A retrospective survey of post-graduate career paths of Technikon Witwatersrand (TWR) Homoeopathic graduates from 1998 to 2004

By

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This mini-dissertation was submitted for examination in partial compliance with the requirements for the Master's Degree in Technology: Homoeopathy, in the Faculty of Health Sciences at the Durban Institute of Technology.

I, Melanie Jill Sweidan, do hereby declare that this dissertation is representative of my own work, both in conception and execution.

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APPROVED FOR FINAL SUBMISSION

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To my Loving parents, thank you for your care and support and constant belief in me.

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ABSTRACT

This study aimed to assess the perceptions and career choices made by Technikon Witwatersrand Homoeopathy graduates from 1998 to 2004. It is noted that Technikon Witwatersrand (TWR) is now known as University of Johannesburg; however as the name change did not occur at the time of this study, this study refers to this institution as TWR throughout. The study was designed to investigate their demographic composition as well as aspects concerning career choices, the status of their practices and the reality of Homoeopathy being a viable and satisfactory career choice.

The total number of graduates from 1998-2004 was 120, of that only 89 were contactable. There were 52 positive responses, and 6 refusals to take part in the study. None of the responses were considered invalid therefore the sample size for the group amounted to 58. There were 2 responses for group B, never practiced previously, 8 responses for group C, not practicing but practiced previously, and 42 responses in group D, currently practicing.

Data was collected via a self-administered questionnaire (Appendix A). The questionnaire was divided into four parts:

Part A related to demographic data.

Part B related to graduates that had never practiced Homoeopathy.

Part C applied to graduates who have practiced but are not currently practising. Part D related to those graduates who were currently in Homoeopathic practice. All graduates were required to complete Part A and then to choose one of the other sections that were relevant to their current status according to the definition of a “Homoeopathic practice” provided.

The graduates were initially contacted via telephone or e-mail to inform them of the research and to confirm their participation. Those willing to participate were sent questionnaires (Appendix A), an information letter (Appendix C) and an informed consent document (Appendix B), via post, fax or e-mail. Due to the preservation of confidentiality the responses were returned to a neutral third party in the Faculty of Health Sciences at Durban Institute of Technology. The researcher then captured the data, which was collectively analysed statistically using SPSS® for Windows version 13.1 and the results were interpreted.

The study showed that most of the respondents are in practice and as expected they have experienced difficulties in the, education they have received, in the logistical workings of starting and maintaining a practice as well as a discrepancy between what they studied to the reality of putting it into use for financial reward.

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DEFINITIONS

Allied Health Professions Council of South Africa (AHPCSA)

Allied Health Professions Council of South Africa is a statutory council for Natural Health, responsible for the promotion and protection of the health of the population of South Africa and will affect this by regulating and setting standards for our registered professions, under act 63 of 1982.

Classical Homoeopathy

Doctrine or school of Homoeopathic philosophy and therapeutics claiming to be based on strict Hahnemannian principles (Swayne, 2000:43).

Clinical Homoeopathy

School of Homoeopathic philosophy based mainly on guiding symptoms and on the predominant correspondence to somatic symptoms, organ affinities, tissue affinities, disease affinity, etiological prescribing and specifics (Swayne, 2000:44).

Complementary Medicine

A broad term encompassing those forms of treatment which are not widely used by the orthodox health care professions, and the skills of which are not taught as part of the undergraduate curriculum of the orthodox medical courses (Swayne, 2000:47).

Curriculum

Appointed course of study (Fowler and Fowler, 1966).

Graduate

A holder of an academic degree. In this study refers to a Master's Degree in Technology in Homoeopathy from Technikon Witwatersrand (TWR)
(Fowler and Fowler, 1966).

HSA

Homoeopathic Association of South Africa. The current body representing Homoeopaths and Homoeopathic students (Gower, 2006).

Homoeopathic Practice or Practice

To exercise or follow homoeopathy as a registered profession, with or without monetary remuneration by means of providing a professional service to a formal patient base, from a fixed contactable address or addresses. (This does not include informal consultation with family, friends and acquaintances) (Adapted from: Fowler and Fowler, 1966).

Law of similars

The fundamental principle of homoeopathy, which states that substances may be used to treat disorders whose manifestations are similar to those which they themselves induce in a healthy subject. Expressed as similia similibus curentur (let like be cured by like) (Swayne, 2000:193).

MBChB

Bachelor of Medicine and Bachelor of Surgery Degree.

M.Tech.: Homoeopathy (M.Tech.: Hom)

A Master's Degree in Technology in Homoeopathy (Technikon Witwatersrand, 2005).

Pilot Study

A preliminary study to assess the validity of an intended future study (Fink, 1995).

Qualification

Qualification means any degree, diploma or certificate awarded after examination of a person's proficiency in a particular subject (South Africa 2001: R127).

Retrospective Study

A survey of what is past (Fowler and Fowler, 1966).

SERTEC

A Certification Council for Technikon Education (SERTEC, 1995).

SAHA

South African Homoeopathic Association, a body representing Homoeopaths in South Africa, no longer in existence (Frazer, 2005).

CHAPTER ONE:

INTRODUCTION

1.1 INTRODUCTION

Information regarding graduate progress is useful in order to assess their perceptions, their accomplishments and workplace opportunities since qualifying. The career path of TWR Homoeopathy graduates have never been investigated, and was therefore deemed viable to do so. Not only would it clarify areas of difficulty regarding the education provided and the profession as a whole but would also serve to ascertain the viability of Homoeopathy as a career. Very little was previously known about the status of homoeopathy within South Africa until a similar study to this one was undertaken by Fotini Babaletakis (2006). She conducted a formal study on the career choices of Durban Institute of Technology (DIT) Homoeopathy graduates, the research design of both studies were constructed together and as a result comparatives can be drawn between this study and the DIT one, to provide a realistic view of the status of Homoeopathy as a profession within South Africa. Prior to the DIT study there was anecdotal evidence to suggest that most Homoeopaths do not practice, it was shown however that the majority of the DIT graduates do practice, however they experience a wide range of problems, from the education they received, financial viability of staying in practice, to the practical logistics of actually running a practice whether successful or not.

1.2 AIM OF STUDY

This study can be seen as a retrospective survey of post-graduate career paths of Technikon Witwatersrand (TWR) Homoeopathic graduates from 1998 to 2004, with comparisons to DIT where applicable and appropriate.

1.3 RATIONALE FOR STUDY

The evidence gleaned from the study done by Babaletakis (2006) showed that most Homoeopathic graduates from Durban Institute of Technology (DIT) do practice Homoeopathy. However they experience difficulty in running successful practices. In light of the above, this study was therefore designed to give an overview of the following main issues regarding TWR Homoeopathic graduates:

1. The proportion of TWR graduates practicing Homoeopathy.
2. The demographics of both practicing and non-practicing TWR Homoeopathic graduates.
3. Possible reasons for giving up or not practicing Homoeopathy at all.
4. Difficulties that the graduates may have in practice.
5. The career opportunities for TWR Homoeopathic graduates
6. The viability of Homoeopathy as a career choice.

7. General attitudes towards the Homoeopathic profession as felt by the TWR graduate.
8. General attitudes of the graduates regarding the education they received.
9. Compare data collated from the DIT sample with the TWR sample where appropriate.

1.4 BENEFITS OF THIS STUDY

1. To provide practitioners within the profession with a realistic detailed look at the industry.
2. Assisting future Homoeopathic graduates in making an informed decision about choosing Homoeopathy as a potential career choice.
3. Enable educators of future Homoeopathic students to structure a course that is suited to the needs of the students and the expectations they have regarding Homoeopathy as a career choice.
4. Highlight potential difficulties that Homoeopathic practitioners face.
5. To equip political decision makers with the knowledge needed in order to develop the profession within South Africa.
6. Highlighting the similarities and differences between the results of the DIT study and the TWR study.

1.5 LIMITATIONS

1. Only Homoeopathic Graduates from Technikon Witwatersrand participated within this study.
2. Only persons that graduated between and including 1998 to 2004 were considered for the study.
3. Only correctly completed questionnaires were analysed.

CHAPTER TWO:

LITERATURE REVIEW

2.1 GRADUATE SURVEYS

2.1.1 Introduction

This study aimed to assess the perceptions and career choices made by TWR graduates. Previously, little was known about the status of Homoeopathy within South Africa, as no formal studies had been conducted on the demographics and professional activities of students since their graduation. Babaletakis (2006) conducted a retrospective study on Durban Institute of Technology (DIT) Homoeopathic Graduates, and results can be paralleled with this study in order to formulate a realistic view of the status of the Homoeopathic profession in South Africa.

The focus on graduates is essential, given the considerable resources invested in their education by both public and private individuals, and their contribution to a healthy economy. Therefore research of any sort, in order to remain valid and of applicable quality requires constant evaluation and development (Das, 2002).
By regularly surveying graduates, a picture can be built up as to their entry into, and progression through, the current employment market. The creation of a regular graduate tracking system can potentially provide prospective and current

students, as well as employers, with in depth information on the way in which the graduate employment market works, thus helping them to make realistic plans. It would also help training institutions and government to develop longer term strategies for the development and retention of people with the necessary levels of knowledge and skill (Moleke, 2004). TWR produced their first graduates in 1998. Information regarding their progress was considered important in order to assess their accomplishments and workplace opportunities since qualifying. In addition the research findings aim to equip students with information to use in their own career decision making as well as inform educators as to how graduates perceive and evaluate the education received.

2.1.2 General graduate studies

There have been many studies assessing the efficacy of graduate education worldwide over a broad spectrum of fields including engineering (Robinson, 1999), medical specialists (Lannon, 1999), scientists (Mervis, 2001), physicians and architects (Virtanen, 2001) as well as Moleke (2004) who conducted a survey on the employment experiences of graduates from top universities in South Africa focusing in particular on their movement within the post graduate employment market.

These studies highlighted any difficulties the graduates experienced as well as showing that people with higher education experience a persistent advantage in

the labour market. When they are employed it is often in relatively better paid jobs and their likelihood of being unemployed is low, and when this does occur, the period of unemployment is of a relatively short duration. However Moleke (2004) also points out that this advantage is not experienced by all segments of people with higher education.

2.1.3 Homoeopathic graduate surveys

Courage (2006) completed a survey on subject failure and delays in qualification of DIT graduates from 1994 to 2004. Courage was investigating the certain difficulties that DIT Homoeopathic graduates may have had during their education process. Unlike the Courage (2006) study, this research covers aspects of post graduation difficulties. These difficulties can to some extent be linked to the education they received and the transition into practice, looking at failure rate and delays in graduation is therefore relevant to this study.

Babaletakis (2006) assessed the career choices and paths of Durban Institute of Technology (DIT) graduates from 1994 to 2004. The final outcome of the research refuted the anecdotal evidence that the majority of DIT Homoeopathic graduates are not practicing. However a large percentage of these graduates are supplementing their practice incomes, with other modalities and varying work. The principal factor that seems to motivate these graduates to continue practice is the intrinsic rewards it provides as a career. Financial considerations seemed

to be the main factor that influenced graduates that were practicing to give up. A number of these graduates were working in the health care industry and in hindsight they would have rather chosen another medical field other than Homoeopathy as a career option. The model of the Bableta kis (2006) research was constructed together with this one, and the results can be paralleled.

2.2 CONCEPTION OF THE PROFESSION

2.2.1 The history of homoeopathy

Samuel Hahnemann was the founder of Homoeopathy. A medical doctor, pharmacist and scientist, he investigated the action of various substances on the human organism, which led him to conclude that cure was based on a set of principles. The most central of these principles which the science of Homoeopathy is subsequently based is the Law of Similars or the idea that “like cures like.” He documented his findings in the Organon of the Healing Art, first published in 1800. He subsequently revised the document six times, resulting in the sixth edition of the Organon that lays out the guidelines on which Homoeopathy as a complete system of medicine is currently largely based (De Scheeper, 2001).

2.2.2 Homoeopathy in South Africa

Homoeopathy and complimentary medicine alike are fast becoming a more popular choice of health care amongst the general public within South Africa. Often fraught with resistance from the government, Homoeopathy in South Africa has been born out of highly restrictive and limiting laws regarding education and scope of practice. It can be regarded as a young profession emerging through the confines of governmental red tape and has only in the last 20 years or so been legalised and a clear scope of practice been defined. Homoeopathy was registered with the Department of Health under Act 1964. In 1974, Act 52 of 1974 was in operation for approximately 6 months, which provided a window of opportunity for the registration of qualified Homoeopaths, after which the register was closed (Caldis, 2000).

In 1985, the register was re-opened and a governing body was established, currently know as the Allied Health Professionals Council of South Africa (AHPCSA) (Caldis, 2000). Also in 1985, a bill was passed allowing tertiary Homoeopathic education to be formalised through government tertiary education institutions. A programme was laid out by the South African Homoeopathic Association (SAHA) that was approved by SERTEC (Educational Certification Council for Technikons), the Department of Health and the Department of Education. Standards of the programme were drawn up for Homoeopathic

educational standards from all over the world including Holland, Mexico, Australia, England and Germany (Babaletakis, 2006). Of course this new issue of legality demanded that a formal tertiary programme be set up that would ensure that the training received would be of a standard suitable to cope with the ethics and scientific knowledge needed to provide quality health care.

Various institutions were approached and eventually Technikon Natal (now Durban University of Technology) agreed to run the programme. This programme, which was initiated in 1989, consisted of a five year full time training and research dissertation and internship. After completion of the programme graduates were awarded a Master's Diploma in Homoeopathy, which was then converted to a Masters Degree in Technology in 1994. In 1998, the Technikon Witwatersrand became the second tertiary institution in South Africa to offer Homoeopathy as a higher education course, which has since changed its name to the University of Johannesburg. Both institutional programmes were designed according to SAQA to be five years of full time academic study and one year of practical internship, however no practical internship has been formally implemented in either one of the institutions.

Students graduating from these courses would then be eligible for registration with the relevant statutory body, namely the Allied Health Professions Council of South Africa (AHPCSA). Only practitioners registered with this council have the legal right to practice as Homoeopaths (South Africa 2001: R127). In South

Africa, medical aid societies will only recognise registered Homoeopaths with relevant dispensing licenses.

2.2.3 Homoeopathy as a profession in South Africa

According to the Allied Health Service Professions Council of South Africa, the Homoeopathic practitioner is like the medical practitioner. He/she is a primary contact practitioner using a different medicinal approach and not performing surgery. He/she makes a normal differential diagnosis based on physical and other examination method, prescribes medication and other therapeutic procedures (Milani,1995), this is all very well but the definition falls short to the reality that the graduates face on completion of their degrees, as will be noted in the discussion many graduates are disillusioned with their career choice, and besides their perceived lack confidence in their skills, they do not feel integrated into mainstream healthcare.

2.2.3.1 Legal Aspects Of Practice

Rule 9(1) of the Health Professions Act, 56 of 1974, restricts free communication between complementary health professionals and medical professionals (South Africa, 2004:26497). On 11 October 1994, the Medical and Dental Council proposed to abolish this rule (Van der Veen, 1996). However, this has not yet come into effect and the limitations it might create for Homoeopathic practitioners

will already have had an effect. Some of the graduates noted how they do not feel a part of the medical profession as a whole and how limiting this has been in the medical profession taking them seriously.

2.2.3.2 Supportive Homoeopathic Bodies

The South African Homoeopathic Association (SAHA) was the original representative body of Homoeopaths that lobbied for major changes in South African legislation regarding Homoeopathic education and scope of practice.

Subsequently, a number of other bodies were formed by various individuals or groups of individuals, all having differing ideas of how the profession should develop. Only recently, in 2004 was a cohesive body formed to represent Homoeopathic practitioners, students and educators alike. The new body established, the Homoeopathic Association of South Africa, better known as the HSA, has been committed to promoting Homoeopathy as an effective and professional form of medicine (Babaletakis,2006).

2.2.3.3 Attitudes to Homoeopathy as a Profession within the Medical Field

Maharaj (2005) conducted a study to determine the perceptions general practitioners and pharmacists in the Durban area had towards Homoeopathy. It was found that 65,75% of all respondents felt that Homoeopathy is a legitimate form of medicine (65,98% of GP's and 65,52% of pharmacists). Another similar study was conducted by Sukdev (1997) to ascertain the perceptions of medical practitioners with regards to the role of complementary medicine in health care in South Africa. She found that although Homoeopathy was thought to be effective in the treatment of some conditions such as allergies, asthma, common cold and hay fever, the majority of practitioners (77.01%) viewed complementary therapies as supportive, 27.95% believed it to be recuperative for illness, 26.39% see complementary medicine as preventative and only 14.59% viewed complementary medicine as a primary therapy.

2.2.3.4 Future Development of the Homoeopathic Profession

The future development of the Homoeopathic profession in South Africa is dependant on a number of direct factors. An assessment of these factors regarding Homoeopathic graduates will help determine the development of the profession in South Africa. i.e.:

- Number of students enrolling in the tertiary Homoeopathic programme. According to Small (2004), the awareness level of the programme and Homoeopathy in general is very low.
- The number of students completing the course and delays in qualification (Courage, 2006).
- The amount of graduates going into and staying in Homoeopathic practice (Babaletakis, 2006).
- The support and promotion of Homoeopathy by its representative body.
- The quality of education that the graduates receive, according to Babaletakis (2006), the quality of education is generally inadequate to prepare for the vision that the Allied Health profession originally stipulated.
- The number or proportion of Homoeopathic graduates that do practice Homoeopathy, but leave South Africa to do so. According to governmental statistical services, between 70 to 100 medical doctors have emigrated from South Africa per year from 1994 to 1998; this is apparently a conservative estimate (Jones, 1999). This may be an issue however the Babaletakis (2006) study showed that this was not an issue directly affecting the profession.

2.3 POSSIBILITIES FOR EMPLOYMENT AND CAREER ADVANCEMENT

2.3.1 General employment trends in South Africa

According to Moleke (2004) the outlook for graduate employment is influenced by three important demand and supply factors. The first being the growth rate in the number of jobs requiring graduate level education, the second is the number of new graduates coming on to the market and the third is the ability of new graduates to make connections with the job openings. Increases in the number of jobs requiring graduate level education arises largely from growth in industries with occupations requiring a degree, and upgrading of jobs as skills required become more complex because of technological change or new business practices.

While being employed is an important indicator of economic outcome, the type of job one holds is just as important. It can be expected that the type of jobs that graduates hold not only reflects the utilisation of their education but also contributes towards paying off their investment in education.

Like employment, unemployment rate and incidence differs for graduates and is influenced by factors such as study fields, race and gender. Moleke (2004) found that the humanities and arts had the highest proportion of those unemployed. Interestingly, two of the other general fields, economic and management

sciences, and natural sciences had lower rates of those unemployed. Thus, while they also do not necessarily prepare graduates for a specific occupation, this reflects the relative advantage they hold over humanities and arts as fields of study. Intuitively, this makes sense as these fields provide a relatively sound springboard for building a career. For example, economic and management science graduates mostly hold B.Comm degrees. These could be springboards for accounting, business management and economics careers, which have relatively better prospects in the labour market.

Anecdotal evidence suggests that Homoeopathy as a career even though from a medico-scientific background functions more as a humanity and arts degree whereby the highly specific skills acquired during the course of study cannot be used as a springboard to other areas of potential employment. As was noted in the DIT study (2006), choices available to the graduates are restrictive and prescriptive to homoeopathy alone and possibly a few related complimentary therapies. Majority of the graduates said they would have rather studied medicine first and then done a post graduate qualification in Homoeopathy as this would have afforded them greater scope of practice and financial gain.

2.3.2 The need for a skills base

Employment trends in South Africa indicate that employment is skills based, and that professionals are among the fastest growing occupational category (Bhorat, 2001).

The unemployment rate of people with higher education is seen to be relatively low. This is reflected in the graduate study undertaken on University graduates from 1990-1999 across all fields (Moleke, 2004). In the study it was found that 60% of graduates found employment immediately. The study also showed that graduates in the field with a more professional focus, such as the medical sciences and engineering had higher rates of rapid employment than those who studied in fields that were largely of a general nature. In addition it was shown that in the medicine related fields, graduates can normally move into employment immediately after completing their studies and thus implied that their employability relates to their skills base that allowed them to be useful immediately. However, fewer humanities and arts graduates found employment rapidly after obtaining their qualifications. The experiences of the arts and humanities group reflected the disadvantage that their qualifications do not have a career specific focus applicable to industry needs, which makes it more difficult to find jobs.

2.3.3 Homoeopathic education and skills base development in South Africa

According to the European and International Councils for Classical Homoeopathy (1993), a trained homeopath should be able to work in a variety of roles ranging from an independent consultant in private practice through to being an integrated member of a team of therapists and diagnosticians working in an institutionalised setting. The range of educational experiences should prepare students for the full range of potential therapeutic experience they are likely to meet in practice. These educational experiences are grown within a pre determined curriculum and provide:

- A specification for the development and delivery of effective educational experience for student Homoeopaths,
- A guide for evaluation of the students and of the college course itself, and
- Facilitates on-going professional and curriculum development (European and International Councils for Classical Homoeopathy, 1993).

The ECCH/ICCH Core curriculum Document (1993) outlines a training programme requirement to produce competent professional Homoeopaths. Requirements include competence in the following areas of study: Homoeopathic philosophy, practice methodology, materia medica, anatomical sciences, psychology, clinical training, ethics and practice management.

The TWR Homoeopathic training course covers all of these aspects of Homoeopathic education to a greater or lesser extent (Appendix G). As was shown in the DIT study these principles fail to produce graduates in the majority of cases that are integrated into mainstream medicine as it stands in South Africa.

2.3.3.1 Matching jobs with education

A survey on Graduate Scientists in the USA (Mervis, 2001) found a three way mismatch between student goals, training and their actual careers. Most positions available to graduates are academic in nature, the majority did not wish to pursue academic careers and encountered difficulties in broadening the scope of possibilities available to them. The report recommends changes to the curriculum to better prepare students for today's economic realities as well as emphasising that more information be made available on the relevant job market. Moleke (2004) showed that as graduates changed jobs, the matching of jobs to their field of education improved. Most graduates moved to jobs that were related to their field of study, which was the case in all study fields. Only humanities and arts had a high proportion of those whose current jobs were not related to their study field, which reflects the general nature of this field.

In the Bradley (2001) study, researchers conducted a survey on Ph.D candidates covering eleven disciplines at twenty seven universities in the United States. It

was shown that graduate school does not adequately prepare students for the jobs they take, they state the PhD programmes persist in preparing graduates mainly for academic careers at research universities, despite an on-going shortage of such jobs.

The level of education received by a Homoeopathic student in South Africa is one of the best in the world however, future employability other than private practice is minimal. There appears to be a mismatch in what is learnt and what is applicable in our job market. By far the most significant component of any health system is its health personnel. Without a foundation of skilled human resources, health care systems cannot function adequately or effectively, particularly in the public sector at the primary level of care. Health sectors in Africa face significant shortfalls in human resources.

According to the World Health Organisation, 31 countries in Africa do not meet the 'Health for All' standard of a minimum of one doctor per 5000 people. Homoeopathic training in South Africa is a medico-scientific degree emphasising correct patient diagnosis and pathology recognition. With guided implementation, graduate skills can be effectively utilised in overcoming the shortfall that faces the relative lack of primary health care in Africa. However the scope of Homoeopathic skills utilisation in South Africa is relatively non existent in addressing this problem due to government restrictions and the lack of vision as to what graduates can offer outside the scope of private practice, this is despite

the World Health Organisation emphasising the fact that most of the populations in developing countries depend on traditional medicine for primary health care, and therefore that the practitioners of traditional medicine are a potentially important resource for health care.

The services provided by primary health care workers include immunisation, communicable and disease prevention, maternity care, screening of children and child health care, health care promotion, youth health services, counseling services, taking care of chronic diseases, rehabilitation and family planning. Patients visiting health care clinics are treated mainly by primary health care nurses and doctors. It should be up to the institutions that offer Homoeopathy and their respective governing bodies in ensuring that the scope of current training could be useful to the government in many ways. It therefore becomes imperative that a formal internship programme be set up by the institutions to adequately prepare graduates for primary health care positions. The current lack of an internship was highlighted in the 2006 study of Durban Institute of Technology Homoeopathy graduates (Babaletakis,2006) and has been brought to the fore in this study.

In May 2004 the Minister of Health inaugurated the new Health Profession of South Africa and with effect from 2005 student doctors have to undergo a five year medical programme followed by two years of internship, currently the Homoeopathy degree is a five year qualification however it falls short of providing

an adequate internship programme. If Homoeopaths wish to be given the same status as a doctor this problem needs to be addressed. In 2004 the Minister launched the Medical/Physician assistant who will provide a link between nurses and doctors and alleviate some of the stress on the already strained primary health care model, their education will be a three year in-house training period and will be managed and conducted through the universities. Within the public sector homeopathic graduates could potentially fulfill this assistant role adequately, thereby sparing additional expense to the government as Homeopathic graduates are already trained in patient management and care.

A study conducted on internal medicine – paediatrics combined residency graduates in the USA, shows that the principal activity of almost 70% of graduates was direct patient care. This shows a large proportion of graduates are prepared for practical application of their training. This is an important finding as the article states that “academic training programmes face increasing political pressure to reallocate residency positions to favour primary care specialties”, and thus places the emphasis of skills on a practical rather than a theoretical level (Lannon, Thomas, Geurin, Day and Tunnessen, 1999).

According to these findings, it would be of relevance to determine how practically applicable our current Homoeopathic training is, especially since the current South African health policy has its focus on primary health care, and thus emphasizes the need for basic practical skills rather than theoretical knowledge.

Babaletakis (2006) clearly shows the impact the lack of internship and a more practically orientated course can have on the confidence levels of those wanting to practice effectively as “Doctors”.

However, aside from the above statements, with regards to the private sector evidence shows that the international growth of complementary medicine is paralleled in South Africa. In 2000, the health products industry had an estimated annual turnover of over R1.2 billion (Caldis, 2000), showing an increase of 46% over four years. In addition, there has been substantial growth in the numbers of practitioners of complimentary therapies and an increasing number of publications covering the topic. It is estimated that some 60 – 80% of the South African population use traditional medicine as their first contact for advice or treatment.

Traditional and complementary practitioners have tremendous potential in a country such as South Africa where the health care system is severely overburdened and health care to so many is restricted. Traditional and complementary practitioners and medical practitioners need to focus their aims together to form a broader health care base. This can only be accomplished when there is an attitude of acceptance between the two systems. Complementary medicine with its focus on prevention of illness and maintenance of health can prove to be highly economical and socially beneficial (Selli, 2003).

2.3.3.2 Job satisfaction and career fulfillment

The beginning of a career may involve stressful experiences, where the relative freedom of student life is replaced by new kinds of responsibilities, such as being able to financially support oneself in the chosen career. This psychosocial development of a career was studied using a comparison between Finnish physicians and architects (Virtanen, 2001). The physicians' employment prospects were so much higher than that of the graduate architects and this uncertainty about future employment has adverse consequences in the mental health of the architects. This was characterised by an insecure entry into the work environment for the architects and as a result skills never reach an optimal level. Lack of financial stability also makes it difficult to resist the strain caused by the transition into the labour market. These psychological factors come into play with most Homoeopathic graduates, there is a transition period between finishing their academic criteria and their research before they graduate, often extending to a two year period. They are unable to practice at this time and many have loans to pay back. In addition there is a relatively wide gap between when they graduate and when they enter private practice, if ever (Babletakis, 2006).

The research uncovers some of the reasons as to why graduates have given up their practices or have chosen not to practice. Some career frustrations were highlighted in an engineering study (Robinson, 1999); where despite their

qualifications, many felt stale in their jobs and could not see what the future held for them in terms of new challenges and job satisfaction. In the same report the researchers highlighted a void in the industry in terms of opportunities to develop skills and providing job security. With the relatively small growth in the Homoeopathic profession questions arise in terms of the uncertainty about future success, especially from a financial point of view. There is limited spectrum for the use of the Homoeopathic degree besides private practice (Babletakis, 2006).

2.4 MEASUREMENT TOOLS

2.4.1 Use and Importance of Surveys

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 (Mitchell and Jolley, 1992). They state that "Surveys are used most often to assess people's beliefs, attitudes, and self-reported behaviour. Researchers use surveys to describe behaviour and to develop causal hypotheses that can be tested in experiments, surveys cannot, by themselves, establish causality."

Graduate surveys help career planning departments discover how graduates evaluate their services and provide their institutions with an accurate reflection of what their graduates do (Murray, 1994). Richter and Reubling (2003) developed

a survey model to assess curriculum and student outcome needs. A pilot study using the physiotherapy department at the Saint Louis University, confirmed the extent to which other medical programmes can use this model in similar studies. According to the researchers, three surveys are needed to assess graduate performance comprehensively in relation to curriculum and post graduate outcomes:

- A one year post graduate survey.
- A three year post graduate survey.
- An employer survey.

On collation of the results these three surveys would provide the following information:

- The perceptions of graduates towards their practice.
- Information about graduate professional activities since graduation.
- Demographic information such as type of work set up and patients seen.

For the purposes of this research study, and to provide an adequate sample size it was decided that the survey model be modified to encompass all TWR Homoeopathic graduates from 1998-2004. Research would have to be carried out in the future to follow up on the progression of the profession, to see if any relevant shifts have taken place. At this stage the scope of the research does not cover employers of graduates, it is noted however that research could be excluding valuable input from employers.

2.4.2. Advantages and disadvantages of Surveys

The advantages of surveys are that they can be used to investigate problems in realistic settings, and they allow researchers to examine a large number of variables which can be analysed with the help of multivariate statistics. The disadvantages are that independent variables cannot be manipulated as in experimental research, and reliability and validity are not always easy to ensure.

Cooper et al (2001:295) state that “The major weakness is that the quality and quantity of information secured depends heavily on the ability and willingness of respondents to cooperate. Often, people refuse an interview or fail to reply to a mail survey.” Cooper acknowledges that there may be many reasons for the 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. The questioning technique has further problems in that respondents may interpret the question differently than what was intended by the researcher. They may intentionally mislead the researcher by giving false information, thus survey information should be accepted for what they are – statements by others that reflect varying degrees of truth.

2.4.3 Types Of Surveys And Data

Descriptive survey: a descriptive research is a study that attempts to describe that which exists as accurately as possible. The purpose of a descriptive survey is to count, descriptive surveys chiefly tell us what proportion of a population has a certain opinion or characteristic (Oppenheim, 1992).

Experimental survey: experimental designs are characterised by arranging to compare two or more groups, at least one of which is experimental. The other is a control or comparison group. The experimental group is given a new or untested, innovative programme, intervention or treatment. The control is given an alternative (Fink, 1995).

Qualitative survey: a qualitative research survey has an undefined scope and procedures are not strictly formalised, the approach is of a rather philosophical nature. Thus is characterised by open-ended questions requiring personal input and opinions (Mouton and Marais, 1990).

Quantitative survey: qualitative data collection is highly formalized, explicitly controlled, and has exactly defined range. Thus questions are of a precise nature (Mouton and Marais, 1990).

2.4.4 The Design Of This Study

This survey was designed as a self-administered, descriptive, qualitative / quantitative questionnaire. The questionnaire was obtained from the graduate survey done by Babaletakis (2006) on DIT graduates. The questions were relevant for the TWR study and therefore were not altered.

Section A, the demographic section, was largely based on and adapted from Verhoogt (2003), who conducted a clinical audit on registered Homoeopathic practitioners in Kwazulul Natal and Ferrucci (1995) who did a study of demographic data relating to clinical methods of Homoeopathic practitioners and students.

Guidelines regarding layout, wording and structure of a questionnaire as set out by Murray (1994), were used to formulate specific questions in Sections B, C and D of the questionnaire. These included:

- Using easy to understand words.
- Being very explicit with instructions.
- Using multiple choice questions.
- Creating opportunity for the respondent to give answers not anticipated by the researcher by including a “other, please specify or please elaborate” portion for particular questions.

- A space for additional comments was left at the end.

A pilot study was done before the research was initiated to determine the validity of the questionnaire.

CHAPTER THREE:

METHODOLOGIES

3.1 Type of Study:

The study took the form of a descriptive (observational) survey, by means of a self-administered questionnaire (Appendix A). In this type of study no new groups were created, and in this case, the group being surveyed was TWR Homoeopathic graduates from the years 1998 to 2004. The survey was constructed specifically to be a cross sectional design, which is a portrait of the group at one point in time. In most cross sectional surveys, the study population is representative of the group being studied (Fink, 1995) and in the case of this study on TWR graduates, the group was small enough for all members to be included in the study.

The sample group consisted of 120 participants, of that 120, 89 were contacted. This number made contacting them all both manageable and feasible. In order for the study to realistically represent the true nature of the industry being studied, it was decided that a minimum of fifty percent of the total group, i.e.44 responses were required for statistical analysis. If this requirement had not been met then the research would have been declared null and void. This research obtained 58 viable responses, six of which were refusals to participate.

3.2 Research participants:

Participants in the study were all graduates of Technikon Witwatersrand (TWR) Homoeopathic Department, from the first year of graduates of the course in 1998 to midyear graduates of 2004. The participants may have done part of their qualification at another institution or have received subject credits as a result of previous study of comparable subjects from another institution, but they would have completed their qualification and graduated from TWR. The study therefore excluded Homoeopathic practitioners that have qualified but have not yet formerly graduated, as there is a time lapse between the two.

3.3 Design and layout of questionnaire:

A questionnaire was drawn up (Appendix A) and designed according to the aims established at the outset of this survey. The covering page of the questionnaire gave the graduates detailed instructions as to how to correctly fill out the questionnaire. It also outlined a definition of a “Homoeopathic practice”, which for the purposes of this study was drawn up in order to enable the graduates to select the sections relevant to them.

The questionnaire consisted of 4 parts, only two of which would be answered by any one participant:

- Part A was compulsory for all graduates to complete and consisted of questions covering demographic data and educational details.
- Only one of Parts B, C or D was to be completed by any one participant. The participant would decide which part related to him or her according to their status outlined in the definition:
- Part B was to be completed by graduates who had never practiced Homoeopathy.
- Part C was to be completed by graduates who had once previously practiced Homoeopathy but were not currently practicing Homoeopathy at the time of the survey.
- Part D was to be completed by graduates who were currently practicing Homoeopathy at the time of the survey.

3.4 Pre-assessment of questionnaire:

This consisted of a two part assessment to ensure that the questionnaire was of a high standard and it effectively addressed the aims of the survey.

3.4.1 Statistician Assessment:

On completion of the questionnaire, it was submitted to a qualified statistician for review. This was primarily undertaken to ensure that the questions with their potential answers were optimally constructed to allow for applicable statistical

analysis. Any comments and recommended changes were taken into account and applied to the final draft of the questionnaire.

3.4.2 Pilot assessment:

A pilot assessment was undertaken to determine the face validity of the questionnaire (Appendix E). This was done because the questionnaire was drawn up by the researcher and had not been used before, as well as establishing whether or not the questionnaire fulfilled the criteria stipulated by Fink and Kosecoff (1985), which highlighted the purpose of a pilot study, which is used as a tool to assess the following:

- Will the questionnaire provide the needed information?
- Are certain questions redundant or misleading?
- Are the questions appropriate for the people who will be surveyed?
- Will the information collectors be able to use the survey forms properly?
- Are the procedures standardised?
- How consistent is the information obtained by the survey?
- How accurate is the information obtained by the survey?

The pilot assessment was done using the following 12 people, who were chosen because of their similarity regarding education level, age and possible language barriers, to the graduates who would eventually complete the survey (Fink and Kosecoff, 1985):

- 3 DIT qualified Homoeopathic practitioners.
- 3 DIT Homoeopathic research students.
- 3 DIT qualified Chiropractors.
- 3 members of the general public with a university degree.
- Of these 12 participants, 3 were fluent in English with it being their second language.

The 12 assessors were asked to comment on and recommend any needed changes to the questionnaire. They were asked to comment on:

- Clarity.
- Understandability.
- Possible ambiguity.
- Time taken to complete questionnaire.
- Suggestions for improvement.

After the assessment was completed, the suggestions were correlated and reviewed, and appropriate changes were then made to the questionnaire.

3.5 Data collection:

3.5.1 Obtaining the list of participants:

A list of graduates from 1998 to 2004 was obtained from the TWR Department of Homoeopathy (Appendix F). This was cross referenced against a list of Homeopathic practitioners and their contact details obtained from the Allied

Health Professionals Council. Contact details of graduates were also sourced from friends, family and colleagues of the graduates as well as the internet and telephone directory.

3.5.2 Primary contact and confirmation of delivery method:

The graduates were all contacted telephonically or via e-mail if they were abroad in order to introduce them to the proposed research study. This initial contact served the purpose of confirming their willingness to participate and to establish how they would like to receive the questionnaire i.e. e-mail, fax or post. It was anticipated that a number of graduates may be abroad during the time that this research was being conducted. Every effort was made to establish contact with these graduates either telephonically or via e-mail. Any graduates that could not be traced were then automatically excluded from the survey.

3.5.3 Methods of distribution:

Regardless of the method of delivery all graduates received an information letter (Appendix C) as well as an informed consent form (Appendix B). Both of these documents outlined the contact details of the researcher and the research supervisor should any difficulties or questions have arisen.

All posted questionnaires were supplied with a return self- addressed envelope to make the return of the questionnaire easy and convenient. The e-mailed questionnaires were broken up into their four sections and sent as a PDF type

document to ensure that the format of the questionnaire did not change when they opened it their side.

3.5.4. Methods of collection:

All completed questionnaires were received by an independent party Miss Deonarian, within the Faculty of Health Sciences at DIT. This independent party had no direct association with the homoeopathic profession and therefore ensured complete confidentiality of the responses. The two methods of collection were via post or fax.

Postal return:

The Faculty Assistant

Miss L Deonarian

DIT Faculty of Health

PO BOX 1334

Durban

4000

Fax return:

(031) 204 2407

The names from the returned questionnaires were ticked off against a list of graduates in order to establish a response rate. They were then deleted from the

questionnaires to ensure confidentiality. Only then, did the researcher and her supervisor have access to the questionnaires.

3.5.5 Data storage:

All returned questionnaires were classified as confidential documents and therefore once in the custody of the researcher, were locked in a cabinet. Only the researcher and the research supervisor had access to the anonymous files.

3.5.6 Response time:

The researcher allowed for a 2-week time lapse, for a response. After this time the participants were again contacted telephonically to confirm that they had received the questionnaire and as a reminder to complete and return the document. A further 2 weeks were allowed for return of questionnaires, after which time the non-complying candidates were excluded from the study. The entire process was conducted over a six month period as not all participants could be contacted simultaneously and frequently several attempts had to be made to make contact with some participants. The researcher then considered the data capture completed and proceeded with data analysis.

3.6 Critical pathways of the survey:

3.6.1 Tracing potential participants:

The ability to contact all the graduates and confirm their contact details correctly so that distribution and data collection ran smoothly was of vital importance to the success of this research. Some of the graduates' contact details had changed several times since they had qualified and the researcher experienced difficulties in tracing them. Similarly, a number of the female participants had married since graduation and their surnames had changed, which also presented the researcher with difficulty in establishing initial contact.

3.6.2 Lack of compliance:

3.6.2.1 Role of the information letter:

In trying to ensure compliance of participants, it was imperative to thoroughly inform graduates of the proposed research and to emphasise the importance of the information. Much care was taken in the presentation of the questionnaire to avoid the notion that the survey was simply a "marketing" ploy or that the information would be used against the respondent. A careful explanation of the intention of the study was laid out in the information letter, which each potential participant received. The information letter also clearly explained the measures,

which were taken to ensure the confidentiality of the responses, to avoid responses that may have been given because they sounded proper, rather than truthful.

3.6.2.2 Time constraints of participants:

Another serious concern was that, due to the nature of the sample group, participants might be reluctant to spend their valuable time on completing the questionnaire. The questionnaire was limited to only the essential questions revolving around pertinent areas, which were identified by the researcher and confirmed by the pilot study. The questionnaire was structured so that there were questions, which required writing of details. Open- ended questions in the form of “Additional comments” were left until last so that participants could add any further information that they felt had been omitted earlier in their answers. Each potential participant was also informed of the estimated time taken to complete the questionnaire, which according to the pilot study was approximately 20 minutes.

3.6.2.3 Convenient methods of response

To encourage participation in the study, it was important to make the methods by which participants could respond as flexible and convenient as possible. Hence,

each participant was offered 2 methods by which they could respond and could do so according to whichever method best suited him/her.

3.7 Statistics:

3.7.1 Key for analysis:

Once the questionnaires were collected the researcher went through each one individually and created a list of categories for each question. These were assigned numbers and a key was drawn up. (Appendix H)

3.7.2 Data analysis:

Data was entered into Excel® XP™ for Windows™ .
Statistical analysis was conducted using SPSS® for Windows™ (Version 13.1) Software Suite. This statistical software programme is manufactured by SPSS® Inc, 444n. Michigan Avenue, Chicago, Illinois, USA.

3.7.3 Statistical tests:

The Phi Co-efficient and Kendalls Rank Correlation Co-efficient were calculated to determine the existence of correlations between demographic and educational variables and the responses given by individuals in the sample.

3.8 FLOW CHART OF PROCESS

Questionnaire was drawn up and statistician analysis of questionnaire

↓

Pilot Study was done on questionnaire

↓

Adjustments were made to questionnaire

↓

List of graduates obtained and contact details sourced

↓

Graduates were contacted telephonically or by email to confirm:

a) Their willingness to participate in the study

b) The method by which the would like to receive the questionnaire

↓

The questionnaires were sent out

↓

A 2-week time lapse was allowed for return of questionnaires

↓

Graduates who had not returned the questionnaires were telephoned to

a) Remind them to return questionnaires

b) Check if questionnaire had been received

↓

Further 2 weeks allowed to lapse for further response

↓

Data collection was completed

↓

Data was analysed

↓

Statistics were completed

↓

Final write up of study

CHAPTER 4:

RESULTS

4.1 Introduction:

Following the methodology described in Chapter 3, the study produced raw data in the form of completed questionnaires. Questionnaires consisted of a demographic section (Section A), completed by all respondents; and three sections exploring issues specific to the three identified subgroups: qualified graduates who have never practiced (Section B), qualified graduates who have practiced but are not currently practicing (section C) and qualified graduates currently practicing (Section D).

The total number of graduates from 1998-2004 was 120, of that only 89 were contactable. There were 52 positive responses, and 6 refusals to partake in the study. None of the responses were considered invalid therefore the sample size for the group amounted to 58. There were 2 responses for group B, never practiced previously, 8 responses for group C, not practicing but practiced previously, and 42 responses in group D, currently practicing.

The specific objectives of the analysis were as follows:

(1) To describe the demographic characteristics of the population of qualified graduates of the TWR.

(2) To quantitatively describe the responses of the population of qualified graduates as explored in Sections B, C, and D.

(3) To quantitatively describe differences in responses across the three subgroups.

(4) To determine the existence of correlations between any of the demographic factors and the issues represented (as described by the frequency distribution of responses to the various questions).

The analysis of the data was done using SPSS® for Windows™ and Excel® XP™.

4.2 Overview of Results Chapter

4.2.1 Descriptive data

4.2.1.1 Location

These comprised graphics and distribution tables for the geographic location of the population of qualified graduates.

4.2.1.2 Demographics

These comprised distribution tables and graphs for the demographic data (Gender, Age Category, Ethnic Group, Marital Status, Language Preference, Country of Birth and Country of Citizenship).

4.2.1.3 Educational History

These comprised distribution frequencies for the data relating to educational history (calendar year of registration, age on first registration, tertiary qualifications (including type of qualification and institution obtained from), year of qualification, age on qualification, and qualifications obtained after completion of Homeopathic Masters Degree (M.Tech.Hom).

4.2.1.4 Registration and Financial Details

These comprised frequency distributions for the data relating to registration and financial details (annual income level, professional boards registered with and professions registered for).

4.2.2 Analysis

The Pearson Chi Squared Co-efficient and Asymmetric measures (Phi and Cramers V) as well as Kendalls Tau Rank Correlation Co-efficient was calculated to determine the existence of correlations between demographic and educational variables and the responses given by individuals in the sample.

4.2.3 Comments

This comprised a description of the comments made by respondents. Further discussion of these in light of the above statistical analysis follows in Chapter 5.

4.3 Abbreviations

Respondent = individual satisfying inclusion criteria who completed the questionnaire

H_0 = null hypothesis

H_1 = alternative hypothesis

S.D. = Standard deviation

z= Standardised z value for statistical measurements

p= two tailed probability of equalling or exceeding z/2

N.S. = No statistically significant difference

S = statistically significant difference

If $p < 0.05$ then a significant difference was concluded (5% level of significance)

If $p > 0.05$ then no significant difference was concluded (5% level of significance)

Sample Characteristics

The population that the research aimed to describe comprised graduates of the TWR Homeopathic Masters programme. (See Research Methodology)

The population characteristics in terms of the responses received are described in Table 4.1

Table 4.1Population size and Responses received

	Number	Percentage
Total number of Graduates	120	
Number Contactable	89	100%
Number of Positive Responses	52	58%
Number of Refusals	6	6.7%
Invalid	0	
Sample Size	58	65%

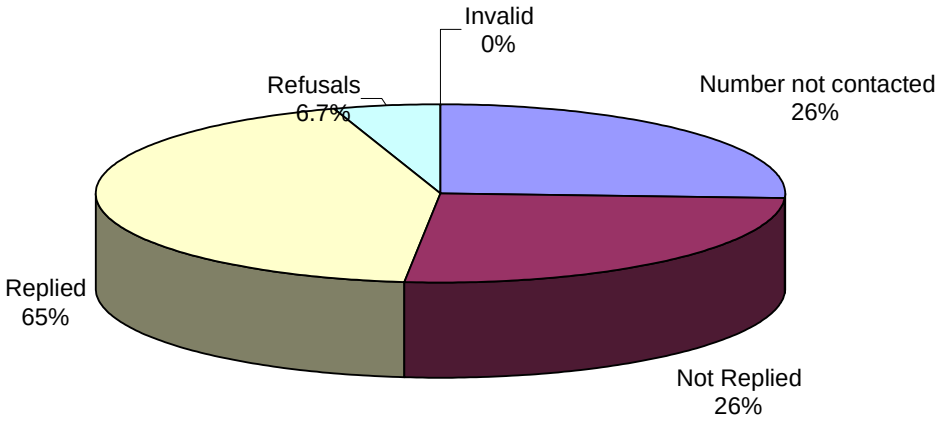
It was difficult to obtain contact details for the 31 graduates not contacted due to the following reasons:

They were not registered with any particular board, therefore it can be assumed that they are not in active practice.

Some graduates married and were using their married name as their professional name.

Majority of class mates lost contact with each other over the years.

Figure 4.1 Graph Showing Breakdown of Questionnaire Returns



Total Number of Graduates =120

4.4 Descriptive statistics

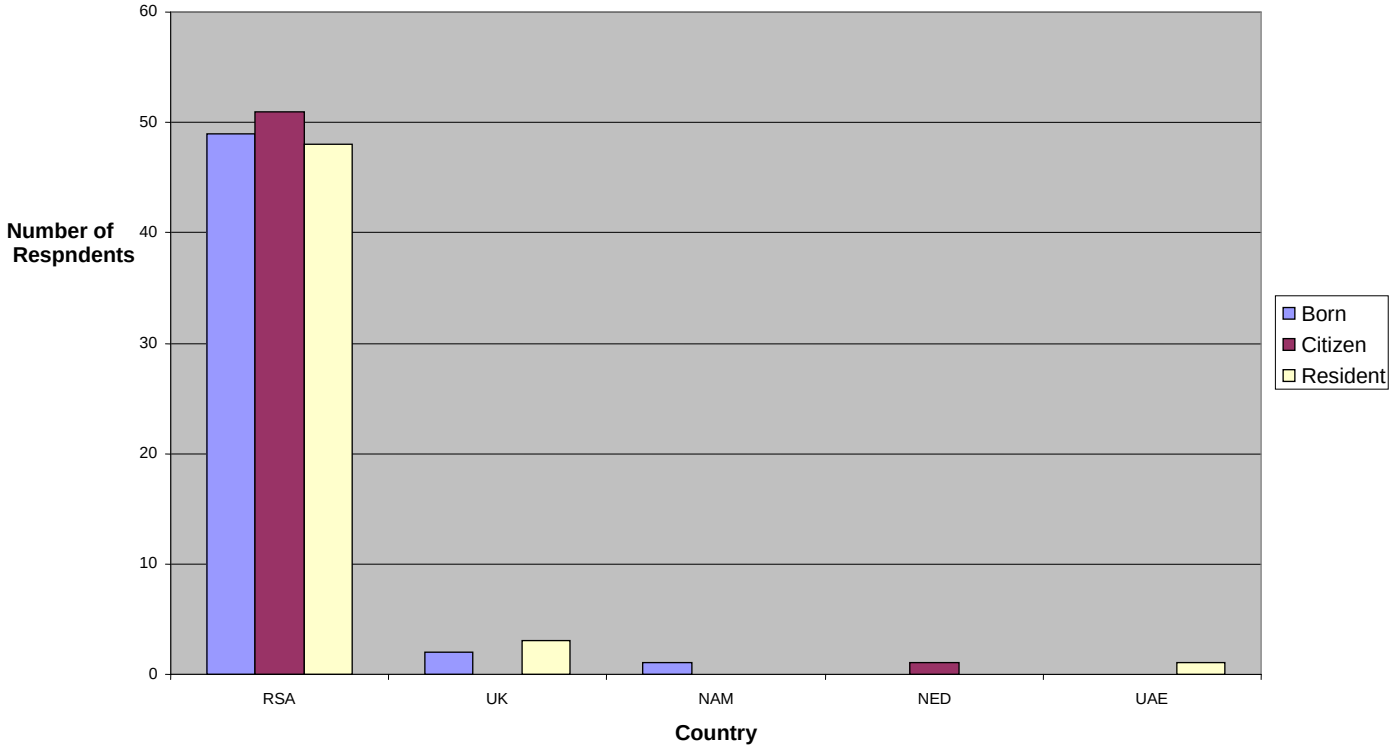
The data used for the following analyses were obtained from Section A. In terms of Objective one described in the Introduction, the distributions of the demographic variables are described.

4.4.1 Geographic Distribution:

Table 4.2 Table Showing Country of Birth and Country of Citizenship and Country of Residence of Respondents

Country	No of Respondents Born in Country	No of Respondents Holding Citizenship in Country	No of Respondents Resident in Country
RSA	49	51	48
UK	2	0	3
NAM	1	0	0
NED	0	1	0
UAE	0	0	1

Figure 4.2 Graph Showing Country of Birth, Country of Citizenship and Country of Residence of Respondents



From the above graphs it appears that there is a minimal level of emigration in the sample population.

Table 4.3 Table Showing Breakdown of Geographic Distribution of Respondents

Country	Province		Municipality	
RSA	Gauteng	34	Johannesburg	34
68	Northern	4	Pretoria	4
	Western Cape	7	Cape Town	6
			Mossel Bay	1
	Mpumalanga	1	Middelburg	1
	North West	1	Polokwane	1
	Limpopo	1	Waterberg	1
UK	London	2		
4	Woking	1		
	Surrey	1		
UAE 1	Dubai	1		

34 of the 52 respondents who qualified at TWR remained in Johannesburg. This represents a significant proportion (65%).

4.4.2 Demographics:

Table 4.4 Gender Distribution of Respondents

	Gender
Male	14
Female	38

Figure 4.3 Chart Showing Gender Proportions of the Sample

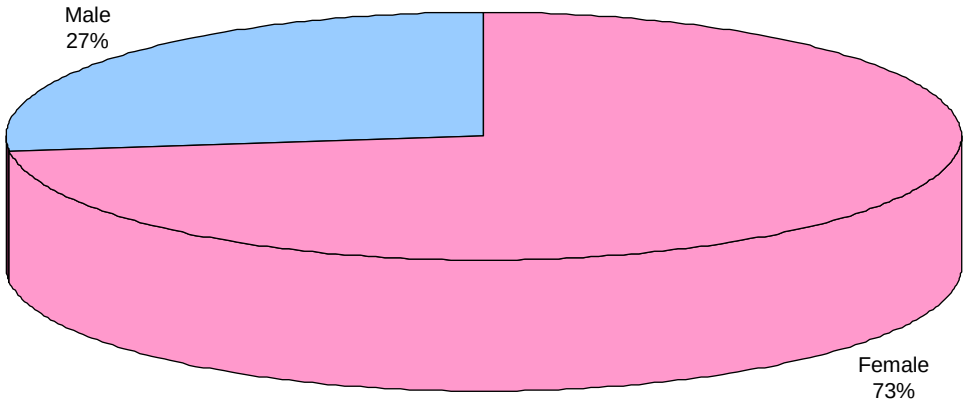
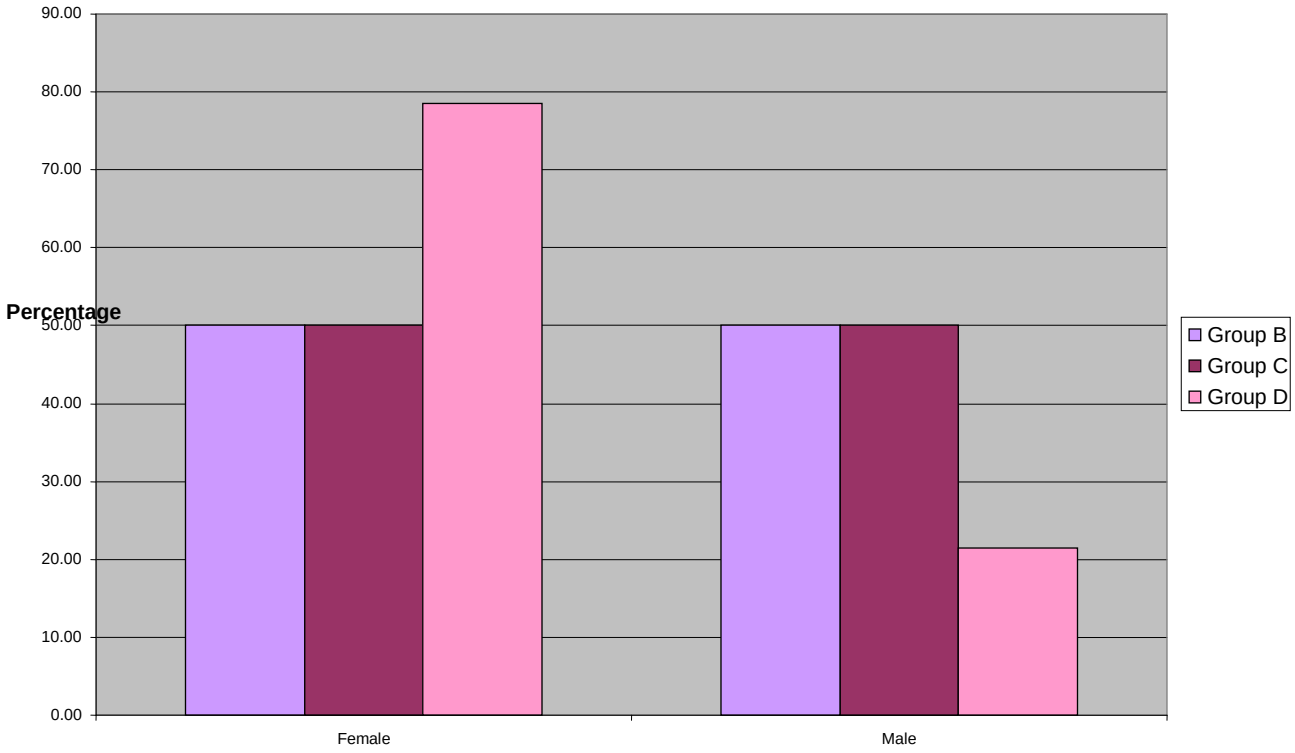


Figure 4.4 Graph Showing Comparative Gender Composition of the Three Groups



The low number of respondents in Groups B (8) and C (2) reduce the value of this comparison. The gender proportion in Group D more closely approaches that of the sample population.

Table 4.5 Age Distribution of Respondents (by Category):

Age Category	No in Category
21-25 years	1
26-30 years	21
31-35 years	21
36-40 years	5
41-45 years	0
46-50 years	1
>51 years	3

Figure 4.5 Graph Showing Age Distribution of Sample:

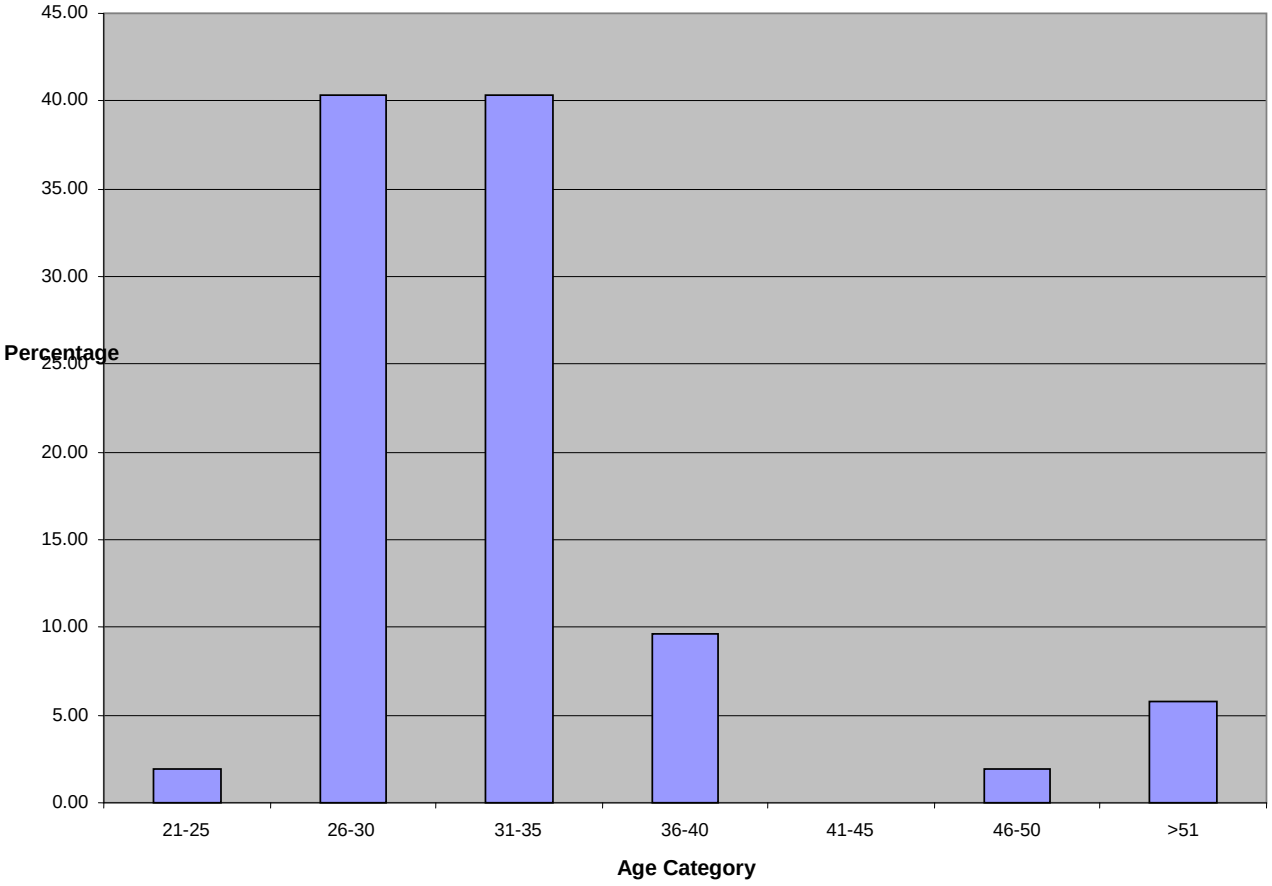
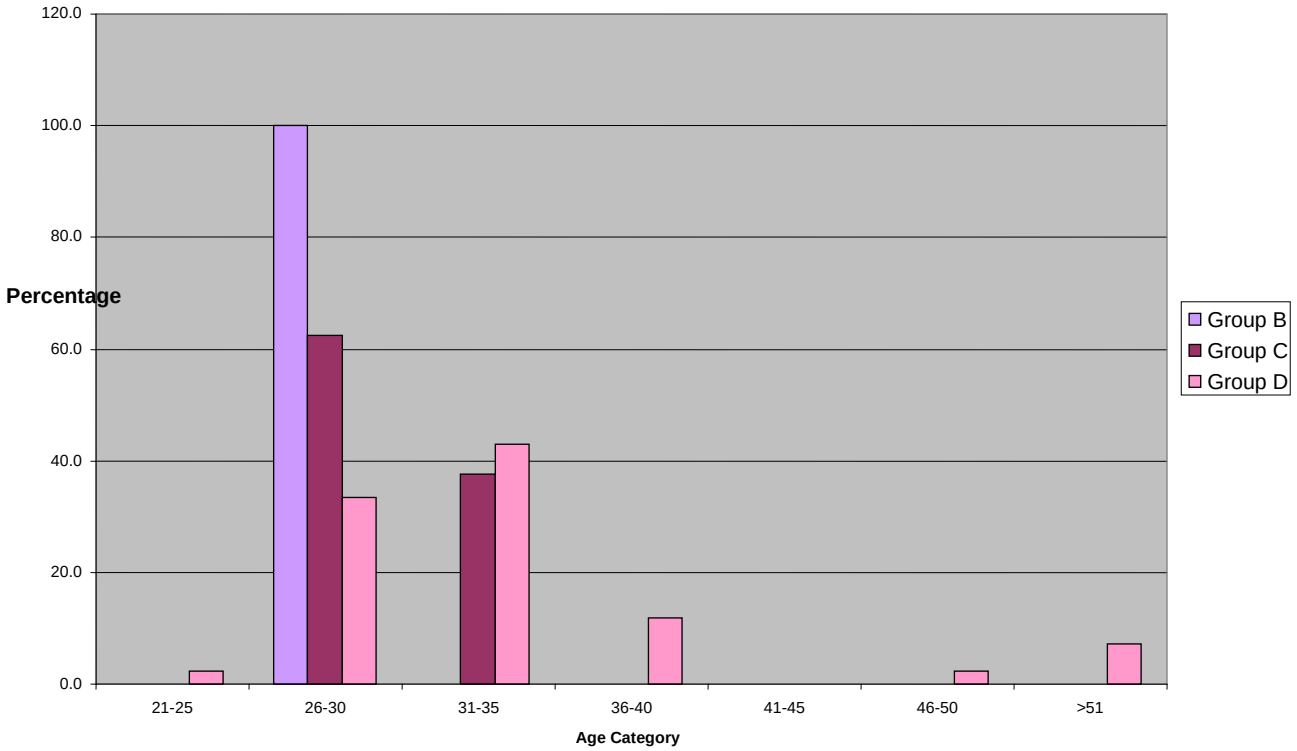


Figure 4.6 Graph Showing Comparative Age Distribution of the Three Groups:



Note that Group B (consisting of graduates who have never practiced) appear to consist of individuals in younger age categories. Both Group C and D consist of individuals in older categories. This may reflect the fact that younger graduates are less likely to commit and settle down into starting a practice, whether successful or not. However, the low number of respondents in Groups B (8) and C (2) reduce the value of this conclusion. Further discussion of this is found in Chapter 5.

Table 4.6Ethnic Composition of Sample:

Ethnic Composition	No of Respondents
Asian	0
Black	0
Coloured	1
Indian	5
White	46

Figure 4.7 Graph Showing Ethnic Composition of Sample:

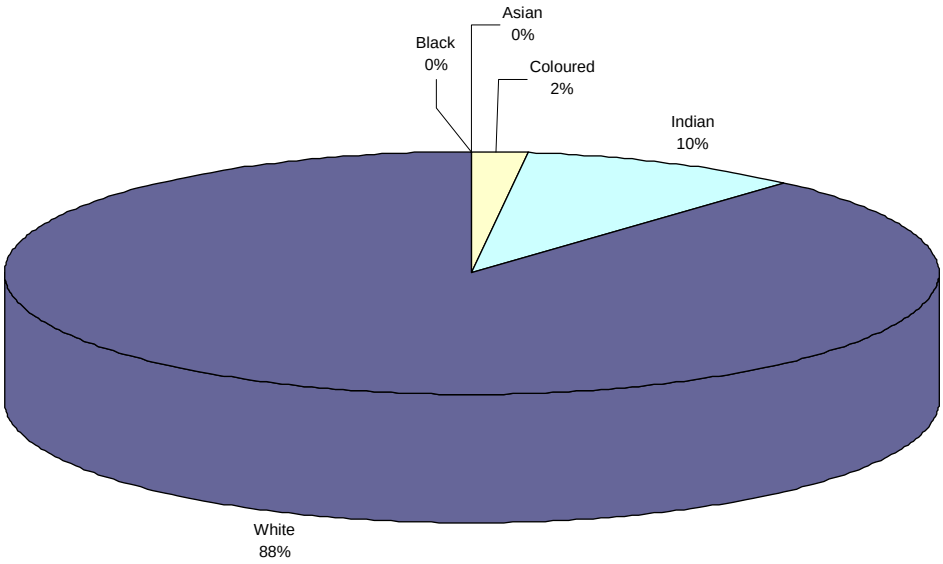
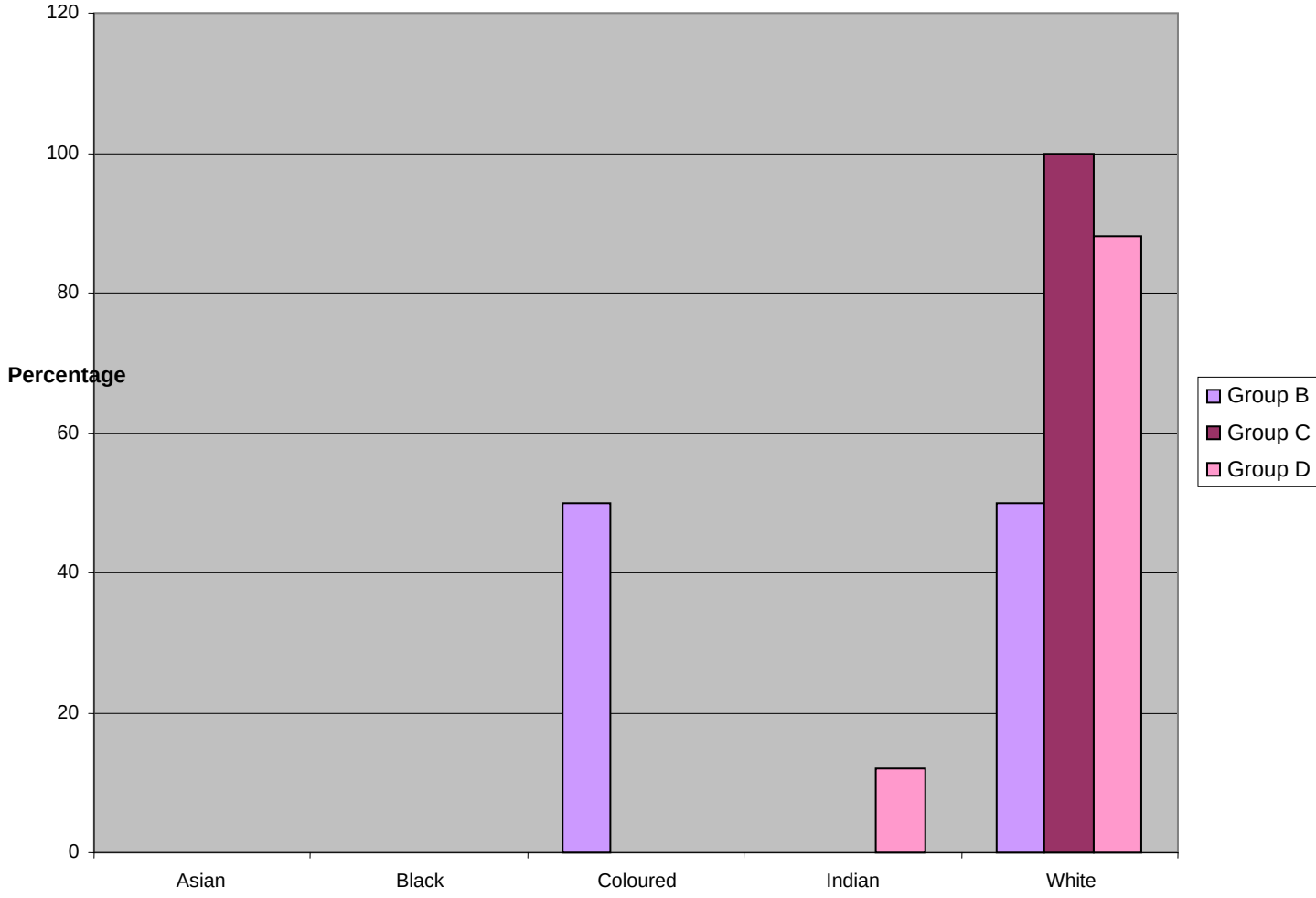


Figure 4.8 Graph Showing Comparative Ethnic Composition of the Three Groups:

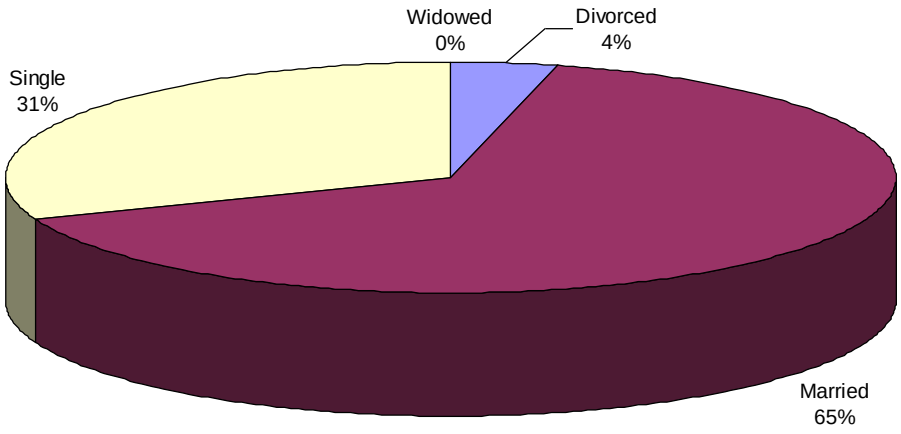


The ethnic composition of the sample is very homogenous. Most graduates (88%) of the Homeopathic Masters program at the TWR are white. Group B appears to be a little more diverse however the low number (2) of respondents in this group makes this conclusion impossible to assess statistically.

Table 4. 7 Current Marital Statuses of Respondents:

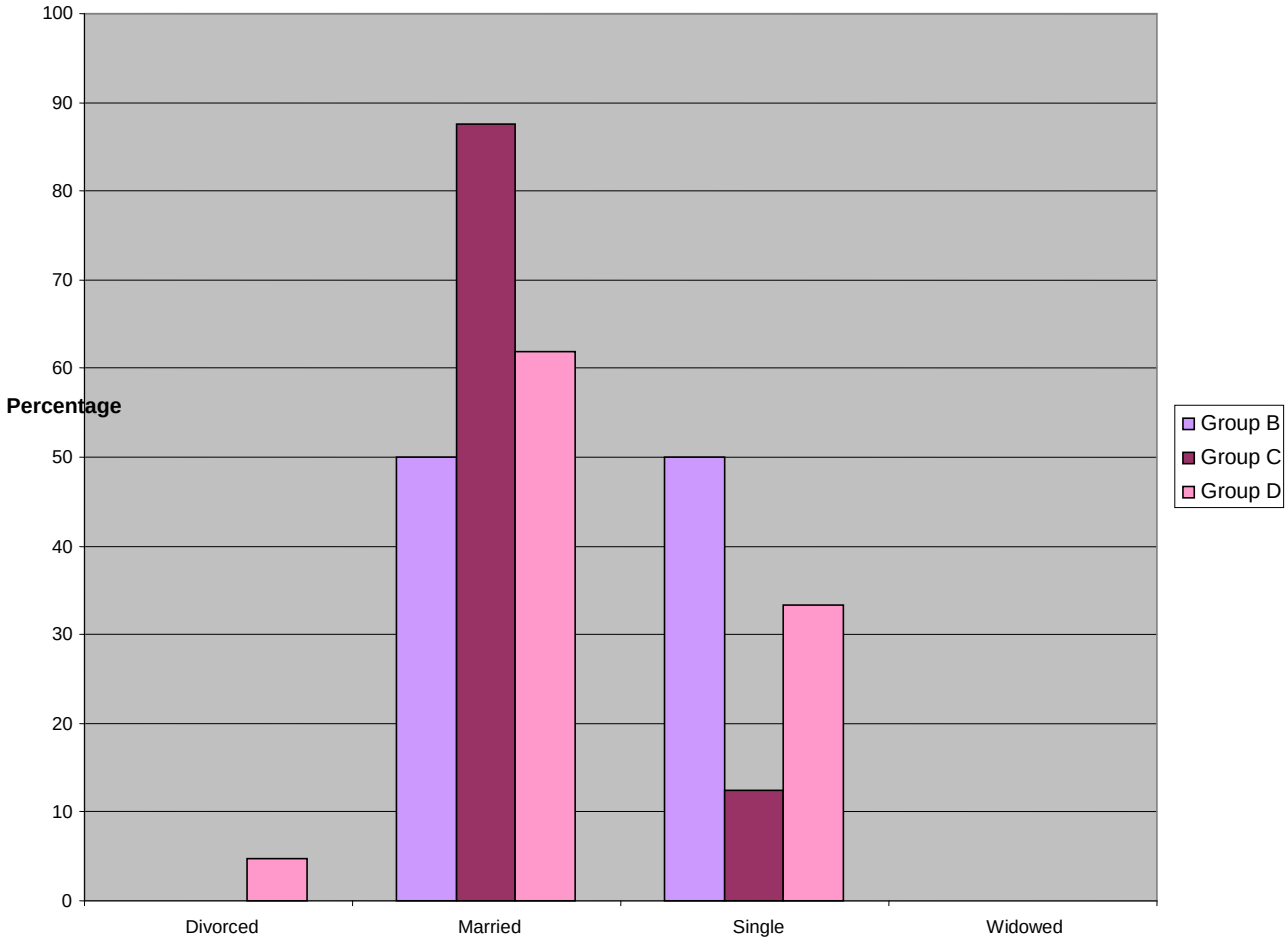
Marital Status of Respondents	No of Respondents	Percentage of Respondents
Divorced	2	3.85
Married	34	65.38
Single	16	30.77
Widowed	0	0.00

Figure 4.9 Graph Showing Current Marital Status of Respondents:



This population variable reflects the general maturity level (in terms of stage of life) of the population. However, it does not serve any inferential function in understanding the population as the respondents may not have been married at the time of studying or at the time of starting a practice.

4.10 Graph Showing Comparative Marital Status of the Three Groups:

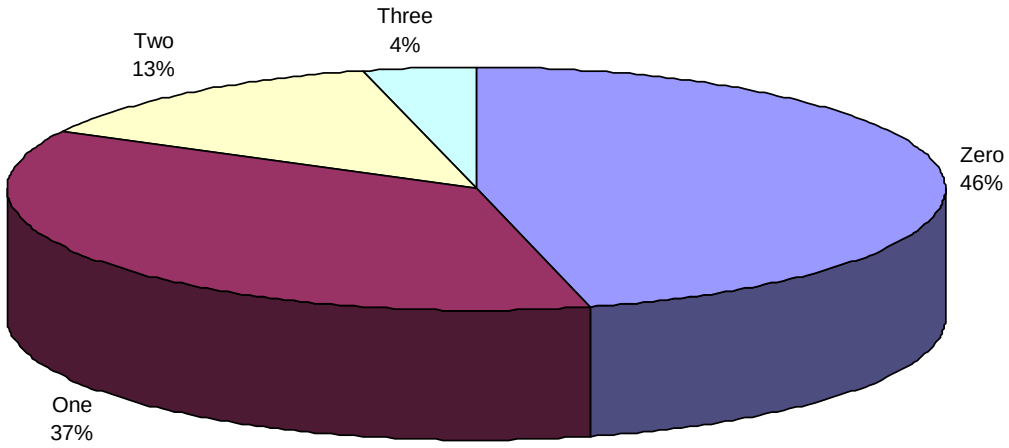


The majority of respondents in both groups C and Group D were married. This appears to confirm the impression that respondents in these groups were more mature in terms of general life stage. Again, the low number of respondents in Group C and B weaken this conclusion.

Table 4.8 No of Dependants relying on Respondents:

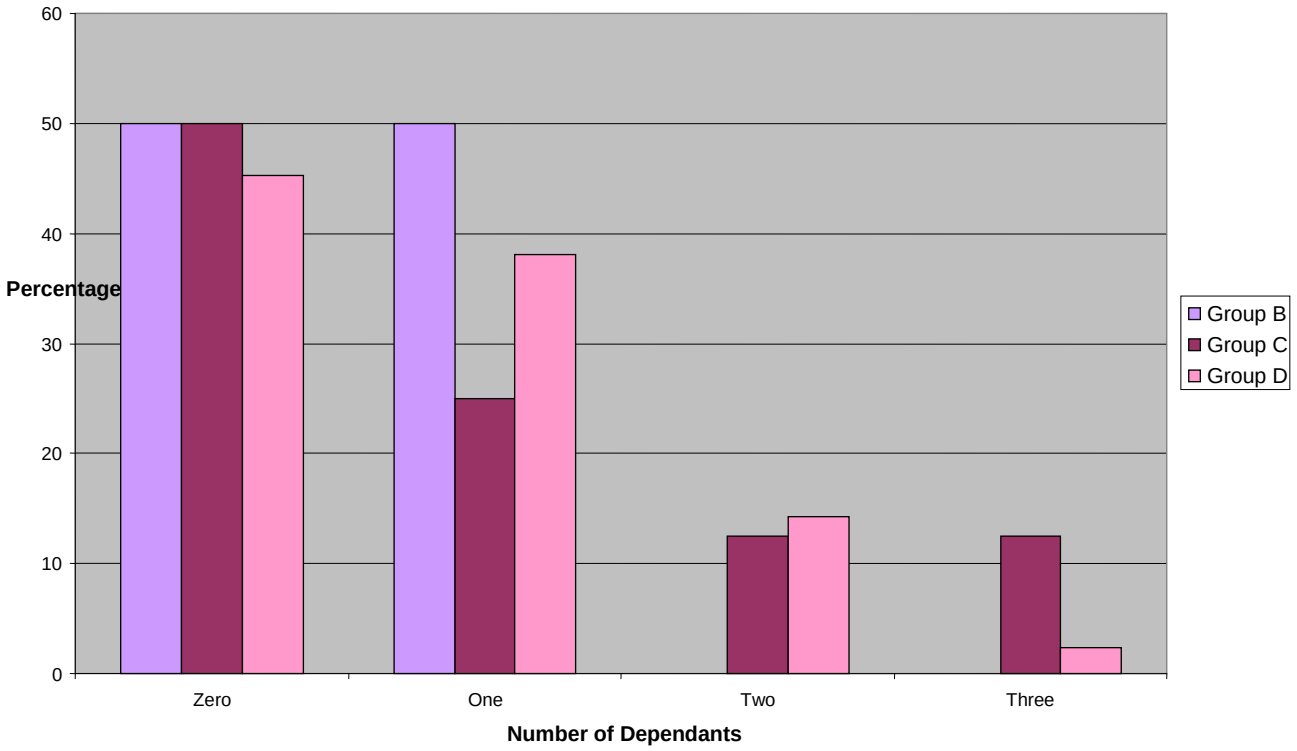
No of Dependants	No of Respondents	Percentage of Respondents
Zero	24	46.15
One	19	36.54
Two	7	13.46
Three	2	3.85

Figure 4.11 Graph Showing No of Respondents' Dependants :



This population variable may have important inferential functions: as the life stage of the population changes one expects different issues to become important e.g. financial considerations may become more important as the number of dependants increase. This variable helps to describe the population in terms of maturity.

4.12 Graph Showing Comparative Number of Dependants of the Three Groups:



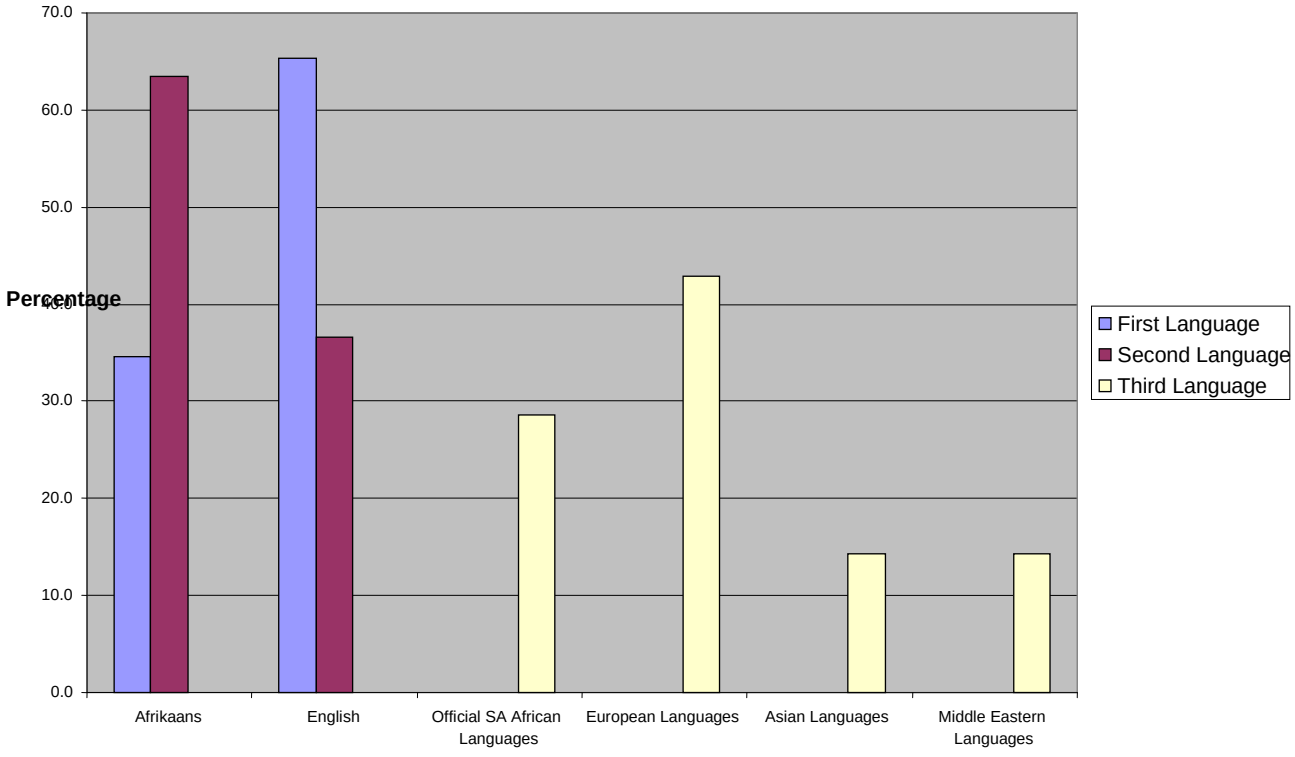
We find the majority of respondents in Group B with fewer dependants, While Groups C and D both also reflect the majority with no dependents, and the spread extends further across the graph.

Figures 4.11- 4.12 imply that the respondents in Group B are generally younger and less mature (in terms of life stage – marriage, dependants) than respondents in group C or D. This may have predictive significance i.e. younger graduates are less likely to go into practice. The low number of respondents in Group B however makes this conclusion impossible to confirm statistically.

Table 4.9 Language Preference of Respondents:

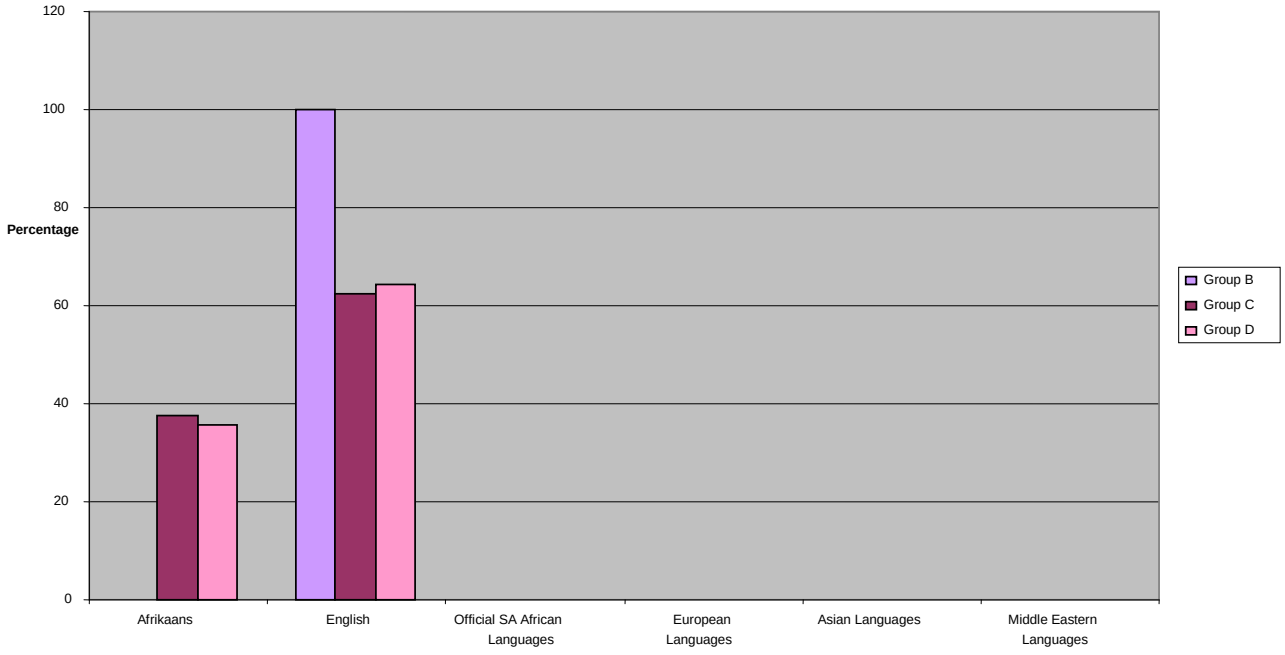
	Number of Respondents		
Language	First Language	Second Language	Other Language
Afrikaans	18	33	0
English	34	19	0
Official SA African Languages	0	0	2
European Languages	0	0	3
Asian Languages	0	0	1
Middle Eastern Languages	0	0	1

Figure 4.13 Graph Showing Language Preferences of Respondents:

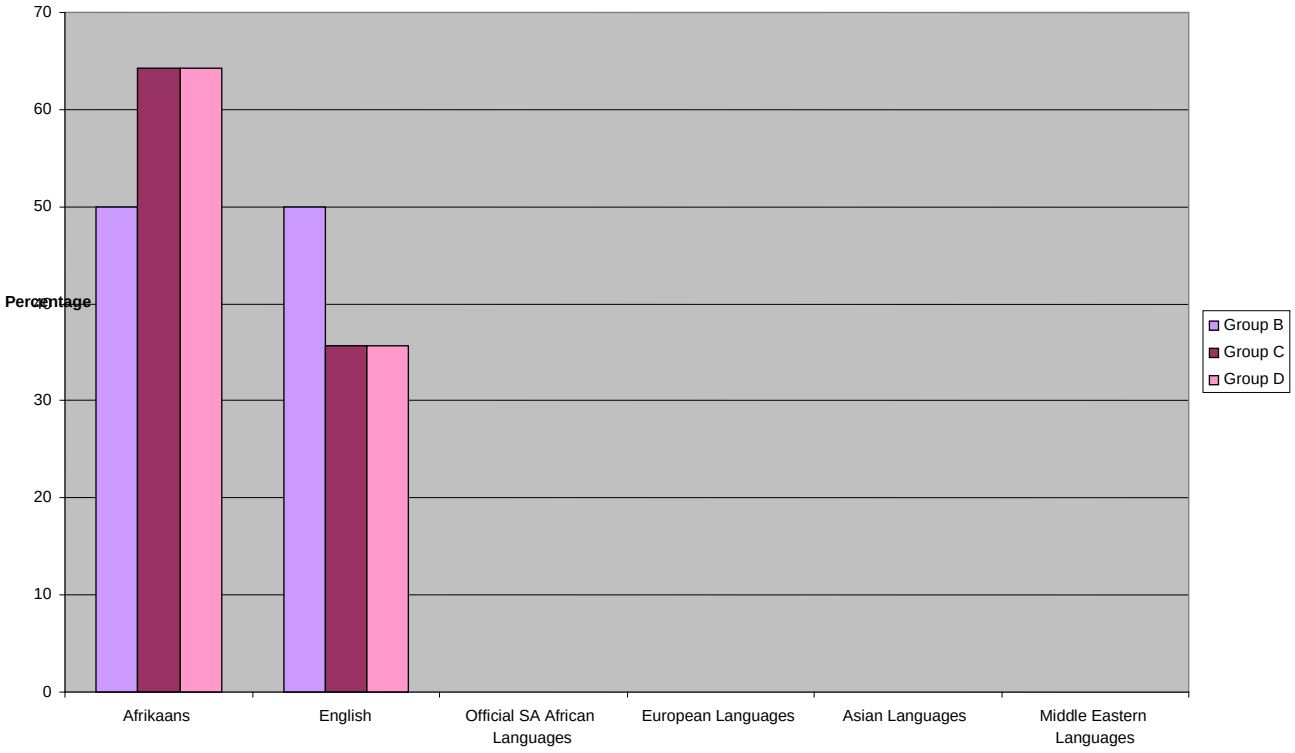


The majority of respondents speak English as first and Afrikaans as second language. The remainder speak Afrikaans first and English second. This language split is reflective of the ethnicity of the population (i.e. mostly white).

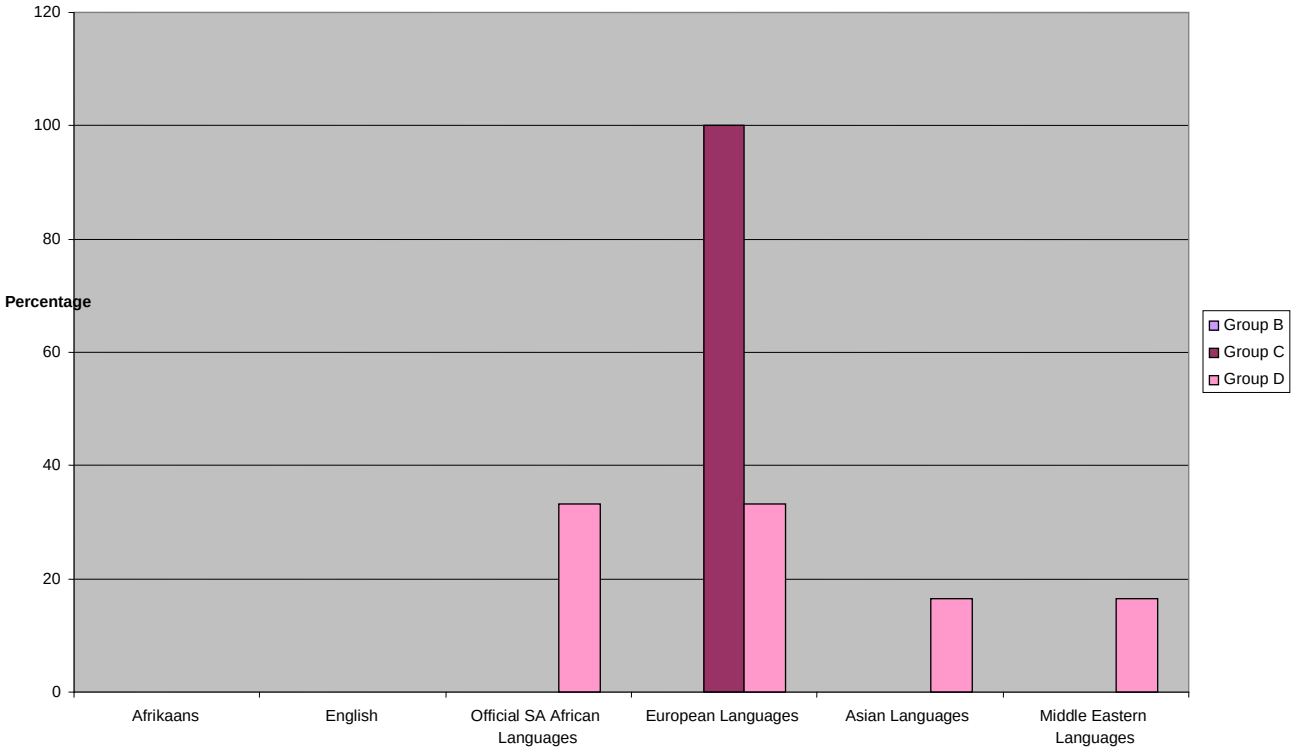
4.14 Graph Showing Comparative First Language Usage of the Three Groups:



4.15 Graph Showing Comparative Second Language Usage of the Three Groups:



4.16 Graph Showing Comparative Third Language Usage of the Three Groups:



The above graphs reflect the language (and by inference ethnic) homogeneity of the population.

4.4.3 Academic History:

The data used for the following analyses were derived from Section B of the completed questionnaires. In terms of Objective 2 in the introduction, the respondents' academic history was described.

Table 4.10 Table showing calendar year of first registration

Calendar Year First Registered	No of Respondents
1992	1
1993	12
1994	10
1995	6
1996	7
1997	10
1998	3
1999	3
2000	0

4.17 Graph Showing Calendar Year of first registration:

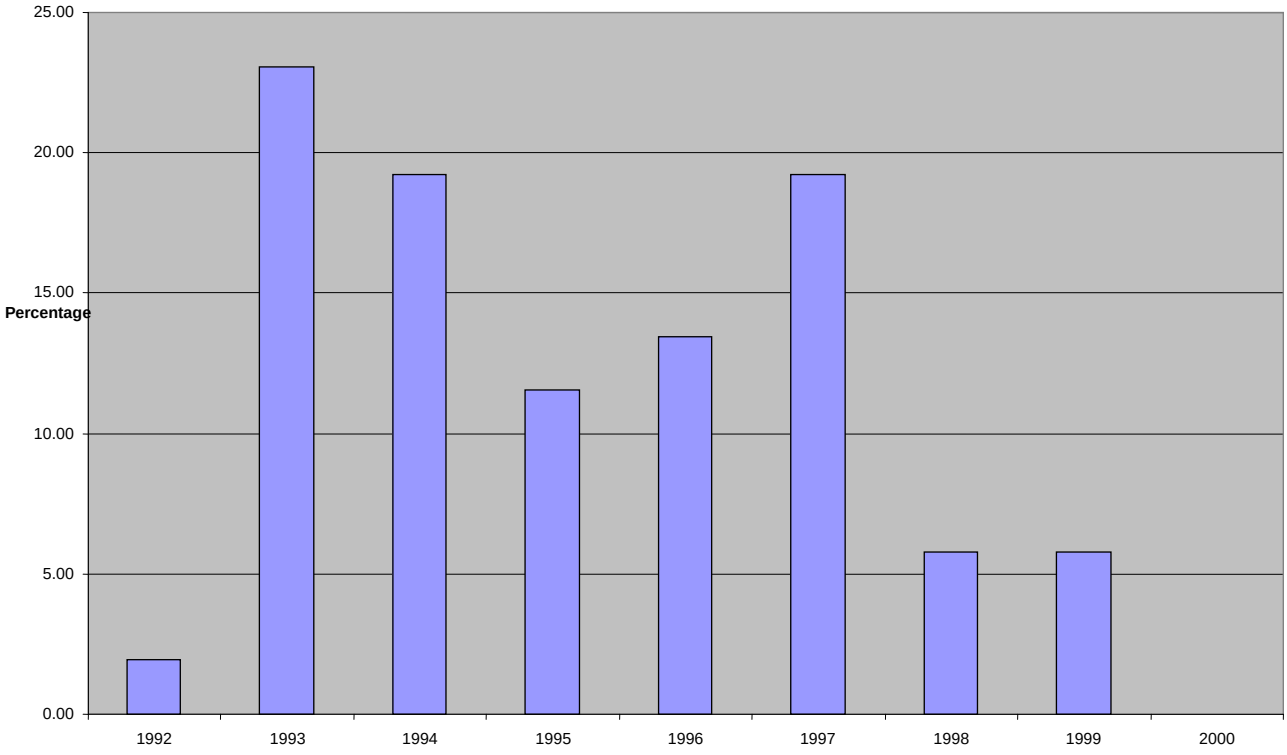
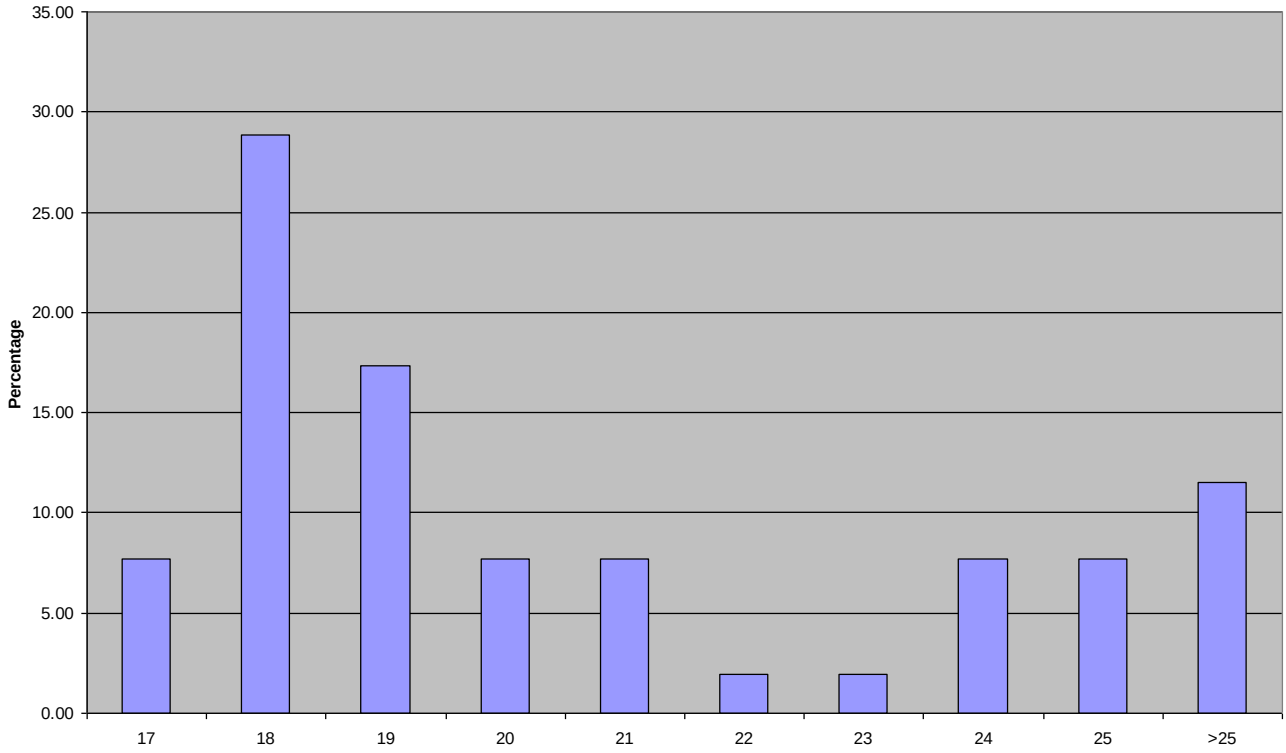


Table 4.11 Table showing age of respondents at first registration:

Age at First Registration	Number of Respondents	Percentage of Respondents
17	4	7.69
18	15	28.85
19	9	17.31
20	4	7.69
21	4	7.69
22	1	1.92
23	1	1.92
24	4	7.69
25	4	7.69
>25	6	11.54

Figure 4.18 Graph Showing Age Distribution of the sample on first Registration:



The majority (61.5%) of the population fell into the range between 17 and 20. This supports the contention that most qualified graduates started studying homeopathy soon after leaving school. This is supported by the fact that 51 (98%) of the respondents entered the course in the first year i.e. none had any exemptions leading to starting at a higher level.

Table 4.12 Table showing Level of Previous Qualification of Respondents:

Level of Qualification	1st Qualification	1st Qualification (%)	2nd Qualification	2nd Qualification (%)
Degree	17	32.69	2	0.00
Diploma	6	11.54	2	50.00
Certificate	1	1.92	0	50.00
Matric	28	53.85	0	0.00

Only 24 (46%) of the respondents had a previous qualification. Of these only 16 had completed them. This indicates that 16 of the 52 (30.6%) had completed previous educational qualifications. The following tables detail the field and institution in which the qualification was obtained/pursued.

Table 4.13 Table Showing Field the Previous Qualification was obtained in:

Qualification	No of Respondents	Percentage of Respondents
None	28	53.85
Health	6	11.54
Science	6	11.54
Social Science	3	5.77
Economics	4	7.69
Education	0	0.00
Arts	4	7.69
Performing Arts	0	0.00
Other not specified	1	1.92

Table 4.14 Table Showing Institution the Previous Qualification was Obtained from:

	1st Qualification		2nd Qualification	
Institution	No of Respondents	Percentage of Respondents	No of Respondents	Percentage of Respondents
None	28	53.85	48	92.3
University	16	30.77	1	1.9
Technikon	4	7.69	0	0
Private Institution	4	7.69	3	5.8

4.4.3.1 Qualification Process Details:

This section provides summary and interpretation of the process to complete the qualification i.e. research, internship, length of time taken to qualify and year of qualification.

Figure 4.19 Graph showing length of time taken to complete Research:

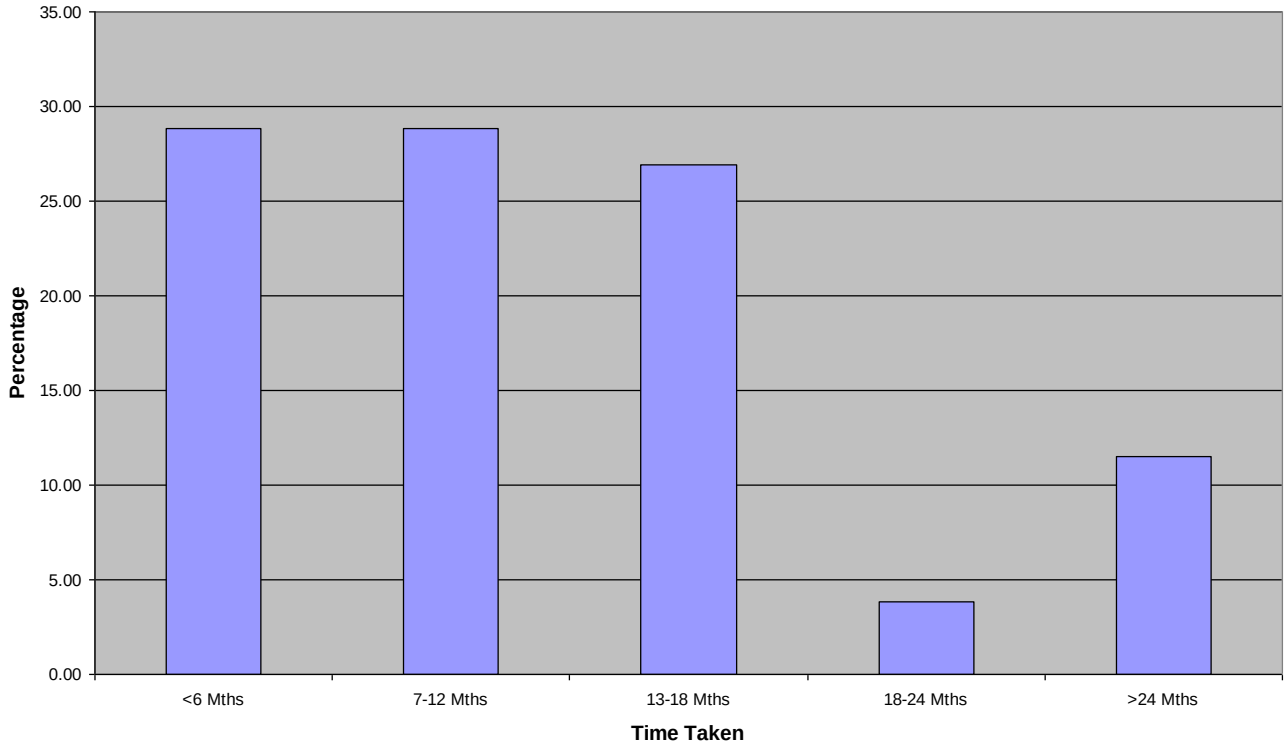


Table 4.15 Table Showing Mean time taken to complete Research, Graduate and Qualify after completion of Final Academic Year:

Mean Time between completion of 5th year and completion of Research thesis	Std Deviation	Mean Time taken to Complete Degree from Year of First Registration	Std Deviation	Total Mean time to Graduation	Std Deviation
12.8 Months	10.1	4.3	1.1	5.34 years	1.77
Mean Time between first Registration and Final Qualification	Std Deviation	Mean Age difference between First Registration and Final Qualification	Std Deviation		
5.69 Years	1.12	5.79 years	1.43		

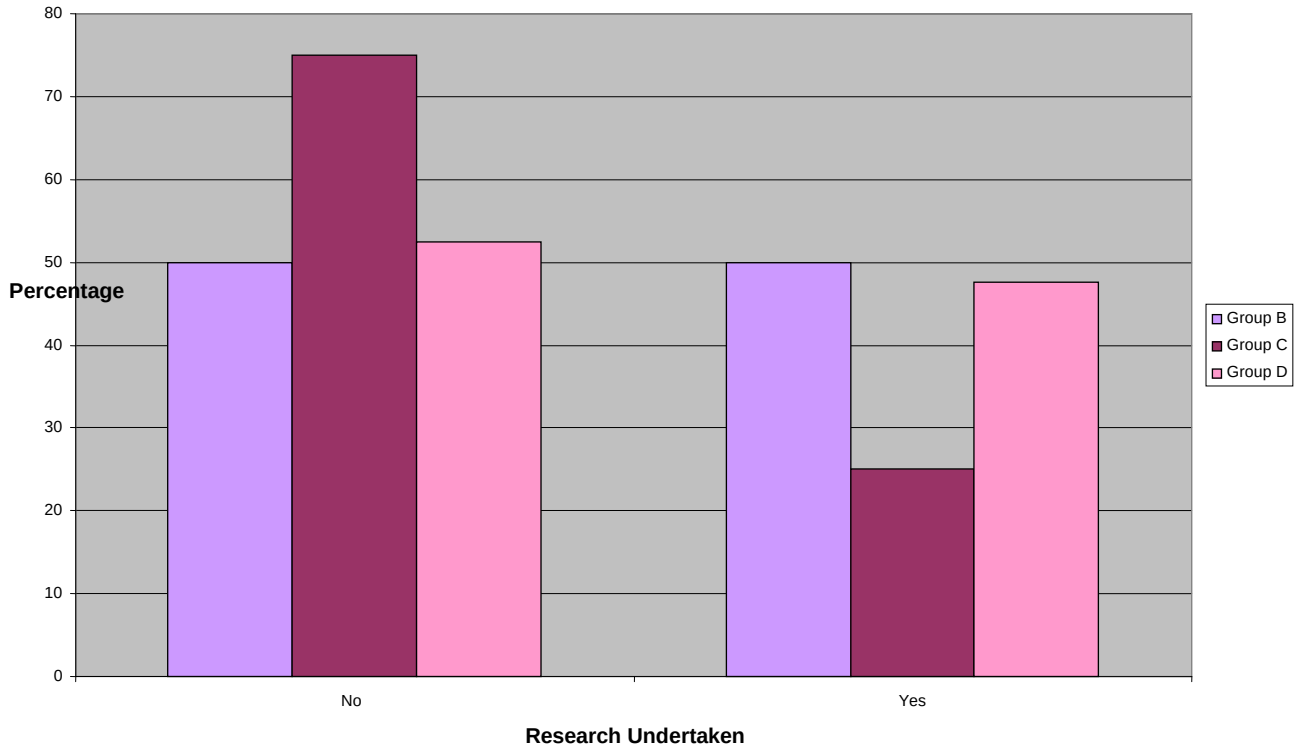
This table reflects the fact that the research component is a significant source of delay in qualification. The mean length of time however is in accordance with the length of time a Masters level thesis would require. The standard deviations are relatively large. This may be artefactual in that the questionnaire required respondents to return a calendar year in which they qualified- this response covers 12 months. I.e. two respondents qualifying in February and December would enter the same year in the response field. The second measure of the length of time taken to qualify is the age difference between first registration and final qualification. This is slightly larger, with a larger standard deviation. These measures both support the contention that the length of time taken to qualify varies significantly around the average of nearly 6 years.

Table 4.16 Table Showing Details of Internships Completed:

<table>
<tr><th>Internship Undertaken</th><th>No of Respondents</th><th>Type of Internship Undertaken</th><th>Length of Internship Undertaken</th></tr>
<tr><td>No</td><td>29</td><td></td><td></td></tr>
<tr><td>Yes</td><td>23</td><td>
<table>
<tr><td>Hospital</td><td>3</td><td>5.77%</td></tr>
<tr><td>Overseas</td><td>1</td><td>1.92%</td></tr>
<tr><td>Technikon Clinic</td><td>1</td><td>1.92%</td></tr>
<tr><td>Private Practice</td><td>18</td><td>34.62%</td></tr>
<tr><td>Rural Clinic</td><td>0</td><td>0.00%</td></tr>
<tr><td>Other Clinic e.g. community clinic</td><td>0</td><td>0.00%</td></tr>
<tr><td>Pharmacy</td><td>0</td><td>0.00%</td></tr>
</table>
</td><td>
<table>
<tr><td><6 Mths</td><td>8</td></tr>
<tr><td>7-12 Mths</td><td>11</td></tr>
<tr><td>13-18 Mths</td><td>1</td></tr>
<tr><td>18-24 Mths</td><td>1</td></tr>
<tr><td>>24 Mths</td><td>1</td></tr>
</table>
</td></tr>
</table>

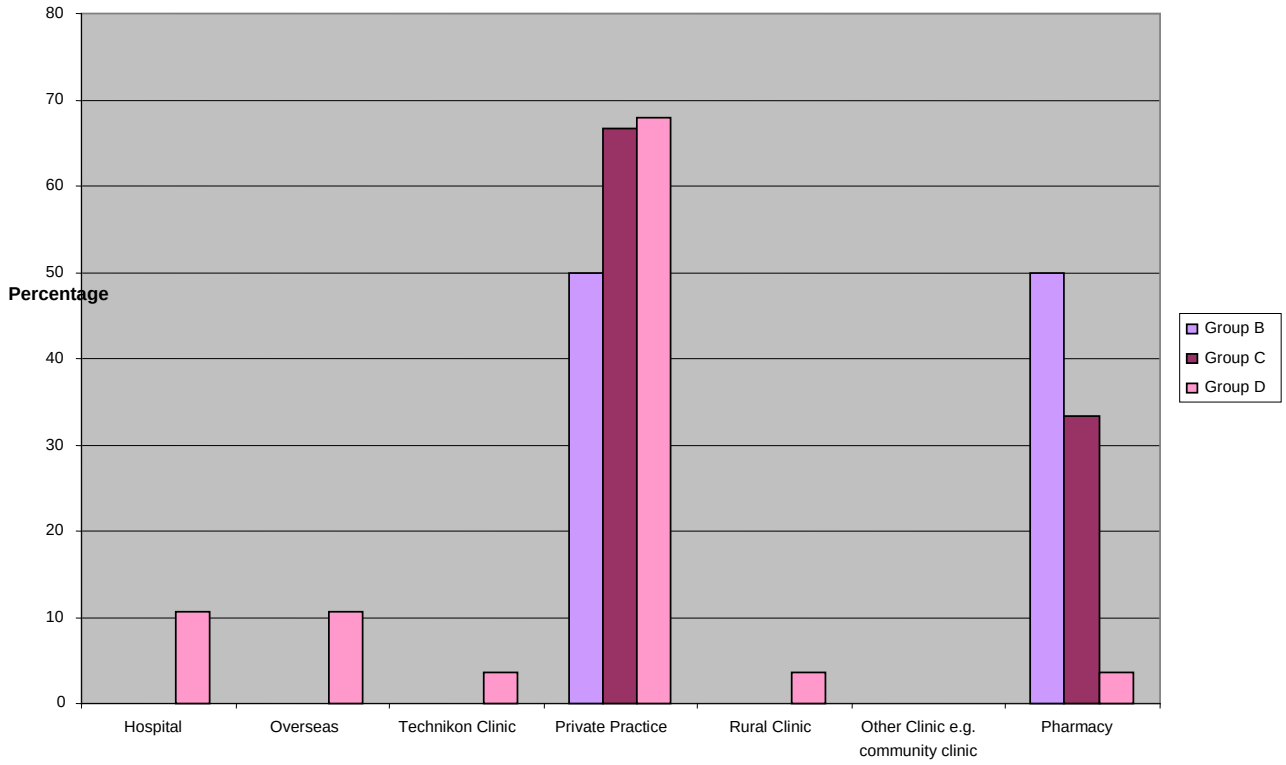
The majority of respondents (55.8 %) had not undertaken any form of internship. Further, the majority of internships undertaken were in private practices. This is indicative of the informal nature of the internship program.

Figure 4.20 Graph showing Breakdown of whether Internship was undertaken according to Group:



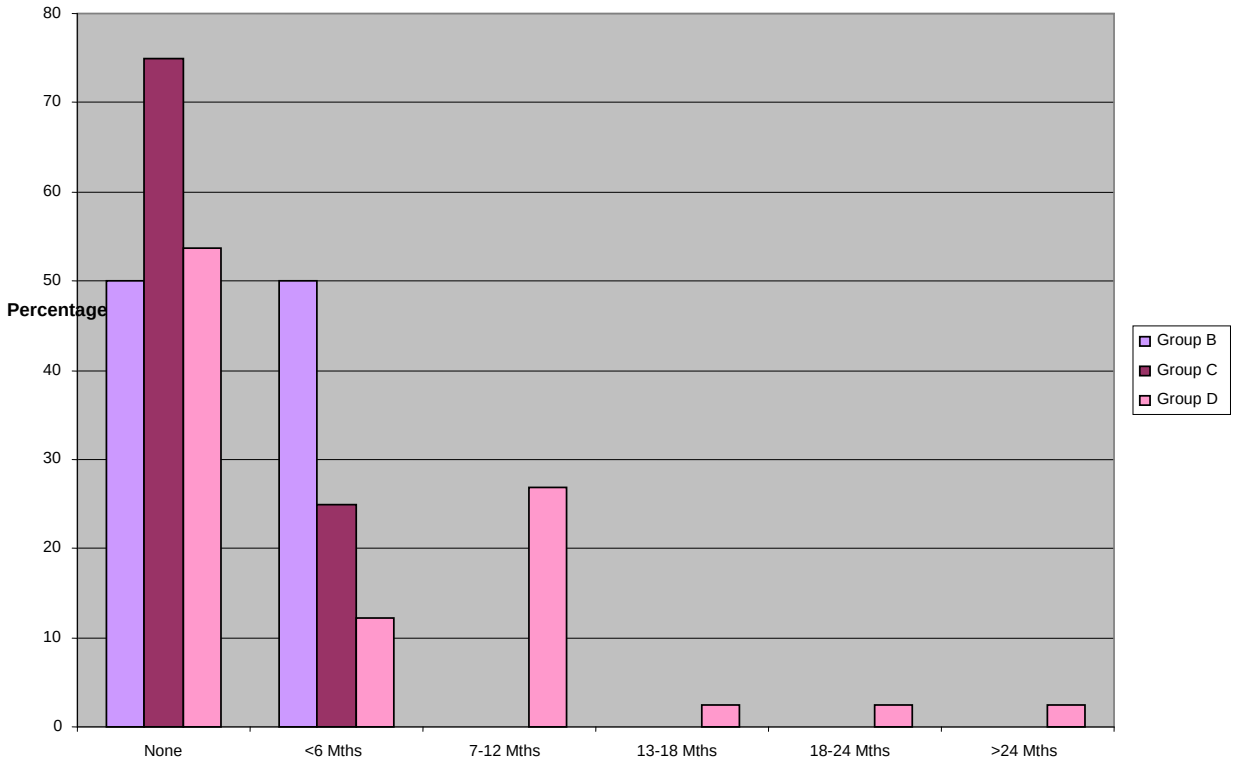
Interesting to note is that the respondents who have remained in practice (Group D) have the highest relative percentage of having undertaken internships. Group B seems to have a high rate, however there are only 2 respondents in Group B.

Figure 4.21 Graph showing where internships were completed:



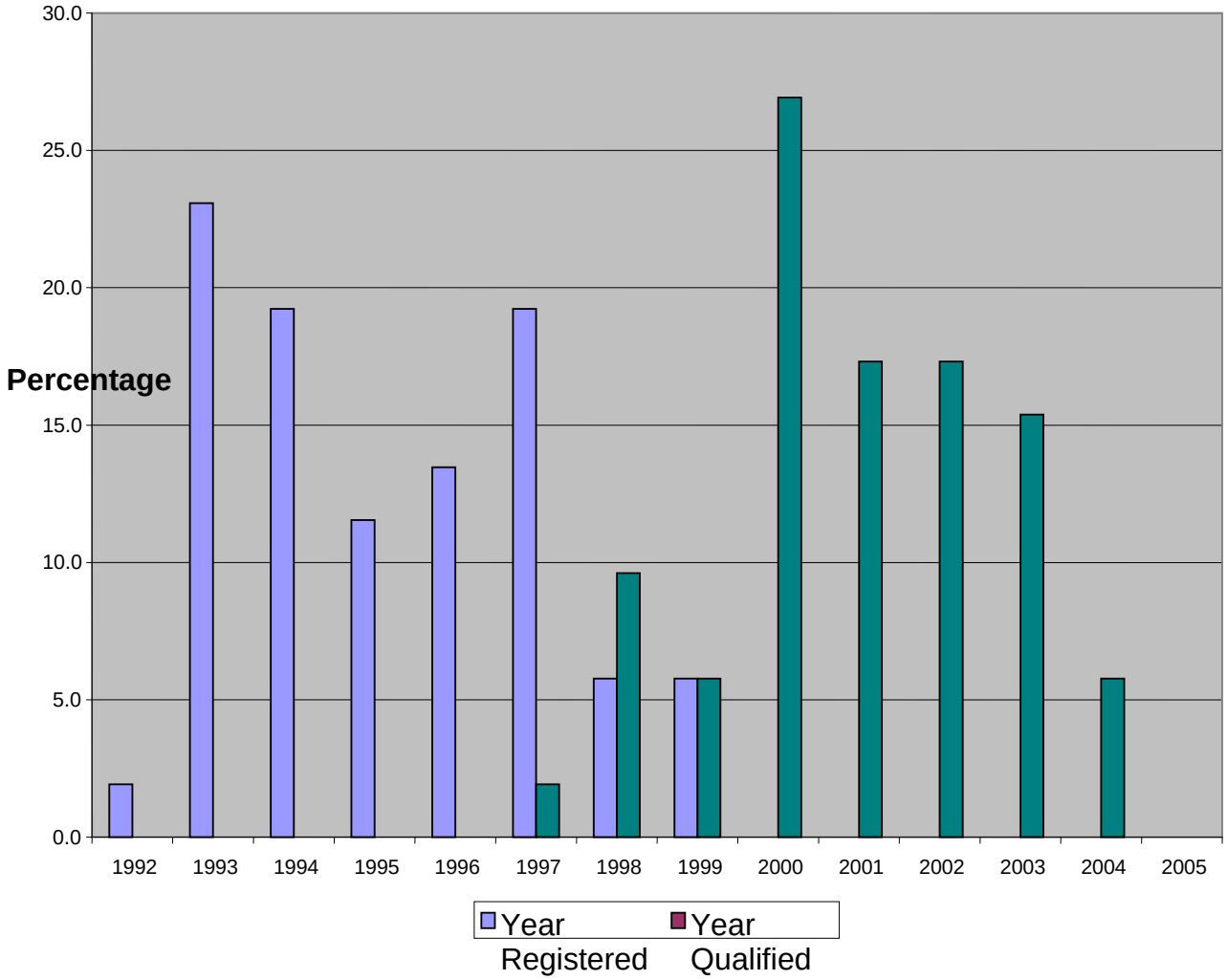
The majority of internships across all three groups were undertaken in private practice situations

Figure 4.22 Graph showing length of internships undertaken in each group:



Most respondents (across all three groups) did not undertake internships, and if they were undertaken the duration was mostly short.

Graph 4.23 Graph showing year of first registration vs year of qualification of the respondents:



The above graph shows that the no of graduates qualifying in a particular year is slightly less than the number of students first registering in the calendar year 8 - 9 years earlier. This is explained by natural attrition, failure of subjects and failure to complete research. The relative increase in number of graduates qualifying in the year 2000 could be explained by the fact that some students take longer than the 7 years to qualify. This could be due to subject failure, failure to complete research project or other components of the qualification requirements.

4.4.3.2 Post Qualification Education Details:

Table 4.17 Table showing qualifications obtained after studying:

	Group	Number of Respondents
Extension Of Homeopathic Education	Group B	0
	Group C	0
	Group D	5
Profession Registered With AHPC	Group B	0
	Group C	2
	Group D	8
Alternative Health Methods Not Registered As Profession With AHPC	Group B	0
	Group C	0
	Group D	6
Profession unrelated to Homoeopathy	Group B	0
	Group C	2
	Group D	3
Basic extension of medical education	Group B	0
	Group C	0
	Group D	2

Table 4.18 Table Showing Type of Qualifications Obtained after completion of MTech Hom:

Type Of Qualification Obtained	1st	2nd
Extension Of Homeopathic Education	3	2
Profession Registered With AHPC	7	2
Alternative Health Methods Not Registered As Profession With AHPC	2	4
Profession unrelated to Homoeopathy	4	1
Basic extension of medical education	0	2

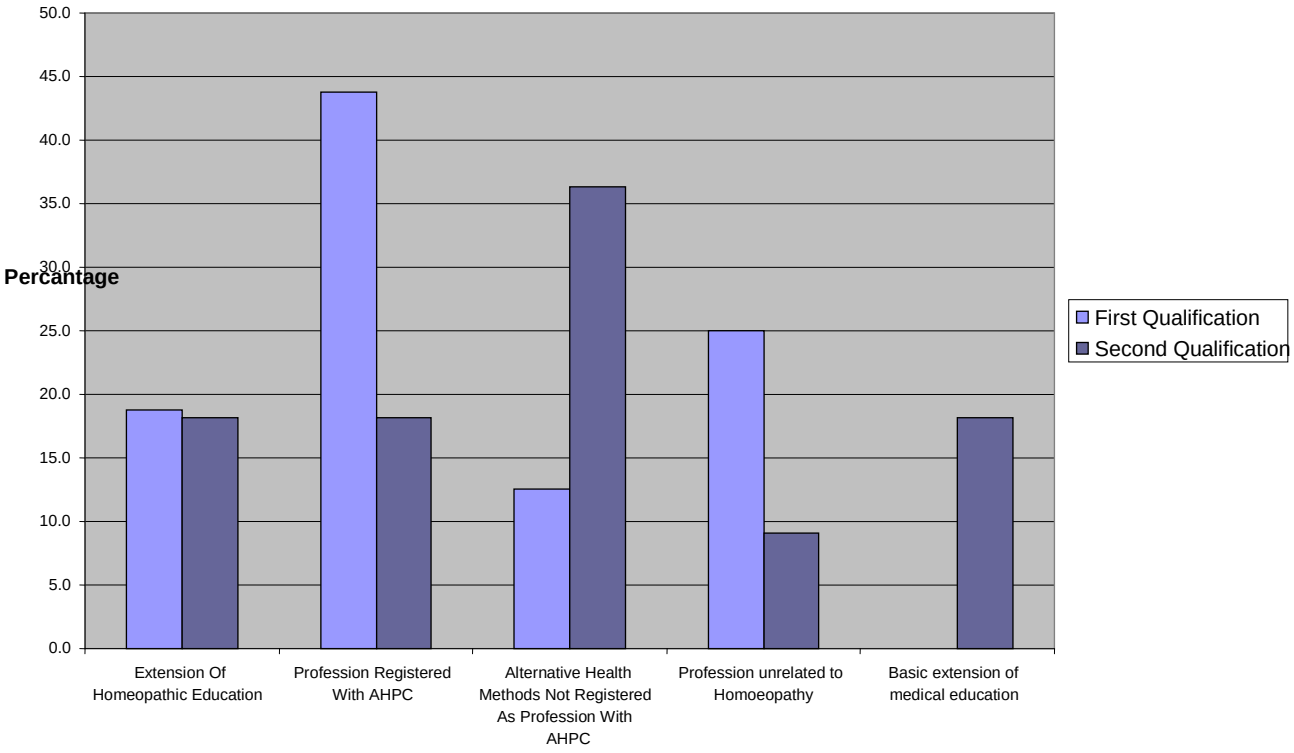
Table 4.19 Table Showing Level of Qualifications Obtained after completion of MTech Hom:

Level of Qualification	1^{st} Qualification	2^{nd} Qualification
Degree	1	1
Diploma	10	4
Certificate	5	6

Table 4.20 Table Showing Institution qualification obtained from:

Institution Obtained from	1st Qualification	2nd Qualification
University	1	1
Technikon	0	0
Private Institution	15	10
Hospital	0	0

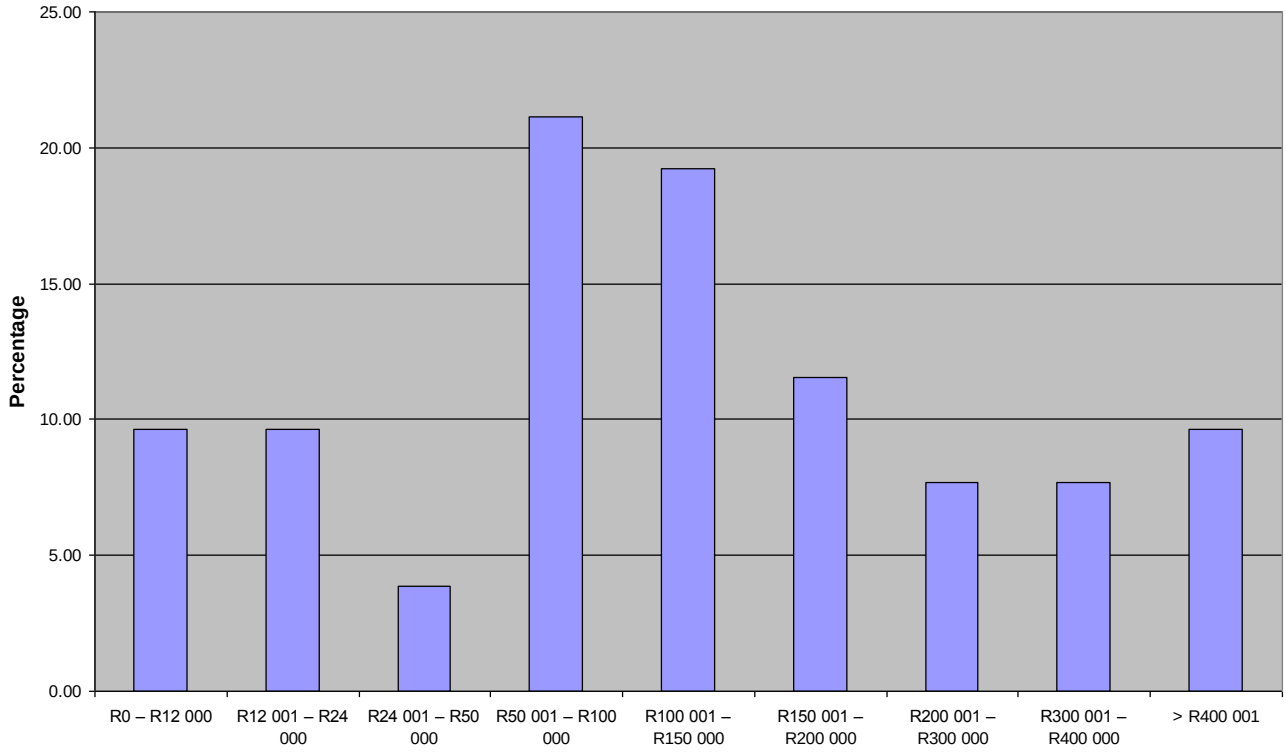
Figure 4.24 Graph showing Field of Qualification obtained after studying:



A large proportion of the those respondents who had completed post homeopathic qualifications were focussing primarily on professional qualifications registered with the AHPCSA and secondarily (secondary qualifications) on health methods to complement their practices but not registered with the AHPCSA.

4.4.3.3 Financial Details and Information Pertaining to Council registration

Figure 4.25 Graph showing Respondents income per Annum:

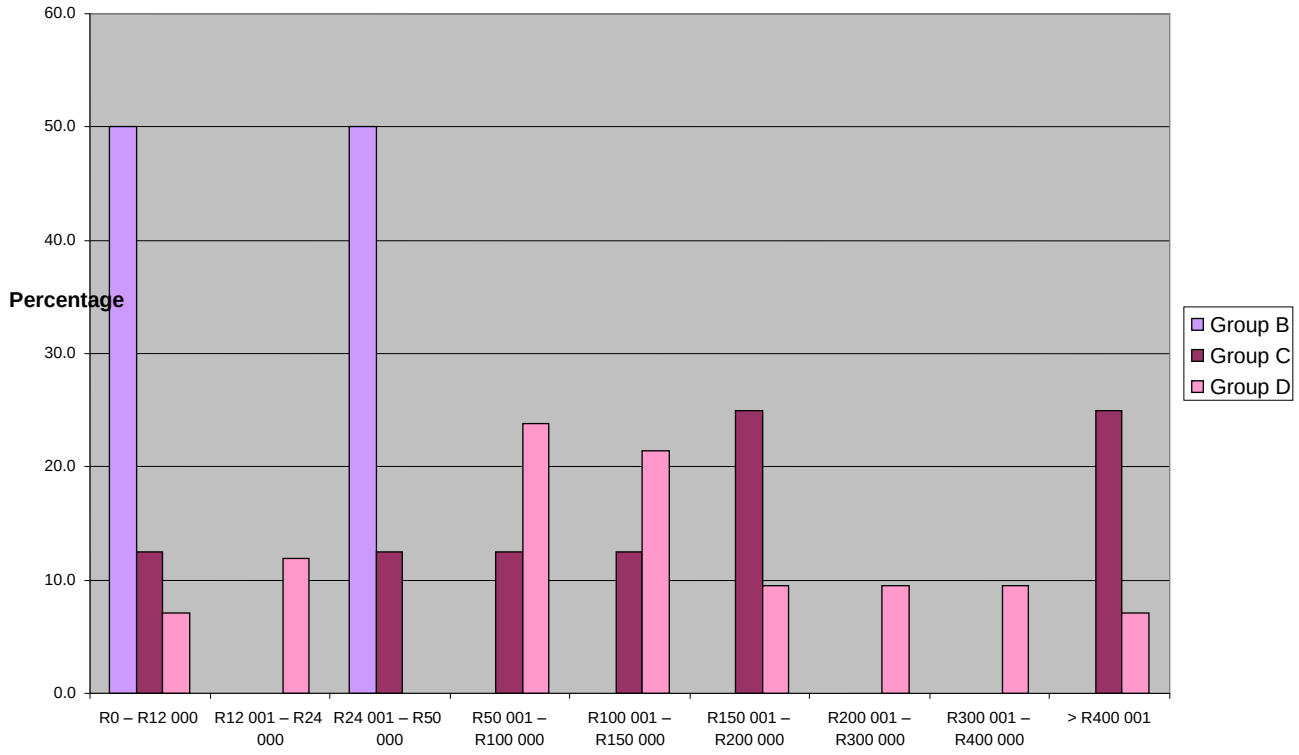


It is worth noting that all of the 5 respondents who earn >R400000 per annum live in South Africa. They are all based in Gauteng (Jhb and Pretoria), except for one (Middelburg). Of these high income earners, two i.e. 40%, are no longer practicing Homeopathy.

Four respondents fall into the R300 001 – R400 000 income range. Of these two are practicing overseas (UK and UAE). The income level is high because the earnings are converted to Rands at current exchange rates. Both of the other practitioners are practicing in Gauteng (Jhb).

Fully 21.15% of the respondents earn between R50 001 and R100 000. Together 40% of the respondents fall into the range of income between R50 001 and R150 000.

Figure 4.26 Graph Showing Income Distribution across the three Groups:



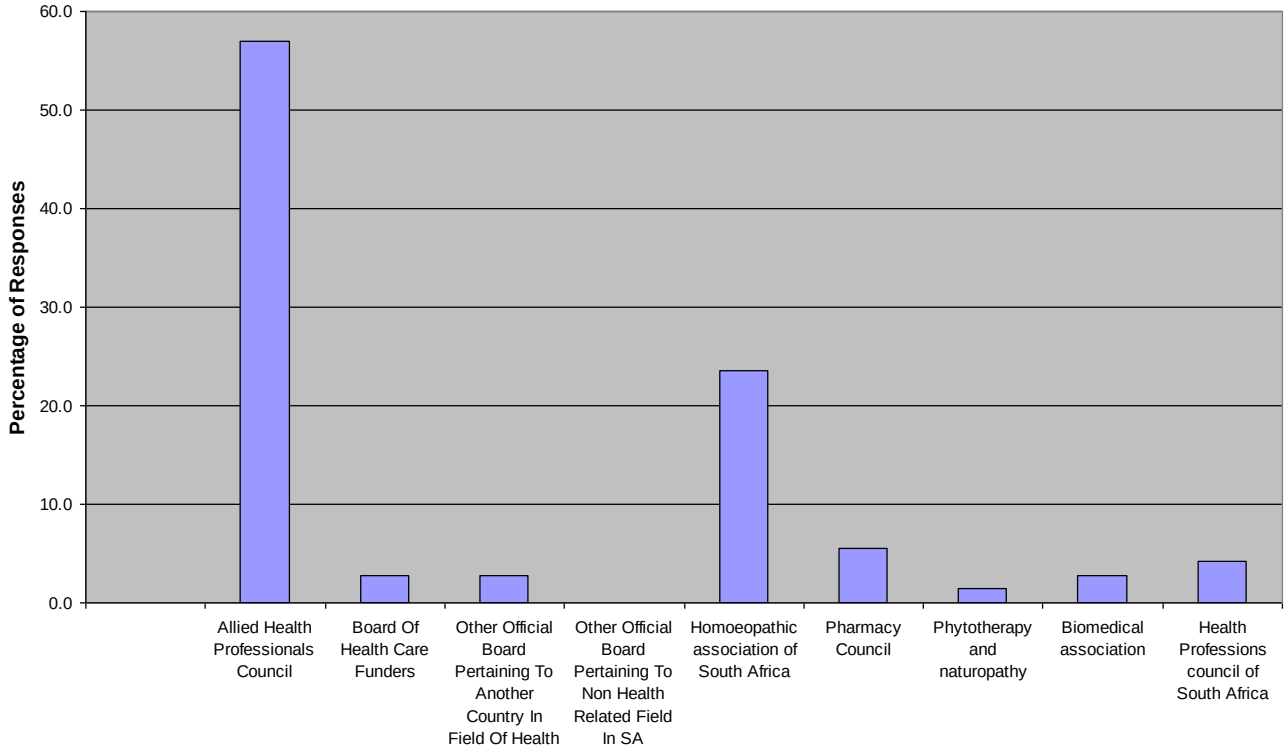
It appears that Group C have a relatively higher distribution of income. This may reflect the fact that financial considerations are often given as a reason to stop practicing i.e. respondents had stopped practicing to earn more money doing something else. Group B seem to have a relatively low income distribution. (Again, due to the low numbers in Group B it is not possible to make a conclusion).

Table 4.27 Table Showing Professional Boards Respondents registered with:

Name of Board	No of Respondents	Percentage of Respondents
None	8	19.0
Allied Health Professionals Council	37	56.9
Board Of Health Care Funders	0	2.8
Other Official Board Pertaining To	0	2.8

Another Country In Field Of Health		
Other Official Board Pertaining To Non Health Related Field In SA	0	0.0
Homoeopathic association of South Africa	4	23.6
Pharmacy Council	3	5.6
Phytotherapy and naturopathy	0	1.4
Biomedical association	0	2.8
Health Professions council of South Africa	0	4.2

Figure 4.27 Figure Showing Distribution of Professions Respondents registered for

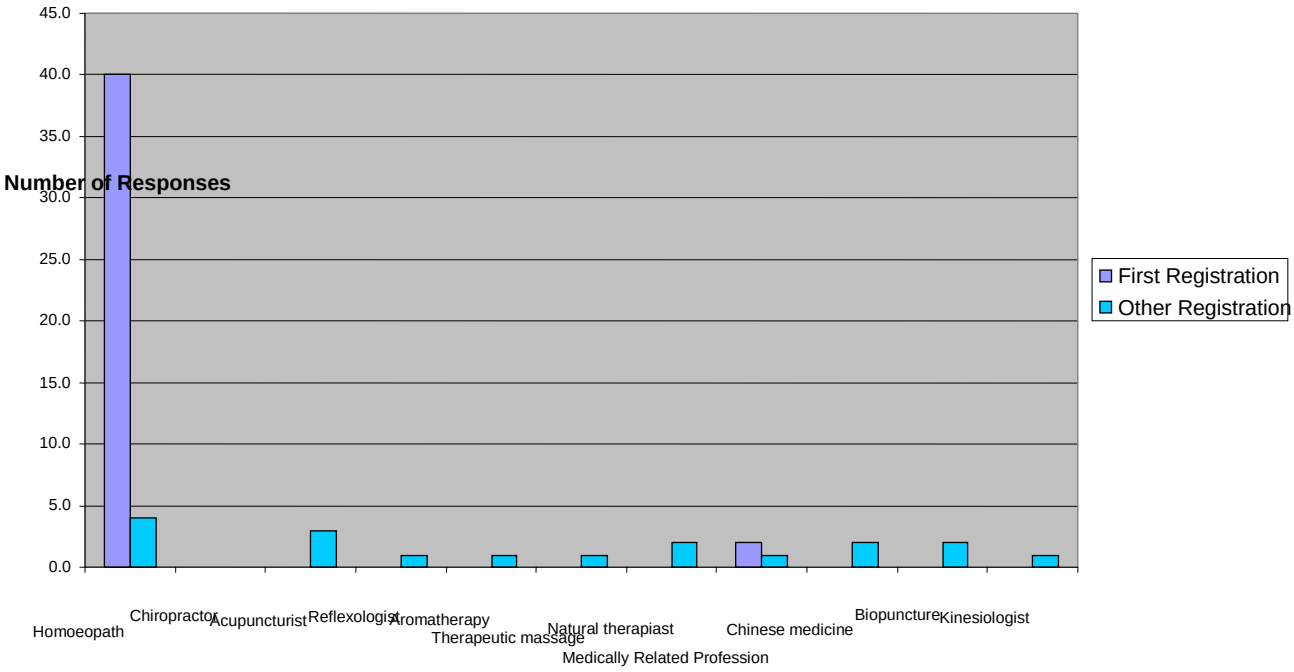


The majority of respondents are registered with the Allied Health Professions Council. A significant percentage (8 out of 52, 15%) are not registered with any board. This is a concern as this constitutes illegal practice (5 (12%) of currently practicing respondents are not registered).

It is interesting to note that very few of the responses indicated registration with the board of healthcare funders. Registration with the BHF however is necessary for medical aid claims,

and maintaining a practice number. It is reasonable to assume, therefore, that this question was not understood or answered completely accurately.

Figure 4.28 Graph showing Field of Qualification Registered for:



As expected, most respondents are registered for Homeopathy.

4.5 Quantitative Comparative Description of Sub-Groups of the Population of Graduates

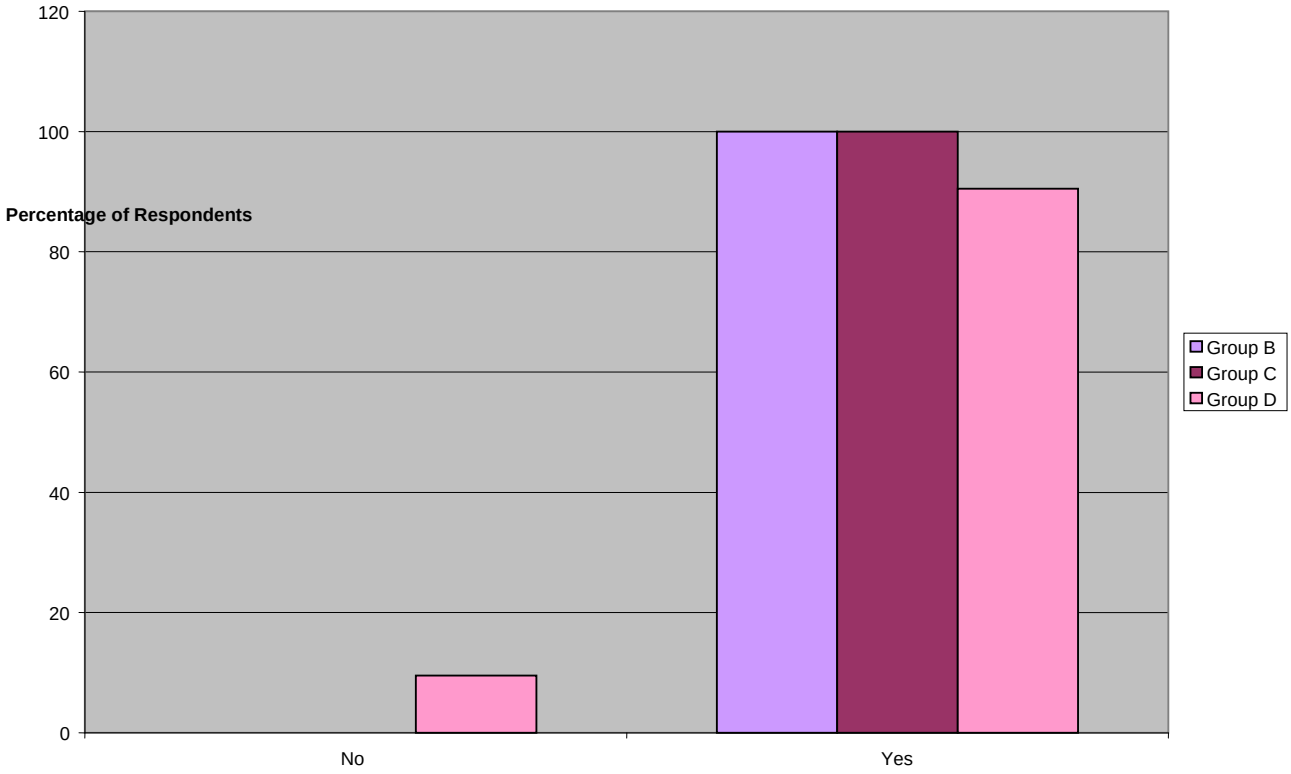
4.5.1 Group Comparisons: Groups B, C and D

The responses given by respondents from Sections B, C, and D were compared graphically to highlight any differences for later statistical consideration. Responses to the questions common to these three groups were evaluated. These questions dealt with the following aspects of the homeopathic profession, common to non-practicing, practicing and never practiced homeopaths:

- Aspects of the Homeopathic education found lacking (2.4, 3.24, 4.22).
- Impressions of being supported by the Homeopathic profession (2.5, 3.25, 4.23).
- Experience of being part of the general medical profession (2.6, 3.26, 4.24).
- Whether active interest still taken in Homeopathy and what form this takes (2.7, 3.27, 4.25).
- Whether the respondent would study Homeopathy again if they had the choice, which centre this would have been studied at and why. Reasons for not choosing Homeopathy were also evaluated as well as what other careers would have been pursued. (2.10, 3.29, 4.27).
- Finally, if the respondent had left South Africa, reasons for this were explored across the three groups. (2.11, 3.31, 4.28).

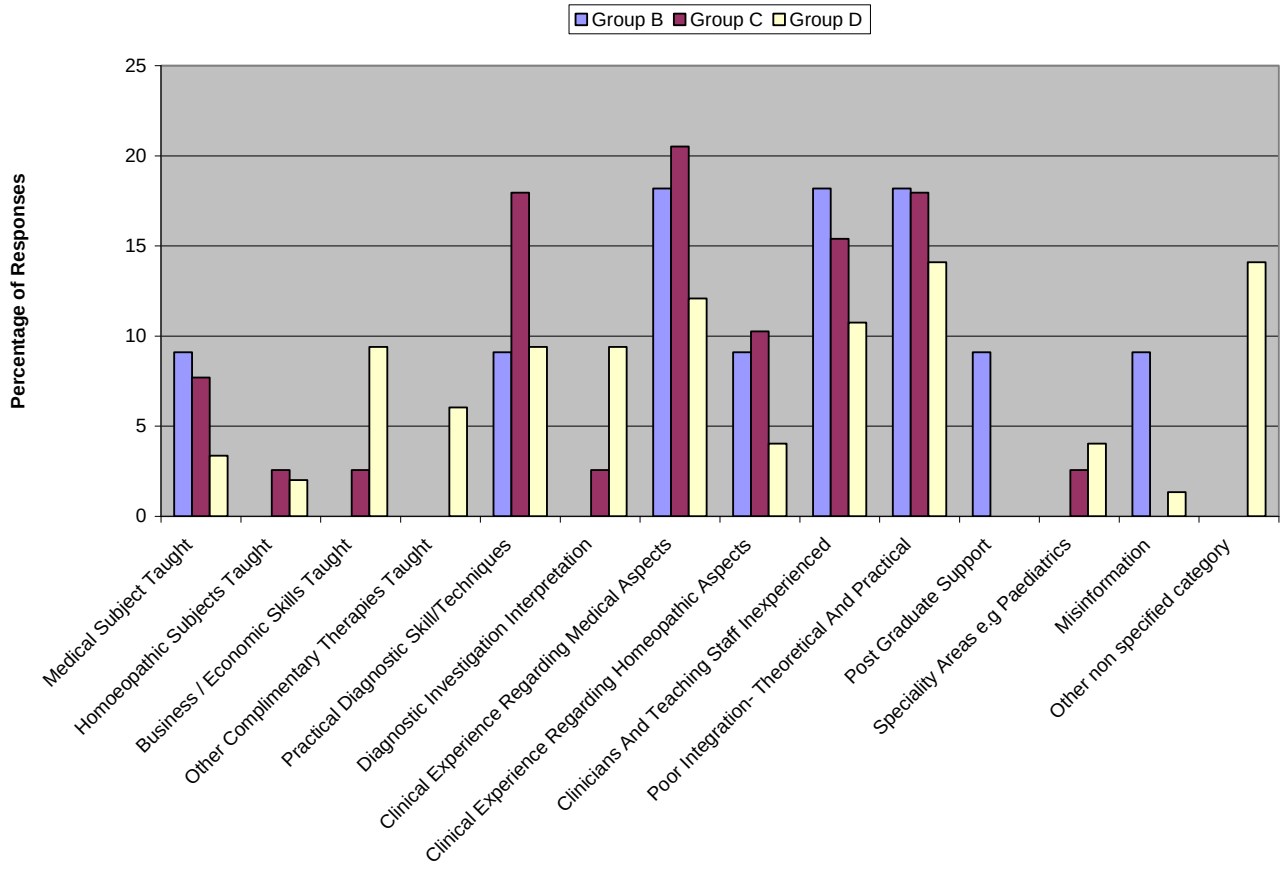
Due to the small size of Group B no conclusions can be extended to the general population of graduates who have never practiced. Interesting points are however noted for consideration.

Figure 4.29 Graph showing whether respondents felt the Homeopathic education to be lacking :



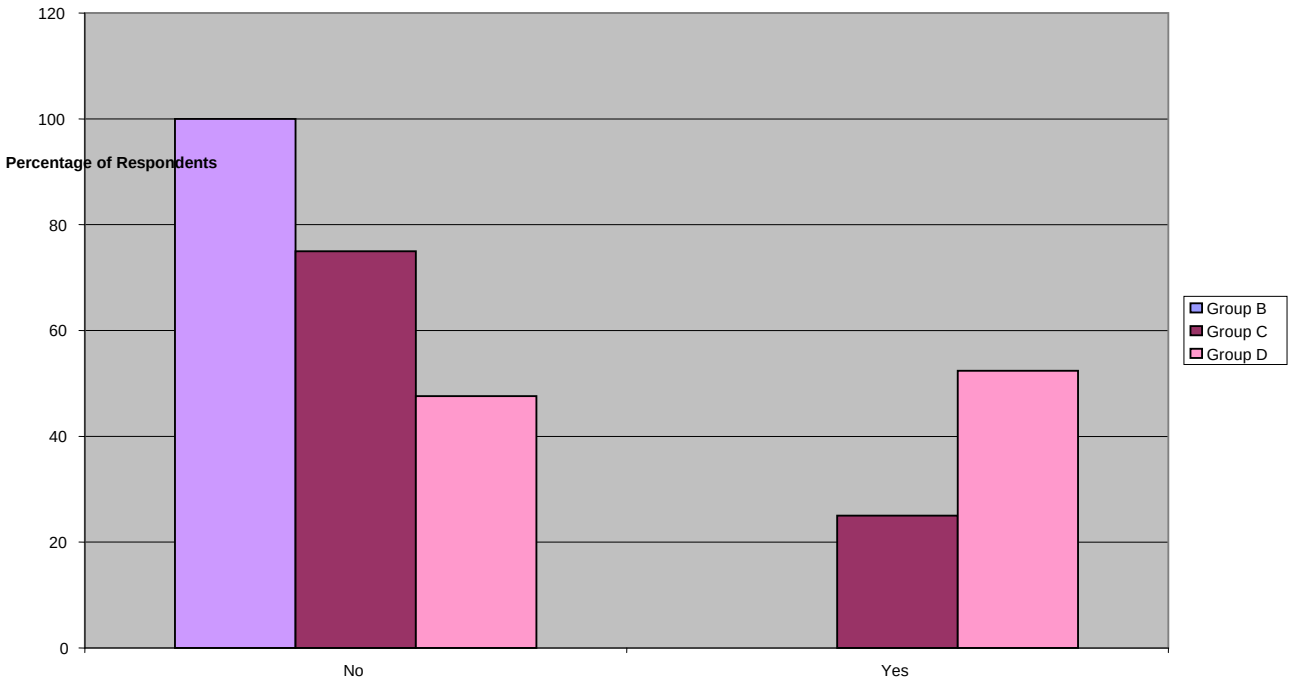
The majority of respondents felt the education to be lacking. This could indicate a unanimous perception of significant shortfalls in the education.

Figure 4.30 Graph Showing Aspects of the Homeopathic education found lacking:



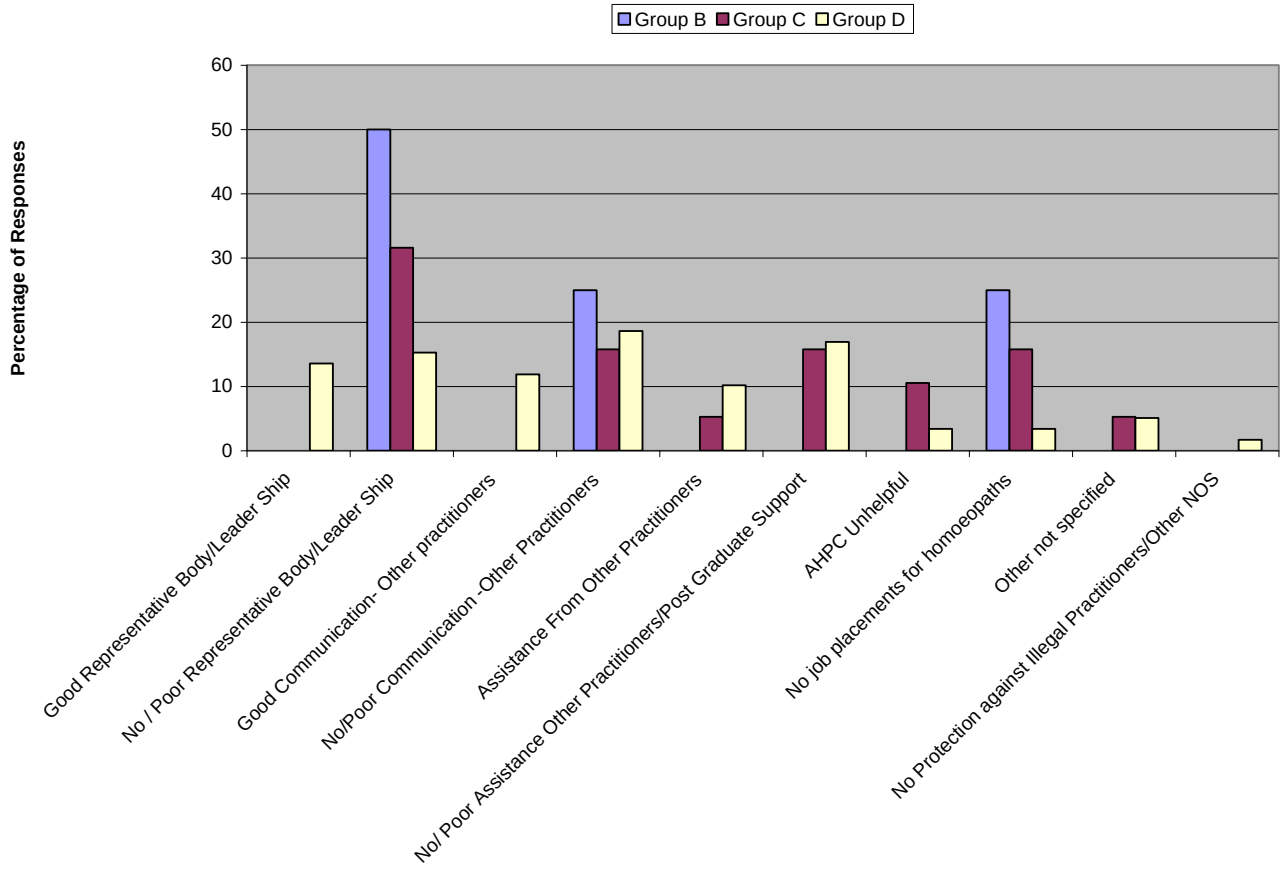
Group B and C's responses are clustered around the following perceptions: medical subjects taught, practical diagnostic skills and techniques, clinical experience regarding medical aspects, inexperience of clinicians, lecturers and teaching staff and poor integration of theoretical and practical aspects of knowledge. Group D's responses are more evenly distributed across the range of options. This is possibly due to the wider experience (and larger size) of this group i.e. there are more respondents who have more experience of a wider variety of cases and clinical situations and therefore recognise lacks in the education more specifically. The most common response from Group D was the poor integration of theoretical and practical aspects of knowledge and a non-specified response.

Figure 4.31 Graph Showing Impressions of being supported by the Homeopathic profession:



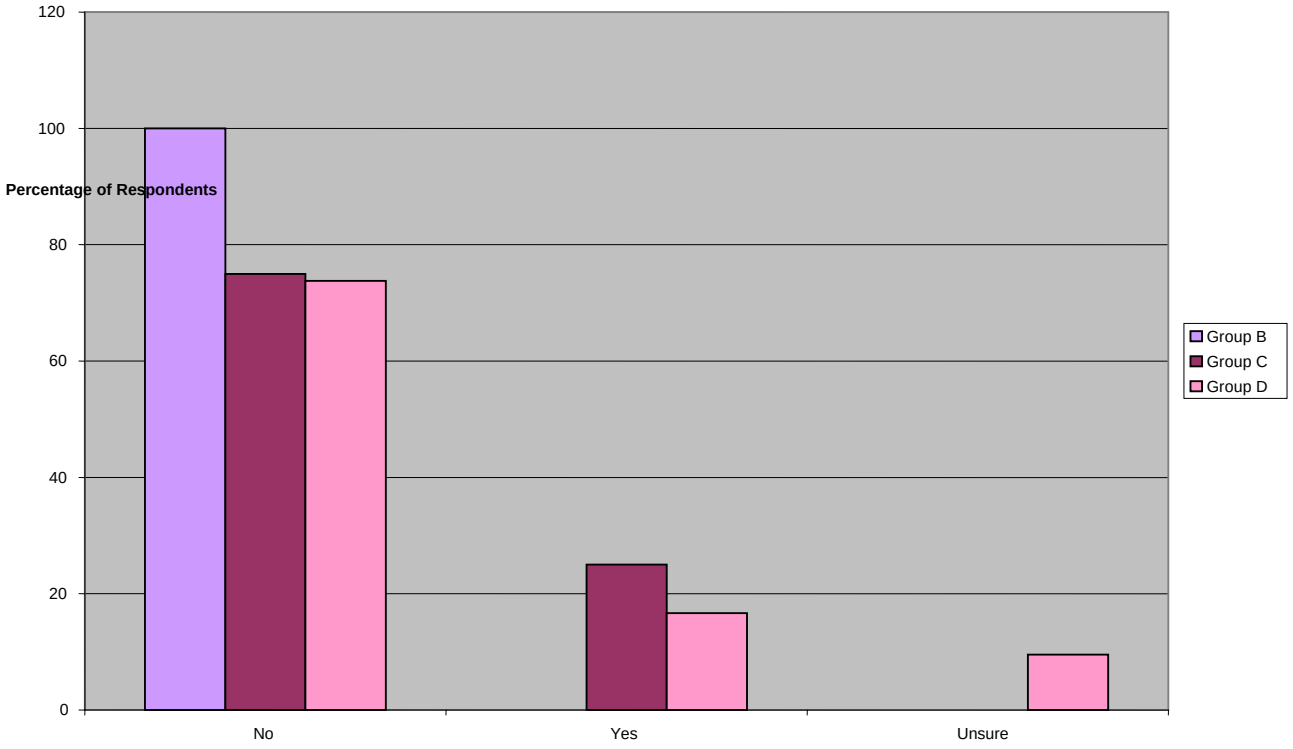
The majority of respondents in Group B and C felt unsupported by the homeopathic profession. Group D respondents generally feel more supported. This could be due to the fact that this group has remained in practice over time and has discovered/established and nurtured available professional support channels.

Figure 4.32 Graph showing elaboration on issue of support by Homeopathic profession:



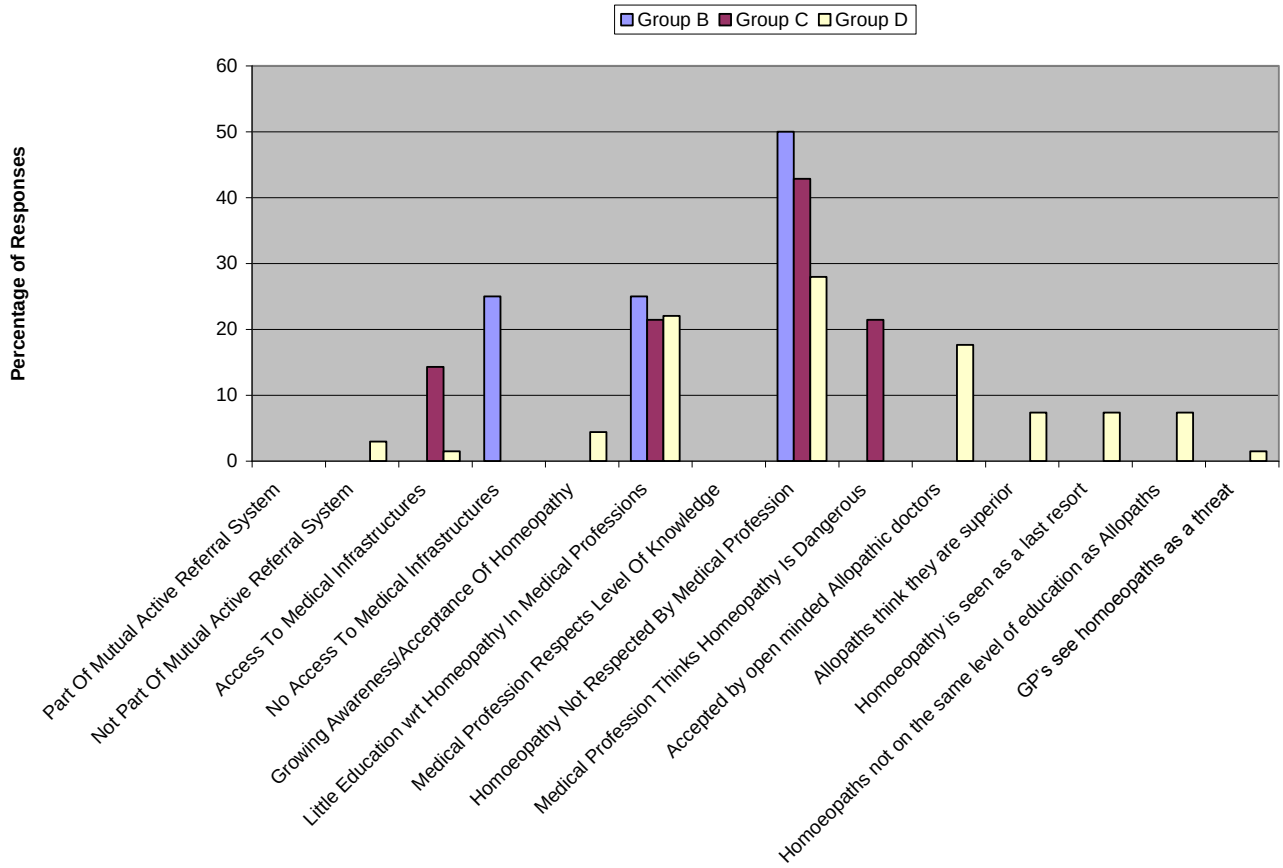
A common response from Group B and C was the absence of a good representative body and leadership. Again Group D responses are more evenly distributed. Poor communication with other practitioners is a response common to all three groups.

Figure 4.33 Graph showing whether respondents felt part of/supported by the general medical profession:



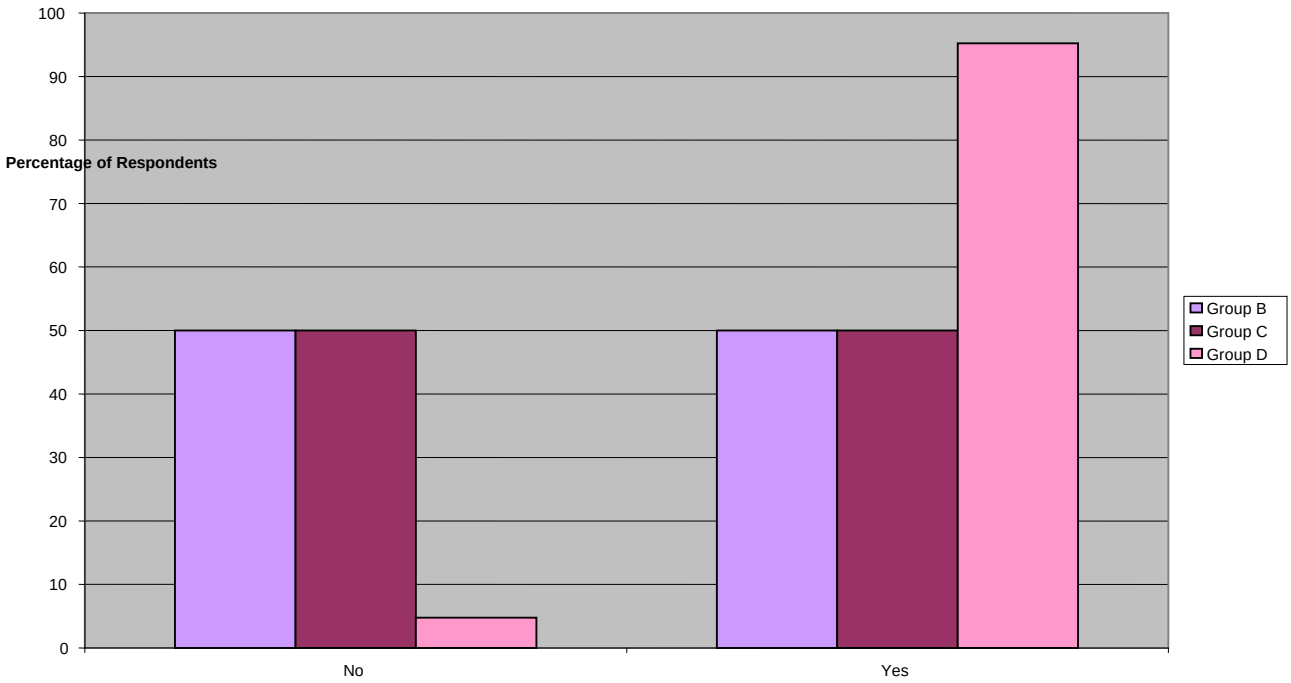
A significant majority of all three groups felt not part of or not accepted by the medical profession in general. Group D has the lowest relative level of disaffection. This could again be due to the fact that they have had time to establish channels and support structures.

Figure 4.34 Graph showing elaboration of whether respondents felt part of/supported by the general medical profession:



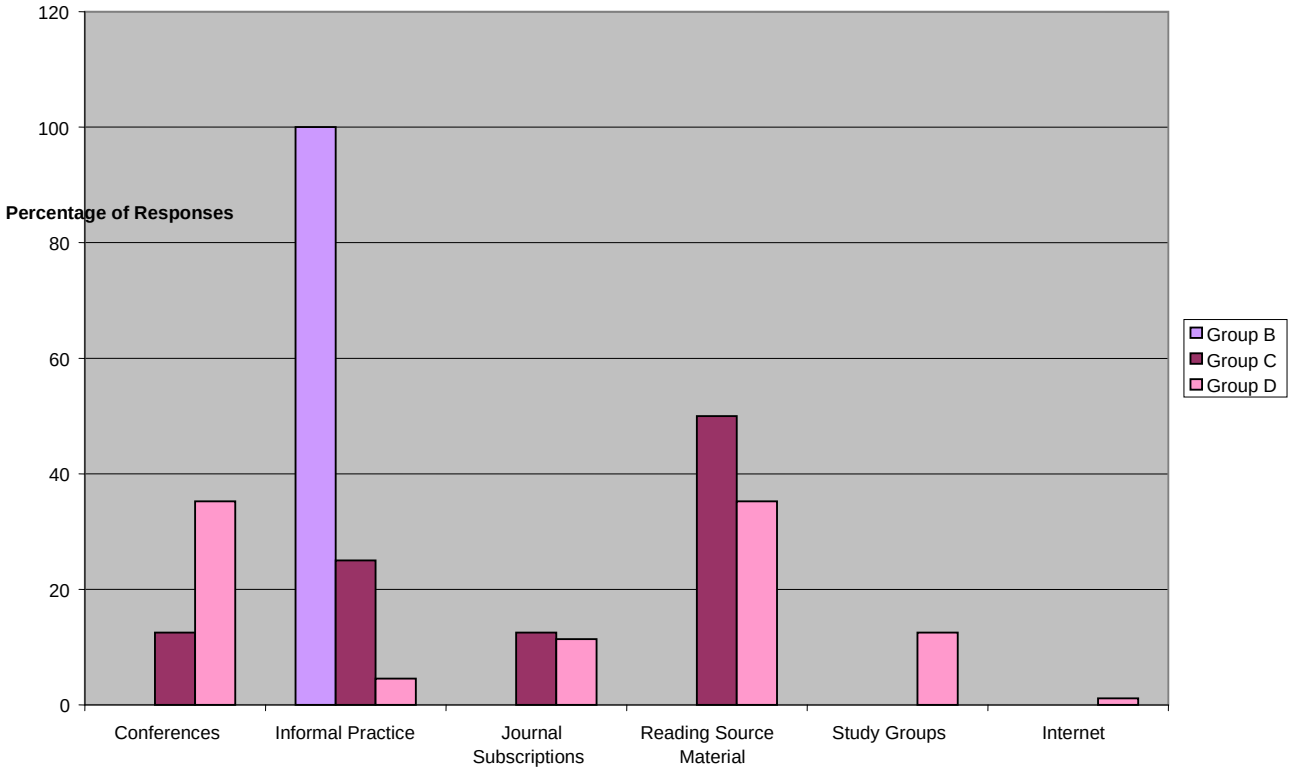
The predominant response across all three groups was the perception that homeopathy is not acknowledged or respected by the medical profession. This was supported by the perception (also across all three groups that there is little or no education with respect to Homeopathy in the medical profession).

Figure 4.35 Graph showing whether active interest is still taken in Homeopathy:



Between Group B and C the respondents are split as to whether active interest in homeopathy is taken. The majority of Group D respondents report taking an interest (as would be expected).

Figure 4.36 Graph showing what form the active interest take:



Most responses indicate that a variety of methods are used to express the ongoing active interest in homeopathy. The variety of different options used increases as the size of the group increases.

Table 4.21 Table showing whether the respondent would study Homeopathy again if they had the choice:

	Group B	Group C	Group D
No	100	75.0	23.8
Yes	0	25.0	76.2

Table 4.22 Table showing which centre they would have been studied at if they had the choice:

	Group B		Group C		Group D	
	Number	Percentage	Number	Percentage	Number	Percentage
Durban Institute Of Technology	0	0	0	0.0	6	15.8
Witwatersrand Technikon	0	0	1	16.7	17	44.7
No Preference Of Technikons	1	100	3	50.0	10	26.3
Medicine With Post Graduate Homoeopathy	0	0	2	33.3	5	13.2

Figure 4.37 Graph showing reasons for the centre they would have studied at if they had the choice:

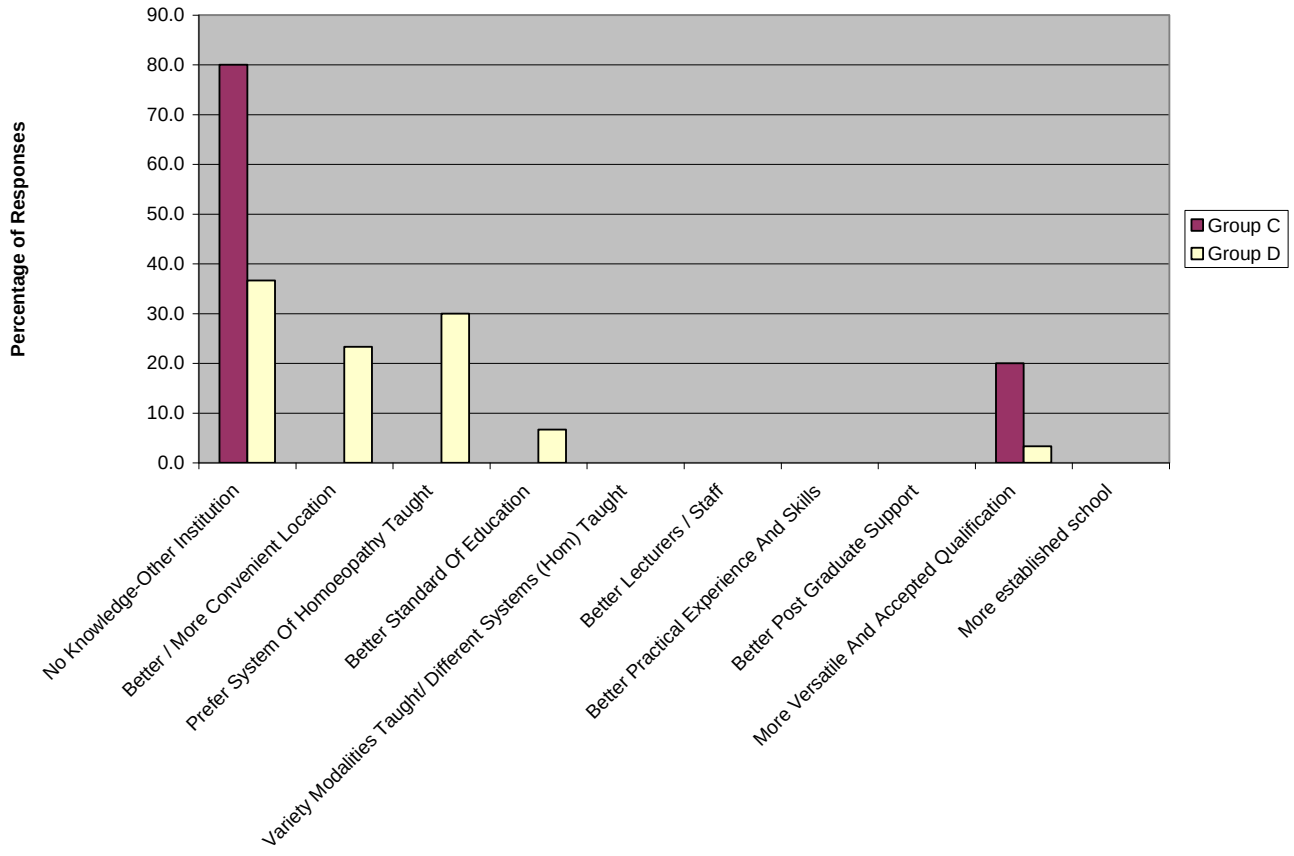
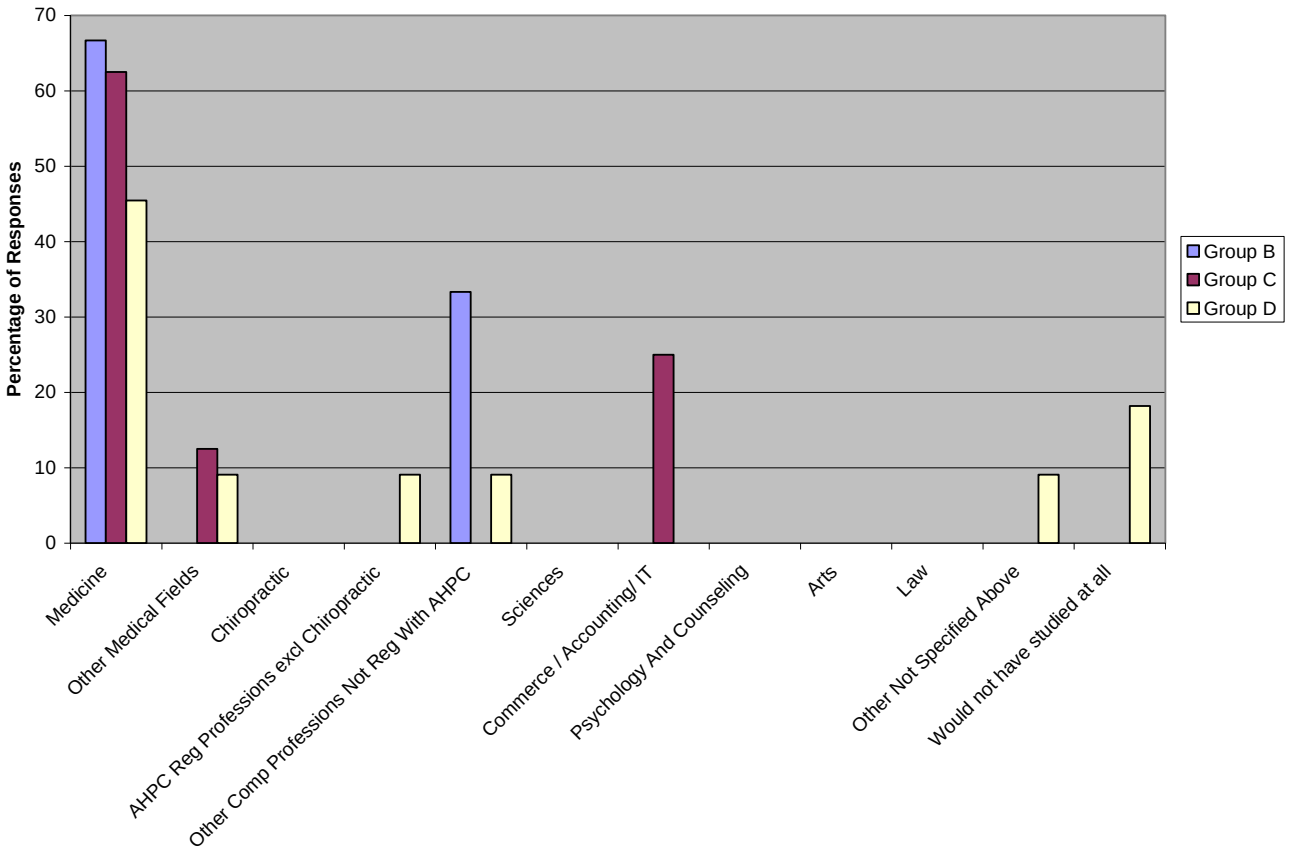


Table 4.23 Table showing why Homeopathy would not have been chosen again:

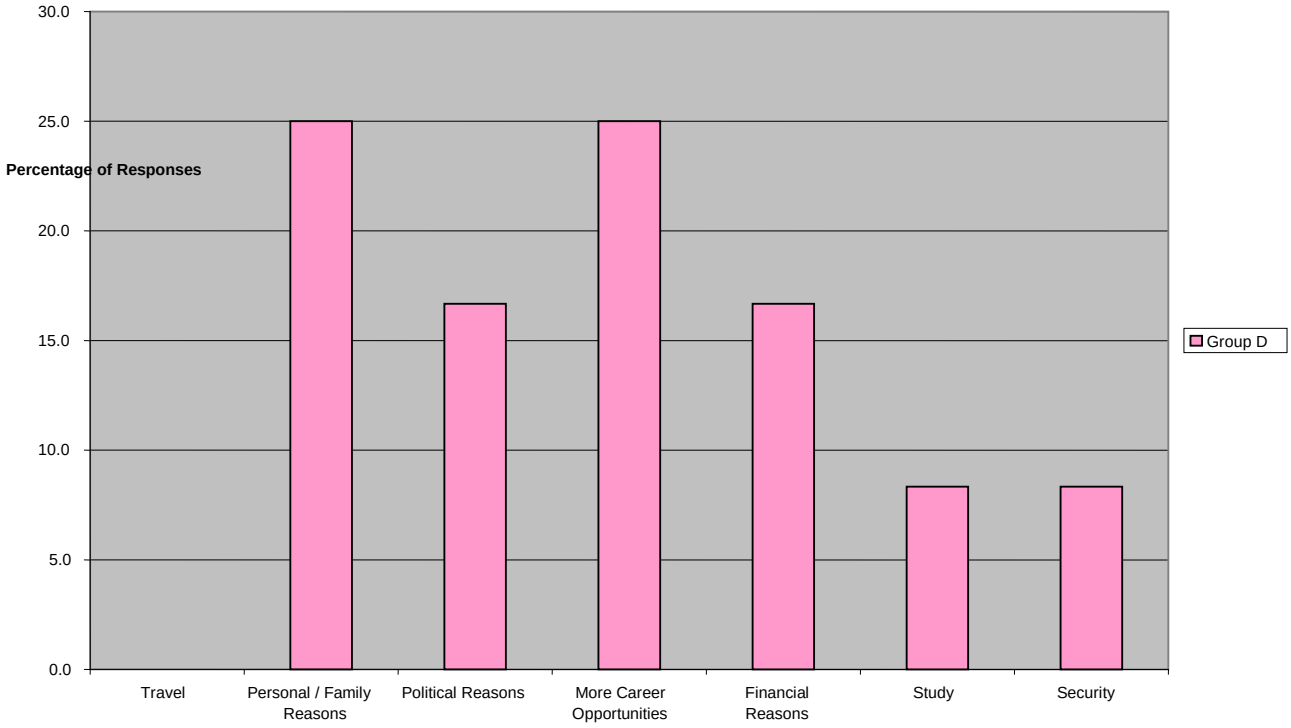
Reasons given	Group B		Group C		Group D	
	No.	%	No.	%	No.	%
Not Financially Rewarding / Viable	2	100	5	33.3	4	36.4
Not Rewarding Career / No Job Satisfaction	0	0	0	0.0	0	0.0
Difficult, Stressful Work	0	0	0	0.0	0	0.0
Not Versatile / Flexible Career	0	0	2	13.3	0	0.0
No Recognition Of Education Or Profession	0	0	5	33.3	2	18.2
Course Too Long	0	0	2	13.3	0	0.0
Other Not Specified	0	0	0	0.0	0	0.0
Medicines do not work	0	0	1	6.7	0	0.0
Poor homoeopathic education	0	0	0	0.0	4	36.4
There is more to life	0	0	0	0.0	1	9.1

Figure 4.38 Graph showing what profession would have been followed instead:



The majority of respondents who would not have studied homeopathy again, would have studied medicine. This reflects a significant level of disillusionment with homeopathy. Possible reasons for this are discussed in Chapter 5.

Figure 4.39 Graph Showing reasons for leaving if the respondent had left South Africa:



4.5.2 Group Comparisons: Sections C and D

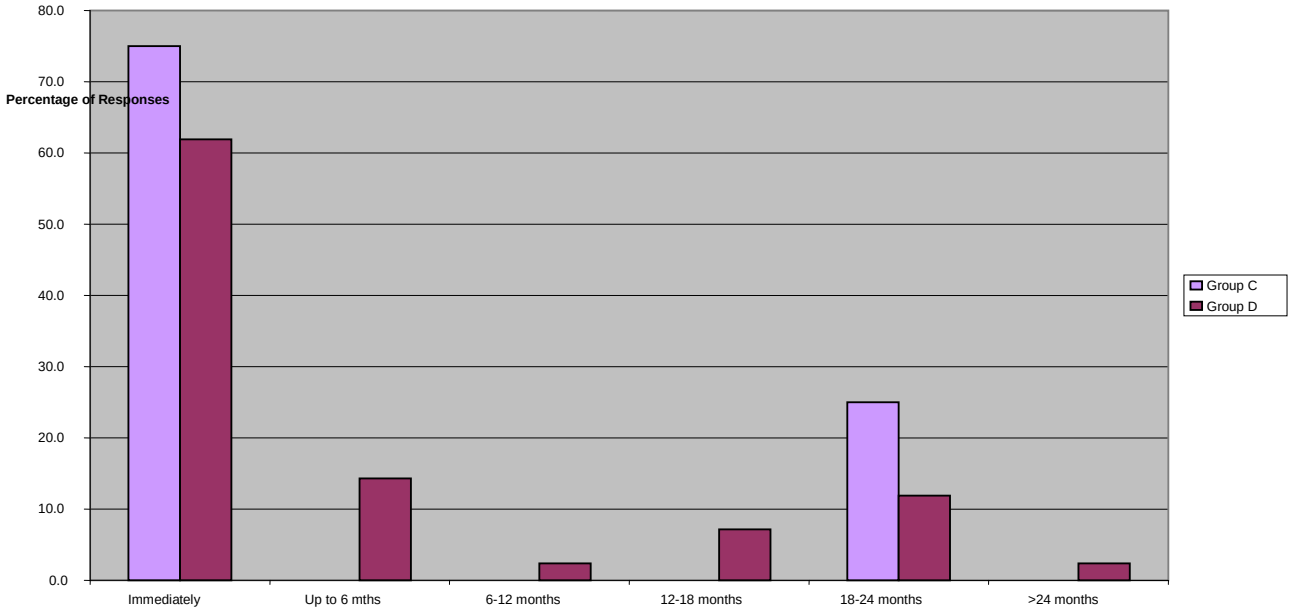
The responses given by respondents from Sections C and D were compared graphically to highlight any differences for later statistical consideration. Responses to the questions common to these two groups were evaluated. These questions dealt with the following aspects of the homeopathic profession, common to homeopaths that have practiced (whether currently practicing or not):

- Length of time taken between qualification and practice, and activity engaged in before practicing (3.1, 4.1).
- Age on starting to practice (3.2, 4.2).
- Length of time in active practice (3.3, 4.3).
- Number of practices (3.4, 4.4).
- Ease with which practice was started and factors affecting this (3.6, 4.6).
- How the practice was financed (3.7, 4.7).
- Whether practice is full or part time (3.8, 4.8).
- Nature of practice and types of practice setup, as well as forms of association with other professionals (both financial and multi-disciplinary associations) (3.9, 4.10).
- Referral base, both who referred to and who receive referrals from (3.10, 3.11, 4.11, 4.12).
- Source of patients and average numbers of patients seen per week (3.12, 3.13, 4.13, 4.14).
- Financial considerations (average consultation rates (both for initial, follow up and telephone consultations); whether income is supplemented and how (both inside and outside the consultation), length of time before profit was shown, and difficulties experienced) (3.14, 3.15, 3.16, 3.17, 4.15, 4.16, 4.17, 4.18).

- Dispensary information (use of own dispensary or outsourced, and where remedies are obtained) (3.18, 3.19, 4.19, 4.20).
- Prescription aids used in the consultation (3.20, 4.21).

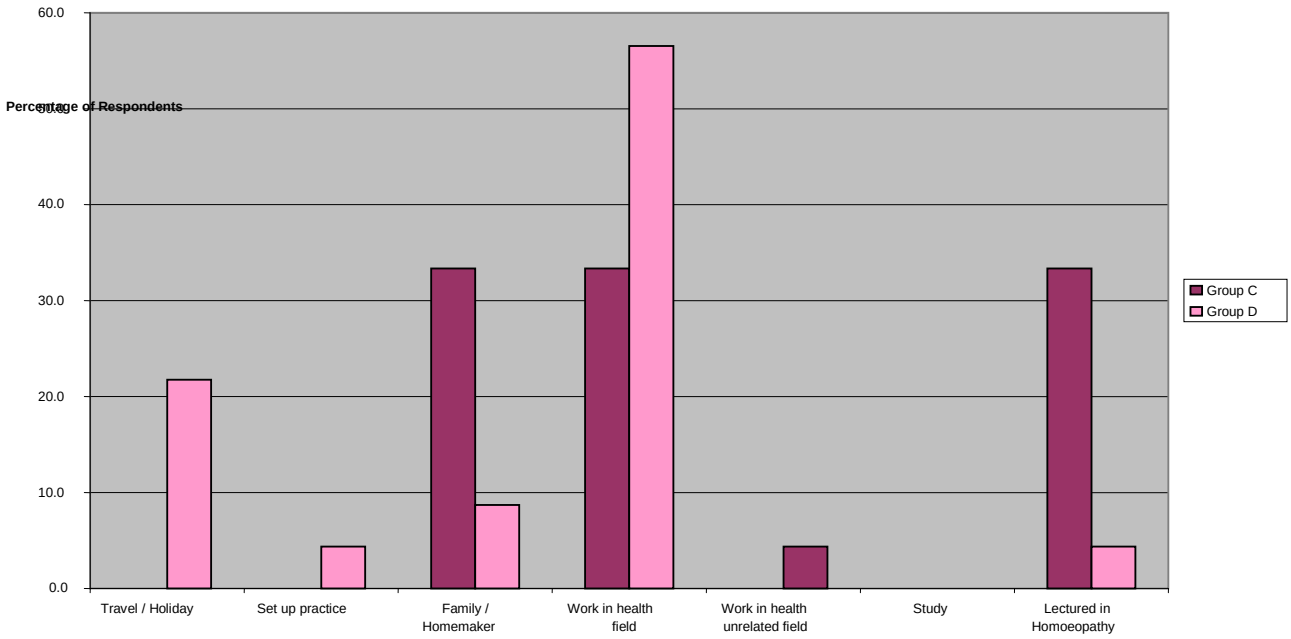
A large number of these issues relate to the practicalities of the profession of homeopathy. Financial considerations, methods and types of practice, dispensary information and prescription aids will describe the way that graduates of the TWR practice homeopathy (in the business sense).

Figure 4.40 Graph showing comparison of the Length of time taken between qualification and practice:



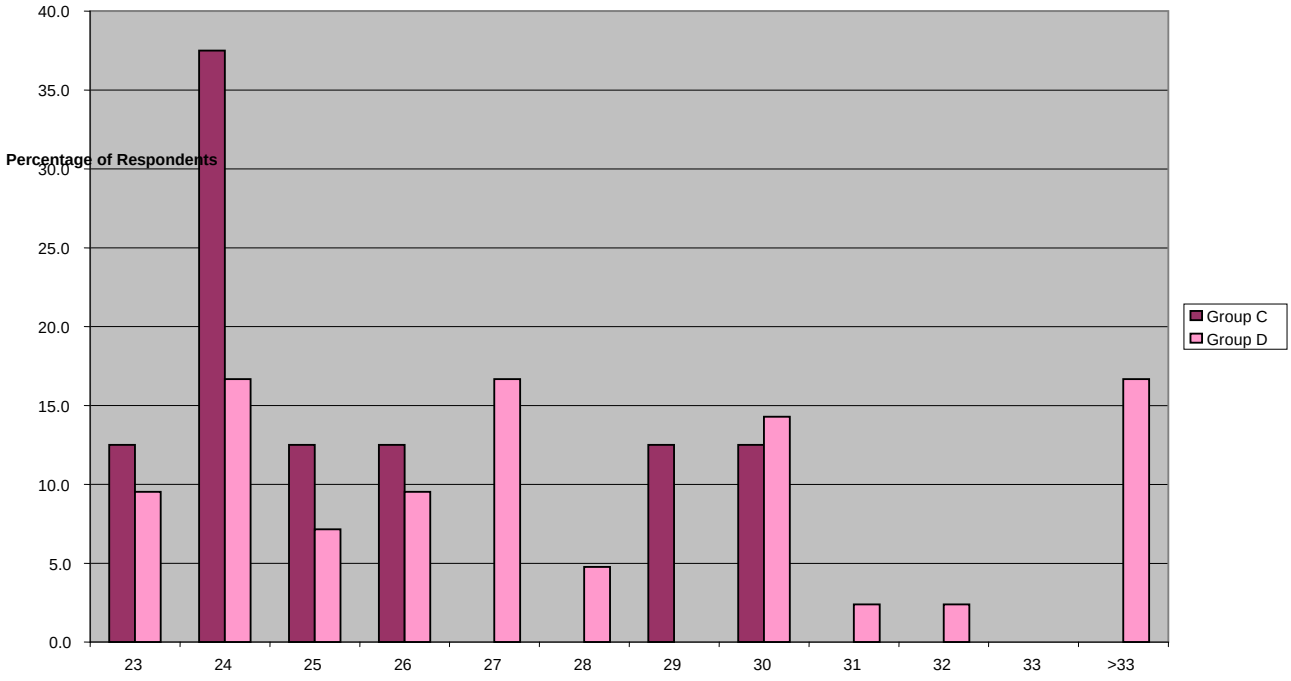
Most of the respondents commenced practice immediately on qualification. The lengthy delays between graduation and qualification (due to research, internship and other factors) may contribute to this trend. Casual work in the health field (particularly health shop work) is a common initial step into the alternative health care profession. This is evident in Fig 4.43 below.

Figure 4.41 Graph showing comparison of the activity engaged in before practicing:



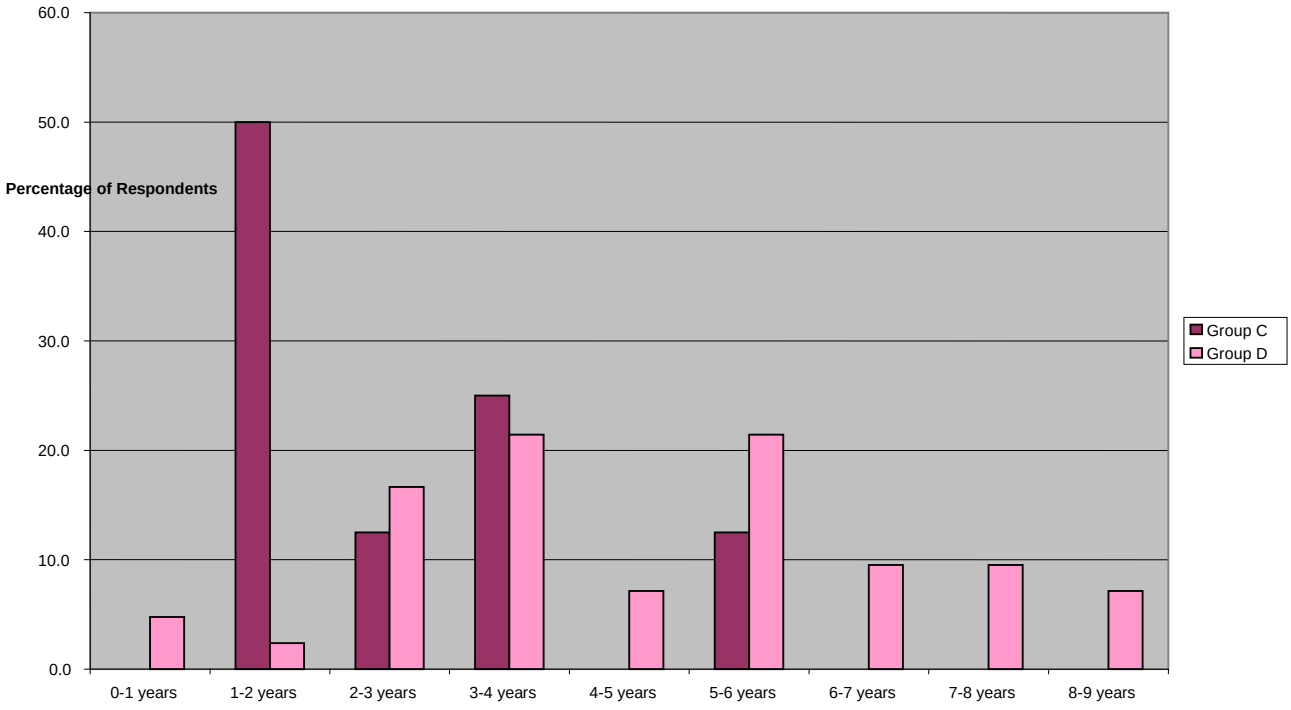
The majority of respondents in Group D worked in the health field between graduation and qualification. In relative and absolute numbers this is the predominant avenue for graduates i.e. 56.5% (13 respondents) followed this avenue.

Figure 4.42 Graph showing comparison of the Age on starting to practice:



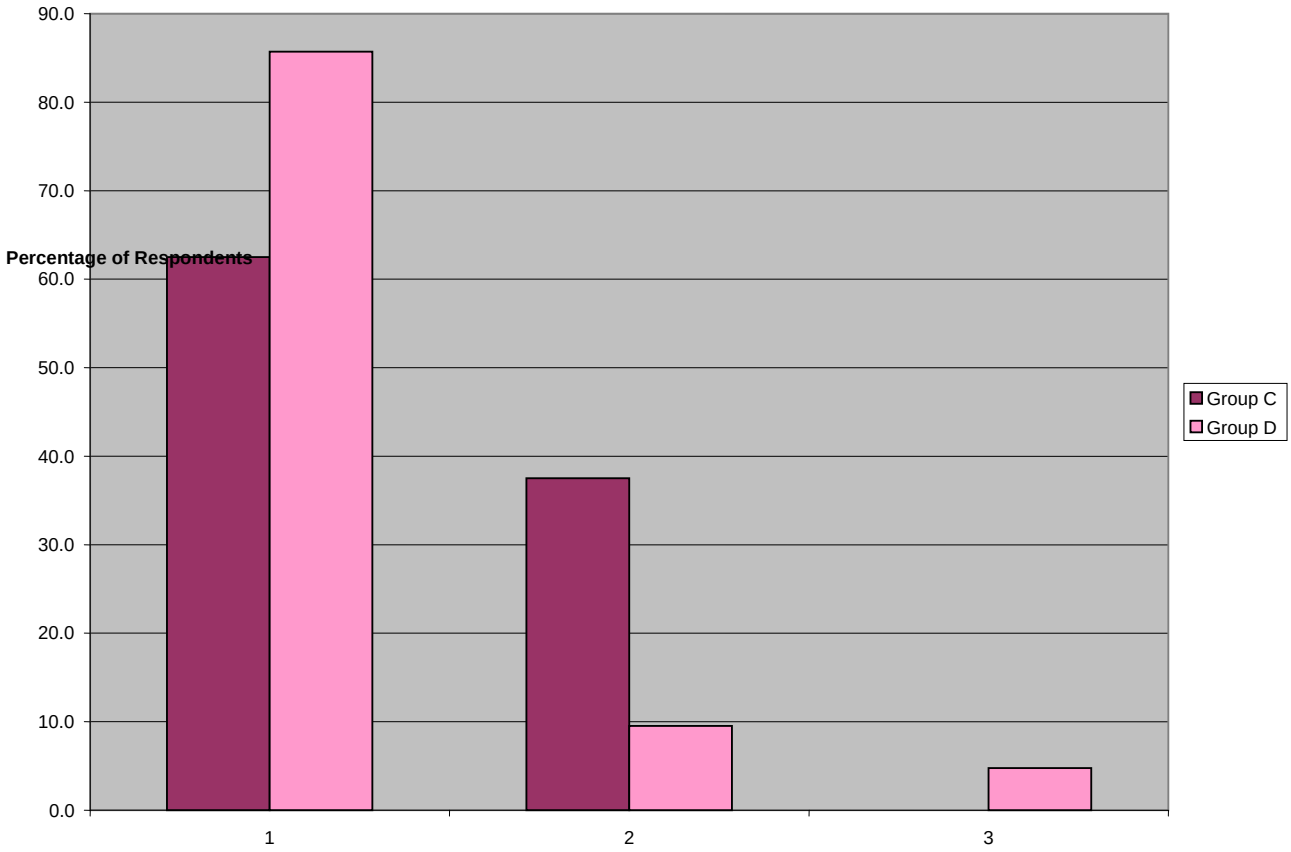
The respondents in Group D were an older age than Group C. The spread was more even as well as Group D having more representation in the older age groups. This may be explained by the contention that older, more mature graduates are better equipped, more motivated and more committed to practicing homeopathy and continuing to do so than younger graduates.

Figure 4.43 Graph showing comparison of the Length of time in Active practice:



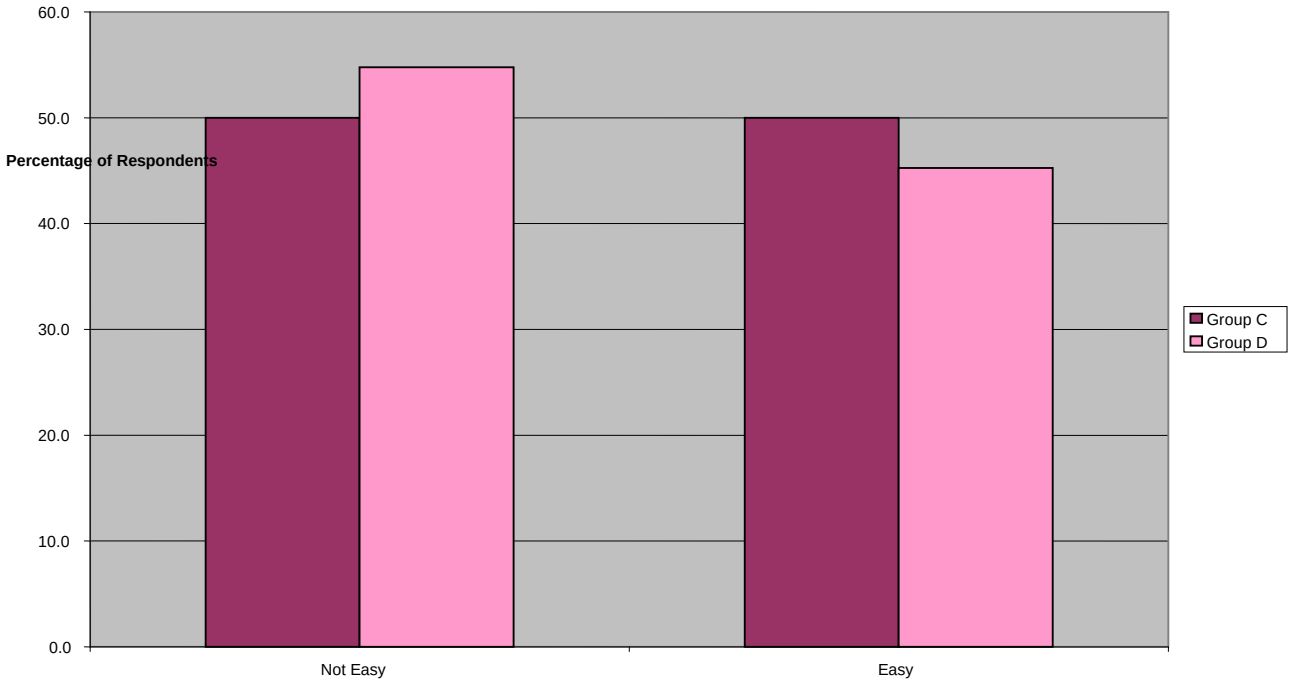
In the above figure it is apparent that the majority (87.5%) of the respondents from Group C, were in practice less than 4 years. Fully 50% practiced for less than 2 years. This could indicate that respondents realised fairly soon that practice was not the best path for them. It could also be interpreted that the length of time to build a sustainable practice (both on financial and personal levels) is in the order of 4-5 years (the length of time after which few graduates stop practicing).

Figure 4.44 Graph showing comparison of the Number of Practices:



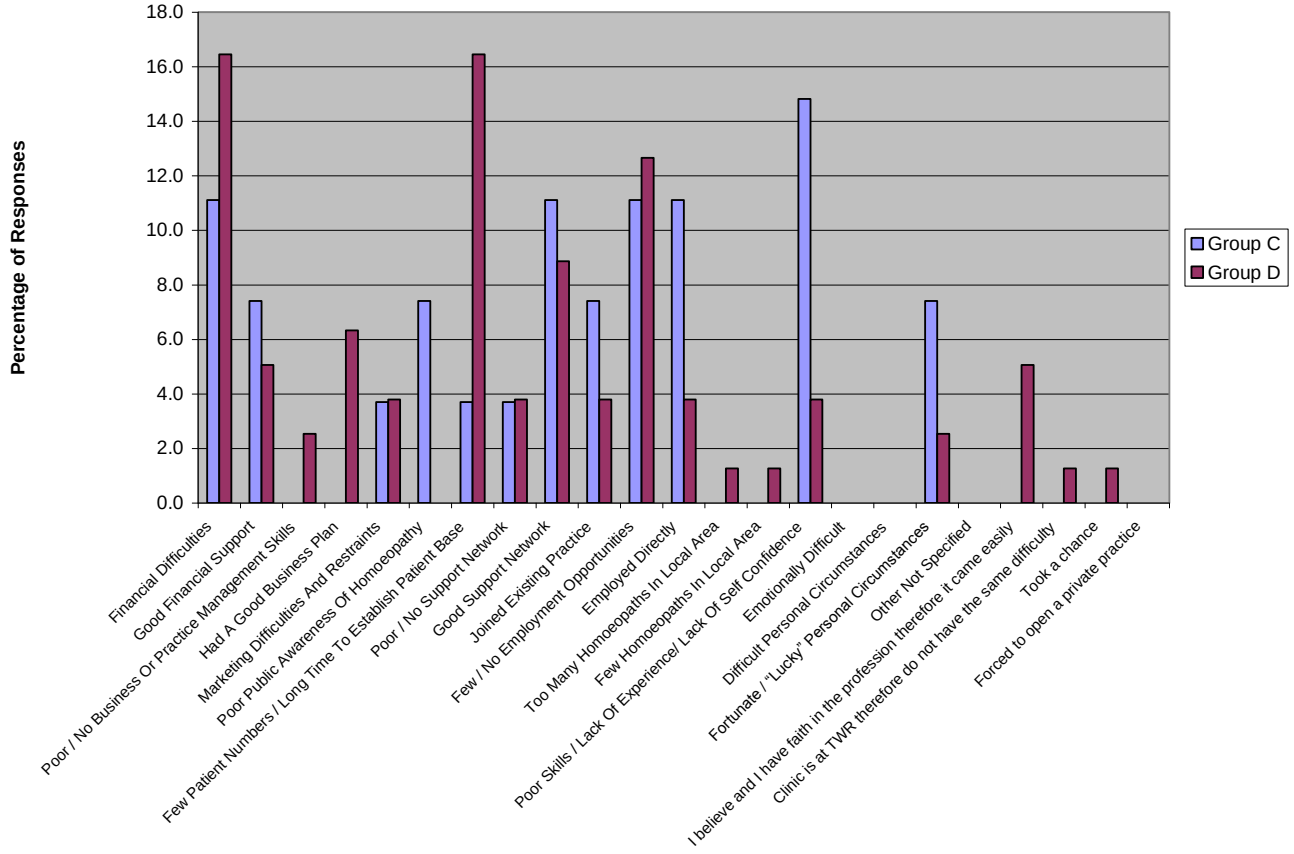
Most respondents (in both groups) had only one practice.

Figure 4.45 Graph showing comparison of the Ease with which practice was started:



The proportion of respondents who found it easy to start is fairly uniform across the groups and is also fairly similar to the proportion who did not find it easy to start. Interesting to note is that relatively fewer individuals in Group D found it easy to start.

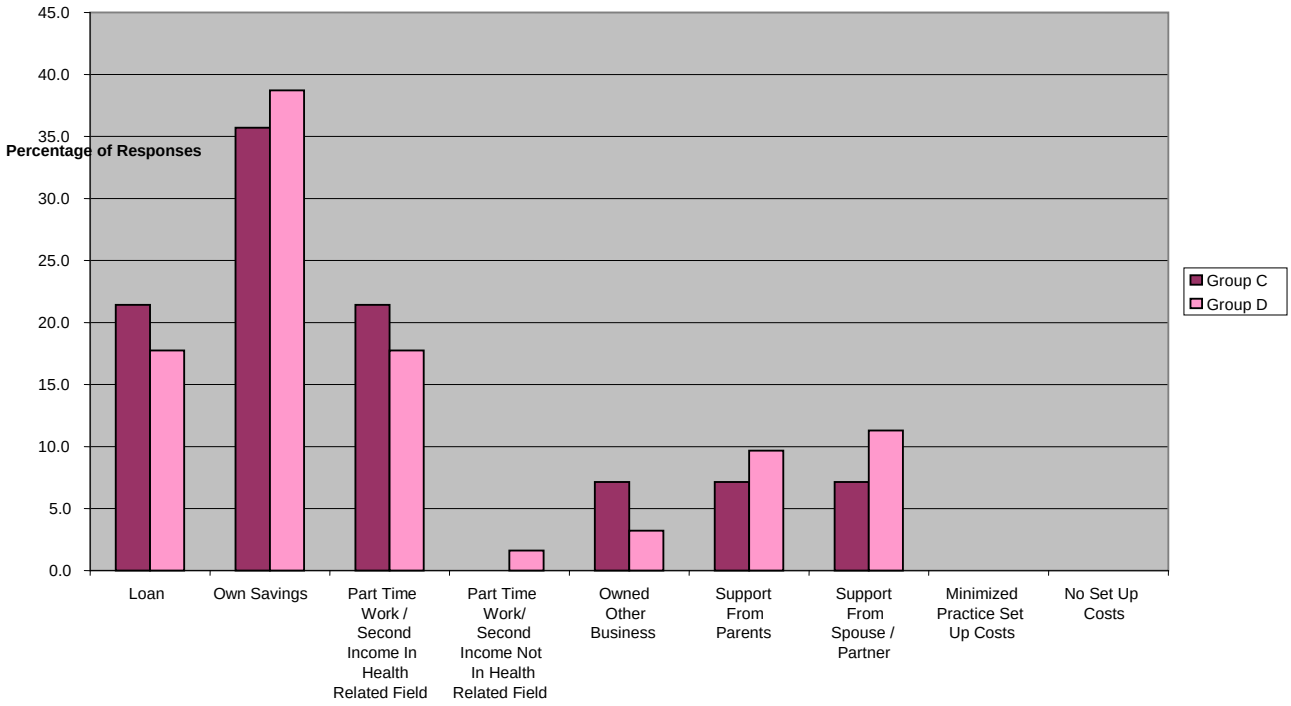
Figure 4.46 Graph showing comparison of the factors affecting ease of starting to practice:



In terms of difficulties experienced, Group C responded with poor skills and confidence as the most common difficulty experience. Also significant were financial difficulties, poor public awareness of Homeopathy and the lack of employment opportunities. Group D felt that financial difficulties and the low numbers of patients and length of time required to build a patient base were the most common problems.

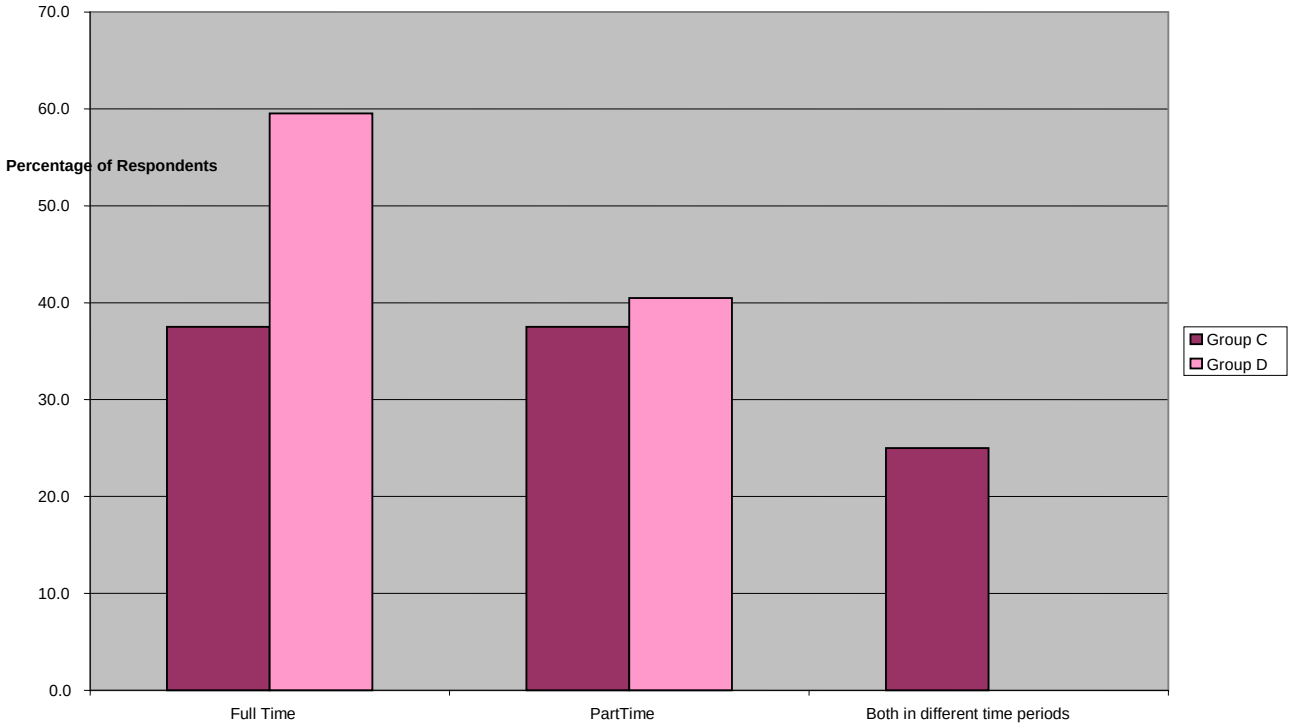
These were balanced by experiencing a good support network (Group C and D), having good financial support (C and D), fortunate personal circumstances and being directly employed (Group C) and having had a good business plan (Group D).

Figure 4.47 Graph showing comparison of the how the practice was financed:



Self sourced finance (loans, savings and income from related work) were the main avenues for financing for both groups. The distributions of sources are fairly homogenous across the two groups.

Figure 4.48 Graph showing comparison of the whether practice is/was full or part time:



It is evident that a far higher percentage of respondents from Group D were engaged full time. This may have had an effect on the success of this group, in terms of staying in practice.

Figure 4.49 Graph showing comparison of the nature of practice:

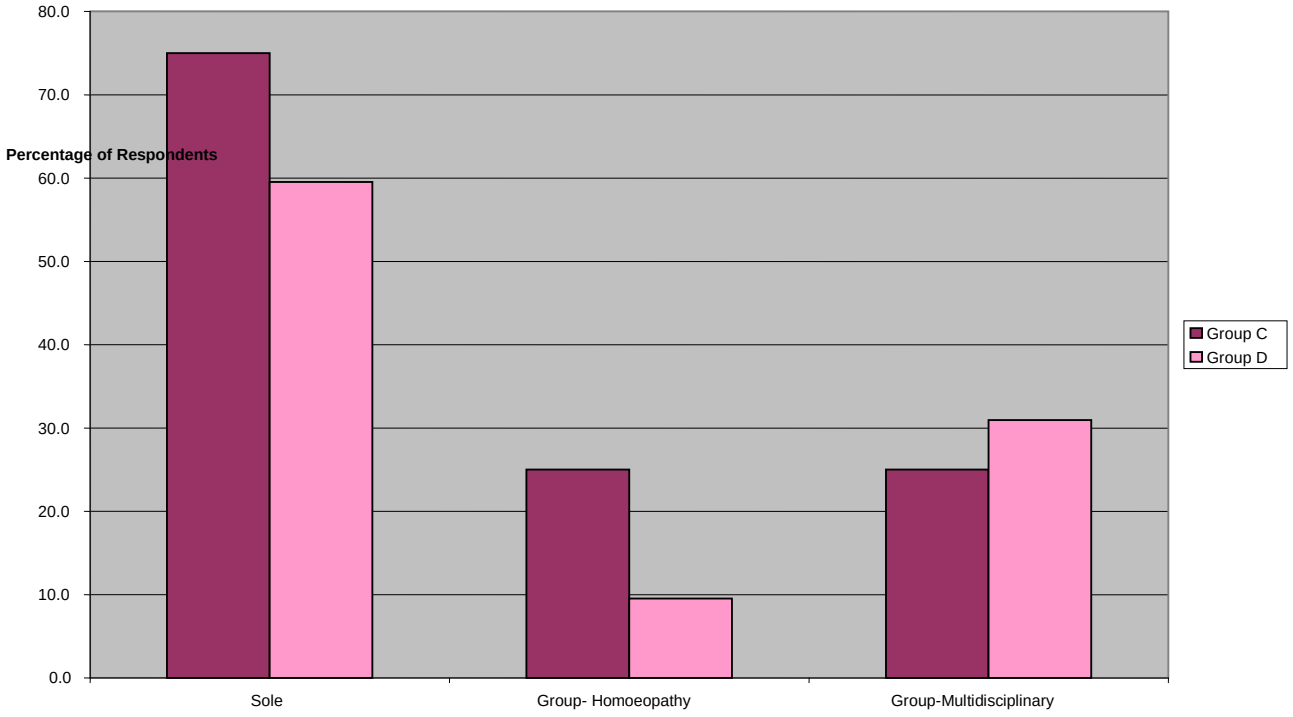
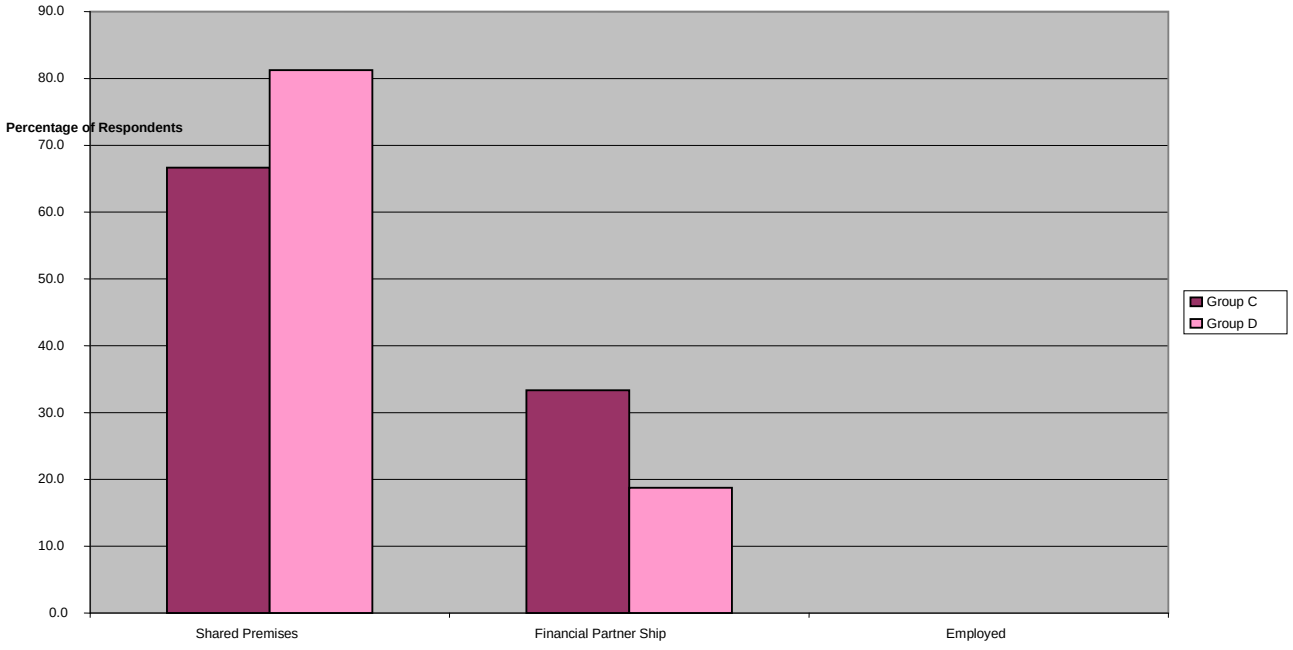
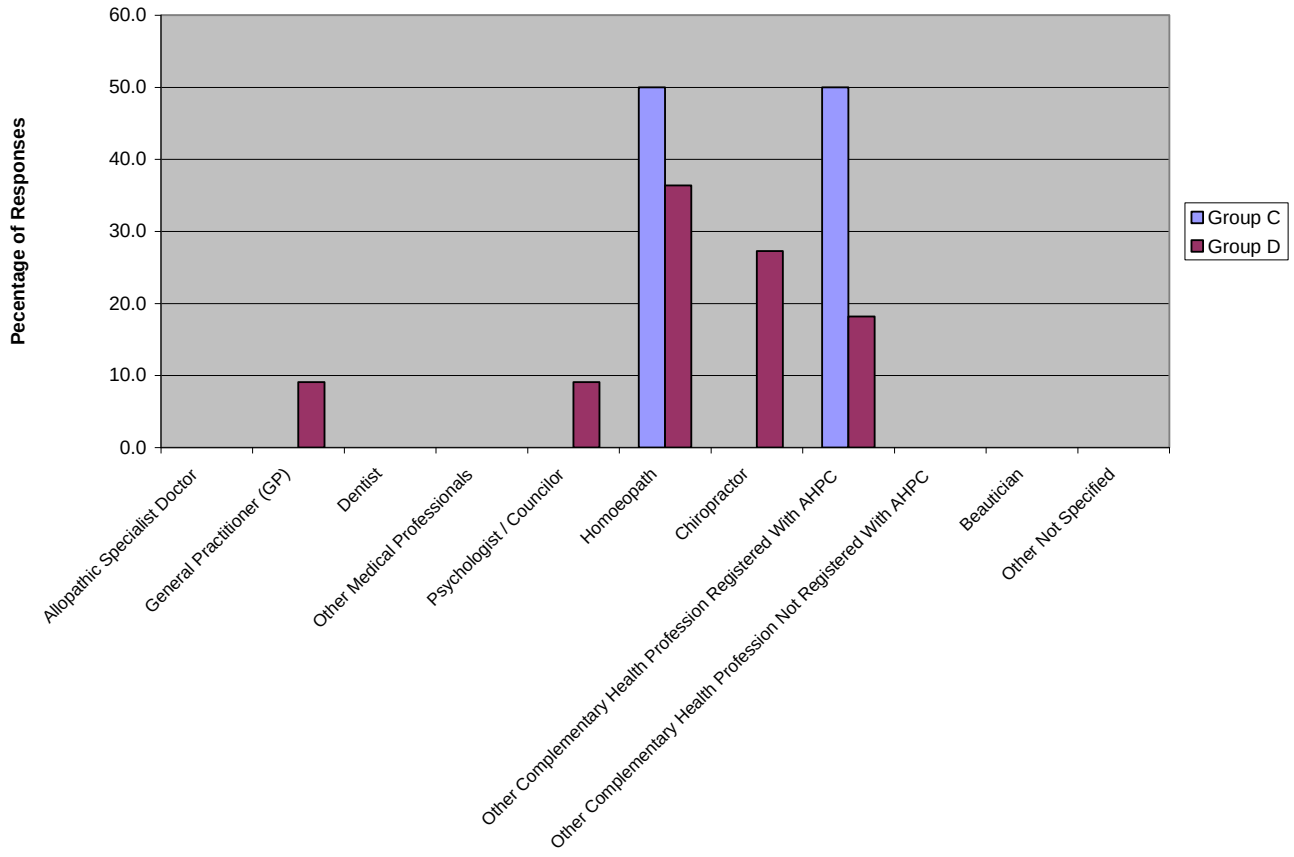


Figure 4.50 Graph showing comparison of the types of practice setup:



It appears that respondents from Group D make use of more support in terms of sharing premises and engaging in group multi-disciplinary practices. These situations offer significant advantages in terms of profile, referral base and building and maintaining a patient base.

Figure 4.51 Graph showing comparison of the forms of financial association with other professionals:



The above figure confirms the impression that respondents from Group D avail themselves of more options in terms of financial associations with other health professionals. Respondents from Group C appear to be more confined (higher percentage engaged in sole practice, fewer shared premises, and tended to make narrow partnerships- more with other homeopaths and allied health practitioners rather than the full spectrum).

Figure 4.52 Graph showing comparison of the multi-disciplinary associations:

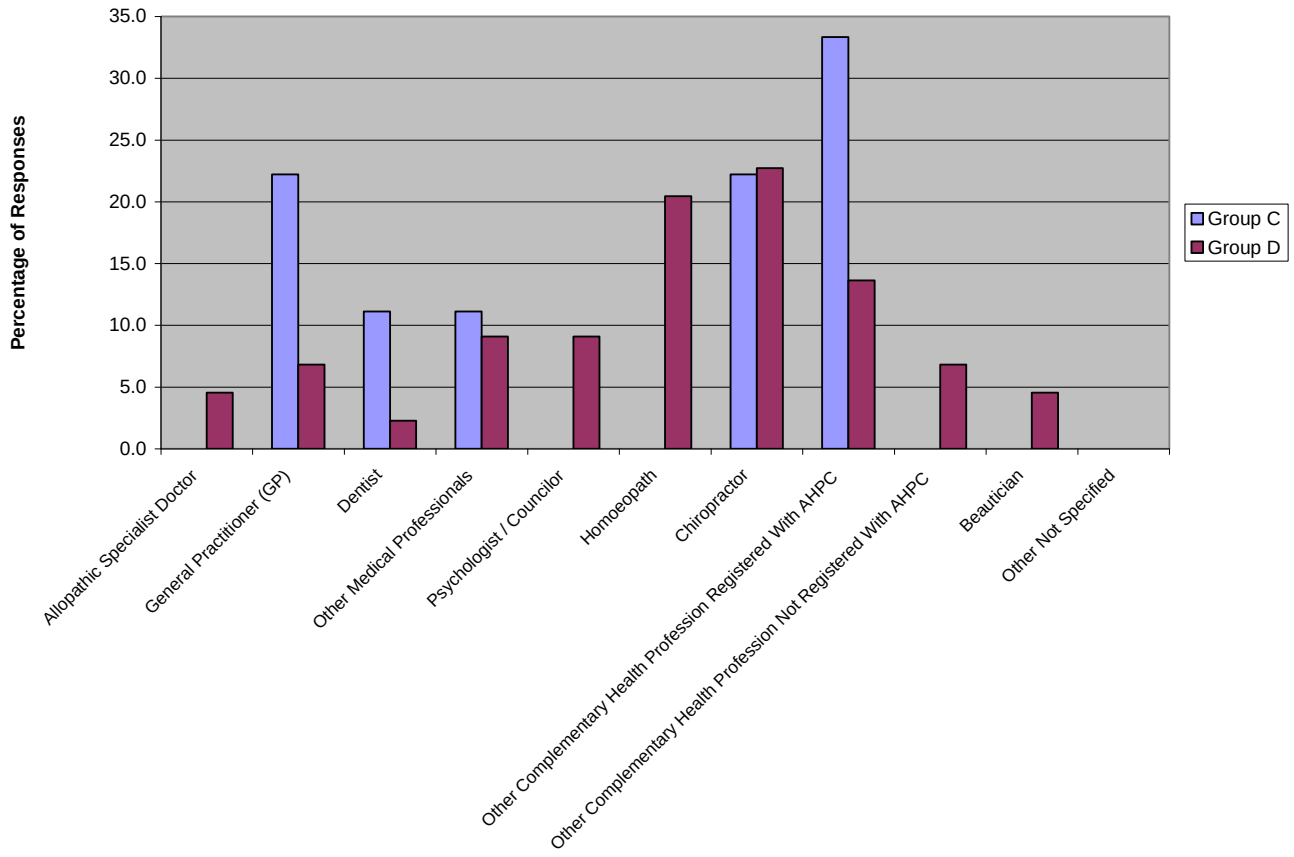


Figure 4.53 Graph showing comparison of the referral base- who respondents referred to:

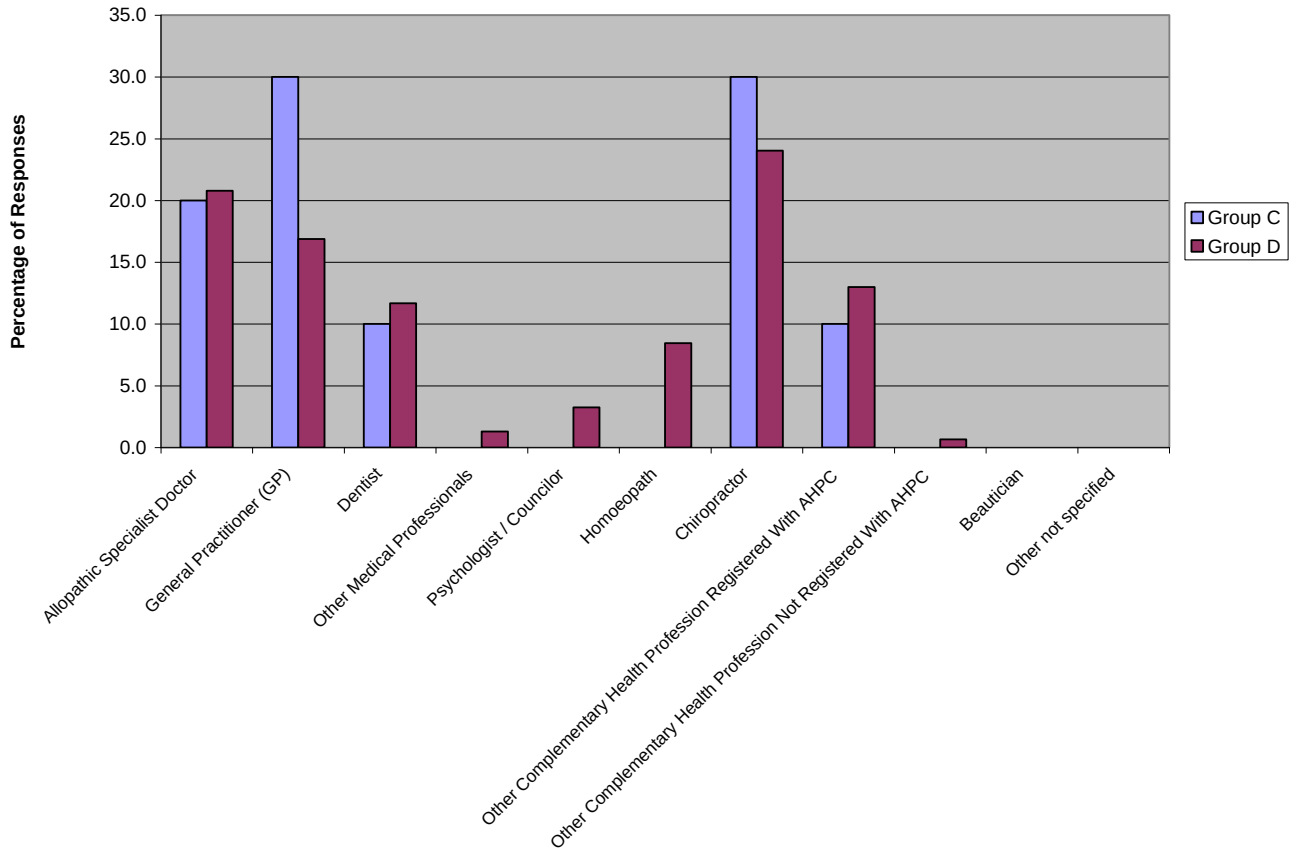
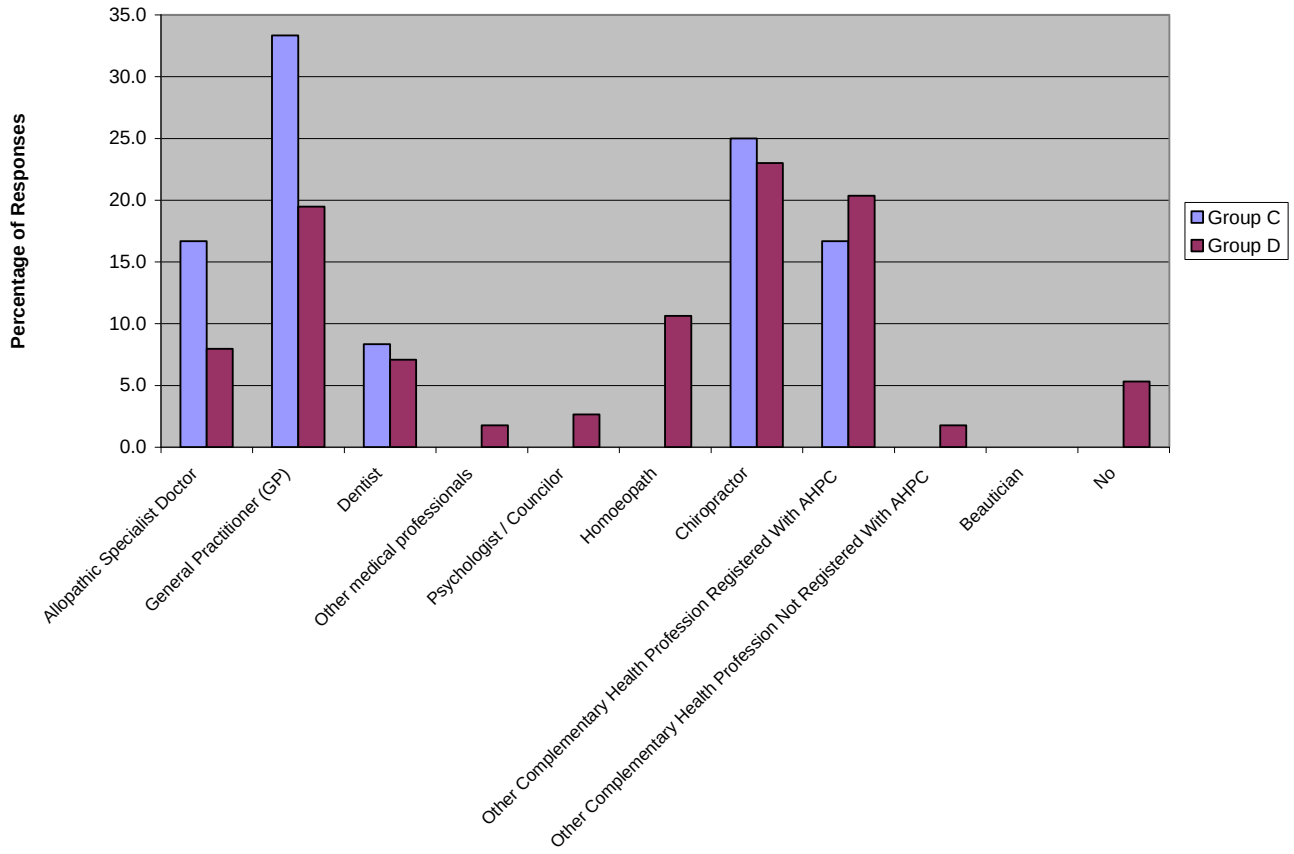
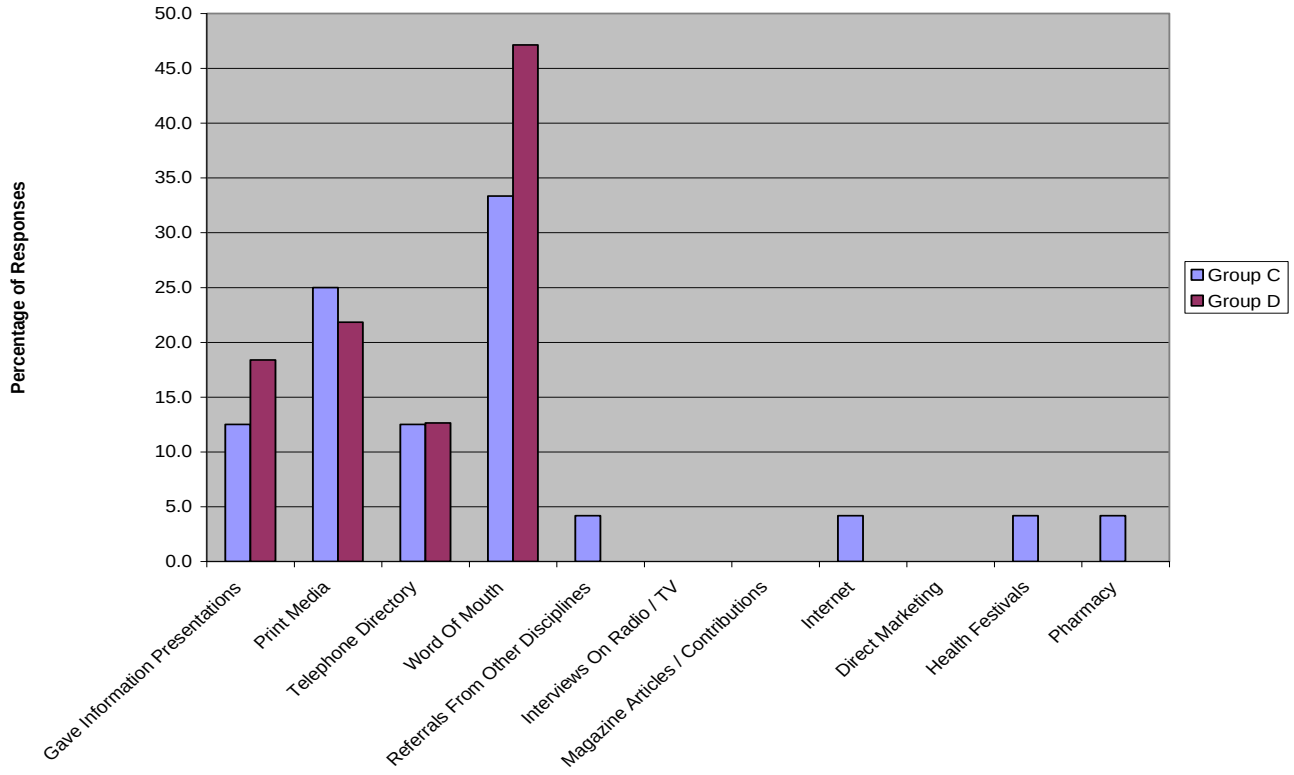


Figure 4.54 Graph showing comparison of the referral base- who respondents receive referrals from:



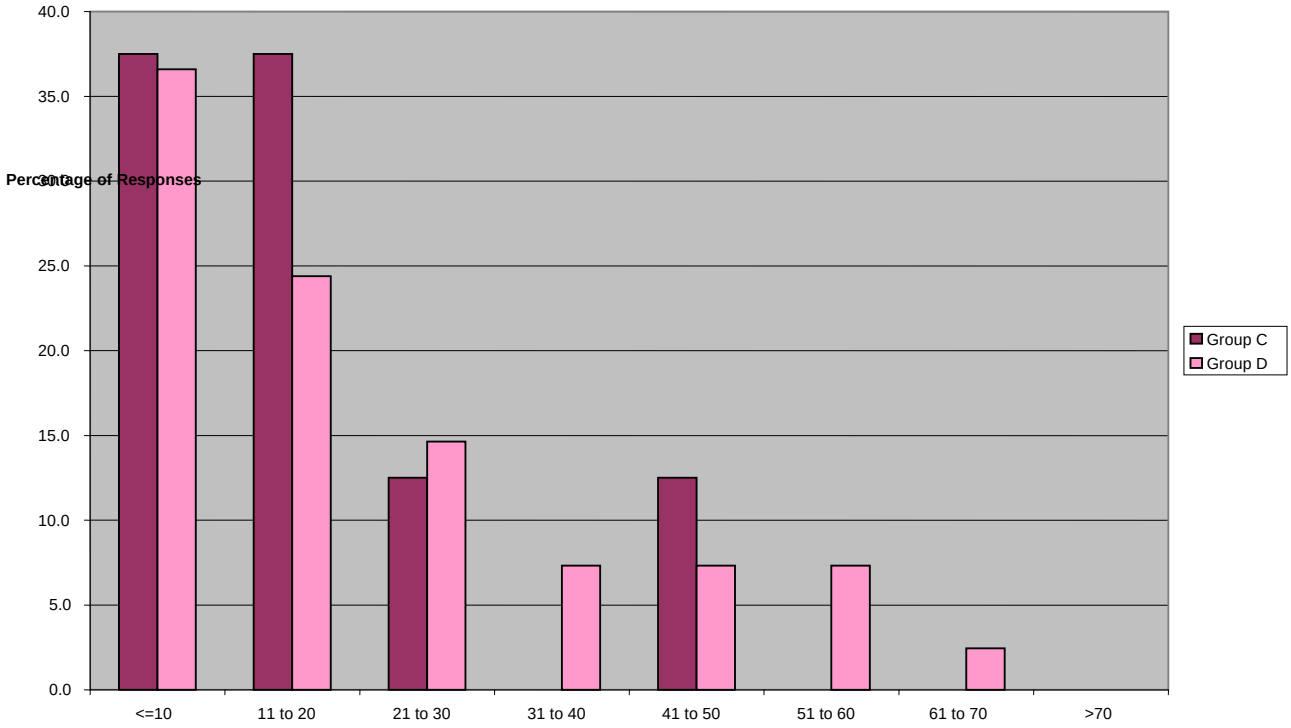
Group C and Group D appear fairly homogenous in terms of both who they refer to and which professionals they receive referrals from. Group D has more variety, although this may be due to the small size of the Group C (8 respondents).

Figure 4.55 Graph showing comparison of the source of patients:



It appears that Group D rely more on word of mouth and presentations than Group C. Group C has a wider variety of outreach avenues.

Figure 4.56 Graph showing comparison of the average numbers of patients seen per week:



Both Group C and Group D have most of the respondents seeing less than 20 patients a week. Group D has more respondents who see greater numbers of patients. This is explained by the fact that respondents from Group D have been in practice for longer than Group C on average and therefore have built up more of a patient base.

Figure 4.57 Graph showing comparison of financial considerations- average consultation rates: Initial appointment:

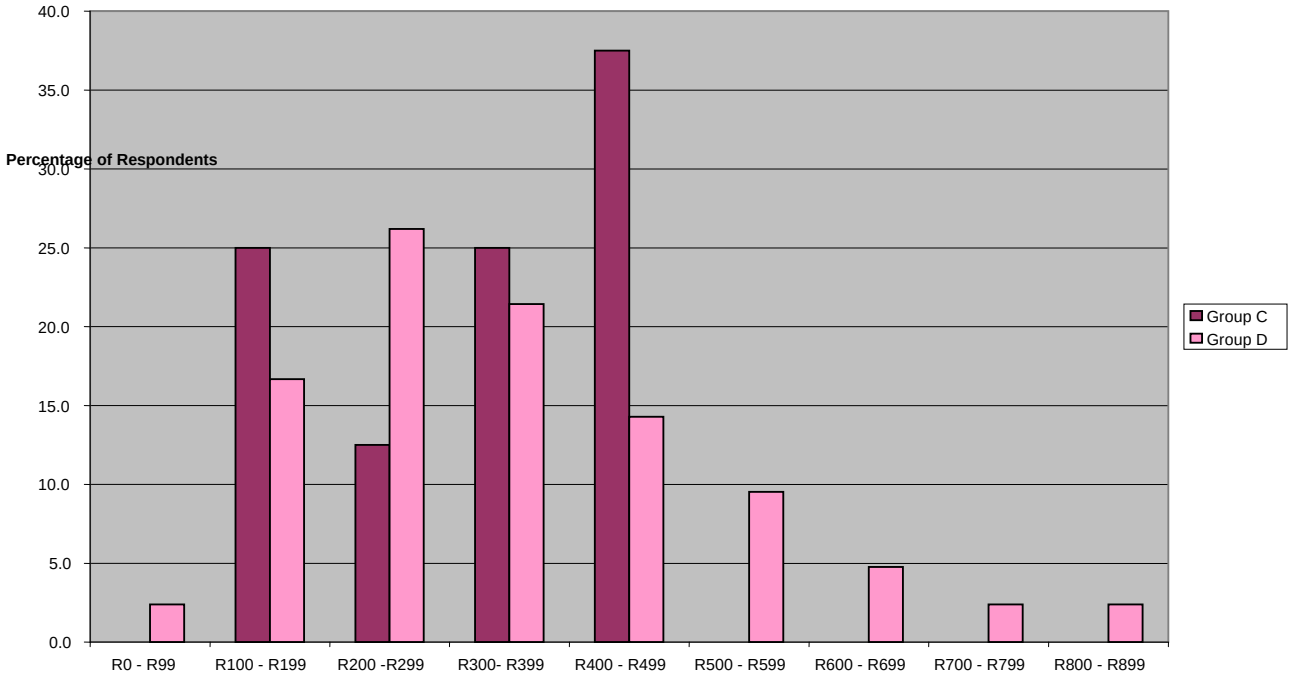


Figure 4.58 Graph showing comparison of the financial considerations- average consultation rates: Follow-up appointment:

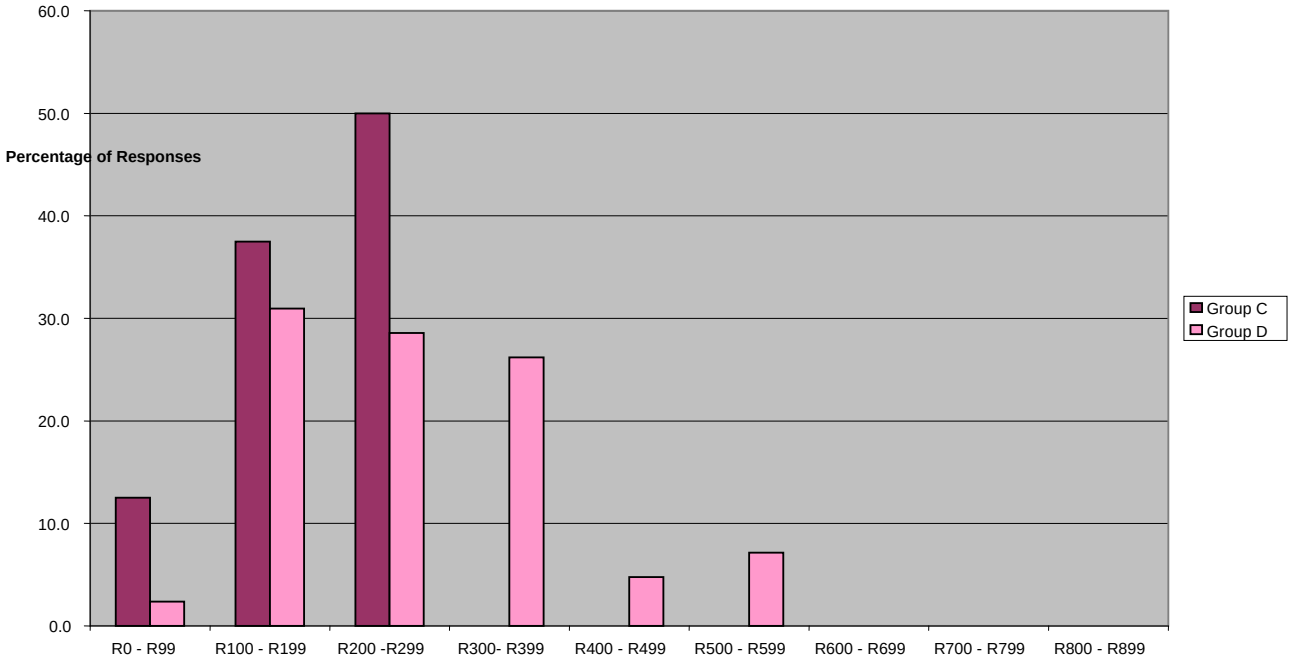
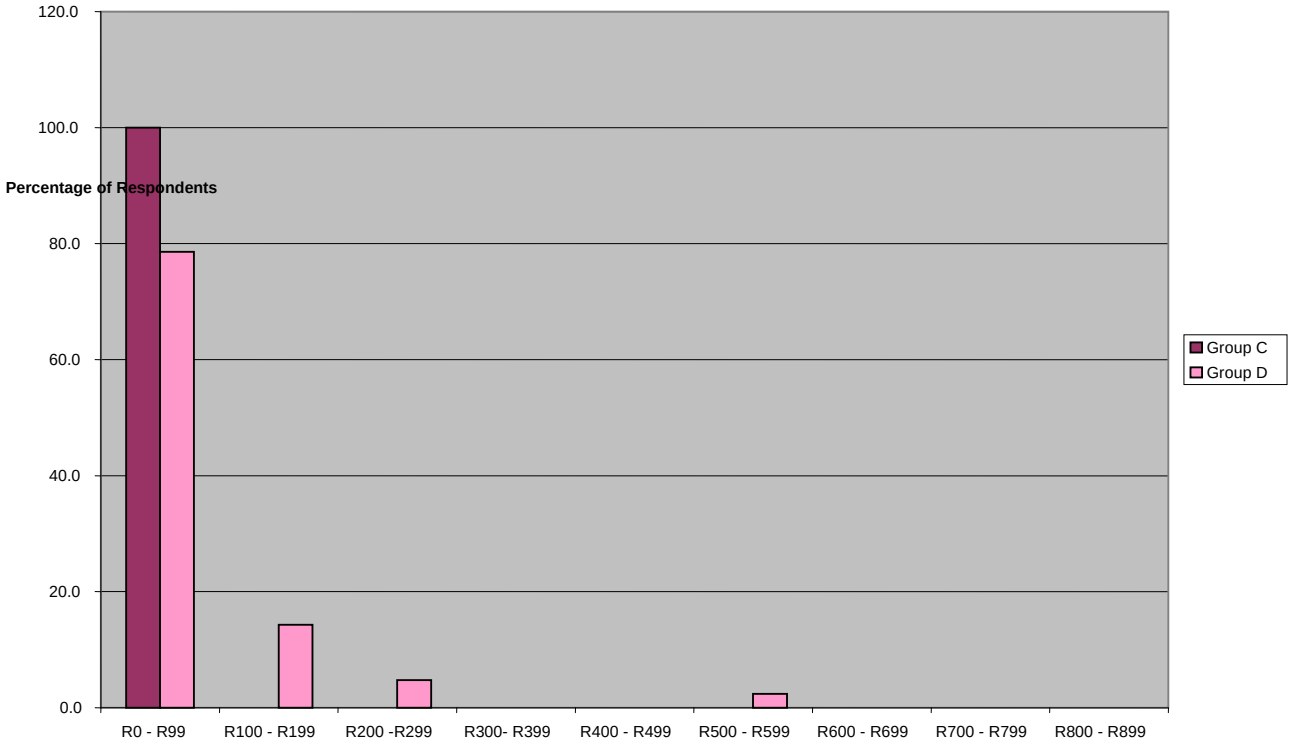


Figure 4.59 Graph showing comparison of the financial considerations- Average consultation rates: telephonic consultation:



There are more respondents from Group D in the higher fee categories. Both groups appear to charge significantly more for the first consultation.

Figure 4.60 Graph showing comparison of whether income is/was supplemented:

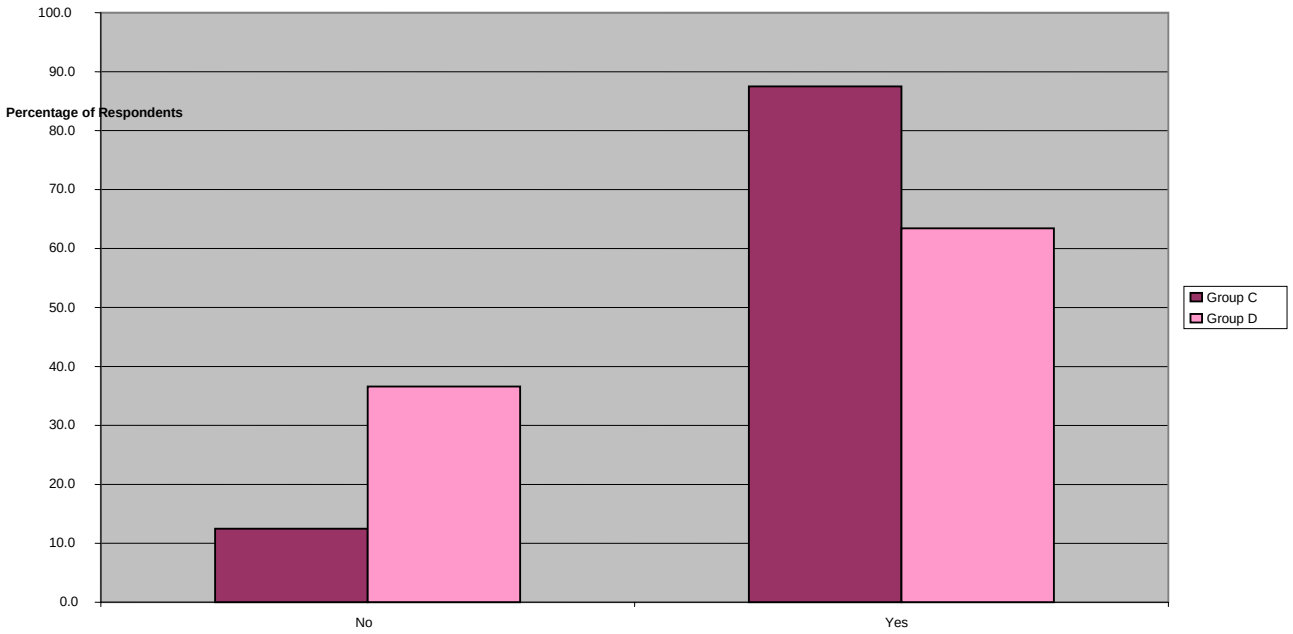


Figure 4.61 Graph showing comparison of how income is/was supplemented- within consultation:

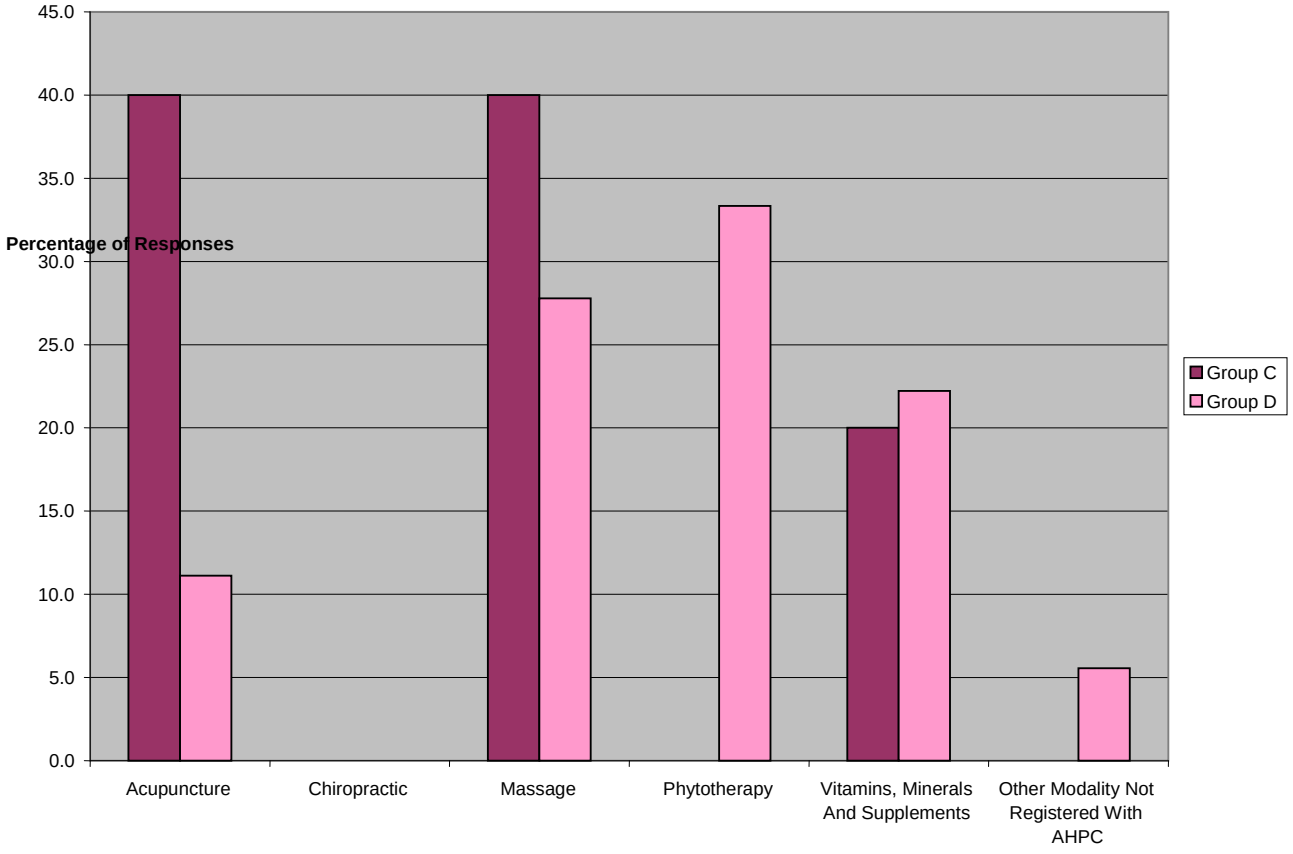
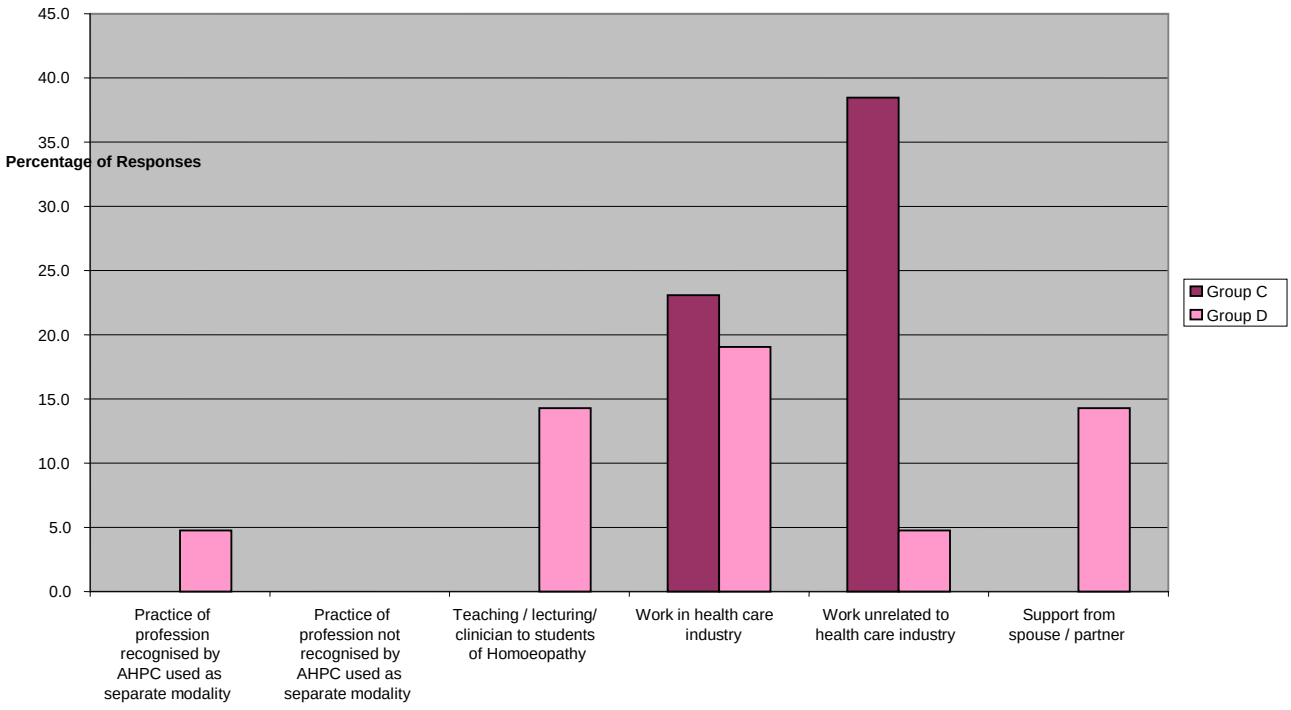
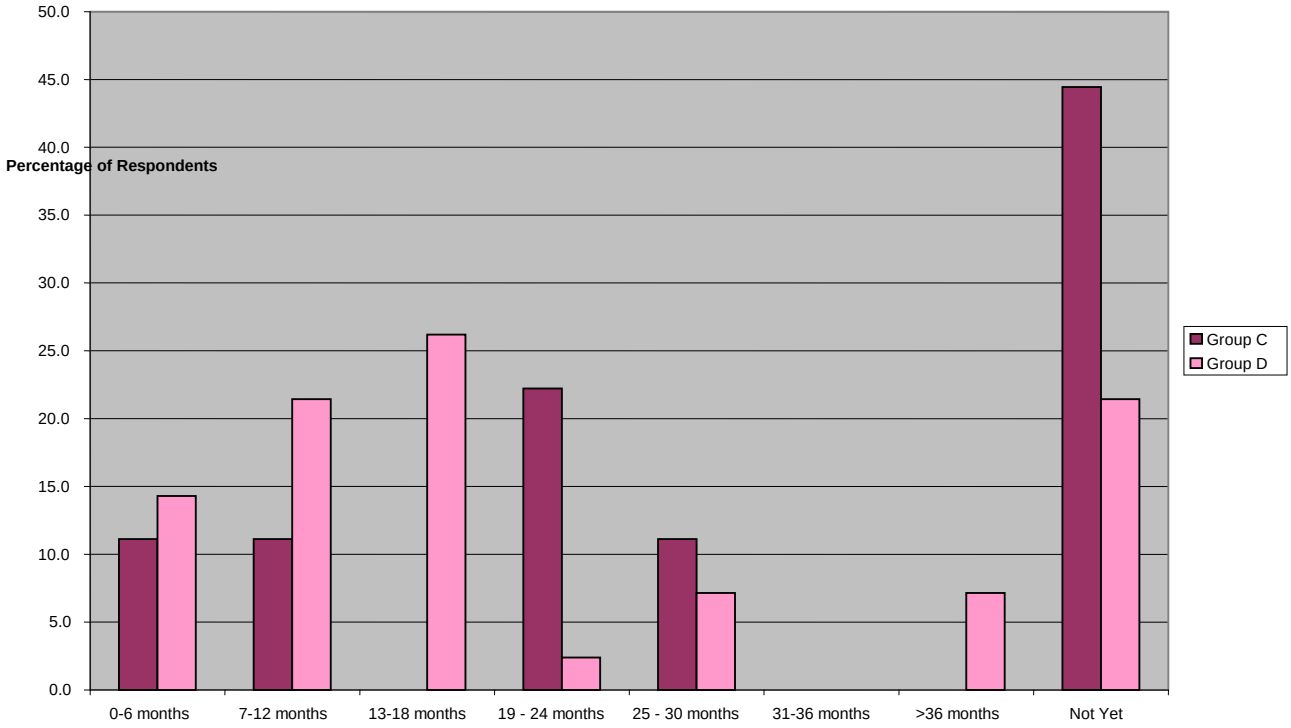


Figure 4.62 Graph showing comparison of how income is/was supplemented- outside the consultation:



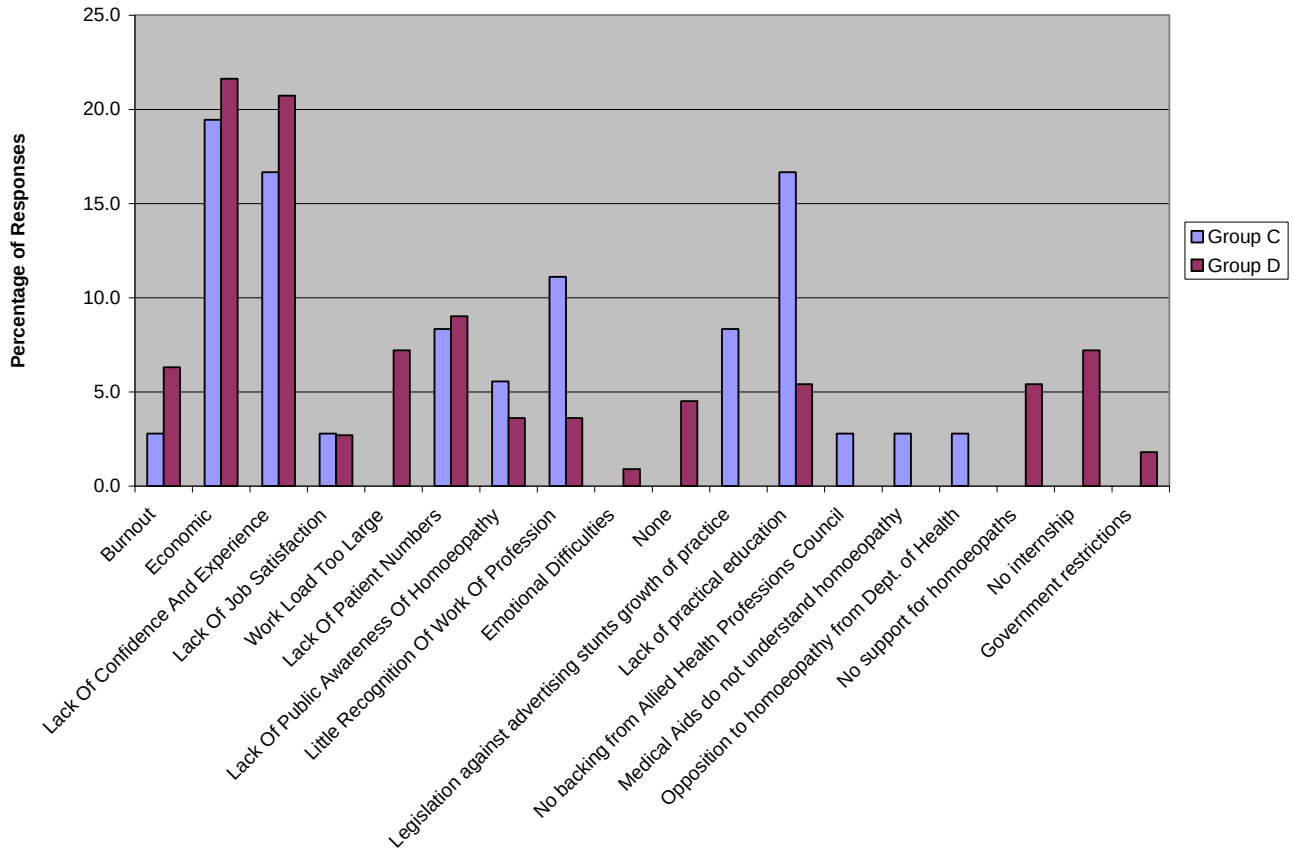
A lower proportion of respondents from Group D supplements income, however both within and outside the consultation Group D respondents rely on a wider range of options to supplement the consultation rate.

Figure 4.63 Graph showing comparison of the length of time before profit was shown:



Respondents from Group D reported making a profit sooner and more consistently than the Group C respondents. No firm conclusions can be drawn however, because the size of Group C is small in comparison to Group D.

Figure 4.64 Graph showing comparison of the difficulties experienced



Economic difficulties and lack of confidence and experience are the two most common difficulties experienced by both groups. Group C also felt a lack of practical education. This may have aggravated the confidence and skill issues. This is in agreement with the graph showing problems experienced with starting the practice.

Figure 4.65 Graph showing comparison of the use of own dispensary:

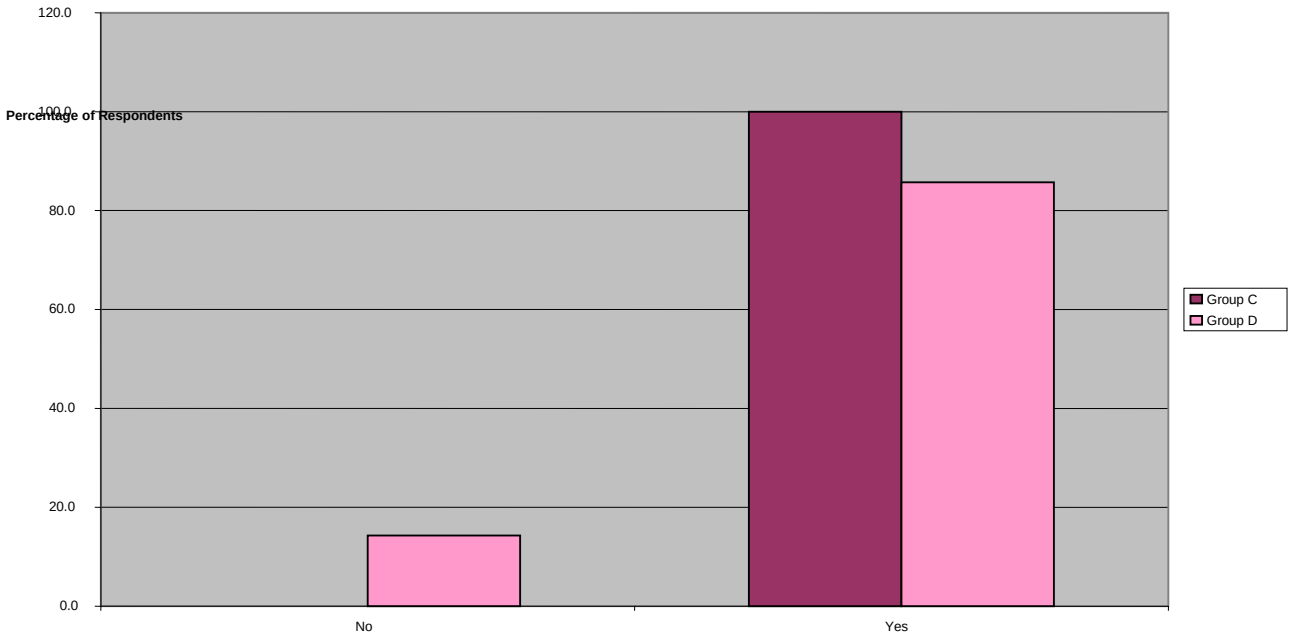
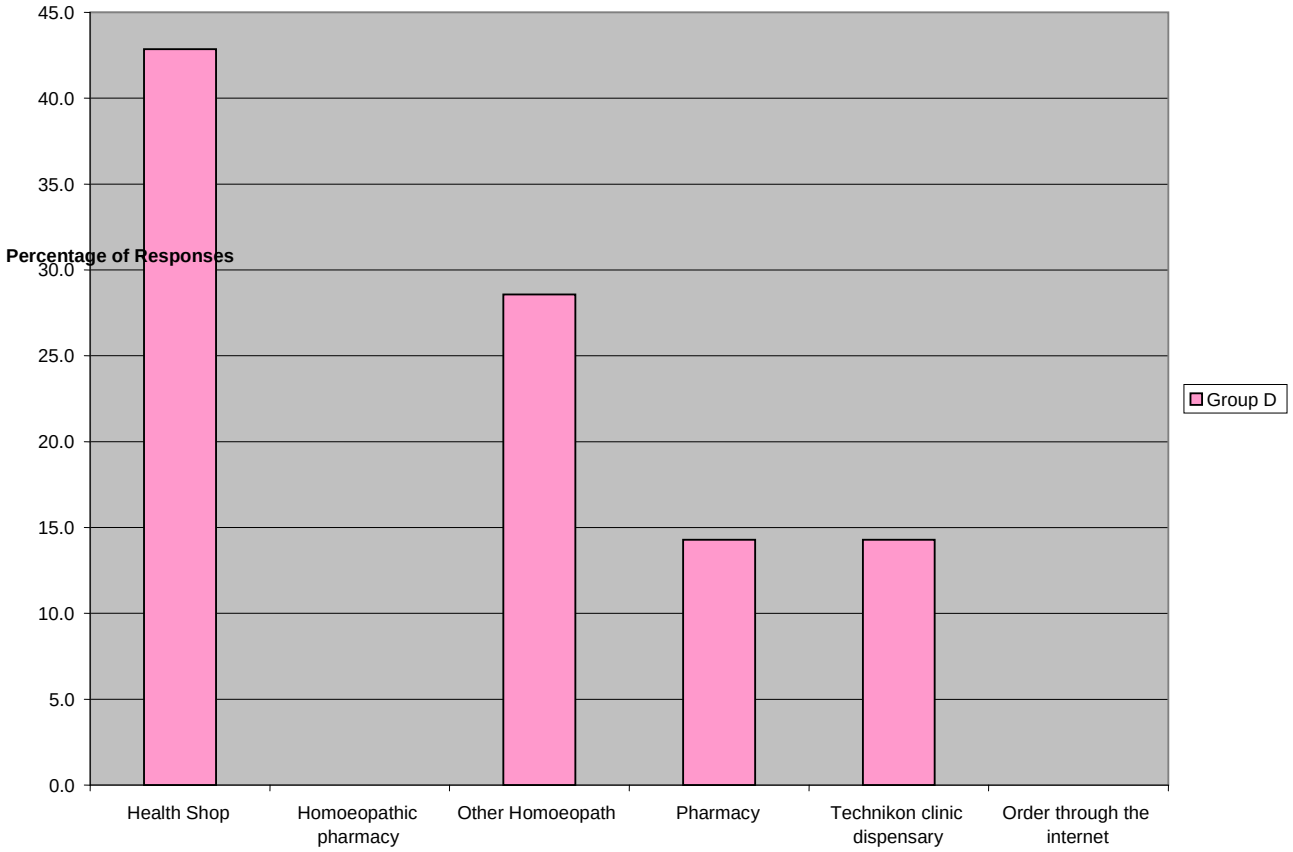
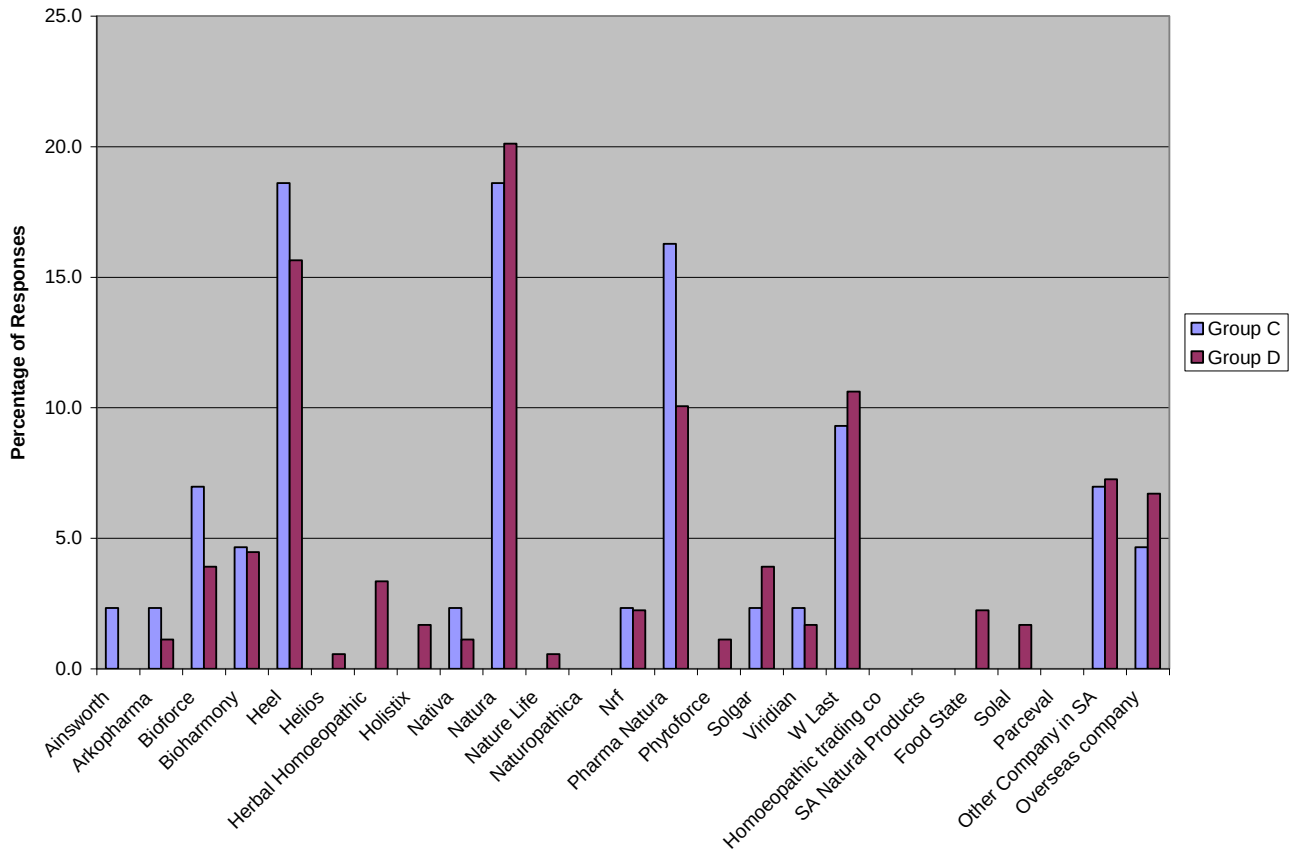


Figure 4.66 Graph showing comparison of the where remedies are obtained:



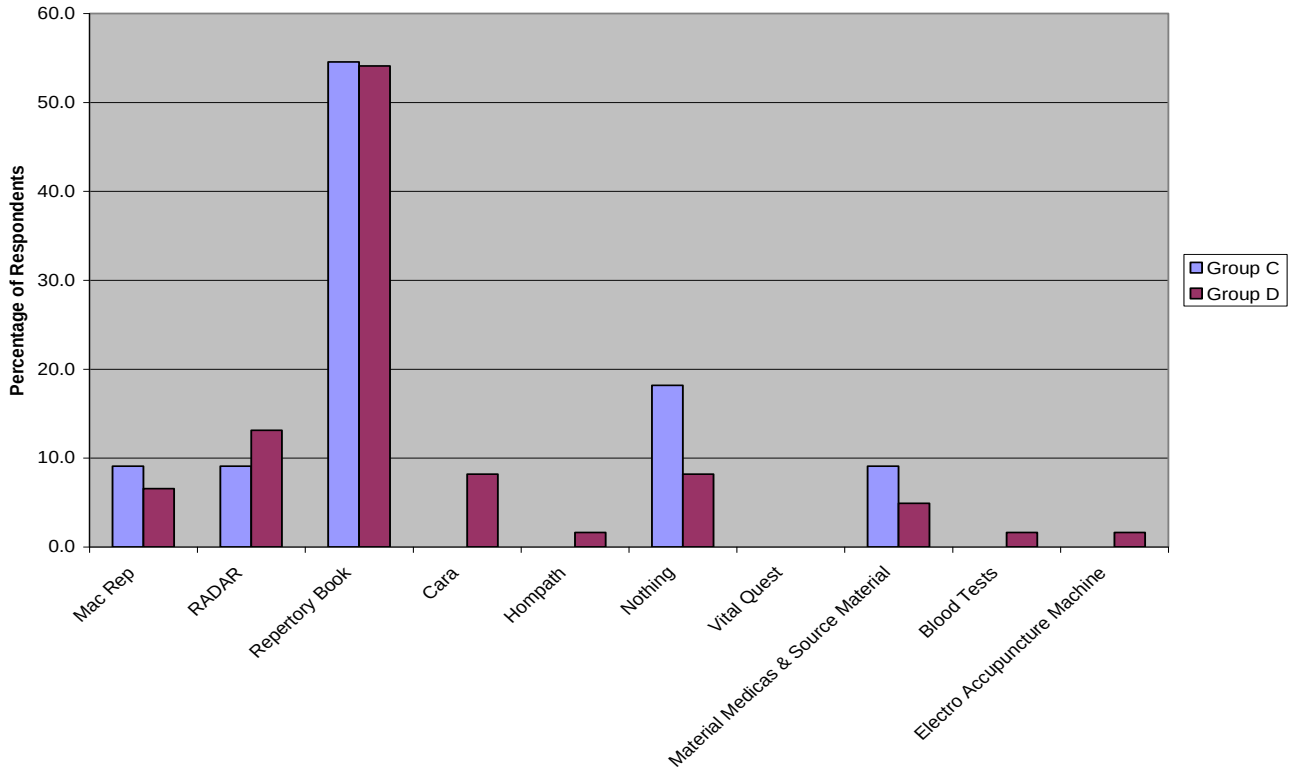
Most respondents had access to their own remedies. Where this was not the case, patients were referred mainly to health shops and other homeopaths.

Figure 4.67 Graph showing comparison of the respondents suppliers:



Group C and Group D appear to use mostly the same suppliers. The main suppliers are the main homeopharmaceutical companies in South Africa- Heel, W Last, Natura and Pharma Natura.

Figure 4.68 Graph showing comparison of the prescription aids used in the consultation:



By far the most used prescription aid was the repertory book.

Interesting to note is the far higher proportion of respondents in Group C who did not use any prescription aids.

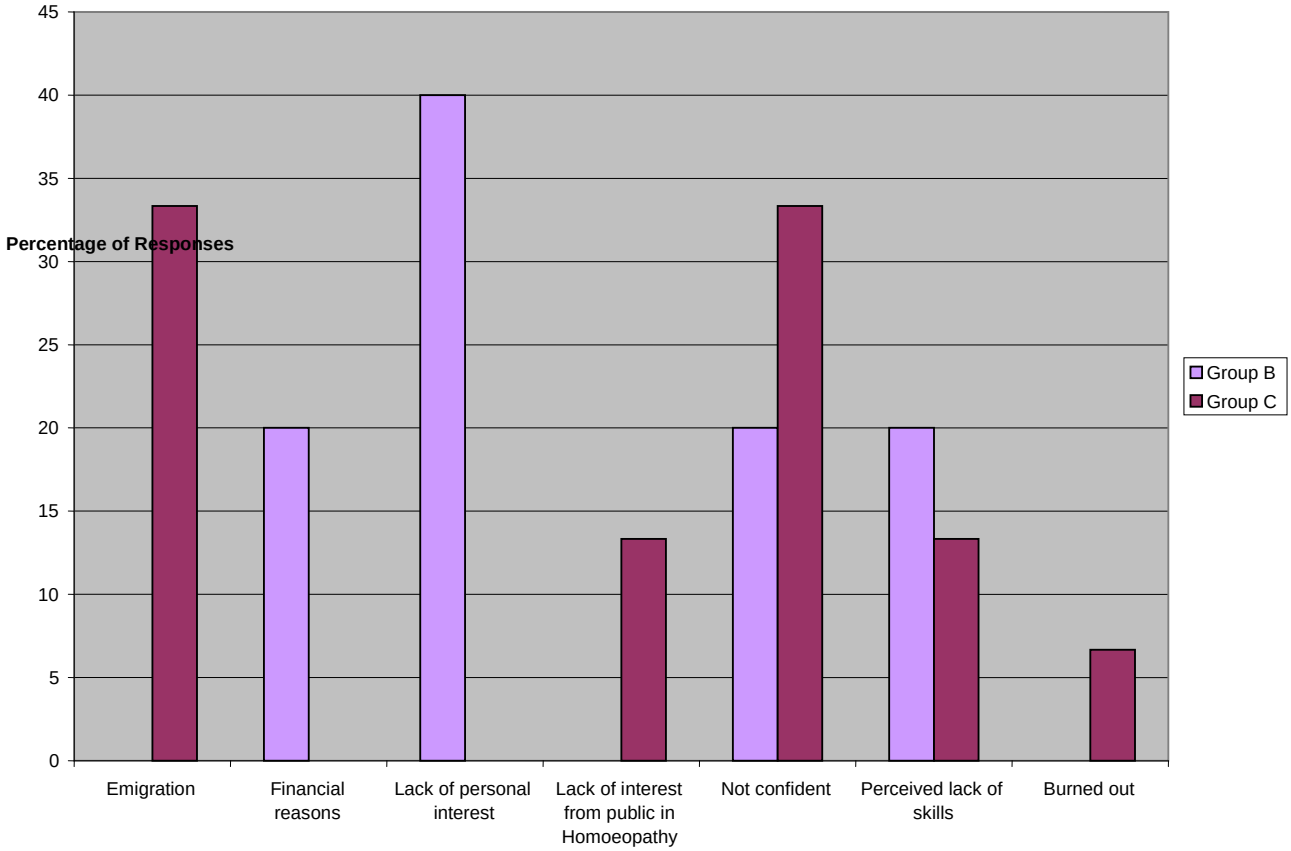
4.5.3 Group Comparisons: Groups B and C

The responses given by respondents from Sections B and C were compared graphically to highlight any differences for later statistical consideration. Responses to the questions common to these two groups were evaluated. These questions dealt with the following aspects of the homeopathic profession, common to currently non-practicing homeopaths (whether they had previously practiced or not):

- Reasons for not practicing (2.1 and 3.21)
- Current Occupation (2.2 and 3.22)
- Whether Homeopathic education is useful in current occupation and which aspects particularly (2.3, 3.23 , 2.3.1 and 3.21.1)
- Whether planning to practice again in the future and in what time frame.(2.9, 3.29, 2.9.1 and 3.29.1)

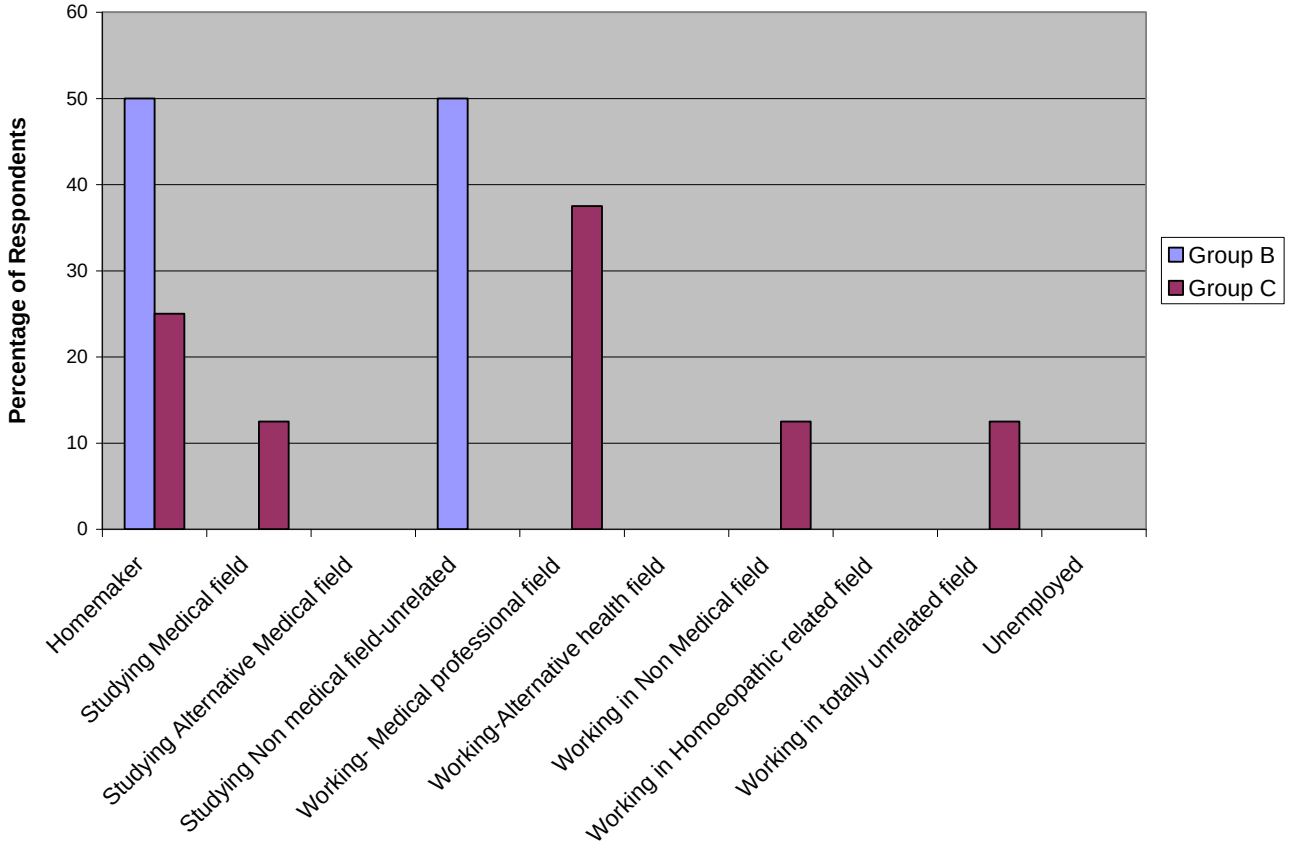
Due to the small size of both Group B and Group C (2 and 8 members respectively), these comparisons are in no way conclusive as to the general characteristics of these two population sub-groups.

Figure 4.69 Graph showing reasons for not practicing (2.1 and 3.21):



The reasons stated for not practicing appear to be fairly diverse and multi-factorial.

Figure 4.70 Graph Showing Current Occupation (2.2 and 3.22):

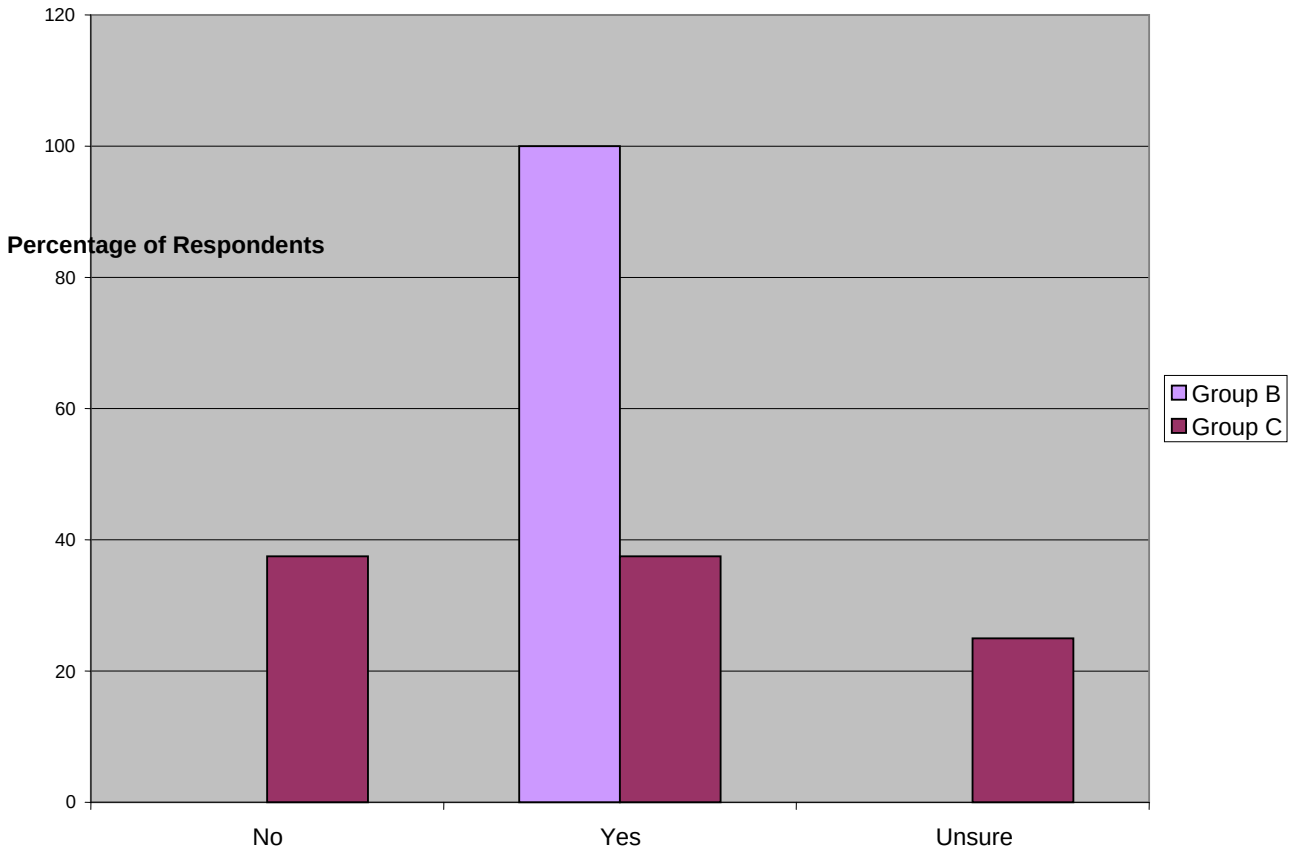


Studying again, and working in related fields are common sequelae to the decision not to practice homeopathy. A small percentage of respondents are working in a totally unrelated field.

Table 4.24 Table showing whether Homeopathic education is useful in current occupation and which aspects particularly (2.3, 3.23 , 2.3.1 and 3.21.1):

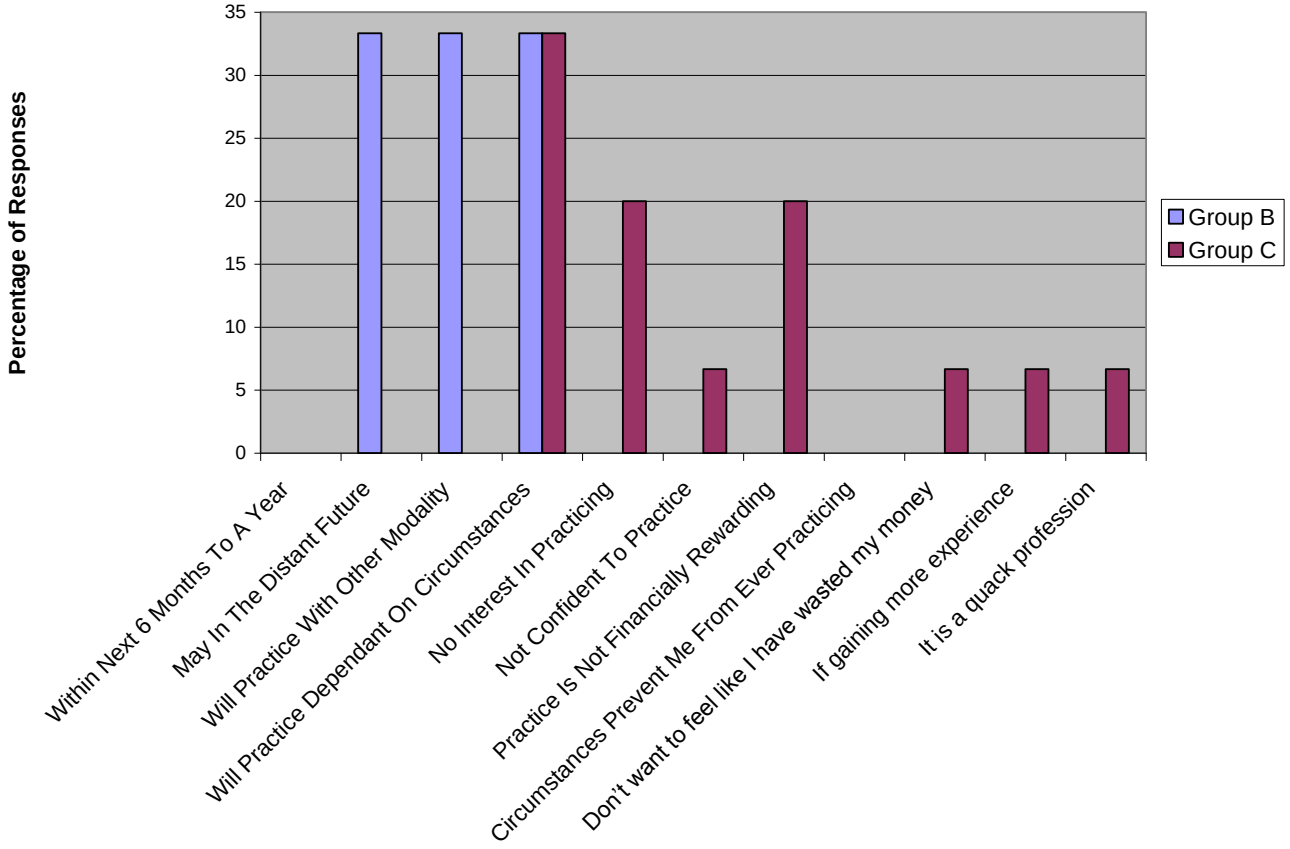
Homeopathic Education Useful in Current Occupation	Group B	Group C	Which aspects are found useful	
No	100	62.5		
Yes	0	37.5	Homeopathic Materia Medica And Clinical Applications Of Remedies	33.3%
			All Subjects / Aspects Of Education	66.6%

Figure 4.71 Graph Showing whether planning to practice again in the future:



Both the respondents in Group B indicate plans to practice at some point in the future. (They qualified in 2000 and 2001). The responses from Group C are more variable reflecting more diversity in experience and the fact that it is a larger group.

Figure 4.72 Graph showing details of plans to practice again:



Group B respondents are again more homogenous in the responses, while Group C has more diverse responses. This may indicate more experience (therefore more reasons/options) or a larger group.

Figure 4.73 Graph showing comparison of job satisfaction by group

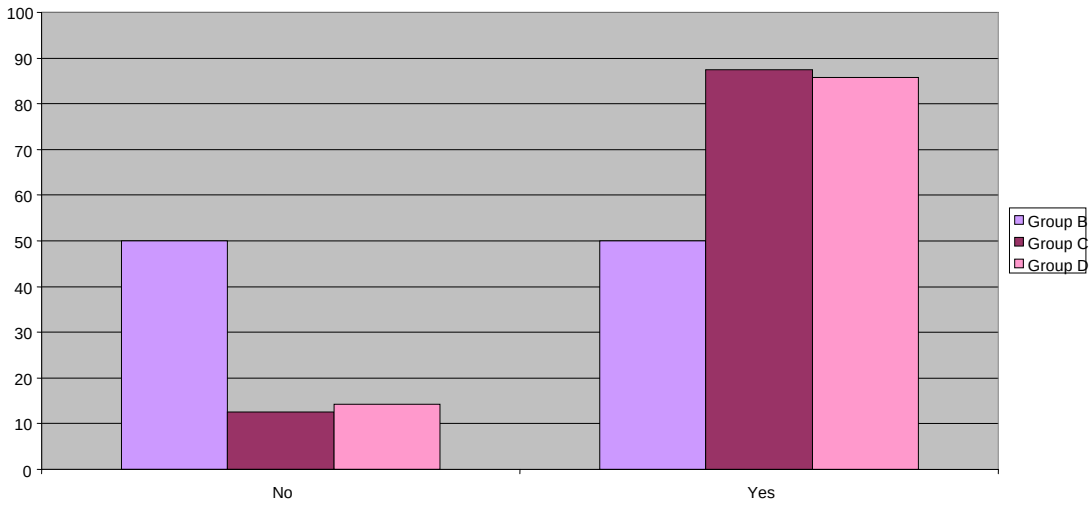


Figure 4.74 Graph showing whether respondents in each group were satisfied with their career choice

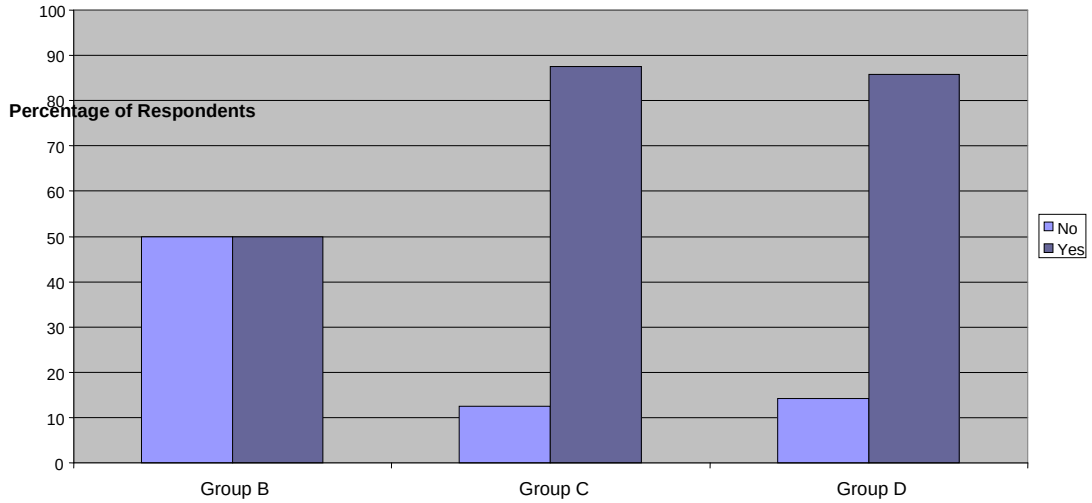
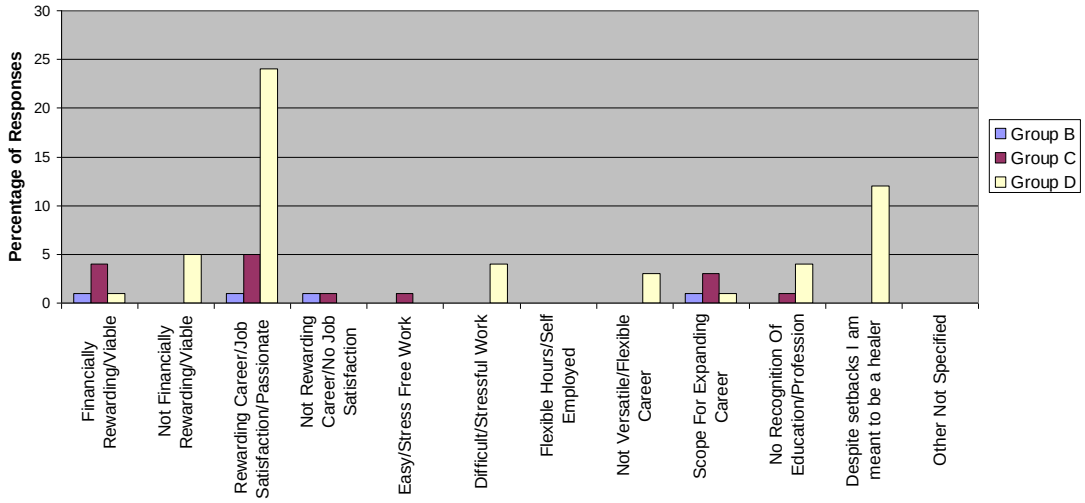


Figure 4.75 Graph showing comparison of components of respondents' job satisfaction by group



4.6 Correlation Analysis:

In terms of the objectives described in the introduction, the relationship between the demographic and academic variables and the responses given was explored. This was done by hypothesis testing using the Pearsons Chi Square Co-efficient (Phi and Cramers V as asymmetric measures) The level of significance was set at 5% i.e. p<= 0.05.The following demographic variables describing the population parameters were used in the correlation analyses. These were derived from the answers to questions in Part A of the questionnaire.

Table 4.25 Table showing variables describing population characteristics used in correlation analysis:

Variable	Population Characteristic Described
Gender	Gender of Respondent
Country	Geographic Location of Residence: Country
Prov	Geographic Location of Residence: Province
Municipal	Geographic Location of Residence: Municipal Area
Age	Age of Respondent
Ethnic	Ethnic Group of Respondent
Marital	Marital Status of Respondent
Dents	No. of Dependants relying on Respondent
First_lang	First Language preference of Respondent
Income	Income Category

Year_first reg	Year of First Registration at TWR
Age_first_reg	Age at First Registration at TWR
Edu_lev	Prior Education Level at Registration at TWR
Tme_tkn	Time taken to complete research dissertation
Interns	Whether Internship was undertaken
Years_comp	No of years taken to complete MTech
Year_qual	Year of Qualification
Age_qual	Age on Qualification
Edu_after	Level of Education attained after Graduating from TWR
Reg_brds	Professional Boards Registered

4.7 Hypothesis testing- All Graduates (Groups B, C and D)

Null hypothesis 1: There was no significant correlation between the demographic grouping of the respondents and their responses to issues common to all graduates (as described by responses to relevant questions in Section B, C and D).

Alternative hypothesis 1: There was a significant correlation between the demographic grouping of the respondents and their responses to issues common to all graduates (as described by responses to relevant questions in Section B, C and D).

Correlations between Demographic variables and the following factors/issues were assessed:

- Aspects of the homeopathic Education found lacking (Edu_Lack- Questions 2.4, 3.24, 4.22)
- Impressions of being supported by the homeopathic profession (Support- Questions 2.5, 3.25, 4.23)
- Experience of being part of the General Medical Profession (Accepted- Questions 2.6, 3.26, 4.24)
- Whether active interest still taken in homeopathy (Act_int- Questions 2.7, 3.27, 4.25)

- Whether the respondent would study homeopathy again if they had the choice (Study again), which centre this would have been studied at (Where), or if not why not as well as what they would have studied (What_instead) (Questions 2.10, 3.29, 4.27).
- Finally, if the respondent had left South Africa, reasons for this were explored across the three groups (Left SA - Questions 2.11, 3.31, 4.28).

Significant correlations were established i.e. H_0 was rejected for certain categories. The significant correlations are shown in Table 4.25 .

Table 4.26 Table Showing Test statistics for correlation of demographic variables and responses to common issues:

Variables	Statistical Measures			Nature of Relationship
	Pearson Chi Square (p-Value)	Significance Value (Z Values	Value of Asymmetric Measure (Phi)	
AResCountry * BCDEduLackin	15.618	0.000	0.548	Strong Correlation. Respondents who are resident in the UK are more likely not to view the education as lacking.
AResCountry * BCDPartMedProf	13.188	0.010	0.504	Strong correlation. Respondents resident in the UK are more likely to not feel part of or accepted within the medical profession.
AResProv * BCDEduLackin	16.625	0.020	0.577	Strong correlation. Respondents who are resident in Gauteng are slightly more likely not to view education as lacking.
AResMunic * BCDEduLackin	18.449	0.030	0.596	Strong correlation. Respondents resident in London or Woking are more likely not to view the education as lacking (ref first line of this table).
ANoDepndts*BCDSuppProf	8.560	0.036	0.406	Strong correlation. Respondents with more dependants are more likely to feel supported by the homeopathic profession.
AIncmAnnum * BCDIntstHom	17.377	0.026	0.578	Strong correlation. Respondents who fall into higher income categories are less likely to report an active interest in homeopathy outside of consultations. *May be due to no time if very busy seeing patients whereas the lower income groups have more time to explore further interest.*
AYearFstReg * BCDPartMedProf	28.588	0.012	0.741	Strong correlation. Respondents who registered more recently are less likely to feel part of or accepted by the medical profession.
AYearQual * BCDPartMedProf	28.665	0.012	0.742	Strong correlation. Respondents who qualified more recently are less likely to feel part of or accepted by the medical profession.

ABoardsReg * BCDPartMedProf	11.513	0.021	0.512	Strong correlation. Respondents who are members of the HSA are more likely to feel part of or accepted within the medical profession as a whole.
AEduLev * SatCareer	19.261	0.004	0.609	Strong correlation. Respondents with prior education in Arts or Social sciences are less likely to report being satisfied with career.

The statistical procedure was repeated while controlling for membership of one of the three groups (B- never practiced, C- not currently practicing, D- currently practicing). Statistical correlations were noted. Many are the same as the correlations above (Table 4.25). This is to be expected due to the numerical weighting of Group D (42) as opposed to Groups B and C (2 and 8 respectively).

Table 4.27 Table Showing Test statistics for correlation of demographic variables and Responses to common issues- controlling for groups:

Variables	Statistical Measures			Nature of Relationship	
	Pearson Chi Square (p-Value)	Significance Value (Z Values	Value of Asymmetric Measure (Phi)	Group Correlation Valid for	Correlation strength and Nature
AResCountry * BCDEduLackin * Group	12.274	0.002	0.541	Group D	Strong correlation. Respondents who are resident in the UK are more likely not to view the education as lacking.
AResCountry * BCDPartMedProf * Group	10.741	0.030	0.506	Group D	Strong correlation. Respondents resident in the UK are more likely to not feel part of or accepted within the medical profession.
ANoDepndts * BCDSuppProf * Group	8.000	0.046	1.000	Group C	Strong correlation. Respondents with more dependants are more likely to feel supported by the profession.
AIncmAnnum * BCDStdyHomAgain * Group	15.540	0.030	0.608	Group D	Strong correlations. Respondents who fall into the higher income groups are more likely to respond that they would study homeopathy again if given the choice.
AEduLev * BCDStdyHomAgain * Group	14.109	0.028	0.580	Group D	Strong correlation. Respondents who had a prior qualification were more likely to respond that they would study homeopathy again if given the choice.
AYearQual * BCDPartMedProf * Group	24.833	0.036	0.769	Group D	Strong correlation. Respondents who qualified more recently are more likely

					to not feel part of or accepted within the medical profession.
ABoardsReg * BCDPartMedProf * Group	9.524	0.049	0.507	Group D	Strong correlation Respondents who are registered with the HSA are more likely to feel part of or accepted within the medical profession.
AEduLev * SatCareer * Group	21.972	0.001	0.723	Group D	Strong correlation. Respondents with prior education in Arts or Social sciences are less likely to report being satisfied with career i.e. homeopathy.

Using the complete sample as an indicator of the current population of homeopathic graduates of TWR, a bivariate correlation procedure was performed on the primary demographic variables. This serves to highlight common groupings/correlations within the population as a whole. These primary variables are contained in Table 4.27 below.

Table 4.28 Table showing primary demographic variables used to explore the population parameters of the population of homeopathic graduates of TWR:

Variable	Population Characteristic Described
Gender Age	Gender of Respondent Age of Respondent
Ethnic	Ethnic Group of Respondent
Marital	Marital Status of Respondent
Depndts	No. of Dependants relying on Respondent
First_lang	First Language preference of Respondent
Income	Income Category
Year_first reg	Year of First Registration at TWR
Age_first_reg	Age at First Registration at TWR
Interns	Whether Internship was undertaken
Years_comp	No of years taken to complete MTech

Null hypothesis 2: There was no significant correlation between any of the primary variables describing demographic grouping of the respondents.

Alternative hypothesis: There were significant correlations between variables describing demographic grouping of the respondents.

Significant correlations were established i.e. H_0 was rejected for certain categories. The significant correlations are shown in Table 4.29.

Table 4.29 Table showing Correlations between variables describing the population of homeopathic graduates (significant values are italicised bold):

		AGender	AAgeCat	AEthnic	AMartlStats	ANoDepndts	AfstLang	AIncmAnnum	AYearFstReg	AAGeFstReg	AIntrnshp	AYearsCo4
AGender	Pearson Correlation	1	.254	.046	-.121	.115	.160	***.428***	-.074	.209	-.066	-.154
	Z-value		.075	.753	.404	.425	.268	***.002***	.610	.145	.648	.287
AAgeCat	Pearson Correlation	.254	1	.148	-.022	-.059	-.139	.074	-.014	***.894***	-.017	.023
	Z-value	.075		.304	.881	.682	.334	.610	.923	***.000***	.905	.876
AEthnic	Pearson Correlation	.046	.148	1	.038	-.095	-.250	-.052	-.028	.140	-.107	-.035
	Z-value	.753	.304		.792	.510	.080	.718	.848	.333	.458	.809
AMartlStats	Pearson Correlation	-.121	-.022	.038	1	***-.543***	-.265	.092	-.002	-.111	.099	-.331
	Z-value	.404	.881	.792		***.000***	.063	.526	.987	.441	.495	.019
ANoDepndts	Pearson Correlation	.115	-.059	-.095	***-.543***	1	.133	.245	***-.312***	-.051	-.035	.255
	Z-value	.425	.682	.510	***.000***		.356	.087	***.028***	.723	.811	.074
AfstLang	Pearson Correlation	.160	-.139	-.250	-.265	.133	1	-.023	-.210	-.228	.161	.155
	Z-value	.268	.334	.080	.063	.356		.872	.144	.111	.264	.282
AIncmAnnum	Pearson Correlation	***.428***	.074	-.052	.092	.245	-.023	1	***-.352***	-.003	.266	-.056
	Z-value	***.002***	.610	.718	.526	.087	.872		***.012***	.981	.062	.697
AYearFstReg	Pearson Correlation	-.074	-.014	-.028	-.002	***-.312***	-.210	***-.352***	1	.248	***-.529***	***-.439***
	Z-value	.610	.923	.848	.987	***.028***	.144	***.012***		.082	***.000***	***.001***
AAGeFstReg	Pearson Correlation	.209	***.894***	.140	-.111	-.051	-.228	-.003	.248	1	-.142	-.077
	Z-value	.145	***.000***	.333	.441	.723	.111	.981	.082		.324	.596
AIntrnshp	Pearson Correlation	-.066	-.017	-.107	.099	-.035	.161	.266	***-.529***	-.142	1	***.284***
	Z-value	.648	.905	.458	.495	.811	.264	.062	***.000***	.324		***.045***
AYearsCo4	Pearson Correlation	-.154	.023	-.035	***-.331***	.255	.155	-.056	***-.439***	-.077	***.284***	1
	Z-value	.287	.876	.809	***.019***	.074	.282	.697	***.001***	.596	***.045***	

Table 4.30 Table showing schematic of correlations between primary demographic variables. Non significant values are omitted while significant values are bold and italicised:

		AGender	AAgeCat	AEthnic	AMartlStats	ANoDepndts	AfstLang	AIncmAnnum	AYearFstReg	AAGeFstReg	AIntrnshp	AYearsCo4
AGender	Pearson Correlation	1						***.428***				
	Z-value							***.002***				
AAgeCat	Pearson Correlation		1							***.894***		
	Z-value									***.000***		
AEthnic	Pearson Correlation			1								
	Z-value											
AMartlStats	Pearson Correlation				1	***-.543***						
	Z-value					***.000***						
ANoDepndts	Pearson Correlation				***-.543***	1			***-.312***			
	Z-value				***.000***				***.028***			
AfstLang	Pearson Correlation						1					
	Z-value											
AIncmAnnum	Pearson Correlation	***.428***						1	***-.352***			
	Z-value	***.002***							***.012***			
AYearFstReg	Pearson Correlation					***-.312***		***-.352***	1		***-.529***	***-.439***
	Z-value					***.028***		***.012***			***.000***	***.001***
AAGeFstReg	Pearson Correlation		***.894***							1		
	Z-value		***.000***									
AIntrnshp	Pearson Correlation								***-.529***		1	***.284***
	Z-value								***.000***			***.045***
AYearsCo4	Pearson Correlation				***-.331***				***-.439***		***.284***	1
	Z-value				***.019***				***.001***		***.045***	

4.8 Hypothesis testing- Non-Practicing Graduates whether not currently practicing or never practiced (Groups B and C):

Due to the small number of members in group B and C (2 and 8 respectively) no comparison/correlation could be performed. The non-parametric tests require greater sample size to be meaningful.

4.9 Hypothesis testing- Graduates who have practiced (whether or not currently practicing) (Groups C and D)

Null hypothesis 1: There was no significant correlation between the demographic grouping of the respondents and their responses to issues common to graduates who have practiced.

Alternative hypothesis 1: There was a significant correlation between the demographic grouping of the respondents and their responses to issues common to Graduates who have practiced.

Correlations between demographic variables and the following factors/issues were assessed:

- Length of time between qualification and practice (Long_Prac) (Questions 3.1, 4.1);
- Age practice was started (Age_Strt) (Questions 3.2, 4.2);
- Number of practices running (or run) (How_Many_Pracs) (Questions 3.4, 4.4);
- Whether the Respondents found it easy to start (Easy) (Questions 3.6, 4.6);
- Whether respondents practice/d part-time of full-time (Prt_Full) (Questions 3.8, 4.8);
- Fee charged for an initial consulatation (Cost1), fee charged for a follow-up consultation (Cost2) and fee charged for a telephone consultation (Cost3) and how long it took to reach a profit (Prof_Long) (Questions 3.14, 3.15, 3.16, 3.17, 4.15, 4.16, 4.17, 4.18);
- Whether the respondent owned their own dispensary or not (Disp) (Questions 3.18, 3.19, 4.19, 4.20);

- Significant correlations were established i.e. H_0 was rejected for certain categories. The significant correlations are shown in Table 4.30

Trivial correlations were not included i.e. residence in a country (or province or municipal area) correlates highly with practicing in that country.

Table 4.31 Table Showing Significant correlations between the variables describing population characteristics and responses to issues common to graduates who have practiced:

Variables	Statistical Measures			Nature of Relationship	
	Pearson Chi Square (p-Value)	Significance Value (Z Values	Value of Asymmetric Measure (Phi)	Cramers V	Correlation strength and Nature
AResCountry * cdOwnDisp	9.102	0.011	0.427	0.427	Strong correlation. Respondents who are resident overseas are more likely not to own their own dispensary.
AGender * cdFTPT	11.650	0.009	0.483	0.483	Strong correlation. Males were more likely to be working/have worked full time.
AAgeCat * cdAge_Start	94.796	0.000	1.377	0.616	Strong correlation. Older respondents were more likely to have started at an older age.
AAgeCat * cdEasyStart	13.306	0.021	0.516	0.516	Strong correlation. Respondents in the mid age categories were more likely to find it easier to start.
AMartlStats * cdLong_Prac	35.490	0.034	0.843	0.596	Strong correlation. Divorced respondents were more likely to have been in practice longer.
ANoDepndts * cdFTPT	33.209	0.000	0.815	0.471	Strong correlation. Respondents with fewer dependants were more likely to practice full time.
AfstLang * cdAge_Start	13.298	0.039	0.516	0.516	Strong correlation. English speaking respondents were more likely to start at a younger age.
AfstLang * cdHow_Many_Pracs	7.656	0.022	0.391	0.391	Strong correlation. English speaking respondents were more likely to have a second practice.
AfstLang * cdWhereProv	12.340	0.030	0.512	0.512	Strong correlation. English speaking respondents were more likely to be practicing in Gauteng.
AIncmAnnum * cdTot_Time (Banded)	86.344	0.033	1.314	0.465	Strong correlation. Respondents in the higher income categories were more likely to have been practicing for a greater length of time.
AYearFstReg * cdTot_Time (Banded)	83.075	0.011	1.289	0.487	Strong correlation. Respondents who first registered earlier, were more likely to have been in practice for longer.

AYearFstReg * cdWhereProv	50.381	0.045	1.035	0.463	Strong correlation. Respondents who first registered earlier were more likely to be practicing in Gauteng. Respondents who first registered later were more likely to be practicing in different areas i.e. more distributed).
AYearFstReg * cdWhereMunc	78.846	0.024	1.269	0.479	Strong correlation. Respondents who first registered earlier were more likely to be practicing in Johannesburg or Pretoria. Respondents who first registered later were more likely to be practicing in different areas i.e. more distributed).
AAGeFstReg * cdAge_Start	212.917	0.000	2.061	0.842	Strong correlation. Respondents who first registered earlier were more likely to start practicing earlier.
AEduLev * cdAge_Start	93.750	0.000	1.369	0.559	Strong correlation. Respondents with prior qualifications were more likely to start at a later age.
AIntrnshp * cdTot_Time	15.993	0.042	0.566	0.566	Strong correlation. Respondents who undertook some form of internship were more likely to have taken a longer total time to complete their qualification.
AIntrnshp * cdFTPT	10.923	0.012	0.467	0.467	Strong correlation. Respondents who undertook some form of internship were more likely to be or have been practicing full-time.
AYrsCompDeg * cdLong_Prac	95.637	0.010	1.383	0.565	Strong correlation. Respondents who took longer to complete their degrees were more likely to have been in practice for longer.
AYearQual * cdTot_Time	87.369	0.005	1.322	0.005	Strong correlation. Respondents who qualified more recently were more likely to have taken less time to complete the qualification in total.
AYearQual * cdOwnDisp	14.357	0.045	0.536	0.536	Strong correlation. Respondents who qualified more recently were less likely to have their own dispensaries.
AAgeQual * cdAge_Start	266.658	0.00	2.309	0.943	Strong correlation. Respondents who were qualified at a younger age were more likely to have started practice at a younger age.

Table 4.32 Table Showing Significant correlations between demographic variables and the financial factors involved in practicing Homeopathy (Fees charged and number of patients seen):

	Pearson Chi-Square	z-value	Phi	Cramers V	Nature of Relationship
AResCountry * cdFeeFollowUp (Banded)	27.609(a)	0.00	0.74	0.53	Strong correlation. Respondents who are resident in the UK or UAE are more likely to charge more (in Rand value) for the first consultation.
AResProv * cdPtsWeek (Banded)	85.399(a)	0.00	1.35	0.55	Strong correlation. Respondents who are resident in the UK or UAE are more likely to charge more (in Rand value) for the follow up consultation.
AResProv * cdFeeFollowUp (Banded)	43.633(a)	0.03	0.95	0.48	Strong correlation. Respondents resident in Surrey and Mpumalanga more likely to report higher numbers of patients per week.
AResMunic * cdPtsWeek (Banded)	73.932(a)	0.00	1.25	0.51	Strong correlation. Respondents who are resident in larger municipal areas have a wider distribution of patients per week. Relatively fewer see large numbers per week.
AResMunic * cdFeeTel (Banded)	25.655(a)	0.03	0.73	0.52	Strong correlation. Residents of overseas municipal areas are more likely to charge more for telephone consultations.
AGender * cdPtsWeek (Banded)	14.115(a)	0.03	0.54	0.54	Strong correlation. Females are more likely to see more patients per week.
AMartlStats * cdFeeFirst (Banded)	32.315(a)	0.00	0.80	0.57	Strong correlation. Married respondents are more likely to charge more for a first consultation than single or divorced respondents.
ANoDepndts * cdPtsWeek (Banded)	34.208	0.012	0.836	0.482	Strong correlation. Respondents with more dependants are more likely to see more patients in a week.
AIncmAnnum * cdPtsWeek (Banded)	68.801(a)	0.03	1.18	0.48	Strong correlation. Respondents who fall into higher income categories are more likely to see more patients in a week.
AYearFstReg * cdFeeFollowUp (Banded)	42.566(a)	0.04	0.92	0.46	Strong correlation. Patients first registered between 1995 and 1997 are more likely to charge higher rates for follow-up consultations.
AEduLev * cdFeeFirst (Banded)	62.436(a)	0.02	1.12	0.46	Strong correlation. Respondents with no prior education were more likely to charge more for the first consultation.
AYrsCompDeg * cdFeeFirst (Banded)	74.867(a)	0.00	1.22	0.50	Strong correlation. Respondents who took longer to complete their degree were more likely to charge less for the first consultation.

CHAPTER 5:

DISCUSSION

5.1 INTRODUCTION

For a future comparative result to be drawn up between the results of this study and the results of the Babaletakis (2006) study this chapter will deal with very similar issues. Once the results were analysed it was deemed relevant as the studies appeared to highlight the same existing issues facing the profession. In this chapter, three aspects of Homoeopathy in general will be discussed as it affects the TWR Homoeopathic graduate and possible future graduates.

- The general demographics of the graduates;
- Homoeopathic education, graduate satisfaction thereof and the choice for Homoeopathy as a career;
- Homoeopathy as a profession and its future within South Africa.

Issues relevant to each area will be according to the statistical data shown in Chapter 4.

As per survey format the following groups are referred to in this chapter:

- Demographic section (Part A), completed by all respondents;
- Qualified graduates who have never practiced (Group B);
- Qualified graduates who have practiced but are not currently practicing (Group C);
- Qualified graduates currently practicing (Group D).

Comparatives are considered between Groups B, C and D according to the statistical data obtained.

5.2 SAMPLE CHARACTERISTICS

The population that the research aimed to describe comprised graduates of the TWR M.Tech. Homoeopathy programme. There were 120 graduates, 89 of those were contactable, 58 (65%) replied with viable responses (Table 4.1). This sample size is adequate to assume that the data is valid and representative of the TWR Homoeopathic graduates up until 2004. Anecdotal evidence suggested that the majority of graduates do not practice after graduating. Babaletakis (2006) showed that this is not true as 58 (67%) of the graduate sample is currently in practice. This study reinforced that with 78% of the graduates in practice. The researcher does acknowledge the fact that the graduates, who were readily contactable and listed, considering the sources of contact information, were practicing graduates. Only 3% have never practiced. The group that is most interesting is the 15% of graduates who practiced before, but are now not practicing. This shows that there is an interest in starting a practice, but due to numerous factors described in this chapter, this is not sustainable.

5.3 DEMOGRAPHICS

This section analyses information concerned with: gender, age, ethnicity, and marital status, number of dependants, language preference, and geographical distribution. This is contrasted with the practice status of the different groups. This was deemed to be important, as it gives and idea as to the factors that prevent practice or could highlight factors that result in financial difficulties.

5.3.1 Gender

This research supports the anecdotal evidence that there is a greater proportion of female Homoeopaths world wide, as there were 38 (73%) females in this study (Fig. 4.3).

The comparative gender composition of the three groups shows that males and females equally are more likely to never practice, but once in practice females are more likely to continue to practice (78 %) (Fig. 4.4).

By comparison, Babaletakis (2006) showed that the gender composition of the three groups shows that females are more likely to never practice (77.78%), but once in practice females are more likely to continue to practice (67.28 %).

5.3.2 Age / Maturity

Majority of the graduates of the total sample were between the ages of 26 and 35 (Fig. 4.5). The retrospective nature of this study over 7 years may have resulted in this, as presumably most students would have entered the TWR programme at school leaving age (Fig. 4.19).

The comparative age distribution (Fig 4.5) reflects that group B consisting of graduates who have never practiced appears to consist of individuals in younger age categories. Both group C and D consist of individuals in older categories. This may reflect the fact that the younger graduates are less likely to commit and settle down into starting a practice, whether successful or not. The researcher does acknowledge however that the low number of respondents in group D (8) and group C (2) reduce the value of this conclusion. If they continue not to practice as time moves on, future studies may reflect a shift in this as these people age. Age does appear to be a factor that influences decision to practice. Those who have practiced (Groups C and D) are close in percentages of age, with the latter having a higher “tail end” reaching between ages 46 to 50 and are slightly more in the older age categories. It can be assumed that a certain level of maturity may be required to practice Homoeopathy and life experience may be a valuable asset to those that are practicing, which possibly separates them from those that never did practice.

Other evidence to support this notion is that the majority of respondents in group C and D were married. This appears to confirm the impression that respondents in these groups were more mature in terms of general life stage (Fig 4.11). This population variable may have important inferential functions: as the life stage of the population changes one expects different issues to become important e.g. financial considerations may become more important as the number of dependants increase. This variable helps to describe the population in terms of maturity. We find the majority of respondents in Group B with fewer dependants, while Groups C and D both also reflect the majority with no dependents, and the spread extends further across the graph 4.12.

Figures 4.11- 4.12 imply that the respondents in Group B are generally younger and less mature (in terms of life stage – marriage, dependants) than respondents in group C or D. This may have predictive significance i.e. younger graduates are less likely to go into practice. The low number of respondents in Group B however makes this conclusion impossible to confirm statistically. Other contributing factors to the age disparity between the groups may be that some may have started studying later in life as table 4.14 shows that all older students have practiced. On the other hand Group B, which have as yet never practiced, have only recently graduated and therefore have not yet, had the opportunity to do so.

5.3.3 Ethnic Group and Language Preference

The majority of graduates were white (88%) with the next biggest group being Indians at only 10%. The ethnic composition of the three groups is roughly homogenous and reflects the overall ethnic composition of the population of graduates (Fig. 4.8).

Figure 4.13 show that 65% of the total response group has English as a first language, and Afrikaans as the second language. This was an expected result as the TWR programme is run in English and would thus attract English speakers, also in comparison to the Babaletakis (2006) study 35% of the respondents spoke Afrikaans as the first language. This is congruous with the ethnic demographic make up of the group, being majority white.

5.3.4 Marital Status

The two groups that had the greatest proportion of married individuals were those that had experienced practice (Fig. 4.10). This may be an important contributing factor to being able to practice as “support from spouse” is cited as one of the ways, which both groups use to supplement their income (Fig. 4.48).

5.3.5 Dependants

Having dependants could be a factor for the respondents in Group C to have given up practice. 15% of this Group cited family commitments as a reason for not practicing, also there is a delay to start a practice if they had started a family soon after graduation. Family commitments were also shown in this study to reflect the financial demands placed on one, and with the delay in seeing a profit in practice could indicate why graduates do not practice after starting a family. As the largest proportion of graduates are females, the implication could perhaps be due to women graduates having babies and thus having the increased demands of being a mother placed on them.

5.3.6 Geographical Demographics

The study shows the vast majority of graduates are South African born (94.2%) and South African citizens (98%) as shown in Figure 4.2. These numbers however do not reflect the proportion of graduates currently in South Africa; with 17% of graduates out of the country (Fig.4.2). The reasons for this are varied and tie up with complex economic, social and political factors that are part of the greater South African milieu.

It is interesting to note that 34 out of the 52 respondents who qualified at TWR remained in Johannesburg. This represents a significant portion of 65%.The

three largest representations thereafter are The UK with 8 (15.4%), Western Cape with 7 (13.5%) and the Northern Province 4 (7.6%).

This distribution has lead to a “clustering” of Homoeopaths in the main centers (Durban, Johannesburg and Cape Town) with other parts of the country being poorly covered. Vast areas of the country are not serviced by TWR graduates with entire provinces not having a single graduate and thus no practitioner or potential practitioner available. Some graduates, practicing and otherwise, mentioned that there were too many Homoeopaths in some areas. Johannesburg given the large population can absorb some of this discrepancy, however if it was still cited as a problem to practicing. The smaller provinces such as the majority of graduates in the Babaletakis (2006) study practicing in Natal, this clustering effect poses a large problem. The answer could very well lie in the authority bodies that govern how graduates practice. The larger cities would have a greater burden on the health care system, and as shown in South Africa the public health system is not coping and with the large amount of Homoeopaths in those larger cities, could be used in the public health care system to address this problem.

5.3.7 Financial Details

It is worth noting that all of the 5 respondents who earn >R400000 per annum live in South Africa. They are all based in Gauteng (Jhb and Pretoria), except for one (Middelburg). Of these high income earners, two i.e. 40%, are no longer

practicing homeopathy. Four respondents fall into the R300 001 – R400 000 income range. Of these two are practicing overseas (UK and UAE). The income level is high because the earnings are converted to Rands at current exchange rates. Both of the other practitioners are practicing in Gauteng (Jhb).

Fully 21.15% of the respondents earn between R50 001 and R100 000. Together 40% of the respondents fall into the range of income between R50 001 and R150 000. It appears that Group C have a relatively higher distribution of income. This may reflect the fact that financial considerations are often given as a reason to stop practicing i.e. respondents had stopped practicing to earn more money doing something else. Group B seem to have a relatively low income distribution. (Again, due to the low numbers in Group B it is not possible to make a conclusion).

A proportion (25%) of the practitioners that have given up practice (Group C) earn more than R400 000 per year (Fig. 4.26). This is congruent with other data, as 20% of both group B and C cited financial reasons as a major reason for not practicing (Fig. 4.69). Presumably they did not start or left practice for a more financially lucrative career, reflected in the above data. The annual income generated by currently practicing graduates (Group D) ranges from low to high, with the largest proportion earning between R50 001-100 000 per annum. This income may not be solely generated by practice as 64% of Group D state that their practice income is supplemented (Fig4.6).

It is noted that this was not taken into consideration by the researcher when structuring the question regarding income, as it was not expected that income supplementation levels would be so high. Furthermore there was no question incorporated into the questionnaire regarding extent of practice income supplementation by practicing individual. Thus this research does not give a clear reflection as to how much a TWR Homoeopathic graduate is able to earn from practice alone.

5.3.8 Profile of Different Groups

From the above analysis the following can be concluded:

The “average” profile of the graduate who never practiced (Group B) is single white, English speaking, female between ages 21 to 30, with no dependants. She is more than likely to be a South African citizen with English as a spoken language. Annual income is likely to be low to middle range.

The respondent who started to practice but gave up (Group C) has income ranging from low to high. They are by far the largest proportion of high-income earners. The person is likely to be between the ages of 26 to 35, roughly equal chance of being male or female, married or single. They too are white, English speaking, South African citizens.

The profile of the graduate that continues to practice (Group D), is likely to be a married, white female, aged 31-35 or older, within the low to middle income bracket.

5.4 EDUCATION

5.4.1 Academic History

5.4.1.1 Previous Education

Only 24 (46%) of the respondents had a previous qualification. Of these only 16 had completed them. This indicates that 16 of the 52 (30.6%) had completed previous educational qualifications. This shows that Homoeopathy was not the first consideration of career for a third of graduates. This may be important as perhaps more thought and consideration goes into a second choice, having already tried something else. The decision to embark on a five-year full time study programme may have been made with more caution by this group who had experienced tertiary education and so had some understanding of what it entails. Respondents in Group D, who are currently practicing, had higher overall previous education levels, which was largely in the health and science fields (Table 4.13). It would stand to reason that their second choice in career was made with more care and reflects “what they really want to do”.

Further, those who have never practiced (Group B) had the least prior qualifications (Table 4.12). This shows that Homoeopathy was their first choice of career and to some extent may have been a less carefully considered choice. Maturity also plays a role here as most of this category is young in relation to the other groups.

5.4.1.2 Education level on registration at TWR

It is interesting to note that most respondents had their first year of registration at TWR in 1993, 1994 and 1997. However, no conclusion can be drawn from this statistic, as it is not known how many students registered for any given year, to start with. This study only focused on graduates and not on dropouts or those that have not completed their research.

The majority (61.5%) of the population fell into the range between 17 and 20. This supports the contention that most qualified graduates started studying homeopathy soon after leaving school. This is supported by the fact that 51 (98%) of the respondents entered the course in the first year i.e. none had any exemptions leading to starting at a higher level.

Every respondent in Group B was under the age of 20 on first registration, Therefore being very young and as noted above without prior qualifications. Small (2004) points out that the majority of school leavers in her study had never heard of Homoeopathy. Because of the lack of awareness of Homoeopathy as a profession, this group might have started the programme ill informed and unaware of the potential out come of their study. As Murray (1994) suggested, information gleaned from studies like this one and others, would be well used in implementing a programme to train and inform careers guidance councillors of

the career they are getting into, in this case, regarding the Homoeopathic programme offered by TWR.

Group D, who currently practice, reflect a wider age range at first registration for the TWR programme (Fig 4.17). The questionnaire did not cover reasons for choosing to study Homoeopathy, however seeing that there is a older age group in those that remain in practice it can be assumed that these graduates made more informed decisions before embarking on the five year qualification, and thus been more aware of the implications of practice.

5.4.1.3 Qualification delay from TWR

Table 4.15 reflects the fact that the research component is a significant source of delay in qualification. The mean length of time however is in accordance with the length of time a Masters level thesis would require. The standard deviations are relatively large. This may be artefactual in that the questionnaire required respondents to return a calendar year in which they qualified- this response covers 12 months. i.e. two respondents qualifying in February and December would enter the same year in the response field. The second measure of the length of time taken to qualify is the age difference between first registration and final qualification. This is slightly larger, with a larger standard deviation. These measures both support the contention that the length of time taken to qualify varies significantly around the average of nearly 6 years.

The above graph shows that the number of graduates qualifying in a particular year is slightly less than the number of students first registering in the calendar year 8 - 9 years earlier. This is explained by natural attrition, failure of subjects and failure to complete research. The relative increase in number of graduates qualifying in the year 2000 could be explained by the fact that some students take longer than the 7 years to qualify. This could be due to subject failure, failure to complete research project or other components of the qualification requirements.

Courage (2006) found that subject failure only affected a small proportion of graduates regarding time taken to qualify. This finding is significant in that the research thesis takes a considerable length of time to complete and may not be of practical value to the graduate in terms of practice. Graduates remarked at the "lack of guidance" they received and that the research component "was not representative of the degree". This is a long debated subject, and regardless of the research being seen as "unworthwhile" and a "waste of time" it is still necessary for a Masters degree programme. The research dissertation plays a significant role in the proportion of time and energy spent in 5th year of study as well as of the end mark that a student achieves (Babaletakis, 2006). Therefore it can be said that the research component is unfairly weighted in terms of time and effort taken by students to complete it, in proportion to the perhaps more necessary areas of study, such as clinical experience and internship which most respondents felt were lacking (Fig. 4.31).

5.4.2 Internship

Although the primary goal of the research was to assess the movement of the graduates since graduating, this study also assessed areas in which the graduates found were lacking, in particular the education that they received. The study also attempted to assess inadvertently the level of clinical experience of the graduates. The question was asked if the respondents did “any form” of internship. The implication here was that respondents would stipulate any supervised clinical experience gained over and above that included in their 5th year study programme, which was stipulated to be a pre requisite when the original curriculum was drawn up (Chapter 2). This seemed to be well understood by the respondents.

The question of internship is a controversial one. Internship is a legal requirement for registration with the Allied Health Professions Council of South Africa (AHPCSA), but it is not the duty or obligation of the educational institution to provide this requirement. The onus falls on the governing body to set up and run an internship programme. The Allied Health Professions Act 63 of 1982 states: “An intern must complete a prescribed internship programme before he or she may be registered as a practitioner of the profession in question.” Currently there is no prescribed internship for M. Tech Homoeopathic graduates (Babaletakis, 2006).

Table 4.14 shows details of internships done, it sadly reflects that the majority (55.8%) of the respondents had not undertaken any form of internship. Further the majority of internships undertaken were in private practice (34.62%) between 7-12 months, which is indicative of the informal nature of the internship programme.

What is most significant, shown in Figure 4.20, is that the respondents who have remained in practice (Group D) have the highest relative percentage of internships undertaken. Although this experience may have held them in good stead, this group still reports that lack of confidence and experience is a difficulty in practice (Fig. 4.31). This may indicate that the internship experience they received was enough to allow them to keep practicing, but not nearly adequate to do so confidently.

50% of group B never undertook an internship, it is noted that this figure may not be truly reflective of the internship programme, but they also cite both medical and Homoeopathic clinical experience as the major aspect lacking in their Homoeopathic education (Fig. 4.31), as well as lack of confidence as a reason for not ever going into practice. Taking this information into consideration, it can be argued that had this group done an internship programme they might have had the experience to develop the skills necessary to gain the confidence to practice. Internship may have also afforded them the time and experience to mature to be able to handle the demands of Homoeopathic practice. Thus a larger proportion of Group B would have attempted to go into practice.

The group that gave up practice (Group C) had almost 75% not doing an internship and 25% completing one. This group like group B commented on the fact that their clinical skills were lacking as reflected in Fig 4.31. Extended clinical experience in the form of internship appears to be a large factor in whether graduates ever go into practice initially, but may be only one of other possibly more significant reasons as to whether they stay in practice. This fact was reinforced by the Babaletakis (2006) study.

5.4.3 Post Graduation Education

A large proportion of the respondents who had completed post homeopathic qualifications were focusing primarily on professional qualifications registered with the AHPCSA and secondarily (secondary qualifications) on health methods to complement their practices but not registered with the AHPCSA (Fig 4.24). There may be several explanations for this:

- This shows commitment to expanding their knowledge in the various areas that might have a bearing on the quality of health care they provide to their patients.
- If they can provide their patients with a wider range of skills this could increase their revenue potential. Practitioners use a wide variety of other health care modalities in practice to supplement their income (Fig 4.60).

- There is a correlation between initial consultation price and the number of boards registered with, thus it may be thought that practitioners invest in their further education to be able to have a higher return in practice.
- A third perhaps more subtle reason could be that they are wishing to bridge the gaps that they feel were lacking in their education (Fig. 4.31), this is supported by the correlation between education lacking and education after qualification.
- Another possible contributor to this statistic is that continuing education may result in more credibility in the medical field by virtue of having other degrees or diplomas and being registered with other boards besides the AHPCSA. This is supported by the significant correlation between the number of boards registered with and acceptance within the medical fields (Table 4.35).

5.4.4 Education Deficiencies

The majority of respondents in all three groups felt the education to be lacking. This could indicate a unanimous perception of significant shortfalls in the education.

Group B and C's responses are clustered around the following perceptions: Medical subjects taught, practical diagnostic skills and techniques, clinical experience regarding medical aspects, inexperience of clinicians, lecturers and teaching staff and poor integration of theoretical and practical aspects of

knowledge. Group D's responses are more evenly distributed across the range of options. This is possibly due to the wider experience (and larger size) of this group i.e. there are more respondents who have more experience of a wider variety of cases and clinical situations and therefore recognise lacks in the education more specifically. The most common response from Group D was the poor integration of theoretical and practical aspects of knowledge and a non-specified response. (Fig 4.31). Some graduates noted "learning only begins when in practice", and "lecturers lacked clinical skills themselves". It is interesting to note that not only do they feel that the education is lacking but also that there is no integration in terms of what you learn and implementing it into general practice. A graduate commented that: "How can I possibly be seen as a medical doctor when I cannot even interpret lab results". These statements are bold and frightening. How can the programme possibly be in the ranks of a master's degree when fundamental clinical skills are missing?

All three groups found clinical experience to be a major educational element lacking (Fig. 4.31). As mentioned earlier, this is reflected in the main reason that graduates in Group B don't practice, as they lack confidence and have a perceived lack of skills. What this study showed is that graduates felt inadequately trained to be a primary health care provider, and has been reinforced by the Babaletakis (2006) study.

TWR has in its mission statement that it will aim to produce graduates who will demonstrate competence in differential and holistic diagnosis in order to

determine the cause of the patient's discomfort. The findings in this study shows that a fair proportion of graduates do not feel competent and confident in their work due to lack of clinical experience in both the Homoeopathic and general medical field (Fig 4.31). The question has to ask why this discrepancy is still there despite the course not being in its infancy. This highlights that there are shortfalls that need to be urgently addressed if there is going to be a productive continuation of the profession. Majority of the graduates do not feel a part of the medical profession (fig 4.35), this is not surprising, the perceived lack of internship and the shortfalls highlighted in the education by the graduates in both this study and the Babaletakis (2006) study reinforce the fact that the education received and the skills being utilized by the graduates pales in comparison to the conventional medical field. It can be assumed that there was a drive for the graduate to have an interest in health before studying, but it is interesting to note how many of them would have studied medicine instead, this statistic should be a wake up call for all those involved in educating future homoeopaths, and their respective governing bodies. If the profession wants to be useful and to be implemented into primary health care an educational overhaul needs to take place.

In its Guidelines for Homoeopathic Education (1993), the ECCH states that it is crucial for students to have access to practicing Homoeopaths on whom they can rely for their expertise within the context of the clinical situation. Students are reliant upon these practitioners to share insights and experience. Clinical

learning, tutorials and supervision are stressed as an integral part of education for both students and new graduates in the first years of practice. Graduates, as students, clearly felt that their clinical experience was lacking. This data must be considered when re-curriculating the Homoeopathy course at DIT as well as TWR (Babaletakis, 2006).

A comment in the Babaletakis (2006) study rang true for this study: “The most frustrating aspect of this was that there was no acknowledgement by the Homoeopathy department that actually this was a poorly run, academically sub standard subject. There are always excuses and reasons why, but at the end of the day – students are left with no knowledge or should I say insufficient knowledge”, a graduate commented that “There was a lack of guidance due to lecturers being inexperienced themselves. Most subjects in medical school are taught and tutored by experienced professors and why can’t the same ring true for Homoeopathy, where only lecturers and heads of department are chosen than have exhibited some form of experience in the field, where graduates therefore become adequately prepared for the “real world”.

In the light of these findings and the Babaletakis (2006) study, it can be said that Homoeopathic education in South Africa should seek to provide an education that has a working practical value, rather than an academic and largely theoretical slant, which as it stands now makes employment of graduates difficult in the current market place.

5.4.5 Alternative Education Choices

None of group B would have studied Homoeopathy again, 75% of group C would not have studied again and 23.8% of group D would not have studied homoeopathy again. 25% of group C and 76.2% of group D would have studied it again. Majority of respondents had no particular preference to which institution, purely based on the fact that they had no knowledge of the other institution (fig4.39). 30% of group D felt that TWR offered a better system of homoeopathy. 35% felt that the location was more convenient. This makes sense as the convenience of the location may make it easier in studying a long course like that at TWR. There has been a debate as to the system of homoeopathy taught by the two institutions, on investigation it became clear that graduates were not really sure as to what that meant. It has always been considered that DIT was more Classical and TWR more clinical, if that was the case surely there would be a greater discrepancy as to the perceptions the graduates have regarding their respective courses, and as highlighted in this one and the Babaletakis (2006) study the concerns seem to be pretty standard.

Of the respondents who would not study homoeopathy again, 68% of group B, 63% of group C and 45% of group C, would have studied medicine. This may reflect a significant level of disillusionment with Homoeopathy, and also may reflect the way in which education is perceived to be lacking and the reasons for not practicing (fig4.31). These are significant figures and could show the relevant

lack of confidence in the education provided by TWR and by a lack of confidence in Homoeopathy as a profession.

5.4.6 Relevance of Homoeopathic Education

Of Groups B and C, the question was posed as to whether they felt that their education was useful in their current career choice. Of Group B 100% said no, group C, 62.5% said no (Table 4.23), 37.5% of Group C commented that there were aspects that they have found to be relevant, despite most respondents saying that their education was found to be lacking. The highest useful subjects strangely enough seem to be Materia Medica with the relevant application of the remedies 33.3% and broadly all aspects of education 66.6%. This supports the notion that Homoeopathy is based on universal principles that are widely applicable (Osawa, 2001).

Given the broad nature of the question it would be beneficial to refine the question further, this will not only remove the chance of discrepancy, but can also potentially highlight where educators should restructure the curriculum.

5.4.7 Continuing Homoeopathic education

Between Group B and C the respondents are split as to whether active interest in homeopathy is taken. The majority of Group D respondents report taking an interest (as would be expected). Majority of practicing Homoeopaths relied more on reading source material and going to conferences. Interestingly the group that

have never formally practiced maintain an interest in Homoeopathy through informal practice (fig 4.37).

As was shown in the Bableta kis study (2006) and this one, groups C and D follow more ways of pursuing interest, possibly reflecting a greater investment in continuing to explore Homoeopathy. Practitioners that have previously practiced possibly chose to continue their interest in the subject for their own personal development. While currently practicing Homoeopaths may also consider continuing Homoeopathic education as part of their personal development, it is more likely that they wish to expand their knowledge for the treatment and benefit of their patients, given their perception that their education is lacking (fig4.31).

5.5 CAREER

5.5.1 Demographics

Most respondents currently not practicing indicated that they are either homemakers or studying in a non medical field unrelated to homoeopathy (Fig. 4.70). A possible reason for this could be disillusionment with Homoeopathy as a practical profession on the part of those who have never practiced, whereas the majority of graduates who have stopped practicing have stayed in the alternative health field (35%) or are homemakers (25%). Possibly they are using the skills obtained or they are possibly attempting to bridge the gaps in their education that they thought was lacking through work experience, especially with regards to

medical training, accounting for those respondents that are now studying medicine.

The demographic data for those groups that have or are practicing seems to show a fairly homogenous spread regarding length of time between qualification and practice, age on starting to practice and how practice was financed. However it is worth noting that graduates that are still in practice had a higher tail end distribution (Fig. 4.44). This phenomenon could be explained by postulating that the graduates who continue to practice were more mature students who had the specific intention of practicing Homoeopathy. This theory is also supported by the fact that more than a third of this group had Homoeopathy as a second study choice.

Regarding the total time in practice (Fig 4.45) it is apparent that the majority (87.5%) of the respondents from Group C were in practice less than 4 years. Fully 50% practiced for less than 2 years. This could indicate that respondents realised fairly soon that practice was not the best path for them. It could also be interpreted that the length of time to build a sustainable practice (both on financial and personal levels) is in the order of 4-5 years (the length of time after which few graduates stop practicing). Graduates that have given up practice cited financial difficulties as the main reason for doing so, thus it can be assumed that this group went into practice for a fair length of time to ascertain the financial viability of the venture and after two to three years gave up to enter a more

financially lucrative career, yet still a massive 44% of Group C never realised any profit at all (Fig. 4.63).

However this figure regarding profit may be slightly inaccurate as the researcher did not stipulate gross or net profit, and there may have been doubts as to whether it meant covering fixed costs or did it include allowing the practitioner to draw a salary and live off the practice. Respondents may have interpreted the question in different ways. Also due to the wording of the question, if a graduate had practiced for 3 months and still not reached a profit, they would have responded that profit had not been reached. This dilutes the conclusions available, so that it can only reliably be asserted that a higher percentage of graduates who stopped practicing never reached a profit point than graduates who are currently practicing.

The respondents in Group C cited other reasons beside lack of financial viability as reasons for stopping practice. Included are emigration, perceived lack of skills, family commitments and burn out. As mentioned earlier, regarding family commitments it could be that the female practitioner decided to have a child and was thus not able to fulfil her practice demands. The conclusion that may be made is that if the practitioner can practice for 3-4 years then it will become sustainable (assuming successful management of other non-financial aspects).

5.5.2 Practice and logistical management

The following discussion explores the practical, management and financial aspects of running a practice.

5.5.2.1 Financial Aspects of practice management

One of the most significant outcomes of this study is that more than three quarters of all the graduates who have ever practiced supplemented their income from some other source (Table 4.60), mostly in the field of the health care industry in general (Fig. 4.61). Although it may at first appear that a fair proportion of graduates do practice, most of them do not rely on a "homoeopathic" practice solely for their livelihood. This is disconcerting for the individual in practice, as most homoeopaths have to work in pharmacies and health shops to supplement their income and education that does not seem very professional or fair for five years full time study. It has become evident that in order to financially get rewards modalities have to be included in consultation, as homoeopathy alone does not seem to be enough. This statement is reinforced by the Babaletakis (2006) study. There could be a number of factors contributing to this finding. One being that the profession and Homoeopathic education is fairly new in South Africa, and the public and other medical fields are not aware of the profession or of the training that is involved (Maharaj, 2005). Little awareness of Homoeopathy by other medical professions (Fig. 4.35) as well as poor public awareness of Homoeopathy were considered factors by graduates, when

commenting on feeling part of the medical profession and difficulties in starting practice respectively.

It is evident that those graduates that did or do practice, many must have used their Homoeopathic education to some extent, as the two main fields of work regarding income supplementation were cited to be working in the health care industry and lecturing or teaching Homoeopathy. (Fig.4.43). From this information it is difficult to ascertain if the extra work was needed solely for financial reasons or was also to benefit the practitioner in terms of knowledge and experience in the Homoeopathy and the health care field. Both these theories could be valid as the main difficulties in practice that were cited were economic, lack of confidence and experience and lack of patient numbers which potentially could be increased if working in a health related environment such as a health shop (Fig 4.47). Nonetheless the economic factor may be more relevant to the group that has given up practice. In other professional fields like medicine, the graduate should be able to earn an income solely derived from selling their services. This does not appear to be the case regarding TWR graduates. Evidence thus far has pointed to the graduate having to have more entrepreneurial business skills than to provide a professional service, as well as offer modalities over and above what they learnt, as the education has been perceived to be lacking.

The lower level of respondents who practiced full time in Group C (Table 4.49) could indicate a decreased commitment to practice as a profession, the more likely reason is that as 87% of this group supplemented their practice income (Fig 4.60) and therefore have to make time to do so.

Furthermore this lack of general awareness may lead to the financial difficulties that both groups experience in practice. Both groups commented that few patient numbers and taking a long time to establish a patient base along with marketing constraints that are placed on practitioners by the AHPCSA all contributed to difficulties starting up their practices. They also reported that the major way of sourcing new patients is by word of mouth (Fig. 4.55), which is a slow process and accounts for the perception that practice takes a long time to build. It is understandable that financial difficulties contributed to difficulties in starting a practice, as is expected with any new business, but the continued financial stress was more than likely the major factor for practitioners to have to supplement their income and to eventually give up practice altogether.

The figures for the costs of initial (Fig. 4.57) and follow up consultations
(Fig. 4.58) exhibit similar characteristics to the patient numbers graph (Fig. 4.56). Respondents from Group C are clustered in the lower levels of consultation charges. This is possibly reflective of a different pricing/charging scale that may have contributed to failure of their practices. Alternately an explanation could be

that the practitioners did not develop the experience and practice base that allowed them to charge more for consultations.

The respondents for Group D are more evenly spread across the price scale. This would support the second explanation above. If the low levels of charging were contributing to the failure of practices in Group C, we should see a high level of charging in Group D. This is not the case however. The question may also be fundamentally flawed as currently practicing graduates would quote current consultation prices, while those that gave up practice would be quoting prices charged in the past which may not be presently market related.

There are no jobs as yet available in the public sector for practicing Homoeopaths, and as stated in the Babaletakis (2006) study, A Master's degree in Homoeopathy qualification is not of any use in securing employment in health care. It stands to reason that private practice is virtually the only choice a graduate has to see patients in a professional Homoeopathic capacity, which has proven in this study and in the Babaletakis (2006) study to be restrictive and unproductive to the profession as a whole.

5.5.2.2 Operations Management

The proportion of respondents who found it easy to start is fairly uniform across the groups and is also fairly similar to the proportion who did not find it easy to

start. Interesting to note is that relatively fewer individuals in Group D found it easy to start (Fig 4.47).

In terms of difficulties experienced (Fig 4.47), Group C responded with poor skills and confidence as the most common difficulty experience. Also significant were financial difficulties, these difficulties were the greatest obstacle to ease of practice, it can be assumed that this is not exclusive to Homoeopathic practice but is a universal phenomenon regarding business. However practitioners found that this was an on going problem when describing their difficulties. Poor public awareness of homeopathy was also cited as a difficulty. Small (2004) concluded that there was a low awareness of Homoeopathy amongst grade 12 learners in Kwa Zulu Natal, this may not be so for the rest of the country but considering the similarity of this study to the Babaletakis (2006) study this can be seen has having some form of validity, and therefore perception that there is poor public awareness of homoeopathy may not be unfounded. As has been shown word of mouth is the major way of sourcing new patients, it would thus stand to reason that creating an awareness of Homoeopathy would be a slow gradual process. There is also the lack of employment opportunities. As a reinforcement group D felt that financial difficulties and the low numbers of patients and length of time required to build a patient base were the most common problems.

Saying that however, there were respondents who did find it easy to start up a practice, by experiencing a good support network (Group C and D), having good financial support (C and D), fortunate personal circumstances and being directly

employed (Group C) and having had a good business plan (Group D). These can be attributed to a few things. The main factors that contributed to an easy start of practice were joining an existing practice and having a good support network. This is also supported by Freeborn (2001), who found that social support from colleagues was a significant predictor of professional satisfaction among physicians working for Health Maintenance Organisations in the USA. Lack of such support resulted in burnout within members of the profession. With the relatively recent inception of the HSA governing body it is hoped that encouragement would be given to practitioners to create a wider support base, as well as offer practical business management tools that were perceived to be lacking in the education.

The majority of respondents in both groups practiced in a financially sole setting but where they shared premises with other medical professionals (Fig. 4.51). This may reflect the fact that it is easier to practice with this support both clinically and practically e.g. sharing costs of receptionists, rent and telephone lines, but most importantly having access to a potential referral network supported by the evidence that the professions that most practicing graduates associated with was Homoeopaths, Chiropractors and other complimentary practitioners registered with the Allied Health professions Council of South Africa (Fig. 4.52).

In terms of being in association with other Homoeopaths, the reasons could be the clinical and practical factors mentioned above, but also may include other

systems of support. These being sharing of a dispensary or remedies, and locuming for each other when one takes leave or is ill. Furthermore sharing premises with another Homoeopath may give a feeling of added security in respect that one practitioner “knows” what the other one is doing (Babaletakis, 2006).

5.5.2.3 Patient Management

Both Group C and Group D have most of the respondents seeing less than 20 patients a week. Group D has more respondents who see greater numbers of patients. This is explained by the fact that respondents from Group D have been in practice for longer than Group C on average and therefore have built up more of a patient base. Thus the number of patients per week was unlikely to have reached a sustainable level as these Homoeopaths stopped practicing (most within three years and many never showed a profit). Yet again the need for business skills is highlighted, possibly compounded by lack of confidence and perceived lack of skills that may have resulted in a poor patient follow up rate. So the practitioner was unable to build a strong patient base.

There was however some of these practitioners in group C who consulted with over between 41-50 patients a week. This is intensive work, it can be assumed that the practice was financially lucrative, this has proved not to be the case though, and possibly the little amounts charged for the consultations could be a factor. Also possible family commitments and burn out as shown in the statistics may have been contributing factors for them to stop practice.

The questionnaire failed to ask how long the average initial and follow up consultations were. Thus making it difficult to assess the working hours of practitioners, which may contribute to burn out and affect the rate charged per unit time.

The majority of currently practicing Homoeopaths see less than 10 patients a week (Fig. 4.56). These figures do not seem to be conducive in sustaining a business. It cannot be said that they are new to practice, maybe it is the vast number of Homoeopaths in the same are. But unnerving as it seems only 7% or so sees enough patients to have a sustainable income. Perhaps if this study was to be repeated in a few years or so those in Group D would be included in group C and they may be in danger of having to give up practice.

5.5.2.4 Dispensing practice

An added expense is the cost of setting up a dispensary; more than 80% of both groups that have practiced owned their own dispensary (Table 4.65). At first it would seem to be a less financially sensible thing to do when first starting to practice. Perhaps it would make more sense to build up a solid patient base and then make this large investment. The explanations for the high rate of dispensary ownership may be as follows:

- Perhaps they did not/do not have access to remedies, other than their own; some graduates used the University/Technikon clinic remedies.

- It may have been thought that selling remedies to patients would generate increased revenue.
- It is common Homoeopathic practice to dispense placebo, for which the practitioner is able to charge the same as medication.
- The practitioner would also be able to medicate his own granules and make a considerable mark up on medication.
- The practitioner may have wanted to be sure that the patient receives remedies of a known quality, and that they are correctly advised, which may not be the case if the process goes through a third party.

5.5.3 Job Satisfaction

5.5.3.1 Currently practicing graduates

Given that 76.2% of the currently practicing homoeopaths would study Homoeopathy again given the choice, and less than 3% said they were not satisfied with their current career (Fig 4.74), is surprising to note that such a high percentage of graduate practitioners are happy as Homoeopaths despite the financial and emotional difficulties that practice presents. This finding was in accordance with the findings of Smith Randolf and Johnson (2005) who identified intrinsic factors to be more important than extrinsic factors regarding their influence in contributing to career satisfaction and desire to stay in a job.

Majority of these practitioners said that they found Homoeopathy to be a rewarding career, and that “despite all the set backs I am meant to be a healer”

and “Homoeopathy is a powerful form of medicine”. From these statements it seems to show that the practice of Homoeopathy is one that affords the individual great personal satisfaction, presumably to be able to contribute to the health and welfare of others in a relatively safe manner. The nature of the Homoeopathic consultation often affords one with a sense of reaching out to someone in thoroughly exploring the mental, emotional and physical realms (Vithoulkas, 1986). This interaction between practitioner and patient allows for the practitioner’s personal growth to occur (Wilber, 2004). Also the very nature of the consultation lends itself with a particular type of person, this could give an indication to educators as to the type of students they should be selecting for the educational pragramme. It would be beneficial for educators to be aware of the information in this study, to refine the student selection process, so that valuable time and energy is not spent on and by those who will not practice in the future.

This may be the greatest offering that the practice of Homoeopathy may have to offer the practitioner and is arguably the main reason that the vast majority of practicing graduates have made such passionate statements regarding their career choice. This statistic may be the key to the fundamental reason why graduates continue to practice, and perhaps it should be this that should be further researched rather than looking at why other graduates don’t practice (Babaletakis, 2006).

5.5.3.2 Not Currently Practicing Graduates

75% of those that had practiced before would elect not to study Homoeopathy again (Table 4.21). Presumably this could be because they have found the difficulties they had to deal with and decided that it was not a viable career choice for them. For those who would have studied Homoeopathy again, half said that they would prefer to study it as a postgraduate adjunct to medicine (Fig 4.40). In addition to this, a quarter of those who would choose another career elected medicine as an option.

None of the group who have never practiced before would study homoeoapthy again given the choice (Table 4.21). This could be seen to be because they have not had a chance to experience practice, but given the way they rated their education, one could assume it would be more than likely because of their perceived lack of skills, as they would have chosen medicine instead. Given the nature of conventional medical consultation it can be said that these graduates don't find other aspects of medicine, such as patient interaction, long hours and study problematic, but rather the difficulty is fundamentally lying within Homoeopathy.

Despite this, the majority of non-practising respondents are satisfied with their current career choice, i.e. that not being Homoeopathic practice. Of these, a large percentage of these say that their new careers afford them job satisfaction and financial viability.

5.5.4 Alternative Career Choices

The majority of Groups B and C that would not choose Homoeopathy again cite medicine and other medical fields as well as other alternative health fields as a preferred career choice (Fig.4.40). This could either reflect a perception of better viability of other fields or a misperception of the Homoeopathic profession when originally making a career choice.

Of the non-practicing Homoeopaths who used to practice (Group C), 75% would not follow the same choice of study (Fig 4.40). Again this indicates a level of satisfaction at having stopped practicing as a career. Perhaps if Homoeopathy was more widely accepted and had a place in public sector health care, where graduates could be employed there as opposed to having to start their own private practice which has proved to be stressful, these opinions would be different. As in the Babaletakis (2006) study, some graduates commented that there were no career opportunities in Homoeopathy other than private practice. Also that there is lack of hospital exposure and community service which is afforded to some of the more main stream medical professionals which not only hampers career opportunities for graduates but also limits the scope for clinical experience needed by students and graduates.

5.5.5 Intention to Practice Again

The respondents in Group B indicate plans to practice at some point in the future. (They qualified in 2000 and 2001). The responses from Group C are more variable reflecting more diversity in experience and the fact that it is a larger group (Fig 4.71). It would seem to indicate that the subject/system of Homoeopathy is attractive, although the practical aspects are a constraint in pursuing Homoeopathy as a profession. This is re-enforced by the data reflected earlier that the large proportion of respondents indicated a need to supplement the income they received from Homoeopathy. Also the predominance of responses in the category “will practice again depending on circumstances” suggests that the practical and logistical aspects of Homoeopathy are a constraint rather than disillusionment with the system itself.

5.6 PROFESSION

This study only concentrated on the M. Tech. Hom graduates from TWR, it is therefore difficult to give an overview of the profession as a whole when it is made up of a wide range of differently qualified people, this includes a number of MBChB who have done the M.F.Hom qualification, as well as M.Tech. Hom graduates from the Durban institute of Technology, not to mention those that claim to be Homoeopaths with 3 month correspondence qualifications. However, M.Tech. Hom graduates do make up the majority of registered Homoeopaths. The greater proportion of which are currently DIT graduates, partly because the

DIT course has been running about four years longer than programme than the TWR Pragramme. A look at this data in the light of the profession as a whole thus may not be entirely accurate. It may however be able to reflect possible broad trends in the profession as a greater proportion of registered Homoeopaths in South Africa are M.Tech.Hom graduates seeing that this is the legal requirement for Homoeopathic practice, excluding those with the M.F.Hom qualification.

5.6.1 Registration with professional boards

The majority of respondents are registered with the Allied Health Professions Council of South Africa. A significant percentage (8 out of 52, 15%) are not registered with any board. This is a concern as this constitutes illegal practice (5 (12%) of currently practicing respondents are not registered).

It is interesting to note that very few of the responses indicated registration with the board of healthcare funders. Registration with the BHF however is necessary for medical aid claims, and maintaining a practice number. It is reasonable to assume, therefore, that this question was not understood or answered completely accurately. Other professions registered for (Fig 4.29) may reflect the ongoing education and need for income supplementation of income discussed earlier.

5.6.2 Interaction within Homoeopathic Profession

Not being supported by the Homoeopathic profession was the dominant feeling of the respondents (Table 4.32) and reasons were varied across the different groups. Many of the responses included not having a good functioning representative body (Fig. 4.33). The majority of respondents in Group B and C felt unsupported by the homeopathic profession. Group D respondents generally feel more supported. This could be due to the fact that this group has remained in practice over time and has discovered/established and nurtured available professional support channels.

The HSA with welcomed foresight has begun to tackle some of the issues highlighted in this study directly and indirectly. An example would be the study they commissioned to assess fee structures for submission to medical aids (Babaletakis, 2006). This is one way in, which the financial problems of practitioners is being addressed. Hopefully more and more students and graduates will become part of HSA to support them in the work they are doing to further the Homoeopathic profession.

A common response from Group B and C was the absence of a good representative body and leadership. Again Group D responses are more evenly distributed. Poor communication with other practitioners is a response common

to all three groups. This ties up with the good network needed to make starting practice easier. If graduates felt part of a greater network, perhaps there would be more graduates practicing. Graduates that did feel supported by the profession largely attributed this to good communication with colleagues and good assistance from other practitioners. Here again the importance of intra-professional communication is stressed, especially as regards to a newly developing profession like Homoeopathy. What is encouraging is that there seems to be a fair amount of intra professional referral where Homoeopaths are both referred to and receive referrals from their Homoeopathic colleagues (Fig 4.54), which could indicate that the situation is changing.

5.6.3 Interface with Other Health Professions

A significant majority of all three groups felt not part of or not accepted by the medical profession in general. Group D has the lowest relative level of disaffection. This could again be due to the fact that they have had time to establish channels and support structures (Fig 4.34).

The predominant response across all three groups was the perception that homeopathy is not acknowledged or respected by the medical profession. This was supported by the perception (also across all three groups that there is little or no education with respect to homeopathy in the medical profession (Fig 4.35).

The law has been responsible for creating several gaps. As stated in chapter two, rule 9 (1) of the Health Professions Act, 56 of 1974, currently restricts free

communication between complementary health professionals and medical professionals, thus limiting the interaction between the general medical community and Homoeopaths, effectively isolating the Homoeopath (South Africa, 2004:26497). The registration of Homoeopaths was only reopened in 1985, so it has only been operational in its full capacity for some 20 years. As a result other medical professionals, especially the older generation, may not be aware or are ignorant of the scope of the profession thus excluding Homoeopaths from any medical interaction, which may lead to the feeling of not being accepted (Babaletakis, 2006).

5.6.4 Reasons for Emigration

There seem to be a broad spectrum of reasons for emigration (Fig 4.41). There is no evidence that any are related specifically to Homoeopathy, but rather to the greater South African social and political context.

CHAPTER SIX:

CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

It can be stated that the majority of the TWR Homoeopathic graduates are in practice despite the setbacks and numerous problems they have stated throughout the research. Homoeopathy as a profession however can be seen to fall short of being a financially viable career as most of the graduates have to support themselves one way or another, often most times the graduates use homoeopathy as the side income. For a five year degree that in theory covers all aspects of practice this should not happen. A number of problems can be highlighted:

- The education offered by TWR although being certified as being of a high standard does not provide adequate practical exposure and experience to their students and graduates. As was highlighted in this study most graduates whether practicing or not doubted their confidence and skills in handling the health of their patients. Producing graduates that felt like “frauds” when dealing with their patients is not an objective of the curriculum but the reality is that this is exactly what is happening.

- Financial difficulties experienced by so many TWR graduates results in less graduates going into practice and more graduates giving up practice, thus limiting the growth of the profession.

- There are limited employment options available to the graduate, the majority have to go into private practice as there are very few employment opportunities in the public health sector and industry. This is strange as there are such shortfalls in the public health care sector. How can the skills of the homoeopath be utilized is this sector?

If the issues of the graduates are not taken into consideration when promoting and strengthening the profession for the future, the profession may not be able to expand to take its place as a primary health care modality in South Africa.

6.2 RECOMMENDATIONS

6.2.1 Recommendations Regarding This Study

6.2.1.1 Questions to Be Omitted

- Country of Birth and Citizenship (Question 1.4;1.5)
- Languages spoken (Question 1.10)

- Reasons for emigration (Questions 2.11, 3.31 and 4.28), and which suppliers were used for medication and remedies (Questions 3.19 and 4.20).

In hindsight these questions are irrelevant.

6.2.1.2 Questions to Be Amended

Q 1.11 to be amended to ask for net annual income. And more specifically only with homoeopathy, as it is difficult to assess how much one makes if most consultations are made up of other modalities as well.

6.2.1.3 Questions to Be Included

- Average consultation time, this would be necessary to determine a realistic consultation fee.
- Reasons for choosing homoeopathy as a career.
- Suggestions on how the course should be structured.
- Should homoeopathy be only a post graduate study at medical school like most European countries.

6.2.1.4 General Recommendations

If a survey of a similar nature is to be conducted, it is recommended that the key (Appendix H) be used or adapted for survey distribution. The questionnaire compiled by the researcher was done with limited knowledge of the scope of answers; more comprehensive multiple-choice answers are included in the key, thus making data collection easier. It is also recommended that the survey be broken up into smaller areas of concern, for example, different surveys to assess the education, the career and the profession.

6.2.2 Recommendations for Future Specific Research

- This study type and design should be seen as a pilot study and the research should be repeated with a more refined questionnaire to further assess the industry.
- A comparative study should be done between TWR and DIT.
- The financial viability of Homoeopathic practice in South Africa.
- Attitudes and treatment protocol of successful homoeopaths which could be used as the basis of setting up a new curriculum for study.
- Research should be done on the need for a Homoeopathic internship programme.
- Educational Audit of subjects currently offered at TWR and their relevance to practice.

- Factors' contributing to delays in qualification as a result of research dissertation and the impact it has on practice.
- The relevance of the research dissertation as opposed to practical work to practice.
- A study to highlight what skills graduates can offer the government in public health.
- The role of Homoeopathy in public health.

6.2.3 Recommendations for educators and representative professional Bodies

- Homoeopathic educators need to set up programmes to train school and TWR careers guidance councillors to adequately inform potential students of the opportunities their homoeopathic education will afford them.

- It would be beneficial for the future development of the profession for formalised postgraduate Homoeopathic workshops to be run, covering numerous varied topics. Run by both the institutions offering Homoeopathy and their representative councils.

- More practical exposure is needed and should be offered in the five year study programme.

- The lecturers chosen to teach homoeopathy or to run the department should have adequate working knowledge and experience of the realities of private practice, as apposed to most never having practiced homoeopathy.

- A set internship should be formalised and implemented as soon as possible.

- Practice management and a proper financial planning curriculum should be taught, as well as computer accounting systems to better equip graduates in practice.

- Extensive marketing should be done to promote homoeopathy to the general public and other health care professionals. Not only to serve as an effective educational tool but also to show the potential homoeopathy has in the world.

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Appendices

Appendix A: Questionnaire

Appendix B: Informed consent

Appendix C: Information Letter

Appendix D: Thank you letter

Appendix E: Pilot Assessment form

Appendix F: List of Graduates from 1998 to 2004

Appendix G: Rule Book for TWR department of Homoeopathy

Appendix H: Key used for analysis

Appendix I: Official languages for South Africa

Appendix J: Regional Maps for South Africa

Appendix k: Professions registered with The AHPC

Appendix A
QUESTIONNAIRE

This survey takes about 25 minutes to complete. The data will only be identified by code numbers and no names and contact details will be connected to them ensuring confidentiality.

INSTRUCTIONS:

- All graduates are requested to fill in Part A (Demographic data).
- **Only** one of either Parts B or C or D is applicable to any one graduate. To ascertain which category you fall into please refer to the definition of "Practice" provided below.
- Part B applies to graduates who have never practiced homoeopathy as stated by the definition.
- Part C applies to graduates who have practiced homoeopathy previously, but are currently not practicing, as stated by the definition.
- Part D applies to graduates who are currently practicing homoeopathy as stated by the definition.
- **Circle** answers where appropriate.
- When an option is given for "other" please specify in the space provided.
- Additional comments can be noted on page 14.

For the purposes of this study
***"HOMOEOPATHIC PRACTICE"* is defined as:**

To exercise or follow homoeopathy as a registered profession, with or without monetary remuneration by means of providing a professional service to a formal patient base, from a fixed contactable address or addresses. (This does not include informal consultation with family, friends and acquaintances.)

Part A: Demographic data

Personal details:

1.1

First names	
Surname	

1.2

City:	Country:

1.3 Gender:

Female	**1**	Male	**2**

1.4 Country of Birth: ***1.5 Country of Citizenship:***

1.6 Age category:

21-25	**1**	26-30	**2**	31-35	**3**	36-40	**4**	41-45	**5**	45-50	**6**	>51	**7**

1.7 Ethnicity:

1	Black	**2**	Coloured	**3**	Indian	**4**	White

Other:_____

1.8 Marital status:

Divorced	**1**	Married	**2**	Single	**3**	Widowed	**4**

1.9 Number of dependents:

1.10 Languages spoken:

1st:

Afrikaans	**1**
English	**2**
IsiNdebele	**3**
IsiSwazi	**4**
IsiTsonga	**5**
IsiTswana	**6**
IsiVenda	**7**
IsiXhosa	**8**
IsiZulu	**9**
North Sotho	**10**
South Sotho	**11**

2nd

Afrikaans	**2**
English	**1**
IsiNdebele	**8**
IsiSwazi	**5**
IsiTsonga	**9**
IsiTswana	**6**
IsiVenda	**7**
IsiXhosa	**4**
IsiZulu	**3**
North Sotho	**10**
South Sotho	**11**

Other: _____

1.11 Income per annum:

R0 – R12 000	**1**
R12 001 – R24 000	**2**
R24 001 – R50 000	**3**
R50 001 – R100 000	**4**
R100 001 – R150 000	**5**
R150 001 – R200 000	**6**
R201 000 – R300 000	**7**
R300 001 – R400 000	**8**
> R400 001	**9**

Educational details:

1.12 Year of first registration at Technikon Witwatersrand:

1.13 Age of first registration at Technikon Witwatersrand:

yrs

1.14 Year of Entry on first registration (i.e. what year did you start in?):

1st yr	**1**	2nd yr	**2**	3rd yr	**3**	4th yr	**4**	5th yr	**5**

1.15 Level of education on first registration at Technikon Witwatersrand: (Please specify institution also include degrees and education not completed e.g. did 1st year of BSc. at RAU then registered for homoeopathy):

	Qualification	Institution
1	Matric:	
2		
3		
4		

1.16 Time taken to complete research after fifth year:

years	months

1.17 Did you do any form of internship, excluding 5th year patient quotas?

No	**1**	Yes	**2**

1.17.1 If yes, where did you do your internship?

Hospital	**1**	Overseas	**2**		
Technikon clinic	**3**	Private practice	**4**	Rural clinic	**5**

Other: _____

1.17.2 How long was your internship in months?

months

1.18 Number of years taken to complete degree from year of first registration:

3 yrs	**1**	4 yrs	**2**	5 yrs	**3**	6 yrs	**4**
7 yrs	**5**	8 yrs	**6**	9 yrs	**7**	> 10 yrs	**8**

1.19 Year of qualification from Technikon Witwatersrand:

1.20 Age on qualification from Technikon Witwatersrand:

yrs

1.21 Additional qualifications obtained after the Homoeopathy Degree:

	Qualification	Institution
1		
2		
3		
4		

1.22 List the official boards with which you are registered:

	Boards	Qualification
1		
2		
3		
4		

Part B: Non practising – Never practised previously

2.1 Reasons for not practising? (More than one choice possible)

Emigration	**1**	Travel	**5**
Financial	**2**	Family commitments	**6**
Lack of interest	**3**	Perceived lack of skills	**7**
Not confident	**4**	Burned out	**8**

Other_____

2.1.1 Please elaborate (e.g. having baby or qualification not valid in other country):

_____

_____

2.2 What is your current occupation?

Homemaker	**1**
Studying	**2**
Unemployed	**3**
Working in health professional field	**4**
Working in Homoeopathic related field	**5**
Working in totally unrelated field	**6**

Other_____

2.2.1 Please elaborate:

_____

_____

2.3 Is your homoeopathic education directly useful in your current work?

No	**1**	Yes	**2**

2.3.1 Please elaborate:

_____

_____

2.4 Do you feel the education you received was lacking in any way?

No	**1**	Yes	**2**

2.4.1 Please elaborate:

_____

_____

2.5 Do you feel that you have the support of the homoeopathic profession?

No	**1**	Yes	**2**

2.5.1 Please elaborate:

_____

_____

2.6 Do you feel part of or accepted within the medical profession as a whole?

No	1	Yes	2

2.6.1Please elaborate:

_____

_____

2.7 Do you still take an active interest in homoeopathy?

No	1	Yes	2

2.7.1 If yes, in what way do you show interest?

Conferences	1	Informal practice	2	Journal subscriptions	3
Reading source material	4	Study groups	5	Other:_____	

2.7.2 If no, please elaborate:

_____

_____

2.8 Are you satisfied with your current career choice?

No	1	Yes	2

2.8.1 Please elaborate:

_____

_____

2.9 Do you plan on practising homoeopathy in the future?

No	1	Yes	2

2.9.1 Please elaborate:

_____

_____

2.10 Would you study Homoeopathy again, given the choice?

Yes	1	No	2

2.10.1. At DIT or Wits and elaborate on reasons why?

_____

_____

2.10.2 If no, what would you rather have studied?

_____

2.11 If you have left South Africa, please elaborate on reasons why.

_____

_____

_____

Part C: Non practising – Practised previously

Previous practice information:

3.1 How long after you qualified did you start to practise?

years	months	Straight away

3.1.1 ***Elaborate on what you did between the time of graduation and opening a practice.***

_____

_____

3.2 At what age did you start to practise? | yrs |

3.3 Total time in practice? | years | months |

3.5 How many practices did you have? _____

3.4 Where did you have your practice(s)?

City:	Country:
City:	Country:
City:	Country:

3.6 Did you find it easy to start up a practice or find employment?

No	**1**	Yes	**2**

3.6.1 Please elaborate:

_____

_____

3.7 How did you finance the set up of your practice? (More than one answer possible)

Loan	**1**	Parents	**2**	Own savings	**3**
Second income	**4**	Spouse	**5**	Other_____	

3.7.1 Please elaborate:

_____

_____

3.8 Did you practise part time or full time?

Full time	**1**	Part time	**2**

3.9 How did you practice?

Sole	**1**	Group- Homoeopathy	**2**	Group-Multidisciplinary	**3**

3.9.1. Please elaborate:

_____

_____

3.9.2 If you were in financial association with other practitioners state which: (More than one choice possible)

Allopathic Specialist Doctor	**1**	General Practitioner (GP)	**5**
Aromatherapist	**2**	Homoeopath	**6**
Chiropractor	**3**	Reflexologist	**7**
Dentist	**4**	Other:_____	

3.9.2 If you were in a multidisciplinary set up with other practitioners, state which ones are applicable (More than one choice possible)

Allopathic Specialist Doctor	**1**	General Practitioner (GP)	**5**
Aromatherapist	**2**	Homoeopath	**6**
Chiropractor	**3**	Reflexologist	**7**
Dentist	**4**	Other:_____	

3.10 Did you ever refer patients to? (More than one choice possible)

Allopathic Specialist Doctor	**1**	General Practitioner (GP)	**5**
Aromatherapist	**2**	Homoeopath	**6**
Chiropractor	**3**	Reflexologist	**7**
Dentist	**4**	Other:_____	

3.11 Did you ever receive referrals from? (More than one choice possible)

Allopathic Specialist Doctor	**1**	General Practitioner (GP)	**5**
Aromatherapist	**2**	Homoeopath	**6**
Chiropractor	**3**	Reflexologist	**7**
Dentist	**4**	Other:_____	

3.12 How did you source new patients? (More than one answer possible)

Gave information presentations	**1**
Print media	**2**
Telephone directory	**3**
Word of mouth	**4**

Other_____

3.13 How many patients on average did you see a week? |

3.14 Average consultation fee, including average price of mediation dispensed?

Initial	**R**	Follow-up	**R**	Telephone consult	**R**

3.15 Did you supplement your income? (Including other modalities employed in the treatment of your patient

No	**1**	Yes	**2**

3.15.1 If yes, please elaborate: (More than one answer possible)

	ELABORATE	
Acupuncture		**1**
Chiropractic		**2**
Massage		**3**
Phytotherapy		**4**
Second job related to homoeopathy		**5**
Second job unrelated to homoeopathy		**6**
Spouse		**7**

Other:_____

3.16 How long before you started to show a first net profit?

Months	***Years***	***No profit***

3.17 In what areas did you experience difficulties? (More than one answer possible)

Burnout	**1**	Economic	**2**
Lack of confidence in skills	**3**	Lack of job satisfaction	**4**
None	**5**	Work load	**6**

Other:_____

3.17.1Please elaborate:

_____

_____

3.18 Did you have your own dispensary?

No	**1**	Yes	**2**

3.18.1 If no, where did your patients get their medication and remedies from?

Health Shop	**1**	Homoeopathic pharmacy	**2**	Other Homoeopath	**3**
Pharmacy	**4**	Other_____			

3.19 Which suppliers did you use for your medication and remedies? (More than one answer possible)

Ainsworth	**1**	Herbal Homoeopathic	**7**	Nrf	**13**
Arkopharma	**2**	Holistix	**8**	Pharma Natura	**14**
Bioforce	**3**	Nativa	**9**	Phytoforce	**15**
Bioharmony	**4**	Natura	**10**	Solgar	**16**
Heel	**5**	Nature Life	**11**	Viridian	**17**
Helios	**6**	Naturopathica	**12**	W last	**18**

Other:

_____

3.20 What prescription aids did you use in your practice? (More than one answer possible)

Cara	**4**	Hompath	**5**	Nothing	**6**
Mac Rep	**1**	RADAR	**2**	Repertory Book	**3**

Other_____

Current status:

3.21 Reasons for not practising? (More than one choice possible)

Emigration	**1**	Travel	**5**
Financial	**2**	Family commitments	**6**
Lack of interest	**3**	Perceived lack of skills	**7**
Not confident	**4**	Burned out	**8**

Other_____

3.21.1 Please elaborate (e.g. having baby or qualification not valid in other country):

_____

_____

3.22 What is your current occupation?

Homemaker	**1**
Studying	**2**
Unemployed	**3**
Working in health professional field	**4**
Working in Homoeopathic related field	**5**
Working in totally unrelated field	**6**

Other_____

3.22.1 Please elaborate:

_____

_____

3.23 Is your homoeopathic education directly useful in your current work?

No	**1**	Yes	**2**

3.23.1 Please elaborate:

_____

_____

3.24 Was the education you received lacking in any way?

No	1	Yes	2

3.24.1 Please elaborate:

_____

_____

3.25 Do you feel that you have the support of the homoeopathic profession?

No	1	Yes	2

3.25.1 Please elaborate:

_____

_____

3.26 Do you feel part of or accepted within the medical profession as a whole?

No	1	Yes	2

3.26.1Please elaborate:

_____

_____

3.27 Do you still take an active interest in homoeopathy?

No	1	Yes	2

3.27.1 If yes, in what way do you show interest?

Conferences	1	Informal practice	2	Journal subscriptions	3
Reading source material	4	Study groups	5	Other_____	

3.27.2 If no, please elaborate:

_____

_____

3.28 Are you satisfied with your current career choice?

No	1	Yes	2

3.28.1 Please elaborate:

_____

_____

3.29 Do you plan on practising homoeopathy in the future?

No	1	Yes	2

3.29.1 Please elaborate:

_____

_____

3.30 Would you study Homoeopathy again, given the choice?

Yes	1	No	2

3.30.1 At DIT or Wits and elaborate on reasons why?

_____

_____

3.30.2 If no, what would you rather have studied?

_____

3.31 If you have left South Africa, please elaborate on reasons why.

_____

_____

_____

Part D: Currently practising

4.1 How long after you qualified did you start to practise?

years	months	Straight away

4.1.1 ***Elaborate on what you did between the time of graduation and opening a practice.***

_____

_____

4.2 At what age did you start to practise? | yrs |

4.3 Total time in practice? | years | months |

4.4 How many practices do you have? _____

4.5 Where do you have your practice(s)?

City:	Country:
City:	Country:
City:	Country:

4.6 Did you find it easy to start up a practice or find employment?

No	**1**	Yes	**2**

4.6.1 Please elaborate:

_____

_____

4.7 How did you finance the set up of your practice? (More than one answer possible)

Loan	**1**	Parents	**2**	Own savings	**3**
Second income	**4**	Spouse	**5**	Other_____	

4.7.1 Please elaborate:

_____

_____

4.8 Do you practise part time or full time?

Full time	**1**	Part time	**2**

4.9 Did you ever give up practice and then return?

Yes	**1**	No	**2**

4.9.1 If yes please elaborate:

_____

_____

4.10 ***How do you practice?***

Sole	**1**	Group- Homoeopathy	**2**	Group-Multidisciplinary	**3**

4.10.1 Please elaborate:

_____

_____

4.10.2 Are you in a financial association with other practitioners state which: (More than one choice possible)

Allopathic Specialist Doctor	**1**	General Practitioner (GP)	**5**
Aromatherapist	**2**	Homoeopath	**6**
Chiropractor	**3**	Reflexologist	**7**
Dentist	**4**	Other_____	

4.10.3 If you are in a multidisciplinary set up with other practitioners, state which ones are applicable (More than one choice possible?)

Allopathic Specialist Doctor	**1**	General Practitioner (GP)	**5**
Aromatherapist	**2**	Homoeopath	**6**
Chiropractor	**3**	Reflexologist	**7**
Dentist	**4**	Other_____	

4.11 Do you ever refer patients to? (More than one choice possible)

Allopathic Specialist Doctor	**1**	General Practitioner (GP)	**5**
Aromatherapist	**2**	Homoeopath	**6**
Chiropractor	**3**	Reflexologist	**7**
Dentist	**4**	Other_____	

4.12 Do you ever receive referrals from? (More than one choice possible)

Allopathic Specialist Doctor	**1**	General Practitioner (GP)	**5**
Aromatherapist	**2**	Homoeopath	**6**
Chiropractor	**3**	Reflexologist	**7**
Dentist	**4**	Other_____	

4.13 How do you source new patients? (More than one answer possible)

Gave information presentations	**1**
Print media	**2**
Telephone directory	**3**
Word of mouth	**4**

Other:_____

4.14 How many patients on average do you see a week? | |

4.15 Average consultation fee, including average price of mediation dispensed?

Initial	**R**	Follow-up	**R**	Telephone consult	**R**

4.16 Do you supplement your income? (including other modalities employed in the treatment of your patient

No	**1**	Yes	**2**

4.16.1 ***If yes, please elaborate: (More than one answer possible)***

	ELABORATE	
Acupuncture		**1**
Chiropractic		**2**
Massage		**3**
Phytotherapy		**4**
Second job related to homoeopathy		**5**
Second job unrelated to homoeopathy		**6**
Spouse		**7**

Other_____

4.17 How long before you started to show a first net profit?

Months	***Years***	***No profit***

4.18 In what areas did you experience difficulties? (More than one answer possible)

Burnout	**1**	Economic	**2**
Lack of confidence in skills	**3**	Lack of job satisfaction	**4**
None	**5**	Work load	**6**

Other_____

4.18.1Please elaborate:

_____

_____

4.19 Do you have your own dispensary?

No	**1**	Yes	**2**

4.19.1 If no, where do your patients get their medication and remedies from?

Health Shop	**1**	Homoeopathic pharmacy	**2**	Other Homoeopath	**3**
Pharmacy	**4**	Other_____			

4.20 Which suppliers do you use for your medication and remedies? (More than one answer possible)

Ainsworth	**1**	Herbal Homoeopathic	**7**	Nrf	**13**
Arkopharma	**2**	Holistix	**8**	Pharma Natura	**14**
Bioforce	**3**	Nativa	**9**	Phytoforce	**15**
Bioharmony	**4**	Natura	**10**	Solgar	**16**
Heel	**5**	Nature Life	**11**	Viridian	**17**
Helios	**6**	Naturopathica	**12**	W last	**18**

Other:

_____

4.21 What prescription aids do you use in your practice? (More than one answer possible)

Cara	**4**	Hompath	**5**	Nothing	**6**
Mac Rep	**1**	RADAR	**2**	Repertory Book	**3**

Other_____

4.22 Was the education you received lacking in any way?

No	**1**	Yes	**2**

4.22.1 Please elaborate:

_____

_____

4.23 Do you feel that you have the support of the homoeopathic profession?

No	**1**	Yes	**2**

4.23.1 Please elaborate:

_____

_____

4.24 Do you feel part of or accepted within the medical profession as a whole?

No	**1**	Yes	**2**

4.24.1Please elaborate:

_____

_____

4.25 Besides patient consultation do you still exercise an interest in Homoeopathy?

No	**1**	Yes	**2**

4.25.1 If yes, in what way do you show interest?

Conferences	**1**	Informal practice	**2**	Journal subscriptions	**3**
Reading source material	**4**	Study groups	**5**	Other_____	

4.25.2 If no, please elaborate:

_____

_____

4.26 Are you satisfied with your current career choice?

No	**1**	Yes	**2**

4.26.1 Please elaborate:

_____

_____

4.27 Would you study Homoeopathy again, given the choice?

Yes	**1**	No	**2**

4.27.1 At DIT or Wits and elaborate on reasons why?

_____

_____

4.27.2 If no, what would you rather have studied?

_____

4.28 If you have left South Africa, please elaborate on reasons why.

_____

_____

_____

Additional comments:

APPENDIX B

PRACTITIONER INFORMED CONSENT DOCUMENT

TITLE OF RESEARCH PROJECT:

A retrospective survey of post-graduate career paths of Technikon Witwatersrand (TWR) Homoeopathic graduates from 1998 to 2004

NAME OF SUPERVISOR: Dr I.M Couchman (MTech(Hom)) 072 233 2458

Date: _____

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 study that will look at Homoeopathic practitioner demographics, career choices, education evaluation and difficulties experienced when/if setting up a practice.

I am aware that this involves answering certain questions regarding my current status as a qualified Homoeopath.

Please print in block letters:

Practitioner's name: _____ Signature: _____

Witness name: _____ Signature: _____

Research student name: _____ Signature: _____

APPENDIX C

Research information:

A retrospective survey of post-graduate career paths of Technikon Witwatersrand (TWR) Homoeopathic graduates from 1998 to 2004

I am currently a masters student doing research involving a study on the career choices Homoeopathic graduates have made since completing their course. Your participation in this research study would be invaluable and necessary for us to obtain a realistic view of demographics and the current status of practice of Technikon Witwatersrand Homoeopathy graduates.

The purpose of this research study is to determine:

- The demographics of Homeopathic graduates from 1998 to midyear 2004.
- What proportion of Homeopathic graduates formally practice Homeopathy.
- The status of their practice.
- Possible areas of difficulty they may have regarding practice.
- Other career choices made by the graduates.
- Reasons for their career choice.

An assessment will also be made regarding:

- How many successfully practicing Homeopaths Technikon Witwatersrand has produced, where they tend to practice as well as the difficulties they may be experiencing, so that educators may be well informed of the effectiveness of the education provided.
- The reasons why some graduates do not practice Homoeopathy. This information may be of value to other practicing homeopaths and to all those involved in the promotion and development of the profession.
- The career opportunities available to TWR graduates either in practice or in related fields.

INSTRUCTIONS:

You are required to complete a questionnaire, which should take no longer than 15 minutes of your time. To ensure your complete privacy, the questionnaire will not be returned directly back to the researcher, instead it will be received by an independent third party in the Faculty of Health. This person will not be a homoeopath nor will they have any personal vested interest in the homoeopathic profession. The third party will then delete your name and contact details before handing the completed document over to me.

- All graduates are requested to fill in Part A (Demographic data).
- **Only** one of either Parts B or C or D is applicable to any one graduate. To ascertain which category you fall into please refer to the definition of “Practice” provided below.
- Part B applies to graduates who have never practiced homoeopathy as stated by the definition.
- Part C applies to graduates who have practiced homoeopathy previously, but are currently not practicing, as stated by the definition.
- Part D applies to graduates who are currently practicing homoeopathy as stated by the definition.
- **Circle** answers where appropriate.
- When an option is given for “other” please specify in the space provided.

- Additional comments can be noted wherever applicable

For the purposes of this study
***"HOMOEOPATHIC PRACTICE"* is defined as:**

To exercise or follow homoeopathy as a registered profession, with or without monetary remuneration by means of providing a professional service to a formal patient base, from a fixed contactable address or addresses. (This does not include informal consultation with family, friends and acquaintances.)

How to return the questionnaire:

IIf you receive the questionnaire by e mail and fax please print out the relevant attachments and fax the completed sections to
Melanie Sweidan
c/o Lavisha Deonarian
031 204 2407

or alternatively you can post the questionnaire to
Melanie Sweidan
c/o Lavisha Deonarian
Faculty of health sciences
Durban Institute of Technology
P O Box 1334
Durban
4000

Do not hesitate to contact me should you require any further information regarding the research study.

Yours sincerely

Melanie Sweidan
RESEARCH STUDENT
(031) 201 2893
082 665 4598

Dr I.M.S Couchman MTech:(Hom)
SUPERVISOR

APPENDIX: D

THANK YOU LETTER

2 Lancaster Court
15 Lancaster Road
Musgrave
4001

Date:

Dr.
P O Box
Durban
4001

Dear Dr.

Thank you for your participation in the research study on the evaluation of career choices made by Technikon Witwatersrand Homoeopathic graduates.

The information supplied has been valuable to the ongoing education and training as well as to the realistic economic viability of the Homoeopathic qualification in South Africa.

Please do not hesitate to contact us should you have any further questions. A copy of the research study will be available at the Durban Institute of Technology (DIT) library.

I wish you all the success in the future.

Sincerely

Melanie Sweidan
Research student

Dr I.M.S Couchman MTech:(Hom)
Supervisor

APPENDIX: E

Pilot assessment form

A Survey to Determine and Evaluate the Career Choices of Technikon Witwatersrand (TWR) Homoeopathic Graduates from 1998 to 2004.

Once you have completed the questionnaire you are required to fill out the following assessment form. Comments can also be written on the questionnaire itself. All gathered information will be useful to us to ensure that the intended results of the survey are achieved.

Please answer and elaborate on the following:

Time taken to complete the questionnaire _____
Do you feel the time taken to complete the questionnaire was too long in the context of another practitioner who would have to take time from work to complete it?

_____
_____
_____

Is the presentation and layout of the questionnaire appropriate?

_____
_____
_____

Were the instructions easy to follow?

_____
_____
_____

Did you understand what was meant by the definition of 'practice'?

_____
_____
_____

Were the questions clear?

_____
_____
_____

Did they follow a logical sequence?

_____
_____
_____

Were any questions irrelevant / inappropriate in your opinion?

_____
_____
_____

Additional comments

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank You for your cooperation

Yours Sincerely

Melanie Sweidan
Research Student

Dr I.M Couchman
Supervisor

APPENDIX F:

NAME	Date
Roohani, Joanne	1998Apr
Woodcock, Gillian Elizabeth	1998Sep
Bond, Joddina	1998Sep
Breedveld, Sancia Nicole	1998Sep
Lessing, Anna Christina	1998Sep
Sutherland, Jodi Elizabeth	1998Sep
Quaroni, Loretta	1999Apr
van Es, Sonia	1999Apr
de Klerk, Marike	1999Apr
Rautenbach, Hanli	1999Sep
Scarcella, Daniela	1999Sep
Long, Angela Christine	1999Sep
Mower, Gary Wayne	1999Sep
Davey, Karen Lee	1999Sep
Pieterse, Carine	1999Sep
Didcott, Helen Sarah	1999Sep
Johnston, Gavin Ewan	1999Sep
Penny, Ryan Hilton	1999Sep
Penny, Sean Ivan	1999Sep
Jordi, Marie Louise	2000Apr
Razlog, Radmila	2000Apr
Cox, Samantha J	2000Apr
Mckechnie, Bronwen	2000Apr
Schultz, Jacquelyn Loren	2000Apr
Smith, Debbie	2000Sep
Cole, Caron Luanne	2000Sep
Moore, Heloise	2000Sep
Traub, Gabrielle Amber	2000Sep
Wolf, Natascha Melanie	2000Sep
Cascioli, Tracy Rozanne	2000Sep
Baillie, Trevor Douglas	2000Sep

Bradshaw, Candice Louise	2000Sep
Groves, Isabel	2000Sep
Hatzikonstandinou, Kanellie	2000Sep
Piedallu, Sacha DM	2000Sep
Straus, Leon Christiaan	2000Sep
Vlok, Tania Ann	2000Sep
Bengsch, Heidi	2001Apr
Doolabh, Pranay	2001Apr
Neaves, Nicholas	2001Apr
Vermeulen, Jacqueline	2001Apr
Bayer, Philip	2001Apr
Jeannes, Rene	2001Apr
Mercer, Monica	2001Apr
Smit, Adriaan	2001Apr
Vlachos, Dimitrios	2001Apr
Ferguson, Glen	2001Apr
Hardy, Robert	2001Apr
Leibenguth, Manfred	2001Apr
Jooste, Petra	2001Apr
le Roux, Yolande	2001Apr
Teixeira, Noel Deon	2001Apr
du Plessis, Jan Leonard	2001Apr
Lewis, George	2001Apr
Khayltash, Shekufeh	2001Apr
Beukes, Stefan	2001Apr
Donly, Alan	2001Apr
Knipe, Irene	2001Apr
Motala, Vicky	2001Apr
Panovka, Leigh	2001Apr
Robinson, Denise	2001Apr
van de Veen, Robert John	2001Sept
Squara, Sandra	2001Sept
Torline, John Ross	2001Sept
Baerveldt, Cherise	2001Sept
Eden, Julie, M	2001Sept
Meyer, Johan	2001Sept
Dracevac, Ivanka	2002Apr
Lazarus, Kerri Leigh	2002Apr
Smith, Lauren	2002Apr

Fleming, Colleen	2002Apr
Singh, Raksha	2002Apr
Domeison, Debbie	2002Apr
Leggatt, Karin	2002Apr
Martin, Chanel	2002Apr
Smit, Sandra	2002Sept
Blake, Graeme	2002Sept
Jacobs, Taryn	2002Sept
Leckie, Vera	2002Sept
van Meygaarden, Erica	2002Sept
van Niekerk, Sonja	2002Sept
Brodie, Kerian	2002Sept
Montgomerie, Kylie	2002Sept
Compere, Vicki	2003Apr
Thomson, Rowena Emmeline Kathryn	2003Apr
Castro de Canha, Nicole	2003Apr
Hoorzoak, Zureena	2003Apr
McLeod, Lynette Ann	2003Apr
Prangley, Adrian Bryan	2003Apr
Yutar, Graham Marc	2003Apr
Jeena, Anjana	2003Apr
Lala, Brijesh	2003Apr
Parbhoo, Anupa	2003Apr
Durandt, Gerhardus	2003Apr
Moukangoe, Phaswane Isaac Justice	2003Apr
Ings, Zanatoa Tanya	2003Sep
Pretorius, Nellie Elizabeth	2003Sep
Rohl, Angelika	2003Sep
Pelser, Karin	2003Sep
Dieltiens, Ivy L	2003Sep
Pellow, Janice	2003Sep
Bauer, Rael	2004Apr
Cara, Raakhi	2004Apr
Schiefelbein, Babette	2004Apr
Coutts, Candida	2004Apr
Fourie, Samantha	2004Apr
Saunders, Claire	2004Apr
Frost, Carolyn	2004Apr

Leistner, Elke	2004Apr
Mullinder, Louis	2004Apr
Selli, Tanya	2004Apr
Penny, Bronwen	2004Oct
Forsyth, Stuart	2004Oct
Lankesar, Yasmeen	2004Oct
Vermeulen, Adele	2004Oct
Saunders, Brenda	2004Oct
Redelinghuys, Arnike	2004Oct
Khan, Tandweer	2004Oct
Bekker, Marelize	2004Oct
Kholer, Robin	2004Oct

APPENDIX G:

RULE BOOK FOR TWR DEPARTMENT OF HOMOEOPATHY

APPENDIX H: KEY:

Part A: Demographic data

Personal details:

1.2 Place of Residence:

1.2 a Country	1.2b Province/State	1.2c Municipal area/City
RSA = South Africa	GAU = Gauteng	JHB= Johannesburg (Metropolitan municipality City of Johannesburg)
	NP= Northern Province	PRE=Pretoria(Metropolitan municipality of Pretoria)
	WC = Western Cape	CT= Cape Town (Cape Town Metropolitan Area)
		MB=Mossel Bay
	MP= Mpumalanga	POT= Potchefstroom
		MD=Middleburg
	NW= North West	POL=Polokwane
	LP=Limpopo Province	WB=Waterberg District
UK = United Kingdom		LON = London
		WK=Woking
		SUR=Surrey
UAE=United Arab Emirates		DUB=Dubai

1.3 Gender:

Female	**1**	Male	**2**

1.4 Country of Birth:

RSA = South Africa
UK = United Kingdom
NAM= Namibia

1.5 Country of Citizenship:

RSA = South Africa
UK = United Kingdom
NED = Netherlands

1.6 Age category:

21-25	**1**	26-30	**2**	31-35	**3**	36-40	**4**	41-45	**5**	46-50	**6**	>51	**7**

1.7 Race:

Asian	**1**	Black	**2**	Coloured	**3**	Indian	**4**	White	**5**

1.8 Marital status:

Divorced	**1**	Married	**2**	Single	**3**	Widowed	**4**

1.9 Number of dependents: ☐

1.10 Languages spoken:

1.10 a 1st language	**1.10b 2nd language**	**1.10c other language**	**Language**
1	**1**	**1**	Afrikaans
2	**2**	**2**	English
3	**3**	**3**	Official SA African Languages
4	**4**	**4**	European Languages
5	**5**	**5**	Asian Languages
6	**6**	**6**	Middle Eastern Languages

1.11 Income per annum:

R0 – R12 000	**1**
R12 001 – R24 000	**2**
R24 001 – R50 000	**3**
R50 001 – R100 000	**4**
R100 001 – R150 000	**5**
R150 001 – R200 000	**6**
R201 000 – R300 000	**7**
R300 001 – R400 000	**8**
> R400 001	**9**

Educational details:

1.12 Year of first registration at TWR: ☐

1.13 Age of first registration at TWR: yrs

1.14 Year of Entry on first registration (i.e. what year did you start in?):

1st yr	**1**	2nd yr	**2**	3rd yr	**3**	4th yr	**4**	5th yr	**5**

1.15 Level of education on first registration at TWR:

	Field (1.15a)	**Type(1.15b)**	**Institution (1.15c)**	**Complete or Not (1.15d)**
1	Health	Degree	University	Completed
2	Science	Diploma	Technikon	Not completed
3	Social Science	Certificate	Private Institution	
4	Economics	Matric		
5	Education			
6	Arts			
7	Performing Arts			
8	Other not specified			

1.16 Time taken to complete research after fifth year: months

1.17 Did you do any form of internship, excluding 5th year patient quotas?

No	**1**	Yes	**2**

1.17.1 If yes, where did you do your internship?

Hospital	**1**	Overseas	**2**		
Technikon Clinic	**3**	Private Practice	**4**	Rural Clinic	**5**
Other Clinic e.g. community clinic	**6**	Pharmacy	**7**		

1.17.2 How long was your internship in months? months

1.18 Number of years taken to complete degree from year of first registration:

3 yrs	**1**	4 yrs	**2**	5 yrs	**3**	6 yrs	**4**
7 yrs	**5**	8 yrs	**6**	9 yrs	**7**	> 10 yrs	**8**

1.19 Year of qualification from TWR:

1.20 Age on qualification from TWR: yrs

1.21 Additional qualifications obtained after the Homoeopathy Degree:

	Field (1.21a)	**Type(1.21b)**	**Institution (1.21c)**
1	Extension Of Homeopathic Education	Degree	University
2	Profession Registered With AHPC	Diploma	Technikon
3	Alternative Health Methods Not Registered As Profession With AHPC	Certificate	Private Institution
4	Profession unrelated to Homoeopathy		Hospital

5	Basic extension of medical education		

1.22 List the official boards with which you are registered:

Boards (1.22a)

1 Allied Health Professionals Council
2 Board Of Health Care Funders
3 Other Official Board Pertaining To Another Country In Field Of Health
4 Other Official Board Pertaining To Non Health Related Field In SA
5 Homoeopathic association of South Africa
6 Pharmacy Council
7 Phytotherapy and naturopathy
8 Biomedical association
9 Health Professions council of South Africa

Qualification (1.22b)

1 Homoeopath
2 Chiropractor
3 Acupuncturist
4 Reflexologist
5 Aromatherapy
6 Therapeutic massage
7 Natural therapiast
8 Medically Related Profession
9 Chinese medicine
10 Biopuncture
11 Kinesiologist

Part B: Non practicing – Never practiced previously

2.1 Reasons for not practising? (More than one choice possible)

Emigration	**1**	Family Commitment Reasons	**8**
Financial Reasons	**2**	Studying Full / Part Time	**9**
Lack Of Personal Interest	**3**	Travel	**10**
Lack Of Interest From Public In Homoeopathy	**4**	Other Not Specified	**11**
Not Confident	**5**		
Perceived Lack Of Skills	**6**		
Burned Out	**7**		

2.2 What is your current occupation?

1	Homemaker
2	Studying Medical Field
3	Studying Alternative Medical Field
4	Studying Non Medical Field (Unrelated Field)
5	Working In Medical Professional Field
6	Working In Alternative Health Field
7	Working In Non Medical Field (Unrelated Field)
8	Working In Homoeopathic Related Field
9	Working In Totally Unrelated Field
10	Unemployed

2.3 Is your homoeopathic education directly useful in your current work?

No	**1**	Yes	**2**

2.3.1 Subjects / aspect of education useful in current work

1	Sciences (Physics and chemistry)
2	Human Biology (Anatomy and physiology)
3	Medicine (Pathology and diagnostics)
4	Pharmacology
5	Nutrition and Phytotherapy
6	Auxiliary Therapeutics (incl. acupuncture, massage, hot and cold therapy etc.)
7	Homoeopharmaceutics
8	Homoeopathic Philosophy And Psychology
9	Homoeopathic Material Medica And Clinical Applications Of Remedies
10	All Subjects / Aspects Of Education

2.4 Do you feel the education you received was lacking in any way?

No	**1**	Yes	**2**

2.4.1 Aspects of education lacking:

1	Medical Subject Taught
2	Homoeopathic Subjects Taught
3	Business / Economic Skills Taught
4	Other Complimentary Therapies Covered / Taught
5	Practical Diagnostic Skill And Techniques
6	Diagnostic Test And Investigation Interpretation
7	Clinical/Practical Experience Regarding Medical Aspect Of Consultation
8	Clinical/Practical Experience Regarding Homeopathic Aspect Of Consultation
9	Lecturer, Clinicians And Teaching Staff Inexperienced
10	Poor Integration Of Theoretical And Practical Knowledge
11	Post Graduate Support
12	Speciality Areas e.g Paediatrics
13	Misinformation
14	Other non specified category

2.5 Do you feel that you have the support of the homoeopathic profession?

No	**1**	Yes	**2**

2.5.1 Please elaborate:

1	There Is A Good Functioning Representative Functioning Body And Leader Ship
2	No / Poor Functioning Representative Body And Leader Ship
3	Good Sharing Of Info And Communication With Other Practitioners/Colleagues
4	No/Poor Sharing Of Info And Communication With Other Practitioners / Colleagues
5	Good Assistance From Other Practitioners
6	No/ Poor Assistance From Other Practitioners And Post Graduate Support
7	AHPC Unhelpful
8	No job placements available for homoeopaths
9	Other not specified

2.6 Do you feel part of or accepted within the medical profession as a whole?

No	**1**	Yes	**2**

2.6.1Please elaborate:

1	I Am Part Of A Mutual Active Referral System
2	I Am Not Part Of A Mutual Active Referral System

3	Have Access To Medical Infrastructures
4	Have No Access To Medical Infrastructures
5	There Is A Growing Positive Awareness And Acceptance Of Homeopathy
6	Little Awareness And Education Regarding Homeopathy In The Medical Professions
7	The Medical Profession Recognises And Respects Our Level Of Knowledge And Training
8	Homoeopathy Not Respected Or Taken Seriously By Medical Profession
9	Medical Profession Thinks Homeopathy Is Dangerous

2.7 Do you still take an active interest in homoeopathy?

No	**1**	Yes	**2**

2.7.1 If yes, in what way do you show interest?

Conferences	**1**	Informal Practice	**2**	Journal Subscriptions	**3**
Reading Source Material	**4**	Study Groups	**5**	Internet	**6**

2.7.2 If no, please elaborate:

1	No Interest And No Time
2	Despondent About Homoeopathy
3	Will Never Practice

2.8 Are you satisfied with your current career choice, i.e. not homeopathy?

No	**1**	Yes	**2**

2.8.1 Please elaborate:

1	Financially Rewarding / Viable
2	Not Financially Rewarding / Viable
3	Rewarding Career / Job Satisfaction
4	Not Rewarding Career / No Job Satisfaction
5	Easy Stress Free Work
6	Difficult, Stressful Work
7	Flexible Working Hours Being Self Employed
8	Not Versatile / Flexible Career
9	Scope For Expanding Career
10	No Recognition Of Education Or Profession
11	Other Not Specified

2.9 Do you plan on practising homoeopathy in the future?

No	**1**	Yes	**2**	Unsure	**3**

2.9.1 Please elaborate:

1	Will Practice Within The Next 6 Months To A Year
2	May Practice In The Distant Future

3	Will Practice With Other Modality
4	Will Practice Dependant On Circumstances
5	No Interest In Practicing
6	Not Confident To Practice
7	Practice Is Not Financially Rewarding
8	Circumstances Prevent Me From Ever Practicing

2.10 Would you study Homoeopathy again, given the choice?

No	**1**	Yes	**2**

2.10.1. a. Where would you have liked to study homoeopathy?

1	Durban Institute Of Technology
2	Witwatersrand Technikon
3	No Preference Of Technikons
4	Medicine With Post Graduate Homoeopathy

2.10.1. b. Reasons for choice

1	No Knowledge About Other Institution
2	Better / More Convenient Location
3	Prefer System Of Homoeopathy Taught I.E. Classical Homoeopathy
4	Better Standard Of Education
5	Wider Variety Of Modalities Taught
6	Better Lecturers / Staff
7	Better Practical Experience And Skills
8	Better Post Graduate Support
9	More Versatile And Accepted Qualification

2.10.2a If no, why not?

1	Not Financially Rewarding / Viable
2	Not Rewarding Career / No Job Satisfaction
3	Difficult, Stressful Work
4	Not Versatile / Flexible Career
5	No Recognition Of Education Or Profession
6	Course Too Long
7	Other Not Specified

2.10.2b If no, what would you rather have studied?

1	Medicine
2	Other Medical Fields
3	Chiropractics
4	AHPC Registered Professions Other Than Chiropractics
5	Other Complementary Professions Not Registered With AHPC

6	Sciences
7	Commerce / Accounting/ IT
8	Psychology And Counseling
9	Arts
10	Law
11	Other Not Specified Above

2.11 If you have left South Africa, please elaborate on reasons why.

1	Travel
2	Personal / Family Reasons
3	Political Reasons
4	More Career Opportunities
5	Financial Reasons
6	Study

Part C: Non practicing – Practiced previously

Previous practice information:

3.1 How long after you qualified did you start to practise?

months	0= Straight away

3.1.1 Elaborate on what you did between the time of graduation and opening a practice.

1	Travel / Holiday
2	Set Up Practice
3	Family / Homemaker
4	Work In Health Field
5	Work In Health Unrelated Field
6	Study
7	Lectured homoeopathy to undergraduates

3.2 At what age did you start to practise? yrs

3.3 Total time in practice? years

3.4 How many practices did you have?

3.5 Where did you have your practice(s)?

3.5a Country	3.5b	3.5c Municipal area/City

	Province/State	
RSA = South Africa	GAU = Gauteng	JHB= Johannesburg (Metropolitan municipality City of Johannesburg)
	NP= Northern Province	PRE=Pretoria(Metropolitan municipality of Pretoria)
	WC = Western Cape	CT= Cape Town (Cape Town Metropolitan Area)
		MB=Mossel Bay
	MP= Mpumalanga	POT= Potchefstroom
		MD=Middleburg
	NW= North West	POL=Polokwane
	LP=Limpopo Province	WB=Waterberg District
UK = United Kingdom		LON = London
		WK=Woking
		SUR=Surrey
UAE=United Arab Emirates		DUB=Dubai

3.6 Did you find it easy to start up a practice or find employment?

No	**1**	Yes	**2**

3.6.1 Please elaborate:

1	Financial Difficulties
2	Good Financial Support
3	Poor / No Business Or Practice Management Skills
4	Had A Good Business Plan
5	Marketing Difficulties And Restraints
6	Poor Public Awareness Of Homoeopathy
7	Few Patient Numbers / Long Time To Establish Patient Base
8	Poor / No Support Network
9	Good Support Network
10	Joined Existing Practice
11	Few / No Employment Opportunities
12	Employed Directly
13	Too Many Homoeopaths In Local Area
14	Few Homoeopaths In Local Area
15	Poor Skills / Lack Of Experience/ Lack Of Self Confidence
16	Emotionally Difficult
17	Difficult Personal Circumstances
18	Fortunate / "Lucky" Personal Circumstances
19	Other Not Specified

3.7 How did you finance the set up of your practice? (More than one answer possible)

1	Loan
2	Own Savings
3	Part Time Work / Second Income In Health Related Field
4	Part Time Work/ Second Income Not In Health Related Field
5	Owned Other Business
6	Support From Parents
7	Support From Spouse / Partner
8	Minimized Practice Set Up Costs
9	No Set Up Costs

3.8 Did you practice part time or full time?

Full time	**1**	Part time	**2**	Both in different time periods	**3**

3.9 How did you practice?

Sole	**1**	Group- Homoeopathy	**2**	Group-Multidisciplinary	**3**

3.9.1. Please elaborate:

1	Shared Premises
2	Financial Partner Ship
3	Employed

3.9.2 If you were in financial association with other practitioners state which:

1	Allopathic Specialist Doctor
2	General Practitioner (Gp)
3	Dentist
4	Other Medical Professionals
5	Psychologist / Councilor
6	Homoeopath
7	Chiropractor
8	Other Complementary Health Profession Registered With AHPC
9	Other Complementary Health Profession Not Registered With AHPC
10	Beautician
11	Other Not Specified

3.9.3 If you were in a multidisciplinary set up with other practitioners, state which ones are applicable

1	Allopathic Specialist Doctor
2	General Practitioner (GP)
3	Dentist
4	Other Medical Professionals
5	Psychologist / Councilor
6	Homoeopath
7	Chiropractor
8	Other Complementary Health Profession Registered With AHPC
9	Other Complementary Health Profession Not Registered With AHPC
10	Beautician
11	Other Not Specified

3.10 Did you ever refer patients to?

1	Allopathic Specialist Doctor
2	General Practitioner (GP)
3	Dentist
4	Other Medical Professionals
5	Psychologist / Councilor
6	Homoeopath
7	Chiropractor
8	Other Complementary Health Profession Registered With AHPC
9	Other Complementary Health Profession Not Registered With AHPC
10	Beautician
11	Other Not Specified

3.11 Did you ever receive referrals from?

1	Allopathic Specialist Doctor
2	General Practitioner (GP)
3	Dentist
4	Other medical professionals
5	Psychologist / Councilor
6	Homoeopath
7	Chiropractor
8	Other complementary health profession registered with AHPC
9	Other complementary health profession not registered with AHPC
10	Beautician
11	Other not specified

3.12 How did you source new patients? (More than one answer possible)

1	Gave Information Presentations
2	Print Media
3	Telephone Directory
4	Word Of Mouth
5	Referrals From Other Disciplines
6	Interviews On Radio / TV
7	Magazine Articles / Contributions
8	Internet
9	Direct Marketing
10	Health Festivals
11	Pharmacy

3.13 How many patients on average did you see a week? |

3.14 Average consultation fee, including average price of mediation dispensed?

Initial **(3.14a)**	**R**	Follow-Up **(3.14b)**	**R**	Telephone Consult **(3.14c)**	**R**

3.15 Did you supplement your income? (Including other modalities employed in the treatment of your patient

No	**1**	Yes	**2**

3.15.1 If yes, please elaborate: (More than one answer possible)

3.15.1 a Supplement income with extra modalities used during Homoeopathic consultation

1	Acupuncture
2	Chiropractic
3	Massage
4	Phytotherapy
5	Vitamins, Minerals And Supplements
6	Other Modality Not Registered With AHPC

3.15.1 b Income supplemented outside of Homoeopathic consultation

1	Practice of profession recognised by AHPC used as separate modality
2	Practice of profession not recognised by AHPC used as separate modality
3	Teaching / lecturing/ clinician to students of Homoeopathy
4	Work in health care industry
5	Work unrelated to health care industry
6	Support from spouse / partner

3.16 How long before you started to show a first net profit?

Months	***No profit =N*** ***Immediately = 0***

3.17 In what areas did you experience difficulties? (More than one answer possible)

1	Burnout
2	Economic
3	Lack Of Confidence And Experience
4	Lack Of Job Satisfaction
5	Work Load Too Large
6	Lack Of Patient Numbers
7	Lack Of Public Awareness Of Homoeopathy
8	Little Recognition Of Work Of Profession
9	Emotional Difficulties
10	None
11	Legislation against advertising stunts growth of practice
12	Lack of practical education
13	No backing from Allied Health Professions Council
14	Medical Aids do not understand homoeopathy
15	Opposition to homoeopathy from Dept. of Health

3.18 Did you have your own dispensary?

No	**1**	Yes	**2**

3.18.1 If no, where did your patients get their medication and remedies from?

1	Health Shop
2	Homoeopathic pharmacy
3	Other Homoeopath
4	Pharmacy
5	Technikon clinic dispensary

3.19 Which suppliers did you use for your medication and remedies? (More than one answer possible)

Ainsworth	**1**	Herbal Homoeopathic	**7**	Nrf	**13**	Homoeopathic trading co	**19**
Arkopharma	**2**	Holistix	**8**	Pharma Natura	**14**	SA Natural Products	**20**
Bioforce	**3**	Nativa	**9**	Phytoforce	**15**	Food State	**21**
Bioharmony	**4**	Natura	**10**	Solgar	**16**	Solal	**22**
Heel	**5**	Nature Life	**11**	Viridian	**17**	Parceval	**23**
Helios	**6**	Naturopathica	**12**	W Last	**18**	Other Company in SA	**24**
						Overseas company	**25**

3.20 What prescription aids did you use in your practice? (More than one answer possible)

Mac Rep	**1**	RADAR	**2**	Repertory Book	**3**
Cara	**4**	Hompath	**5**	Nothing	**6**
Vital quest	**7**	Material medicas & source material	**8**		

Current status:

3.21 Reasons for not practising? (More than one choice possible)

Emigration	**1**	Family commitment reasons	**8**
Financial reasons	**2**	Studying full / part time	**9**
Lack of personal interest	**3**	Travel	**10**
Lack of interest from public in Homoeopathy	**4**	Other not specified	**11**
Not confident	**5**		
Perceived lack of skills	**6**		
Burned out	**7**		

3.22 What is your current occupation?

Homemaker	**1**
Studying Medical field	**2**
Studying Alternative Medical field	**3**
Studying Non medical field (unrelated field)	**4**
Working in Medical professional field	**5**
Working in Alternative health field	**6**

Working in Non Medical field (unrelated field)	**7**
Working in Homoeopathic related field	**8**
Working in totally unrelated field	**9**
Unemployed	**10**

3.23 Is your homoeopathic education directly useful in your current work?

No	**1**	Yes	**2**

3.23.1 Subjects / aspect of education useful in current work

1	Sciences (Physics And Chemistry)
2	Human Biology (Anatomy And Physiology)
3	Medicine (Pathology And Diagnostics)
4	Pharmacology
5	Nutrition And Phytotherapy
6	Auxiliary Therapeutics (Incl Acupuncture, Massage, Hot And Cold Therapy Etc.)
7	Homeopharmaceutics
8	Homoeopathic Philosophy And Psychology
9	Homeopathic Material Medica And Clinical Applications Of Remedies
10	All Subjects / Aspects Of Education

3.24 Was the education you received lacking in any way?

No	**1**	Yes	**2**

3.24.1 Please elaborate:

1	Medical Subject Taught
2	Homoeopathic Subjects Taught
3	Business / Economic Skills Taught
4	Other Complimentary Therapies Covered / Taught
5	Practical Diagnostic Skill And Techniques
6	Diagnostic Test And Investigation Interpretation
7	Clinical/Practical Experience Regarding Medical Aspect Of Consultation
8	Clinical/Practical Experience Regarding Homeopathic Aspect Of Consultation
9	Lecturer, Clinicians And Teaching Staff Inexperienced
10	Integration Of Theoretical And Practical Knowledge
11	Post Graduate Support
12	Speciality Areas e.g Paediatrics
13	Other Non Specified Category

3.25 Do you feel that you have the support of the homoeopathic profession?

No	**1**	Yes	**2**	Not active in profession so not applicable	**0**

3.25.1 Please elaborate:

1	There Is A Good Functioning Representative Functioning Body And Leader Ship
2	No / Poor Functioning Representative Body And Leader Ship
3	Good Sharing Of Info And Communication With Other Practitioners/Colleagues
4	No/Poor Sharing Of Info And Communication With Other Practitioners / Colleagues
5	Good Assistance From Other Practitioners
6	No/ Poor Assistance From Other Practitioners And Post Graduate Support
7	AHPC Unhelpful
8	No job opportunities
9	It is not a profession
10	Other not specified

3.26 Do you feel part of or accepted within the medical profession as a whole?

No	**1**	Yes	**2**	Not Active In Profession So Not Applicable	**0**

3.26.1Please elaborate:

1	I Am Part Of A Mutual Active Referral System
2	I Am Not Part Of A Mutual Active Referral System
3	Have Access To Medical Infrastructures
4	Have No Access To Medical Infrastructures
5	There Is A Growing Positive Awareness And Acceptance Of Homeopathy
6	Little Awareness And Education Regarding Homeopathy In The Medical Professions
7	The Medical Profession Recognises And Respects Our Level Of Knowledge And Training
8	Homoeopathy Not Respected Or Taken Seriously By Medical Profession
9	Medical Profession Thinks Homoeopathy Is Dangerous

3.27 Do you still take an active interest in homoeopathy?

No	**1**	Yes	**2**

3.27.1 If yes, in what way do you show interest?

Conferences	**1**	Informal Practice	**2**	Journal Subscriptions	**3**
Reading Source Material	**4**	Study Groups	**5**	Internet	**6**

3.27.2 If no, please elaborate:

1	No Interest And No Time

2	Despondent About Homoeopathy
3	Will Never Practice
4	Still passionate about homoeopathy but it has no future

3.28 Are you satisfied with your current career choice, i.e not homoeopathy?

No	**1**	Yes	**2**

3.28.1 Please elaborate:

1	Financially Rewarding / Viable
2	Not Financially Rewarding / Viable
3	Rewarding Career / Job Satisfaction
4	Not Rewarding Career / No Job Satisfaction
5	Easy Stress Free Work
6	Difficult, Stressful Work
7	Flexible Working Hours Being Self Employed
8	Not Versatile / Flexible Career
9	Scope For Expanding Career
10	No Recognition Of Education Or Profession
11	Other Not Specified

3.29 Do you plan on practising homoeopathy in the future?

No	**1**	Yes	**2**	Unsure	**3**

3.29.1 Please elaborate:

1	Will Practice Within The Next 6 Months To A Year
2	May Practice In The Distant Future
3	Will Practice With Other Modality
4	Will Practice Dependant On Circumstances
5	No Interest In Practicing
6	Not Confident To Practice
7	Practice Is Not Financially Rewarding
8	Circumstances Prevent Me From Ever Practicing
9	Don't want to feel like I have wasted my money
10	If gaining more experience
11	It is a quack profession

3.30 Would you study Homoeopathy again, given the choice?

No	**1**	Yes	**2**

3.30.1. a. Where would you have liked to study homoeopathy?

1	DIT

2	WITS
3	No Preference Of Technikons
4	Medicine With Post Graduate Homoeopathy

3.30.1. b. Reasons for choice

1	No Knowledge About Other Institution
2	Better / More Convenient Location
3	Prefer System Of Homoeopathy Taught I.E. Classical Homoeopathy
4	Better Standard Of Education
5	Wider Variety Of Modalities Taught
6	Better Lecturers / Staff
7	Better Practical Experience And Skills
8	Better Post Graduate Support
9	More Versatile And Accepted Qualification

3.30.2a If no, why not?

1	Not financially rewarding / viable
2	Not rewarding career / no job satisfaction
3	Difficult, stressful work
4	Not versatile / flexible career
5	No recognition of education or profession
6	Course too long
7	Medicines do not work
8	Other not specified

3.30.2b If no, what would you rather have studied?

1	Medicine
2	Other medical fields
3	Chiropractics
4	AHPC registered professions other than chiropractics
5	Other complementary professions not registered with AHPC
6	Sciences
7	Commerce / accounting/ IT
8	Psychology and counseling
9	Arts
10	Law
11	Other not specified above

3.31 If you have left South Africa, please elaborate on reasons why.

1	Travel
2	Personal / family reasons
3	Political reasons
4	More career opportunities
5	Financial reasons
6	Study

Part D: Currently practicing

4.1 How long after you qualified did you start to practise?

months	0 = Straight away

4.1.1 What did you do between the time of graduation and opening a practice.

1	Travel / Holiday
2	Set up practice
3	Family / Homemaker
4	Work in health field
5	Work in health unrelated field
6	Study
7	Lectured in Homoeopathy

4.2 At what age did you start to practise? yrs

4.3 Total time in practice? years

4.4 How many practices do you have?_____

4.5 Where do you have your practice(s)?

4.5a Country	**4.5b Province/State**	**4.5c Municipal area/City**
RSA = South Africa	GAU = Gauteng	JHB= Johannesburg (Metropolitan municipality City of Johannesburg)
	NP= Northern Province	PRE=Pretoria(Metropolitan municipality of Pretoria)
	WC = Western Cape	CT= Cape Town (Cape Town Metropolitan Area)
		MB=Mossel Bay
	MP= Mpumalanga	POT= Potchefstroom
		MD=Middleburg
	NW= North West	POL=Polokwane
	LP=Limpopo Province	WB=Waterberg District
UK = United Kingdom		LON = London
		WK=Woking
		SUR=Surrey
UAE=United Arab Emirates		DUB=Dubai

4.6 Did you find it easy to start up a practice or find employment?

No	**1**	Yes	**2**

4.6.1 Please elaborate:

1	Financial Difficulties
2	Good Financial Support
3	Poor / No Business Or Practice Management Skills
4	Had A Good Business Plan
5	Marketing Difficulties And Restraints
6	Poor Public Awareness Of Homoeopathy
7	Few Patient Numbers / Long Time To Establish Patient Base
8	Poor / No Support Network
9	Good Support Network
10	Joined Existing Practice
11	Few / No Employment Opportunities
12	Employed Directly
13	Too Many Homoeopaths In Local Area
14	Few Homoeopaths In Local Area
15	Poor Skills / Lack Of Experience/ Lack Of Self Confidence
16	Emotionally Difficult
17	Difficult Personal Circumstances
18	Fortunate / "Lucky" Personal Circumstances
19	I believe and I have faith in the profession therefore it came easily
20	Clinic is at TWR therefore do not have the same difficulty
21	Took a chance
22	Forced to open a private practice

4.7 How did you finance the set up of your practice? (More than one answer possible)

1	Loan
2	Own Savings
3	Part Time Work / Second Income In Health Related Field
4	Part Time Work/ Second Income Not In Health Related Field
5	Owned Other Business
6	Support From Parents
7	Support From Spouse / Partner
8	Minimized Practice Set Up Costs
9	No Set Up Costs

4.8 Do you practice part time or full time?

Full time	**1**	Part time	**2**

4.9 Did you ever give up practice and then return?

No	**1**	Yes	**2**

4.9.1 a: Duration of absence from formal practice

1	1-3 months
2	4-6 months
3	7 –12 months

4.9.1b: Reason for absence from formal practice

1	Travel
2	Moved Location
3	Had A Child/ Maternity Leave
4	Lack of time
5	Worked in health related field

4.10 How do you practice?

Sole	**1**	Group- Homoeopathy	**2**	Group-Multidisciplinary	**3**

4.10.1 Please elaborate:

1	Shared Premises
2	Financial Partner Ship
3	Employed

4.10.2 If you are in a financial association with other practitioners state which: (More than one choice possible)

1	Allopathic Specialist Doctor
2	General Practitioner (GP)
3	Dentist
4	Other Medical Professionals
5	Psychologist / Councilor
6	Homoeopath
7	Chiropractor
8	Other Complementary Health Profession Registered With AHPC
9	Other Complementary Health Profession Not Registered With AHPC
10	Beautician
11	Other Not Specified

4.10.3 If you are in a multidisciplinary set up with other practitioners, state which ones are applicable (More than one choice possible?)

1	Allopathic Specialist Doctor
2	General Practitioner (GP)
3	Dentist
4	Other Medical Professionals
5	Psychologist / Councilor
6	Homoeopath
7	Chiropractor

8	Other Complementary Health Profession Registered With AHPC
9	Other Complementary Health Profession Not Registered With AHPC
10	Beautician
11	Other Not Specified

4.11 Do you ever refer patients to? (More than one choice possible)

1	Allopathic Specialist Doctor
2	General Practitioner (GP)
3	Dentist
4	Other Medical Professionals
5	Psychologist / Councilor
6	Homoeopath
7	Chiropractor
8	Other Complementary Health Profession Registered With AHPC
9	Other Complementary Health Profession Not Registered With AHPC
10	Beautician
11	Other not specified

4.12 Do you ever receive referrals from? (More than one choice possible)

1	Allopathic Specialist Doctor
2	General Practitioner (GP)
3	Dentist
4	Other medical professionals
5	Psychologist / Councilor
6	Homoeopath
7	Chiropractor
8	Other Complementary Health Profession Registered With AHPC
9	Other Complementary Health Profession Not Registered With AHPC
10	Beautician
11	No

4.13 How do you source new patients? (More than one answer possible)

1	Gave Information Presentations
2	Print Media
3	Telephone Directory
4	Word Of Mouth
5	Referrals From Other Disciplines
6	Interviews On Radio / TV
7	Magazine Articles / Contributions

8	Internet
9	Direct Marketing

4.14 How many patients on average do you see a week?

4.15 Average consultation fee, including average price of mediation dispensed?

Initial **(4.15a)**	**R**	Follow-up **(4.15b)**	**R**	Telephone consult **(4.15c)**	**R**

4.16 Do you supplement your income? (including other modalities employed in the treatment of your patient

No	**1**	Yes	**2**

4.16.1 If yes, please elaborate:

4.16.1 a Supplement income with extra modalities used during Homoeopathic consultation

1	Acupuncture
2	Chiropractic
3	Massage
4	Phytotherapy
5	Vitamins, Minerals And Supplements
6	Other Modality Not Registered With AHPC

4.16.1 b Income supplemented outside of Homoeopathic consultation

1	Practice Of Profession Recognised By AHPC Used As Separate Modality
2	Practice Of Profession Not Recognised By AHPC Used As Separate Modality
3	Teaching / Lecturing/ Clinician To Students Of Homoeopathy
4	Work In Health Care Industry
5	Work Unrelated To Health Care Industry
6	Support From Spouse / Partner
7	Own another business

4.17 How long before you started to show a first net profit?

Months	***No profit =N*** ***Immediately = 0***

4.18 In what areas do you experience difficulties? (More than one answer possible)

1	Burnout
2	Economic
3	Lack Of Confidence And Experience
4	Lack Of Job Satisfaction
5	Work Load Too Large
6	Lack Of Patient Numbers

7	Lack Of Public Awareness Of Homoeopathy
8	Little Recognition Of Work Of Profession
9	Emotional Difficulties
10	None
11	Lack of practice management skills
12	No support for homoeopaths
13	No internship
14	Government restrictions

4.19 Do you have your own dispensary?

No	**1**	Yes	**2**

4.19.1 If no, where do your patients get their medication and remedies from?

1	Health Shop
2	Homoeopathic Pharmacy
3	Other Homoeopath
4	Pharmacy
5	Technikon Clinic Dispensary
6	Order through the internet

4.20 Which suppliers do you use for your medication and remedies? (More than one answer possible)

Ainsworth	**1**	Herbal Homoeopathic	**7**	Nrf	**13**	Homoeopathic Trading Co	**19**
Arkopharma	**2**	Holistix	**8**	Pharma Natura	**14**	SA Natural Products	**20**
Bioforce	**3**	Nativa	**9**	Phytoforce	**15**	Food State	**21**
Bioharmony	**4**	Natura	**10**	Solgar	**16**	Solal	**22**
Heel	**5**	Nature Life	**11**	Viridian	**17**	Parceval	**23**
Helios	**6**	Naturopathica	**12**	W Last	**18**	Other Company In SA	**24**
						Overseas Company	**25**

4.21 What prescription aids do you use in your practice? (More than one answer possible)

Mac Rep	**1**	RADAR	**2**	Repertory Book	**3**
Cara	**4**	Hompath	**5**	Nothing	**6**
Vital Quest	**7**	Material Medicas & Source Material	**8**	Blood Tests	**9**
Electro Accupuncture Machine	**10**				

4.22 Was the education you received lacking in any way?

No	**1**	Yes	**2**

4.22.1 Please elaborate:

1	Medical Subject Taught

2	Homoeopathic Subjects Taught
3	Business / Economic Skills Taught
4	Other Complimentary Therapies Covered / Taught
5	Practical Diagnostic Skill And Techniques
6	Diagnostic Test And Investigation Interpretation
7	Clinical/Practical Experience Regarding Medical Aspect Of Consultation
8	Clinical/Practical Experience Regarding Homeopathic Aspect Of Consultation
9	Lecturer, Clinicians And Teaching Staff Inexperienced
10	Poor Integration Of Theoretical And Practical Knowledge
11	Post Graduate Support
12	Speciality Areas e.g. Paediatrics
13	Real learning only takes place when you are working
14	No internship
15	Had an internship
16	Education did not inspire the true spirit of classical homoepathy
17	Teething problems with the new course

4.23 Do you feel that you have the support of the homoeopathic profession?

No	**1**	Yes	**2**

***4.23.1 Please elaborate*:**

1	There Is A Good Functioning Representative Functioning Body And Leader Ship
2	No / Poor Functioning Representative Body And Leader Ship
3	Good Sharing Of Info And Communication With Other Practitioners/Colleagues
4	No/Poor Sharing Of Info And Communication With Other Practitioners / Colleagues
5	Good Assistance From Other Practitioners
6	No/ Poor Assistance From Other Practitioners And Post Graduate Support
7	AHPC Unhelpful
8	They do not provide an internship
9	More progressive practitioners are looked down upon by classical homoeopaths
10	No protection against illegal practitioners

4.24 Do you feel part of or accepted within the medical profession as a whole?

No	**1**	Yes	**2**	Both	**3**

4.24.1Please elaborate:

1	I Am Part Of A Mutual Active Referral System
2	I Am Not Part Of A Mutual Active Referral System
3	Have Access To Medical Infrastructures
4	Have No Access To Medical Infrastructures
5	There Is A Growing Positive Awareness And Acceptance Of Homeopathy

6	Little Awareness And Education Regarding Homeopathy In The Medical Professions
7	The Medical Profession Recognises And Respects Our Level Of Knowledge And Training
8	Homoeopathy Not Respected Or Taken Seriously By Medical Profession
9	Medical Profession Thinks Homeopathy Is Dangerous
10	Accepted by open minded Allopathic doctors
11	Allopaths think they are superior
12	Homoeopathy is seen as a last resort
13	Homoeopaths are not on the same level of education as Allopaths
14	GP's see homoeopaths as a threat

4.25 Besides patient consultation do you still exercise an interest in Homoeopathy?

No	**1**	Yes	**2**

4.25.1 If yes, in what way do you show interest?

Conferences	**1**	Informal Practice	**2**	Journal Subscriptions	**3**
Reading Source Material	**4**	Study Groups	**5**	Internet	**6**

4.25.2 If no, please elaborate:

1	No Interest
2	Despondent About Homoeopathy
3	Will Never Practice
4	No time

4.26 Are you satisfied with your current career choice? Ie homoeopathy

No	**1**	Yes	**2**

4.26.1 Please elaborate:

1	Financially Rewarding / Viable
2	Not Financially Rewarding / Viable
3	Rewarding Career / Job Satisfaction / Passionate about homoeopathy
4	Not Rewarding Career / No Job Satisfaction
5	Easy Stress Free Work
6	Difficult, Stressful Work
7	Flexible Working Hours Being Self Employed
8	Not Versatile / Flexible Career
9	Scope For Expanding Career
10	No Recognition Of Education Or Profession
11	Despite setbacks I am meant to be a healer
12	Other Not Specified

4.27 Would you study Homoeopathy again, given the choice?

No	**1**	Yes	**2**

4.27.1.a. Where would you have liked to study homoeopathy?

1	DIT
2	WITS
3	No Preference Of Technikons
4	Medicine With Post Graduate Homoeopathy

4.27.1 b. Reasons for choice

1	No Knowledge About Other Institution
2	Better / More Convenient Location
3	Prefer System Of Homoeopathy Taught
4	Better Standard Of Education
5	Wider Variety Of Modalities Taught/ More Different Systems Of Homeopathy Taught
6	Better Lecturers / Staff
7	Better Practical Experience And Skills
8	Better Post Graduate Support
9	More Versatile And Accepted Qualification
10	More established school

4.27.2a If no, why not?

1	Not Financially Rewarding / Viable
2	Not Rewarding Career / No Job Satisfaction
3	Difficult, Stressful Work
4	Not Versatile / Flexible Career
5	No Recognition Of Education Or Profession
6	Course Too Long
7	Poor homoeopathic education
8	There is more to life

4.27.2b If no, what would you rather have studied?

1	Medicine
2	Other Medical Fields
3	Chiropractics
4	AHPC Registered Professions Other Than Chiropractics
5	Other Complementary Professions Not Registered With AHPC
6	Sciences
7	Commerce / Accounting/ IT
8	Psychology And Counseling
9	Arts
10	Law
11	Other Not Specified Above
12	Would not have studied at all

4.28 If you have left South Africa, please elaborate on reasons why.

1	Travel
2	Personal / Family Reasons
3	Political Reasons
4	More Career Opportunities
5	Financial Reasons
6	Study
7	Security

APPENDIX I

SOUTH AFRICAN OFFICIAL LANGUAGES

Afrikaans

English

IsiNdebele

IsiXhosa

IsiZulu

Sepedi

Sesotho

Setswana

siSwati

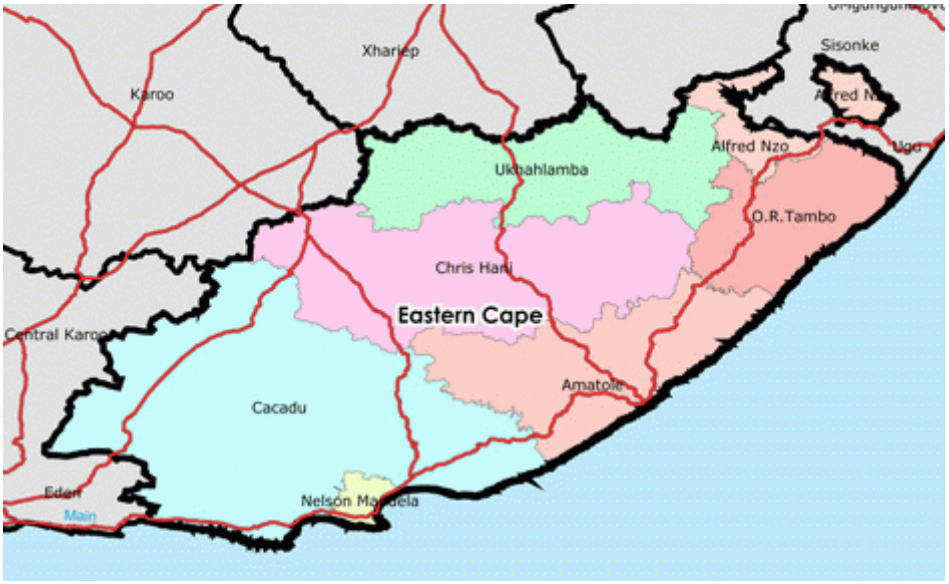
Tshivenda

Xitsonga

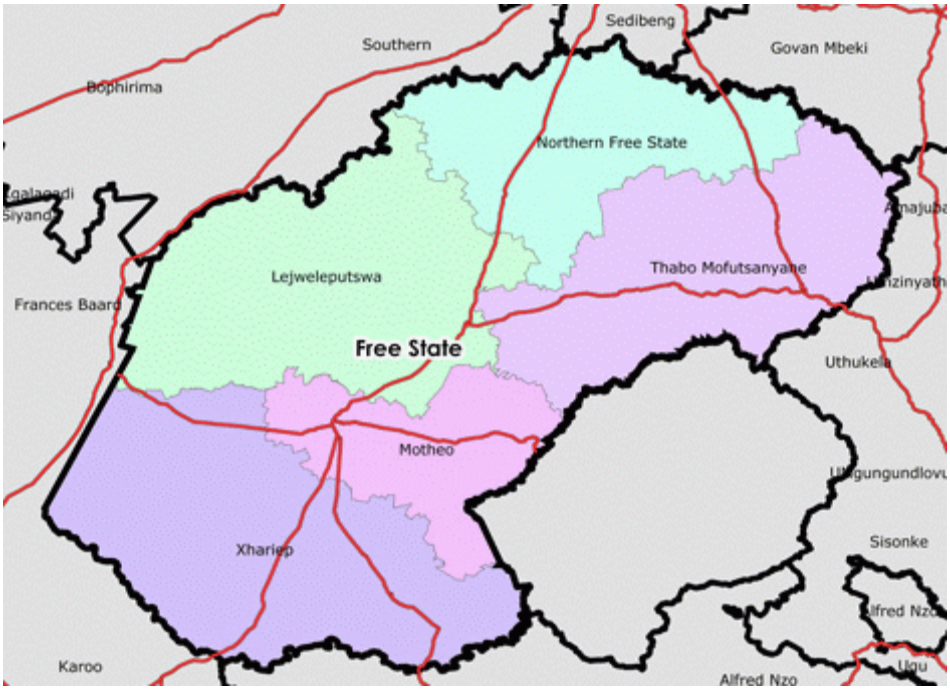
APPENDIX J

MAPS OF SOUTH AFRICAN PROVINCES AND DISTRICT MUNICIPAL AREAS: AS SHOWN BY MUNICIPAL DEMARCATION BOARD

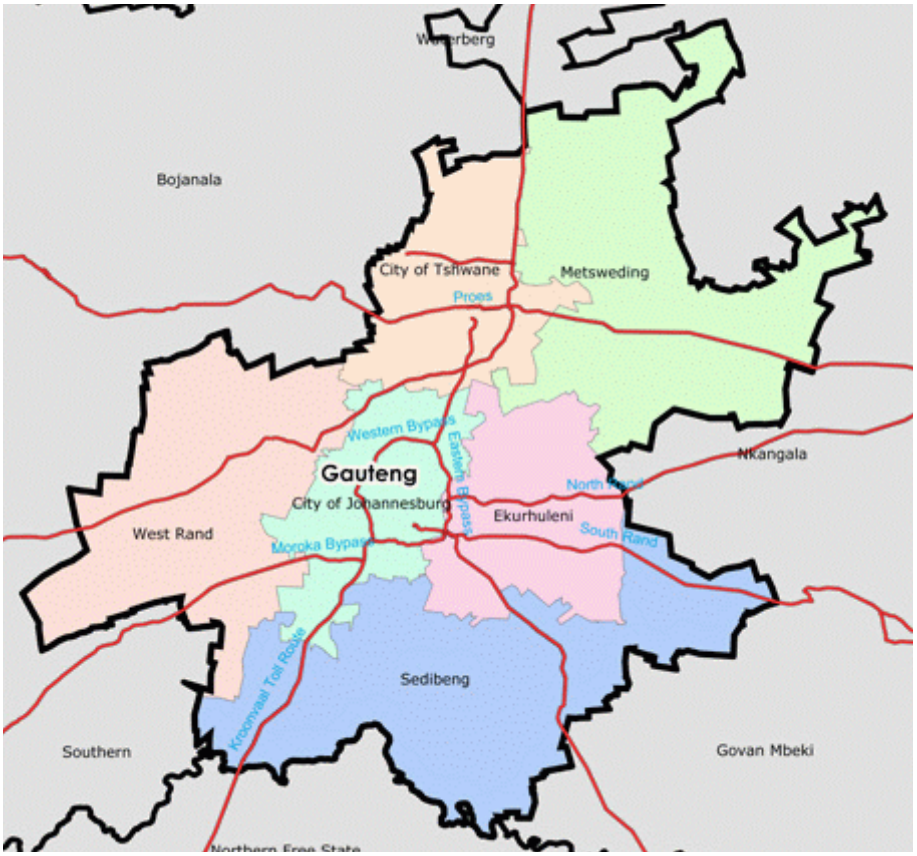
Map Of South Africa Showing Provinces



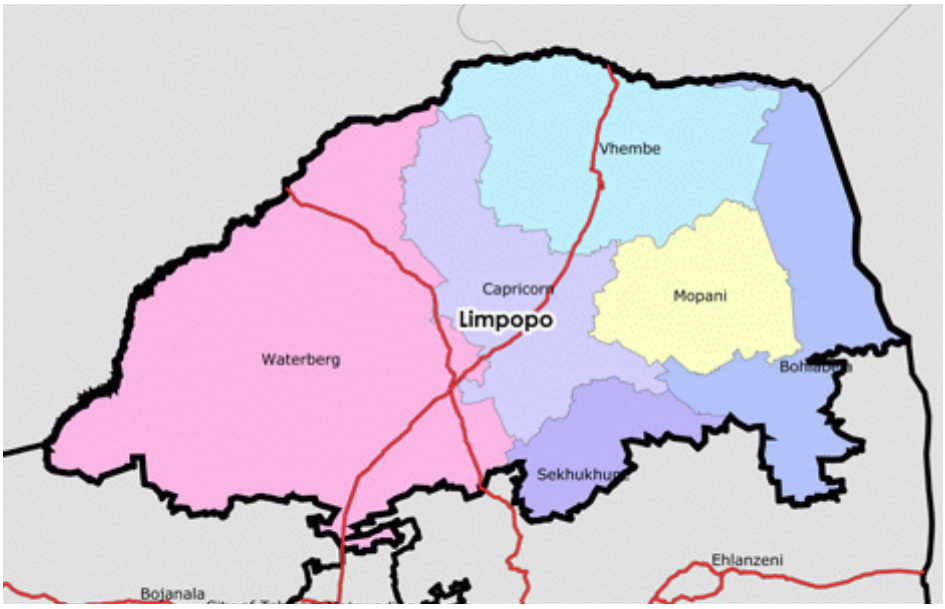
Map Showing Municipal District Areas Eastern Cape Province



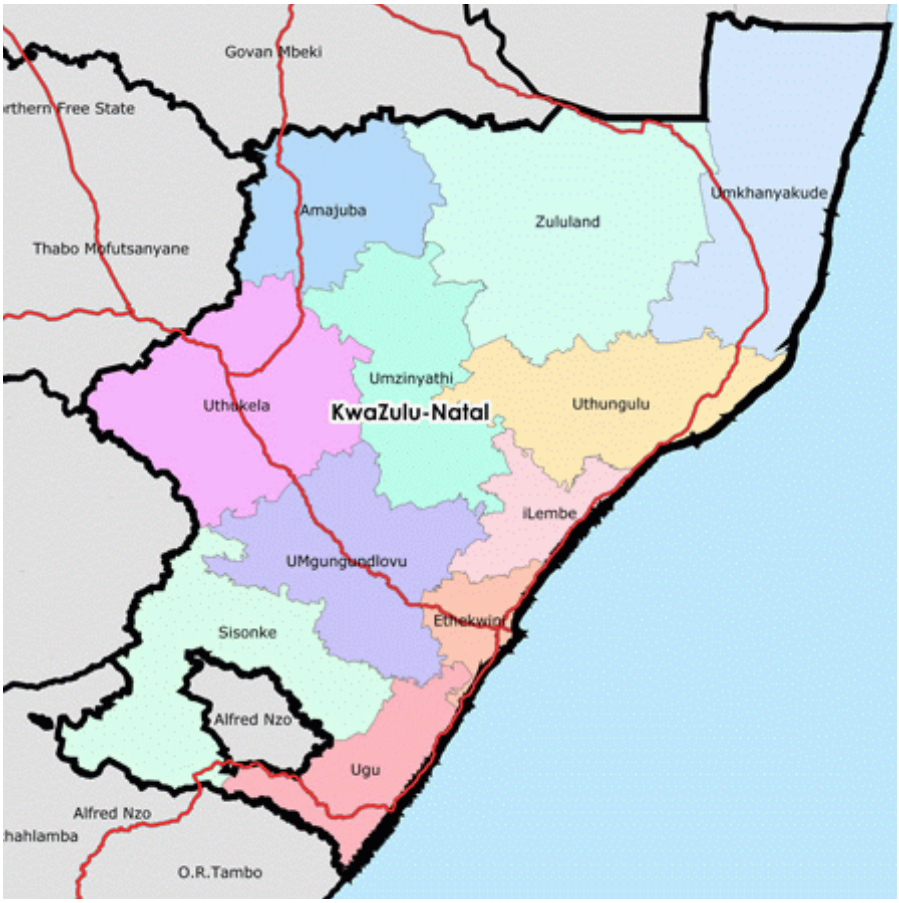
Map Showing Municipal District Areas Free State Province



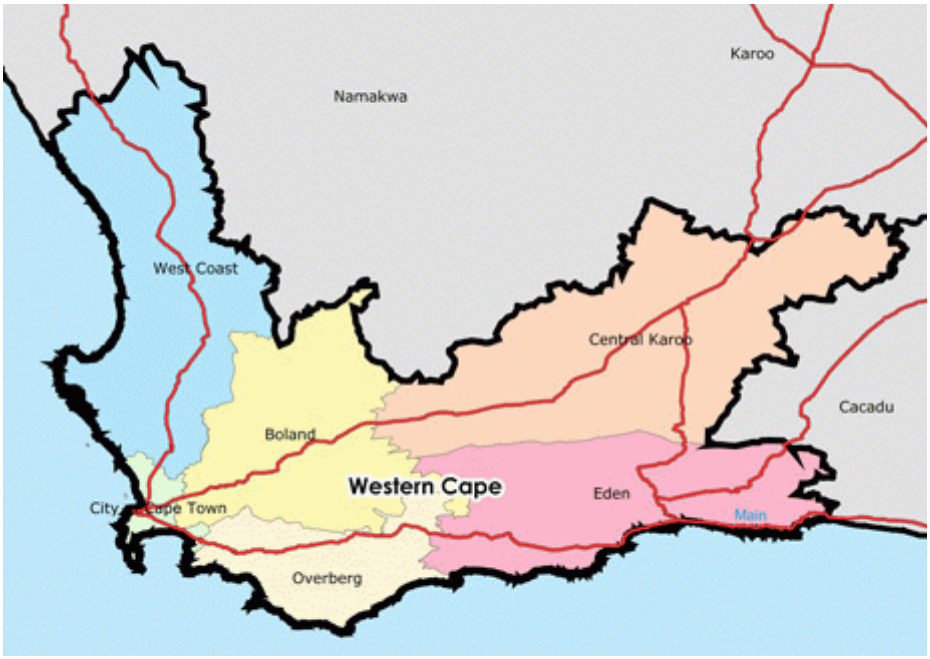
Map Showing Municipal District Areas Gauteng Province



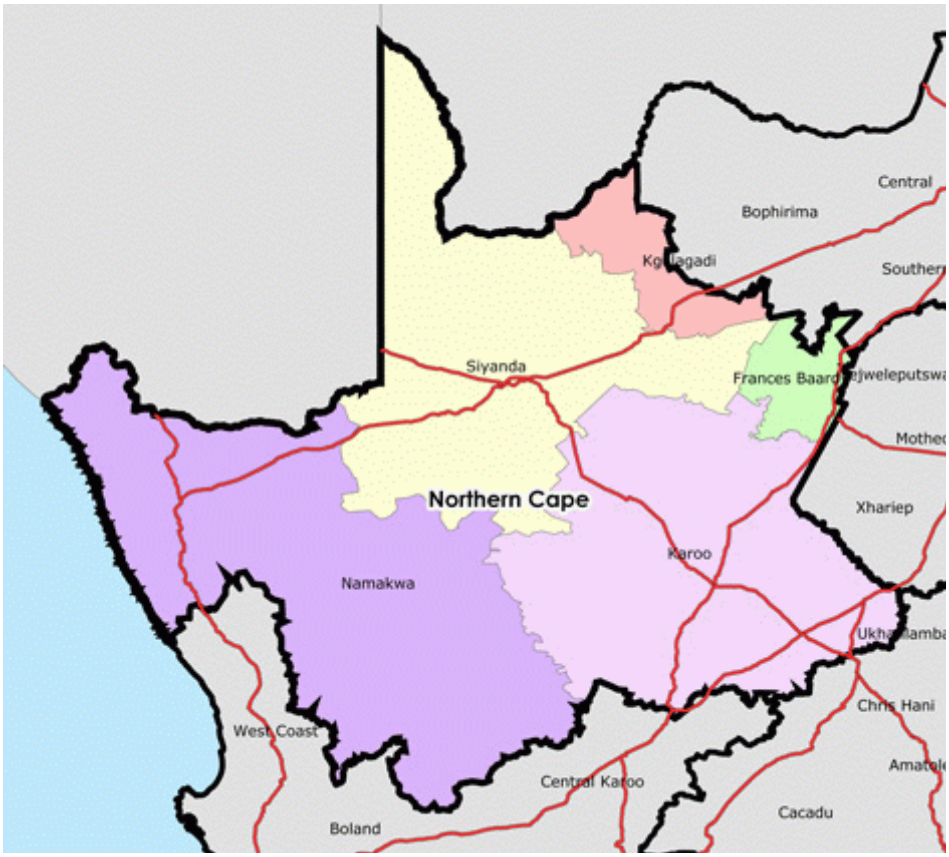
Map Showing Municipal District Areas Limpopo Province



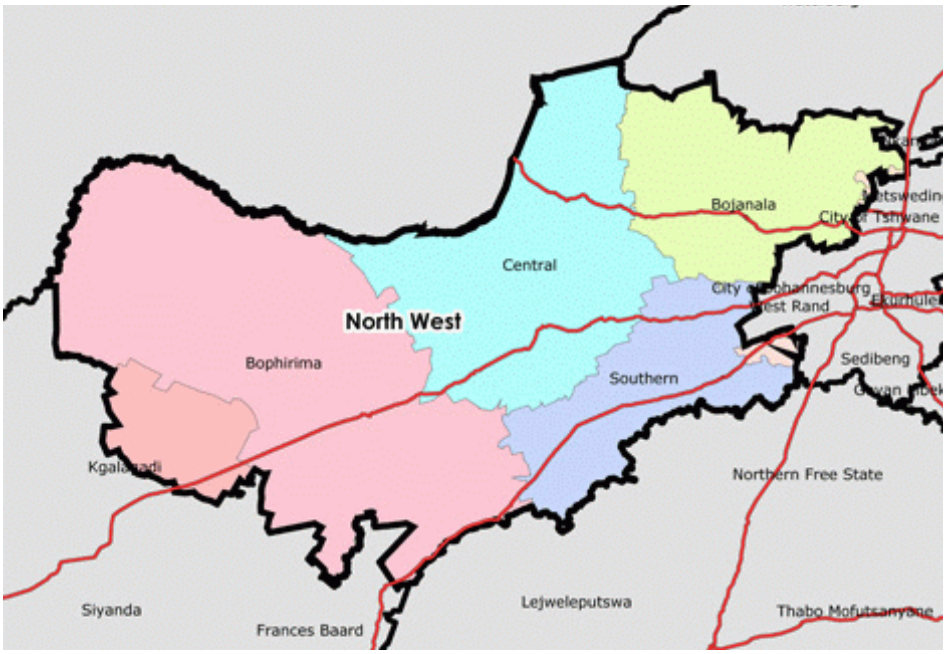
Map Showing Municipal District Areas Kwa Zulu Natal Province



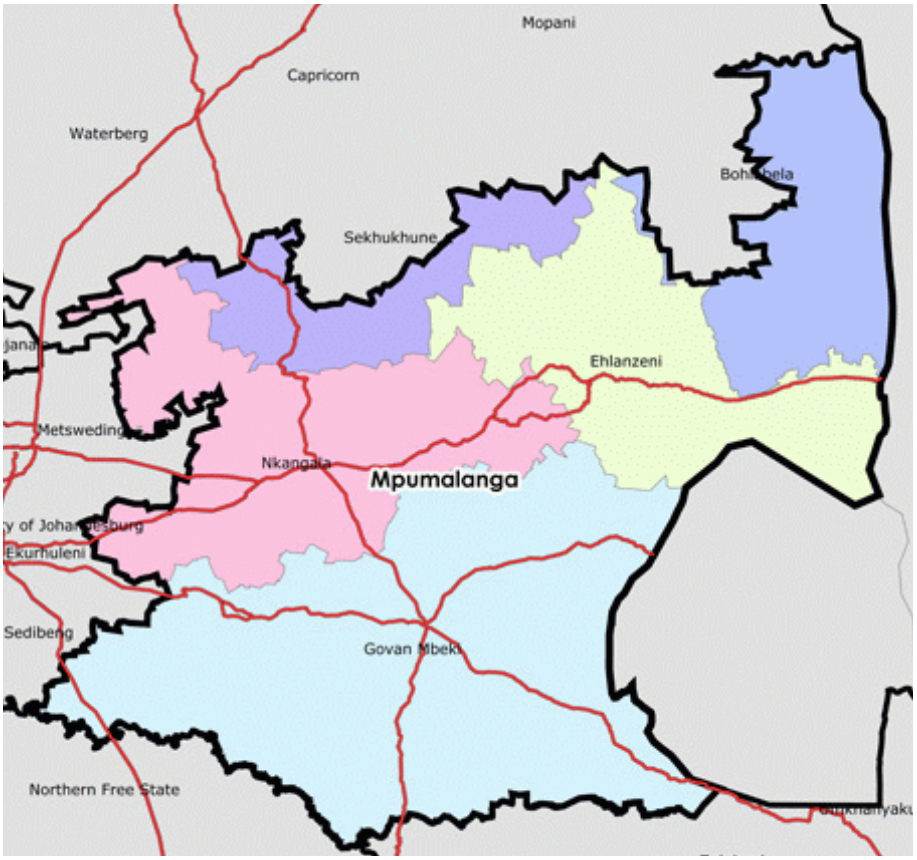
Map Showing Municipal District Areas Western Cape Province



Map Showing Municipal District Areas Northern Cape Province



Map Showing Municipal District Areas North West Province



Map Showing Municipal District Areas Mpumalanga Province

APPENDIX K

PROFESSIONS (MODALITIES) REGISTERED WITH ALLIED HEALTH PROFESSIONALS COUNCIL OF SOUTH AFRICA :

'Allied health profession' means the profession of:

Ayurveda

Chinese Medicine

Acupuncture

Chiropractic

Homoeopathy

Naturopathy

Osteopathy

Phytotherapy

Therapeutic Aromatherapy

Therapeutic Massage Therapy

Therapeutic Reflexology

Unani-Tibb

or any other profession contemplated in section 16(1) to which Act 63 of 1982 applies.