Sustaining Homoeopathy in Australia: Results and Analysis of First National Practice Survey.

CJ Salter, G Brodie, L Jordan, L Mattiolo, A Manning, S Bhouraskar, and DC Levy.

All authors affiliated with The Aurum Project Brookvale, NSW, 2100

Abstract

While the research team for the First National Survey of Homoeopaths in Australia would like to bring encouraging news about the state of homoeopathic practice, the news is dire. The profession is ageing and vulnerable to extinction. It needs to put in place measures to ensure sustainability through education, research, training and professional cohesion. These measures cannot be left to speculation and action needs to be swift and focussed. All of us can contribute to the effort to keep the profession personally and collectively present. This National Survey does provide some good news. It shows the support we are providing in our communities. Baseline data are now available for homoeopaths and patient demographics in Australia. We can see 'who we are, where we are,' and 'how we are' supporting the health needs of our community. Homoeopaths see patients of all ages from birth to their late 80s. The health needs of our community are supported in areas spanning mental health, general needs, gastrointestinal and skin conditions. The core issue is sustainability. If we don't exist as a profession how will the community continue to receive the support homoeopathy offers? Our discussion examines some key areas to consider to enhance sustainability including education, regulation, training, and research, and we pose some unanswered questions for future studies.

Introduction

Little is known about the composition and characteristics of professional homoeopathy in Australia and comparatively limited research has been conducted. The Aurum Project undertook a study to explore the significant gaps in knowledge about the homoeopathy profession. This paper summarises the results of the First National Survey of Homoeopaths in Australia. It then discusses some of the critical issues arising as a result of its analysis and draws conclusions about the sustainability of the profession.

Consider two fictional Australian homoeopaths with different clinical experiences. Homoeopath A has a thriving practice, seeing thirty-plus patients each week for several years, and has great patient satisfaction. Patients return at intervals, bring their friends and family, and the practice continues to grow. The NHMRC report [1, 2] has had very little impact on homoeopath A's practice; in fact, they cannot see any appreciable negative impact. Very few of these patients used Private Health Insurance (PHI) rebates as a reason for seeking homoeopathic care and their removal in April 2019 has made little difference to homoeopath A's business. To homoeopath A, the negativity in the media [3, 4] about homoeopathy seems to have had a positive effect with increased demand for their services.

Homoeopath B had a thriving practice, consulting thirty-plus patients a week but this figure has slowly declined to ten or fewer per week. Homoeopath B feels how homoeopaths and their profession are under attack and sees the impact of this in the practice. Patients are satisfied with their treatment, but the number of patients is insufficient to continue full-time practice. Marketing makes no difference to the viability of homoeopath B's practice; patients do not come. Quite a few patients have stopped since the PHI rebates were removed in April 2019[1] as they cannot afford to visit any more.

The experiences of these fictitious homoeopaths are an entry point to take you on a journey, where we began to investigate the characteristics of Australian homoeopathic practice. Is A or B's experience exclusively representative? Research suggests that neither A nor B practises a singular method of practice [5-7]. Rather, the nature of practice is extremely diverse. What follows must surely sharpen your curiosity.

The seeds for the First Australian National Survey were planted 12 years before the study commenced. Homoeopathy practitioner surveys have been conducted elsewhere. Studies in the UK, USA, Norway [8-10] highlighted unique aspects about what homoeopaths do and how their services are valued by patients. No such survey focussed solely on homoeopaths and their practice had been conducted in Australia, though the PRACI survey included homoeopathy within its classification of complementary medicine [11]. The imperative to reveal what the profession is and how the service it provides to the community has deepened. There is an increased need for a definition and description of the profession's activity in an increasingly politicised, polarising and delegitimising public discourse [3, 4, 12, 13].

We used the International Classification of Primary Care 2 (ICPC-2) [14] as a guide to recording patients' main complaints. ICPC-2 is a validated clinical tool used in primary care, internationally. It is a concise way of classifying the main complaints and is understood by health care professionals in primary care. This ensured that the data we collected and analysed could be compared with similar types of studies. We believe that the results have the potential to act as a bridge between homoeopathy and other healthcare disciplines. The intention of using ICPC-2 was not to replace or alter homoeopathic methods.

1 https://www.privatehealth.gov.au/health_insurance/phichanges/index.htm

Method

Aims

This prospective descriptive study aimed to determine the characteristics of Australian homoeopathic practice. Participants recorded data about their patients over an eight-week period from January to March 2019.

Study Design

Taking the necessary steps to build a robust project is critical for the production of rigorous research. These steps can be used to evaluate the hierarchy and the quality of the evidence produced. Some examples of tools which measure the hierarchy and quality of evidence are the GRADE [15] and COREQ systems [16, 17]. For this study, it should be noted that a prospective study is considered more rigorous (and acceptable) than a retrospective study.

Ethical clearance

This study was approved by the Human Research Ethics Committee of the Endeavour College of Natural Health (#20181005).

As bias is an inevitable problem in research, it is necessary to employ methods that reduce it. The ideas and views expressed through A and B's explanations about their practice are biased, failing to inform the actual nature of homoeopathic practice in Australia. The First National Survey of Homoeopathic practice provides tools to move from the hypothetical into the real world.

Setting

Data was collected by participating homoeopaths in their Australian clinics using an online data collection tool. Data was recorded for visits made during the eight-week period commencing January 28, 2019 and ending March 22, 2019. An extra week was provided in order to complete data entry. Weekly email messages were sent to participants throughout the study period. These messages included links to the data recording tool and information on how to seek more assistance with their data recording if needed.

Participants

Sixty-nine participating homoeopaths residing within Australia enrolled in the eight-week study. Sixty-five completed the study, which represented 14% of the eligible registered professional Australian homoeopaths. The inclusion criterion for participation was limited to current professional registration with the Australian Register of Homoeopaths (ARoH). This criterion ensured that the participants were trained, qualified, registered and competent.

Recruitment

Participants were recruited from October 2018 until January 2019 using a variety of outreach methods. These included: a presentation to the 11th Australian Homoeopathic Medicine Conference in Sydney October 2018; emails and bulletins to members of the AHA, Aurum Project, and ARoH registrants; social media releases were made; and personal networking. Participation was voluntary and a detailed informed consent process was undertaken with all potential participants. All participants were eligible to claim five hours of continuing professional development for participating in the study regardless of the level of activity in their practice during the study period, or if they dropped out of the study.

Patient data

Informed consent was obtained for all patient data recorded in this study. Demographic information collected included date of birth, gender, country of birth and state of residence. Clinical data from the consultation was also recorded, including up to three main complaints, and remedies prescribed with potency (up to three could be recorded). An option for adding free form comments (Notes) was also given for each visit.

Data management and analysis

An online data collection and management tool, HomeoStats [18] was used by homoeopaths to record patient demographic and clinical data. Each visit made by the patient during the study period was recorded. Homoeopaths assigned the patient's main complaint into the most relevant ICPC-2 classification category. Homoeopath demographic data were recorded at the time of registration, including their age, gender, state of practice, country of birth, and their ARoH identification to ensure eligibility to participate.

Data were extracted from HomeoStats in comma-separated values (.csv) then matched to registration data using an email address. All patient identifying details were removed prior to extraction from HomeoStats. Participant data was de-identified once the two data sets were matched. Data was cleaned and visits were deleted if there was a lack of clarity about the date of the patient visit and birth date. This reduced the data set from 1447 to 1339 visits. All other visits were included in the descriptive analysis including missing data. Any other alterations to the data are discussed in the results. This descriptive analysis is based on 1339 individual consultation visits.

Participant Feedback

A three-question questionnaire was sent to participants in Week 3 via email using Survey Monkey [19]. The questionnaire was completed by 23% of participants and remained open to them throughout the survey timeframe. The three questions were:

Q1

How comfortable are you with entering your patient data into the HomeoStats database? (choose one answer only). Answer choices were on a five-point scale:

very comfortable, moderately comfortable, neutral, moderately uncomfortable and very uncomfortable. 14 / 15 respondents

Q2

Is there any other feedback you would like to give the research team on your experience so far? - Free form answers from all 15 respondents

Q3

Would you like a member of the research team to contact you to discuss your experience in a more personal fashion? Yes / No recorded from 14 / 15 respondents

One participant requested contact for more discussion. Thirteen participants indicated they were very or moderately comfortable using the data entry tool.

Results

The data from the study is reported in three subsections: the reliability of the sample; the results about homoeopaths and the results about their patients.

Sample reliability

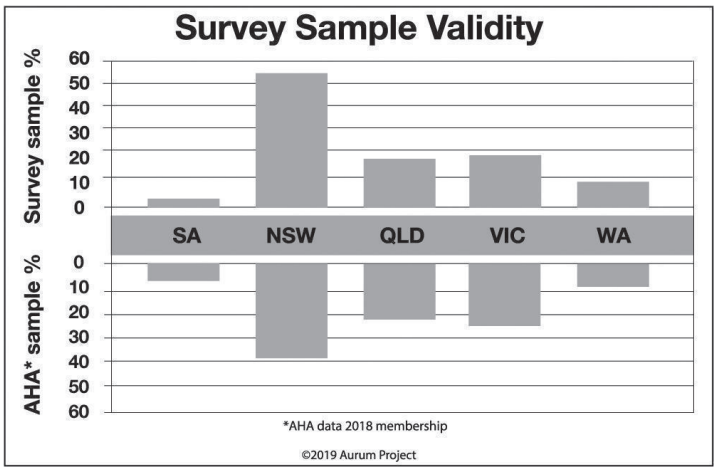

Figure 1 Comparison of the study sample with the population of Australian homoeopaths as measured by the Australian Homoeopathic Association.

Homoeopaths from all of the states in Australia participated. The sample distribution was compared with data supplied by the Australian Homoeopathic Association for membership in 2019 [20] using the chi squared test ($X^2 = 0.00$) confirming that our sample was a reliable representation of the population of Australian homoeopaths at the time.

Homoeopath demographics

Sixty-six percent of participants recorded data over the eight-week period. Thirty-four percent (22 participants) recorded no data. Ninety-one percent of the practitioners were female, and nine percent were male. During the study, female homoeopaths recorded 82% of the visits and male homoeopaths recorded 17.5%. The average age of the homoeopath was 52 years (range 31 to 76 years). Most practitioners in the study were born in Australia, with some from India, UK, Europe, New Zealand, South African continent and other countries (Table 1).

Table 1 Country of Birth for the Homoeopaths in Study

Place of Birth	% (n= 65)
Australia	62
India	14
UK / Scotland	6
Germany / France	5
New Zealand	5
South Africa / Zimbabwe	5
Other countries	3

Patient Demographics

Seventy-two percent of visits to homoeopaths were made by female patients and 28% by male patients. Three patients did not identify a gender. Figure 2 shows a generally normal distribution for patients over the age of 19 through to 86 years, and a non-normal distribution for children up to the age of 18 years.

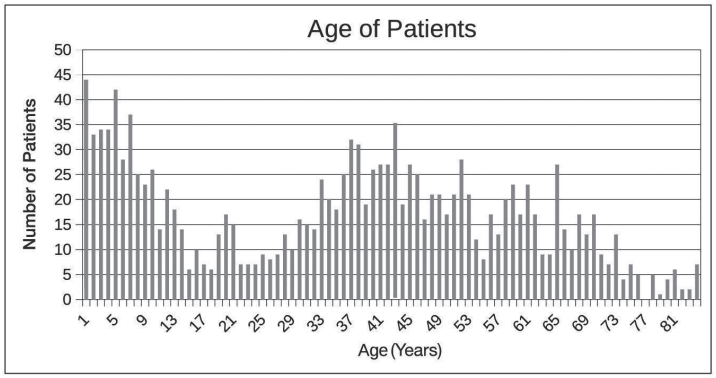

Figure 2 Age distribution of patients visiting homoeopaths over the 8-week study period.

The main reason for visiting a homoeopath is shown in Table 2. There were 19 main categories used by homoeopaths to record the main complaint and 122 subcategories. After adjustment, there are 20 main categories. For ease of interpretation, the Main Category has been summarised where possible as a description of a body system.

Table 2 Main reasons patients visited homoeopaths during study

Main Category for Complaint	Number of visits	%	Adjusted number of visits	%
Mental health	358	26.7	369	27.6
Not recorded	151	11.2	69	5.2
General	135	10.1	165	12.3
Skin	127	9.5	135	10.1
Digestion	120	9.0	125	9.3
Reproduction	93	6.9	97	7.2
Respiratory	62	4.6	66	4.9
Musculo-skeletal	51	3.8	54	4.0
Nose	42	3.1	43	3.2
Endocrine	42	3.1	44	3.3
Throat	24	1.8	24	1.8
Head	24	1.8	30	2.2
Face	24	1.8	28	2.1
Ears	20	1.5	20	1.5
Nervous System	18	1.3	19	1.4
Eyes	14	1.0	14	1.0
Heart	13	1.0	13	1.0
First aid	9	0.7	11	0.8
Kidney	7	0.5	7	0.5
Vertigo	5	0.4	5	0.4
Circulation	0	0	1	0.1
Total	**1339**	**100**	**1339**	**100**

The number of visits could represent the same patient in more than one category. The General category in Table 2 does not refer to the General category commonly used in homoeopathic repertories and materia medica. The General category includes A-Z conditions such as allergies, ADHD, autism, bedwetting, cancer, drug abuse, influenza, hyperglycaemia, infectious diseases, obesity, shingles, sleep disorders, quitting smoking, and other general conditions not defined elsewhere.

Table 2 shows a 'Not Recorded' category accounting for 11.2% of the data. In these cases, 70% of the homoeopaths recorded data in the Notes section. Where possible, these data were assigned a main complaint category where the Notes given clearly describe the reason for the visit. After this adjustment, 5.2% of the visits had no main complaint recorded, and one extra category Circulation was identified. These changes are shown in the 'Adjusted' number of visits in Table 2.

Discussion

The results of this study demonstrate that the Australian homoeopathic profession has reached a critical point. The population of Australian homoeopaths stands at 457 [21], and the study sample represents 14.2%, including urban, rural, and remote practitioners. However, as the mean practitioner age increases and training options diminish, it is clear that the profession as an entity faces an undoubtable decline. This decline has not occurred in a vacuum. Since the NHMRC's 2012-2015 review of the evidence base[2], the profession has faced continuous and sustained public scrutiny [3, 4, 12, 13]. Notwithstanding this [1, 2] the Aurum Project agreed to proceed with this overdue study.

Changes in the complementary medicine landscape have been considerable in recent years. The composition of the homoeopathic profession has evolved in Australia as it has in other countries. Practitioner studies conducted in other countries including the USA, Norway, and the UK have described the characteristics of homoeopathic practitioners and their patients in these countries. The UK and Norwegian studies showed similar patient age distributions to our study [8, 9]. In the UK study, as in ours, there was a marked decrease in the visits for the age range 15-25 years. At this time, we do not have a clear understanding of why this age group presents less often for treatment. We suggest that women visit homoeopaths for the treatment of small children [22] for example for support in the treatment of children's acute otitis media [23, 24] or for attention hyperactivity disorder [25-27]. Homoeopaths report that upon successful children's treatment, these women frequently seek homoeopathic treatment for themselves, their partner and wider family.

Why patients consult homoeopaths

In this study, mental health constituted 27.6% of the total visits recorded. The other main complaints recorded included General conditions (12.3%), gastrointestinal health (9.3%) and skin conditions (10.1%). This finding differs somewhat to US homoeopathic practitioner experience [9] where the main reasons for seeking treatment were General Health (20.6%), followed by psychiatric reasons (16.2%), musculoskeletal issues (8.1%) and infectious disease treatment (7.7%). Also, our findings differ from the reported experience of naturopaths in 14 countries where the main complaints seen were musculoskeletal (18.5%), gastrointestinal (12.2%), and mental illness (11.0%) [28]. To a large extent our results reflect the results of the RACGP's report [29] that the primary reason given for visiting a general practitioner (GP) was the patient's mental health. This important correlation suggests that the concerns of patients who visit homoeopaths align with the health needs of the broader community. At more than twice the number of presentations than any other category, the details and characteristics of this important result will be discussed in a subsequent paper.

Data recording issues

Attention to data recording was inconsistent across the sample. Our results show that while some homoeopaths recorded substantial data, other homoeopaths did not. One of the inconsistent results was that 11.2% of homoeopaths, who recorded patient demographics for a visit, did not record a complaint in the Main Complaint category. Of these visits recorded, 5.2% failed to record any information that could be interpreted as a main complaint. We have no explanation for this.

Of some concern, we noted that a considerable number of homoeopaths (34%) who registered as study participants did not record any data in HomeoStats during the study timeframe. Various assumptions can be made in this respect. Two clear possibilities are that these participants did not understand the process of data recording in HomeoStats or the participant withdrew from the study without letting the researchers know. In the former case, the research team recognises that additional training in the registration and use of HomeoStats may have been required to mitigate this event. In the latter case, we cannot make any assumptions as to why participants would register as participants and then not participate. Four participants did in fact register and formally withdraw from the study. This type of self-exclusion is typical in some studies [30].

Main Complaint "not recorded"

It is not known why 11.2 % of the visits made during the study were recorded with no main complaint. Of the 151 visits that fell into this category, 70% had a Note recorded with more information. In roughly 50% of these, the Note allowed the complaint to be identified clearly. In many cases, the notes were free form descriptions from the homoeopath, providing no insight into the data recording process. These "not recorded" instances occurred regularly throughout the study period, were seen for 28 homoeopaths, many of whom did record main complaints at other visits. The redistribution of "not recorded" was into 13 of the 20 main categories measured in this study, suggesting that it was not failure to find a specific category that led to the lack of recording. We do know from anecdotal feedback that some found it onerous to try to find the category that best fitted the patient visit, and this highlighted the unforeseen difficulty in using ICPC-2. Reviewing how data were recorded in other categories, we surmise that more intensive training on the categories of ICPC-2 would have been helpful to acquaint homoeopaths with the classification system, in particular how to find a category that best fitted the visit.

The effort in using ICPC-2 needs to be balanced with the aims of providing a bridge in the discourse between homoeopathy and western medical practice. ICPC-2 was not being explored as a new approach for recording homoeopathic cases. We wonder if this is highlighting a point of difference between homoeopathy and western medical practice where the tool is used as a diagnostic

2 https://www.nhmrc.gov.au/sites/default/files/images/nhmrc-statement-on-homoeopathy.pdf

recording device. It is a tool that would assist in translating our profession's approach into a language WHO adopted for a Primary Care setting. It could certainly form part of a significant bridge between two divergent discourses.

Informal feedback to the research team from experienced homoeopaths participating in the study was that the ICPC-2 structure was quite limiting as it caused the need to extract poor representations of what they had done to determine a prescription. In ICPC-2 within a category there is an "Other" option that can be selected when the specific condition cannot be described by the options available, for instance when the mental health condition is not listed there is an option Mental Health Other. This may also explain in part the large percentage of "Other" and "General" conditions categories recorded.

Another alternative to the homoeopath recording the patient's main complaint is to allow the patient to record it. This approach, described by Steinsbekk and Lüdtke [10] asks the patient to record the main reason for their visit, and the research team identifies the main complaint from their feedback. This reduces practitioner bias in explaining why homoeopathy is chosen by patients. However, in reducing one bias, another arises, as valuable information about the diagnosis of disease within the homoeopathic interview is lost when the practitioner is not able to describe the main concern they used for the treatment. This alternative approach could be considered in future studies, including patient self-assessment of treatment, using tools such as MYMOP2 [31].

Ageing Profession

Australian homoeopaths practise in urban, rural and remote areas [20, 21]. In this study, homoeopaths were aged between 31 and 76 years (mean 52 years). The homoeopathic profession is ageing with a likely year on year increase in the mean age due to the fact Australian CAM sector education is not enrolling new students in the study of homoeopathy.

As basic training courses are being phased out from Australian CAM sector colleges (e.g. Endeavour College of Natural Health), it is likely there will be no students studying homoeopathy face to face in Australia in 2021. This fact is also reflected in the nearly 50% reduction in AHA student membership between 2017 and 2018 [20]. This loss has been gradual. For comparison, one author of this paper notes that during his basic homoeopathy training (1983-1986) he undertook study in a class of roughly 80 students.

We do not have data regarding the number of Australians enrolled in international study courses accredited by ARoH. These include courses based in Malaysia[3], or delivered online in the UK[4] and Greece[5]. The implications for professional sustainability are evident, and of tremendous concern [32].

Country of Origin and Training

After Australian born practitioners (62%), the second largest category of practitioners were born in India (14%). The remaining practitioners came from Europe (11%), New Zealand (5%), Southern Africa (5%) and then other countries (3%). The government of India delivers and regulates a five-year homoeopathy medical program[6]. It is likely the majority of Indian born homoeopaths have completed Indian homoeopathic medical training, although this assumption cannot be made from the current dataset.

The average years in practice of the participants is unknown, as this data was not collected. Similarly, it is not known in which country the participants undertook their homoeopathic study. All participants satisfied the ARoH professional registration requirements which we used as a measure of a level of competency, that transcended the style and methodology of practice that would have been used by individual practitioners and is known to be divergent [5, 6].

Any future study needs to assess these measures so that assumptions about the quality of practice outcomes can be commented upon. At this stage, we can only speculate on the influence of lifelong learning on good practice, while we suspect that more experienced practitioners are providing a different kind of service to their patients than novice practitioners. Assumptions about experience cannot be based on practitioner age, given the entry point for practice as already discussed.

Limitations of Study

Other data needing exploration

It would have been valuable to have ascertained the years of experience of the participants. This would have enabled us to explore whether there is a correlation between years of professional experience and the complexity of health conditions treated. Variables including practice size, revisit frequency, method of treatment, among others were not collected and need to be explored. The country of training and the type of homoeopathic training might have yielded insights into these relationships, in addition to prior training and experience in other disciplines.

Overall practice activity was not established, minimising our ability to estimate a more detailed picture about how the community uses homoeopathy. This measure would have given insight into the participation rate of the patient and allowed the issue of obstacles to patient participation in practice surveys to be explored.

Questions that were not asked

Questions regarding co-treatments, ingestive as well as somatic, medically prescribed and self-administered, would have provided more insight into how patients use homoeopathy for their wellbeing. A record of the patient's previous treatment for the main complaint and other diagnosed conditions pertaining to the patient's overall health (possibly not reflected in the record of the main complaint category) would have also allowed deeper exploration on how homoeopathic treatment is used by patients.

This was a small study within the Australian context. We are unable to generalise the results to homoeopaths in other countries.

Treatment effectiveness was beyond the scope of our study. The study was constrained by 1) time 2) budget 3) the fact it was not a clinical trial and 4) it relied on self-reporting. Future studies will explore how best to measure and assess these complex matters and we acknowledge the substantial literature available assessing treatment effectiveness in the main complaint areas that were shown in this study [33-36].

3 http://cyberjaya.edu.my/bachelor-of-homoeopathic-medical-science/

4 https://www.homoeopathyschool.com/courses/worldwide

5 https://www.vithoulkas.edu.gr

6 https://www.ayush.gov.in

Implications and Conclusions

At the outset, we considered two fictitious homoeopaths. It would be an error to adopt either of these as being an actual reflection of Australian practice as they are a fiction, not grounded in data. The National Survey results reported here and presented at three conferences[7] provide a critical foundation for the current assessment and sustainability of our profession.

The numbers in our profession are currently low; the number of students is diminishing and the education pathways for basic homoeopathic training in Australia are limited. These circumstances are extremely problematic for the sustainability of our profession. The profession needs to be future-proofed. How can this be achieved? We assert that the three core requirements in order to build a sustainable future for homoeopathy in Australia are 1) education and regulation, 2) research and its implementation and 3) developing stronger networks with related professions. We will now consider each of these requirements.

Education and regulation

We have discussed the concern that opportunities for fundamental homoeopathy education in Australia are now severely restricted. We infer that this hampers opportunities for aspiring professionals to train and jeopardises the next generation. Homoeopathy is frequently taken up as a second or third career, predominantly by women in their thirties and forties. The lived experience and other skills they bring could be acknowledged and recognised. It is also possible that prior formal knowledge/experience could be formally recognised (Recognition of Prior Learning). For example, this would enable experienced naturopaths to transition easily into homoeopathy, acknowledging their vast clinical and life experience, in addition to their prior training. We propose that a new, sustainable model of homoeopathic training needs to utilise and build upon the knowledge, skills and experience the aspiring homoeopath brings to their training program. The traditional model of didactic homoeopathic training is out of step with contemporary educational thinking and planning. Modes of teaching have merged with mixed modes of online learning. However, we would not suggest throwing out the proverbial baby (e.g. homoeopathic theory, materia medica) with the bathwater (outdated teaching and learning models).

An evaluation of the types of knowledge and skills that are essential for a homoeopath to conduct a successful practice must include how to provide effective support to their patients. If, as we can see in this study, the vast majority of main complaints are concerned with mental health it would suggest that sound grounding in how to interact with people, using skills and knowledge from the mental health field would be essential for our profession. For example, knowledge of the mind section of a repertory or the mental characteristics of any remedy are not sufficient for understanding how to interact with the patient who has mental health issues. Equally important are knowledge of mental health issues as well as careful attention to the scope of homoeopathic practice.

We propose that professional bodies such as ARoH expand their continuing professional development requirements, incorporating rigorous research skills. These could include practice-based research skills. The minimum annual ARoH CPD requirement is not a meaningful measure of the actual skills and competence required of the practitioners. A research project assessing the full picture of the skills and training of currently registered homoeopaths could assist in defining how to expand education that is relevant and focussed for professionals who already bring a large skill set into a profession, one that is largely we suggest, hidden and unacknowledged. Another element to consider is increasing the research skill base of current professionals, increasing opportunities for upskilling professionals, and participating in translational research [37] will also strengthen the profession.

Research and its Implementation in Practice

Research for its own sake has limited traction in the real world. Given the lack of funding for homoeopathy research, the profession can ill afford to expend its resources on research of limited clinical value. The homoeopathy profession can best be developed through translational research that is relevant to real-world practice. Knowing ten remedies for the treatment of notifiable diseases is of limited value if the treatment of such diseases is beyond the legal scope of practice for Australian homoeopaths. Translational research for the effective treatment of paediatric eczema or irritable bowel syndrome are examples of research that would be both valuable and within the scope of practice. Moreover, these conditions were represented in this study as the third and fourth most common presentations to the participants.

Developing networks

Establishing stronger networks and relationships with our fellow colleagues in CAM is essential for our sustainability. As many of our professionals come from other CAM disciplines this is a prudent course of action. It means that we might need to ask the question of our CAM colleagues, how can we best support each other in the aim of serving the health of our patients? A second study into homoeopathic practice diversity needs to ask this important question "What other treatments and approaches are being used concurrently with their homoeopathic treatment?" This information from patients will inform the direction best taken to develop CAM relationships professionally in more depth. An integrated approach with patients, and with other practitioners whether conventional or complementary will produce the best health outcomes for patients. Future projects could quantify what patients are already doing and what homoeopaths are already doing in this area.

The NHMRC's evaluation of homoeopathy has paradoxically put Australian homoeopathy in the spotlight, indeed, on the international agenda. The lack of scientific endeavour has been scrutinised and we have been found wanting. However, as a consequence, the support Australian homoeopathy has garnered from professional organisations globally, for example Homoeopathy Research Institute (HRI) and Liga Medicorum Homoeopathica Internationalis (LMHI), has been critical. Developing strong international networks is essential for the sustainability of the profession, driving us to increase our professional standards. As a consequence of this study, Australian homoeopathy is no longer provincial. Like an outer shell electron, we have marked the significance of our place in the global homoeopathic landscape.

7 First National Survey of Homeopathy in Australia presented at HRI 4th International Conference 14th -16th June 2019 London; LHMI Rome, NZ Conference of Homeopathy

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