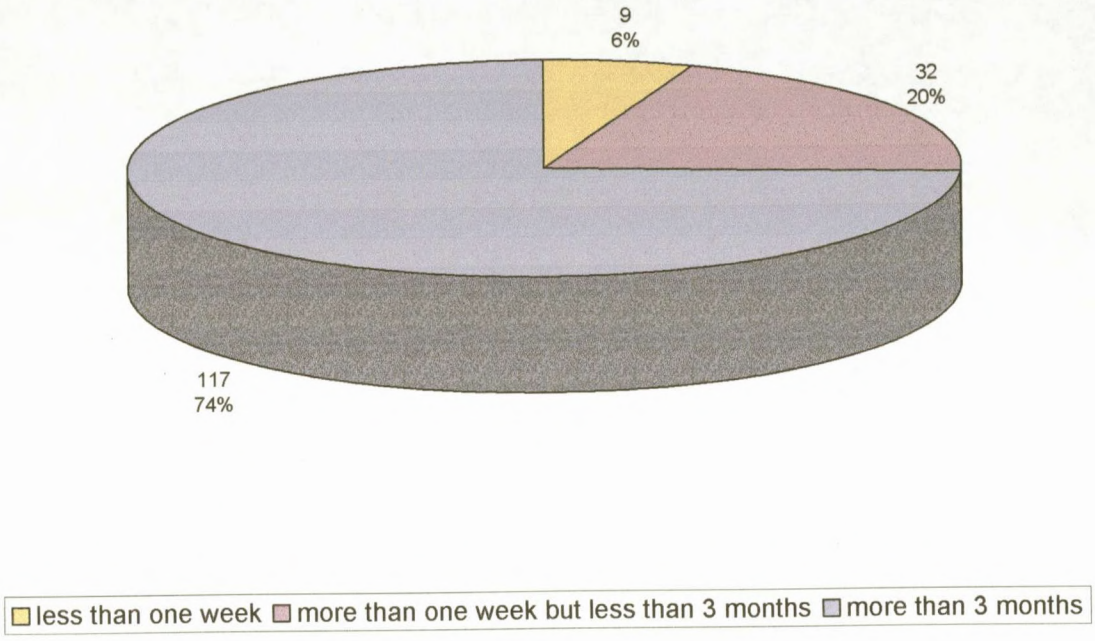

Figure 17. Duration of complaint.

The complaints are largely of a chronic nature. In Figure 17, it can be seen that 74.1% of patients had been suffering from their condition for more than three months.

4.2.4.2 Recurring complaints (re: Q3.1.11)

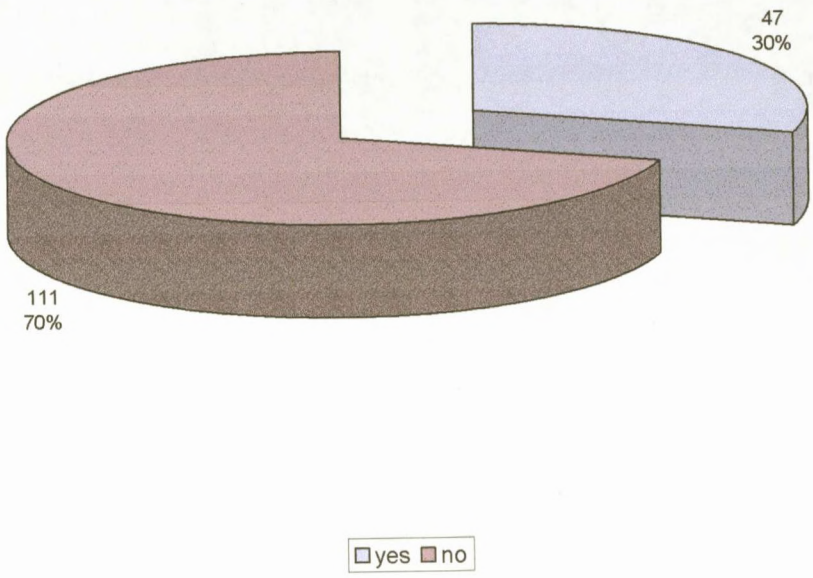

Figure 18. Recurring complaints.

70.3% of patients responded that this was not the first time that they had experienced the complaint. See Figure 18.

4.2.5 Main complaints (re: Q3.1.9)

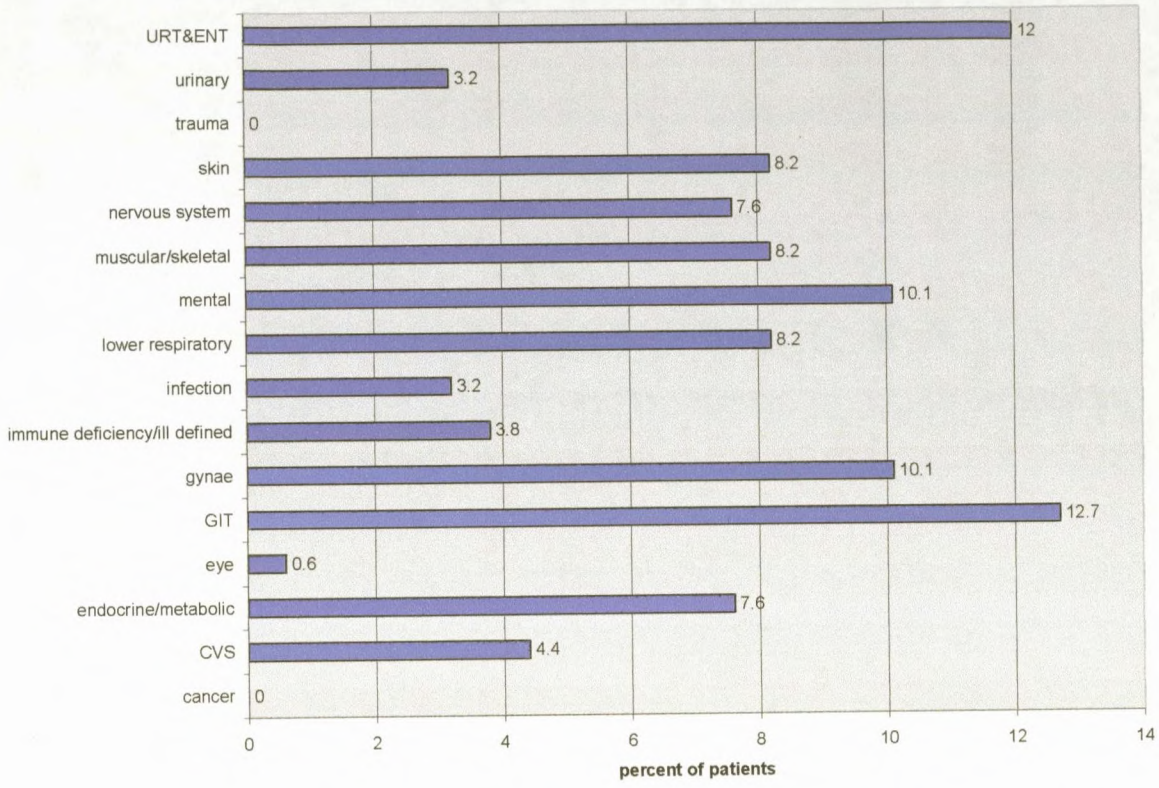

Figure 19. Diagnostic group break-down of the patient's main complaints.

From Figure 19 it can be seen that the main complaints were spread across many diagnostic categories. Gastro-Intestinal tract pathology amounted to the largest diagnostic group at 12.7% of respondents. A second important area of pathology was upper respiratory tract (URT) and ear, nose and throat (ENT) at 12%. Mental illness and gynaecological pathology were also dominant areas with 10.1% of patients falling in these diagnostic groups. Other important areas were lower respiratory, muscular-skeletal, skin and nervous system conditions. Homeopaths participating in this study were not consulted for complaints that would fall into cancer and trauma categories.

Table 10 gives a detailed list of the specific conditions that were treated by homeopaths participating in this study. Sinusitis/ allergic rhinitis and depression were most prevalent.

Table 10. Prevalence of specific main complaints amongst patients.

Rating	Main Complaint	No. of pts.	% of pts.	Rating	Main Complaint	No. of pts.	% of pts.
1	sinusitis/allergic rhinitis	13	8.2	43	colic	1	0.6
2	depression	11	7.0	44	conjunctivitis	1	0.6
3	migraine/headache	7	4.4	45	croup	1	0.6
4	arthritis	7	4.4	46	duodenal ulcer	1	0.6
5	asthma	5	3.2	47	dyspepsia	1	0.6
6	bronchitis	5	3.2	48	emphysema	1	0.6
7	menopause	5	3.2	49	enuresis	1	0.6
8	eczema	4	2.5	50	fibroids	1	0.6
9	abscess	3	1.9	51	fungal infection	1	0.6
10	anxiety	3	1.9	52	ganglion	1	0.6
11	food allergies	3	1.9	53	gastro reflux	1	0.6
12	influenza	3	1.9	54	gastro-enteritis	1	0.6
13	acne	2	1.3	55	hepatic duct block	1	0.6
14	anaemia	2	1.3	56	hyperglycaemia	1	0.6
15	constipation	2	1.3	58	hypertension	1	0.6
16	cystitis	2	1.3	59	immune boost	1	0.6
17	diabetes mellitus	2	1.3	60	Incontinence	1	0.6
18	dysmenorrhoea	2	1.3	61	induced indigestion	1	0.6
19	fatigue	2	1.3	62	Infertility	1	0.6
20	hiatus hernia	2	1.3	63	labial cyst	1	0.6
21	hypoglycaemia	2	1.3	64	loss of weight	1	0.6
22	hypotension	2	1.3	65	lymph adenopathy	1	0.6
23	hypothyroidism	2	1.3	66	memory loss	1	0.6
24	IBS	2	1.3	67	metrorrhagia	1	0.6
25	insomnia	2	1.3	68	molluscum contagiosum	1	0.6
26	neurasthenia	2	1.3	69	morning sickness	1	0.6
27	otitis media	2	1.3	70	myalgia	1	0.6
28	round worms	2	1.3	71	nicotine addiction	1	0.6
29	sciatica	2	1.3	72	orchitis	1	0.6
30	tonsillitis	2	1.3	73	otorrhoea	1	0.6
31	acute gout	1	0.6	74	ovarian cyst	1	0.6
32	adhesive capsulitis	1	0.6	75	post viral	1	0.6
33	angina	1	0.6	76	psoriasis	1	0.6
34	angular stomatitis	1	0.6	77	teething	1	0.6
35	ascites	1	0.6	78	tendonitis	1	0.6
36	bi-polar	1	0.6	79	trigeminal neuralgia	1	0.6
37	bladder spasm	1	0.6	80	tuberculosis	1	0.6
38	BPH	1	0.6	81	uraethemia	1	0.6
39	bromhidrosis	1	.0.6	82	urticaria	1	0.6
40	candidiasis	1	0.6	83	venous insufficiency	1	0.6
41	cellulites	1	0.6	84	verrucea	1	0.6
42	chronic URT	1	0.6		Total no. of patients	158	

4.3 Data related to Questionnaire 2 – consultation and treatment characteristics

4.3.1 The case history (re: Q2.3.1.1-2)

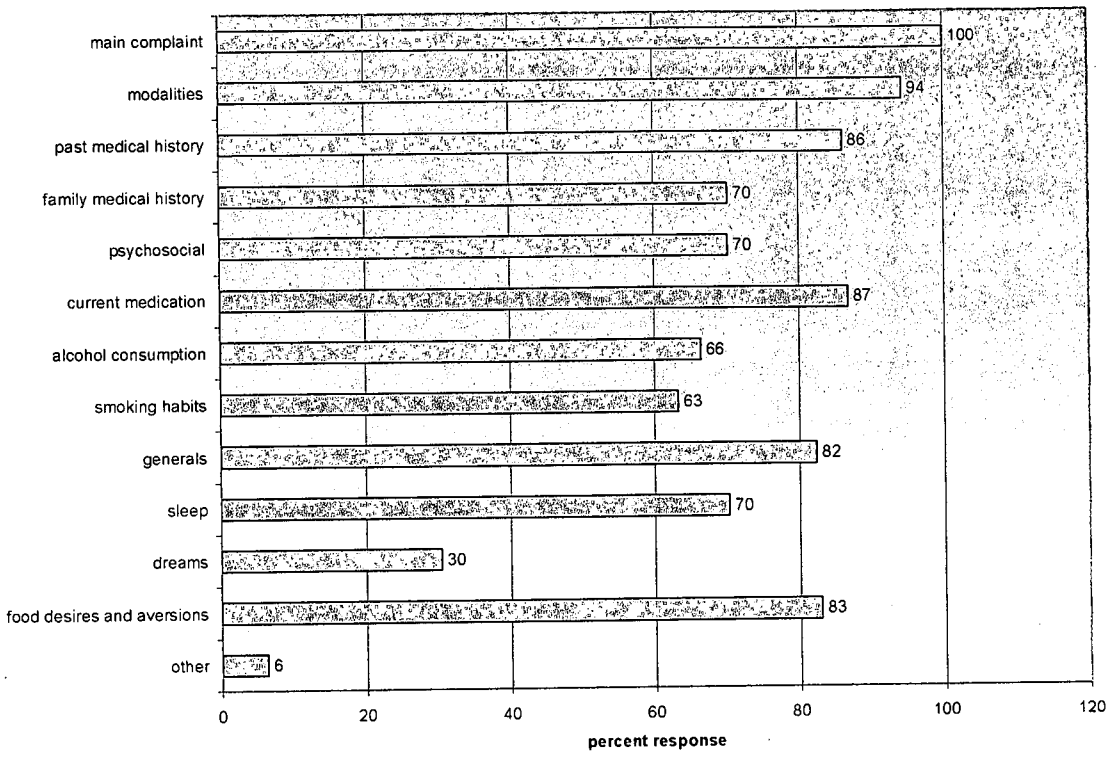

Figure 20. Areas covered in the case history.

All practitioners took a case history of the main complaint. Figure 20 illustrates by means of a bar chart the areas covered in taking the case history. Modalities of the main complaint were elicited in 94% of the cases. Past history, current medication, generals and food preferences were covered in over 82% of the consultations. 70% of the consultations covered areas of psycho-social, family history and sleep patterns. Smoking and alcohol consumption was discussed in 63% and 66% of the consultations respectively. Dreams were covered in 30% of the consultations. The areas listed as 'other' included gynaecological and sexual history, gastrointestinal tract and spiritual.

4.3.2 The physical examination (re: Q2.3.2.1-2)

A physical examination was undertaken in 134 consultations (85%). Three quarters of the patients who were physically examined had their blood pressure and pulse taken (74% and 75%, respectively). The areas examined corresponded to the main complaint. The areas of respiratory rate, chest, mouth, and glands were examined in more than 40% of the patients. See Figure 21.

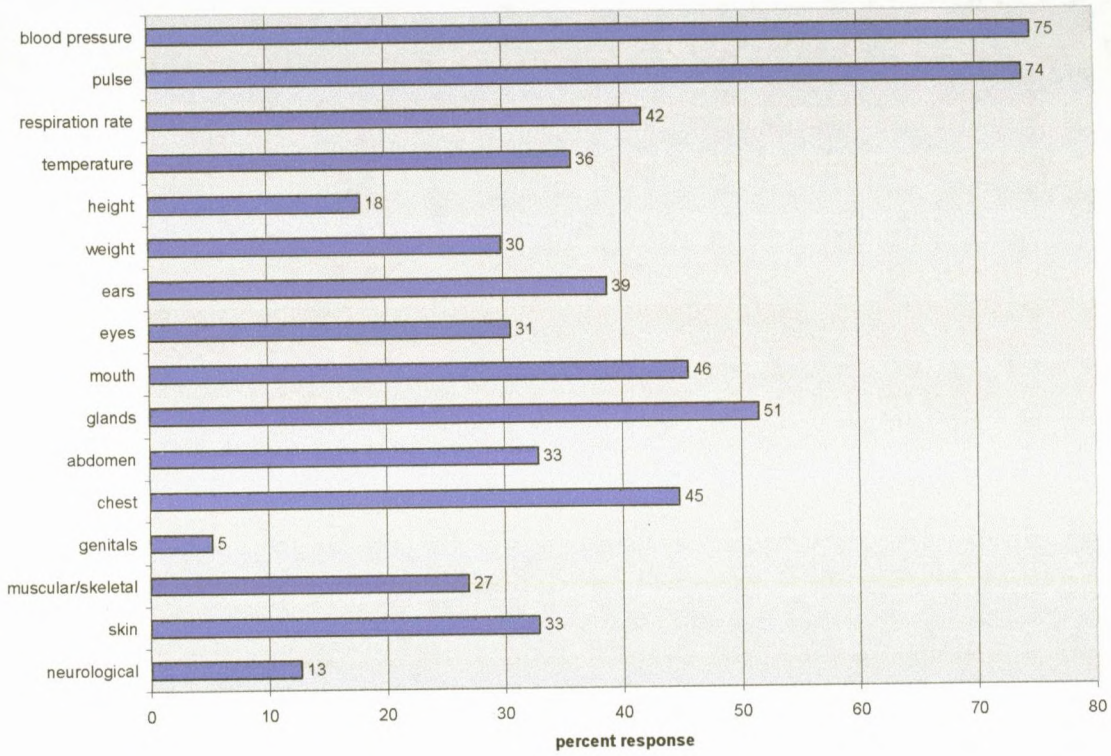

Figure 21. Areas covered in the physical examination.

4.3.3 Tests undertaken or requested (re: Q3.3.3-6)

Table 11. Tests undertaken or requested (more than one option available).

Blood & urine	**No. of patients**	**% of patients**
None	132	83.5%
Blood	13	8.2%
Urine	11	7%
Both blood and urine	2	1.3%
Other		
None	134	84.8%
Glucose	4	2.5%
QXCI	10	6.3%
Vegatest device	10	6.3%

In Table 11 it can be seen that very few special investigative tests were performed. Blood tests were ordered for 9.5% of the patients. Urine dipstick tests were undertaken for 8.2% of the patients. The only other orthodox medical investigative test listed included glucose tests for four (2.5%) patients. The practitioners who utilised the Vegatest and QXCI machines used these machines for investigative purposes for every patient that they saw.

4.3.4 Length of consultation (re: Q2.4.9)

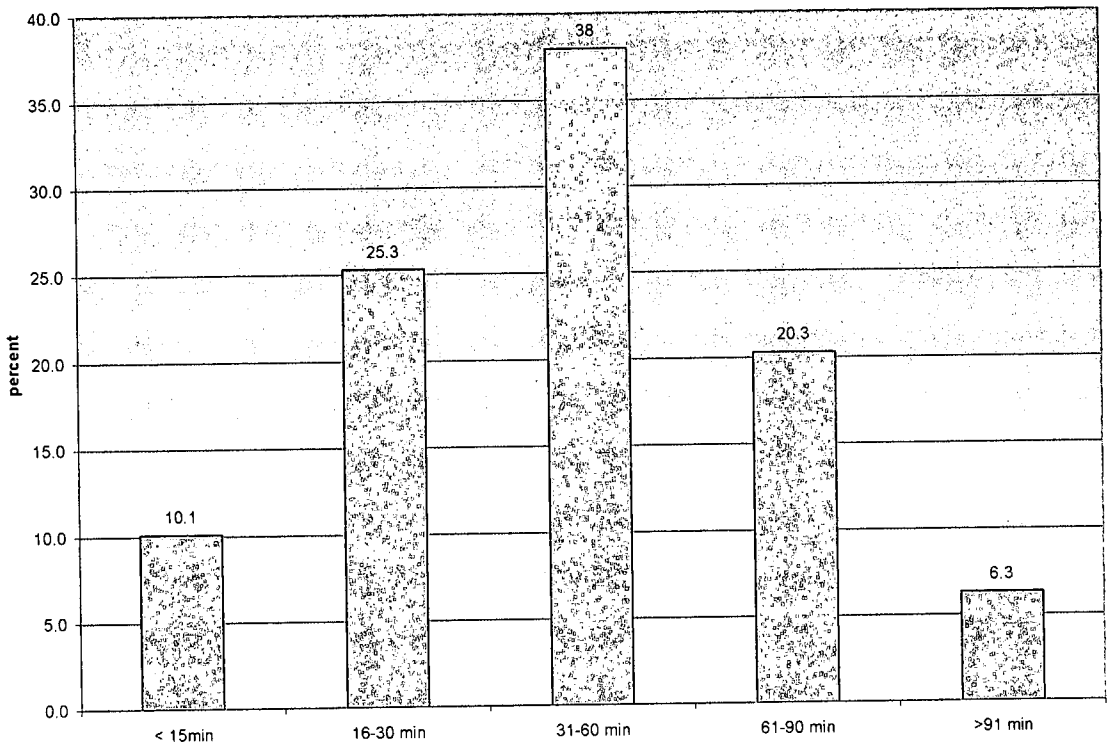

Figure 22. Duration of initial consultation.

From Figure 22 one can see that for the majority (38%) of the initial consultations, practitioners spent between 31-60 minutes. Sixteen consultations (10.1%) were less than 15 minutes.

4.3.5 Repertory use (re: Q2.4.3)

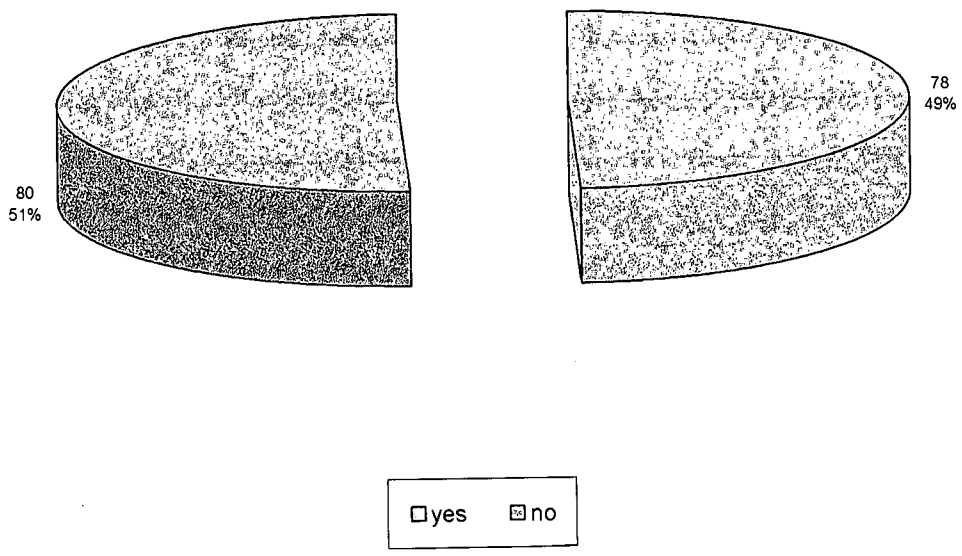

Figure 23. Repertory use.

Looking at Figure 23 one can see that of the total 158 prescriptions, just under half were made with the aid of a repertory.

4.3.6. Approaches to analysing cases (re: Q2.4.4)

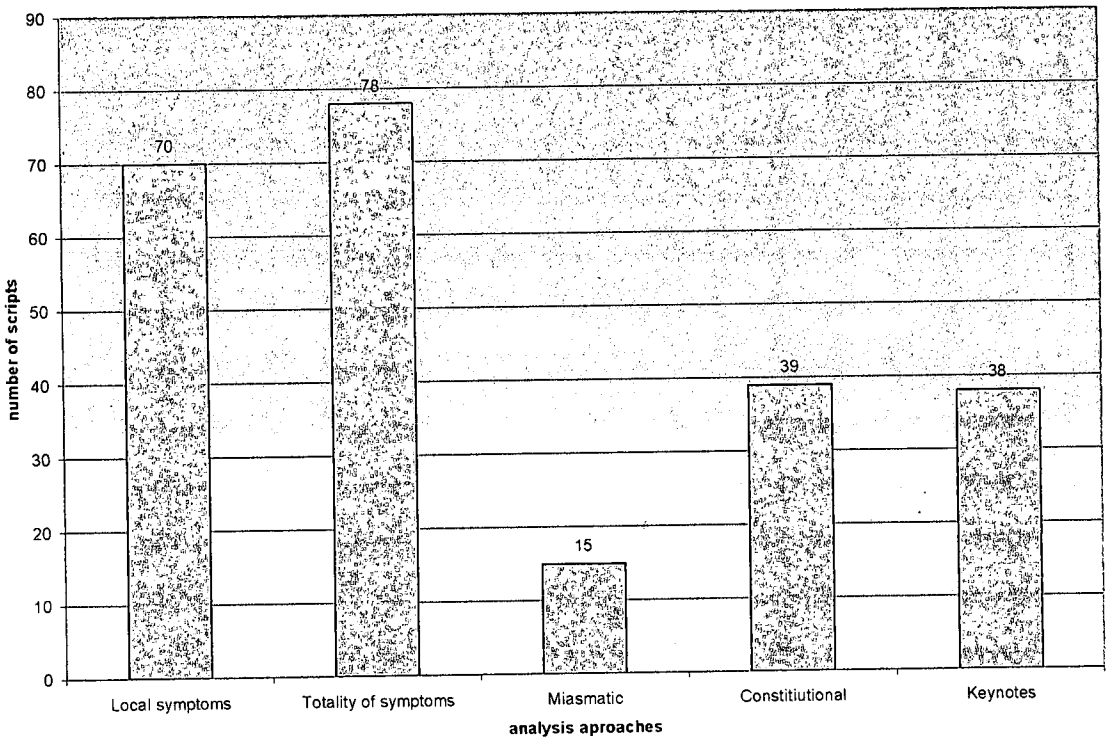

Figure 24. Basis of prescription (more than answer was permissible).

In more than half of cases (51%) the approach most relied on to analyse the case was "totality of symptoms", followed by "local symptoms" (45.8%). "Constitutional prescribing" was at 25.5%, followed closely by "keynotes" (24.8%). The patient's miasmatic state was used as a basis for prescribing in 9.8% of cases. See Figure 24.

4.3.7 Treatment prescribed

4.3.7.1 Prescription of homeopathic medicine (re: Q2.4.1-4.1.1)

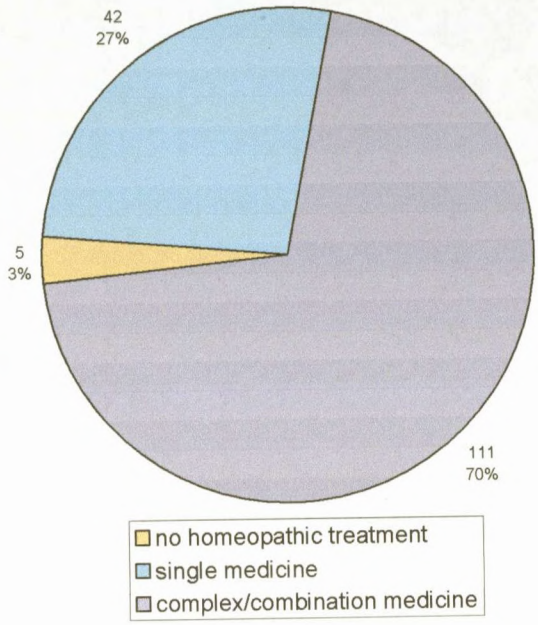

Figure 25. Single medicine vs complex/combination medicines.

Homeopathic treatment was prescribed in 96.8% of cases. From Figure 25 it can be seen that single medicines were prescribed in 27.5% of the cases. The majority of patients were prescribed complex or combination medicine. 60 complexes were prescribed, 29 of these being homeopathic complex medicines supplied by Natura, Weleda or -Heel. Twenty one complexes listed were prescribed at the Health Awareness Clinic which has its own complexes. The remaining ten complexes were the QXCI drops that are made during treatment on the machine. Nineteen patients received more than one complex

The treatment prescribed for the five cases that did not receive homeopathic treatment are shown in Table 12 .

Table 12 Patients that did not receive homeopathic treatment.

Main complaint	Treatment option
Benign prostatic hypertrophy	Herbal supplement
Ascites	Referred to hospital no treatment given
Panic attacks	Bach flower medicines and counselling
Myalgia	Acupuncture
Depression	Bach flower medicines and herbal supplements

4.3.7.2 Most frequently prescribed homeopathic medicines (re Q24.2)

Excluding complexes, 97 different medicines were prescribed either as a single medicine or in combination with 2-4 other medicines. Figure 26 shows the 31 most frequently prescribed medicines based on percentage of prescriptions. The top five medicines included Natrum muriaticum, Silicea, Lycopodium, Aconite, and Pulsatilla. Natrum muriaticum was prescribed to 25 people, making up 15.8% of the total scripts.

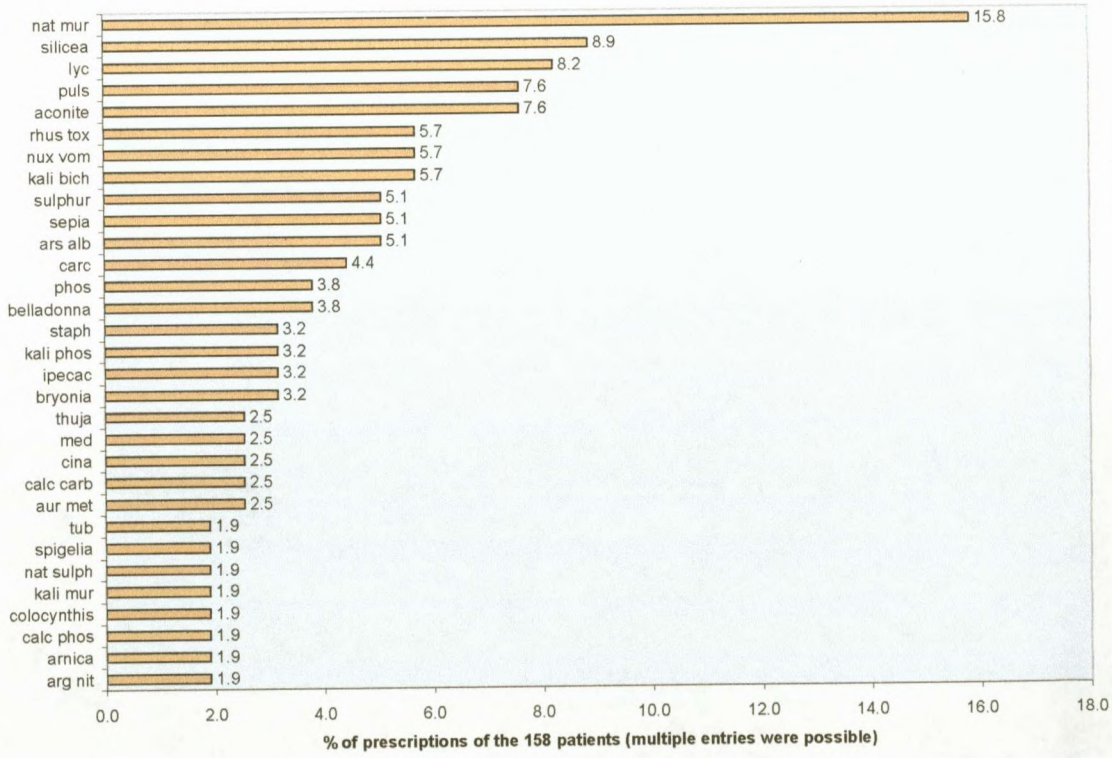

Figure 26.The most frequently prescribed medicines.

4.3.7.3 Posology (re:Q2.4.1.1-4.2)

4.3.7.3.1 Single medicine posology – unincist

Table 13 gives details of posology techniques. Within the 42 single medicine scripts a large variety of posology techniques were followed by the practitioners. 10 scripts consisted of a single dose of a single homeopathic medicine in low or medium or high potency. Of these the five scripts of a single dose of a single medicine in a high potency (10M) were prescribed by one practitioner only. Multiple dosing was prescribed more readily. Doses were either taken weekly or bimonthly (4 scripts) or on consecutive days (14 scripts).

Only one LM was prescribed, with five cases receiving plussed potencies. Eight scripts were for ascending potencies (i.e. 30/200/M). 17 scripts consisted of low potency selection (30c or lower), this included three of the plussed medicines.

4.3.7.3.2 Multiple medicine posology – pluralist

Again a large variety of ways of prescribing is evident. 19 scripts were for combination medicines i.e. 2-4 medicines at one time taken in multiple doses daily. 16 scripts were for a single complex, whilst 19 scripts were for 2-3 complexes, both taken in multiple doses daily. 14 scripts were for two alternating low potency medicines, taken daily. Another common practice was to give three doses of a single medicine over a period of two weeks, supplemented by a low potency medicine or complex daily (22 scripts), or a variation of this to give ascending potency's of the medicine supplemented with daily doses of a low potency single medicine or a complex (13 scripts). See Table 13.

Table 13. Posology techniques.

Single medicine: (unicist))	**No. of patients**	**No. of practitioners who use this method**
Single dose high potency (10M)	5	1
Single dose medium potency (200-1M)	3	2
Single dose low potency (30C or lower)	2	2
Multiple dosing weekly or bimonthly of high or medium potency	1	1
Multiple dosing weekly or bimonthly of low potency	0	0
Multiple dosing weekly or bimonthly of ascending potency	3	1
Multiple dose, 3-10 doses consecutively high or medium potency	7	3
Multiple dose, 3-10 doses consecutively low potency	3	3
Multiple dose, 3-10 doses consecutively ascending potency	4	4
Single medicine, multiple dose daily low potency	8	6
LM potency	1	1
Plussed potency	5	2
	42	
More than one medicine: (pluralist)		
Single dose high or medium with weekly or daily low potency	1	1
Multiple dosing weekly of high/medium potency and daily low potency	2	2
Ascending potency (30,200,M) with daily low potency or complex	13	4
Split dose (3x30, or 3x200) with weekly or daily low potency or complex	22	6
Split dose (3x30, or 3x200) with high potency for acute	2	1
2-4 medicines together, multiple doses daily	19	7
Low potency alternating 2 single medicines daily	14	9
Complex multiple doses daily	16	6
Multiple complex, multiple doses daily	19	5
	108	
Missing data:		
No medicine prescribed	5	3
not enough detail on Posology	3	1
	8	
TOTAL NO OF PATIENTS	**158**	

4.3.7.3.3 The relationship between the type of homeopathic treatment given and the type of training.

A crosstabulation (Table 14) of treatment type against DIT graduates and non-graduates has been performed. Because the practical training at DIT changed between 1995 and 1996, from pluralist, clinical homeopathy to more classical, the DIT graduates have been divided into two groups depending on the year of internship at the DIT Homoeopathic Day Clinic. The Pearson's Chi-Square Test was used to test the relevant hypothesis (see 3.4.1.1).

Table 14. Crosstabulation regarding the type of homeopathic treatment given and the type of training.

year in clinic * type of homeopathy Crosstabulation

Count

		type of homeopathy			
		classical	pluralist	complex	Total
year in clinic	1993-1995	15	46	19	80
	1996+	23	15		38
	not Tech graduate	4	12	16	32
Total		42	73	35	150

Table 15. Chi-Square Test 1.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	40.936[a]	4	.000
Likelihood Ratio	44.847	4	.000
Linear-by-Linear Association	.667	1	.414
N of Valid Cases	150		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.47.

Table 15 shows that the test gives a P value = .000 (<.001) < .05. Therefore it has been established that there is an association (dependency) between the two characteristics. Thus the type of homeopathic treatment practiced by the

graduates of TN/DIT who participated in this study correlates with the year in which they did their practical training, and reflects the type of homeopathy that the practitioner has been trained in.

4.3.7.4 Placebo (re: Q2.4.5)

Fourteen scripts included placebo doses, 13 of these scripts were for support for a single medicine choice of medium to high potency. One script used the placebo as continuity for four days after an ascending dose of one medicine, before beginning a second low potency medicine. Four practitioners utilised placebo medicines within the script, reasons given included ensuring patient compliance, continuity and patient need.

4.3.7.5 Non-homeopathic prescriptions (re: Q2.4.5)

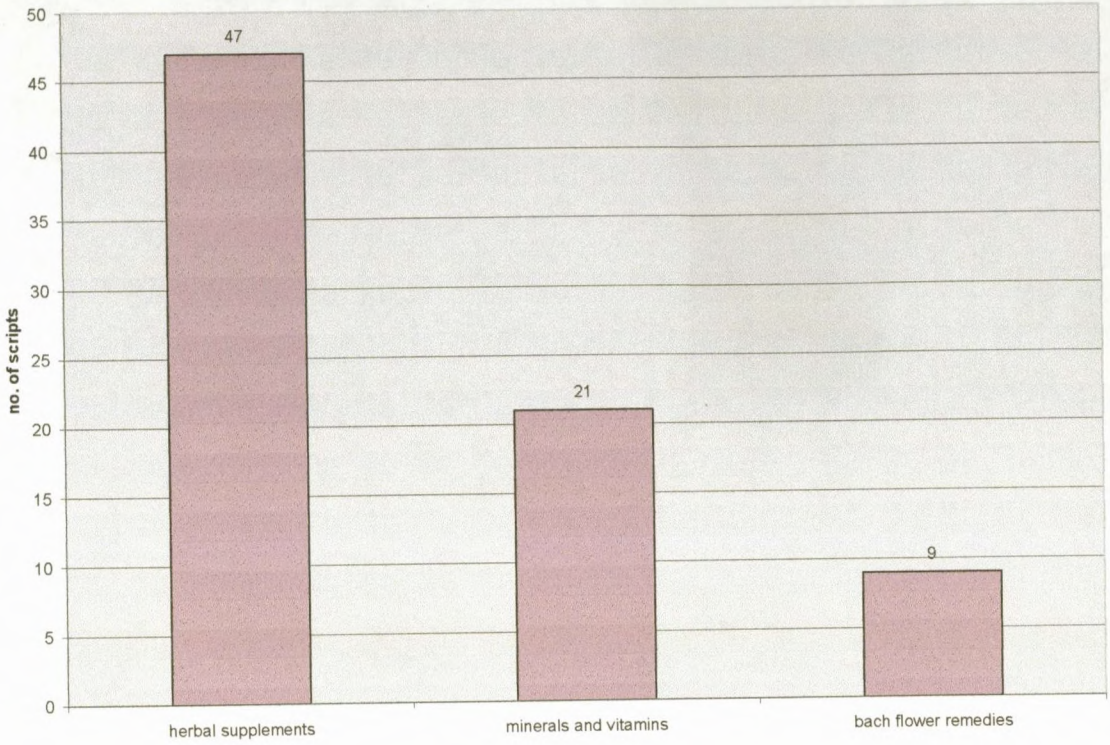

Figure 27. Other medicines prescribed.

Figure 27 shows that the use of non-homeopathic prescriptions was limited, with less than half of the patients being prescribed herbal, mineral and vitamins or Bach flower remedies. Herbal supplements were prescribed for 47 cases, mineral and vitamins for 21 and Bach flower remedies for nine patients. Herbal, minerals and vitamin supplements were given for a variety of conditions, across diagnostic groups, however two thirds of the patients who were given Bach flower remedies, suffered from mental or nervous system complaints.

4.3.7.6 Other treatment given (re: Q2.4.6)

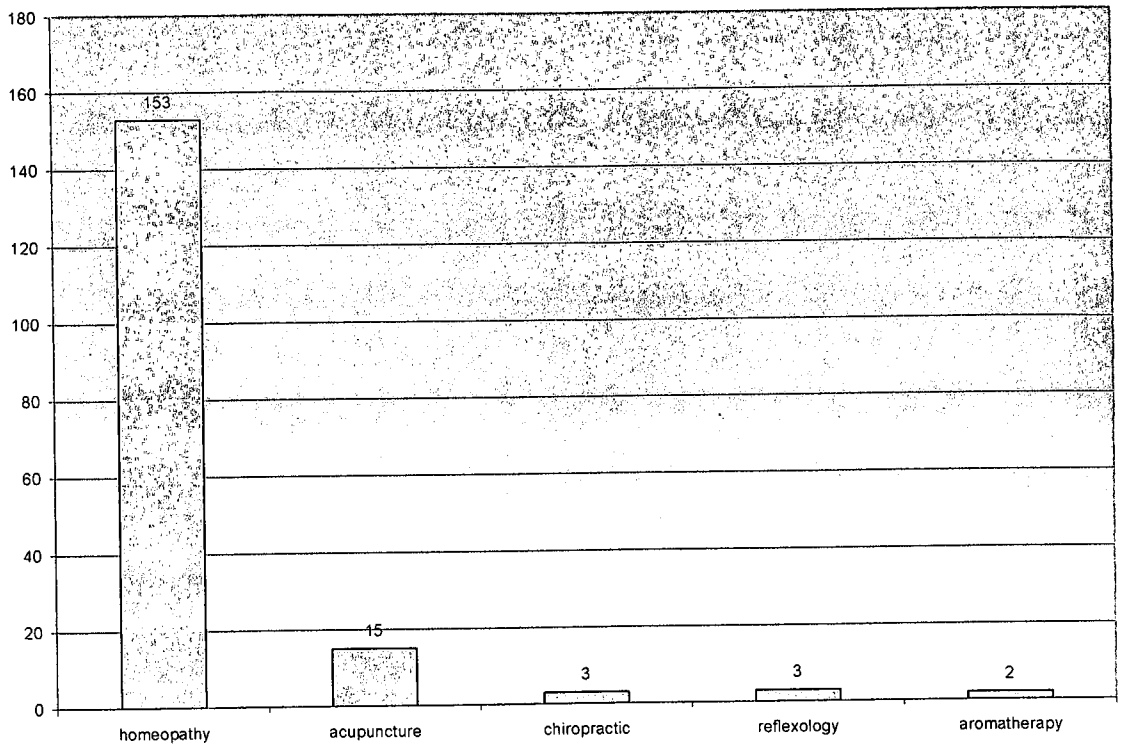

Figure 28. Number of patients receiving homeopathy compared to other modalities.

From Figure 28 it can be seen that acupuncture was given to 15 patients, 3 received chiropractic treatment, 3 reflexology, and 3 massage. Aromatherapy treatment was received by two patients.

4.3.8 Patient referrals (re: Q2.4.7-8)

Table 16 gives details of the 13.3% of the patients who were referred. General Practitioners were most often referred to, followed by chiropractors, gynaecologists and psychologists.

Table 16. Referrals of patients within the study sample.

Practitioner referred to:	**No. of patients**
General practitioner	4
Chiropractor	3
gynaecologist	3
Psychologist	3
ENT specialist	2
Endocrinologist	1
Gastroenterologist	1
Hospital	1
Paediatrician	1
Radiologist	1
Surgeon	1

4.4 Data related to Questionnaire 4 and 6 - The follow-up consultation and treatment outcomes

4.4.1 Attendance of the follow-up consultation

Figure 29 shows that 113 (71.5 %) patients attended the follow-up. Six patients (3.8%) did not attend the follow-up but the practitioners contacted them by telephone. Thirty nine (25%) did not attend either the follow-up or have a telephonic follow-up. Questionnaire 4 was therefore not completed by the practitioner for these patients. However 22 of these were administered the exit questionnaire by the researcher telephonically. Unfortunately the remaining 17 (10.8%) of the patients were not contactable.

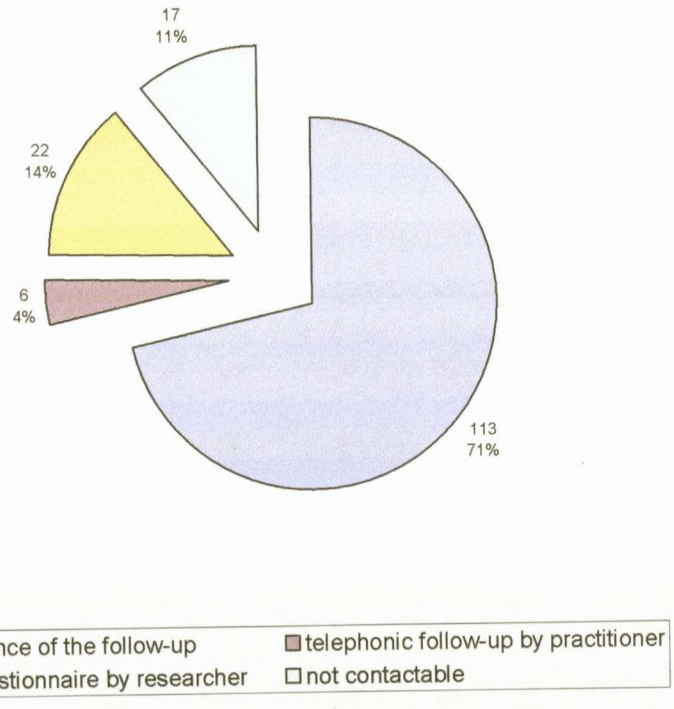

Figure 29. Follow-up attendance.

The 22 patients contacted telephonically by the researcher were asked why they did not attend the follow-up. 36.4% (n = 8) said that they did intend to attend the follow-up appointment made, but would go for a follow-up in the future. Three

patients (13.6%) said that they felt there was no need to attend because of cure. 22.7% (n = 5) felt that there had been no change or improvement. Two patients said that it was inconvenient timing to go for a follow-up. One patient was very dissatisfied with the treatment and therefore would not return. Three patients had no comment.

4.4.2 Length of time before follow-up (re: Q4.01)

The data is based on the 119 patients (75.3%) who had a follow-up consultation, including telephonic consultations by the practitioner. The practitioners were instructed to ensure that a follow-up appointment was booked, so that Questionnaires 4 and 5 were completed. It was communicated to the practitioner that this follow-up time was to suit their normal practice methods. However they were also instructed to please ensure that a follow-up was scheduled, thus the data reflecting greater than 8 weeks follow-up includes 4 patients that the practitioners had to phone to ensure they came for a follow-up.

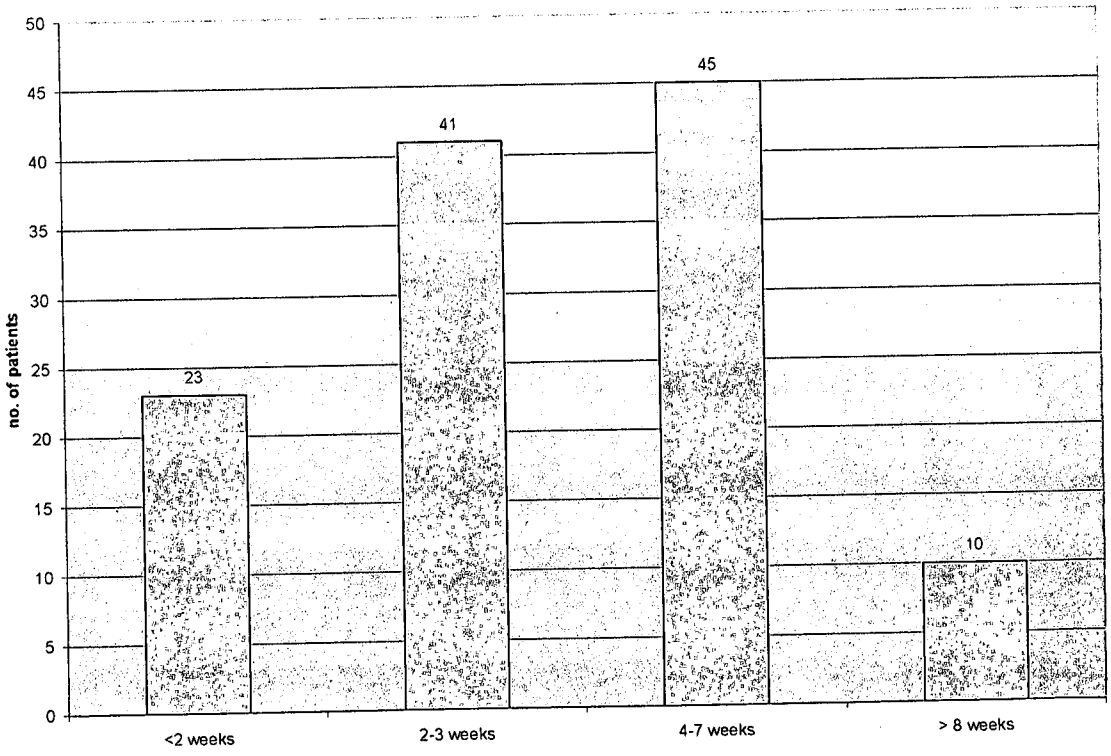

Figure 30. Time between the initial consultation and the follow-up.

Figure 30 shows that the highest proportion of patients (37.8%), were seen 4-7 weeks later. 34.5% were seen within 2-3 weeks, and 19.3% were seen within two weeks. Ten patients attended a follow-up more than 8 weeks later, but as discussed above this was not the original scheduled time for four patients. The remaining six patients in this category were scheduled follow-up times of greater than 8 weeks by one particular practitioner.

4.4.3 Duration of follow-up consultation (re: Q4.2.4)

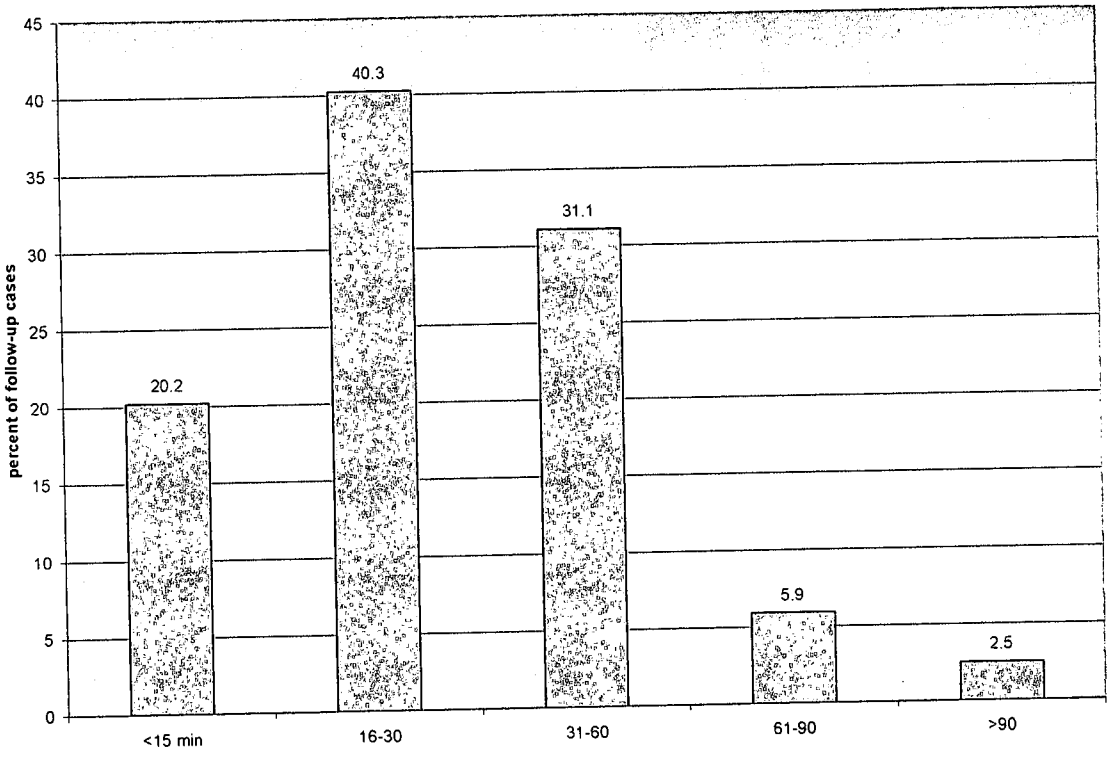

Figure 31. Duration of the follow-up consultation.

The majority (40.3%) of the follow-up consultations were between 16-30 minutes. 31.1% were between 31-60 minutes. Only the patients that had treatment on the QXCI machine fell into the greater than 60 minutes. 20.2% of consultations were less than 15 minutes. See Figure 31.

4.4.4 Treatment outcome - GHHOS

4.4.4.1 GHHOS assessed by the practitioner (Q4.2.1)

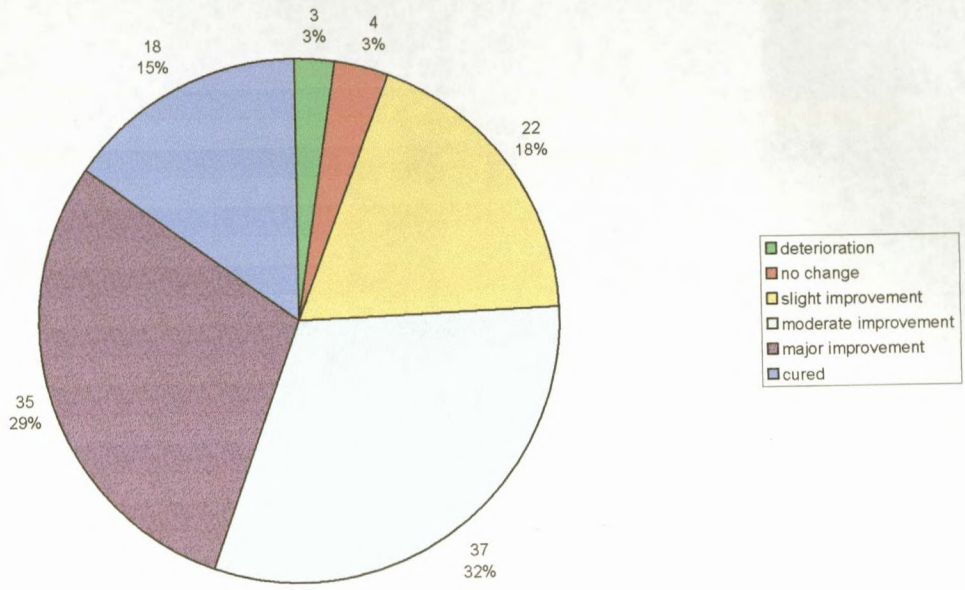

Figure 32. Outcome of treatment (assessed by the practitioner).

Practitioners were asked to assess their patients based on the Homoeopathic Hospital Outcome Scale (GHHOS). The percentages illustrated in Figure 32 are based on 119 patients (only those who were assessed by the practitioner are represented). 44% of patients were assessed as cured/back to normal, or as showing a major improvement. 50% were categorised as showing moderate or slight improvement. 3% of patients were assessed as showing deterioration, none falling in the disastrous deterioration subgroup. 3% showed no change.

4.4.4.2 GHHOS assessed by the patient (Q6.1.4)

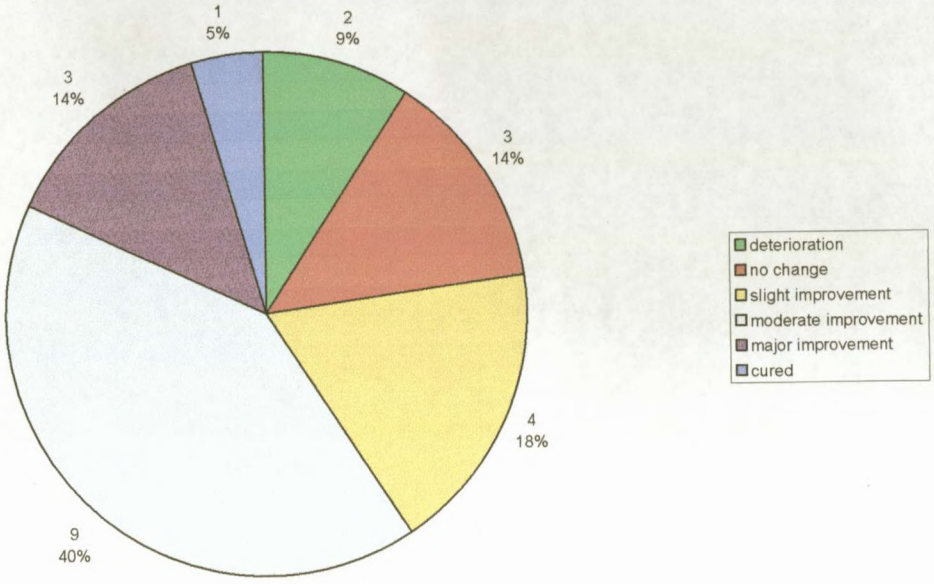

Figure 33. Outcome of treatment (assessed by the patient).

Figure 33 illustrates the outcome of treatment for the 22 patients (14% of the total number of patients), who completed the Exit Questionnaire telephonically with the researcher. 58% (n = 9) showed moderate improvement. In general this group had poorer results in comparison to Figure 32. A greater percentage of patients showed deterioration (9%, n = 2) or no change (14%, n = 3) and less showing cure or major improvement (19%, n = 4).

4.4.4.3 Type of homeopathy practiced against outcome

Table 17 looks at the type of homeopathy practiced, (classical, clinical or pluralist) crosstabulated against GHHOS. The Pearson's Chi-Square Test was used to test the relevant hypothesis (see 3.4.1.2).

Table 17. Crosstabulation of the type of homeopathy practiced against GHHOS.

GHHOS * type of homeopathy Crosstabulation

Count

		type of homeopathy			
		classical	pluralist	complex	Total
GHHOS	major deterioration		2		2
	slight deterioration	1	1		2
	no change	1	4	2	7
	slight improvement	5	15	6	26
	moderate improvement	16	19	9	44
	major improvement	12	19	7	38
	cured/back to normal	7	6	6	19
Total		42	66	30	138

Table 18. Chi-Square Test 2.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.508[a]	12	.744
Likelihood Ratio	9.937	12	.621
Linear-by-Linear Association	.229	1	.632
N of Valid Cases	138		

a. 10 cells (47.6%) have expected count less than 5. The minimum expected count is .43.

The association is not statistically significant. The Pearson Chi-Square tests (Table 18) gives a P-value = .744 ≥ .05. Therefore it is established that there is no association between type of homeopathy practiced and outcome of treatment.

4.4.4.4 Outcome by Age

Table 19 looks at the crosstabulation of the age of the patients against the GHHOS. The Pearson's Chi-Square Test was used to test the relevant hypothesis (see 3.4.1.3).

Table 19. Crosstabulation of age against GHHHOS.

GHHOS * age Crosstabulation

Count

		age							
		0-24 months	2-15 y	16-25y	26-50y	51-65y	66-80y	over 80y	Total
GHHOS	major deterioration				1	1			2
	moderate deterioration				1				1
	slight deterioration			1	1				2
	no change	1	1	1	3	1			7
	slight improvement		1	3	14	6	1	1	26
	moderate improvement	1	2	7	21	7	6	2	46
	major improvement		7	5	22		4		38
	cured/back to normal	4	5	3	6	1			19
Total		6	16	20	69	16	11	3	141

Table 20. Chi-Square Test 3.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	51.584[a]	42	.148
Likelihood Ratio	54.024	42	.101
Linear-by-Linear Association	7.482	1	.006
N of Valid Cases	141		

a. 48 cells (85.7%) have expected count less than 5. The minimum expected count is .02.

From Table 20 it can be seen that P = .148 >.05. Therefore it is established that there is no association between age and outcome of treatment. Thus one can say that there was improvement in all age groups. However from Table 19 one can see that the number of children (aged 2-15) who showed a major

improvement or cure was high at 75% (n = 12). Likewise the assessed outcome of treatment of the six infants (<2 years) showed a high cure rate of 67% (n = 4). These groups showed a higher than average improvement rate, although not statistically significant.

4.4.4.5 Outcome by duration of complaint

Table 21 shows the crosstabulation of the duration of the complaint and the GHHOS. The Pearson's Chi-Square Test was used to test the relevant hypothesis (see 3.4.1.4).

Table 21. Crosstabulation of duration of complaint against GHHOS.

GHHOS * acute vs chronic Crosstabulation

Count

		acute vs chronic			
		less than 1 week	more than one week less than 3 months	more than 3 months	Total
GHHOS	major deterioration			2	2
	moderate deterioration			1	1
	slight deterioration			2	2
	no change		2	5	7
	slight improvement		6	20	26
	moderate improvement	1	4	41	46
	major improvement		9	29	38
	cured/back to normal	6	7	6	19
Total		7	28	106	141

Table 22. Chi-Square Test 4.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	45.361[a]	14	.000
Likelihood Ratio	36.710	14	.001
Linear-by-Linear Association	13.369	1	.000
N of Valid Cases	141		

a. 16 cells (66.7%) have expected count less than 5. The minimum expected count is .05.

From Table 22, the P-value = .000 (<.001) < .05. Therefore, it is established that there is an association between duration of complaint and outcome. The greatest percentage of patients who were rated as cured/back to normal were for patients that had complaints lasting less than one week (88%, n = 6). This is in comparison to 25% of patients who had complaints of duration of more than one week but less than three months, and 5.6% of patients who had complaints for longer than 3 months, who were rated as cured/ back to normal by the practitioners.

4.4.4.6 Level of improvement (re: Q4.2.2)

The practitioners were asked to assess on what level the improvement was noted, more than one answer was permitted. The majority of improvements were on a general level 64%. 56% were on a local level and the least improvements were noted on a mental level at 37%. See Table 23.

Table 23. On what level was the improvement noted?

	Mental	**General**	**Local**
Improvement noted	48	82	71
Percentage	37%	64%	56%

4.4.4.7 Adverse events (re:Q4.2.3.1-3)

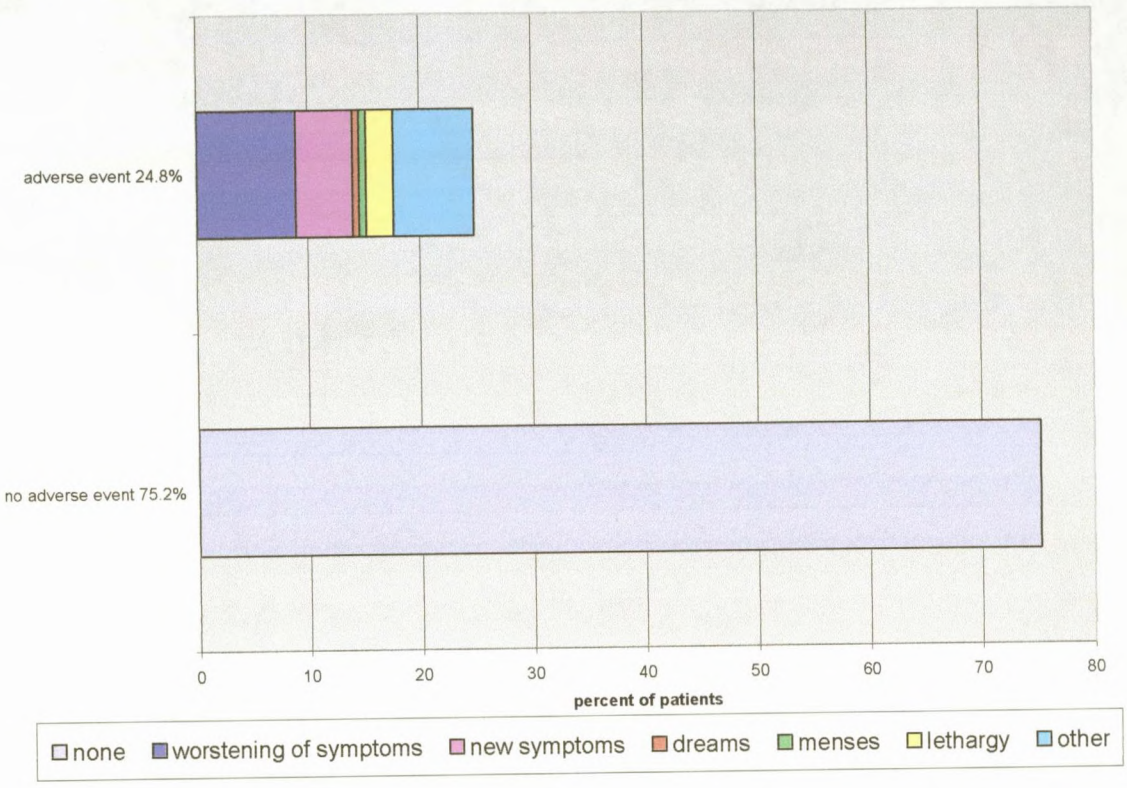

Figure 34. Adverse events.

This is based on the 113 patients that had a follow-up consultation. From Figure 34 it can be seen that adverse events (aggravations) were noted in 25% of cases. Half of these were described as worsening of the symptoms. New symptoms were noted in 28.6% of cases. 83.3% of the aggravations lasted for four days or less. When asked the relationship to the treatment, the majority of the aggravations were seen as possibly (43%) or probably (39.3%) related to the treatment.

4.5 Data related to Questionnaire 3, 5 and 6 - patient assessed treatment outcomes

Questionnaire 3 was completed at the first consultation (pre-treatment) and Questionnaire 5 at the follow-up (post-treatment.) Questionnaire 6 was the exit questionnaire completed telephonically with patients who did not attend a follow-up consultation. Questionnaires completed by patients were only entered as data if both the first and follow-up consult were attended (n = 113). Data was rejected if the manner of completion of the form suggested that the responses were not genuine, i.e. not completed by the patient.

4.5.1 Illness Intrusiveness Ratings Scale (re: Q3.2/Q5.2)

Patients were asked to rate on a scale of 1 (not very much) to 7 (very much) how much their illness and/or its treatments interfered with various aspects of their lives. From Table 24 the responses show a shift from "very much" pre-treatment to "not very much" post-treatment in almost all areas. In the first question on health, the movement into "not very much" was dramatic with a more than 10% increase post-treatment. If one combined 1, 2 and 3 the shift from 37.4% to 63.6% shows a vast improvement in health. Equally a large shift can be seen in the area of self expression and self improvement from 54.3% to 71.4%. The financial situation and religious expression showed marginal decreases; yet again if 1, 2 and 3 are combined there is still a movement towards an improvement. Some patients chose not to complete all the questions, and for children some questions were not appropriate. The lowest response rate was for the question on sex life where only 87 patients responded (77%).

Table 24. Illness Intrusiveness Rating Scale.

(Figures given are percentages rounded to the first decimal place.)

How much does your illness and/or treatment interfere with your.....								
		not very much----------very much						
	Time	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Health	Pre	17.2	13.1	7.1	14.1	21.2	7.1	20.2
	Post	28.3	21.2	14.1	14.1	12.1	3	7.1
Diet	Pre	32.3	13.1	10.1	11.1	8.1	8.1	17.2
	Post	37.4	13.1	14.1	14.1	8.1	7.1	6.1
Work/schooling	Pre	22.3	6.4	11.7	16	11.7	8.5	23.4
	Post	31.3	15.6	18.8	10.4	13.5	6.3	4.2
Active recreation e.g. sport	Pre	28.6	8.2	9.2	8.2	7.1	14.3	24.5
	Post	38.1	13.4	11.3	12.4	6.2	9.3	9.3
Passive recreation e.g. reading	Pre	41.7	13.5	10.4	10.4	11.5	9.4	3.1
	Post	48	22.4	9.2	5.1	10.2	2	3.1
Financial situation	Pre	52.1	12.8	7.4	5.3	9.6	1.1	11.7
	Post	47.9	17.7	8.3	9.4	6.3	5.2	5.2
Relationship with spouse/partner	Pre	41.7	14.3	11.9	13.1	8.3	1.2	9.5
	Post	48.9	14.4	12.2	7.8	7.8	4.4	4.4
Sex life	Pre	45.7	12.3	3.7	9.9	7.4	7.4	13.6
	Post	51.7	12.6	10.3	8	4.6	4.6	8
Family relations	Pre	40.2	19.6	8.2	10.3	11.3	4.1	6.2
	Post	50	17.3	14.3	7.1	6.1	3.1	2
Other social relations	Pre	39.2	15.5	8.2	12.4	14.4	2.1	8.2
	Post	44.9	23.5	11.2	6.1	8.2	4.1	2
Self expression/ self improvement	Pre	29.2	18.8	6.3	8.3	12.5	12.5	12.5
	Post	40.8	13.3	17.3	10.2	10.2	4.1	4.1
Religious expression	Pre	71.3	12.8	2.1	2.1	4.3	5.3	2.1
	Post	69.5	11.6	7.4	5.3	1.1	4.2	1.1
Community and civic Involvement	Pre	56.3	10.4	8.3	8.3	6.3	4.2	6.3
	Post	60.4	19.8	5.2	4.2	6.3	1	3.1

The pre- and post-treatment results were statistically tested. The Wilcoxon Signed Ranks Test was performed to test the relevant hypothesis (3.4.1.5). Table 25 tabulates the results.

Table 25. Wilcoxon Signed Ranks Test for pre- and post-treatment results regarding the Illness Intrusiveness Rating Scale.

Test statistic[b]

Area in life	Z	Asymp. Sig. (2-tailed) P-values
Health	-5.043 [a]	.000
Diet	-2.343 [a]	.019
work/schooling	-4.886 [a]	.000
Active recreation e.g. sport	-4.334 [a]	.000
passive recreation e.g. reading	-2.854 [a]	.004
Financial situation	-.755 [a]	.450
relationship with spouse/partner	-1.512 [a]	.131
sex life	-1.825 [a]	.068
Family relations	-3.183 [a]	.001
other social relations	-3.298 [a]	.001
self expression/ self improvement	-3.36 [a]	.001
Religious expression	-.554 [a]	.580
Community and civic Involvement	-2.401 [a]	.016

a. Based on positive ranks

b. Wilcoxan Signed Ranks Test

The results of this test (Table 25) demonstrate that most areas showed pre- and post-treatment improvements (P-values < .05). The areas of financial situation, relationship with spouse/partner, sex life, and religious expression showed no statistical improvements (P-values > .05).

4.5.2 Visual Analogue Scales (re: Q3.3.1-2/Q5.3.1-2)

4.5.2.1 General health

Patients were asked to describe by means of marking an X, their general health in the past four weeks, on a scale of 1 (poor health) to 10 (excellent health). Figure 35 illustrates the results. There is a clear movement at each rating level towards excellent health.

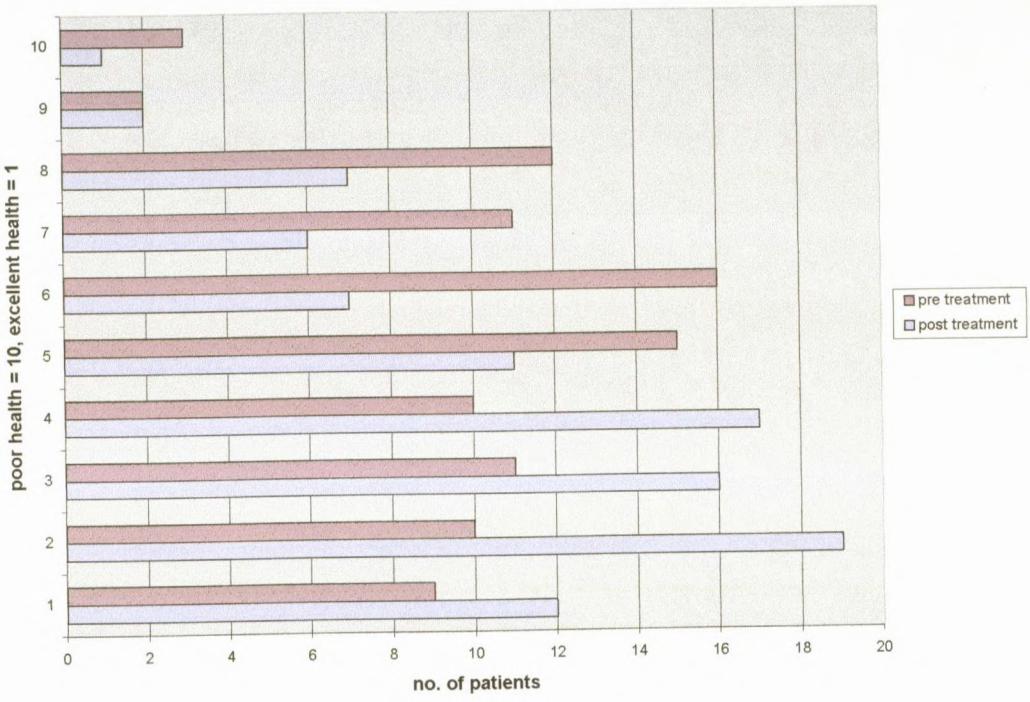

Figure 35. Pre-and post-treatment comparison of general health.

The Wilcoxon Signed Ranks Test was performed to test the relevant hypothesis (3.4.1.6). It has been established that there is a difference between pre- and post-treatment results (P-value = .000 < .001). See Table 26.

Table 26. Wilcoxon Signed Ranks Test for the Visual Analogue Scale

Test statistic[b]

Visual Analogue Scale	Z	Asymp. Sig. (2-tailed) P-value
General Health	-5.043 [a]	.000
'life-state' assessment	-2.343 [a]	.019

a. Based on positive ranks

b. Wilcoxan Signed Ranks Test

4.5.2.2 'Life-state' assessment

Patients were asked to describe by means of marking an X, where their life is now, on a scale of 1 (best possible life) to 10 (worst possible life). Figure 36 illustrates the results. There is movement at each rating level towards the 'best possible life' side of the scale.

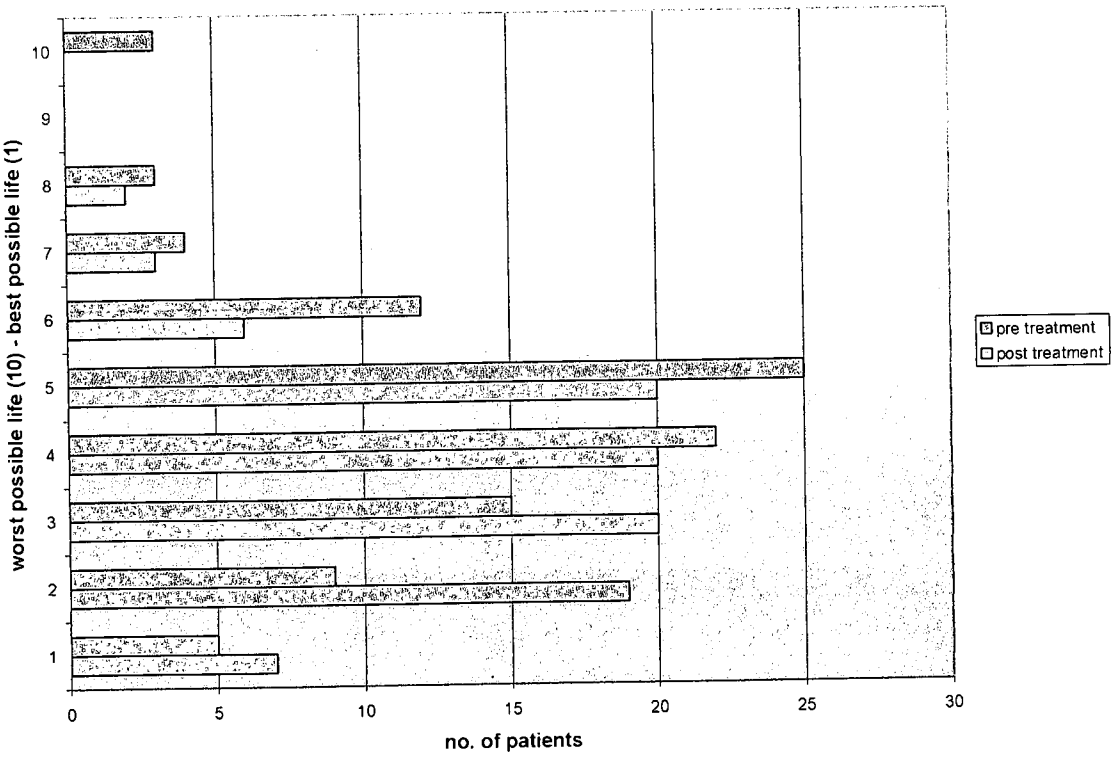

Figure 36. Pre-and post-treatment comparison of 'life-state' today.

The Wilcoxon Signed Ranks Test was performed to test the relevant hypothesis (3.4.1.6). It has been established that there is a difference between pre- and post-treatment results (P-value = .000 < .001). See Table 26.

4.5.3 Consumer Satisfaction Survey (re: Q5.4/Q6.2)

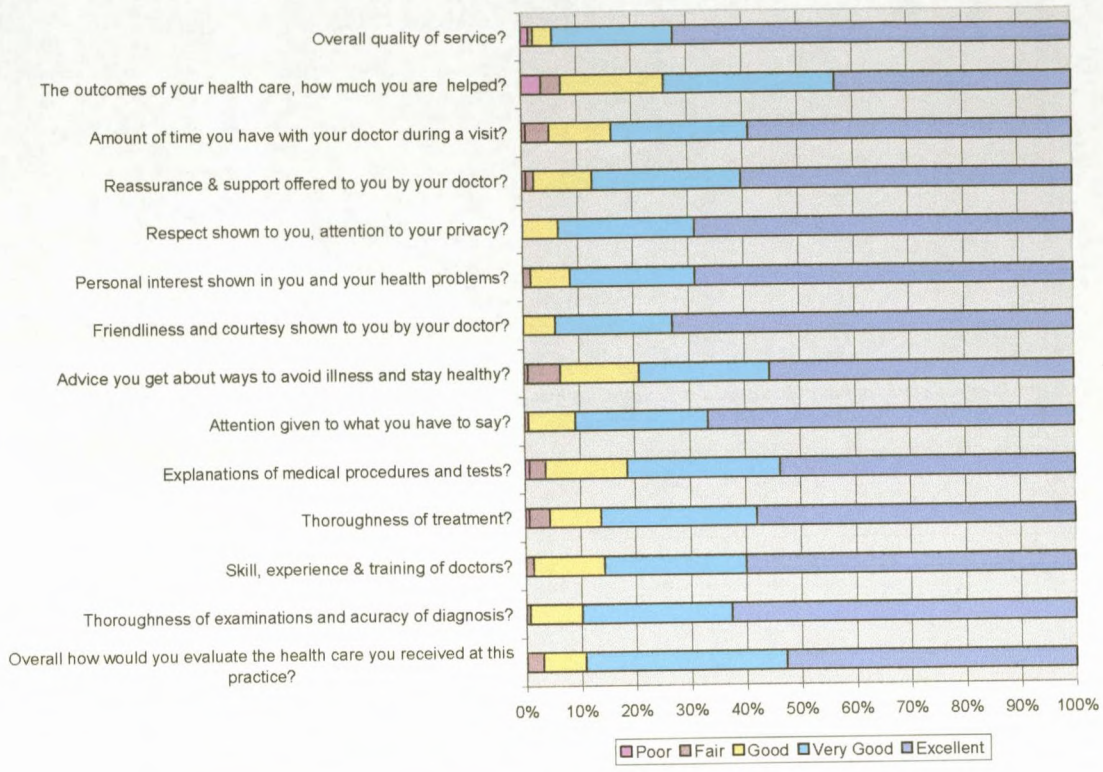

Figure 37. Consumer Satisfaction Survey ratings.

Patients were asked to complete a series of questions rating the quality of healthcare received at the homeopathic practice they had attended. The scale used "poor, fair, good, very good and excellent". 17 patients were not contactable and thus did not complete the data. Those that were contactable and had attended the follow-up did not always complete all the questions. The lowest response rate was 84.4% for the question on explanations of medical tests (Q5.4.5/Q6.2.5). Figure 37 shows the percentage response within each scale category. For all questions the majority of answers fell in the excellent rating. The highest "excellent" ratings were at 72.9% for the friendliness and courtesy shown by the doctor and at 72.3% for the overall quality of service. The "excellent" rating for the outcomes of healthcare was the lowest at 43.2%, however when the responses are widened to include the "very good" rating of 30.9% the total response is at 74.1%.

4.5.3.1 Patient assessed outcome vs duration of initial consultation

Table 27 shows the crosstabulation.

Table 27. Crosstabulation of the outcome of healthcare as assessed by the patient against the duration of the initial consultation.

the outcomes of your health care, how much you are helped? * duration of intial Crosstabulation

Count

		duration of intial					Total
		<15 min	16-30 min	31-60 min	61-90 min	>60 min	
the outcomes of your health care, how much you are helped?	poor	1		2	2		5
	fair			4	1		5
	good	1	10	7	4	4	26
	very good	2	8	17	12	4	43
	excellent	8	18	22	11	1	60
Total		12	36	52	30	9	139

The relevant the hypothesis (see 3.4.1.7) was tested by means of the Pearson Chi-Square tests (see Table 28).

Table 28. Chi-Square Test 5.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.754[a]	16	.151
Likelihood Ratio	24.483	16	.079
Linear-by-Linear Association	3.042	1	.081
N of Valid Cases	139		

a. 15 cells (60.0%) have expected count less than 5. The minimum expected count is .32.

The P-value = .151 > .05. Therefore it is established that there is no association between healthcare outcome as assessed by the patient and duration of consultation.

4.5.4 Holistic practice outcome (re:Q5.5/Q6.3)

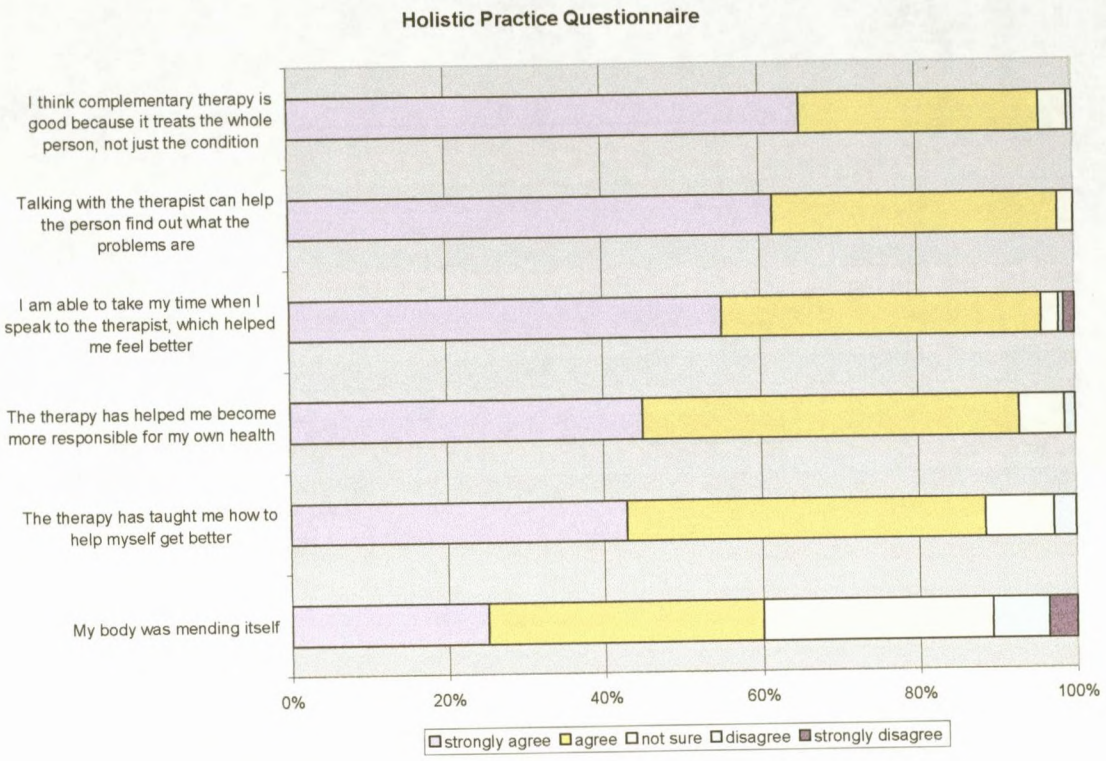

Figure 38. Complementary medicine opinion.

Figure 38 shows the responses given by patients to a series of six statements pertaining to complementary medicine. The patients had to select a response between "strongly agree, agree, not sure, disagree and strongly disagree". In general the responses favoured "strongly agree" or "agree". The strongest agreement (65.2%) was in response to the statement that complementary medicine is good because it treats the whole person not the just the condition. 61.7% of patients "strongly agreed" that talking with the therapist can help them find out what the problems are. The statement "my body was mending itself" had a large "not sure" response of 29.3% and the smallest agreement levels.

CHAPTER 5

DISCUSSION

In this discussion, three groups are referred to:

1. The total population - all registered, contactable homeopaths to ascertain basic demographics of practice status, age, gender, race and area. These numbered 59;
2. The sample of practitioners - i.e. practitioners willing to participate. These numbered 30 (51% of the population);
3. The sample of patients - in total these numbered 158 (Only 17 practitioners completed stages 2 and 3 of the study).

The initial challenge of the research study was in contacting the practitioners and enlisting participation. Seventy nine practitioners were registered with the AHPCSA as at September 2001, however only seventy were contactable. Of those who were contactable, 11 no longer practised in KZN. (7 had moved out of KZN, and 4 had left South Africa.) This left 59 practitioners as potential participants of the study and as the group forming the total available population. The difficulty in contacting the practitioners because they had moved practices within KZN or were no longer practicing in KZN (n = 11), as well as the fact that a further two practitioners dropped out of the study because they moved out of KZN, all suggest that the industry is subject to change. This may well be because of the status of the South African economy, specifically in KZN. Other provinces and countries may provide better economic opportunities. Opportunities of earning foreign currency may draw practitioners overseas, especially for recently qualified practitioners who have to pay off student loans.

5.1 Practitioner demographics and practice characteristics

5.1.1. Practitioner demographics of the contactable population

Demographics of practice and participation status, age, gender, race, and area of practice are based on the entire contactable population of 59.

5.1.1.1 Practice status

From the total contactable population of 59, fourteen practitioners were not practising as homoeopaths at present, because of illness, retirement, maternity leave, or other personal reasons. Thus only forty five (64%) of the contactable registered practitioners homeopaths were actually practicing in KZN. The low number of homeopaths actually practicing homeopathy is surprising, considering that the DIT has been training homeopaths since 1989, with the first set of graduates in 1993. The total number of students who have graduated up to and including the 2001 graduation is 85. Only 28 of these are practising in KZN. The question that needs to be asked is where are all the other graduates? This may well be due to: dropping out of practice; practicing in other provinces; emigration.

5.1.1.2 Participation status

Three practitioners were excluded from the study because of ethical reasons (they were very involved in the study design and supervision). Twelve practitioners were not willing to be part of the study, and nine felt they were too busy. Two of the 'not willing' practitioners had had previous experience with questionnaires and felt that patient compliance would negatively effect the efficacy of the study. The third practitioner ran a practice in a largely rural area, and his reason for not participating is perhaps unique to the situation in South Africa. This practitioner who is black stated that he could not participate because of fear that the community might launch a mass action protest that may force

closure of his practice. A district surgeon in the region had suffered this fate for being suspected of letting a third person have knowledge on his patients HIV status. In his district he states "that 95% of residents are potentially political mis-influenced, regarding the HIV epidemic" (Practitioner A, 2001). The practitioner felt that the community have very negative views on "white practitioners" or anything associated with white practitioners. He said that many in the community believe that white doctors are responsible for the spread of HIV to the black population. The practitioner thus felt that patient compliance would be difficult, and even his own safety would be at risk.

5.1.1.3 Age

Nearly half (n = 28) the number of practitioners fell in the 20-34 age-group (47.5%), whilst 15.3 % (n = 9) were over 65 years old. Two overseas studies give details on homeopathic practitioner demographics, including age. Golovatiouk *et al.* (2000) surveyed 5 European countries (Germany, The Netherlands, Norway, Russia, and the Ukraine), found that the largest group (40%) was between 40-49 years, with 30% between 30-39 years old. The smallest groups were in the 20-29 years group at 6.7%, with those aged more than 60 years at 5%. The current study shows a different trend, that South African practitioners have a higher representation in the younger or older ends of the spectrum, than do European practitioners. The researcher feels that this difference may be due to two reasons.

- The age structure may be the result of the political history of the homeopathic community in South Africa. The effects of a closed register during 1974-1985 probably accounts for the lower representation in the 40-49 age group. The greater representation in the younger age groups is in line with the opening of the Technikon Natal course in 1989, since most of the practitioners who are graduates from this course fall into the younger age groups. The Golovatiouk *et al.* (2000) study gives details per country, where lower ages are seen in Norway, Russia and Ukraine, the

reason for this being that in those countries homeopathy in established form is still a young discipline. South Africa too can be regarded as a country where homeopathy in established form is regarded as a young discipline.

- The duration of training varies greatly between Europe and South Africa, with Europeans generally having to study longer before they can qualify as homeopaths. Golovatiouk *et al.* (2000:15) states that most homeopathic training in Europe takes place after the end of medical studies. In addition, many physicians turn towards homeopathy after a long period of experience of allopathic medicine. In South Africa the majority of homeopaths are trained through the Technikons, which takes 5 years, followed by a period of completing a masters degree dissertation. In the current study only one homeopath had previously qualified as an allopathic physician and received a MFHom. (United Kingdom) Thus in KZN, it can be said that students of homeopathy graduate and start practicing at a younger age than their counterparts in Europe.

5.1.1.4 Gender

There are more male homoeopaths (60%, n = 35) practising in KZN than is the case in other studies. In the Golovatiouk *et al.* study (2000) more than 70% who completed the study were female. However in the break-down per country, there are more male practitioners in the established countries of Germany and the Netherlands, revealing that females are under-represented in the older generations. The reason given for this trend, is that there is not a long tradition of woman studying medicine. This tradition may be true for South Africa too, however it is anticipated that this proportion will change in the future because on average more females graduate each year from DIT, than males. Looking at the gender make-up for the last three years of 5th year students, there were more female students than males in every year. In 2000, there were 4 males and 11

females, in 2001 there were 4 males and 15 females and in 2002 there were 3 males and 9 females (Macquet-Maurel, DIT Homoeopathic Day Clinic Secretary, 2003).

5.1.1.5 Race

The homeopaths in the population for this study were mostly white (n = 44). Ten were Indian, four black and one coloured. The limited number of black practitioners is probably due to a host of political, educational, economic and social factors.

The most important reason for the limited number of black practitioners is the limited number of black practitioners being trained. Dr Ashley Ross (2003), Head of the Department of Homoeopathy DIT, states that there has been only one black student to graduate since the inception of the course in 1989. There are three main reasons for this;

- Firstly, the department receives very few black applicants. This is attributed to the lack of awareness of homeopathy in the black community. In the black community there seems to be use of either Traditional African medicine (in the form of inyangas, and sangomas), or westernised medicine (in the form of orthodox medical treatment).
- Secondly, the academic requirements of the course are intense, and very few black students are accepted onto the course, further few make it passed first year. For example, in 2002 four black students were accepted onto the course, however only one of these student remains in the course and is repeating some of the subjects (Ross, 2003). Although education has being addressed by the current government, historically poor educational infrastructure for black learners means that black students are disadvantaged. There is at present no bridging course available to disadvantaged students.

- Thirdly, on an economic level, the duration of the course is at least 5 years full time study, and is thus very costly to the student. Only in recent years have students from disadvantaged backgrounds had access to the government bursaries for tertiary education at Technikon Institutions. There are no private bursaries to study homeopathy.

The limited number of practitioners and limited awareness of homeopathy in the black community has an influence on the race demographics of the patient base in this study. This will be discussed in section 5.2.1.1.

5.1.1.6 Area

The large majority of practitioners of this study practice in Durban (68%, n = 40), the largest city in the province of KZN.

5.1.2 Demographics of the study sample

The study sample (n = 30) was compared to the contactable broader population of registered homeopaths (n = 59). The study sample is younger, less white and more highly represented in the greater KZN areas than the total contactable population. Graduates of Technikon Natal made up a high proportion of the study sample, resulting in a younger representation. The higher participation rates may be because they felt sympathy with the researcher in undertaking a research project, having had to do research dissertations themselves. Some of the older practitioners felt that they could not participate because they were largely retired, and did not see many new patients which was one of the requirements for participation in the study. Thus, they are underrepresented in the study.

5.1.2.1 Qualification

Two thirds (n = 20) of the practitioners held a Masters in Technology (Homeopathy) diploma or degree from Natal Technikon (now DIT). The remaining practitioners (n = 10) held diplomas from a variety of schools, most of these practitioners had been practising for over 10 years. Even though the majority of practitioners trained at the same institution, this does not mean that their practice styles are the same. This was evident from the analyses of the type of homeopathic treatment given and the type of training (4.3.7.3.3), which reveals a correlation between year of practical training and type of homeopathy practiced (P-value = .000<.001). Seven practitioners (23%) held other professional degrees/diplomas; this is comparable to a survey of Dutch Chiropractors conducted by Assendelft *et al.* (1995) where 29% had additional training at college or university level.

Regarding allopathic training in the current study, only one practitioner is trained as a medical doctor, and one as a laboratory nurse. Galavotiouk *et al.* (2000) found that 80% of the respondents of Germany, Russia and the Ukraine had more than 10 years experience as a general physician. This again is a result of the training differences in SA, to practice or train as a homeopath in SA one does not need to have a medical degree first. From the Caldis study (2000) she found that only 15% of 2330 complementary practitioners were trained as medical practitioners in South Africa.

5.1.2.2 Years of experience

The average number of years of practice is 9. 43% (n = 13) have had less than five years of experience and 30% (n = 9) less than ten. Only 11% (n = 3) of practitioners have between 11 and 20 years experience. However 16.7% (n = 5) have between 21-30 years experience, none have more than 30 years

experience. Again a gap is evident between two sides of the spectrum which reflects the historical legal practice and tuition status of homeopathy in SA.

The Jacobs *et al.* study (1998) in the USA, found that practitioners had an average of 11.5 years experience, a slightly higher number than in the current study. Galavatiouk *et al.* (2000) found that generally in Europe more than 80% of physicians had less than 10 years of experience with homeopathy. However, in Germany, where homeopathy is an established profession, practitioners had more years of experience, with over 50% having more than 11 years of experience. In Russia and the Ukraine, where homeopathy is less well established, the largest group had less than 5 years experience (46.8%). In KZN, South Africa, it would seem as if the years of experience of practitioners are generally more in line with the countries where homeopathy is still becoming established.

5.1.2.3 Other disciplines practiced

Phytotherapy (70%, n = 21), naturopathy (60%, n = 18) and acupuncture (53%, n = 16) were the most common disciplines practised. Three of the four black practitioners surveyed practised as traditional healers. With regards to the percentage of homeopathy practised, twenty (66.7%) practitioners indicated that they practised homeopathy more than 75% of the time, with more than half of these respondents declaring 100% use of homeopathy. This shows a greater use of other disciplines as compared to the Jacobs *et al.* study (1998), where 85% of respondents said that they used homeopathy in 75% or more of their patients' visits. In the current study, of the ten practitioners who stated that 50% or less of their practice was homeopathy, three more often treat with acupuncture, three are traditional healers, three use phytotherapy extensively and one practices chiropractic treatment.

5.1.2.4 Ongoing homeopathic education

To gauge this factor, practitioners were questioned regarding journal subscriptions and conference attendance. In general the participation in ongoing education seemed limited. More than 50% (n = 16) of practitioners responded that they did not subscribe or have access to any journals. Only 30% (n = 9) of practitioners subscribed to or have access to homeopathic journals. The most popular homeopathic journal read is Homoeopathic Links (mentioned by 8 practitioners). Update subscribed to by 3 practitioners was the most mentioned medical journal.

Attendance at conferences was slightly better, with 57% (n = 17) stating that they had attended a conference in the past year. The most well attended (n = 11) was the South African Complementary Medicine Association (SACMA) conference. Five practitioners attended -Heel (a homeopharmaceutical company) seminars. The SACMA and –Heel events were held in Durban, whilst conferences or seminars held in other provinces showed poor support from KZN practitioners.

Of the thirteen practitioners (43%) that had not attended any conferences in the past year, ten did not subscribe to any journals either (30%). It would seem as if KZN homeopaths are spending limited time on ongoing education. The only study that looks at this question from a clinical audit perspective is the Assendelft *et al.* study on chiropractors (1995). They found that 88% had followed some form of postgraduate training in the 3 years preceding the survey, for a median of 5 days per year. In addition 4 hours a week were spent on home study and the reading of professional literature. This latter issue was not assessed in the current study.

It is stipulated by the Registrar of the AHPCSA (Mac Donald, 2000:5) that for annual registration practitioners are required to dedicate 15 hours per year to earn CPD points (attending conferences is a way of gaining Continuing

Professional Development Points). Unfortunately the survey did not ask the specific question of how practitioners are obtaining their points, but this low attendance at conferences suggests that these practitioners are not fulfilling their CPD point requirements. However the AHPCSA has not made an effort to broadly publicise this requirement, and there appears to be no mechanisms in place to access whether it has been achieved by any particular practitioner. Further, it is not yet enforced as a requirement for re-registration each year.

5.1.3 Practice characteristics

5.1.3.1 Type of practice

40% (n = 12) of practitioners had solo practices, 23.3% (n = 7) practiced with other homeopaths, whilst 36.7% (n = 11) were part of a multi-disciplinary practice (including General Practitioners, nurses, psychologists, physiotherapists, chiropractors, aromatherapists, and massage therapists). These results indicate a trend in KZN toward working in association with other health professionals rather than solo.

5.1.3.2 The patient load

The number of patients seen per week varied from 4 to 75. This was dependant on the actual hours of practice as well as on the experience of the practitioner. 23 practitioners run full time practices.

In the informal discussion with the practitioners around this question (Q1.1.12), the issue of the number of hours/days practiced per week arose. Seven practitioners do not run a full time practice for the following reasons:

- 3 practitioners are lecturers, and thus only practice 2-3 days per week;
- 1 practitioner works as a clinician in the DIT Homoeopathic Day Clinic two afternoons per week;

- 2 practitioners run a morning practice only;
- 1 practitioner practices homeopathy only one day per week.

This meant that 23% of the study practitioners did not practice full-time. A concern arises when one looks back at the fact that of the general population of registered homeopaths in KZN in 2002 (n = 79), only 45 homeopaths were practicing and of these at least seven are not full-time. Thus, despite the fact that the DIT has been enrolling 30 homeopathic students per year since 1989, very few qualified homeopaths actually run full-time practices in KZN.

The question that needs to be asked is; Are homeopaths able to make a sustainable living in KZN? Or do they need to supplement their incomes with other work? Or do they have to move to Gauteng, and Cape Town? It seems as if the market is more viable in these two areas. In the course of this study two of the original participating practitioners, moved to Gauteng.

5.1.3.3 Duration of consultations

The estimated average duration for a first consultation was 56 minutes, with a follow-up consultation estimated at an average of 36 minutes. Data from the second stage of the current research showed that 38% of the 158 consultations had an actual duration of between 31-60 minutes, 25% were greater than 60 minutes and 25% were between 16-30 minutes. 10% were less than 15 minutes. In the follow-up consultation, as expected, the duration per consultation was shorter. However, nearly 40% of consultations still lasted longer than 30 minutes.

These results are similar to Ferruccci (1994) who studied a random selection of patients at both the DIT Homoeopathic Day Clinic and private practitioners. Unfortunately no distinction was made between initial and follow-up consultations but the result was that 61% of day clinic consults and 59% of private practitioners

were between half an hour to one hour. The IIPCOS-01 study (Heger *et al.*, 2001) gave a surprisingly different picture. Two-thirds of initial consultations were shorter than 16 minutes.

What is interesting is that the outcome of treatment from the point of view of the patient was no better when the length of consultation lasted up to 30 minutes. The conclusion reached was that homeopathic treatment with regards to the physicians' time expenditure is comparable to conventional methods and can thus be integrated into existing healthcare system without any compromise on treatment outcome. In the current study when treatment outcome from the point of view of the patient is crosstabulated against the duration of consultation, statistically there is no relationship between the two variables (P-value = .151). This implies that the outcome of short consultations was just as good as long consultations. However, the concern with scheduling shorter consultation times is that many patients appreciate the fact that in complementary therapy they feel that can talk to the therapist. In the current study 55% strongly agreed with the following statement, "I am able to take my time when I speak to the therapist which helped me feel better."

5.1.3.4 Consultation Fees

The average fee for the first consultation was R121.35 and the follow-up R94.52. The fees varied between R56 to R375. The variance in fee for the follow-up consultation is between R45 to R375. The average fee depended on the area of practice, with consultations in Durban being on average more expensive than in Greater KZN. The Caldis study (2000) found that the fees of an initial consultation can vary from R100 - R360. Considering the effects of inflation, KZN practitioners seem to be charging less in 2002 than the national norm in 2000.

5.1.3.5 Diagnostics and prescription aids.

Just less than one third (n = 9) of practitioners have a computer repertorising programme. 86% (n = 26) of practitioners stated that they used a repertory. A limited variety of aids were used by a few practitioners, namely the QXCI machine (n = 2), pendulum (n = 2), iridology (n = 2), the Vegatest device (n = 1), blood (n = 1) and pulse (n = 1). When 17 of these practitioners gave details on actual patient consultations in Stage 3 of the research, just under half of the prescriptions were made with the aid of a repertory. The practitioners who used either the Vegatest device or QXCI did not or seldom made use of a repertory.

5.1.3.6 The dispensary

Almost the entire study sample dispenses medicine. In KZN there are no specific homeopathic pharmacies, thus one could suggest that the situation might be different in Johannesburg where Weleda pharmacies fill scripts for practitioners.

5.1.3.7 Referrals

In the current study, as in the Assendelft *et al.* study (1995) of Dutch chiropractors, practitioners noted self-referral as the largest source of their patients i.e. where the patient may have heard about the doctor or taken the advice of a significant other who has seen the doctor. 50% (n = 15) of the practitioners reported that they received patients via referrals from General Practitioners sometimes, often or always. The referrals from General Practitioners would seem consistent with world trends. Lewith *et al.* (2001) looked at the attitudes and use of complementary and alternative medicine amongst physicians in the UK, and found that 49% refer patients to CAM. Within the current study, the "other" option includes referrals from health shops, pharmacists, reflexologists, aromatherapists, nursing staff and specialists. Homeopaths tend to refer out to General Practitioners (66% answered

sometimes) more often than they receive referrals from them. A strong inter-referral relationship seems to exist with chiropractors

Chiropractors, General Practitioners, psychologists, gynaecologists and colleague homoeopath were most often referred out to. This was found to be true when the referrals of the actual 158 consultation in Stage 3 of the study were analysed. It was found that only 13.3% of patients were referred, These were to a general practitioner (n = 4), chiropractor (n = 3), gynaecologist (n = 3), and psychologist (n = 3). Most practitioners mentioned specialists in the other option as referral practitioners, including surgeons, ENT specialists, cardiologists, urologists.

There are very few referrals to naturopaths and acupuncturists; this is probably because over 50% of practitioners practice these modalities themselves.

The Assendelft *et al.* (1995) study found that most chiropractors seldom refer patients to other forms of complementary or orthodox healthcare. They state that most of their patients had had intensive preceding contact with medical doctors, thus the low referral rate. The current survey did not ask the specific question of patients on previous healthcare, however the majority of patients had suffered for more than three months with their complaint, thus one could assume that most patients go to homeopaths after they have tried various other treatments.

5.2 Patient characteristics

5.2.1 Patient demographics

The majority of patients who consulted the homoeopaths participating in this study were white (61.4%, n = 97), English speaking (78.5%, n = 124), females (68%, n = 108) between the ages of 26-50 years (46.5%, n = 73).

5.2.1.1 Race

The results of the current study suggest that homeopathy appeals to the white (61.4%) and Indian market (22.2%). This is similar to the Jacobs *et al.* (1998) study who compared the demographics of patients using homeopathic medicine as compared with patients of physicians using conventional medicine in the USA. They found that the former saw a higher percentage of white (91%) and Asian patients (5.5%). The high Indian statistic may be because the study took place in KZN which has a large Indian population.

The low number of black patients in the study (15.2%, n = 24) as compared to total population, relates back to 5.1.1.5 (the discussion regarding the limited awareness of homeopathy within the black communities). In the current study, black patients were seen almost exclusively by black practitioners who practice within the black community, all of whom had additional training - two as traditional healers, and one as a nurse. This broader training may have helped the practitioners gain credibility amongst the community.

5.2.1.2 Gender

The predominance of female patients is consistent with the findings of Ferruccci (1994) within the SA market. As well as in the IIPCOS-01 study (Heger *et al.*, 2001) undertaken in Europe and the USA (66.7% female split)

5.2.1.3 Age

The Ferruccci (1994) study excluded patients under the age of eighteen, but found, as in the current study, that the largest distribution of patients in the SA market was the age groups of 26-55 years. Both the Dempsey and Swayne (1990, UK) and Jacobs *et al.* (1998, USA) studies found a larger representation in the younger age groups, specifically aged less than15 years. These are at 23% and 23.9% respectively, whilst the current study only had 16.5% in this age group. Heger *et al.* (2001, USA & Europe) study found even more of a dramatic youth patient base, with 47.2% under the age of 12. They suggested that this may be because of the type of complaints that were investigated, which often arise as acute complaints in children.

The smaller distribution of children within the patient base of the current study may be a result of the community's perception of what homeopathy can treat. Moys (1998) found that only 36.4% of the white and 44.4% of the Indian communities in two residential Durban areas perceived homeopathy to be effective in common childhood complaints (e.g. otitis, measles).

5.2.1.4 Occupation

Nearly half (48%) were employed remuneratively in a large variety of occupations. Housewives were the largest single group at 13.9% (n = 22). 8.2% were pensioners, with only 1.9% unemployed. These totalled 24%. The remaining 27% were students, scholars and infants. In the Ferruccci (1994) analysis of private practitioner patients, (limited to those aged over 18 years), the unemployed category (which included pensioners, and housewives) made up 29%. The current study is also comparable to Colin (2000), where in France, pensioners, housewives and unemployed made up 25%. However pensioners were the largest segment of this group at 18%.

The current study shows a higher student base (10.8%) if compared to the private practitioners of the Ferruccci study (4.3%) as well as against Colin's private practice study (5.5%). However Ferrucci also looked at the demographics of patients attending the DIT Homoeopathic Day Clinic, and found student attendance to be higher than in private practice at 36%. The current study may show an increased percentage of student attendance as two participating practitioners run a private practice from the DIT Homoeopathic Day Clinic and thus may draw a larger student patient base.

5.2.2 Medical aid scheme membership and coverage

Over half (57%, n = 90) of the patients belonged to a medical aid scheme. 64% (n = 58) of patients who had medical aid had the full cost and 12% (n = 11) had part of the cost thereof covered by the medical aid scheme. In 1994 Ferrucci found a slightly higher membership of medical aid schemes, specifically in private practice (61%), however no detail was given as to the degree which the schemes covered the cost. In the IIPCOS-01 (Heger *et al.*, 2001) study, for cases in Europe more than half had their costs paid for by the Governmental health insurance, only 38.4% of cases were self-payers. In the USA, the figures are more comparable with the current study's results, with 55.8% of patients paying for the treatment themselves. In 2002 the Board of Healthcare Funders (BHF) benchmark tariffs for a first consultation was set at R72.80, and R65.40 for a follow-up. These recommended rates are set very low, considering that the current study found that the average cost per first consultation was R117.30, and thus the medical aids are providing only partial coverage. It would seem as if the BHF have not catered to the unique setup of a homeopathic consultation and treatment methods. Just looking at the actual consultation time, 38% of practitioners spent between 30 and 60 minutes on the initial consultation, and 27% over 60 minutes. In the actual follow-up consultations, only 10% of practitioners took less than 15 minutes, the majority took between 16-30 minutes. The BHF rates need to be set according to these long consultation times.

5.2.3 Main complaints.

The majority of complaints are of a chronic and recurring nature. The complaints are spread across a variety of categories. The highest proportion of respondents fell into the following diagnostic groups: GIT disorders, mental, gynaecological, dermatological, muscular/skeletal, and respiratory. More specifically the most common types of illness the patients suffered from were sinusitis/allergic rhinitis (8.2%), depression (6.9%), migraine/headache (4.4%), arthritis (4.4%), asthma (3.2%), bronchitis (3.2%), menopause (3.2%), eczema (2.5%), anxiety (1.9%), food allergies (1.9%) and influenza (1.9%) The similarity of types of illness that are treated by homeopathy is remarkable across many different studies.

In the Ferruccci study (South Africa, 1994), the private practitioners treated the following complaints: "functional bowel disease", unexplained fatigue, headaches, neurotic disorders and allergic rhinitis, whilst at the DIT Homoeopathic Day Clinic, dermatological and premenstrual syndrome were the largest groups.

The Jacobs *et al.* study (1998, USA) lists ten of the most common principle diagnoses made by the homeopaths studied of which eight are the same as in this study. These are asthma (4.9%), depression, (3.5%), allergic rhinitis (3.4%), headache/migraine (3.2%), neurotic disorders (2.9%), other allergy (2.8%), eczema (2.6%) and arthritis (2.5%). Likewise in the Jansen and Koster (1995, Netherlands) study again eight of the top ten most common diagnoses are the same, namely, eczema (19.2%), allergic rhinitis/sinusitis (14.2), migraine (10.1%), anxiety (8.6%), depression (8.6%), asthma (8.2%), bronchitis (6.4%) and arthritis (6.2%).

As borne out in this study, Jacobs *et al.* (1998) state that homoeopaths tend to treat conditions that are difficult to cure with conventional medicine, or for which modern medicine offers mostly symptomatic relief or treatment which does not

satisfy patients. It would seem, therefore, that homeopaths treat mainly chronic functional disorders. However, all of the above studies have been of patients in developed first world countries. It would be interesting for research to be conducted in less developed countries or settings such as India. Unfortunately this study only includes data from 23 rural patients (15%), but from this group one can see that the main complaints are of a slightly different nature with conditions such as worms, gastro-enteritis, abscess and tuberculosis becoming apparent. Not one of the rural patients had the top two diseases of depression and allergic rhinitis/ sinusitis.

5.3 Consultation and treatment characteristics

5.3.1 Case taking

As expected all patients had an oral case history taken, with emphasis on the main complaint (94%). In most cases the practitioners (84%) asked about modalities, past history, current medication, generals and food (cravings, desires and aversions). 70% of the consultations covered psychosocial history. However, dreams were only covered in 30% of the consultations. This was an area that differed considerable amongst homoeopaths. Four practitioners never covered this area of questioning, whereas four practitioners covered this area with almost every patient they consulted. From the delegate list (Pharma Natura, 1996) of the 1996 Sankaran conference in Johannesburg (Dr R. Sankaran is known to place importance on dreams), one can see that only three of the 30 practitioners in this survey attended this conference. These three practitioners were included in the four practitioners who consistently covered this area in the consultation. The impact and importance of attending such conferences, if homeopaths are to develop their skills and broaden their knowledge of homeopathy is clearly illustrated here.

5.3.2 Physical examination

A physical examination was undertaken in the majority the cases (85%). Ferrucci (1994) found that almost all patients stated that they were physically examined at the Homeopathic Day Clinic; whilst in private practice the proportion was lower (74%). The implication is that the training received by DIT graduates has a strong focus on medical examination and perhaps this practice is carried through into private practice once they graduate. Whether a physical examination is undertaken seems to be dependant on the time available in the consultation, and the actual complaint. The routine areas of examination were blood pressure and pulse rate; thereafter the most examined areas were the respiratory rate,

chest, glands and examination of the mouth. These areas correspond with the most common illnesses treated by the practitioners, i.e. bronchitis, allergic rhinitis and sinusitis. In general the areas examined corresponded to the main complaint.

5.3.3 Diagnostic services

The practitioners ordered and conducted few special investigative tests for their patients. Blood tests were ordered for only 9.5% of patients, and only 8.2% had urine-analysis. The limited use of diagnostic testing by homeopathic physicians is corroborated in Jacobs *et al.* (1998), who found that physicians who practised homeopathy ordered fewer tests than orthodox medical physicians. One possible explanation for this is that homeopaths regard case taking and physical examination as being sufficient to determine the diagnosis and course of treatment. Other possible reasons are that the patients seen were less ill and required fewer tests or that extensive testing had already been done by another physician.

5.3.4 Basis for prescription

The most frequent basis for prescribing given was the totality of symptoms (51%), followed by local symptoms (45.8%). "Constitutional prescribing" was at 25.5%, followed closely by "keynotes" (24.8%). The patient's miasmatic state was used as a basis for prescribing in 9.8% of cases.

In the IIPCOS-01 study (Heger *et al.*, 2001) the totality of symptoms and keynotes were the most frequent basis for prescription. The use of the clinical pathology (which may be compared with local symptoms in the current study) was the basis for prescription in 25% of the cases, whilst the use of "essence", (which could be compared with constitutional prescribing in the current study) was at only 14.4%. The short duration of consultation (two thirds less than 16

minutes) could be a reason for the strong reliance on keynotes and limited use of "essence".

In the current study the KZN homeopaths spent an average of 56 minutes on the first consultation and this may allow for a stronger basis for constitutional prescribing than the IIPCOS-01 study. The strong emphasis on local symptoms i.e. symptoms related to the main complaint, suggests that many practitioners practice "clinical" homeopathy.

5.3.5 Homeopathic treatment

Homeopathic treatment was prescribed in 96.8% (n = 152) of cases.

5.3.5.1 Single medicines vs complex/combination prescriptions

The majority of patients (70%) were prescribed a complex, i.e. more than one medicine, either in combination or alternating. Single medicines were prescribed in only 27.5% of the cases. This is in strong contrast to the Bernard (2000) potency survey of "classical" homeopaths, which found that the majority (83.8%) prescribed a single dose of 200C-1M, most often. Similarly in Jansen & Koster (1995) all the 58 homeopathic physicians prescribed almost exclusively one homeopathic medicine at a time. The low use of single medicines and high use of combination of medicines in the current study shows that the majority of KZN homeopaths do not practice "classical" homeopathy, rather pluralist or complex homeopathy. In addition, 29 of the prescriptions included complexes which one could buy over the counter in a health-shop or pharmacy; these were often prescribed together with a more individualised medicine.

5.3.5.2 The most frequently prescribed medicines

The most frequently prescribed medicine (excluding complexes), was Natrum muriaticum, with nearly 16% of scripts including Natrum muriaticum. Other important medicines included Silicea, Lycopodium, Aconite and Pulsatilla, with Rhus toxicodendron, Nux vomica, Kalium bichromicum, Sulphur, Sepia and Arsenicum album making up the top 11 medicines.

In one of the earliest studies undertaken by Dempsey and Swayne (1990) the top medicine was Pulsatilla. However, the following were also in the top 10, Rhus toxicodendron, Natrum muriaticum (4^{th}) Sulphur, Sepia, Arsenicum album, Lycopodium and Nux vomica. Thus eight of the top ten medicines are the same as in the current study.

Looking at other studies, Jansen and Koster (1995) had Calcerea carbonica as the top prescribed medicine, in the current study Calcerea carbonica was ranked 19^{th}. Aconite ranked 4^{th}, and Kalium bichromium ranked 6^{th} in the current study, were ranked 29^{th} and 38^{th} respectively in the Jansen and Koster study. However within the top ten were Lycopodium, Natrum muriaticum (3^{rd}), Nux vomica, Pulsatilla, Sepia, Silica, and Sulphur as in the current study. They note that nosodes were prescribed in 6% of the cases. In the current study, nosodes were included in 10% of the scripts, with Carcinosinum predominating (ranked 12^{th} in frequency of use).

A retrospective study of 4 years of prescribing trends at the Glasgow Homeopathic Hospital (Kayne and Beattie, 1998) showed that in all four years Natrum muriaticum was the most frequently prescribed medicine. Lycopodium, Pulsatilla, Rhus toxicodendron, Sulphur and Sepia also consistently fell in the top ten medicines. Arsenicum only featured in one year. Aconite, Kalium bichromium, Nux vomica and Silicea unlike the current study did not feature in any of these years within the top 10 medicines.

In the IIPCOS-01 study (Heger *et al.*, 2001), the top medicine was Pulsatilla. Also in common with the current study's top medicines are, Lycopodium, Sulphur, Kalium bichromium, Arsenicum album and Rhus toxicodendron.

From the above comparison it is clear that KZN prescriptions are in line with trends from other studies. The high rank of Aconite (4^{th} – making up 7.6% of scripts) in the current study is interesting because in no other study was it so prominent. Aconite was prescribed mainly for respiratory conditions (Vermeulen, 1994:13). Aconite is also prescribed for states of shock or fright (Vermeulen, 1994:9). Given the high crime rate and violence in South Africa, it would be interesting to explore if there is a connection. The high use of Natrum muriaticum is not so surprising when one considers that the most frequent conditions treated were allergic rhinitis/ sinusitis, depression and migraines/headaches, all three of which are covered well in the materia medica of Natrum muriaticum (Vermeulen, 1994:684-686).

5.3.5.3 Placebo

9% of the patients were given placebo in addition to medication. The reasons stated were to ensure patient compliance, continuity and because of patient need.

5.3.5.4 Posology

The current study revealed a large variety of prescribing techniques i.e. the potency and number of doses used. Bernard (2000) comments, that there are many different opinions, even amongst so called "classical" homeopaths, on how to apply potency in practice. She suggests that there are valid reasons for all methods of prescribing, and one needs to keep one's mind flexible in this regard. She cautions against getting stuck in one mode of prescribing, in which case one would not be doing justice to one's patients. Within the current study trends were

difficult to pick up amongst the practitioners, however it can be said that many practitioners appear to be using a specific style for the majority of patients they saw.

28% of the scripts were for single medicines, with 2% of the total scripts being for a single dose of 200C. This is in contrast to Bernard (2000) who found that the majority (83.8%) of homeopaths surveyed prescribed a single dose of 200C-1M, most often. In the current study only one practitioner prescribed for 5 patients a single dose of a high potency (10M) medicine. Only one LM was prescribed. This is in contrast to the Bernard study where the use of LM potency was the second most popular method. Five scripts were for plussed potencies, prescribed by 2 of the homeopaths practicing from the DIT Homoeopathic Clinic. For the majority of single remedy scripts, multiple dosing was used, either by means of three ascending potencies, or split doses on consecutive days or weekly/bimonthly split doses. 11% of the scripts were multiple dosing daily of low potency medicines.

By far the majority of scripts consist of a combination of using more than one medicine and multiple dosing, i.e. a few doses of a medium potency medicine supplemented by a low potency medicine or complex given daily (20%) or the use of one complex daily (20%) or more than one complex given daily (13%) and finally the daily alternation of two low potency single medicines (11%).

The posology technique relates to the type of training that the practitioners received. In the current study an association between the year of practical training and type of homeopathy practiced amongst graduates of DIT was found (P-value = .000<.001). Those that completed their practical training at DIT between 1993 and 1995 mostly tended towards prescribing more than one medicine in combination or alternation in low potencies (pluralist homeopathy). The 5th year materia medica lecturer at the time was Dr R Boyer MD (Montpellier, France). He practiced clinical/pluralist homeopathy. In the course of 1996 a

deliberate move away from this method of treatment was made and the teaching became more "classical" (Dr A Ross, 2003). More classical prescribing is evident amongst practitioners that completed their practical training from 1996 onwards.

5.3.6 Non-homeopathic prescriptions and treatment

Additional therapy was received by 60% (n = 96) of the patients. Of the non-homeopathic prescriptions and treatments, herbal medicine was most prescribed (29.7%, n = 47), followed by minerals and vitamins (13.3%, n = 21) and the most prevalent treatment was acupuncture (9.5%, n = 15). Bach flower medicines (5.6%, n = 9), massage (3.2%, n = 5) and chiropractic (1.9%, n = 3) were of lesser importance.

Heger *et al.* (2001) found that additional therapy was given to nearly half of the patients. Herbal medicines were likewise most frequently used at 19.5%. However, conventional medicines were used for 16.1% of patients. There was less use of acupuncture (2.3%). It must be remembered that the majority of South African homeopaths are not trained as medical doctors first; rather they have additional training in complementary and alternative therapies, and thus the increased use of these therapies.

The use of additional therapies was also seen in the Ferrucci study where private practitioners used acupuncture (+/-28%) and massage (+/-20%) quite extensively as additional modalities. Since this study was done in 1994, it would appear as if the use of these therapies by practitioners has decreased. This may be because of the sample bias in the current study towards DIT graduates, and perhaps the older homeopaths use these therapies more extensively.

5.3.7 The follow-up consultation

Three quarters of patients (75.3%, n = 119) had a follow-up consultation. Patients were seen either 2-3 weeks later (34.5%, n = 41) or 4-7 weeks later (37.8%, n = 45). Bernard (2000) found that the normal follow-up time was listed as 4-6 weeks, by 69% of practitioners. Bernard states that this is dependent on the case, i.e. whether it is with children, an acute situation, or a more severe case, where an earlier follow-up would be required. In the current study, the follow-up timing seems to be based on individual practitioners' patterns of practice.

5.4 Treatment outcomes

5.4.1 The Glasgow Homoeopathic Hospital Outcome Scale (GHHOS)

The practitioners used the GHHOS to rate the effect of treatment. On this scale, 45% (n = 53) of patients were rated as cured (+4) or showed major improvement (+3), with a further 50% (n = 59) showing slight (+2) or moderate improvement (+1). 2.5% (n = 3) showed some deterioration. Similarly, Sevar (2000) conducted an outcomes audit on his own patients. He rated 43% as showing cure or major improvement. In comparison, the IIPCOS-01 study (Heger *et al.*, 2001) shows much greater levels of improvement, with an average of 80.5% of USA and European patients cured or with major improvement. 2.3% fell in the deterioration category. The difference in this study is that the patients were asked to assess the change. In the study by Moys (1998) patients too where asked to perceive outcomes of the homeopathic treatment they had received. She found that the majority felt that the treatment had helped considerably (67.7%) or resulted in cure (56%). This was again the perceived outcome from the patients view point. From looking at the results of practitioner and patient assessed outcome studies, it appears that patients have a more positive assessment of their outcomes than do practitioners.

For the patients who completed the Exit Questionnaire, the patients assessed their treatment outcomes according to the GHHOS. In comparison to the practitioner assessed results, these results showed less improvement, which may be the reason for not attending the follow-up.

The outcome of treatment was crosstabulated against the type of homeopathic treatment received, i.e. classical, pluralist or complex. It was established that there was no association between the type of treatment received and the outcome of the treatment (P-value = .744). Thus no one homeopathic treatment type gave better results. This is an important finding, because it implies that no

one type of homeopathy being practiced in KZN can be deemed to be more effective than any other.

5.4.2 Improvements and deteriorations

The improvements were noted largely on a general and local level. The greatest response to treatment was amongst the younger patients. 75% (n = 12) of patients aged between 2-15 years showed major improvement or cure. The babies (0-24 months) also responded well with 67% (n = 4) rated as cured. No statistical relationship was found between age and outcome (P-value = .148). The IIPCOS-01 study (Heger *et al.,* 2001) found that children between the ages of 2-17 years seem to profit particularly from homeopathic treatment. In the current study the conditions rated as pure acutes showed an 86% (n = 6) cure rate. Only four chronic patients were assessed as cured but 46% (n = 49) showed moderate to major improvement. The statistical analysis showed that there was an improvement across all categories, i.e. acute, sub-chronic and chronic and not only in acutes (P-value = .000<.001).

A more accurate assessment would be to rate the effectiveness of homeopathic treatment of chronic conditions over a longer period of treatment. Richardson (2001) conducted an outcome survey at the Liverpool Regional Department of Homoeopathic Medicine, on patients that had completed at least two courses of homeopathic treatment. He states that a minimum of three visits, including the initial consultation, was necessary to give a fair picture of the benefits of homeopathic treatment. The example is given of Chronic Fatigue Syndrome, where the clinical impression had been that homeopathy was not very effective in treating this condition. The research showed a 57.1% improvement (practitioner assessed GHHOS +2, +3, +4). However these patients attended an average of 12 times.

In the current study, 3.5% of the patients were rated as experiencing deterioration in their condition. These were all chronic patients.

5.4.1.3 Adverse events

One quarter of the follow-up patients had adverse events (AE), the majority of these were described as a worsening of the existing complaints that lasted for 4 days or less. The practitioners felt the reactions were possibly or probably related to the treatment, and thus can be described as classic homeopathic aggravations. The Figures are high in comparison to the IIPCOS-01 study (Heger *et al.*, 2001). Only 8.3% of patients experienced AE and only in 3.4% of cases was there a relationship with the study medication suggested.

5.5. Patient satisfaction and assessment of outcome

5.5.1 Illness Intrusiveness Ratings Scale

In the current study the patients showed strong satisfaction with the treatment and the outcomes of the treatment. The patients were asked to rate the impact of the disease in various areas of their lives via an Illness Intrusiveness Scale pre- and post-treatment. The ratings showed that patients found improvements in all areas of their lives. Dramatic changes were noted specifically in health and self expression/self improvement. This suggests that homeopathy is effective in treating the whole person and in moving people to a position of wellness and not just the absence of disease. Statistically significant improvements were found for the areas of health (P-value = .000<.001), diet (P-value = .019), work (P-value = .000<.001), active recreation (P-value = .000<.001), passive recreation (P-value = .004), family and other social relations (P-value = .001), self expression/self improvement (P-value = .001) and community/civic involvement (P-value = .016).

5.5.2 Visual Analogue Scale

This scale showed that patients rated their general health as having improved after treatment (P-value = .000<.001). The scale also showed a more positive shift in their perception of their "'life-state' today" in the post-treatment results (P-value = .019)

5.5.3 Consumer Satisfaction Survey

Patients also completed a Consumer Satisfaction Survey. The majority of responses fell in the excellent range. The patients gave highest ratings for the friendliness and courtesy shown by the doctor, and for overall service. 74.1% of patients found the outcomes of their healthcare to be very good or excellent

5.5.4 Holistic practice outcome

Over 90% of the follow-up patients 'strongly agreed' or 'agreed' that; complementary medicine was good because it treats the whole person and not just the condition, that talking with the therapist can help the person find out what the problems are, and that they felt that they could take their time when speaking to the therapist which helped them feel better. Less well agreed with were the notions of patient responsibility and role in promoting their own cure. This would suggest that patients have largely still traditional views of the patient/doctor relationship and of healing. These questions were specifically added to the study as part of a tool to measure holistic practice (Long *et al.*, 2000). The very favourable feedback given by patients specifically around the interaction between the therapist and the therapy user show that homeopathy is very effective holistic practice therapy.

5.6 Critique of current research

The results do not reflect the total picture of homeopathy in KZN because of the minimal participation of more experienced practitioners and the difficulty in contacting the black practitioners in more rural areas. It would be beneficial to see what these groups add to the clinical audit if done in the future.

Only 19 practitioners of the 30 study sample completed Section 2 of the study which required them to document data for 10 new patients. Of these 19, two practitioners collected data that the researcher rejected on the basis that data was incomplete. Of the 17 practitioners who did complete the data, only 13 completed data for a total of 10 patients each. The disadvantage of doing practice based research is that the practitioners were very busy and thus gaining co-operation was in some cases very difficult.

There was a certain amount of reluctance and suspicion from the practitioners as to the nature of the study and their participation in it. The researcher had to stress that anonymity of the practitioners was paramount, and that the researcher had not set out to "report" on individual practitioners. The question related to homeopathic qualification was reluctantly and poorly answered by some practitioners. The researcher had in mind that this data could be validated via the registration records at the AHPCSA. However when the researcher approached the AHPCSA for access to this data, the request was denied.

The question on posology was poorly answered by some practitioners, if the study were to be repeated the practitioners must be asked to give a clear breakdown of the prescription i.e. which remedy, what potency, how many doses, and how often.

The research is merely a descriptive study, with the questionnaires on treatment outcome, completed by the practitioner and the patient, thus no objective measure was used to base improvement score on.

The treatment outcomes assessment for diseases of chronic nature was limited. For a better reflection of the benefit of homeopathy in these cases a longer time period of assessment is recommended.

Gaining consent from the patients and ensuring completion of questionnaires at the Health Awareness Clinic was problematic. The receptionist did not feel she had time to explain the study and gain co-operation of the patients, since patients are seen every 15 minutes, and the waiting room is very busy. The researcher thus attended the clinic personally to enroll and ensure that the questionnaires were completed. The researcher thus had first hand experience of the difficulties that some patients had in completing some of the questions. Specifically the VAS question on best possible life (Q3.3.2/Q5.3.2) seemed difficult for some of the more elderly patients to understand. The researcher was left questioning the reliability of the responses to this question in general. For future studies, specifically if a more rural based research is to be done, amongst less educated patients, questions need to be carefully developed.

An area that was omitted in the study was level of patient education. It is felt that homeopathy would be more prevalent in the more educated groups. It is suggested that future studies include this demographic.

An area that was omitted in the study was a question on how data is captured by individual practitioners. It would be interesting and useful for further data capture studies to know how many homeopaths are collecting data via computer, as it is the easiest way of data exchange.

The survey did not question the cost of medication. This is an important area in a clinical audit, if one is to compare the cost effectiveness of homeopathy, and its contribution to cost reduction in the healthcare system.

The survey did not question practitioners regarding their dispensary. However, during the course of the study it became apparent that this was an area that may affect quality assurance. Because Questionnaire 1 was administered by the researcher in a face to face interview, all the practitioners invited the researcher to tour their rooms. From this, the researcher was informed that 4 practitioners utilised radionics machines to prepare their medicine. This information was not included as it was not formally surveyed. In hind sight it would have been interesting to have gathered information regarding the dispensary. Questions could include; where the practitioners obtain their medicines from? In what form, i.e. medicating potencies vs medicated granules? Do they use radionics machines to make up their medicines?

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The results of this clinical audit provide demographic data on homeopaths in Kwazulu Natal and how they practice, as well as demographics and characteristics of their patients. The procedures of diagnosis, care and treatment, have been assessed and conclusions can be drawn with regards to quality assurance. The treatment outcomes were assessed by the practitioner and the patient. Patients gave feedback on consumer satisfaction.

The majority of homeopaths who participated in the study are graduates of DIT who had had less than ten years experience. The older more experienced practitioners did not want to participate for various reasons. The study included data from four black practitioners practising in one area only of central rural KZN only, since no other black practitioners were contactable or willing to participate. The study thus reflects a bias to younger, white, DIT trained homeopaths, and thus the data collected may not be a true reflection of how homeopathy is being practised in KZN as a whole, or South Africa as a whole.

The main aim of this study was to conduct a clinical audit, i.e. "documenting what we are doing". The aspect of documenting the demographic and practical aspects of homeopathy in KZN was achieved. However, a clinical audit includes three areas - quality assurance, treatment outcomes and economic outcomes. This study addressed the first two of these areas.

Areas of concern regarding quality assurance emerge from this study. The first of these is the area of ongoing education, as represented by the attendance of conferences and journal subscriptions. From a quality assurance perspective it is

essential that practitioners are keeping abreast of new methods and findings in homeopathy. The development of Continuing Professional Development points is a means of ensuring that a certain standard is maintained within the profession. A copy of this research will be sent to the AHPCSA, whose task it is to implement the structures that will enable practitioners to meet the requirements of CPD points. One hopes that the Council will enforce the CPD ruling when practitioners reregister annually. A second area of concern was the high use of complexes. Of specific concern was the prescribing of complexes that one can buy from a health shop or pharmacy without having an homeopathic consultation. Some of these scripts were in addition to more individually simplex prescriptions, but some were not.

Looking at treatment outcomes, the strength of this clinical audit comes through. Despite the variety of treatment approaches, the results of treatment outcomes did not vary across the practitioners. Treatment outcome results as rated by the practitioner showed that 44% of patients experienced major improvements or cure. From the patients perspective treatment outcome was rated as very good to excellent for all the practitioners. No association was found between the outcomes of their healthcare against the type of homeopathy practiced, nor against the duration of time of the first consultation. Patients saw homeopathic treatment as holistic and patients showed improvements in all areas. Consumer satisfaction with all aspects of the treatment was very high.

From this study one can conclude that homeopathy as it is practiced by this sample of homeopaths in KZN, is an effective form of medical treatment. The findings will be very encouraging to the homeopathic community, but can also play a role in communicating the clinical effectiveness of homeopathy to the medical establishment and the general public. Finally, this study is a significant contribution to the international movement for the collection of homeopathic data, and will be forwarded to the DCG.

6.2 Recommendations

The current study represents just a tip of an ice-berg of data that needs to be collected and documented, in order to ensure that homeopathy makes vital and significant contribution to the healthcare system in South Africa. The following recommendations are made:

a. The current study was limited to KZN. It is recommended that clinical audits be conducted in other areas of South Africa. It would be interesting to see if there are differences across the various provinces, particularly in Gauteng where there would be a large number of graduates from Technikon Witwatersrand. Thus future audits need to be carried out on homeopaths in other provinces;

b. The practitioner sample in the current study did not adequately reflect the population of homeopaths in KZN, future studies should aim to include more black and older homeopaths;

c. Future studies should be designed with minimal participation requirements on the practitioners. It is felt that this would increase their co-operation and participation in the study;

d. Questions on posology need to be clearly worded and broken down as follows: remedy name, potency, and dosage (how often, how many and for how long).

e. In future quality assurance research, questions on the practitioners dispensary need to be included;

f. A study could be done on treatment outcomes measured against different treatment methods, i.e. practitioners who prepare medicines radionically vs non radionically prepared medicines;

g. Data collection projects that look at the economic outcomes, and cost effectiveness of homeopathic treatment need to be carried out;

h. It is recommended that a long term study on treatment outcomes be done, so that the impact of homeopathy on chronic disease can be assessed;

i. Comparisons of South African orthodox medical practitioners and homeopaths need to be done;

j. In-depth studies of those practitioners who practice both traditional medicine and homeopathy would provide information on how uniquely homeopathy is being practiced by these practitioners;

k. Research with regards to the awareness of homeopathy both in terms of healthcare and as a career choice needs to be conducted in the black community;

l. Research into the reasons why practitioners who are registered with council or qualified with M.Tech. (Hom) degrees, are not practicing homeopathy fulltime or not at all;

m. A study amongst practitioners looking at what economic and social challenges, homeopaths face by practicing in South Africa.

CHAPTER 7

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APPENDICES

APPENDIX A SURVEY ON HOMOEOPATHY: 10-ITEM DATA SET

1. Patient identification (initials//date of birth//sex).
2. Chief complaint/s (severity of chief complaints//onset of complaint/s).
3. Clinical diagnosis (acute//chronic//since when?).
4. General well-being (how have you been feeling in general during the past month?).
5. Health state (health state today: 0=worst imaginable, 100=best imaginable health state).
6. Treatment prescribed (homoeopathic treatment {medication/potency}// other treatment/s// therapeutic placebo//no treatment, why?).
7. Total length of consultation (minutes//hours).
8. Outcome of treatment.
9. Adverse events (no//yes//if yes observed adverse event//start date//end date or ongoing//relationship with treatment {none//improbable//possible//probable//unable to evaluate} //initial aggravation).
10. Date of patient contact/consultation.

Note:
All items have to be completed by the practitioner except for those items related to the patient's complaints and quality of life (2,4 &5).
Items 8 and 9 N/A at initial contact.

The proposed study's relationship to the DCG 10-item data set:

	Data researched	10 item data Set	Completed by:
Questionnaire 1 (appendix D1)	Demographic information and general practice information of homoeopathic practitioners.	N/A	Researcher
Questionnaire 2 (appendix D2)	Clinical audit of consultation characteristics.	1,3,6,7and 10	Practitioner
Questionnaire 3 (appendix D3)	Patient assessment of severity of complaint, general well-being and health state.	2,4 and 5	Patient
Questionnaire 4 (appendix D4)	Outcome of treatment.	8 ,9 and 10	Practitioner
Questionnaire 5 (appendix D5)	Outcome of treatment. Consumer satisfaction.	2,4 and 5 N/A	Patient
Questionnaire 6 (appendix D6)	Consumer satisfaction-exit questionnaire.	N/A	Researcher

APPENDIX B1

TECHNIKON NATAL

P.O. Box 953
Durban, 4000

Berea Campus:
Telephone (031) 204-2111
Facsimile (031) 22-3405

City Campus:
Telephone (031) 204-2111
Facsimile (031) 22-3405

TITLE OF RESEARCH PROJECT:

A Clinical Audit of Registered Homoeopathic Practitioners in Kwazulu Natal.

NAME OF SUPERVISOR: **Dr R. Steele (B.A.,H.D.E, MTech(Hom))**

As part of my Masters Degree in Homoeopathy I have chosen to undertake a clinical audit of homoeopathic practitioners practising in Kwazulu Natal, and I am asking you to be a participant. This is in line with international trends of researching the effectiveness of homoeopathy under real life circumstances.

Participation will involve completing a short questionnaire for 10 new patients attending your practice during a particular time-period at their initial consultation and first follow-up consultation, and requesting the patients to complete a short questionnaire before their first consultation and before their follow-up consultation.

All 64 registered practicing Homoeopaths in Kwazulu Natal have been asked to participate from which a sample group of 30 will be selected as follows; From those practitioners that respond positively, those that are in the two smallest demographic groups will automatically be selected (to ensure a representative cross section) the remainder of the sample group will be randomly selected.

Information is to be collected by means of questionnaires. The following table outlines the various aspects of the study:

	Data researched	Completed by
Questionnaire 1	Demographic information and general practice information of homoeopathic practitioners.	Researcher
Questionnaire 2	Clinical audit of consultation characteristics.	Practitioner
Questionnaire 3	Patient assessment of severity of complaint and general well being and health state.	Patient
Questionnaire 4	Outcome of treatment.	Practitioner
Questionnaire 5	Outcome of treatment. Consumer satisfaction.	Patient
Questionnaire 6	Consumer satisfaction-Exit questionnaire	Researcher

If you would like to participate, please complete the attached form and fax it to me. I will then set up an appointment with you to complete Questionnaire 1, and to discuss in depth what is required of you and clear procedures with your receptionist. This meeting will take about 30 minutes of your time.

The procedure will be as follows:

1. During a particular 2-3 week period, you will be required to complete Questionnaire 2 for the next 10 new patients that you see.
2. The patients will complete Questionnaire 3 prior to their consultation.
3. Your receptionist will collect the questionnaires and place them in a box provided.
4. Your receptionist will schedule a follow-up consultation in 4 weeks time, unless you deem it necessary to see the patient earlier.
5. I will collect the data on completion of the 10 patients.
6. At the follow up consultation, you will complete Questionnaire 4
7. Questionnaire 5 will be completed by the patient prior to the consultation.
8. Your receptionist will place all the completed questionnaires in the box provided, which I will collect.
9. The receptionist will contact patients that do not attend the follow-up consultation and the patient will be given the option of a second appointment. If the patient still does not attend or does not want to reschedule, Questionnaire 6 will be administered telephonically by the researcher.

I realise that your time is valuable and thus each questionnaire has been limited to only the most crucial information, yet still including enough questions to ensure that the study provides meaningful information. Questionnaires 2 and 4 take about ten minutes each to complete.

Please note that you will be assigned a practitioner number and your patients will be assigned a specific code, thus ensuring anonymity. Only in cases where patients do not attend the follow-up consultation will the name of the person be revealed to me so that I can administer the exit questionnaire (Questionnaire 6)

The benefits of this study for you as a practitioner is to provide vital information of Homoeopathy in KZN, which can be used to:

- provide the SA homoeopathic community with the basis of proving it's effectiveness.
- contribute to the development of an empirical and coherent picture of homoeopathic practice, which can be projected to the public, other medical professions, business and government.
- develop baseline data that can provide a platform for launching a national clinical audit data collection project.
- provide the Allied Health Professions Council of South Africa with data that will aid in identifying areas that can be focused on for Continued Practitioner Development.

The researcher and participants will receive no remuneration for undertaking and participating in the study. The cost of the study will be born by Technikon Natal.

I will be available at all times to answer any queries you may have and deal with problems you may encounter. Please do not hesitate to contact me at: (031) 2020160 or 0827261858.

When the dissertation is complete, the abstract and table of contents will be sent to you. A copy of the full dissertation will be available for loan to you if you are interested.

I believe that this study will provide valuable information regarding homoeopathy in South Africa and contribute to developing the homoeopathic profession. Your co-operation is greatly appreciated.

Yours sincerely

Marianne Verhoogt
Investigator

Dr A. Ross
Head of Homoeopathy Dpt.

FAX REPLY SLIP

Attention: Marianne Verhoogt

Fax no: 031 202 3002

Tel no: 031 202 0160

From:.....

Tel no:.....

Yes I would like to participate in the clinical audit study.

Practitioner Name.....

Signature.....

Date .....

APPENDIX B2 PRACTITIONER INFORMED CONSENT DOCUMENT

TITLE OF RESEARCH PROJECT:
A Clinical Audit of Registered Homoeopathic Practitioners in Kwazulu Natal.

NAME OF SUPERVISOR: **Dr R. Steele (B.A.,H.D.E, MTech(Hom))**

Date: _____

Practitioner's Full Name:_____

Please circle the appropriate answer		
Have you read the research information sheet?	Yes	No
Have you had an opportunity to ask questions regarding this study?	Yes	No
Have you received satisfactory answers to your questions?	Yes	No
Have you had an opportunity to discuss this study?	Yes	No
Have you received enough information about this study?	Yes	No
Who have you spoken to?		
Do you understand the implications of your involvement in this study?	Yes	No
Do you understand that you may withdraw from the study? a) At any time b) Without having to give any reason for withdrawing	Yes	No
Do you agree to voluntarily participate in this study?	Yes	No

If you have answered "no" to any of the above, please obtain the necessary information before signing.

I, _____ hereby agree to participate in a clinical audit study that will look at practitioner demographics, clinical methods and treatment procedures and treatment outcome of homoeopathic practitioners in Kwazulu Natal.

I am aware that this involves answering certain questions regarding my practice and entering data into questionnaires for 10 new patients at their initial and first follow-up consultation. I will arrange for these 10 patients to fill out separate questionnaires at the initial consultation and first follow-up consultation.

Please print in block letters:

Practitioner's name: _____ Signature: _____

Witness Name: _____Signature: _____

Research Student Name: **Marianne Verhoogt** Signature: _____

APPENDIX B3

INFORMATION SHEET FOR THE PATIENT

To Whom It May Concern:

TITLE OF RESEARCH PROJECT:
A Clinical Audit of Registered Homoeopathic Practitioners in Kwazulu Natal.
NAME OF SUPERVISOR: **Dr R. Steele (B.A.,H.D.E, MTech(Hom))**

As part of my Masters Degree in Homoeopathy I am required to research a specific topic relating to the practice of homoeopathy. I have chosen to undertake a clinical audit, which means collecting data under real life circumstances. Thank you for agreeing to participate in this research project.

There are two stages to the research. In the first stage I have asked your homoeopath to complete a questionnaire for the next 10 new patients who attend their practice in a two-week period. The questionnaire asks questions regarding the procedures, diagnosis, and treatment that he or she uses in your consultation. The second stage is the follow-up consultation, where your practitioner must complete information on the outcome of the treatment. In addition, I am asking you to complete a questionnaire at each consultation, which will provide information regarding your well being before and after the treatment as well as your satisfaction with the treatment.

At no stage will your homoeopath reveal any confidential information that you have discussed with him/her to myself as the investigator. Please note that the information relating to personal details e.g. name, address etc. will remain confidential to your homoeopath. However, if you do not return for your follow-up consultation your name and telephone number will be passed on to me, so that I can phone you to complete a final questionnaire. No names or addresses will appear in the dissertation.

There will be no remuneration to the researcher, the practitioner or to you for participating in the study. The costs incurred by the investigator for the study will be born by Technikon Natal. If you have any problems or questions, please do not hesitate to contact me. My phone numbers are (031) 2020160 or 0827261858.

The data gathered in the study will provide valuable information on the nature of homoeopathic practice in Kwazulu Natal. This information will be used to develop and improve homoeopathic practice. It is hoped that the results can also be used to promote homoeopathy in the eyes of the public, medical aid schemes, and the government. Your participation will be greatly appreciated; please complete the informed consent form attached to this letter and hand it to the receptionist. Please keep this page.

Thank you for your co-operation,

Marianne Verhoogt
Investigator

APPENDIX B4
PATIENT INFORMED CONSENT FORM

TITLE OF RESEARCH PROJECT:
A Clinical Audit of Registered Homoeopathic Practitioners in Kwazulu Natal.

NAME OF SUPERVISOR: **Dr R. Steele (B.A.,H.D.E, MTech(Hom))**

Date: _____

Patient's Full Name:_____

Please circle the appropriate answer

Have you read the research information sheet?	Yes	No
Have you had an opportunity to ask questions regarding this study?	Yes	No
Have you received satisfactory answers to your questions?	Yes	No
Have you had an opportunity to discuss this study?	Yes	No
Have you received enough information about this study?	Yes	No
Who have you spoken to?		
Do you understand the implications of your involvement in this study?	Yes	No
Do you understand that you may withdraw from the study? a) at any time b) without having to give any reason for withdrawing c) without affecting your future health care	Yes	No
Do you agree to voluntarily participate in this study?	Yes	No

If you have answered "no" to any of the above, please obtain the necessary information before signing.

I, _____ hereby agree to take part in the above-mentioned study conducted by Marianne Verhoogt of Technikon Natal. I understand that all information I volunteer will be regarded as strictly confidential.

I understand that once I agree to participate, it is important that I attend the follow up appointment.

Please print in block letters:

Patient name: _____ Signature: _____

Parent/Guardian: _____ Signature: _____

Witness Name: _____ Signature: _____

Research Student Name: **Marianne Verhoogt** Signature: _____

APPENDIX C GUIDELINES TO THE RECEPTIONIST

The completion of this research project is necessary in order for me to meet the requirements on my Masters Degree in Technology: Homoeopathy and hence your assistance is needed. The study can be described as a clinical audit, which means I will collect data regarding practitioner demographics, clinical methods, treatment procedures and treatment outcome of homoeopathic practitioners in Kwazulu Natal. With the aim of using the data to promote homoeopathy and to enhance the understanding of it to the public, medical aids, business and government. Thus the study will provide valuable information. Your assistance in this study is greatly appreciated. Here are some guidelines that may help you.

1. Please inform the patient that the research is taking place with the consent of the relevant practitioner and that he/she would appreciate them completing the questionnaire.
2. Please give the next 10 new patients entering your reception a patient informed consent document once the patient has agreed to participate in the study. Kindly hand him/her Questionnaire 3 provided, which is to be completed before the consultation.
3. If appropriate, please assure the patient that no names will be used and that all information obtained will be treated as strictly confidential.
4. Kindly sign as a witness on the consent documentation.
5. Please ensure that the practitioner has a copy of Questionnaire 2 and collect the completed questionnaires from the practitioner.
6. After the consultation please make a follow-up appointment for 4 weeks time, unless otherwise specified by the Homoeopathic practitioner? Please fill in the patient register with the appointment details and contact telephone number for the patient.
7. Once the required number of new patients has been seen (10) please contact me at the number below.
8. It is important that the patients attend the follow-up consultation, please could you give the patients a reminder call two days before the follow-up consultation date. If the patient misses the follow-up please will you contact the patient and reschedule an appointment within the next two weeks. If they do not attend this second follow-up or do not want to reschedule kindly note this on the patient register.
9. At the follow-up consultation, please give the patient Questionnaire 5 to complete prior to the consultation.
10. Please ensure that the practitioner has a copy of Questionnaire 4 and collect the completed questionnaires from the practitioner.
11. Place all completed questionnaires in the box provided.
12. If you have any difficulties please contact me on telephone number (031) 2020160 or 0827261858

Thanking you in anticipation.

Marianne Verhoogt
Intern (6th year student)

APPENDIX D1

QUESTIONNAIRE 1: Practitioner demographics		Completed by Researcher
0.1 Date of Interview *(Use listing dd/m, i.e. 30th June = 306)*	0.2 Name of Practitioner	PRACTITIONER CODE:

1. DEMOGRAPHICS Researcher to circle the relevant number

1.1	Date of birth (yy/mm/dd)		1.2	Sex of Practitioner *1=male 2= female*	
1.3	Race *1=white 2=black 3=Indian 4= coloured*		1.4	Year of 1st registration with council	
1.5	Homoeopathic Qualification		1.6	Institution from which qualified	
1.7	Other Qualification		1.8	How many years/months practicing Homoeopathy *(answer in years and months)*	
1.9	What Type of practice *1=sole 2= group –Homoeopathy only 3 =group multidiscplinery*				
1.10	Other disciplines employed by the practitioner alongside homoeopathy				

1= allopathic medicine *4=phytotherapy* *7=Iridology*
2= acupuncture *5=naturopathy* *8=Aromatherapy*
3=chiropractic *6=traditional healer* *X=other (specify)*

1.11	What percentage of your practice is Homoeopathy? *1 = 25% 2 = 50% 3 = 75% 4 = 100%*				
1.12	Average patient load per week?		1.13	What is the avarage time for a new patient consultation	Min
1.14	What is the fee for a consultation-New?		1.15	What is the fee for a consultation- Follow up?	
1.16	Do you utlise any of the following to aid your diagnosis or prescription? *1=Repertory 2=Pendulum 3=Radionics X=other (specify)* _____				
1.17	Do you make use of a computer reportrising programme? *1=yes 2= No*		1.18	Do you dispense your own medicines? *1=yes 2= No 3=sometimes*	
1.19	Please circle which of the following journals you subscribe to?				

1=Homoeopathic Links
2= New England Journal of Homoeopathy
3=British Homoeopathic Journal
3=Simillimum
4=Health and Homoeopathy
5=HomInt R&D Newsletter
6=none
X=other (specify) _____

1.20	Have you attended any Homoeopathic conferences in the last 12month period? *1=yes 2= No*	
1.20.1	If answered yes to 1.20 which ones have you attended?	
1.21	What areas would you like to see the Allied Health Professions Council of South Africa cover in terms of earning continuing professional development points?	

1=Homeopharmaceutics *4=Pathology* _____
2=Emergency Procedures *5=Diagnostics*
3=Materia medica *X=other (specify)*

	1.22 Sources of new patients?			1.23 Referrals to others?		
	Seldom or never	Sometimes	Often or always	Seldom or never	Sometimes	Often or always
1.Self referral	1	2	3	1	2	3
2.Naturopath	1	2	3	1	2	3
3.Chiropractor	1	2	3	1	2	3
4.Physiotherapist	1	2	3	1	2	3
5.Acupuncturist	1	2	3	1	2	3
6.Colleague Homoeopath	1	2	3	1	2	3
7. General Practitioner	1	2	3	1	2	3
8.Psychologist	1	2	3	1	2	3
9.Pediatrician	1	2	3	1	2	3
10.Gyneacologist	1	2	3	1	2	3
11.other medical (specify)	1	2	3	1	2	3

QUESTIONNAIRE 2: Initial consultation cont. | Completed by Practitioner

4. Treatment prescribed

4.1 In this case did you prescribe homoeopathic remedies?

1=yes 2= no

4.1.1 If yes,did you prescribe a single remedy only?

1=yes 2= no

4.1.2 If no, in 4.1.1 did you prescribe more than one remedy...?

1= at different times (e.g. alternating)
2=in combination (more than one remedy in each dose)

4.2 Which remedy/s did you prescribe (including potency and frequency of dosage)

4.3 Did you use a repertory to help you prescribe?

1=yes 2= no

4.4 Which of the following approaches did you rely on most in analysing the case

1=local symptoms
2=totality of symptoms
3=miasmatic
4=constitutional
5=keynotes
X=other (speciify) _____

4.5 In this case did you prescribe any of the following

1 = bach flower remedies 2=herbal rmedies 3=vitamins X=placebo

4.5.1 If you did prescribe a placebo, Why?

4.6 Did you perfom any of the following treatments

1= Acupuncture
2=Chiropractic
3=Electrotherapy (laser/ultrasound)
4=Refexology
5=Aromatherapy
6=Massage
7=Radionics
X = other (specify) _____

4.7 DID YOU REFER THIS PATIENT?

1=YES 2=NO

4.8 IF YES, TO WHOM?

2=General Practitioner
3=Naturopath
4=Chiropractor
5=Physiotherapist
6=Acupuncturist
7=Colleague Homoeopath
8=Psychologist
9=Pediatrician
10=Gyneacologist
X=other (specify) _____

4.9 HOW LONG WAS THIS CONSULTATION?

1=less than 15min
2=between 16-30 min
3=between31-60 min
4=between 61-90 min
5=more than 90min

APPENDIX D3

QUESTIONNAIRE 3: Initial consultation		Completed by patient
0.1 Date of Consultation *(Use listing dd/m, i.e. 30th June = 306)*	Practitioner code	Patient code

5. Please complete the following: where options are given please circle the relevant answer

1.1	Patient Initials		1.2	Date of birth (yy/mm/dd)	
1.3	Gender *1=male 2= female*		1.4	Occupation	
1.5	Race *1=white 2=black 3=indian 4=coloured*		1.6	Home language? *1=English 2=Afrikaans 3=Zulu X=other (specify)*	
1.7	Do you belong to a medical aid? *1=yes 2=no*		1.8	Does your medical aid pay for homoeopathic service? *1=yes 2=no 3=partially*	
1.9	Chief complaint _____ _____		1.10	How long have you been suffering from this complaint? *1=less than one week 2=more than one week, but less than 3 months 3=more than 3 months*	
1.11	Is this the first time that you have suffered from this complaint? *1=yes 2=no*				

2. The following items ask about how much your illness interferes with different aspects of your life. PLEASE CIRCLE THE ONE NUMBER THAT BEST DESCRIBES YOUR CURRENT LIFE SITUATION. If an item is not applicable please circle the number one (1) to indicate that this aspect of your life is not affected very much. Please do not leave any item unanswered. **(Illness Intrusiveness Scale -*Lorig et al., 1996*)**

How much does your illness and.or its treatments interfere with your...									
a) Health	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
b) Diet	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
c) Work	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
d) Active recreation e.g. sports	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
e) Passive recreation e.g. reading	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
f) Financial situation	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
g) Relationship with spouse	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
h) Sex life	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
i) Family relations	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
j) other social relations	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
k) Self expression/ self-improvement	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
l) religious expression	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
m) community and civic involvement	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH

3. Visual Analogue Scales (*Lorig et al., 1996*)

3.1 Please mark an "X" in the box below to describe your general health in the past four weeks.

Excellent health	1	2	3	4	5	6	7	8	9	10	Poor Health

3.2 Take a moment and think of the best possible life and the worst possible life in general. Now in the box below, place an "X" to indicate where your life is now:

Best Possible life	1	2	3	4	5	6	7	8	9	10	Worst possible life

APPENDIX D4

QUESTIONNAIRE 4: Follow-up consultation		Completed by practitioner
0.1 Date of Consultation *(Use listing dd/m, i.e. 30th June = 306)*	Practitioner code	Patient code

Please circle the relevant number

1. **Patient Identification**

1.1	Patient initials		1.2	Date of birth (yy/mm/dd)	

2. **Outcome measures**

2.1	**Glasgow Homoeopathic Hospital Outcome Scale** (Steinsbekk, 1999) **In this case which have you noticed?**			
	0=no change *-1 slight deterioration* *-2 moderate deterioration affecting daily living* *-3 major deterioration* *-4 Disastrous deterioration*		*+1 slight improvement* *+2 moderate improvement affecting daily living* *+3 major improvement* *+4 cured/back to normal*	
2.2	**If an improvement was noted on what level** *(please circle more than one if needed)* *1=mental 2=general 3=local*			
2.3	**Were there any adverse events?** *(i.e. worstening of symptoms, development of new symptoms)* *1=yes 2= no*			
2.3.1	**If yes, what was the observed adverse event?**	2.3.2	**Start date?** **End date?** **Ongoing?**	
2.3.3	**Relationship to treatment?** *1=none* *3=possible* *5=unable to evaluate* *2= improbable* *4=probable*			
2.4	**How long was this consultation?** *1=less than 15min* *3=between31-60 min* *5=more than 90min* *2=between 16-30 min* *4=between 61-90 min*			

APPENDIX D5

QUESTIONNAIRE 5: Follow-up consultation		Completed by patient
0.1 Date of Consultation *(Use listing dd/m, i.e. 30th June = 306)*	Practitioner code	Patient code

Please complete the following: Question 2 and 3 are a repeat of the previous questionnaire and relates to your state of health today after receiving initial treatment.

1. Patient Identification

1.1	Patient initials		1.2	Date of birth (yy/mm/dd)	

2. **Illness intrusiveness Ratings Scale** (Lorig *et al.*, 1996)

Instructions: the following items ask about how much your illness interfere with different aspects of your life. **PLEASE CIRCLE THE ONE NUMBER THAT BEST DESCRIBES YOUR CURRENT LIFE SITUATION.** If an item is not applicable please circle the number one (1) to indicate that this aspect of your life is not affected very much. Please do not leave any item unanswered.

How much does your illness and/or its treatments interfere with your...									
a) Health	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
b) Diet	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
c) Work	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
d) Active recreation e.g. sports	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
e) Passive recreation e.g. reading	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
f) Financial situation	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
g) Relationship with spouse	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
h) Sex life	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
i) Family relations	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
j) other social relations	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
k) Self expression/ self-improvement	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
l) religious expression	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH
m) community and civic involvement	NOT VERY MUCH	1	2	3	4	5	6	7	VERY MUCH

3. Visual Analoque Scales

3.1 Please mark an "X" in the box below to describe your general health in the past four weeks.

Excellent health	1	2	3	4	5	6	7	8	9	10	Poor Health

3.2 Take a moment and think of the best possible life and the worst possible life in general. Now in the box below, place an "X" to indicate where your life is now:

Best Possible life	1	2	3	4	5	6	7	8	9	10	Worst possible life

Please turn over

4 **Group Health Association of America Consumer Satisfaction Survey** (Lorig *et al.*, 1996)

Thinking about your own health care, how would you rate the following?					
Please circle one number on each line	**Poor**	**Fair**	**Good**	**Very good**	**Excellent**
4.1 Overall, how would you evaluate the health care you recieved at this practice?	1	2	3	4	5
4.2 Thoroughness of examinations and accuracy of diagnosis?	1	2	3	4	5
4.3 Skill, experience and training of doctors?	1	2	3	4	5
4.4 Thoroughness of treatment?	1	2	3	4	5
4.5 Explanations of medical procedures and tests?	1	2	3	4	5
4.6 Attention given to what you have to say?	1	2	3	4	5
4.7 Advice you get about ways to avoid illness and stay healthy?	1	2	3	4	5
4.8 Friendliness and courtesy shown to you by your doctors?	1	2	3	4	5
4.9 Personal interest shown in you and your health problems?	1	2	3	4	5
4.10 Respect shown to you, attention to your privacy?	1	2	3	4	5
4.11 Reassurance and support offered to you by your doctor?	1	2	3	4	5
4.12 Amount of time you have with your doctor during a visit?	1	2	3	4	5
4.13 The outcomes of your health care, how much you are helped?	1	2	3	4	5
4.14 Overall quality of service?	1	2	3	4	5

Below are some things people say about their health care. Please read each one carefully, keeping in mind your health care received at this practice. Although the statements look similar, please answer each one seperately.

Circle one number on each line	**Strongly agree**	**Agree**	**Not sure**	**Disagree**	**Strongly disagree**
4.15 I am very satisfied with the medical care I receive	1	2	3	4	5
4.16 There are some things about the medical care I receive that could have been better	1	2	3	4	5
4.17 The medical care I have been receiving is just about perfect	1	2	3	4	5
4.18 I am dissatisfied with some things about the medical care I receive.	1	2	3	4	5

5 Holistic Practice Questionnaire (Long, A.F *et al.*, 2000) Circle one number on each line	**Strongly agree**	**Agree**	**Not sure**	**Disagree**	**Strongly disagree**
5.1 Talking with the therapist can help the person find out what the problems are.	1	2	3	4	5
5.2 I think complementary therapy is good because it treats the whole person, not just the condition.	1	2	3	4	5
5.3 The therapy has helped me become more responsible for my own health.	1	2	3	4	5
5.4 The therapy has taught me how to help myself get better.	1	2	3	4	5
5.5 I am able to take my time when I speak to the therapist which helped me feel better.	1	2	3	4	5
5.6 My body was mending itself.	1	2	3	4	5

APPENDIX D6

QUESTIONNAIRE 6: Exit questionnaire		Completed by researcher
0.1 Date of Consultation *(Use listing dd/m, i.e. 30th June = 306)*	Practitioner code	Patient code

1.	Patient Identification				
1.1	Patient initials		1.2	Date of birth (yy/mm/dd)	
1.3	Why did you not attend the follow-up appointment?				
1.4	Glasgow Homoeopathic Hospital Outcome Scale (Steinsbekk, 1999) In this case which have you noticed?				

0=no change
-1 slight deterioration
-2 moderate deterioration affecting daily living
-3 major deterioration
-4 Disastrous deterioration

+1 slight improvement
+2 moderate improvement affecting daily living
+3 major improvement
+4 cured/back to normal

2 Group Health Association of America Consumer Satisfaction Survey

Thinking about your own health care, how would you rate the following?					
please circle one number on each line	Poor	Fair	Good	Very good	Excellent
2.1 Overall, how would you evaluate the health care you recieved at this practice?	1	2	3	4	5
2.2 Thoroughness of examinations and accuracy of diagnosis?	1	2	3	4	5
2.3 Skill, experience and training of doctors?	1	2	3	4	5
2.4 Thoroughness of treatment?	1	2	3	4	5
2.5 Explanations of medical procedures and tests?	1	2	3	4	5
2.6 Attention given to what you have to say?	1	2	3	4	5
2.7 Advice you get about ways to avoid illness and stay healthy?	1	2	3	4	5
2.8 Friendliness and courtesy shown to you by your doctors?	1	2	3	4	5
2.9 Personal interest shown in you and your health problems?	1	2	3	4	5
2.10 Respect shown to you, attention to your privacy?	1	2	3	4	5
2.11 Reassurance and support offered to you by your doctor?	1	2	3	4	5
2.12 Amount of time you have with your doctor during a visit?	1	2	3	4	5
2.13 The outcomes of your health care, how much you are helped?	1	2	3	4	5
2.14 Overall quality of service?	1	2	3	4	5

Please turn over

Here are some things people say about their health care. Although the statements sound similar, please answer each one separately.

Circle one number on each line	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
2.15 I am very satisfied with the medical care I receive	1	2	3	4	5
2.16 here are some things about the medical care I receive that could have been better	1	2	3	4	5
2.17 The medical care I have been receiving is just about perfect	1	2	3	4	5
2.18 I am dissatisfied with some things about the medical care I receive.	1	2	3	4	5

3.Holistic Practice Questionnaire (Long,A.F *et al.*,2000) Circle one number on each line	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
3.1 Talking with the therapist can help the person find out what the problems are.	1	2	3	4	5
3.2 I think complementary therapy is good because it treats the whole person, not just the condition.	1	2	3	4	5
3.3 The therapy has helped me become more responsible for my own health.	1	2	3	4	5
3.4 The therapy has taught me how to help myself get better.	1	2	3	4	5
3.5 I am able to take my time when I speak to the therapist which helped me feel better.	1	2	3	4	5
3.6 My body was mending itself.	1	2	3	4	5

APPENDIX D7

IPHEPHA ELINEMININGWANO LESIGULI
Kumuntu okhathazekile :
ISIHLOKO SOCWANINGO LWEPHROJEKTHI :
Ukuhlolwa Kwemitholampilo Yabalapha Ngamakhambi babhaliswa Ngokusemthethweni KwZulu Natal.
IGAMA LOMELULEKI: **Dkt. R. Steel(B.A., H.D.E.,MTech(Hom))**

Njengengxenye yeziqu zami ze Masters ekwelapheni ngamakhambi ngimelwe ukucwaninga ngesihloko esithile esihambelana nendlela okwelashwa ngayo nga-makhambi.Ngikhethe umkhakha wokuhlola ngomtholampilo, okungukuqoqa ulwazi olubhekene nezimo zempilo. Ngiyabonga ukuba uvume ukubamba iqhaza kulolu-cwaningo lwephrojekthi.

Kunezigaba ezimbili ocwaningeni. Esigabeni sokuqala ngicele umelaphi wakho ukuba agcwalise imibuzo yeziguli eziyishumi ezintsha ezelashwe uyena esikhathini esingangamasonto amabili. Imibuzo ibuza mayelana nenqubo, okutholakalayo, imithi lena ayisebenzisayo uma ekuxilonga. Isigaba sesibili siphathelene nokubonwa umelaphi wakho, lapha umelaphi wakho kumele agcwalise ulwazi olumayelana nomphumela wokusetshenziswa kwemithi ayisebenzisayo. Ukuthasisela, Ngiyanicela ukuba nigcwalise imibuzo njalo uma nizobonwa udokotela, okungaba nolwazi oluthinta ubunjalo bakho ngaphambi nangemuva kokuthatha imithi kanye nokugculiseka kwakho ngemithi.

Asikho isigaba lapho umelaphi wakho angaveza khona ulwazi oluyimfihlo enixoxisane naye ngalo kimina njengomcwaningi. Ngicela uqaphele ukuthi ulwazi oluphathelene nemininingwano yakho isib. igama, ikheli, njll. kuzohlala kuyimfihlo kumelaphi wakho. Kanjalo, uma ungabuyi ukuzobonwa udokotela ngesikhathi esinqunyiwe, igama lakho nenombolo yocingo kuzodluliselwa kimina, khona ngizokuthinta ngocingo ukuqedela ukugcwalisa umbuzo wokugcina. Awekho amagama namakheli azovela noma azobhalwa kokubhaliwe okuhlakaniphile (dissertation).

Akukho okuzozuzwa umcwaningi, umelaphi, noma ukubamba kwakho iqhaza kulesisifundo. Izindleko ezidalwe umcwaningi zalesisifundo zizobhekelwa i-Technikon Natal. Uma unemibuzo noma izinkinga, sicela ungabi nokungabaza bokuthintana nami. Izinombolo zami yilezi (031) 2020160 noma 0827261858

Ulwazi olutholakale kulesisifundo luzoletha ulwazi olunzulu mayelana nendlela yokwelapha ngamakhambi esintu KwaZulu Natal. Loluhwazi luzosetshenziswa ukwakha nokuthuthukiswa kwamakhambi. Kunethemba lokuthi imiphumela ingase-tshenziswa ekukhangiseni kwamakhambi emehlweni omphakathi,usizo lokwelashwa (medical aid scheme) kanye nakuhulumeni. Ukubamba kwakho iqhaza kuzoncomeka kakhulu; Ngicela ugcwalise ifomu eligcwele lesivumelwano elibhanqwe nalencwadi ebese ulinika umsizikazi. Ligcine leliphepha

Ngiyabonga usizo lwakho.

Marianne Verhoogt (Umcwaningi)

IFOMU ELIGCWELE LESIVUMELWANO

ISIHLOKO SOCWANINGO LWEPHROJEKTHI :
Ukuhlolwa kwemitholampilo yabalapha ngamakhambi babhaliswa ngokusemthethweni KwaZulu Natal.

IGAMA LOMELULEKI :**Dkt. R. Steel(B.A.,H.D.E.,MTech(Hom))**

Usuku:_____

Igama lesiguli eligcwele:_____

Yenza isikokela empendulweni okuyiyona yona

Usuke walifunda iphepha elinolwazi ngocwaningo ?	Yes	No
Usuke waba nalo ithuba lokubuza imibuzo emayelana nalesisifundo ?	Yes	No
Uzitholile izimpendulo ezikugculisayo zemibuzo yakho?	Yes	No
Uke waba nalo ithuba lokuxoxa ngale sisifundo?	Yes	No
Uyitholile imininingwano eyanele mayelana nalesisifundo?	Yes	No
Ukhulume nobani ?		
Uyawazi umthelela ongaba khona ekuzimbandakanyeni kwakho Kulesisifundo?	Yes	No
Uyazi ukuthi unelungelo lokuhoxa kulesisifundo? a)noma yinini b)ngaphandle kokunikeza isizathu sokuhoxa c)ngaphandle kokuphazamisa impilo yakho	Yes	No
Uyavuma ukubamba iqhaza kulesisifundo ngokungaphoqwa?	Yes	No

Uma uphendule wathi cha kulemibuzo engenhla , sicela uthole imininingwane edingekayo ngaphambi kokuba usayine.

Mina, _____ngiyavuma ukubamba iqhaza kulesisifundo esesichazwe ngenhla esilawulwa uMarianne Verhoogt wase Technikon Natal . Ngiyakuqonda ukuthi lonke ulwazi enginalo nengizolusho luzoba yimfihlo.

Ngiyakuqonda ukuthi uma ngike ngavuma ukubamba iqhaza , kubalulekile ukuba ngibonane nodokotela ngezikhathi ezibekiwe.

Sicela ubhale ngosonhlamvukazi :

Igama lesiguli _____Isisayino_____

Umzali/Umqaphi_____ Isisayino_____

Igama lofakazi_____Isisayino_____

Igama lomfundi ocwanigayo:**Marianne Verhoogt** Isisayino_____

Umbuzo 3:	Okwehhovisi:

0.1 Date of Consultation *(Use listing dd/m, i.e. 30th June = 306)*	Practitioner code	Patient code

1. Gcwalisa lokhu okulandelayo: lapho onikwe khona okuningi kheta ukokele impendulo okuyiyona yona.

1.1	**Izihloko zamagama esiguli**		1.2	**Usuku lokuzalwa (yy/mm/dd)**	
1.3	**Ubulili** 1=owesilisa 2=owesifazane		1.4	**Umsebenzi**	
1.5	**Ubuhlanga** 1=omhlophe 2=omnyama 3=indiya 4=ikhaladi		1.6	**Ulimi lwasekhaya?** 1=isingisi 2=isibhunu 3=isizulu x=okunye(cacisa)	
1.7	**Ingabe uyilungu lokulekelelwa kwezokwelashwa (medical aid)** 1=yebo 2=cha		1.8	**Usizo lokwelashwa lwakho luyaku- khokhela yini ukwelashwa ngamakhambi?** 1=yebo 2=cha 3=kwesinye isikhathi	
1.9	**Isikhalazo esikhulu** _____ _____		1.10	**Unesikhathi esingakanani ucindezeleke kulesisikhalazo ?** 1=ngaphansi kwesonto elilodwa 2=ngaphezu kwesonto elilodwa, kodwa ngaphansi Kwezinyanga ezintathu 3=ngaphezu Kwezinyanga ezintathu	
1.11	**Ingabe okokuqala ucindezelekekulesisikhalazo?** 1=yebo 2=cha				

2. Lokhu okulandelayo kumayelana nokuthi isifo onaso siyiphazamisa kangakanani impilo yakho. SICELA UKOKELEZE INOMBOLO EYODWA ECHAZA KANGCONO ISIMO SEMPILO YAKHO OKWAMANJE. Uma kukhona okungakuthinti kokelela inombolo yokuqala (no. 1) Ukutshengisa ukuthi lomkhakha wempilo yakho awuphazamiseki kakhulu. Sicela ungashiyi nokukodwa kungaphenduliwe.

Kukangakanani isifo sakho kanye noma nemithi oyithathayo kuphamisa...									
a) Impilo	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
b) Indlela odla ngayo	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
c) Umsebenzi	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
d) Okokuzijabulisa ngokuzivoca isib. Imidlalo	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
e)Okokuzijabulisa ngokungazivoci umzimba isib. Ukufunda	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
f)Isimo semali	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
g)Ubudlelwane noshade naye	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
h)Impilo yocansi	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
i)Ubudlelwane nomndeni	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
j)Okunye okuthinta umphakathi	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
k)Ukuzichaza /Ukuzithuthukisa	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
l)Ukuzichaza ngokwenkolo	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
m)Ukuzimbandakanya kanye nomphakathi	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU

3.1. Bhala u "X" ebhokisini elingezansi ukuchaza impilo yakho nje emasontweni amane edlule.

Impilo enhle kakhulu	1	2	3	4	5	6	7	8	9	10	Impilo engayinhle hle

3.2. Thatha isikhashana ucabange ngempilo engenzeka kahle kakhulu kanye nempilo engayinhle engenzeka nje. Manje ebhokisini elingezansi, bhala u "X" ukutshengisa impilo yakho okwamanje.

Impilo enhle engenzeka	1	2	3	4	5	6	7	8	9	10	Impilo embi engenzeka

UMBUZO 5:	Okwehhovisi

0.1 Date of Consultation *(Use listing dd/m, i.e. 30th June = 306)*	Practitioner code	Patient code

Gcwalisa lokhu okulandelayo : Umbuzo 2 no 3 ufana nemibuzo edlule futhi ihambelana nesimo sempilo yakho namhlanje emva kokuthola imithi okokuqala .

1.Imininingwane yesiguli

1.1	Izihloko zamagama esiguli		1.2	Usuku lokuzalwa (yy/mm/dd)	

2. Lokhu okulandelayo kumayelana nokuthi isifo onaso siyiphazamisa kangakanani impilo yakho. SICELA UKOKELEZE INOMBOLO EYODWA ECHAZA KANGCONO ISIMO SEMPILO YAKHO OKWAMANJE. Uma kukhona okungakuthinti wena kokelezla inombolo yokuqala (no. 1) Ukutshengisa ukuthi lomkhakha wempilo yakho awuphazamiseki kakhulu. Sicela ungashiyi nokukodwa kungaphenduliwe.

Kukangakanani isifo sakho kanye noma nemithi oyithathayo kuphamisa...									
a) Impilo	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
b) Indlela odla ngayo	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
c) Umsebenzi	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
d) Okokuzijabulisa ngokuzivoca isib. Imidlalo	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
e)Okokuzijabulisa ngokungazivoci umzimba isib. Ukufunda	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
f)Isimo semali	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
g)Ubudlelwane noshade naye	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
h)Impilo yocansi	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
i)Ubudlelwane nomndeni	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
j)Okunye okuthinta umphakathi	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
k)Ukuzichaza /Ukuzithuthukisa	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
l)Ukuzichaza ngokwenkolo	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU
m)Ukuzimbandakanya kanye nomphakathi	HHAYI KAKHULU	1	2	3	4	5	6	7	KAKHULU

3.1. Bhala u "X" ebhokisini elingezansi ukuchaza impilo yakho nje emasontweni amane edlule.

Impilo enhle kakhulu	1	2	3	4	5	6	7	8	9	10	Impilo engayinhle hle

3.2. Thatha isikhashana ucabange ngempilo engenzeka kahle kakhulu kanye nempilo engayinhle engenzeka nje. Manje ebhokisini elingezansi, bhala u "X" ukutshengisa impilo yakho okwamanje.

Impilo enhle engenzeka	1	2	3	4	5	6	7	8	9	10	Impilo embi engenzeka

Phenqa ikhasi...

4. Iqembu Lenhlangano Yezempilo laseMelika lokweneliseka kwabathengi

Uma ucabanga ngokunakekela impilo yakho,ungakuqhathanisa ukubeke kuliphi izinga lokhu okulandelayo?					
Kokela inombolo eyodwa emgqeni owodwa	Kubi	Kukahle	Kuhle	Kuhle Kakhulu	Kuyancomeka
4.1 Sekukonke ungakukala kanjani ukunakekelwa kwempilo yakho okuthole kulomsebenzi	1	2	3	4	5
4.2 Ukuhlolwa kahle hle nobunjalo bokutholayo?	1	2	3	4	5
4.3 Ikhono, isipiliyoni , nokuqeqesheka kodokotela?	1	2	3	4	5
4.4 Uyidla yonke kahle hle imithi?	1	2	3	4	5
4.5 Ukuchazwa kwezinqubo zesibhedlela nokuhlolwa?	1	2	3	4	5
4.6 Ukunakwa kwento oyishoyo ?	1	2	3	4	5
4.7 Iseluleko ositholayo mayelana nendlela yokugwema isifo nokuhlala uphilile?	1	2	3	4	5
4.8 Ubungani nozwelo okunikwa udokotela?	1	2	3	4	5
4.9 Ukunakekela ubuwena obutshengiswayo Kanye nezinkinga empilweni yakho?	1	2	3	4	5
4.10 Inhlonipho abakunika yona, ukunakekela ingasese lakho?	1	2	3	4	5
4.11 Ukunikwa ithemba kanye nokunakekelwa udokotela wakho?	1	2	3	4	5
4.12 Isikhathi singakanani oba naso uma uzobona udokotela wakho?	1	2	3	4	5
4.13 Imiphumela yokunakekelwa usizakala kangakanani kuyona?	1	2	3	4	5
4.14 Sekukonke nje usizo olutholayo lunjani ?	1	2	3	4	5

Okungezansi ezinye zezinto abantu abazishoyo mayelana nokunakekelwa kwezimpilo zabo. Sicela ukufunde ngokucophelela , ukubeke engqondweni ukunakekelwa kwempilo yakho okuthole kulomsebenzi.Noma izitatimende zibuye zifane,phendula esisodwa ngokuhlukana.

Kokeleza inombolo eyodwa emgqeni ngamunye	Ngivuma impela	Ngiyavuma	Anginaso isiqiniseko	Angivumi	Angivumi sampela
4.15 Ngiyenelise kakhulu ngokunakekelwa kwempilo engikutholayo.	1	2	3	4	5
4.16 Kukhona ezinye izinto ezimayelana nokunakekelwa kwempilo obekungaba ngcona.	1	2	3	4	5
4.17 Ukunakekelwa kwezempilo ebengikuthola kuyancomeka impela	1	2	3	4	5
4.18 Angenelisekile ngezinye izinto ezimayelana nokunakekelwa kwezempilo engikutholayo.	1	2	3	4	5

5. Kokeleza inombolo eyodwa emgqeni ngamunye	Ngivuma impela	Ngiyavuma	Anginaso isiqiniseko	Angivumi	Angivumi sampela
5.1 Ukukhuluma nomuntu owelaphayo kungamsiza umuntu ukuba athole ukuthi yini izinkinga anazo.	1	2	3	4	5
5.2 Ngicabanga ukuthi ukuthola ukwelashwa kuhle ngoba kulapha umuntu ewonke, hhayi nje isimo akuso kuphela.	1	2	3	4	5
5.3 Ukuthola ukwelashwa kungisizile kwangenza ukuthi ngikwazi ukunakekela impilo yami.	1	2	3	4	5
5.4 Ukwelashwa kungifundise ukuba ngizisize nam ingibe ngcono kakhulu.	1	2	3	4	5
5.5 Ngiyakwazi ukuthatha isikhathi sami uma ngikhuluma nomuntu owelaphalayo okungisizayo ukuba ngizizwe ngingcono.	1	2	3	4	5
5.6 Umzimba wami ube ngcono ngokwawo.	1	2	3	4	5

APPENDIX E FREQUENCY TABLES

Frequencies of total contactable study population of registered homoeopaths in KZN

Statistics

		AGE	gender	race	area
N	Valid	59	59	59	59
	Missing	20	20	20	20

AGE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-34	28	35.4	47.5	47.5
	35-49	11	13.9	18.6	66.1
	50-64	11	13.9	18.6	84.7
	64+	9	11.4	15.3	100.0
	Total	59	74.7	100.0	
Missing	System	20	25.3		
Total		79	100.0		

gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	35	44.3	59.3	59.3
	female	24	30.4	40.7	100.0
	Total	59	74.7	100.0	
Missing	System	20	25.3		
Total		79	100.0		

race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	white	44	55.7	74.6	74.6
	black	4	5.1	6.8	81.4
	indian	10	12.7	16.9	98.3
	coloured	1	1.3	1.7	100.0
	Total	59	74.7	100.0	
Missing	System	20	25.3		
Total		79	100.0		

area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Durban	40	50.6	67.8	67.8
	Greater KZN	19	24.1	32.2	100.0
	Total	59	74.7	100.0	
Missing	System	20	25.3		
Total		79	100.0		

Frequencies of study sample

Statistics

		AGE	gender	race	area
N	Valid	30	30	30	30
	Missing	0	0	0	0

AGE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-34	18	60.0	60.0	60.0
	35-49	7	23.3	23.3	83.3
	50-64	4	13.3	13.3	96.7
	64+	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	18	60.0	60.0	60.0
	female	12	40.0	40.0	100.0
	Total	30	100.0	100.0	

race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	white	20	66.7	66.7	66.7
	black	3	10.0	10.0	76.7
	indian	6	20.0	20.0	96.7
	coloured	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Durban	18	60.0	60.0	60.0
	Greater KZN	12	40.0	40.0	100.0
	Total	30	100.0	100.0	

Frequencies of practice status of population

Statistics

practice status

N	Valid	79
	Missing	0

practice status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	practising	30	38.0	38.0	38.0
	retired/ill	6	7.6	7.6	45.6
	maternity	2	2.5	2.5	48.1
	moved out of province	7	8.9	8.9	57.0
	homoeopharm reps	2	2.5	2.5	59.5
	unethical	3	3.8	3.8	63.3
	unwilling patients	3	3.8	3.8	67.1
	too busy	9	11.4	11.4	78.5
	overseas	4	5.1	5.1	83.5
	not contactable	9	11.4	11.4	94.9
	not practicing	4	5.1	5.1	100.0
	Total	79	100.0	100.0	

Frequencies of practice demographics

Statistics

		Qualification	% homoeopathy	No of Years of Practice	Type of Practice
N	Valid	30	30	30	30
	Missing	0	0	0	0

Qualification from Technikon Natal Vs Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Technikon Natal	20	66.7	66.7	66.7
	other	10	33.3	33.3	100.0
	Total	30	100.0	100.0	

What % of your practice is homoeopathy?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	25	2	6.7	6.7	6.7
	50	8	26.7	26.7	33.3
	75	9	30.0	30.0	63.3
	100	11	36.7	36.7	100.0
	Total	30	100.0	100.0	

No of Years of Practice

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<1 years	4	13.3	13.3	13.3
	1-5	9	30.0	30.0	43.3
	6-10	9	30.0	30.0	73.3
	11-15	2	6.7	6.7	80.0
	16-20	1	3.3	3.3	83.3
	21-25	3	10.0	10.0	93.3
	25+	2	6.7	6.7	100.0
	Total	30	100.0	100.0	

Type of Practice

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	sole	11	36.7	36.7	36.7
	group- Homoeopathy only	7	23.3	23.3	60.0
	group- multidisciplinary	12	40.0	40.0	100.0
	Total	30	100.0	100.0	

Frequency Table

computer reperorising programme

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	9	30.0	30.0	30.0
	no	21	70.0	70.0	100.0
	Total	30	100.0	100.0	

dispense own medicines

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	29	96.7	96.7	96.7
	sometimes	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

medicines made by radionics

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	3	10.0	10.0	10.0
	no	27	90.0	90.0	100.0
	Total	30	100.0	100.0	

Frequencies of patient demographics

gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	50	31.6	31.6	31.6
	female	108	68.4	68.4	100.0
	Total	158	100.0	100.0	

age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-24 months	9	5.7	5.7	5.7
	2-15 y	17	10.8	10.8	16.5
	16-25y	24	15.2	15.2	31.6
	26-50y	73	46.2	46.2	77.8
	51-65y	20	12.7	12.7	90.5
	66-80y	12	7.6	7.6	98.1
	over 80y	3	1.9	1.9	100.0
	Total	158	100.0	100.0	

race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	white	97	61.4	61.4	61.4
	black	24	15.2	15.2	76.6
	indian	35	22.2	22.2	98.7
	coloured	2	1.3	1.3	100.0
	Total	158	100.0	100.0	

home language

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	english	124	78.5	78.5	78.5
	afrikaans	6	3.8	3.8	82.3
	zulu	7	4.4	4.4	86.7
	other	21	13.3	13.3	100.0
	Total	158	100.0	100.0	

occupation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	industrial	1	.6	.6	.6
	clerical	15	9.5	9.5	10.1
	teacher	13	8.2	8.2	18.4
	therapists	4	2.5	2.5	20.9
	managers	6	3.8	3.8	24.7
	professionals	15	9.5	9.5	34.2
	artisan/tradesman	6	3.8	3.8	38.0
	housewife	22	13.9	13.9	51.9
	student	17	10.8	10.8	62.7
	scholar	10	6.3	6.3	69.0
	infant	16	10.1	10.1	79.1
	pensioner	13	8.2	8.2	87.3
	unemployed	3	1.9	1.9	89.2
	farmer	2	1.3	1.3	90.5
	marketing and sales	4	2.5	2.5	93.0
	I.T	2	1.3	1.3	94.3
	self employed	5	3.2	3.2	97.5
	design and decorator	4	2.5	2.5	100.0
	Total	158	100.0	100.0	

medical aid membership

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	90	57.0	57.0	57.0
	no	68	43.0	43.0	100.0
	Total	158	100.0	100.0	

medical aid cover

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	58	36.7	64.4	64.4
	no	9	5.7	10.0	74.4
	partially	11	7.0	12.2	86.7
	not sure	12	7.6	13.3	100.0
	Total	90	57.0	100.0	
Missing	System	68	43.0		
Total		158	100.0		

Diagnostic Groups

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	mental	16	10.1	10.1	10.1
	nervous system	12	7.6	7.6	17.7
	eye	1	.6	.6	18.4
	GIT	20	12.7	12.7	31.0
	urinary	5	3.2	3.2	34.2
	gynae	16	10.1	10.1	44.3
	URT & ENT	19	12.0	12.0	56.3
	lower resp. tract	13	8.2	8.2	64.6
	CVS	7	4.4	4.4	69.0
	muscular/skeletal	13	8.2	8.2	77.2
	skin	13	8.2	8.2	85.4
	infection	5	3.2	3.2	88.6
	endocrine/metabolic	12	7.6	7.6	96.2
	immune deficiency/ ill-defined	6	3.8	3.8	100.0
	Total	158	100.0	100.0	

acute vs chronic

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than one week	9	5.7	5.7	5.7
	less than one week but more than 3 months	32	20.3	20.3	25.9
	more than 3 months	117	74.1	74.1	100.0
	Total	158	100.0	100.0	

Is this the first time you have suffered fron this complaint?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	47	29.7	29.7	29.7
	no	111	70.3	70.3	100.0
	Total	158	100.0	100.0	

Frequencies of practice methods

did you use a repertory

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	78	49.4	49.4	49.4
	no	80	50.6	50.6	100.0
	Total	158	100.0	100.0	

did you refer this patient

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	21	13.3	13.3	13.3
	no	137	86.7	86.7	100.0
	Total	158	100.0	100.0	

time of first consultation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<than 15min	16	10.1	10.1	10.1
	16-30	40	25.3	25.3	35.4
	31-60	60	38.0	38.0	73.4
	61-90	32	20.3	20.3	93.7
	>90	10	6.3	6.3	100.0
	Total	158	100.0	100.0	

tests

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	blood	13	8.2	8.2	8.2
	urine	11	7.0	7.0	15.2
	none	132	83.5	83.5	98.7
	blood & urine	2	1.3	1.3	100.0
	Total	158	100.0	100.0	

other investigative tests

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	glucose	4	2.5	2.5	2.5
	none	134	84.8	84.8	87.3
	Qx	10	6.3	6.3	93.7
	vega	10	6.3	6.3	100.0
	Total	158	100.0	100.0	

Frequencies of prescribing methods

homoeopathic remedy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	153	96.8	96.8	96.8
	no	5	3.2	3.2	100.0
	Total	158	100.0	100.0	

single vs alternating remedies vs complex vs both

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	single remedy	42	26.6	27.5	27.5
	more than one - alternating	42	26.6	27.5	54.9
	complex	41	25.9	26.8	81.7
	alternating and in combination	28	17.7	18.3	100.0
	Total	153	96.8	100.0	
Missing	System	5	3.2		
Total		158	100.0		

Frequencies of posology methods

Statistics

posology

N	Valid	158
	Missing	0

posology

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	single dose, medium potency (200-M)	3	1.9	1.9	1.9
	single dose, high potency (10M)	5	3.2	3.2	5.1
	single dose, 30C or lower	2	1.3	1.3	6.3
	weekly, or bimonthly doses, high or med dose	1	.6	.6	7.0
	weekly, or bimonthly doses, ascending potncy	3	1.9	1.9	8.9
	3-10 doses consecutively high potency)	7	4.4	4.4	13.3
	3-10 doses consecutively low potency	3	1.9	1.9	15.2
	3-10 doses consecutively ascending potency	4	2.5	2.5	17.7
	multiple doses daily, low potency	8	5.1	5.1	22.8
	LM	1	.6	.6	23.4
	plussed	5	3.2	3.2	26.6
	single dose, high or med with weekly or daily low potency	1	.6	.6	27.2
	high or med potency, weekly dosing with daily low potency	2	1.3	1.3	28.5
	30,200.M with daily low potency or complexmpl	13	8.2	8.2	36.7
	split dose with weekly/daily low potency or complex	22	13.9	13.9	50.6
	split dose with high potency for acute	2	1.3	1.3	51.9
	complex or more than 2 remedy, multiple doses	31	19.6	19.6	71.5
	multiple complex, multiple doses daily	20	12.7	12.7	84.2
	low potency, two single remedies alternating daily	17	10.8	10.8	94.9
	missing	8	5.1	5.1	100.0
	Total	158	100.0	100.0	

Frequencies of non-homeopathic support

BACH

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	9	5.7	100.0	100.0
Missing	System	149	94.3		
Total		158	100.0		

HERBAL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	47	29.7	100.0	100.0
Missing	System	111	70.3		
Total		158	100.0		

MINERAL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	21	13.3	100.0	100.0
Missing	System	137	86.7		
Total		158	100.0		

Frequencies of Follow-up consulatation

time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<2weeks	23	14.6	19.3	19.3
	2-3 weeks	41	25.9	34.5	53.8
	4-7 weeks	45	28.5	37.8	91.6
	> 8 weeks	10	6.3	8.4	100.0
	Total	119	75.3	100.0	
Missing	System	39	24.7		
Total		158	100.0		

FOLLOWUP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	attend	113	71.5	71.5	71.5
	telephonic	6	3.8	3.8	75.3
	exit	22	13.9	13.9	89.2
	not contactable	17	10.8	10.8	100.0
	Total	158	100.0	100.0	

why did you not attend the follow-up

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no need	3	1.9	13.6	13.6
	no change/improvement	5	3.2	22.7	36.4
	will attend	8	5.1	36.4	72.7
	inconvenient	2	1.3	9.1	81.8
	not satisfied	1	.6	4.5	86.4
	other	3	1.9	13.6	100.0
	Total	22	13.9	100.0	
Missing	System	136	86.1		
Total		158	100.0		

GHHOS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	major deterioration	2	1.3	1.4	1.4
	moderate deterioration	1	.6	.7	2.1
	slight deterioration	2	1.3	1.4	3.5
	no change	7	4.4	5.0	8.5
	slight improvement	26	16.5	18.4	27.0
	moderate improvement	46	29.1	32.6	59.6
	major improvement	38	24.1	27.0	86.5
	cured/back to normal	19	12.0	13.5	100.0
	Total	141	89.2	100.0	
Missing	System	17	10.8		
Total		158	100.0		

Frequencies of GHHOS per practitioner and per drop out patient

Statistics

		GHHOS	exit
N	Valid	119	22
	Missing	39	136

GHHOS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	major deterioration	1	.6	.8	.8
	slight deterioration	2	1.3	1.7	2.5
	no change	4	2.5	3.4	5.9
	slight improvement	22	13.9	18.5	24.4
	moderate improvement	37	23.4	31.1	55.5
	major improvement	35	22.2	29.4	84.9
	cured/back to normal	18	11.4	15.1	100.0
	Total	119	75.3	100.0	
Missing	System	39	24.7		
Total		158	100.0		

exit

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	major deterioration	1	.6	4.5	4.5
	moderate deterioration	1	.6	4.5	9.1
	no change	3	1.9	13.6	22.7
	slight improvement	4	2.5	18.2	40.9
	moderate improvement	9	5.7	40.9	81.8
	major improvement	3	1.9	13.6	95.5
	cured/back to normal	1	.6	4.5	100.0
	Total	22	13.9	100.0	
Missing	System	136	86.1		
Total		158	100.0		

MENTAL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	48	30.4	100.0	100.0
Missing	System	110	69.6		
Total		158	100.0		

GENERAL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	82	51.9	98.8	98.8
	2	1	.6	1.2	100.0
	Total	83	52.5	100.0	
Missing	System	75	47.5		
Total		158	100.0		

LOCAL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	71	44.9	98.6	98.6
	2	1	.6	1.4	100.0
	Total	72	45.6	100.0	
Missing	System	86	54.4		
Total		158	100.0		

adverse event

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	28	17.7	24.8	24.8
	no	85	53.8	75.2	100.0
	Total	113	71.5	100.0	
Missing	System	45	28.5		
Total		158	100.0		

adverse event

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	worstening of symptoms	14	8.9	50.0	50.0
	new symptoms	8	5.1	28.6	78.6
	dreams	1	.6	3.6	82.1
	period aggravated	1	.6	3.6	85.7
	lethargy	4	2.5	14.3	100.0
	Total	28	17.7	100.0	
Missing	System	130	82.3		
Total		158	100.0		

DURATION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	2	1.3	8.3	8.3
	1	5	3.2	20.8	29.2
	2	2	1.3	8.3	37.5
	3	5	3.2	20.8	58.3
	4	6	3.8	25.0	83.3
	8	1	.6	4.2	87.5
	9	1	.6	4.2	91.7
	10	1	.6	4.2	95.8
	13	1	.6	4.2	100.0
	Total	24	15.2	100.0	
Missing	System	134	84.8		
Total		158	100.0		

relationship to treatment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	1	.6	3.6	3.6
	improbable	2	1.3	7.1	10.7
	possible	12	7.6	42.9	53.6
	probable	11	7.0	39.3	92.9
	unable to evaluate	2	1.3	7.1	100.0
	Total	28	17.7	100.0	
Missing	System	130	82.3		
Total		158	100.0		

length of follow-up consult

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<15 min	24	15.2	20.2	20.2
	16-30	48	30.4	40.3	60.5
	31-60	37	23.4	31.1	91.6
	61-90	7	4.4	5.9	97.5
	>90min	3	1.9	2.5	100.0
	Total	119	75.3	100.0	
Missing	System	39	24.7		
Total		158	100.0		

Frequencies of Illness Intrusiveness Ratings Scale

health1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	17	10.8	17.2	17.2
	2	13	8.2	13.1	30.3
	3	7	4.4	7.1	37.4
	4	14	8.9	14.1	51.5
	5	21	13.3	21.2	72.7
	6	7	4.4	7.1	79.8
	7	20	12.7	20.2	100.0
	Total	99	62.7	100.0	
Missing	System	59	37.3		
Total		158	100.0		

HEALTH

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	28	17.7	28.3	28.3
	2	21	13.3	21.2	49.5
	3	14	8.9	14.1	63.6
	4	14	8.9	14.1	77.8
	5	12	7.6	12.1	89.9
	6	3	1.9	3.0	92.9
	7	7	4.4	7.1	100.0
	Total	99	62.7	100.0	
Missing	System	59	37.3		
Total		158	100.0		

DIET1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	32	20.3	32.3	32.3
	2	13	8.2	13.1	45.5
	3	10	6.3	10.1	55.6
	4	11	7.0	11.1	66.7
	5	8	5.1	8.1	74.7
	6	8	5.1	8.1	82.8
	7	17	10.8	17.2	100.0
	Total	99	62.7	100.0	
Missing	System	59	37.3		
Total		158	100.0		

DIET

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	37	23.4	37.4	37.4
	2	13	8.2	13.1	50.5
	3	14	8.9	14.1	64.6
	4	14	8.9	14.1	78.8
	5	8	5.1	8.1	86.9
	6	7	4.4	7.1	93.9
	7	6	3.8	6.1	100.0
	Total	99	62.7	100.0	
Missing	System	59	37.3		
Total		158	100.0		

work

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	21	13.3	22.3	22.3
	2	6	3.8	6.4	28.7
	3	11	7.0	11.7	40.4
	4	15	9.5	16.0	56.4
	5	11	7.0	11.7	68.1
	6	8	5.1	8.5	76.6
	7	22	13.9	23.4	100.0
	Total	94	59.5	100.0	
Missing	System	64	40.5		
Total		158	100.0		

work

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	30	19.0	31.3	31.3
	2	15	9.5	15.6	46.9
	3	18	11.4	18.8	65.6
	4	10	6.3	10.4	76.0
	5	13	8.2	13.5	89.6
	6	6	3.8	6.3	95.8
	7	4	2.5	4.2	100.0
	Total	96	60.8	100.0	
Missing	System	62	39.2		
Total		158	100.0		

active recreation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	28	17.7	28.6	28.6
	2	8	5.1	8.2	36.7
	3	9	5.7	9.2	45.9
	4	8	5.1	8.2	54.1
	5	7	4.4	7.1	61.2
	6	14	8.9	14.3	75.5
	7	24	15.2	24.5	100.0
	Total	98	62.0	100.0	
Missing	System	60	38.0		
Total		158	100.0		

active recreation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	37	23.4	38.1	38.1
	2	13	8.2	13.4	51.5
	3	11	7.0	11.3	62.9
	4	12	7.6	12.4	75.3
	5	6	3.8	6.2	81.4
	6	9	5.7	9.3	90.7
	7	9	5.7	9.3	100.0
	Total	97	61.4	100.0	
Missing	System	61	38.6		
Total		158	100.0		

passive recreation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	40	25.3	41.7	41.7
	2	13	8.2	13.5	55.2
	3	10	6.3	10.4	65.6
	4	10	6.3	10.4	76.0
	5	11	7.0	11.5	87.5
	6	9	5.7	9.4	96.9
	7	3	1.9	3.1	100.0
	Total	96	60.8	100.0	
Missing	System	62	39.2		
Total		158	100.0		

passive recreation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	47	29.7	48.0	48.0
	2	22	13.9	22.4	70.4
	3	9	5.7	9.2	79.6
	4	5	3.2	5.1	84.7
	5	10	6.3	10.2	94.9
	6	2	1.3	2.0	96.9
	7	3	1.9	3.1	100.0
	Total	98	62.0	100.0	
Missing	System	60	38.0		
Total		158	100.0		

financial situation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	49	31.0	52.1	52.1
	2	12	7.6	12.8	64.9
	3	7	4.4	7.4	72.3
	4	5	3.2	5.3	77.7
	5	9	5.7	9.6	87.2
	6	1	.6	1.1	88.3
	7	11	7.0	11.7	100.0
	Total	94	59.5	100.0	
Missing	System	64	40.5		
Total		158	100.0		

financial situation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	46	29.1	47.9	47.9
	2	17	10.8	17.7	65.6
	3	8	5.1	8.3	74.0
	4	9	5.7	9.4	83.3
	5	6	3.8	6.3	89.6
	6	5	3.2	5.2	94.8
	7	5	3.2	5.2	100.0
	Total	96	60.8	100.0	
Missing	System	62	39.2		
Total		158	100.0		

relationship with spouse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	35	22.2	41.7	41.7
	2	12	7.6	14.3	56.0
	3	10	6.3	11.9	67.9
	4	11	7.0	13.1	81.0
	5	7	4.4	8.3	89.3
	6	1	.6	1.2	90.5
	7	8	5.1	9.5	100.0
	Total	84	53.2	100.0	
Missing	System	74	46.8		
Total		158	100.0		

relationship with spouse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	44	27.8	48.9	48.9
	2	13	8.2	14.4	63.3
	3	11	7.0	12.2	75.6
	4	7	4.4	7.8	83.3
	5	7	4.4	7.8	91.1
	6	4	2.5	4.4	95.6
	7	4	2.5	4.4	100.0
	Total	90	57.0	100.0	
Missing	System	68	43.0		
Total		158	100.0		

sex life

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	37	23.4	45.7	45.7
	2	10	6.3	12.3	58.0
	3	3	1.9	3.7	61.7
	4	8	5.1	9.9	71.6
	5	6	3.8	7.4	79.0
	6	6	3.8	7.4	86.4
	7	11	7.0	13.6	100.0
	Total	81	51.3	100.0	
Missing	System	77	48.7		
Total		158	100.0		

sex life

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	45	28.5	51.7	51.7
	2	11	7.0	12.6	64.4
	3	9	5.7	10.3	74.7
	4	7	4.4	8.0	82.8
	5	4	2.5	4.6	87.4
	6	4	2.5	4.6	92.0
	7	7	4.4	8.0	100.0
	Total	87	55.1	100.0	
Missing	System	71	44.9		
Total		158	100.0		

family relations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	39	24.7	40.2	40.2
	2	19	12.0	19.6	59.8
	3	8	5.1	8.2	68.0
	4	10	6.3	10.3	78.4
	5	11	7.0	11.3	89.7
	6	4	2.5	4.1	93.8
	7	6	3.8	6.2	100.0
	Total	97	61.4	100.0	
Missing	System	61	38.6		
Total		158	100.0		

family relations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	49	31.0	50.0	50.0
	2	17	10.8	17.3	67.3
	3	14	8.9	14.3	81.6
	4	7	4.4	7.1	88.8
	5	6	3.8	6.1	94.9
	6	3	1.9	3.1	98.0
	7	2	1.3	2.0	100.0
	Total	98	62.0	100.0	
Missing	System	60	38.0		
Total		158	100.0		

other social relations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	38	24.1	39.2	39.2
	2	15	9.5	15.5	54.6
	3	8	5.1	8.2	62.9
	4	12	7.6	12.4	75.3
	5	14	8.9	14.4	89.7
	6	2	1.3	2.1	91.8
	7	8	5.1	8.2	100.0
	Total	97	61.4	100.0	
Missing	System	61	38.6		
Total		158	100.0		

other social relations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	44	27.8	44.9	44.9
	2	23	14.6	23.5	68.4
	3	11	7.0	11.2	79.6
	4	6	3.8	6.1	85.7
	5	8	5.1	8.2	93.9
	6	4	2.5	4.1	98.0
	7	2	1.3	2.0	100.0
	Total	98	62.0	100.0	
Missing	System	60	38.0		
Total		158	100.0		

self expression/ self improvement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	28	17.7	29.2	29.2
	2	18	11.4	18.8	47.9
	3	6	3.8	6.3	54.2
	4	8	5.1	8.3	62.5
	5	12	7.6	12.5	75.0
	6	12	7.6	12.5	87.5
	7	12	7.6	12.5	100.0
	Total	96	60.8	100.0	
Missing	System	62	39.2		
Total		158	100.0		

self expression/ self improvement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	40	25.3	40.8	40.8
	2	13	8.2	13.3	54.1
	3	17	10.8	17.3	71.4
	4	10	6.3	10.2	81.6
	5	10	6.3	10.2	91.8
	6	4	2.5	4.1	95.9
	7	4	2.5	4.1	100.0
	Total	98	62.0	100.0	
Missing	System	60	38.0		
Total		158	100.0		

religious expression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	67	42.4	71.3	71.3
	2	12	7.6	12.8	84.0
	3	2	1.3	2.1	86.2
	4	2	1.3	2.1	88.3
	5	4	2.5	4.3	92.6
	6	5	3.2	5.3	97.9
	7	2	1.3	2.1	100.0
	Total	94	59.5	100.0	
Missing	System	64	40.5		
Total		158	100.0		

religious expression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	66	41.8	69.5	69.5
	2	11	7.0	11.6	81.1
	3	7	4.4	7.4	88.4
	4	5	3.2	5.3	93.7
	5	1	.6	1.1	94.7
	6	4	2.5	4.2	98.9
	7	1	.6	1.1	100.0
	Total	95	60.1	100.0	
Missing	System	63	39.9		
Total		158	100.0		

community and civic imvolvement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	54	34.2	56.3	56.3
	2	10	6.3	10.4	66.7
	3	8	5.1	8.3	75.0
	4	8	5.1	8.3	83.3
	5	6	3.8	6.3	89.6
	6	4	2.5	4.2	93.8
	7	6	3.8	6.3	100.0
	Total	96	60.8	100.0	
Missing	System	62	39.2		
Total		158	100.0		

community and civic imvolvement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	58	36.7	60.4	60.4
	2	19	12.0	19.8	80.2
	3	5	3.2	5.2	85.4
	4	4	2.5	4.2	89.6
	5	6	3.8	6.3	95.8
	6	1	.6	1.0	96.9
	7	3	1.9	3.1	100.0
	Total	96	60.8	100.0	
Missing	System	62	39.2		
Total		158	100.0		

general health

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	9	5.7	9.1	9.1
	2	10	6.3	10.1	19.2
	3	11	7.0	11.1	30.3
	4	10	6.3	10.1	40.4
	5	15	9.5	15.2	55.6
	6	16	10.1	16.2	71.7
	7	11	7.0	11.1	82.8
	8	12	7.6	12.1	94.9
	9	2	1.3	2.0	97.0
	10	3	1.9	3.0	100.0
	Total	99	62.7	100.0	
Missing	System	59	37.3		
Total		158	100.0		

general health

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	12	7.6	12.2	12.2
	2	19	12.0	19.4	31.6
	3	16	10.1	16.3	48.0
	4	17	10.8	17.3	65.3
	5	11	7.0	11.2	76.5
	6	7	4.4	7.1	83.7
	7	6	3.8	6.1	89.8
	8	7	4.4	7.1	96.9
	9	2	1.3	2.0	99.0
	10	1	.6	1.0	100.0
	Total	98	62.0	100.0	
Missing	System	60	38.0		
Total		158	100.0		

best possible life

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	3.2	5.1	5.1
	2	9	5.7	9.2	14.3
	3	15	9.5	15.3	29.6
	4	22	13.9	22.4	52.0
	5	25	15.8	25.5	77.6
	6	12	7.6	12.2	89.8
	7	4	2.5	4.1	93.9
	8	3	1.9	3.1	96.9
	10	3	1.9	3.1	100.0
	Total	98	62.0	100.0	
Missing	System	60	38.0		
Total		158	100.0		

best possible life

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	7	4.4	7.2	7.2
	2	19	12.0	19.6	26.8
	3	20	12.7	20.6	47.4
	4	20	12.7	20.6	68.0
	5	20	12.7	20.6	88.7
	6	6	3.8	6.2	94.8
	7	3	1.9	3.1	97.9
	8	2	1.3	2.1	100.0
	Total	97	61.4	100.0	
Missing	System	61	38.6		
Total		158	100.0		

Frequencies of Consumer Satisfaction Survey

Overall how would you evaluate the health care you recieved at this practice?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	fair	4	2.5	2.9	2.9
	good	11	7.0	7.9	10.7
	very good	51	32.3	36.4	47.1
	excellent	74	46.8	52.9	100.0
	Total	140	88.6	100.0	
Missing	System	18	11.4		
Total		158	100.0		

thoroughness of examinations and accuracy of diagnosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	fair	1	.6	.7	.7
	good	13	8.2	9.4	10.1
	very good	38	24.1	27.3	37.4
	excellent	87	55.1	62.6	100.0
	Total	139	88.0	100.0	
Missing	System	19	12.0		
Total		158	100.0		

skill, experience and training of doctors?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	fair	2	1.3	1.4	1.4
	good	18	11.4	12.9	14.3
	very good	36	22.8	25.7	40.0
	excellent	84	53.2	60.0	100.0
	Total	140	88.6	100.0	
Missing	System	18	11.4		
Total		158	100.0		

thoroughness of treatment?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	poor	1	.6	.7	.7
	fair	5	3.2	3.6	4.3
	good	13	8.2	9.4	13.8
	very good	39	24.7	28.3	42.0
	excellent	80	50.6	58.0	100.0
	Total	138	87.3	100.0	
Missing	System	20	12.7		
Total		158	100.0		

explanations of medical procedures and tests?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	poor	1	.6	.7	.7
	fair	4	2.5	3.0	3.7
	good	20	12.7	14.9	18.7
	very good	37	23.4	27.6	46.3
	excellent	72	45.6	53.7	100.0
	Total	134	84.8	100.0	
Missing	System	24	15.2		
Total		158	100.0		

attention given to what you have to say?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	fair	1	.6	.7	.7
	good	12	7.6	8.5	9.2
	very good	34	21.5	24.1	33.3
	excellent	94	59.5	66.7	100.0
	Total	141	89.2	100.0	
Missing	System	17	10.8		
Total		158	100.0		

advice you get about ways to avoid illness and stay healthy?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	poor	1	.6	.7	.7
	fair	8	5.1	5.8	6.5
	good	20	12.7	14.4	20.9
	very good	33	20.9	23.7	44.6
	excellent	77	48.7	55.4	100.0
	Total	139	88.0	100.0	
Missing	System	19	12.0		
Total		158	100.0		

friendliness and courtesy shown to you by your doctor?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	good	8	5.1	5.7	5.7
	very good	30	19.0	21.4	27.1
	excellent	102	64.6	72.9	100.0
	Total	140	88.6	100.0	
Missing	System	18	11.4		
Total		158	100.0		

personal interest shown in you and your health problems?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	fair	2	1.3	1.4	1.4
	good	10	6.3	7.1	8.5
	very good	32	20.3	22.7	31.2
	excellent	97	61.4	68.8	100.0
	Total	141	89.2	100.0	
Missing	System	17	10.8		
Total		158	100.0		

respect shown to you, attention to your privacy?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	good	9	5.7	6.4	6.4
	very good	35	22.2	24.8	31.2
	excellent	97	61.4	68.8	100.0
	Total	141	89.2	100.0	
Missing	System	17	10.8		
Total		158	100.0		

reassurance and support offered to you by your doctor?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	poor	1	.6	.7	.7
	fair	2	1.3	1.4	2.1
	good	15	9.5	10.6	12.8
	very good	38	24.1	27.0	39.7
	excellent	85	53.8	60.3	100.0
	Total	141	89.2	100.0	
Missing	System	17	10.8		
Total		158	100.0		

amount of time you have with your doctor during a visit?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	poor	1	.6	.7	.7
	fair	6	3.8	4.3	5.0
	good	16	10.1	11.3	16.3
	very good	35	22.2	24.8	41.1
	excellent	83	52.5	58.9	100.0
	Total	141	89.2	100.0	
Missing	System	17	10.8		
Total		158	100.0		

the outcomes of your health care, how much you are helped?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	poor	5	3.2	3.6	3.6
	fair	5	3.2	3.6	7.2
	good	26	16.5	18.7	25.9
	very good	43	27.2	30.9	56.8
	excellent	60	38.0	43.2	100.0
	Total	139	88.0	100.0	
Missing	System	19	12.0		
Total		158	100.0		

overall quality of service?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	poor	2	1.3	1.4	1.4
	fair	1	.6	.7	2.1
	good	5	3.2	3.5	5.7
	very good	31	19.6	22.0	27.7
	excellent	102	64.6	72.3	100.0
	Total	141	89.2	100.0	
Missing	System	17	10.8		
Total		158	100.0		

I am very satisfied with the medical care I received

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	97	61.4	69.8	69.8
	agree	38	24.1	27.3	97.1
	not sure	3	1.9	2.2	99.3
	disagree	1	.6	.7	100.0
	Total	139	88.0	100.0	
Missing	System	19	12.0		
Total		158	100.0		

there are some things about the medical care I received that could have been better

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	4	2.5	2.9	2.9
	agree	10	6.3	7.2	10.1
	not sure	25	15.8	18.1	28.3
	disagree	58	36.7	42.0	70.3
	strongly disagree	41	25.9	29.7	100.0
	Total	138	87.3	100.0	
Missing	System	20	12.7		
Total		158	100.0		

the medical care I have been recieving is just about perfect

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	56	35.4	40.3	40.3
	agree	68	43.0	48.9	89.2
	not sure	11	7.0	7.9	97.1
	disagree	4	2.5	2.9	100.0
	Total	139	88.0	100.0	
Missing	System	19	12.0		
Total		158	100.0		

i am dissatisfied with some things about the medical care I received

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	5	3.2	3.6	3.6
	agree	3	1.9	2.2	5.8
	not sure	5	3.2	3.6	9.4
	disagree	57	36.1	41.3	50.7
	strongly disagree	68	43.0	49.3	100.0
	Total	138	87.3	100.0	
Missing	System	20	12.7		
Total		158	100.0		

Frequencies of holistic practice outcome

talking with the therapist can help the person find out what the problems are

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	87	55.1	61.7	61.7
	agree	51	32.3	36.2	97.9
	not sure	3	1.9	2.1	100.0
	Total	141	89.2	100.0	
Missing	System	17	10.8		
Total		158	100.0		

I think complementary therapy is good because it treats the whole person, not just the condition

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	92	58.2	65.2	65.2
	agree	43	27.2	30.5	95.7
	not sure	5	3.2	3.5	99.3
	disagree	1	.6	.7	100.0
	Total	141	89.2	100.0	
Missing	System	17	10.8		
Total		158	100.0		

the therapy has helped me become more responsible for my own health

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	63	39.9	45.0	45.0
	agree	67	42.4	47.9	92.9
	not sure	8	5.1	5.7	98.6
	disagree	2	1.3	1.4	100.0
	Total	140	88.6	100.0	
Missing	System	18	11.4		
Total		158	100.0		

the therapy has taught me how to help myself get better

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	60	38.0	42.9	42.9
	agree	64	40.5	45.7	88.6
	not sure	12	7.6	8.6	97.1
	disagree	4	2.5	2.9	100.0
	Total	140	88.6	100.0	
Missing	System	18	11.4		
Total		158	100.0		

I am able to take my time when i speak to the therapist which helped me feel better

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	77	48.7	55.0	55.0
	agree	57	36.1	40.7	95.7
	not sure	3	1.9	2.1	97.9
	disagree	1	.6	.7	98.6
	strongly disagree	2	1.3	1.4	100.0
	Total	140	88.6	100.0	
Missing	System	18	11.4		
Total		158	100.0		

my body was mending itself

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	35	22.2	25.0	25.0
	agree	49	31.0	35.0	60.0
	not sure	41	25.9	29.3	89.3
	disagree	10	6.3	7.1	96.4
	strongly disagree	5	3.2	3.6	100.0
	Total	140	88.6	100.0	
Missing	System	18	11.4		
Total		158	100.0		