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JATMS

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Lumbopelvic rhythm
Migraine and acupuncture
Holistic primary health care
Spirituality and the holistic practitioner
Characteristics of experienced natural therapists

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Reference:

1. Van der Mei IA, Ponsonby AL, Engelsen O, et al. The high prevalence of vitamin D insufficiency across Australian populations is only partly explained by season and latitude. Environ Health Perspect 2007;115(8):1132-9.

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Contents *June 2012*

President's Message

Dr Sandi Rogers Ed.D. ND

Welcome to this month's journal. Over the past few months I have had the fortunate opportunity to meet up with many through seminars where we were able to have a chat about issues affecting you as members and practitioners in the world of natural medicine.

Issues you felt were important were:

- building your business to earn a reasonable income and
- availability of up-to-date information about your various occupations.

These two issues were quite dominant in the discussions and I promised I would offer a little business advice in my President's report.

Thank you for the feedback about the ATMS Business Seminar I have been presenting, and to hear positive turn-around in income for some of the attendees is gratifying. Please attend as many business seminars you can and keep informed. Seek out seminars from many sectors as you cannot attend too many.

REMEMBER: FOCUS+ACTION = RESULTS.

I know I go on about that and repeat it many times in the business seminar, however, you cannot hear it too often. First of all you must focus on what you want to achieve; really focus. Then act on doing what has to be done to achieve results. Once you work on this very simple, yet effective prescription, business can turn in the right direction.

Remember no-one ever went broke making a profit. Many times I am asked why ATMS does not set prices, as that would make business easier. Well, this is not possible; not only is it against the law, it is not good business sense as we all have different expenses.

You must ascertain what **you** need to charge by working on basic figures; how much it costs to run your business, and ensure that you have taken account of **every** expense, including such items as your salary, superannuation, sick leave and holiday pay. How many hours will you work, how many clients do you have and how much do you need to charge each one to cover the figures you have put together? This is a starting point, where you start thinking like a business person.

Irrespective of what therapy you offer, business is business and you deserve to make a decent living. The only way to do that is to learn as much as you can about the world of business. Buy books and magazines that offer business advice.

Hope that helps.

LATEST INFORMATION RELEVANT TO OCCUPATIONS WITHIN NATURAL MEDICINE

The other issue some members raised was in relation to keeping up with the latest information relevant to their occupation. Many did not know about EBSCO, which is a service offering free access to our members.

The Board voted on spending this money in order that all ATMS members have access to databases across the world. Please go to our web page and use this service as it is there for you.

ELECTIONS

By now voting is closed for the September elections, whereby six members will be elected to the Board. The new Board will commence on the 1st September 2012 with six Directors from the original Board and six new members elected from the membership. These are exciting times and ATMS will be moving forward with this new style of Board.

BOARD ELECTIONS

The six current Directors remaining to ensure continuity of knowledge and help the incoming members settle in are:

Maggie Sands, Bill Pearson, Allan Hudson, Teresa Mitchell-Paterson, David Stelfox and Sandi Rogers

As I suggested in the previous journal, 'the transition is very important as we need to ensure the Board operates as a collective, cohesive and respectful group, making decisions that will keep the organisation moving forward and meeting the needs of our members, as members are the focus of the organisation'.

ONGOING MATTERS

- Quality assurance package
- Regulation of our occupations with NM&TRB
- Developing strategies to engage the public in what we do. This matter will be reported as we develop the strategy
- Research project, *Workforce Survey*, headed by Dr Sandra Grace.

QUALITY ASSURANCE

The Board approved the Quality Assurance project and allocated the budget in preparation for work to commence once our consultant has all the essential Government information. Commencement is not far away and all members will be notified via Rapid News once we require your participation.

REGULATION

The Natural Medicine and Therapies Registration Board is continuing to move forward as the constitution has now reached its final stages, at the time of writing this report. Although there is a long way to go before the Board is fully functional it is very pleasing to see many occupations working together for the best outcomes for the natural medicine workforce.

For additional information there is free information on the ATMS website. You can also ask for a free booklet that explains regulation without the emotion that usually accompanies this subject.

VALE DOROTHY HALL

A short time prior to the closure of this journal I was advised of the passing of Dorothy Hall, Founder of ATMS in 1984. Dorothy was a visionary and passionate supporter of natural medicine and therapies. She worked tirelessly at the coalface of natural medicine for many decades and was instrumental in steering the profession through times of unrest and attacks. She was known as the matriarch of herbal medicine and she should be remembered for her fearless protection of our right to deliver our therapies.

She said to me, 'I always had to have my hand on my sword each and every day as the opposition to us was very fierce'. Dorothy faced that opposition on our behalf and for that we should all be grateful and continue to fight for our freedom to offer our therapies to the Australian consumer

Until next time,
Find happiness in every moment.

CEO'S Report

Matthew Boylan is on leave. In place of his regular CEO's Report three ATMS directors have compiled reports on three events of significance to our members: Teresa Mitchell-Paterson, Head of Academic Studies, (Natural Therapies) ATMS; Bill Pearson, ATMS Vice President; Allan Hudson, ATMS Director.

Teresa Mitchell-Paterson

PARLIAMENTARY RECEPTION FOR COMPLEMENTARY MEDICINES INDUSTRY IN FOCUS

Teresa Mitchell Patterson and Allan Hudson on behalf of ATMS attended this reception on Tuesday 20th March, 2012.

The Complementary Healthcare Council of Australia (CHC) welcomed the Hon. Catherine King, MP, Parliamentary Secretary for Health and Ageing, to open the Complementary Medicines Industry Leaders 2012 Parliamentary Reception in the presence of fellow parliamentarians and industry leaders, among whom were Blackmore's (represented by Marcus Blackmore), Swisse (Radek Sali), Lipa Pharmaceuticals (Dusko Pejnovic), as well as many other major suppliers of supplements.

Mrs King, spoke to leaders of the Complementary Medicines Industry about the future direction of the Industry post TGA reviews. With Health Minister, the Hon. Tanya Plibersek, MP. in attendance, Ms King highlighted a number of the reforms coming out of the, "TGA reforms: A Blueprint for TGA's Future" document released by the Government late last year.

More recently there has been a listing of registered CM products, The Australian Register of Therapeutic Goods (ARTG.) The TGA will also be compiling an electronic listing of products for users, enhancing sanctions and penalties for breaches of compliance, and enforcing changes to explanations on labels to encourage transparency. All of these initiatives are to be established in a collaborative manner with the industry so as to improve trust. Ms King also briefly touched on a vision for a regulatory body. She ended her speech with the comment that the Australian Government recognises the need for CM. "The Australian Government realises the importance of the complementary medicines industry to Australians, to our economy, and to the growing numbers of Australians who choose complementary medicines for their health and wellbeing".

Justin Howden (CHC Political and Consumer Affairs Director) made the point that this was the 3rd CHC meeting. He also mentioned that 70% of the Australian population use CM in some form. The CHC has a seat at the table to influence public policy. Independent studies suggest that 5,000 people in skilled manufacturing jobs are employed directly in CM and 60,000 indirectly (education, science, logistics), and that CM is a $200 million a year export industry that creates 2.3 billion dollars of revenue in Australia. Mr Howden commented that regulation was not easy; however Australia has the strictest TGA in the world and ensures quality and safety.

It was noted during the speech that 41 higher education courses are focused on CM. Sadly there was no mention of the current attacks on the industry. CHC does support consumer demand for education in CM.

The CHC is committed to improve research and standards in CM. The three initiatives for CHC to present to government in 2013 are:

- develop an industry plan, positioning and direction for funding research into export and manufacturing, and structural information;
- conduct clinical trials and increase evidence-based research, encourage an economic base to protect innovations and promote joint funding;
- catalogue and research traditional and indigenous medicines to preserve heritage.

Responding to Catherine's King's opening was CHC President and Blackmore's Director, Richard Henfrey. Mr Henfrey provided an overview of how far the Complementary Medicines Industry has come even since the inaugural Industry Leaders' Parliamentary Reception in 2010 and noted Ms King's comments, the future direction of the Industry, and the CHC. He emphasised the continued collaboration between the Industry and the TGA in implementing reforms and highlighted the recommendations set out in the CHC's Pre-Budget Submission.

Additionally this was an opportunity to launch Complementary Medicines Today (CMT), Australia's first business-to-business magazine focusing on Australia's high growth, innovative, export-driven CM manufacturing industry. Currently the CHC publishes another magazine called Naturally Australia. 100,000 copies of this are distributed nationally, making it the biggest consumer health magazine in Australia.

Radek Sali, Swisse Chief Executive Officer, spoke briefly about his company and its role in promoting CM. He commented that there was an increase in innovation and manufacturing despite the challenges posed by a lack of protection around intellectual property. Dusko Pejnovic, Lipa Pharmaceuticals Chief Executive Officer, shared with the room staggering statistics around

employment and export in the complementary medicines manufacturing sector and highlighted opportunities for future growth. The evening closed with a networking opportunity for suppliers.

Bill Pearson

REPORT ON MEETING WITH PROFESSOR KERRY PHELPS AND DR. PENNY CALDICOTT

On Thursday March 1st President Sandi Rogers and Vice Presidents Teresa - Mitchell Paterson and Bill Pearson were invited to an informal initial meeting at Professor Phelps's apartment in Potts Point.

The meeting was as a direct result of contact between Sandi Rogers and Professor Phelps as well as an invitation from the Australian Integrative Medicine Association (AIMA) seeking a working relationship with the ATMS on many levels including

- Appearing at respective Conferences as speakers
- Articles in respective Journals
- Booths at respective Conferences
- Overtures as to networking together and facilitating relationships between natural medicine and orthodox practice.

Professor Phelps was extremely interested in the ATMS and the work we are doing within the Natural Medicine and Therapies Registration Board, our philosophy and stand against statutory registration and how this differs from co-regulation, educational standards for natural medicine practitioners and the emergence of the national competency standards, our belief in the importance of our political profile, the work we have done over the years bringing associations together and the growth of the ATMS into the country's biggest accrediting agency for practitioners.

All in all a very warm and productive hour was spent. It was great to be invited to Professor Phelps's apartment for the meeting as this was very much seen as a friendly atmosphere in which to discuss important issues.

Allan Hudson

ATMS 2ND INTERNATIONAL NATURAL MEDICINE SUMMIT 2013

We are well under way with preparations for our summit on 3rd, 4th & 5th of May 2013.

The theme is Quality of Life – Healthy Aging Naturally. The summit will be held at the Rosehill Gardens event centre, James Ruse Drive, Rosehill NSW 2142. The venue is easily accessible by public transport: there is a railway station at the front door at Rosehill Gardens and the Parramatta Rivercat is only a short walk away. There is also ample free parking.

Following on from the success of our first international Natural Medicine Summit, Embrace Health, Return to Wellness in 2011 we will continue with a multidisciplinary approach. Presenters will be chosen for their expertise in selected areas, and will give their presentations on the summit theme. Panels will discuss the presentations, assisting participants in evaluating the information presented, answer questions, and invite participants to express their opinions. Breakout sessions will provide for practical workshops.

This will be a very exciting event that will feature great presenters such as Professor Lindsay Brown from the University of Queensland, Dr Airdre Grant and Dr Sonya Brownie of Southern Cross University, Ian White of Australian Bush Flowers, David Stelfox, Head of Naturopathy at Endeavour College, Joe Muscolino, a licensed chiropractic physician from the USA, Dr Peter Spitzer, a Clown Doctor, and the homoeopath Linlee Jordan. As well, we have just secured Dr. Patch Adams to take a workshop and present at the summit

Patch Adams is a medical doctor, clown, performer, social activist and founder and Director of the Gesundheit Institute, a holistic medical community that has provided free medical care to thousands of patients since it began in 1971.

"Extraordinary! One man I can look up to and respect," "Incredibly mind blowing and memorable," and "Incredibly inspiring, amazing human being, invaluable to hear him first hand" are among the tributes heard from participants after experiencing Patch Adams, the man portrayed in the hit movie Patch Adams, starring Robin Williams.

Patch believes that laughter, joy and creativity are an integral part of the healing process and therefore true health care must incorporate these elements into treatment. Doctors and patients in his model relate to each other on the basis of mutual trust, and patients receive plenty of time from their doctors. Allopathic doctors and practitioners of alternative medicine will work side by side. If you think that all sounds like a utopian impossibility, it isn't. Patch and his colleagues have practised medicine at the Gesundheit Institute together in West Virginia that way for twelve years in what he calls their pilot project.

The Board of ATMS is looking forward to meeting many of you in Sydney in May 2013 to enjoy a rewarding, exciting and unique educational event. Mark this event in your diary for 2013 as you will not want to miss a wonderful opportunity to engage with our excellent presenters. Bookings open in June 2012.

Vale Dorothy Hall

Dorothy Hall, the founder of ATMS, passed away on March 24th, 2012.
Si monumentum requiris, circumspice.

I first met Dorothy in 1986, during the campaign to reverse the government's prohibition of comfrey. Dorothy's keen focus, determination and unswerving perseverance were outstanding. She stood out as someone who was exceptionally special. Her charisma was palpable.

Since then, she became my colleague and friend. In the political arena, she was my mentor. At a personal level, it was always a joy to communicate with her. I saw first-hand how she touched the lives of thousands of students, teaching herbal medicine at both the clinical and philosophical levels. The teachings were unique, ahead of their time and emphasised the essence of healing.

The matriarch of Australian herbal medicine, the founder of ATMS, an author of seven books and media personality, her humility was remarkable. Her unexpected passing has broken hearts. Her ashes are scattered in her magnificent garden, but for her students and friends, she continues to live in our hearts. Long live the memory and legacy of this profound teacher and great woman.

Dr Raymond Khoury, Founding Editor of JATMS

Once upon a time, not so very long ago, before Coles sold vitamins, before there was a Diploma of Advanced Western Herbal Medicine, before there was a Complementary and Alternative Medicine Industry, there was the Traditional Herbalist. The practitioner of the garden and the hedgerows and the waste lands and the bush was the keeper of the old ways, the old knowledge, the ancient wisdoms, the elder, the sage. That is where we find Dorothy Hall, walking the well worn paths of ancestral knowledge and bringing that knowledge to modern times.

Dorothy Hall was not a scientist. She practiced the Art of Herbal Medicine. Dorothy had the gift of knowing that there were no two people exactly alike. She had the ability of seeing the whole person behind the symptoms presented. She could source physical discomforts and diseases to the inner turmoil that created them. She would apply the right blend of herbs and flowers for each individual who consulted her, at sensitive doses that encouraged the individual body/mind/heart/spirit to balance and heal itself.

Dorothy Hall was my teacher, perhaps the most influential teacher of my life. She was enlightening. She was enthusiastic. She was anecdotally rich and so entertaining that I can only compare her early teaching to Kent's lectures on Homoeopathy. She was a human bridge of knowledge from the ancients to her little band of students, and in 1975 we were a very little band. The classes were dynamic.

Dorothy brought so many threads together for us to see the patterns of emotions and disease, and paths to wellness. She taught us always to look beneath the presenting problem, and to look on all levels. Why did that problem arise? Why now? What are the underlying causes both physically and emotionally? She taught us to direct out treatments to the underlying causes, and in the process of teaching us how to apply Herbal Medicine, she taught us to think.

Dorothy would treat on three levels: something for the symptom presented; something for the current underlying causes both physical and emotional; and something for the constitutional weakness and constitutional emotional patterns. It was a kind of formula so beautiful in its breadth that it never called for the same remedy twice but changed as the person grew, changed themselves, healed, and faced new challenges. Dorothy's was a dynamic, powerful and empowering treatment. For me she was a dynamic, powerful and empowering teacher.

The Healing Industry outgrew Dorothy Hall, with her cottage garden, sage old ways. I'm certain that she knew it would right from the beginning when she became a driving force behind the formation of The Australian Traditional Medicine Society. She was a founding member of this now thriving organization. An organization confident enough to change itself in order to meet the current and future needs of its practitioners and educators. An organization that is able to secure a place for the Traditional Herbalist in 21st Century Australia.

Let us not forget the impact Dorothy Hall made through her books. She could write in a conversational tone that would reach the general public around the world and inspire her readers to reach for a simple remedy.

Throughout her career, through her writing and through her teaching, Dorothy Hall has positively influenced so many people that she has never even met. Each of her students who went on to practise Herbal Medicine took a small bit of Dorothy with us as we went into the wider world and into the future.

Dorothy Hall.
A pebble in a pond.
The ripples will go on long after her death and reach shores she never dreamt of.
She has done enough for the world.
Let her spirit be free.

For myself, I am honoured and grateful to have known her.

Nancy Evelyn, Herbalist

Studying Herbal Medicine with Dorothy in 1988 I found a robust, strong willed teacher who refused to suffer fools. As I absorbed her words, her knowledge and the effortless and humorous way she delivered it, I realised I was in the presence of someone very special.

Thank you Dorothy for the road you paved and the differences you made. May your memory live on forever and your essence continue to touch us all.

Jayne Elder, ATMS 1515

I first met Dorothy Hall when I became a Director of ATMS 25 years ago, although I had known her by reputation for a long time before then. She was already a leading figure in Australian natural therapies and had become a household name. I remember thinking what a privilege it was to be sitting at a table with her. Over the years we met many times at ATMS meetings and I always enjoyed her depth of knowledge and good humour. I was inspired by her vision for natural medicine in Australia. She has left a great legacy for which we are all indebted to her.

Sandra Grace, Director, ATMS

I first met Dorothy Hall in February 1984 when I was a student of Dorothy's. In August of that year Dorothy was looking for a Private Secretary and I applied for and got the job. At that time Dorothy got together with her personal solicitor, David Patten (who went on to become a District Court Judge) and put together the Memorandum & Articles of Association to form ATMS. I was then appointed Company Secretary of ATMS. Dorothy paid my wages for the first few years as there was no money and it was a tremendous struggle to stay afloat. However, against all odds and under extreme opposition from other associations, with Dorothy's guidance and wisdom it flourished.

Dorothy was a true visionary. Her understand of the needs of the profession was prophetic. She fought the good fight with vigour and great courage. The profession owes Dorothy a great debt of gratitude.

It was a great honour to work for Dorothy and she set the guiding principles for the operation of ATMS with her characteristic wisdom and 'horse sense'. All I had to do was my best to follow her principles (for some 25 years). Needless to say I was a DH devotee and my respect and admiration of her knows no bounds. There will be only one Dorothy Hall, she changed lives. On behalf of the many tens of thousands of her students and the patients she helped and inspired I say a very fond farewell to Dorothy and wish her the peace she so richly deserves. With much love and sadness, Marie Fawcett.

Marie Fawcett, Past Secretary of ATMS

It is with great sadness for me to write this tribute for Dorothy. The day I met Dorothy will remain etched in my mind forever, some 24 years ago at my first meeting as an ATMS Director. In those earlier years we met as Directors seated around a rustic wooden table in the Naturcare cafe at Artarmon. After some years of working under Dorothy's guidance we then worked together on numerous issues that were facing the natural therapies industry. Those were the days when client health fund rebates were unknown – we faced many battles together which bought us the recognition we enjoy today. As practitioners we are best to remember Dorothy's forsight and dedication to alternative medicine. I visited Dorothy numerous times at her home in the Central Highlands of NSW and she asked me on one occasion to find her some 'wizard 'statues for her astrological herb garden. The garden was a masterpiece with an amazing ambience. I was privileged to have Dorothy open my wellness centre at Charmhaven in 2001 were we proudly display a beautiful wall plaque she gifted to the centre. Her insight, dedication, mentorship and friendship have been sincerely appreciated during my own personal journey. Dorothy's efforts to heal and teach so many has left its mark, she has been our true pioneer. Go now in spirit, rest deeply. I feel enormously blessed to have known you.

Maggie Sands N.D, Principal School of Integrated Body Therapy, ATMS Life member/ Executive Director

I feel extremely privileged to have studied under Dorothy Hall/Hand. Her wealth of knowledge and wisdom were endless. She lives with me daily as I hear her voice in my head not only while I am working with my clients but also in my personal life. She will be cherished and never forgotten.

Anne Hughes, Herbalist

You're a household name, a truth seeker, master of seeing the person not the condition, and of keeping it simple. Thank you for changing my life spectacularly. I can see you sitting 'up there' in the infinite spirit, asking all those 'Sagittarian' questions you had on your list. Things like 'why didn't you put a drain hole in the mastoid bone?' Hah! Good on you Dorothy … a worthy life if ever there was one!

Fiona Stephens, DH Grad 1991

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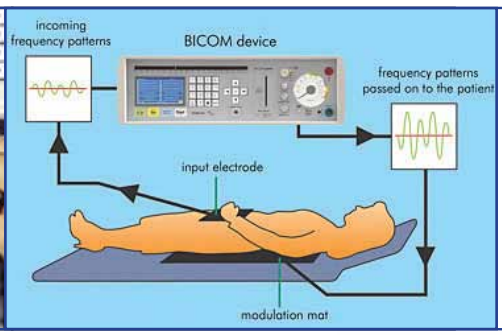

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Holistic Primary Health Care – Origins and History

Jimi Wollumbin, CEO, One Health Organisation

In 2008, to commemorate the 30th anniversary of the Alma Ata Declaration and the Primary Health Care (PHC) model it defined, One Health Organisation (OHO) drafted a document titled 'Holistic Primary Health Care' (HPHC). The purpose of this document was to revisit the foundational principles of the Alma Ata Declaration, which form the internationally agreed upon 'road map to health' summarised in the PHC model. In doing this, OHO drew upon the hard-earned experience of the last three decades as governments all over the world interpreted and implemented PHC in their own unique ways. Any re-evaluation of PHC must also take into account the many relevant international declarations that have followed in its wake. Collectively this represents the distilled wisdom of several generations of healthcare experience with HPHC representing one of the more recent attempts to synthesise this living body of knowledge in a single, integrative policy platform.

To better understand the context of HPHC and why such an integrative approach is so essential, it is necessary to briefly outline the history of the ideas it draws upon. The following discussion charts the history of an holistic approach to health care to show its deep intellectual and ideological roots.

HEALTH CARE AS AN INALIENABLE HUMAN RIGHT

A holistic approach to Primary Health Care is not the novel idea that many believe it to be. To the contrary, it traces its roots to the very core of 20th century international health care policy, forming the original impetus of the PHC model itself. As with many other freedoms and rights, the foundations of modern health care were laid down in December 1948 with the formal adoption of The Universal Declaration of Human Rights (UDHR) by all UN member states. The impetus for this document was the revelation after the end of World War Two of the atrocities that had been committed by Nazi Germany. In order to prevent such horrors recurring the international community drafted the Charter of the United Nations on 26 June 1945, which formally created the UN. In the years that followed, however, a 'universal declaration' that specified the rights of individuals was deemed necessary for realising the UN Charter. When article 25 of the UDHR firmly established health care as an inalienable human right the world collectively endorsed the rights-based approach to health care so often referenced throughout history and yet so commonly ignored. The significance of such a rights-based approach to health care is that it strongly emphasises the importance of equality of access, and ensures that those with greatest need are able to participate in quality health care programs. A rights-based approach also shifts the emphasis away from disease, as regardless of an individual or community's health or financial status they are entitled to quality health care services. This perspective underlies the core of the primary health care movement and most modern approaches to developing countries and indigenous populations.

BAREFOOT DOCTORS

On the eve of China's cultural revolution in 1949, the government found itself facing a health care crisis: for every 10 000 people there was only one registered and qualified medical doctor, yet, as with many developing countries today, there was a practitioner of Traditional Medicine (TM) for every 100 people.

China's unique response was the now-famous 'Barefoot Doctors' program. By incorporating Traditional Chinese Medicine and a general focus on basic hygiene, preventative medicine, family planning and simple treatments for common ailments, the initiative ultimately came to service 80% of China's population with a massive 1.8 million community-based health care workers. The system was highly praised by the World Bank and World Health Organisation at the time and was considered a viable alternative to the Western hospital-based system. It is for this reason that OHO originally traded and was incorporated under the company name of 'The Barefoot Doctors Project'.

A CRUMBLING HEALTH CARE MODEL

At the same point in history the colonialist approach to international development and health care policies was facing serious criticism from many respected western authorities. Out of the ruins of post WW2 Europe came a significant change in ideology that saw the formation of the World Health Organisation and UNICEF.

In 1955 a radical re-evaluation of Primary Health Care began when respected British Professor of Social Medicine, Thomas McKeown, argued that the overall health of England's population had been largely unaffected by medicine, and that the decreased death rates were simply due to better standards of living and nutrition.[1] McKeown's work was followed by the now famous Canadian Government's Lalonde Report[2] of 1974 which is considered the "first modern government document in the Western world to acknowledge that our emphasis upon a biomedical health care system is wrong, and that we need to look beyond the traditional health care (sick care) system if we wish to improve the health of the public".[3]

Although both Lalonde and McKeown's ideas challenged the faith and optimism of the medical establishment, the ideas they espoused were relatively mild compared to the more aggressive thesis of the radical Austrian philosopher and polymath Ivan Illich. Illich's 1975 work, instructively titled *Medical Nemesis*,[4] contended that the western hospital-based and doctor-centric health care system was not only ineffectual but actually detrimental to population health. He contended that this was an effect of 'social iatrogenesis', a process whereby medical doctors expropriated and effectively removed knowledge of healthcare from the public arena, which drove preventable disease vectors upwards. This 'expertism' at the core of the western hospital based-system was seen as a major driver of disease through its negative effect on the dissemination of basic healthcare knowledge.

At the same time the WHO's constitution had radically redefined health to be more than simply the absence of disease, and the then president of WHO, Mr M. Mahler, controversially stated in a 1976 address that, "The scientific and technological structures of public health are crumbling".[5] A radical sense of change was in the air, which was only heightened by growing concerns that the hospital-based and disease-oriented system was not only failing to improve the health of developing nations, but was also failing to meet the needs of the first world nations that had implemented it to begin with. Somewhat controversially, the president of the WHO likened the current technologically-oriented system to the classic Frankenstein myth of the sorcerer's apprentice, as it was deemed to be out of social control.[6] This culminated in a 1975 joint WHO–UNICEF report titled 'Alternative Approaches to Meeting Basic Health Needs in Developing Countries'. According to a recent commentator the term "alternative" underlined the shortcomings of traditional vertical programs concentrating on specific diseases, whilst the 'assumption that the expansion of "Western" medical systems would meet the needs of the common people was again highly criticized'1. Riding on the international recognition of the success of the Barefoot Doctors model, the Chinese delegate to the WHO suggested an international conference to discuss the issue.

THE ALMA ATA DECLARATION

The result, after much debate, was the Alma Ata Conference of 1978 where the principles of Primary Health Care were formally defined; 3000 delegates from 134 nations and 67 International NGO's made this the biggest convergence of world leaders in history. Despite this, most health care providers today are unfortunately unacquainted with the Alma Ata Declaration. As ideas do not occur in an intellectual vacuum, it is important to note that this conference took place at the tail end of the counter-culture revolution of the 60's and 70's, which amongst other things witnessed the massive resurgence of public and professional interest in holistic approaches to health and medicine.

To better understand the heady ideological and intellectual environment of the time, it is illuminating to list some of the other academic fruits of this 'cultural' revolution:

- Rachel Carson's *Silent Spring* (1962),
- Lynn Margulis's Endo-symbiosis Theory (1970),
- James Lovelock's Gaia Hypothesis (1975),
- Benoit Mandelbrot's Fractal Geometry of Nature (1975),
- Noam Chomsky's 'Intellectuals and the State' Huizinga Lecture in Leiden (1977) and
- Bill Mollison's and David Holmgren's Permaculture Model (1978).

This groundswell of intellectual change furthers our understanding of the three key ideas that permeate the declaration of Alma Ata : 1) a preference for non-technological interventions such as nutrition and sanitation, 2) opposition to medical elitism through genuine community involvement in health care strategies, and 3) the notion that health care is inseparable from socio-economic development.

Indeed, Primary Health Care as envisioned at Alma Ata had very strong socio-political implications. It not only specifically stated that we must address the underlying social, economic, and political causes of poor health if the goal of "Health for All" was to be attained by the year 2000, but also viewed health as a major driver and vehicle for social justice issues themselves.

The PHC movement that emerged from the Alma Ata Declaration strongly emphasised disease prevention, health promotion, community participation, self-reliance, and intersectoral collaboration. Furthermore, like the Lalonde Report, it acknowledged that poverty, social unrest, the environment, and a lack of basic hygiene and nutrition contribute more significantly to poor health status than access to medical intervention alone. This perspective strongly echoed that of the popular 'alternative' healthcare movement that was sweeping through industrialised nations with the resurgence of interest in traditional and holistic healthcare treatments such as herbal medicine, nutritional therapy and homeopathy. The prime difference was that the former applied holistic principles to population health, whilst the latter focused upon the health of the individual.

As Cueto notes in his detailed study of the origins of primary health care, the PHC movement voiced strong criticism of the negative role of "disease-oriented technology" and equally strong criticism of the creation of urban hospitals in developing countries since, "these institutions were perceived as promoting a dependent consumer culture, benefiting a minority, and drawing a substantial share of scarce funds and manpower".[7]

Although alternative medical systems were not deeply discussed, despite the centrality of Traditional Chinese Medicine in China's Barefoot Doctors program, the need for working with traditional healers, such as shamans and midwives, in developing countries, was emphasised. This

oversight can in part be explained by the fact that in the 1970's the continuity now acknowledged by the WHO between Traditional Medicine practices and Complementary and Alternative Medicine had not yet been realised.

"SELECTIVE" PRIMARY HEALTH CARE

Despite the universal acceptance of The Alma Ata Declaration it was formally endorsed at the 32nd World Health Assembly, it very quickly came under attack as being too idealistic, and in less than twelve months an alternative system had been proposed. The Rockefeller Conference of 1979 was held to address "disturbing signs of declining interest in population issues"[8] and was attended by a significantly smaller list of elite delegates headed by industry leaders such as the President of the Ford Foundation, and the President of the World Bank and former Secretary for US Defence, Robert McNamara. It was here that an interim model based on a paper by Julia Walsh and Kenneth S. Warren titled "Selective Primary Health Care" was formally endorsed.[9] Rather than broad- reaching policies that addressed health through social justice and economic equity, the worst diseases would be selectively targeted according to their prevalence, morbidity, mortality, and feasibility of control (including efficacy and cost effectiveness).

Four basic services were then to be provided in International Aid, which was defined as the GOBI. approach: Growth Monitoring, Oral Rehydration, Breast Feeding and Immunisation. Rather than implement costly interventions to eradicate world hunger, growth monitoring would be implemented, to see which infants were worst affected. Rather than solve basic sanitation issues that resulted in many dying of dehydration from dysentery and diarrhoea, oral rehydration sachets would be distributed. Rather than engage in long-term programs of economic development and education to slow down population explosion in developing countries, breast-feeding would be promoted to increase birth intervals. And finally, rather than actively promoting health and social justice as defined by Alma Ata, specific diseases would be 'selectively' targeted by immunisation campaigns. The appeal of the GOBI approach was that it clearly outlined a series of low-cost technologically informed interventions that could then be monitored and evaluated. The issue of 'measuring health' has since become the focal point of the debate with purest PHC advocates insisting that health initiatives that are limited to what can be cost-effectively monitored inevitably infringe upon the human rights of vulnerable population groups struggling with health concerns that are difficult to measure using standard protocols.

The underlying philosophy of "selective" Primary Health Care was the system WHO and UNICEF had originally attempted to change, but has since informed most domestic and international health care policies. This system focuses on selected diseases, rather than promoting health: it favours technological interventions over education and prevention, it is the domain of the medical elite rather than the local community, and its costs are steadily escalating rather than decreasing. The international gold standard established at Alma Ata, which was very much in the spirit of the Universal Declaration of Human Rights, has been largely abandoned, and with it the full recognition of health as an inalienable right that must not be neglected nor compromised by reduced "selective" measures. For reasons such as these one of the central figures of the Alma Ata Conference later stated:[10]

"[selective primary health care] is a threat and can be thought of as a counter-revolution. Rather than an alternative, it… can be destructive…Its attractions to the professionals and to funding agencies and governments looking for short-term goals are very apparent. It has to be rejected."

It is important to note here that countries such as Cuba that rejected the selective approach and attempted to enact a more holistic or comprehensive approach to primary health care have achieved remarkable gains in their population health.

THE EARTH CHARTER

The next major international movement away from the reductionist and 'selective' paradigm was to come out of the budding ecological revolution. It began in 1987 as the United Nations World Commission on Environment and Development began addressing the issue of sustainable development, but was then taken on as an independent civil society movement by the Earth Charter Commission. After perhaps the most thorough and inclusive consultative process in history, the Earth Charter was completed 13 years later and was approved by UNESCO in March 2000. Although ecological integrity is described as a major theme, the Earth Charter also recognises:

"that the goals of ecological protection, the eradication of poverty, equitable economic development, respect for human rights, democracy, and peace are interdependent and indivisible".

It therefore provides a groundbreaking 'inclusive, integrated ethical framework' which most similar specialist international documents sadly lack, but is very much in the spirit of the comprehensive approach to primary health care outlined at Alma Ata.

THE BEIJING DECLARATION

In 2008, on the 30th anniversary of the Alma Ata Declaration on PHC, the WHO issued its historic Beijing Declaration at the first International Congress on Traditional Medicine. Although China was chosen due to the integrative nature of its healthcare system, it may equally likely have been selected as the home of the barefoot doctors, due to the strong inspiration this provided to the authors of the PHC movement. The declaration formally called upon all governments to integrate holistic and Traditional Medicine (TM) into their national health care system, acknowledging that it has played an important role in meeting the demands of primary health care in many developing countries and is already widely utilised in many developed countries. At this congress, WHO Director-General Dr Margaret Chan addressed the delegates with the following statement.[10]

"The time has never been better, and the reasons never greater, for giving traditional medicine its proper place in addressing the many ills that face all our modern – and our traditional – societies… The two systems of traditional and Western medicine need not clash. Within the context of primary health care, they can blend together in a beneficial harmony, using the best features of each system, and compensating for certain weaknesses in each".

This represents an extremely significant convergence, for as previously suggested, both the wellness revolution, which gave rise to the current resurgence of holistic medical practices, and the primary health care movement emerged during the same period of time but had until this point remained separate. These may therefore be viewed as the popular and academic expressions of the same basic impulse. A multi-disciplinary, comprehensive and integrative approach to global health would seemingly have the greatest chance of realisation in the combining of both these movements; all the more so if an ecological perspective and a rights-based approach are also included.

HOLISTIC PRIMARY HEALTH CARE

In 2008, also to commemorate the 30th anniversary of the Alma Ata Declaration, One Health Organisation formally defined the principles of Holistic Primary health Care (HPHC) in light of the lessons learned over the last three decades under the "interim" approach of Selective Primary Health Care. In doing so it drew upon not only the declarations listed above, but also from the WHO Constitution, the Geneva Convention, The Ottawa Charter, the Hippocratic Oath, The UN Declaration on the Rights of Indigenous People, and the vast array of wisdom contained in traditional medical systems from around the world. Since the original declaration the West has learnt that economic development does not safeguard health. We have learnt that high immunisation rates alone do not guarantee low infant mortality and morbidity. We have learnt that

- genuine community involvement is also necessary in developed countries and urban environments;
- that natural systems have a finely based ecological balance and must be interfered with gently and cautiously to avoid dangerous and unwanted repercussions;
- that affluence and industrialisation bring their own challenges to health;
- and finally, what the true cost is of failing to prioritise this most inalienable human right, as national health care costs spiral out of control.

As stated in the preamble to HPHC however, the scope of cooperation and integration it espouses goes well beyond that of any normal dichotomies such as orthodox versus 'alternative' or comprehensive versus selective. Rather, it encompasses the vast array of skills and knowledge required to build economically vibrant communities of healthy, educated individuals living sustainably in harmony with each other and their broader environment. An integrative, cooperative, multi-disciplinary and multi-sectoral approach to global health requires the interweaving of rights, principles and values into a single broad road map to global health that crosses normal professional, philosophical or technical boundaries. Like the Earth Charter, HPHC is itself a microcosm of such an approach, drawing the foundational declarations set out in this paper together into a single unifying vision. Such a perspective compels us to take a comprehensive and holistic view; a view that, as the document itself states, 'incorporates spheres of action and thought previously deemed to be unrelated'. In closing it is perhaps fitting to borrow the eloquence of the Earth Charter as it beautifully articulates the common ground that underlies our varied perspectives:

"We stand at a critical moment in Earth's history, a time when humanity must choose its future … Let ours be a time remembered for the awakening of a new reverence for life, the firm resolve to achieve sustainability, the quickening of the struggle for justice and peace, and the joyful celebration of life".

Further information about One Health initiatives is available at *http://onehealthorganisation.org/*

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The Dynamic Of Stress

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Emotions consist of behavioural, endocrine and autonomic responses which are generally maintained in balance by the stress response system. Walter Cannon introduced the phrase "fight-or-flight response" to refer to the physiological reactions required by either fighting or avoiding the stressor.[1] As long as the response is brief, physiological responses may be bearable. However, when stress becomes chronic with an ongoing physiological arousal, it adversely affects the immune, cardiovascular, neuroendocrine and central nervous systems. The wear and tear on the body, also referred to as the allostatic load, results from either too much stress or inefficient management of stress. This load is a significant predictor of all-cause mortality, cognitive decline, physical functioning and cardiovascular disease.[2]

Perception of stress elicits adrenal release of adrenaline, noradrenaline, and cortisol, which feed back negatively to the pituitary and hypothalamus, reducing and normalizing the stress response mediated by the hypothalamic corticotrophin releasing hormone (CHR) and pituitary adrenocorticotropic hormone.[3] Adrenalin and noradrenalin affect glucose metabolism, mobilizing nutrients stored in the muscle to become available and provide energy. They also affect blood flow to the muscles by increasing cardiac blood output and consequently causing high blood pressure.[4] Additionally, norepinephrine is secreted in the brain as a neurotransmitter and in times of stress, release of norepinephrine is particularly high in the hypothalamus, frontal cortex and lateral basal forebrain.[5]

The other stress hormone is cortisol, a steroid hormone secreted in the adrenal cortex. Cortisol helps to break down protein and convert it to glucose (hence the name glucocorticoid), helps make fats available for energy, increases blood flow and stimulates behavioural responsiveness by stimulating the brain. Cortisol also decreases the sensitivity of the gonads to the luteinizing hormone (LH), which suppresses secretion of the sex steroid hormones. In a study conducted by Mulchahey et al.[6] it was found that the blood testosterone of male doctors was severely depressed presumably due to their stressful work schedule. Cortisol also stimulates the dorsal raphae nucleus to produce an increased amount of calming serotonin as well as the release of opioids, which inhibits noradrenalin release, bringing the initial stress-induced response back to normal. Almost every cell in the body has glucocorticoid receptors and consequently almost every cell in the body is affected by the stress hormone.[7]

A stressor always elicits physiological changes that are put in motion to enable the individual to cope with the event. The autonomic and endocrine responses work catabolically by mobilizing the body's energy resources. The stress response is intended to be of limited duration. In this way, its catabolic and immunosuppressive effects are homeostatic and without serious consequences.[8]

The principal role of glucocorticoids during the stress response is thought to be restraint of the effects of the stress response. When a stressor is perceived, the secretion of glucocorticoids is stimulated by the neuronal brain located in the paraventricular nucleus of the hypothalamus. From here, it secretes the corticotropin-releasing-hormone (CRH) that stimulates the anterior lobe of the pituitary gland to produce the adrenocorticotropin-releasing hormone (ACTH), which then enters the blood stream and provokes the adrenal cortex to secrete glucocorticoids. The CRH system activates the stress response and is subject to modulation by cytokines, hormones, and neurotransmitters. The interactions among these organs constitute the hypothalamic-pituitary-adrenal (HPA) axis. The HPA axis has major interactions with the hypothalamic-pituitary-gonadal (HPG) and reproductive axes, the thyroid axis and the growth hormone axis, glucoregulation, insulin resistance and Th1/Th2 balance.[7,9]

Glucocorticoids inhibit the functions of virtually all inflammatory cells. Cortisol works effectively by increasing the intracellular synthesis of IKK-B, which binds to NFkB, thereby blocking the inflammatory cascade at its starting point. Glucocorticoids modulate the stress response at a molecular level by altering gene expression, transcription, and translation, among other pathways. Glucocorticoids receptors, which are expressed in a variety of immune cells, bind cortisol and interfere with the function of NF-kB and its regulation of the activity of cytokine-producing immune cells.[3] The effect is the inhibition of the functions of inflammatory cells, predominantly mediated through inhibition of cytokines, such as IL-1, IL-6, and TNF- alpha.[3,10]

The chronic activation of the hypothalamic-pituitary-adrenal axis (HPA) from chronic stress results in the increase in adrenal glucocorticoids with well documented inhibitory effects on the inflammatory process and in the inflammatory cytokines release. This stimulation not only often results in the disruption of the central nervous system, but also adversely

influences the immune system causing stress, depression and suppression of specific immunity. Circulating levels of pro-inflammatory mediators are widely accepted as a marker of systemic levels of inflammation.[3]

Pro-inflammatory cytokines can penetrate the blood-brain barrier and affect those microglial cells located in specific areas of the brain involved in mood regulation and reward process.[11] Recent human studies have employed randomized double-blind trials, exposing subjects to either immune stimulants (usually endotoxin) that generate low-grade systemic inflammatory responses or saline placebo and then comparing patterns of brain activation across the groups using functional magnetic resonance imagery. Using these methods, peripheral inflammation has been associated with negative mood states that are accompanied by increased activation of the subgenual anterior cingulate cortex (sgACC) and decreased connectivity of the sgACC with the amygdala, prefrontal cortex, nucleus accumbens, dorsal raphae nucleus (DNR) and locus caeruleus (LC). Research with animals has shown that a long term exposure to glucocorticoids destroys the neurons located in the hippocampal formation by decreasing the entry of glucose and decreasing the reuptake of glutamate.[12] This effect makes the neurons more susceptible to harmful events. For example, the increased amount of extracellular glutamate allows calcium to enter the brain through NMDA receptors, the predominant molecular device for controlling synaptic plasticity and memory function. Studies conducted by Brenneman et al. [13] confirm that stress early in life can cause problems in the hippocampal function. Several studies have confirmed that the stress of chronic pain has deleterious effect on the brain and cognitive behaviour.[9]

Consistent evidence shows that individuals with major depressive disorders have higher levels of circulating markers of inflammation than non-depressed individuals. For example, two recent meta-analyses concluded that increased plasma levels of TNF-α, IL-6, IL-1, and CRP accompany major depression.[6,14]

There is ample research confirming that in the immune-to-brain pathways, sickness symptoms mediated by increases in circulating pro-inflammatory cytokines, are consistent with symptoms of depression including fatigue, sleep disturbances, anxiety, negative mood, anhedonia, and loss of appetite.[11] A direct relationship between stress and the immune system was demonstrated by Keicolt-Glaser et al.[3] who found that caregivers of family members with Alzheimer's disease showed weaker immune systems. Grief and bereavement have been found to severely suppress the immune system. In another study, the clinical administration of cytokines or endotoxins resulted in a range of symptoms of depression.[15] It is also a well-known factor that the clinical administration of the pro-inflammatory cytokine interferon (IFN)-α in the treatment of cancer or chronic infection induces symptoms of major depressive disorder in 23% to 45% of all patients, with the degree of depression being positively related to dose and duration of treatment.[16] Epidemiologic evidence also shows that systemic inflammation predicts future risk for depressive symptoms and clinical episodes of depression in some studies.[8,17,18]

Conditions associated with increased and prolonged activation of the HPA axis include anorexia nervosa, obsessive-compulsive disorder and panic disorder[10,12,7] and increased susceptibility to infection and tumours. In contrast, hypo-activation of the stress system/HPA axis, resulting in chronically reduced CRH secretion, may cause pathological hypo-arousal, leading to susceptibility to inflammatory, autoimmune disease, abnormal behavioural response,[19,20] seasonal affective disorder, chronic fatigue syndrome and weight gain. Repeated and prolonged exposure to glucocorticoids causes hippocampal neurons to atrophy, it increases activation of the sympathetic and decreased activation of the parasympathetic branches of the autonomic nervous system.[3] Abnormalities of stress system activation have been shown in inflammatory diseases such as rheumatoid arthritis, as well as behavioural syndromes such as melancholic depression. Thus, the stress response is central to resistance to chronic inflammation and mood disorders.

Cytokines found within the central nervous system play an important part in neuronal cell death.[4] The human central nervous system contains neuronal pathways and receptors for cytokines (e.g. IL-1) in areas that control the acute-phase response.[21] Most cytokines are large molecules, and would not be expected to cross the blood-brain barrier with ease. However, IL-1 stimulates the production of endothelial cell prostaglandins (PGE2, PGI2), which in turn stimulate the secretion of CRH from nerve terminals in the median eminence, which lies outside the blood brain barrier.[9] IL-1 may cross the blood-brain barrier at relatively leaky parts, such as the organum vasculosum of the lamina terminalis, or during disease states such as infection or inflammation which may impair the barrier. IL-1 may also signal centrally via secondary messengers such as nitric oxide and prostaglandins, or via the vagus and other nerves.[22] The chronic production of cytokines can induce glucocorticoids resistance and impair this process.

Cortisol resistance has been associated with insulin resistance. The similarities rest on reduced cellular expression of receptors, compromised receptors pathways through micronutrients deficiency and energy depletion. Long term exposure to glucocorticoids as also been linked to negatively affect the hippocampal formation by decreasing the entry of glucose and decreasing the reuptake of glutamate, thus destroying the neurons.[15,16] High levels of cortisol accelerate the process of adrenal exhaustion and lead to cortisol resistance. This phenomenon is characterized by increased plasma cortisol concentration and high urinary free cortisol. Cortisol

resistance has a variety of different effects including increased blood pressure, damage to muscle tissue, steroidal diabetes, infertility, inhibition of growth, inhibition of the inflammatory responses and suppression of the immune system.[23,24]

Depending on the duration of the stressors, the pattern of the adrenal axis dysfunction will differ. Early in the stress response, there might be elevated cortisol and catecholamines, but with chronic stress the system's ability to produce cortisol and other adrenal steroids maybe reduced and reserve of catecholamines depleted.[25] The consequence is fatigue, exhaustion and the inability to mount an adequate stress response on and hour-to-hour basis.

By helping the body cope with stress, adaptogenic herbs literally help to produce an adequate stress response. Traditionally, the focus has been directed to remedies that help maintain and improve adrenal stress response. Amongst others, they include Siberian Ginseng, Dong Quai and Gotu Kola. In particular, Korean Ginseng acts mainly on the hypothalamus and has a sparing action on the adrenal cortex. Response is stronger and quicker and feedback control is more active, so that when stress decreases, glucocorticoid levels fall more rapidly to normal.[26] During chronic stress, glucocorticoid production is reduced by Korean Ginseng (a sparing effect), while at the same time adrenal capacity is increased (trophic effect). Ginseng also raises plasma ACTH[27] and cortisone in the relaxed state, thereby generating a sense of alertness and well-being. Recommended dosage: 0.5 to 3g/day of the dried main or lateral root or 1 to 6ml of the 1:2 liquid extract. Preparations from the root hairs are therapeutically inferior and should be avoided.

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PRACTITIONER SEMINAR SERIES 2012 - HAIR TISSUE MINERAL ANALYSIS

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Identifying and correcting nutritional imbalances to better treat and manage autoimmune conditions

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- Mineral synergists and antagonists
- Metabolic Typing
- Case studies

HTMA Advanced Course (Sunday)

Autoimmune Disease and Natural Medicine

- Coeliac Disease
- Allergies (seasonal, skin)
- Thyroid conditions (Hashimoto's, Graves')
- Fibromyalgia
- Chronic Fatigue
- Mineral/Nutritional Imbalances
- Case Studies and practical clinical examples

PRESENTED BY:

Zac Bobrov
Technical Director,
InterClinical Laboratories

Reine DuBois Dip ND, Dip HOM
Naturopath, Homeopath, Clinic Director and CEO of IMedicine

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Melbourne:	2nd & 3rd June 2012	Crowne Plaza
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Lumbopelvic Rhythm

Joe Muscolino, DC. Joe Muscolino is a Doctor of Chiropractic. He has been an instructor in the world of massage therapy for over 25 years. He will be in Australia in May 2013 to run CPE classes in clinical orthopaedic (remedial) massage therapy techniques. He will also be a presenter at our 2013 ATMS conference. For more information, visit his website: www.learnmuscles.com or contact him at joe@learnmuscles.com.

The importance of spinal posture is well appreciated: schools perform scoliosis screenings each year for children, a hyperlordotic lumbar spinal curve (swayback) is recognized as a possible cause of facet syndrome and low back pain, and spinal subluxations (joint dysfunction) are often blamed for pinched nerves. What is underappreciated is that the cause of unhealthy spinal posture often lies outside of the spine, and can be attributed to pelvic posture. This is unfortunate because rehabilitation treatment of the spine will only be effective and lasting if it is directed at the cause of the problem.

ANATOMY OF THE PELVIS

The pelvis is composed of the two pelvic bones (each composed of an ilium, ischium, and pubis), sacrum and coccyx (Figure 1). The pelvic bones are bones of the appendicular skeleton; the sacrum and coccyx are vertebral segments and are therefore axial skeletal bones. Composed of appendicular and axial skeleton bones, the pelvis is a transitional body part between the lower extremities and the spine.

The key to understanding the relationship between the pelvis and lumbar spine is that the lumbar spine sits on the sacrum. Therefore, any change in the posture of the pelvis, and therefore posture of the sacrum, directly changes the posture of the lumbar spine. And because the thoracic spine sits on the lumbar spine, and the cervical spine sits on the thoracic spine, changes in lumbar posture directly affect the posture of the spinal regions above.

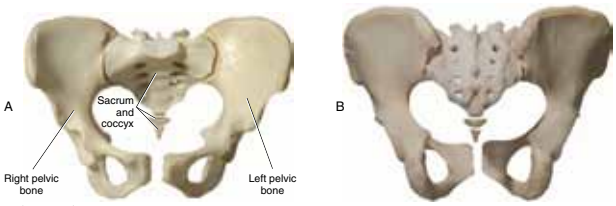

Figure 1

LUMBOPELVIC RHYTHM

The term lumbopelvic rhythm is used to describe the relationship between the pelvis and lumbar spine. Ideal healthy posture of the pelvis allows for ideal healthy posture of the lumbar spine. However, if pelvic posture deviates from ideal, biomechanical compensation resulting in postural distortion patterns will be seen in the lumbar spine and above. These postural distortions can be examined in each of the three cardinal planes: sagittal, frontal, and transverse. Following is a discussion of lumbopelvic posture in the sagittal plane.

SAGITTAL PLANE POSTURE

Although there is some controversy regarding what constitutes ideal posture of the pelvis in the sagittal plane, it is generally considered to be a position of anterior tilt such that the sacral base angle measures approximately 30 degrees. The sacral base angle is determined by measuring the angle formed between a line drawn along the base (top) of the sacrum and a horizontal line (Figure 2). Because anterior tilt of the pelvis causes the sacral base to be unlevel, the lumbar spine compensates with a lordotic curve to ultimately bring the upper spine and head back toward vertical. This allows the centre of weight of the trunk to be balanced over the pelvis and also allows the head to be level for proprioception by the eyes and inner ears. Thus, the normal lordosis of the lumbar spine is a direct result of anterior pelvic (sacral) tilt in the sagittal plane.

Lumbar Spine Compensation

As anterior pelvic tilt and therefore the sacral base angle increases, the lumbar spine must compensate by commensurately increasing its lordosis; similarly, if the sacral base angle decreases, the lumbar spine compensates by decreasing its lordosis (Figure 3). Altered lordotic posture is considered to be unhealthy. Increased lordosis is unhealthy because it shifts weight bearing from the discs toward the facet joints, which are not adapted to accept this increased compression force. Decreased lumbar lordosis is unhealthy because it results in a decreased ability of the lumbar spine to absorb shock.

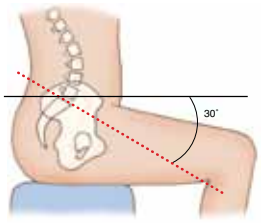

Figure 2

Pelvic Posture and Soft Tissue Tone:

If the degree of lumbar lordosis is a function of the sagittal plane tilt of the pelvis, then ultimately whatever determines pelvic tilt posture determines lumbar lordosis. Sagittal plane posture of the pelvis is created by the tensile forces of soft tissue tone within the sagittal plane. These tensile forces can be passive or active.

Passive Tension – Fascial Tissues:

Passive tension is usually due to joint capsules, ligaments, and other fascial planes. Excessive tautness and fascial adhesions within these tissues restrict the tissue's ability to lengthen and can result in passive tension that does not allow for posture or motion in the opposite direction. Within the sagittal plane, tautness/adhesion in the anterior hip capsule would restrict extension of the thigh at the hip joint, and tautness/adhesions in the posterior hip capsule would restrict flexion of the thigh at the hip joint.

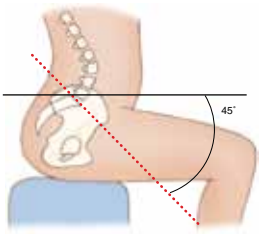

Figure 3a

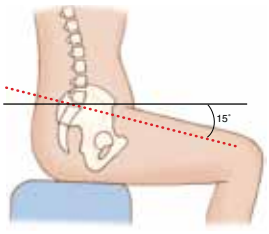

Figure 3b

Active Tension – Musculature

Active/dynamic tension is caused by muscular contraction and is likely the more important factor. Within the sagittal plane, the posture of the pelvis is determined by four muscle groups: hip flexors, hip extensors (gluteal and hamstring muscles) (Figure 4); and paraspinal trunk extensors (low back muscles) and trunk flexors (anterior abdominal wall muscles) (Figure 5). Hip flexors and trunk extensors are anterior tilters; hip extensors and trunk flexors are posterior tilters. The relative balance of the baseline tone pull of these opposing groups determines sagittal plane pelvic posture. If the anterior tilters

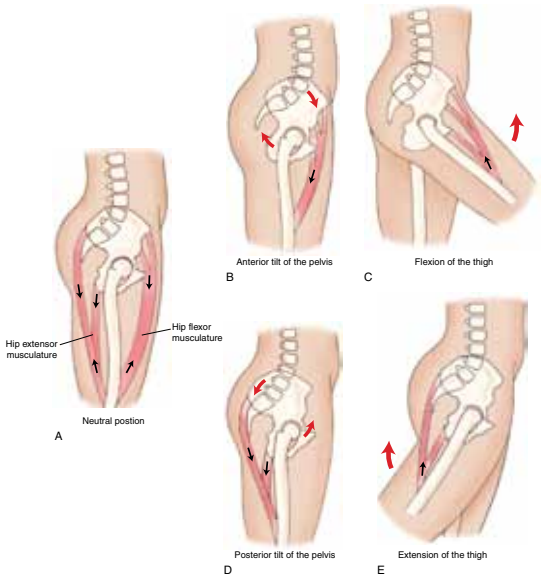

Figure 4

are excessively tight and/or the posterior tilters are excessively weak, the pelvis is pulled toward anterior tilt, with concomitant increased lordosis. Similar, if the posterior tilters are excessively tight and/or the anterior tilters are excessively weak, the pelvis is pulled toward posterior tilt with concomitant decreased lordosis.

Examining the usual balance of these groups, it is most typical for hip flexors and trunk extensors to be tight and anterior abdominal wall and gluteal muscles to be weak.

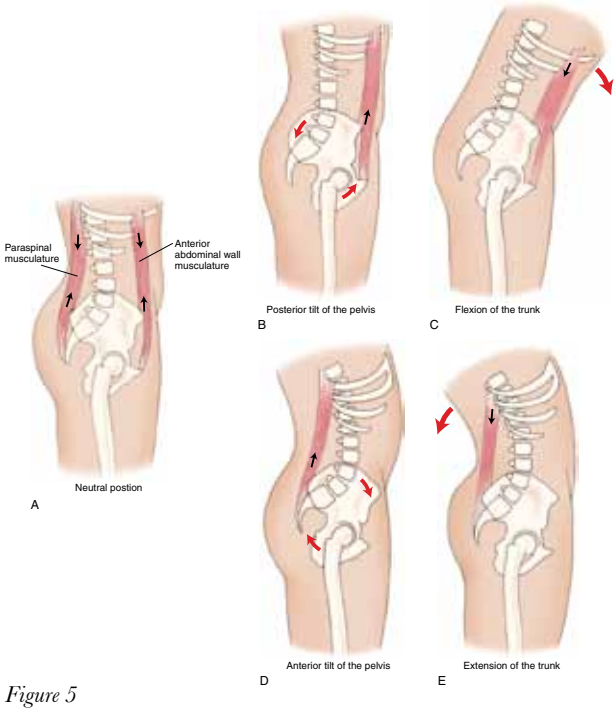

Figure 5

Hip flexors are usually tight because we spend so much time seated. Seated posture places these muscles in a shortened posture; as a result, due to the principle of adaptive shortening, they become tight. Trunk extensors such as the multifidus of the transversospinalis group and erector spinae are often tight due to loads placed on them when bending forward: eccentric loads when flexing forward, isometric loads maintaining a bent-forward posture, and eccentric loads when returning to erect position.

Anterior abdominal wall muscles are usually weak due to a lack of trunk flexion exercise against resistance. Trunk flexion against resistance is not a common activity of daily life, so if it is not specifically targeted with rehabilitative exercise such as sit-ups, the anterior abdominal wall usually weakens with ageing. Posterior gluteal musculature is weak in most people because it is not engaged unless extension of the thigh at the hip joint during gait is performed against resistance, for example walking uphill or upstairs, on a labile surface such as loose sand, or when running.

Due to this typical imbalance of anterior/posterior pelvic tilt musculature, the common sagittal plane postural distortion pattern of the lumbar spine is hyperlordosis.

APPLICATION FOR REHABILITATION

If the cause of lumbar hyperlordosis is an imbalance of tensile forces of anterior/posterior pelvic tilt soft tissues, then it follows that effective and lasting treatment must be directed toward these tissues. Taut/tight soft tissues need to be relaxed and lengthened; and weak muscles need to be strengthened so that their baseline tone increases. With a client who has excessive anterior tilt and hyperlordosis, it is important to loosen and relax anterior tilt musculature so that the pelvis can be moved into its proper tilt posture. This can be accomplished by stretching tight hip flexor and lumbar spinal extensor musculature (Figure 6).

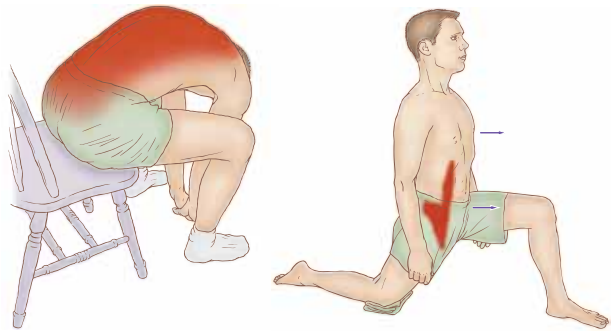

Figure 6

If these stretches are done after the tissues are first warmed up, then they will be more effective. Therefore, it is best to do stretching after heat and hands-on soft tissue manipulation are done. Concomitantly, hip extensor (especially gluteal) and anterior abdominal wall musculature should be strengthened so that proper tilt posture afforded by loosened anterior tilt musculature and other soft tissues can be maintained. Righting the tilt posture of the pelvis to a healthy sacral base angle will then allow for the return of a healthy lumbar lordotic curve.

Ultimately, for any musculoskeletal treatment to be effective, it is important to address the actual mechanical cause of the problem, not the postural compensation. In the case of spinal postural distortion patterns, the underlying cause is often the posture of the pelvis; and in turn, the posture of the pelvis is determined by relative tone of the soft tissues that cross the hip and lumbosacral joints. For this reason, it is important for therapists and trainers to treat the spine by first assessing and treating the pelvis.

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Migraine Treatment And The Role Of Acupuncture: A Literature Review

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ABSTRACT

Migraine is a major health and disability problem. Results of existing pharmacological treatment options have been unsatisfactory. Acupuncture is a non-pharmacological treatment for pain and has been found to be more effective for treating migraine than preventive migraine medicines. The way acupuncture modulates brain structures has been demonstrated by PET and functional MRI studies. Acupuncture has a significant vasodilatory effect on the radial artery diameter of migraine patients which interacts with the mechanisms of pain. Acupuncture also effects cell secretion, signalling and afferent sensory input, and the activity of norepinephrine, angiotensin II, serotonin, enkephalin, beta-endorphin and glutamate. Acupuncture has a strong analgesic effect and should be widely used in migraine treatment.

DIAGNOSIS OF MIGRAINE AND EPIDEMIOLOGY

Migraine is one of the leading reasons among headache patients for visiting doctors. The frequency of migraine episodes ranges from daily headaches to less than a single episode per month.[1] The correct identification and diagnosis of migraine headaches are essential, because migraine may remain underdiagnosed and undertreated even in neurology clinics.[2] Migraine headaches lead to recurrent attacks which are mostly unilateral, pulsating with associated symptoms such as photophobia, phonophobia, nausea, and vomiting. The International Headache Society (IHS) differentiates between migraine with and without aura.[3] The IHS published a second classification of headache disorders (the ICHD-2) in 2004. Primary headache disorders fall into 3 main categories: migraine, tension-type headache, and cluster headache.[4] Both tension-type headache (TTH) and migraine have episodic and chronic forms. The episodic forms are characterized by headache that lasts fewer than 15 days per month, whereas the chronic forms are characterized by headache that lasts at least 15 days per month for at least 3 months a year. Chronic TTH and chronic migraine afflict about 2% of the general population,[5] 15% of the European population[6] and 8% to 13% of people in Asia.[7] The prevalence of migraine in neurology outpatient clinics in Turkey was found to be 24.9%.[8]

Migraine is a major source of disability and, in terms of working days lost by women aged 15–44 years in high-income countries, second only to unipolar depressive disorders.[9] The impact of migraine on adolescents' quality of life is considerable, as recurrent pain causes significant disruption to daily life.[10]

A study conducted in eight Asian countries showed that only 58.6% of migraine patients had received a diagnosis of migraine, and many patients did not benefit from their current migraine management.[11] Patients with migraine were often diagnosed with comorbid depression, anxiety, bipolar spectrum disorders, and more often prescribed medications commonly used to treat insomnia, attention-deficit disorder, and psychosis. Additionally, nearly one in every three migraine patients received psychotropic drugs (other than anticonvulsants or antidepressants) that are not routinely used for migraine treatment. These psychotropic drugs were used twice as frequently among migraine patients, and psychiatric comorbidity has been associated with an increased susceptibility to headaches as well as with potential refractoriness to migraine drug therapy and chronification of migraine.[12] Substance abuse, illicit drug use, and nicotine dependence have also been linked to migraine.[13]

MEDICATIONS PRESCRIBED FOR THE ACUTE AND PREVENTIVE MIGRAINE TREATMENT

Management of migraine may be divided into (1) treatment of the acute headache phase, and (2) long-term migraine prevention. Triptans are highly effective and frequently used medications for the treatment of acute migraine, which raises concerns about overuse in the absence of any preventive medications. Triptans also have unfavourable features such as higher drug costs, potential drug interactions, adverse events and symptomatic medication overuse, with subsequent risk of clinical progression of the migraine from episodic to chronic daily headache.

Only four medications (divalproex sodium, propanolol, timolol, and topiramate) carry U.S. Food and Drug Administration (FDA) indications for the preventive treatment of migraine. In addition to the approved preventive treatment, medications from several classes of drugs (including anticonvulsants, antidepressants, beta-blockers, and other antihypertensives) are frequently prescribed for migraine prophylaxis.[14] Furthermore, unless the definition of preventive treatment is broadened to include any medication potentially used for migraine prevention, only a minority of migraine patients can be claimed to be receiving FDA-approved preventive treatment. More than half of migraine patients receive "off-label" migraine preventive drugs including antidepressants. Finally, patients with migraine are significantly more likely to receive

other psychotropic medications. These findings suggest that efforts to optimize the management of migraine should address the appropriate use of triptans, more effective use of migraine-preventive medications, and better understanding of the use of other psychotropics.[15]

Failure to use approved preventive medication is a serious problem. Patients who have more than two acute migraine attacks per month and/or whose daily activity is compromised by headaches are universally considered candidates for preventive treatment.[16] A significant number of patients eligible for preventive treatment were not prescribed the correct medication, and 19% were high triptan users. This is a serious concern that may lead to medication-overuse headache or chronic daily headache. Population studies show that about 3% of patients with episodic migraine develop chronic daily headache in the follow-up year.[17] Chronic daily headache is linked to excessive use of acute migraine medication.[18]

Interestingly, migraine patients who receive preventive treatment have been found to use greater amounts of NSAIDs and controlled painkillers than those not receiving preventive treatment. It was also found that triptan use was reduced in patients who had started to take migraine-preventive medications.[19] Most notably, use of NSAIDs and controlled painkillers in the untreated migraine group was common, with a prevalence nearly equal to that among patients receiving only acute migraine-specific therapy. Untreated migraine patients were found to have higher rates of comorbidity but to take less psychotropic pharmacotherapy than those receiving only acute migraine treatment. Research results suggested that only 5% of all migraine patients have started to take triptans, which raises questions about whether there is therapeutic inertia against appropriate use of acute migraine medications, and what factors might be influencing this pattern of care.[20]

New drugs are introduced only after a long and expensive research process, whereas it is typical for complementary therapies to undergo rigorous evaluation only after their use has become so widespread that they can no longer be ignored Frequent and severe headaches that cannot be adequately controlled by using analgesics or specific migraine treatment prevent normal activities. Therefore, a variety of nonpharmacologic treatment methods have been suggested to prevent, or to decrease the frequency and severity of, migraine episodes. These modalities focus on the elimination of trigger factors, regular diet, normal sleep patterns, discontinuation of inappropriate and overused analgesics, relief of stress, and use of counseling, relaxation therapy, and biofeedback.[21,22] Acupuncture treatment practised in China for thousands of years has a clinical value as an analgesic therapy.[23] Recently, it has been winning acceptance in western countries as a complementary treatment for various conditions, including chronic pain syndrome.[24-27]

WHAT IS ACUPUNCTURE? CAN ACUPUNCTURE CONTROL PAIN?

Acupuncture, as a needling therapy, is a kind of specialized sensory stimulation that is analyzed through sensory neural pathways. Many neurological theories have been developed to explain the mechanism of acupuncture. Recent studies have revealed the importance of neurophysiological studies in explaining the effect of acupuncture. The anterior lobe of the hypophysis secretes beta endorphin and ACTH as a reaction to the insertion of an acupuncture needle. The signals from the skin are first transmitted to the spinal cord and from there to the thalamus and sensory cortex, and pain control mechanisms are activated as the periaquaductal gray matter in the mesencephalon, and periventricular cortical neurons, are stimulated. These neurons send their axons to enkephalinergic neurons at the nucleus reticularis paragigantocellularis and nucleus raphe magnus. Enkephalinergic neurons are in contact with cerebral cortex and hypothalamus and the signal transmission at these sites is performed by enkephalin. Hypothalamic neurons secrete endorphin to the synaptic cleft. Thus the diencephalic endorphin and mesencephalic enkephalin neurons stimulate the serotonin neurons at the bulbus[28-30] The serotoninergic neurons at the dorsal horn of the spinal cord stimulate the intermediate neurons at the dorsal horn. The intermediate neurons at the dorsal horn are called the enkephalinergic neurons and the synaptic transmission of these neurons is done by enkephalin.[29]

The stimuli generated by the insertion of an acupuncture needle to the acupuncture point first reaches the cortex and activates the pain control system via stimulation of the mesencephalic periaquaductal gray matter and periventricular neurons. Activation of the pain control system increases the concentration of beta endorphin, enkephalin, serotonin and norepinephrine levels in the brain tissue and plasma, thus creating an analgesic effect, as well as many others. It has been determined that endomorphin-1, beta endorphin, encephalin, and serotonin levels increase in plasma and brain tissue through acupuncture application.[31,32]

HOW EFFECTIVE IS ACUPUNCTURE FOR MIGRAINE TREATMENT?

Topiramate and botulinum neurotoxin have been proven effective for migraine treatment in randomized, placebo-controlled trials;[33] however, the therapeutic gain against placebo is only modest. Acupuncture is a widely used, non-pharmacological treatment for migraine. Cochrane systematic review found acupuncture to be as effective as, or possibly more effective than, preventive migraine agents.[34] A beneficial effect of acupuncture in migraine prophylaxis was demonstrated in a prospective randomized trial.[35] Research results showed that in a 12-week treatment period a significantly larger decrease in the mean monthly number of moderate/severe headache days was observed in the acupuncture group compared with the topiramate group. Significant differences were detected that favoured multiple efficacy end points

of acupuncture, including mean change of headache days, Migraine Disability Assessment Scores (MIDAS), Hospital Anxiety and Depression Scale (HADS) scores, Short Form 36 (SF-36) scores, Beck Depression Inventory II (BDI-II) scores, mean days of acute medication use and 50% reduction in monthly moderate/severe headache days. In the context of the topiramate studies[36] and the Phase III Research Evaluating Migraine Prophylaxis Therapy (PREEMPT) trials,33 similar beneficial effects were also observed in patients who were overusing acute medications.

Researchers on acupunture had a clearly defined acupuncture treatment procedure following the Standards for Reporting Interventions in Clinical Trials of Acupuncture (STRICTA) recommendations.[37] The acupoints chosen were classic acupuncture sites, which correspond to the dermatomal distribution of trigeminocervical complexes: V1 dermatome [Cuanzhu (BL 2) and Yintang (EX-HN 3)], V2 dermatome [Taiyang (EX-HN 5)], and C2 dermatome [Fengchi (GB-20)]. The biological and psychological effects of the twice weekly, fixed-site acupuncture over three months were superior to those of topiramate, which is the only evidence-based oral prophylactic drug for treating chronic migraine. The patient's subjective perception of being cared for could be a more important outcome measure than objective parameters when confronting headache disorders wherein objective biomarkers are still lacking. Since the only parameter we can rely on is the patient's subjective rating of pain, the physician's ongoing attention to it may be the greatest benefit.[38]

Large-scale acupuncture trials reported that great differences between true and sham acupuncture were observed when sham points were located far away from true points. Results of the studies have shown that acupuncture provides better pain relief than medication.[39,40]

According to the results of another study comparing the effectiveness of a four-week flunarizine treatment with acupuncture reducing the number of migraine days acupuncture was found to be more effective than flunarizine, whereas no significant differences were found between acupuncture and flunarizine in reduction of pain intensity and improvement of the quality of life.[41]

Diener et al. also reported the effectiveness of acupuncture treatment on migraine.[40] The result of the randomised controlled trial, undertaken to investigate the efficacy of acupuncture versus sham acupuncture, and standard therapy with prophylactic drugs in patients with migraine,40 showed that all three treatments were effective but true acupuncture was better than sham acupuncture and that improvement in the number of migraine days differed (acupuncture treatment over six weeks had efficacy similar to 24 weeks of continuous treatment with standard drug therapy) in all treatment groups. The results can be compared with the results of another study which investigated true and sham acupuncture.[42] Despite being inferior to true acupuncture, needling at non-acupuncture points could exert biological effects similar to the those achieved when needling specific acupuncture points. A similar finding was that injecting either botulinum toxin or saline into pericranial and neck muscles in patients with chronic headache had an almost similar effect.[43]

RESEARCH INTO EXPLANATIONS FOR THE MECHANISM OF ACUPUNCTURE IN MIGRAINE TREATMENT

Acupuncture is a treatment with almost no adverse events or contraindications. The mode of action of most drugs approved for migraine prophylaxis, including beta blockers or antiepileptic drugs, is unknown, so the decision about whether acupuncture should be used in migraine prevention is a matter for the physician and the patient.

Acupuncture has a powerful placebo effect. Placebo treatment exerts powerful effects on pain modulating brain structures, as shown by PET and functional MRI studies.[44] A randomized double-blind study of the effect of acupuncture on the radial artery diameter of patients with severe migraine demonstrated that acupuncture is not limited to a placebo effect and adds support to a measurable objective effect of acupuncture therapy in patients with migraine.[45] A randomized double-blind study demonstrated that true acupuncture has a significant vasodilatory effect on the radial artery diameter of patients suffering from severe migraine, both during the first session of treatment, and one month after the last acupuncture session; changes that were not observed in patients who underwent sham treatments.[45]

Moreover, migraine is characterized by an inadequate vasoreactivity in meningeal and cerebral arteries.[46] Migraine is a chronic and devastating disease with periodic exacerbation of pain during attacks, in which acupuncture has been demonstrated to be more efficient and cost-saving than placebo.[47,48]

In patients with migraine exposed for the first time to true acupuncture, radial artery diameter increased, whereas it did not change in the sham treatment group; radial artery diameter remained elevated one month after the last course of real acupuncture, whereas a vasoconstriction was observed in sham treated patients; and a higher baseline intensity of migraine associated pain was associated with less chronic vasodilatation under acupuncture, either real or sham.[45] Radial artery vasodilatation has been observed in patients complaining of various functional symptoms (dorsalgia, headache, dyspepsia, anxiety) and previously exposed to acupuncture, and not in healthy volunteers naive to acupuncture.[49]

Vasoconstriction is a major feature of the pathophysiology of migraine: although this is not the triggering event, a severe diffuse vasoconstriction in the cerebral and meningeal arteries occurs in migraine.[50] Aura symptoms are followed by a sustained vasodilatation, which is accepted as the cause of headache.48 Patients with the most severe cephalagia at baseline were less prone to dilated arteries during follow-up and a larger radial artery vasodilatation after real acupuncture for any given level of pain intensity, suggesting an interaction

between the mechanisms of pain and the vasodilatory effects of acupuncture.[45]

Several research results showed that the insertion and manipulation of acupuncture needles have both local and remote therapeutic effects via mechanical coupling of the needle to connective tissue which could generate a mechanical signal into cells, including cell secretion, modification of extracellular matrix, amplification and propagation of the signal along connective tissue planes, and modulation of afferent sensory input via changes in the connective tissue milieu, through pulling of collagen fibres during needle manipulation.[51] Acupuncture affects the activity and plasma concentrations of vasomotor agents, including norepinephrine, angiotensin II, serotonin, enkephalins, beta-endorphins and glutamate.[52] Acupuncture could be adopted as a migraine treatment for the prevention of relapse and aggravation.

It is important to educate patients with medication overuse headache to reduce their medication consumption: this type of headache is a serious world-wide problem.[53] Additionally, to reduce the consumption of medication, acupuncture, which has almost no adverse events or contraindications, should be more widely used in migraine treatment and prevention.

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Characteristics Of Experienced Natural Therapists

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INTRODUCTION

Sutherland and Ritenbaugh,[1] in a convincing editorial, proposed to conduct research into the effects of practitioner factors on therapeutic outcomes in complementary and alternative medicine (CAM). The authors suggested research into several aspects of the practitioner including spiritual development, understanding of disease, healing intent, and other personality characteristics. DiMateo et al.[2] reported that research into practitioner personality characteristics is generally rare in medicine, because of the complexity involved in collecting information about physicians and their practices, and linking such data to treatment outcomes. Some research examined motives and personal characteristics that health care professionals themselves value. Vaglum, Wiers-Jenssen, and Ekeberg[3] identified empathy and person-oriented motives to be the most important motivations of medical students. Similarly, Engebretson[4] reported that patient-centred care was at the core of the nursing profession, expressed in the desire to unite head and heart with intent to heal. Chiropractic students were found to also place a high value on work fulfilment and successful interpersonal relations with patients.[5] Professional self-confidence was another personal trait characterizing final year medical students. Beagan,[6] in interviews with 25 third-year students and 23 medical school faculty members, described a process where medical students begin playing a role that becomes more real as responses from others confirm their new identity.

By comparison, the psychotherapy literature has explored practitioner characteristics to a greater depth: typically a positive correlation between practitioner characteristics and treatment outcomes has been reported. For example, in a comprehensive review of 25 studies examining psychotherapist's personal characteristics Ackerman and Hilsenroth[7] found the following attributes to have significant positive effects on the therapeutic alliance: flexible, experienced, honest, respectful, confident, interested, alert, friendly, warm, and open. In another study of the effects of psychotherapists' characteristics, Hatcher[8] found that therapists' confidence had the highest correlations with therapist and patient estimates of improvement. Other therapist factors that enhanced outcomes in psychotherapy included the degree of the therapist's self-disclosure,[9] the therapist's commitment to the work,[10] and therapist's warmth, understanding, competence, and respect for the patient.[11]

In comparison to the psychotherapy literature there is a paucity of research on personality characteristics in CAM. As studies quantifying the effects of CAM practitioner characteristics on health outcomes could not be located, characteristics that practitioners value themselves were examined. Therefore this study aims to examine values, motivators and personality traits that natural therapists believe enhance the therapeutic relationship and the medical outcomes of their clients.

METHOD

Participants and sampling: The sampling strategy was based on the principle of purposeful sampling according to predetermined criteria.[12] The initial and minimum criteria for the selection were natural therapists, including naturopaths, nutritional medicine practitioners, herbalists and homoeopaths, who were registered with a Therapeutic Goods Act-recognized professional association, with at least three years of professional experience. For gender balance five male and five female practitioners were chosen. Preference was given to more experienced over less experienced practitioners, as it was thought that they have a richer story to tell. Interviewees had spent between eight and 29 years in professional practice (mean 15.4 years). The first author, a natural therapist himself, contacted ten experienced natural therapists in South Australia who fulfilled the selection criteria. Sample size was not predetermined but interviews were conducted to the point of redundancy.[13] The tenth natural therapist provided very little new information. A 22 question semi-structured questionnaire was based on the findings from a previously conducted literature review.[14] Face-to-face interviews lasting between 45-90 minutes were conducted in the clinic of each natural therapist.

DATA ANALYSIS

Open coding[15] was used by examining every line of the transcripts, thus defining actions and events in it. After thoroughly reading through the first interview tentative codes were discussed between the first and the second author. In this phase memos were written to make sense of each meaning unit. The Qualitative Data Analysis program WEFT[16] was used for coding. In Grounded Theory the second step of analysis is called axial coding, in which relationships among categories are organized and further explicated.[17] In this study each category was analysed again for sub-categories by grouping codes with similar meaning together. The next step in the development of an overarching grounded theory is theoretical sampling.[18] According to the principles of the constant

comparative method, each interview in this study was summarized on the basis of identified sub-categories and then sent back by email to each interviewee for verification, or refinement. The final stage of analysis in Grounded Theory involved the creation of substantive theory or "core" category.[18] This substantive theory will be published in a future paper.

RESULTS

Therapist characteristics were not asked for in the interviews, as the questionnaire mostly focused on the clinical skills that improved the therapeutic relationship. However, during the interviews it emerged that the therapists believed that 'personal characteristics', enduring personality traits, motivators and values, also affected therapeutic outcomes. Analysis of the transcripts revealed seven practitioner characteristics: authenticity, altruism, intention, self-confidence, intuition, conscientiousness, and fulfilment of the practitioner.

AUTHENTICITY

The practitioners reported that being a natural therapist was a reflection of their life values. Authenticity was seen as a core value which meant several things: to be genuine in clinic rather than playing a professional role, an awareness that the practitioner's personality had an impact on the therapeutic relationship, and a desire to live one's private life according to the holistic and health promoting principles that they promoted to their clients. The practitioners believed that if they were genuine the client would be genuine too and would not simply say things to please the practitioner.

I'm just myself. If you come from your true self then the other person will read you and will be more likely to come from their true self. If you come from your adapted self, the professional self, then that person will be a pleaser, say the right things and do the right things, but they will manipulate the whole thing.

(Naturopathic practitioner 3)

However, one practitioner disagreed, believing that in order to give clients hope practitioners had to be enthusiastic and motivating, especially when feeling low themselves.

I think we put on an act. The therapeutic relationship does impart putting a performance on. It's an up-beat performance. We say, here is another reality, do you want to buy it? All communication is like a play acting game. It is a necessary game, otherwise we would be catatonic schizophrenics banging our heads against the wall.
(Naturopathic practitioner 2)

In spite of disagreements about levels of authenticity, most practitioners thought that their personality contributed to their identity as a healer which affected thetherapeutic relationship.

Some things are inherent in the practitioner's personality type, their temperament which is partially genetically acquired.
(Naturopathic practitioner 2)

Bringing one's personality into the consultation meant different things for different practitioners. The practitioners described aspects of their personality, such as being a jester (Naturopathic practitioner 3, motherly (Naturopathic practitioner 5), or an optimist (Naturopathic practitioner 10). One practitioner raised the concept of the wounded healer. He thought that if the healer and client had a similar emotional pathology the healer would have a better understanding of the patient's suffering, and perhaps get better outcomes.

I think there is a certain truism that a lot of patients see practitioners because the practitioner and the patient reverberate at a similar level of emotional damage.
(Naturopathic practitioner 2)

Authenticity was not seen by the practitioners as confined to the clinic room but extended into their private lives as well. Four practitioners thought that it was imperative to live their personal lives in accordance with the values they expressed to their clients, that is, living a holistic life. This meant eating the diet that they recommend for their clients, and adopting an exemplary, salutogenic personal lifestyle

Every day I have time to dedicate to studies, or work on my property and spend time with my children. So the balance has to be there.
(Naturopathic practitioner 4)

Two practitioners spoke at length about what being a healer meant for them. They wanted to live a value-driven life and therefore considered healing people as an integral part of their life mission, which was to make the world a better place.

Being a homoeopath or any healthcare practitioner is not a career, it is a vocation. I can't imagine how people live without homoeopathy. It's the way I think, it's the way I live, it's who I am, including being a mother, a wife, and a homoeopath. But I think it is also really important to have a life outside of our practice. I am very much part of the world and my community, trying to make a difference, and trying to take some small action that might change things. So homeopathy is a part of a bigger picture making the world a better place.
(Naturopathic practitioner 9)

Healing people was seen as actualization of altruism.

ALTRUISM

The therapists reported being driven by altruistic values such as love, empathy or compassion, rather than monetary values.

You need to love your work and you need to love your patients, and tolerate your patients, and accept them. I don't see patients for money. I see patients to help them. (Naturopathic practitioner 5)

The best thing one can do with one's life is to help others.
(Naturopathic practitioner 2)

One therapist, who was involved in martial arts and Eastern spiritual practices, reported being motivated by compassion married with strong discipline and a sharp mind.

I am almost a compassionate warrior; that tends to be the mind frame that I bring into the clinic. It is a loving, caring, heartfelt approach to people and situations.
(Naturopathic practitioner 10)

INTENTION

Four practitioners indicated that intention was an extension of their altruism. Intention was generally defined as an internal wish for clients to get better.

I am sincerely wishing them to get better.
(Naturopathic practitioner 2)
My intention is automatically I want the best, fastest, most positive outcome out of every consultation. (Naturopathic practitioner 5)

These practitioners talked about putting energy into healing by consciously visualizing a positive outcome. They believed that having an intention can help to achieve the intended outcome.

I think it [healing] is achieved by using the positive energy, use your energy, your mind, your thoughts.(Naturopathic practitioner 9)
But I have a strong belief that our intentions are leading us to where we want to go. I use a lot of intention, a lot of vision; how I want to be and how I want to help people.
(Naturopathic practitioner 5)

The homoeopaths in particular talked about putting healing intention into the medicines when preparing them. They reported visualizing a positive outcome for clients when they were succussing (i.e. shaking) homeopathic remedies.

When I make up remedies for clients I will actually put intention into the remedies. I will be thinking about that client and of the outcome, what I am hoping the remedy will do for them.
(Naturopathic practitioner 1)

SELF-CONFIDENCE

Practitioners actively fostered the belief that they can help clients to overcome their diseases. Therefore it was important for the therapists to feel confident in their diagnostic and prescribing skills.

I really feel that clients can get on top of this [their illness].
(Naturopathic practitioner 1)

According to the participants this confidence was based upon the traditional and evidence-based knowledge of effective treatment for the client's condition gained in professional training. Seven practitioners emphasised that the medical and naturopathic knowledge was indispensable in the understanding of the causes of any patient's disease and consequently finding the most appropriate treatment.

I have a bachelor of medical science, which is a research degree, sometimes in America called the premed degree. So I understand the pathology, the biochemistry, the drugs, how they work.
(Naturopathic practitioner 2)

One naturopath acknowledged that practitioners can be either focused on the medical analysis and decision-making or be emotionally attuned to the client. This naturopath described how she is constantly moving between these two worlds.

When I test them I might go out of the patient and go into my world. I think about the illness, where does it start, what causes it, what is the chain reaction? So I am going into my own world for a moment. I test them, and explain to them, whilst I am doing it, on a very physical level.
(Naturopathic practitioner 5)

Self-confidence was also based on their personal skills and ability to apply this knowledge to individual clients.

One is having confidence in one's skills and knowledge, the ability to work with the client, all that comes through to the client, that's again part of the placebo effect.
(Naturopathic practitioner 8)

While medical and naturopathic training and knowledge were seen as the foundation of the practitioner's confidence, an exclusive focus on medical factors was seen to be insufficient in their work with clients.

INTUITION

Four practitioners remarked that intuition played an essential role in their understanding of the client's subtle non-verbal behaviours and the practitioner's corresponding choice of treatment.

So there are a lot of subtleties to stuff, but it is still real and definite, and if it isn't there the treatment is compromised by 70%.
(Naturopathic practitioner 2)

Intuition was seen as the ability to perceive subtle clues beyond an intellectual understanding of clients, and beyond 'mere' empathy for the client. Particularly for homoeopaths this intuitive understanding was essential for the choice of the correct medicine. Practitioners reported that intuition developed with experience.

Intuition is just acute awareness and intelligence. It's like 'this is going on with their body, this is going on with their mind and this is what happened when they were a child' and when I put all of these things together I really try to experience that, and then I can come into contact with the substance [homeopathic medicine].
(Naturopathic practitioner 1)

My experience is of 5000 patients. Intuition has come in with that too. I use my intuition to work, but my intuition is also linked to my experience.
(Naturopathic practitioner 5)

In order to enhance their intuitive skills meditation was utilized by four therapists. Meditation was seen to serve two purposes: firstly as an activity that practitioners used to put themselves into a frame of mind that enabled them to intuitively see a larger picture, and secondly to intuitively understand information that the patient presented during the interview, but whose importance was missed by the therapist at the time of the interview.

I will actually meditate on people for three days and then I have another conversation with them just about my impression. I meditate on them so that all the different fragmented parts of the picture that they might have given to me start to form a whole picture and sometimes also there are aspects of their biography that I may not have picked up on in the interview.
(Naturopathic practitioner 1)

Another practitioner reported using meditation before seeing clients to put himself into a frame of mind that enabled him to perceive the subtle messages that clients might disclose.

There is a certain mindset that you have to have, a certain meditative frame of mind when you go into a situation, that enables me to be objective, also to be sharp, alert, and focused, and also to be able to pick up on what people are saying, to be really present with people.
(Naturopathic practitioner 10)

Thus, some practitioners saw intuition as an important basis for diagnosis and treatment and some used meditation as a tool for sharpening their intuitive abilities.

CONSCIENTIOUSNESS

Conscientiousness is the character trait of being painstaking and careful. It includes self-discipline, carefulness, thoroughness, organization, deliberation (the tendency to think carefully before acting), and need for achievement. In this study two practitioners emphasised that 'doing my best' with every client was the basis for getting good outcomes.

One thing that I always promise is doing my best, I do my very best.
(Naturopathic practitioner 9)

Doing one's best involved persisting until the practitioner had found the true cause of the disease and an appropriate treatment. They were not satisfied unless they were certain that they had found the right treatment to help the client.

I give everything, I have to find out why they are not well.
(Naturopathic practitioner 5)

I work hard. I don't prescribe unless I am absolutely certain, which sounds like a small thing, but it is not, it is a big thing. I go back to people if I am not certain. I say, there is something missing. I have not got the full story, I need some more. And I do that by following up with a phone conversation.
(Naturopathic practitioner 9)

All practitioners mentioned that doing one's best entailed being fully present for the client. However, the two practitioners mentioned above strove for absolute excellence with every client. For one homoeopath, doing her best was almost a spiritual duty.

If I do my very best I have honoured my gift, my knowledge, my connection with people. (Naturopathic practitioner 9)

FULFILMENT

Three practitioners spoke about the reciprocal nature of being a natural therapist. A close therapeutic relationship clearly benefited clients, but it benefited the practitioner too.

The practitioner-client relationship gives a lot of fulfilment to the practitioner.(Naturopathic practitioner 8)

Two practitioners felt that it was a privilege to be invited into a very vulnerable and precious part of their clients and to be part of their struggle to overcome disease.

I am here to care for them. I am here to help them, and I am honoured to be part of their journey. It's not just this illness, I am honoured.
(Naturopathic practitioner 5)

One homoeopath spoke in depth about the almost spiritual experience of being a therapist accompanying clients on their journey from life to death. In poetic terms she described the healing effects on herself while being with her clients.

What a privilege, people bring me their treasure, their life story, their journey. Often people are telling me things that they have never told anyone else. I feel that this just washes over you just like a balm, an anointing, if you like. I find it very peaceful, calming. I do a lot of work with people who are dying. We are all going to die and often the therapeutic relationship is about allowing for this to happen in the best way possible; we don't always save people. I often say, I love sitting with people these last days and months. You get it in birthing too, a real sense that you are empty of yourself and you are part of it. It is like my food. I draw great strength from this emptiness. For me it is not a stressful thing at all. To me it feels very healing. You might have your own concerns and worries, and your own a private life, and that just dissipates, it just comes into some context. It enables you to live more fully.
(Naturopathic practitioner 9)

DISCUSSION

The natural therapists in our study aimed at living a value-driven life, mostly based upon authenticity and altruism. They generally desired to live authentically both in their private and their professional life. This meant that they aimed to be authentic in clinic, not to hide behind a professional role: a theme reflected by Risdon and Eddy[19] who demanded integration between the professional role and person of physician, which in practice was not always achieved. Authenticity was also put forward by Rogers[20] as one of three necessary and sufficient conditions for therapeutic change in psychotherapy. Perhaps authenticity is necessary in natural therapies as well, but by no means sufficient to cure disease.

Another value that motivated the work of the therapists in our study was altruism, which included empathy and a desire to help their fellow human beings. These values are similar to those of medical students and beginning doctors. Therapist empathy has shown to improve patient satisfaction and outcomes. Price, Mercer, and MacPherson[21] in a study of 51 patients of acupuncture, found that patients' perception of practitioner empathy was associated with patient enablement at initial consultation and predicted changes in health outcome at eight weeks. Koss-Chioino[22], in an historical review of medicine, contends that altruism in medicine emerged out of spiritual traditions of healing and is seen as an integral part of CAM as well as folk and indigenous religious healing traditions.

Some practitioners in our study extended their empathy by consciously setting an intention to heal which they believed led to improve health outcomes. The belief that setting an intention will help to achieve one's goals has been made popular by the bestselling DVD "The Secret"[23] which is based upon ancient religious ideas, in line with a historical associations between religious beliefs and health.[24] More research is needed to find out if intention can affect health outcomes in natural therapies.

Most practitioners in this study identified self-confidence of the practitioner as a core characteristic to meet client's expectations of effective treatment. This confidence was based on professional training, scientific and traditional evidence of

the effectiveness of one's treatment modality, and the possession of personal skills that help a client. Confidence has also been identified to be a key factor in other health care professions. In a qualitative study interviewing six chiropractors and some of their patients Langlois et al.[25] identified practitioners' confidence in the treatment as one of the three general themes characterizing chiropractic treatment. The role of CAM practitioners' confidence in treatment outcomes remains to be further examined. Confidence in one's intellectual knowledge alone was seen as insufficient to be an effective therapist. Intuition in particular was seen by the practitioners in this study to complement medical and naturopathic knowledge. Braude[26] defined *intuition* as a pre-conceptual element of human cognition that within *medicine* pertains to cognitive processes associated with practical reasoning. Thus, clinical *intuition* provides an empathetic means for physicians to visualize the inner essence of individual patients, and taking account of the continual flux of temporal physiological changes.[26] This was confirmed in this study, where practitioners reported that intuition enabled them to perceive subtle non-verbal cues, unspoken factors pertinent to the patient's illness that permitted practitioners to gain a more complete picture of the patient's overall life situation, which in turn increased practitioner's accuracy of diagnosis. According to Hall,[27] intuition is not just confined to the diagnosis but is also an inescapable part of decision-making in medicine and involves personal decision rules of health care professionals. This study suggested that intuition and clinical experience were linked. Both share the ability to draw connections, to see the big picture; an ability to go beyond conscious thought and pure intellectual knowledge.[27]

Three practitioners reported the use of mediation to increase their intuitive skills. They either meditated before the consult in order sharpen their clinical perception and therefore improve diagnosis, or meditated after the consult in order to improve clinical decision-making. Few studies in the medical literature have examined the role of meditation in the practice of health care professionals. Barmark[28] reported that the education of doctors of Tibetan medicine includes a 13-year-long process of meditation training to enable them to understand the patient's mind and the individual's perception of the world. Kabat-Zinn[29] described an eight week program of Mindfulness-Based Stress Reduction for physicians that enables them to convey to patients an authentic first-hand experience of the benefits of meditation. Meditation seems to be a means of self-care for health care professionals as well as an authentic way to help clients improve clinical outcomes, which has been taken up by some natural therapists and medical practitioners.

Whether meditation by health care professionals can improve their clinical perception and decision making, or whether it can improve patients' health outcomes, remains to be examined.

In this study a few practitioners emphasised that conscientiousness was the basis for achieving optimal health outcomes for their clients. Conscientiousness has been the most consistent personality trait in the prediction of job performance in any profession.[30] The practitioners in this study only prescribed medicines once they felt certain that they had found the true cause of the client's disease and the most appropriate treatment. As only two practitioners volunteered this information during the interviews the role of conscientiousness in natural therapies remains to be further examined.

If conscientiousness led to improved patient outcomes perhaps these practitioners would have greater job satisfaction. A number of practitioners reported a deep personal fulfilment from their work, particularly when working with clients on very personal issues, and when supporting clients at birth and death. Professional satisfaction of health care professionals does not only benefit the professional but in turn also benefits the patient. McGlynn[31] found that physicians' job satisfaction was more important in predicting patient satisfaction with care than the time physicians spend with patients. Other studies of physician satisfaction demonstrated increased patients' psychosocial well-being[31] and increased adherence to dietary and exercise advice,[2] all critical in natural therapies. There seems to be a clear reciprocal relationship between patient and practitioner satisfaction which in turn affects health outcomes.

The methodological limitations of this study should be acknowledged. The non-randomized selection used in the recruitment of practitioners tends to attract participants sharing similar views. Furthermore, practitioner characteristics were not an a priori research question, nor asked for in the first three interviews. As practitioner characteristics emerged rather coincidentally than systematically these results may be biased. Future research should objectively assess these characteristics with validated instruments. Future analyses of practitioner characteristics could then be correlated with patient outcomes.

In spite of its limitations the present study is one of the first of its kind to define practitioner characteristics reported by naturopaths as forming the basis of their work. This study suggests that natural therapists consider their personality traits to be an integral part of the healing, but whether practitioner characteristics affect medical outcomes remains to be explored. In conclusion, outcome research in CAM should not only examine specific treatment, but in line with its holistic nature, should also examine non-specific factors such as practitioner characteristics.

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Incorporating Spirituality Into The Work Of The Holistic Practitioner

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ABSTRACT

This paper looks at spirituality and health and the challenge to incorporate spirituality into the holistic model of practice. The holistic approach to health and healing is represented by an integrated balance of mind, body and spirit. Many natural medicine practitioners are trained in treating the physical manifestations of illness; this paper questions to what extent are they familiar with treating the spiritual aspect of being? It looks at definitions of spirituality and religion (S/R), the research on the intersection of S/R and health and the challenges for practitioners to integrate it into practice. Recommendations are made for education to include training about S/R as part of practice protocols, to enable practitioners to incorporate it in practice authentically and with confidence.

SPIRITUALITY AND NATUROPATHY

The consideration that spirituality is a key component of health has always been a part of naturopathic philosophy and traditional health care practices. The philosophies of vitalism and holism acknowledge that there are subtle and apparently immeasurable aspects to health. This essential philosophy underpins a model of practice that works with the body's innate self-healing capacity (vitalism) and embraces all aspects of a person's being (holism) to help them toward health. Known as the mind/body/spirit nexus this approach connects the healing approach with that of the ancients who talked and wrote about working with and respecting nature as an embodiment of spirit and higher forces. The influential nature-cure hygienists who worked in the United States in the early nineteenth century such as Kneipp, Kloss and Lindlhar were deeply Christian men who taught that living by nature's laws was a way of obeying God's will. They would propose, for example, that illness happened when people did not follow the laws of nature, and that a return to health, whilst incorporating sunshine, fresh air, rest and wholesome food, also meant living a moral life. These principles of 'natural' living had a spiritual foundation and this ethos still holds in naturopathy today when naturopaths talk about spiritual wellbeing as a key component of health. However, knowing that spirituality is a key part of healthy wellbeing is one thing. Understanding what this means in practice is another.

DEFINITIONS

To begin with, the struggle for definition is complex. It has been debated and discussed at length and over time. The word spirituality derives from the Latin word spiritus, meaning breath, and signifies an individualistic belief system. Spirituality is seen as a search or quest for the sacred in life, a seeking of answers to life's most meaningful and vital questions. Spirituality is a generalist term that resists a neat, one-size-fits-all definition. It may shift from person to person and as one grows and develops. For example, followers of an Indian guru may end up being Quakers or atheists, whilst all the time considering themselves to be spiritual persons. Spirituality does not necessarily have a Christian foundation. It is described as multi-dimensional, about the search for meaning in life, concerned with connecting with the sacred and a never-ending endeavour to find the link between the finite and infinite.[1] Some writers bring to the discussion the notion of transcendence.[2] This transcendence can be a sense of connectedness with God or a higher consciousness or it can be interpersonal and embody inner knowing and strength, developed as a resource through a sense of spiritual connection with life.

Religion on the other hand is a much more understood term and one that can be classified. Religion comes from the Latin word, religare, meaning to bind, and it is used to describe the formalised set of practices that adhere to belief in a particular deity and is reinforced by a code of behaviour such as going to church on Sundays, or praying at specific times, or holy or sacred days. Religion is described as the organised system of beliefs, practices and rituals and symbols that are designed to facilitate closeness with the sacred and provide the average person with moral and social guidelines for behaviour.[3] What is common is that religious practice often includes membership of a group or community of like-minded individuals following a set of prescribed rituals, for example, taking communion or praying to Mecca five times a day. The practice also often involves regular meetings and guidance talks (sermons) about how to manage and understand the vicissitudes of life.

RESEARCH AND IMPLICATIONS FOR HEALTH AND WELLBEING

There is a considerable amount of research on the subject. There are over 3,000 papers published in medical and nursing literature discussing the role of spiritual and religious beliefs in health.[4] Data shows a range of findings about the efficacy of intercessory prayer[5-7] and distant healing.[8] The Handbook of Religion and Health, 2nd edition is a critical, comprehensive analysis of the research on religion and a variety of mental and physical health conditions, describing and synthesising the results of over 3000 studies that looked at the way religion and spirituality influence health. Research indicates that people who are spiritually directed or have a consistent

religious practice show evidence of greater marital stability, less alcohol and drug use, lower suicide rates, and less anxiety and depression.[9] These behaviours are also associated with less cigarette smoking, less stress (especially with meditators because of the mind-stilling exercises that are part of the practice), lower blood pressure, lower cholesterol, more conservative sexual practices and associated lower STDs.[10] George and colleagues report that data steadily shows a positive relationship between religious and spiritual practices and positive health outcomes.[11] Spirituality and religion affect all of the five main health indicators; mortality, health-related quality of life, disease presence/absence/severity, health service utilisation, specific conditions and functionality.[12]

Within society there is evidence that spiritual convictions have a positive impact on health and wellbeing. For example, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are widely regarded as effective programs that help with alcohol and substance abuse. The twelve-step program that underpins the approach is founded on a principle that there is a higher power and that getting healthy means acknowledging and surrendering to this. Participants are not required to be spiritual per se but the spiritual guidelines of the program are central to its success. Conservative religious groups such as the Seventh Day Adventist and Mormon communities have a code for living that promotes abstinence from alcohol, red meat and tobacco. Many studies have shown this has contributed to improved health outcomes.

Spirituality and religiosity can sometimes have a deleterious impact on health. Religion can be used to justify hatred, violence and prejudice, and can be exclusive and dominating.[13] If the religious or spiritual community has a strong and unyielding moral code, this can invoke guilt or rebellious behavior. Ostracism from a spiritual or religious group or community can cause illness, stress, self-harmful behaviours and depression. An extreme behaviour is when groups of believers take part in mass suicides or sexual practices which go against societal norms, such as polygamy and involving children/virgins in specific rituals. Belief systems can impact on prescribed health care protocols. The Jehovah's Witness community may resist interventions involving blood, according to their beliefs. Christian Scientists can advocate prayer over treatment, depending on their interpretation of their teachings. In a conservative Jewish (Hassidic) community there may be pressure to have a large family that can cause stress if the family is unable to accomplish this or there are health risks involved in repeated pregnancies. Similarly in the Catholic community if the family believes contraception is a sin, there may be health and emotional consequences on a marriage. These beliefs, while valid for the community concerned, can cause issues if they run counter to health protocols deemed necessary by practitioners of the dominant health care model.

IMPLICATIONS FOR PRACTICE

Beliefs in S/R sit squarely in the holistic model of health care. In Australia there has been a rise in interest in the spiritual component of health. Koenig notes that 74% of Australians believe in God or a higher life force and that this aspect of life continues to matter, despite a largely secular and materialist society.[14] In 2007 the Medical Journal of Australia (MJA) ran an issue dedicated to the topic of spirituality and health. Here it was reported that Australian patients want their practitioners to incorporate spirituality into their assessment and treatment protocols.[13] The research strongly indicates that this component of health has ramifications for practitioners and they may experience within themselves uncertainty when faced with patients' expressed desires to talk about their spiritual needs. However, denying or sidestepping this need demonstrates a lack of acknowledgment that people's individual narratives of health are deeply meaningful to them. The research goes further to indicate that absence of recognition and validation of something that matters to patients can further contribute to their suffering and almost certainly diminish the patient/practitioner relationship. Accordingly confidence in dealing with, or being aware of, belief systems and constructs is important in practice as they have influence on prescription and health care recommendations.

CHALLENGES

Astrow and Puchalski observe that illness gives patients many choices – between hope and despair, frustration and resolution, blame and responsibility.[15] For the naturopath, dealing with and acknowledging this internal struggle as part of the process of health and healing can provide challenges in practice. The naturopathic practitioner is often required to deal with complex and chronic conditions for which there has been no easy solution and this means that patients can bring with them substantial 'baggage' which will be in the diagnostic mix. Spiritual distress and confusion may well be part of this and will test the confines of the clinical relationship.

There are difficulties and limitations to be aware of when considering the role of spirituality and healing. Knowing that spirituality/religion are important in people's lives doesn't necessarily make it a given, good or easy thing to incorporate into professional practice. There are several areas of concern. For example practitioners may feel time pressures in the consultation and hesitate to enter another level of complexity, let alone delve into deeper more mysterious/less accessible aspects of disease. They may not feel it is appropriate, that it is their business or that they are trained adequately to deal with or understand the ramifications of any information they receive. There are boundary issues with pastoral care workers and the concern that invoking a more sensitive area of a person's life may begin a discussion in which the practitioner may not feel equipped to participate. Other challenges are that practitioners may have:

- Personal discomfort with spirituality/religion
- Lack of confidence and/or communication skills
- Fear of projecting personal beliefs
- Fear of intrusion into personal lives
- Feeling out of their depth/comfort zone
- Lack of understanding about the nature of spirituality and religion
- Lack of awareness about the beliefs and practices of many people
- No method for addressing these needs
- Seen spirituality/religion as a no go area
- Seen spirituality/religion as politically correct and therefore tokenistic

These very real issues underscore the need for education about how to incorporate this into practice and to understand and utilise spiritual assessment tools effectively.

IMPLICATIONS FOR EDUCATION

Acknowledgement of the role of spirituality in health and healing is shown in the education practices of allied health professions. More than 72 of 126 medical schools in the United States have included in their curricula electives or required courses on religion, spirituality and medicine.[16, 17] Spirituality was introduced as a required component in the teaching curriculum at the University of Sydney Medical School (Australia's oldest and largest medical school) in 2007 in response to feedback from a course review. It was deemed both necessary and appropriate to broaden training to be more inclusive of patient need. In Australian naturopathic education it is unclear if any single course on teaching about S/R and practice exists.[18] This is a concern as it suggests a serious gap in the training of naturopaths to be truly holistic practitioners. This gap diminishes the integrity of the holistic consultation.

CONCLUSION

While both spirituality and religion are constructs that are important for a naturopath to acknowledge in their patients, the real focus in practice is the way it impacts on health. As Hilbers et al. note the issue is not if someone is spiritual or religious but how they express their commitment.[19] The extensive and intricate relationship between spirituality and health has been marginalised as the dominant biomedical model of health care in the West has become increasingly technologised and pathology focused. The resurgence of interest in spirituality as a component of health, evidenced by the increase in research, is demonstrative of patient desire to have a relationship with their practitioner that extends beyond the technical. This renewed interest is reflective of a society burdened by materialism and alienated, to some extent, by an over-efficient technology in modern healing approach. This component of health care is central to the holistic practice of the naturopath. The lack of training about this key plank of philosophy is a serious concern as an integrated holistic approach to health is an identifying feature and signature of the profession. Omission of this element weakens the professional identity of natural medicine, making it easier for the sort of professional poaching that creates "green allopaths" - practitioners who use the tools of natural medicine without embracing the philosophy. It also weakens the ability to claim a truly holistic style of care. It is recommended that there be more research in education standards in Australia and further consideration of the inclusion of spirituality programs into the education and training of the natural medicine practitioner.

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Integrative Medicine

In this section of the journal we present a series of cases selected by our Heads of Departments. Readers are invited to comment on their own or other possible approaches to Stephen Eddey's client with type 2 diabetes. The aim is to stimulate an interdisciplinary discussion about the various natural and mainstream medical approaches to treatment and their possible integration. Please post your comments on http://bit.ly/communitiesofpractice.

Anna is a 65 year old retired school teacher. She is a non-smoker, enjoys a glass of wine with her evening meal and walks for an hour three times a week. She is currently being treated for high blood pressure and type 2 diabetes mellitus. Since her diagnosis 5 years ago, Anna has become more careful about what and how much she eats. Despite this her blood sugar levels have been slowly increasing over the past few months. On examination her blood pressure is 135/80 mmHg, weight 71 kg and height 160 cm. Anna's current medications are aspirin 100 mg daily, perindopril 4 mg daily, metoprolol 25 mg twice daily, metformin 850 mg three times a day and gliclazide 120 mg twice daily with food.

TYPE II DIABETES TREATMENT OPTIONS

Diabetes is very much a nutritional disease. It occurs when the body loses control of the blood sugar levels and blood sugar levels increase in the body beyond healthy levels. High blood sugar levels are toxic for many tissues, eyes, the blood vessels, nerves, kidneys, heart, not to mention the increased risk for cancer and, well, death!

We all have a pancreas that secretes a hormone called insulin, which is pumped out when we eat carbohydrates. Insulin works by facilitating the transport of sugar (glucose) into the cells. The big question is, why does this loss of control occur?

TREATMENT OPTIONS

It is almost stating the obvious but if you have too much sugar in the blood don't eat it! What is not as well known is that all absorbable carbohydrates turn into sugar into the body. The richest source of these carbohydrates is grains and these 'great' sources of sugar need to be eliminated. A diet rich in vegies, non-tropical fruits, salads, nuts, seeds, grass fed meats, fish and eggs needs to be implemented for the diabetic sufferer.

EXERCISE

Exercise is good for pretty much every disease. Diabetes is no exception. In fact, it is a vital part of the treatment. Reducing the consumption of sugar/grains slashes the intake of sugar, while exercise helps to burn off the excessive blood sugar levels. The best exercise is the one you enjoy and is best performed before breakfast. Get a medical check if the diabetic sufferer is unfit and/or overweight, which is often the case.

NUTRIENTS

There are a number of nutrients that may benefit diabetes. These nutrients focus on increasing the sensitivity (or effectiveness) of insulin. Chromium, Magnesium and Selenium are excellent minerals, while vitamin B3 (or a B complex) and Lipoic acid will also help. While these nutrients will help, improving the diet and exercising are your best options.

CONCLUSION

Diabetes is at epidemic proportions and natural therapists are in the best position to treat diabetics. Working with your patient's G.P. is an excellent idea as they can monitor their progress by measuring blood sugar, insulin and haemoglobin A1C levels and (hopefully) their doctor can remove the patient from their diabetic drugs.

Law Report

Ingrid Pagura BA, LLB

One of the first issues a person starting a business needs to decide on is the type of business structure that they will adopt. This first decision then flows on to all other aspects, as many elements will change depending on this. The main business structures for small business owners to choose from are the Sole Trader or a Company. There are advantages and disadvantages associated with each choice.

A sole trader is an individual trading on their own. This is generally a one-person business which is easy to set up, control and take apart. This structure can be established without formal documentation and with minimum reporting needs. The sole trader can use their own Tax File Number (TFN) but can also apply for an Australian Business Number (ABN) to use for all business dealings.

Any income earned from business activity is included together with any other income they earn for tax purposes. A sole trader needs to lodge an individual tax return including income from all sources. As a result, a sole trader pays the same tax rates as an individual, after the $6000 threshold. Sole traders are responsible for their own superannuation contributions.

ADVANTAGES:

- Sole traders control and manage their businesses
- There is flexibility in how and when they work
- Income is treated as their personal income for taxation
- Tax losses are offset against other income
- Sole traders receive the full benefits of the profits made
- Sole traders keep all the after-tax gains if the business is sold

DISADVANTAGES:

- Sole traders are liable for all debts
- Non-business assets are exposed which means they may have to use private assets to cover business debts. Sole traders' personal assets are at risk
- If they have no employees they are saddled with all the work
- Sole traders are legally responsible for all aspects of their businesses
- Sole traders are responsible for their own superannuation arrangements

Another common small business structure is a company. A company is formed by incorporating under the Corporations Act 2001 (C'wealth) which lays down regulations that strictly govern companies. They are registered under the Australian Securities and Investment Commission (ASIC).

A company is defined as an entity created with a view to making a profit. A company must apply for an Australian Company Number (ACN) which is unique to it. This must be used in all transactions. It can also apply for an ABN.

A company is a legal entity in its own right and separate from the people in it. This is the most important differentiation from all other business structures. This is unique to a company. A company is capable of suing and being sued in its own right. A company can own property in its own right and can have limited liability. A company pays tax.

A company is more expensive to set up and maintain as there are laws in relation to its set-up, function and reporting requirements.

There is a number of legal requirements for a company:

- The company must have a business name that is registered to that company and unique to it.
- There must be a registered office and address within Australia. This registered office must be open to the public each business day and is where all communication is sent. It can be a private home as long as there is a sign and it is open during business hours. The company name must be displayed at the registered office.
- Publication is required of the company name, the ACN and/or ABN on all public documents such as letters, invoices and cheques.
- There must be at least one director. Each director must act with due diligence and good faith and show care and skill. The sole director can be you.
- There must also be a secretary appointed by the directors. The secretary is responsible for establishing and maintaining the registered office, preparing and lodging annual tax returns and end-of-year accounts. The secretary must also act with due diligence and good faith and show care and skill.

Company directors have many obligations under the Corporations Act including placing the company's interests above their own and acting honestly, with care and attention to detail and in the best interests of the company;

A company must lodge an annual tax return. A company pays tax on all net profits at a fixed rate of 30%. This tax is paid by the company rather than individuals. If a director receives a wage from the company they will include this income in their personal income tax returns.

The company must pay superannuation contributions to all workers.

All companies must be registered with ASIC. Follow this link and find out what is required by opening the companies tab www.asic.gov.au.

ADVANTAGES:

- A company is a separate legal entity so that non-business assets are protected
- A company is capable of suing and of being sued separately from the individuals in it
- There is greater access to finances
- The tax rate for companies is 30%
- A company is responsible for superannuation payments for staff

DISADVANTAGES:

- Companies are more expensive to set up and maintain
- There are many more regulatory and reporting requirements
- Directors can be held personally liable for company decisions
- Directors have less flexibility in running the business and making decisions

Choosing a structure that suits you needs some thought. Here are some pointers to help you decide.

Liability: How risky is the venture? To what extent will the business be liable for debts?

A company is the safest structure for meeting these considerations, as it is a separate entity from the people in it, meaning that company debts can't be paid for out of the individual's personal assets.

Taxation: different tax rates apply for different structures. Companies pay tax separately from the individuals in the company. The tax rate is a flat rate of 30%. Sole traders include business income with their personal income and pay tax on that total.

Control: sole traders are able to maintain complete control over the business and this gives them a lot of flexibility in how and when they work. In the other structures some of this control is lost. In a company, directors are answerable to the Board and have much less flexibility in how they do their job.

Set-up and running costs: companies are more expensive to set up and there are more requirements. Sole traders require very little to set up requirements.

Recent Research June 2012

MASSAGE THERAPY

Field T, Diego M, Hernandez-Reif M, Medina L, Hernandez A. Yoga and massage therapy reduce prenatal depression and prematurity. Journal of Bodywork and Movement Therapies. 2012;16(2):204–209

Eighty-four prenatally depressed women were randomly assigned to yoga, massage therapy or standard prenatal care control groups to determine the relative effects of yoga and massage therapy on prenatal depression and neonatal outcomes. Following 12 weeks of twice weekly yoga or massage therapy sessions (20 min each) both therapy groups versus the control group had a greater decrease on depression, anxiety and back and leg pain scales and a greater increase on a relationship scale. In addition, the yoga and massage therapy groups did not differ on neonatal outcomes including gestational age and birthweight, and those groups, in turn, had greater gestational age and birthweight than the control group.

Fernandez-Lao C, Cantarero-Villanueva I, Diaz-Rodriguez L, Cuesta-Vargas AL, Fernandez-Delas-Penas C, Arroyo-Morales M. Attitudes towards massage modify effects of manual therapy in breast cancer survivors: a randomised clinical trial with crossover design. European journal of Cancer Care. 2012;21(2):233–241

Our aims were to investigate the immediate effect of myofascial release on heart rate variability and mood state, and the influence of attitude towards massage in breast cancer survivors with cancer-related fatigue. Twenty breast cancer survivors reporting moderate to high cancer-related fatigue participated in this crossover study. All patients presented to the laboratory at the same time of the day on two occasions separated by a 2-week interval. At each session, they received either a massage intervention or control intervention. Holter electrocardiogram recordings and Profile of Mood States questionnaire (six domains: tension–anxiety, depression–dejection, anger–hostility, vigour, fatigue, confusion) were obtained before and immediately after each intervention. The attitude towards massage scale was collected before the first session in all breast cancer survivors. The results showed a significant session × time interaction for standard deviation of the normal-to-normal interval (SDNN) (F= 5.063, P= 0.039), square root of mean squared differences of successive normal-to-normal intervals (RMSSD) (F= 8.273, P= 0.010), high-frequency component (HF) (F= 7.571, P= 0.013), but not for index heart rate variability (F= 3.451, P= 0.080), low-frequency component (LF) (F= 0.014, P= 0.997) and ratio LF/HF (F= 3.680, P= 0.072): significant increases in SDNN, RMSSD and HF domain ($P < 0.05$) were observed after the manual therapy intervention, with no changes after placebo ($P > 0.6$). No influence of the attitude scale on heart rate variability results was found. A significant session × time interaction was also found for fatigue (F= 5.101, P= 0.036) and disturbance of mood (F= 6.690, P= 0.018) scales of the Profile of Mood States: patients showed a significant decrease in fatigue and disturbance of mood ($P < 0.001$) after manual therapy, with no changes after placebo ($P > 0.50$). A significant influence of the attitude scale was observed in tension–anxiety, depression–dejection and anger–hostility scales. This controlled trial suggests that massage leads to an immediate increase of heart rate variability and an improvement in mood inbreast cancer survivors with cancer-related fatigue. Further, the positive impact of massage on cancer-related fatigue is modulated by the attitude of the patient towards massage.

NATUROPATHY

Wardle J, Steel A, Adams J. A Review of Tensions and Risks in Naturopathic Education and Training in Australia: A Need for Regulation. Journal of Alternative and Complementary Medicine. 2012;18(4): 363–370

Objectives: In line with increasing complementary medicine (CAM) use, the Australian government has committed considerable resources to the training of CAM practitioners. However, it has generally failed to complement this support with regulation or accountability measures. This is particularly true in Australia's largest CAM profession (naturopaths), which remains entirely unregulated but attracts approximately AUD$40 million each year in government funding for its education sector. This article explores the consequences of such unfettered support on professional outcomes.

Design: Data on Australian government funding for naturopathic student places were collated and compared with various outcome measures including research and professional outcomes.

Results: Lack of accountabilitymeasures attached to government support has enabled the proliferation of commercial education providers in the sector. This is often at the expense of the university sector, which is financially disadvantaged in naturopathic education delivery through extra academic and research obligations not shared by private for-profit providers. The major beneficiaries of government funding have facilitated few formal contributions to naturopathic research or professional development, whereas those with the highest research, professional, and academic output attracted the least government funding. Course content has declined in the previous 5 years, and government funding is still directed to courses that do not meet the minimum education levels for the prescribed government definition of naturopath.Unfettered support has also resulted in a significant increase in studen

numbers growth, which significantly outstrips growth in utilization, potentially affecting the profession's sustainability.

Conclusions: Lack of regulation in naturopathic education has resulted in significant risks to patients (through reduced standards) as well as the naturopathic profession itself. Although CAM advocates often focus on pushing for government support for the development CAM, support without the development of appropriate regulatory and accountability measures can ultimately be detrimental to the development of CAM.

HERBAL MEDICINE

Shaw D, Ladds G, Duez P, Williamson El, Chan K. Pharmacovigilance of herbal medicine. Journal of Ethnopharmacology. 2012;140(3):513–518

Pharmacovigilance is essential for developing reliable information on the safety of herbal medicines as used in Europe and the US. The existing systems were developed for synthetic medicines and require some modification to address the specific differences of medicinal herbs. Traditional medicine from many different cultures is used in Europe and the US which adds to the complexities and difficulties of even basic questions such as herb naming systems and chemical variability. Allied to this also is the perception that a 'natural' or herbal product must be safe simply because it is not synthetic which means that the safety element of monitoring for such medicines can be overlooked because of the tag associated with such products. Cooperation between orthodox physicians and traditional practitioners is needed to bring together the full case details. Independent scientific assistance on toxicological investigation, botanical verification can be invaluable for full evaluation of any case report. Systematic pharmacovigilance is essential to build up reliable information on the safety of herbal medicines for the development of appropriate guidelines for safe effective use.

Ke Fei, Yadav Praveen, Ju Liu. Herbal medicine in the treatment of ulcerative colitis. Saudi Journal of Gastroenterology. 2012;18:3-10

Ulcerative colitis (UC) is a refractory, chronic, and nonspecific disease occurred usually in the rectum and the entire colon. The etiopathology is probably related to dysregulation of the mucosal immune response toward the resident bacterial flora together with genetic and environmental factors. Several types of medications are used to control the inflammation or reduce symptoms. Herbal medicine includes a wide range of practices and therapies outside the realms of conventional Western medicine. However, there are limited controlled evidences indicating the efficacy of traditional Chinese medicines, such as aloe vera gel, wheat grass juice, Boswellia serrata, and bovine colostrum enemas in the treatment of UC. Although herbal medicines are not devoid of risk, they could still be safer than synthetic drugs. The potential benefits of herbal medicine could lie in their high acceptance by patients, efficacy, relative safety, and relatively low cost. Patients worldwide seem to have adopted herbal medicine in a major way, and the efficacy of herbal medicine has been tested in hundreds of clinical trials in the management of UC. The evidences on herbal medicine are incomplete, complex, and confusing, and certainly associated with both risks and benefits. There is a need for further controlled clinical trials of the potential efficacy of herbal medicine approaches in the treatment of UC, together with enhanced legislation to maximize their quality and safety.

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NUTRITION

Edwards M, Wood F, Davies M, Edwards A. The development of health literacy in patients with a long-term health condition: the health literacy pathway model. BMC Public Health. 2012;12:130

Background: Inadequate health literacy has been associated with poor management of long-term health conditions and has been identified as a key social determinant of health outcomes. However, little is understood about how health literacy might develop over time or the processes by which people may become more health literate. Our objectives were to describe how patients with a long-term condition practice health literacy in the management of their health and communication with health professionals, how they become more health literate over time and their experience of using health services. We also sought to identify and describe the motivations, facilitators and barriers in the practice of health literacy in healthcare consultations.

Methods: We designed a longitudinal qualitative study using serial interviews with 18 participants to explore their experiences of learning to manage their condition and their experiences of health literacy when participating in healthcare processes. Participants were recruited from patient education programmes and were interviewed three times over a period of 9 months. A framework approach was used to analyse data.

Results: A model is presented that illustrates the development of health literacy along a trajectory that includes the development of knowledge, health literacy skills and practices, health literacy actions, abilities in seeking options and informed and shared decision making opportunities. Motivations and barriers to developing and practising health literacy skills partly reflected participants' characteristics but were also influenced by health professionals. Some participants developed their health literacy to a point where they became more involved in healthcare processes (including informed and shared decision-making).

Conclusions: Patients with a long-term condition can develop health literacy skills over time and put their skills into practice in becoming more active in healthcare consultations. Our findings have implications for developing health literacy interventions aimed at patient involvement in healthcare processes and improved self-managementof long-term conditions.

Franko DL, Albertson AM, Thompson DR, Barton BA. Cereal consumption and indicators of cardiovascular risk in adolescent girls. Public Health Nutrition. 2011;14(4):584-90

Objective: To examine the association between cereal consumption and cardiovascular risk factors including waist, height, total cholesterol, LDL cholesterol and HDL cholesterol in a sample of adolescent girls.

Design Longitudinal study: Setting The study was conducted from 1987 to 1997 and data were collected at three study sites (University of California at Berkeley, University of Cincinnati and Westat Inc., Rockville, MD, USA). Mixed models were used to estimate the association between the number of days of eating cereal and these four outcome variables. Subjects Girls (n 2371) who participated in the 10-year National Heart, Lung, and Blood Growth and Health Study (NGHS) and completed a 3 d food diary in years 1-5 and 7, 8 and 10.

Results: Adolescent girls who ate cereal more often had lower waist-to-height ratio ($P < 0{\cdot}005$), lower total cholesterol ($P < 0{\cdot}05$) and lower LDL cholesterol ($P < 0{\cdot}05$), taking into account sociodemographic variables, physical activity levels and total energy intake.

Conclusions Findings suggest that cereal consumption is associated with markers of cardiovascular risk and that childhood patterns of consumption may influence the development of risk factors later in adolescence.

TCM AND ACUPUNCTURE

Luo H, Li Q, Flower A, Lewith G., Liu J. Comparison of effectiveness and safety between granules and decoction of Chinese herbal medicine: A systematic review of randomized clinical trials. Journal of Ethnopharmacology. 2012;140(3):555–567

Background: The clinical use of Chinese herbal medicine granules is gradually increasing. However, there is still no systematic review comparing the effectiveness and safety of granules with the more traditional method of herbal decoctions.

Method: A literature search was conducted using China National Knowledge Infrastructure Databases (CNKI), Chinese Science and Technology Periodical Database (VIP), China Biomedical Database web (CBM), Wanfang Database, PubMed, and the Cochrane Library until March 10, 2011. Clinical controlled trials (CCTs) including randomized trials (RCTs) comparing the effectiveness and safety between Chinese herbal medicine granules and decoction were included. Two authors conducted the literature searches, and extracted data independently. The assessment of methodological quality of RCTs was based on the risk of bias from the Cochrane Handbook, and the main outcome data of trials were analyzed by using RevMan 5.0 software. Risk ratio (RR) or mean difference (MD) with a 95% confidence interval (CI) were used as effect measure.

Results: 56 clinical trials ($n = 9748$) including 42 RCTs and 14 CCTs were included, and all trials were conducted in China and published in Chinese literature. 40 types of diseases and 15 syndromes of traditional Chinese medicine (TCM) were reported. Granules were provided by pharmaceutical companies in 13 trials. The included RCTs were of generally low methodological quality: 7 trials reported adequate randomization methods, and 2 of these reported allocation concealment. 10 trials used blinding, of which 5 trials used placebo which were delivered double blind (blinded participants and practitioners). 98.2% (55/56) of studies showed that there was no significant statistical difference between granules and decoctions of Chinese herbal medicine for their effectiveness. No severe adverse effects in either group were reported.

Conclusions: Due to the poor methodological quality of most of the included trials, it is not possible to reach a definitive conclusion whether both Chinese herbal medicine granules and decoctions have the same degree of effectiveness and safety in clinical practice, but this preliminary evidence supports the continued use of granules in clinical practice and research. Standardization of granules and further more rigorous pharmacological, toxicological and clinical studies are needed to demonstrate the equivalence with decoctions.

Laurence B. Acupuncture may be no more effective than sham acupuncture in treating temporomandibular joint disorders. Journal of Evidence Based Dental Practice. 2012:12(1):2-4

Selecrtion criteria: The study involved a systematic review and meta-analysis of English and non-English electronic databases, including Korean and Chinese databases, for relevant publications from inception to July 2010. The authors also reviewed data from dissertations and abstracts, provided they contained sufficient detail. The study included only parallel or crossover randomized controlled trials (RCTs) that compared the efficacy of acupuncture to sham acupuncture and did not include cohort, case-control, or observational studies of any type. Initially, 491 studies were identified, of which 398 were initially excluded after reading the abstract and title; another 86 were excluded after evaluation of the full-text article. Finally, only 7 publications met the inclusion criteria and were included in the systematic review and meta-analysis.

Key study factor: This review consisted of subjects with temporomandibular joint disorder (TMD) that was diagnosed by any defined or specified diagnosis criteria. Patients were classified as having an articular, muscular, or combined type of TMD. Excluded were complex interventions in which acupuncture was not the sole treatment and studies that included patients with TMD caused by psychogenic, neurologic, or metabolic disorders. The interventions included methods of stimulating acupuncture points that do not involve needle insertion in addition to the stimulation of trigger points via needle insertion. For the comparison group, only sham acupuncture (which may include penetrating or nonpenetrating sham needles or nonactivated laser acupuncture) was considered as an effective control.

Main outcome measure: The primary outcome measure was the relief of pain intensity in the TMD as measured by visual analogue scale (VAS), verbal scale, or algometer.

Main results: A total of 141 patients were included in the remaining 7 RCTs that met the inclusion criteria for systematic review and meta-analysis. For 5 of the 7 studies, the type of TMD diagnosed was classified as muscular, and for the remaining 2, the TMD classification type was combined (none were classified as articular). The primary outcome was the relief of pain intensity, but other clinically important outcomes that were measured included maximum interincisal mouth opening, range of motion, and muscle tenderness. To summarize the effects, the authors abstracted the relative risk estimates for dichotomous data and standardized mean difference (SMD) for continuous data with 95% confidence intervals (CIs). They also reported the weight mean difference (WMD). All 7 RCTs compared acupuncture with sham acupuncture and measured pain intensity using the visual analog scale (VAS). Five showed favorable effects of acupuncture, whereas 2 did not, and the meta-analysis showed significant improvement in pain intensity as measured by the VAS (5 studies, n = 107; WMD −13.63; 95% CI −21.16, −6.10). In stratified meta-analysis, 2 RCTs reported on facial pain using a numeric rating scale, and no significant difference was observed between the acupuncture and sham groups for this analysis. A stratified meta-analysis of muscle tenderness showed significant positive effects of acupuncture (2 studies, n = 46; SMD −1.08; 95% CI −1.88, −0.28), whereas no pooled meta-analysis of mouth opening was possible owing to insufficient original data.

Conclusions: The authors concluded that their systematic review of the literature and meta-analysis produced limited evidence that acupuncture is more effective than sham acupuncture in alleviating pain and masseter muscle tenderness in TMD. The authors discuss in detail the differences in study quality and methodological limitations of the 7 RCTs tested to provide evidence in support of their conclusions.

HOMOEOPATHY

Nayak C, Singh V, Singh VP, Oberai P, Roi V, Shitanshu SS, Sinha MN, Deewan D, Lakhera BC, Ramteke S, Kaushik S, Sarka S, Mandal NR, Mohanan PG, Singh JR, Biswas S, Mathew G. Homeopathy in chronic sinusitis: A prospective multi-centric observational study. Homeopathy. 2012;101(2):84-

Objective: The primary objective was to ascertain the therapeutic usefulness of homeopathic medicine in the management of chronic sinusitis (CS).

Materials and methods: Multicentre observational study at Institutes and Units of the Central Council for Research in Homoeopathy, India. Symptoms were assessed using the chronic sinusitis assessment score (CSAS). 17 pre-defined homeopathic medicines were shortlisted for prescription on the basis of repertorisation for the pathological symptoms of CS. Regimes and adjustment of regimes in the event of a change of symptoms were pre-defined. The follow-up period was for 6 months. Statistical analysis was done using SPSS version 16.

Results: 628 patients suffering from CS confirmed on X-ray were enrolled from eight Institutes and Units of the Central Council for Research in Homoeopathy. All 550 patients with at least one follow-up assessment were analyzed. There was a statistically significant reduction in CSAS ($P = 0.0001$, Friedman test) after 3 and 6 months of treatment. Radiological appearances also improved. A total of 13 out of 17 pre-defined medicines were prescribed in 550 patients, *Sil.* (55.2% of 210), *Calc.* (62.5% of 98), *Lyc.* (69% of 55), *Phos.* (66.7% of 45) and *Kali iod.* (65% of 40) were found to be most useful having marked improvement. 4/17 medicines were never prescribed. No complications were observed during treatment.

Conclusion: Homeopathic treatment may be effective for CS patients. Controlled trials are required for further validation.

Schmidt JM. The biopsychosocial model and its potential for a new theory of homeopathy. Homoeopathy. 2012;111(2):121-128

Since the nineteenth century the theory of conventional medicine has been developed in close alignment with the mechanistic paradigm of natural sciences. Only in the twentieth century occasional attempts were made to (re)introduce the 'subject' into medical theory, as by Thure von Uexküll (1908–2004) who elaborated the so-called biopsychosocial model of the human being, trying to understand the patient as a unit of organic, mental, and social dimensions of life. Although widely neglected by conventional medicine, it is one of the most coherent, significant, and up-to-date models of medicine at present.

Being torn between strict adherence to Hahnemann's original conceptualization and alienation caused by contemporary scientific criticism, homeopathy today still lacks a generally accepted, consistent, and definitive theory which would explain in scientific terms its strength, peculiarity, and principles without relapsing into biomedical reductionism. The biopsychosocial model of the human being implies great potential for a new theory of homeopathy, as may be demonstrated with some typical examples.

State News

News From South Australia

Sandra Sebelis

Greetings from Australia's most liveable city, according to a recent national survey – possibly influenced by our month of March, with its Festival and fringe events which cater for, and bring together all members of our population. My personal favourites are Writers Week, held in the Women's Pioneer Gardens, and Wormad, held in Botanic Park. We are now free to focus on our own ATMS Professional Education Seminars, with the first for the year in April, followed by two others in June and September I believe – I haven't yet received any written details to pass on to you.

I have personally been somewhat "slowed down" these last two months with yet another "learning to heal" experience (Tea Tree oil is not the cure for everything). After treating an infected cut on my right thumb for 5 days, I finally sought medical help with the thumb swollen and throbbing and had a red streak spreading up my arm. My shocked GP offered me the choice of an anti-biotic injection or immediate hospitalisation to deal with Septicemia. I had a mild reaction only this time to the anti-0biotics and even survived anti-histamines 2 weeks later after I was stung on the side of my neck by a bee which had left me with another swollen, red swelling.

Complementary or natural therapies have been several times in the printed media recently with Channel 10's "The Project" featuring Homoeopathy on Sunday 24th March. I haven't received any comments so far – perhaps they were address directly to Meadowbank as most communication from both public and members is.

Best wishes to all for a happy, healthy and fulfilling year.

News from Tasmania

Bill Pearson

In February the Natural Health and Wellness Expo was once again staged at Hobart's City Hall.

I ran this event for seven years, the last one being done in 1997, so it was good to get back to showing the public what natural medicine practitioners are doing and indeed how the profession itself has changed and grown.

It was great to have people coming in from the opening time of 9.00am, seeing many practitioner sites very busy for the entire day and observing the festival and atmosphere of camaraderie happening in a very celebratory way.

It was great this year to have Blackmores on board as the naming sponsor. A relationship I am hoping to develop and the Expo repeated annually.

I have spoken with many of our TCM practitioners these past months as statutory registration looms. We are all in the same boat with this one and of course by the time you are reading this many of us will have received news as to our registration status.

I am pleased to report that I retained my Directorship during the March election for continuing Directors and I look forward to continuing to serve this wonderful association. There are certainly going to be changes from September of this year as the new Board consisting of six of us who have been serving are joined by six new practitioner members. What an exciting time as we move forward with this. There could be changes in other areas as well as all Officer positions within ATMS are up for re election. This of course includes the positions of State Representatives and who knows, maybe there will be a different author come the September issue!

Sadly the ATMS will no longer be sponsoring the Cygnet Herb Fair each year. We have been doing so for many years and I have enjoyed manning the stall each year, talking with visitors and indeed catching up with some of our practitioners. However one could not ignore the greatly reducing numbers attending, not to mention the greatly dwindling organising ability of those supposedly in charge.

I look forward to catching up with as many of you as possible although my trips around Tasmania have had to be curtailed due to other ATMS commitments which see me out of Hobart very regularly. Despite this I am always happy to talk with you on the phone on 62 729 694 or reply to e mails on chimed@billpearson.com.au

From Central and North Queensland

Cathy Lee

Many people in our area including clients and natural therapists are noting that the health issues that we are being presented with are a result of the changing demographic. More and more people living and working in the Rockhampton, Mackay and Townsville regions are associated in some way with the mining industry. Many jobs in the coal mines involve fly in/fly out and drive in/drive out employees working rotating shift rosters with 12 hour shifts and long periods of separation from their families.

These work patterns have an increasing impact on the physical, psychological and social health of the worker and their families. Mine workers often get addicted to the big money that they get paid in comparison to the wages they would receive if they were not working in the mining industry. This makes it difficult for mine workers wishing to escape shift work and spend more regular time with their families and in leisure activities.

We are fortunate that as natural therapists we have a great deal to offer mine workers and their families through the variety of treatment options available.

We are also fortunate in our area that there are a number of workshops to be held throughout this year for therapists to gain the support and ongoing education we require to continue our work. Our seminars are well presented and offer members excellent information, provide support, and are a great way to network with other members. I would encourage anyone with the opportunity to attend an ATMS seminar to do so as you will not be disappointed.

I also invite comments from members of ATMS from Rockhampton north on matters that concern or interest them. I would especially like to hear from our members from the Cairns and Townsville areas as living in Mackay I feel somewhat removed from these members.

Please feel free to contact me through my;

- home email catherine.lee5@bigpond.com, or
- work email evercare@bigpond.com.

News from Victoria

Patricia Oakley

Just a note to say hi from Victoria, now that we are into our autumn 2012. Life has been busy but quiet in Victoria. We have no seminars to advertise at the moment and are looking forward to the ATMS AGM in September to catch up on all the news in our world. No doubt there will be graduations in May and more new members for ATMS. As yet I have only attended a couple of Integrative Medicine Education and Research Group Meetings. At the April meeting on Wednesday April 4th Professor Kerryn Phelps, Adjunct Professor at Sydney University's Faculty of Medicine, gave an interesting talk on probiotics and some of the interesting results she had experienced administering them to her patients, and on the different strands that are useful for certain health problems. Dr Jerome Sarris, Research Fellow at the Centre for Human Psychopharmacology at Swinburne University, and Vice-President of the International Network of Integrated Mental Health, spoke on Wednesday 2nd May on the topic of "Neutraceuticals in Depression and Anxiety – current scientific evidence and research".

Letter to the Editor

DEAR EDITOR,

I have been an ATMS member for some years as well as Sports Medicine Australia (15 years). Over the many years in the soft tissue industry I have not been so affected by information that is published in a magazine or document that bears the name of ATMS or SMA. Mr. Stephen Eddey has collected a number of articles with alternative viewpoints and taken bits and pieces from them to express a dangerous opinion. I have interviewed job applicants that believe they can cure cancer, walk on water and can live on nothing but air ... they did not get the job. A balanced diet ... everything in good measure would have been a better article to write. Alternative scare mongering may stir up some conversation and debate but at the cost of making me wonder if ATMS is really doing my industry any good? Should I continue with my membership of such a radically alternative society? ANTA and SMA do offer me what I need but I like ATMS and your push both in government and social media instils a belief that our industry is heading in the right direction .... but now? Cows' milk causes cancer, grains cause cancer, wheat, barley, oats. What? Eating a grain of wheat will chip your teeth? What a statement. Congratulations, you have really got me thinking. Not of what causes cancer but about my ATMS membership.

Pat McCudden
Queanbeyan, NSW

2012 WORKFORCE SURVEY

This year the ATMS Research Committee will conduct a natural medicine workforce survey. All ATMS members are invited to participate.

This is the first suvey of its kind in that it will attempt to reach the entire natural medicine workforce in Australia. Previous surveys conducted in 2002 reported on the massage, herbal medicine, naturaopthy and acupuncture workforce. The 2012 survey will expand our knowledge of our occupations to include all natural medicine modalities and invite collaboration with all Australian natural medicine professional associations.

Your participation in this survey is vitally important to a complete picture of the natural medicine workforce and their work practices. All ATMS members will receive survey forms in coming months. Findings of the study will inform ATMS policy decisions and lobbying to federal and state governments.

AUTHOR'S RESPONSE,

Thanks for taking an interest in the article I have written. You won't be the first to disagree and I hope not the last. We need a robust, scientific debate about nutritional medicine and it is clear what we are eating is the wrong thing as Australians are collectively putting on 6,000 tonnes of fat per year (CSIRO 2003).

It is true, I have collected a number of scientifically peer reviewed medical journal articles, which is good research practice and again, you are correct to state they have an alternate view to the current dietary recommendations. I believe we need an alternate view in nutrition because the current view is failing us badly.

I have also heard the statement and was taught that 'everything in moderation (or 'good measure' as you stated) but moderate eating leads to moderate health and I am all about optimal eating to achieve optimal health.

As for 'scaremongering' as you put it, all I am doing is quoting the scientific articles that state that eating such foods causes cancer. There are many more articles on this topic than the ones I published here. We didn't evolve to eat grain foods and drink another animals, milk as these foods have only been in our diet for less that 1% of our evolution. These are fad foods as far as our genes are concerned.

As for a whole wheat grain chipping your tooth… have you tried to eat one? Thanks again for your interest and I would like all of our members to take the time to write supportive or otherwise articles to the journal.

Regards,

Stephen Eddey M.H.Sc.,B.Comp.Med.,Dip.App. Sc.(Nat).,Ass.Dip.Chem.Cert.I.V.(Workplace Training and Assessment).

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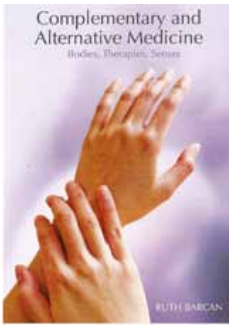
1. Dyerberg J, et al. Bioavailability of marine n-3 fatty acid formulations. *Prostaglandins Leukot Essent Fatty Acids* 2010 Sep;83(3):137–141.

Book Reviews

Stephen Clarke

COMPLEMENTARY AND ALTERNATIVE MEDICINE: BODIES, THERAPIES, SENSES

Barcan, Ruth. Berg, Oxford and New York, 2011. ISBN 978-1-84520-743-4 (paperback edition).



This is a book about alternative therapies from the viewpoint of cultural studies, rather than one about its medical effectiveness, although with a nod to subjectivity its author sets out by professing her fascination with and use of CAM, both as a client and part-time practitioner of Reiki.

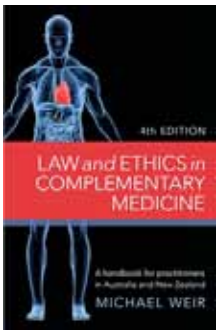
While unhesitatingly endorsing biomedicine for its "management of symptoms, the extension of life and the management of critical incidents" Barcan gives a compelling account of the basis of CAM's appeal to its best-identified categories of clientele: no longer confined to the counter-cultural minority but "empowered, savvy selectors of system-beating alternatives." In other words she proceeds from a rare viewpoint in the discourse between CAM and biomedicine, one combining enthusiasm for "a set of often exciting medical or therapeutic techniques" with the intellectual even-handedness of an accomplished scholar. She draws on a wealth of interviews with CAM practitioners to provide an intensive examination of CAM as a cultural phenomenon in step with contemporary social practices and philosophical values, an examination that reaches far beyond its simple healing and health maintenance functions. Moreover Barcan does not limit her perspective to the light Cultural Studies can shed on CAM as a social phenomenon but performs the corollary as well: she interprets with a professional scholar's insight how understanding the values underlying the practice and reception of CAM has a unique role in expanding our understanding of post-modern culture. What a rich vein of contemplation this is for CAM therapists, who may be very familiar with accounts of how their discipline can be explained by social and philosophical trends, but will be fascinated to consider the obverse, how CAM refines interpretation of the workings of its ambient culture.

A key aspect of this book is its focus on the body and biologism, which are of course issues central to so much of CAM practice but which, Barcan claims, have been marginalized by, particularly, many gender studies-based analyses. She acknowledges how her "curiosity about what the body can do in different circumstances … what effects Tibetan crystal bowls may or may not have on the body … or whether clairvoyants see in colour" has informed her enthusiasm for CAM. The three central chapters approach CAM's significance from the perspectives of sight, sound and touch.

A review this brief can only give a small taste of the depth of this unique and enriching view of CAM. It is replete with profound and compelling insights that deepen the understanding of both CAM practitioners and their clients and help to explain the appeal and effect of CAM to the world at large.

LAW AND ETHICS IN COMPLEMENTARY MEDICINE

Weir, M., Allen and Unwin, Sydney, 2011. ISBN 978-1-74237-405-5. Paperback edition $49.99. Email allenandunwin.com. Telephone 02 8425 0100



This is the fourth edition of this work (the previous three were published under the title *Complementary Medicine: Ethics and Law).* It is a comprehensive handbook on law and ethics suitable for both students and professional practitioners of complementary medicine. The author is Professor of Law at Bond University, Queensland. He has trained in therapeutic massage and has a doctorate in law focused on the regulation of complementary medicine. He has given courses on legal and ethical issues to complementary medicine students for over twenty years.

This edition contains important information about recent changes to the scope of practice of complementary medicine brought about by National Health Practitioner Regulation legislation, including the introduction of national boards to cover each registered health profession in Australia, and by recent consumer law cases. It has become an invaluable reference for professional practitioners, students and the legal profession.

There are eight chapters including an introduction. The latter contains a table, called the *Ten commandments of professional practice,* that list the ten behaviours the author sees as underpinning the main message of the book, that is, practising to continuous professional standards of competence, knowledge, safety, ethics, client welfare and legal compliance. Each behaviour is referenced to page numbers in the book where it is discussed. Other chapters address such issues as ethics and misconduct, legal boundaries to scope of practice, professional responsibility and negligence, consumer entitlements - including legal obligations to clients - and establishing a practice. Chapter six deals with legal issues pertinent to each of eight complementary modalities. For each modality the author presents a clearly set-out action plan, which is a set of steps to follow - and to avoid - to ensure compliance with the particular legal requirements of that modality.

Professional indemnity insurance for health practitioners is an important and often burdensome requirement. This book explains in clarity and detail how best to navigate this essential feature of practice. Most books of this quality on law and complementary practice are written for readerships in other countries. Australian practitioners now have a resource for dealing with their particular need for information and guidance. There is a comprehensive table of federal and state legislation affecting professional practice, and an index.

Health Fund News

AUSTRALIAN HEALTH MANAGEMENT (AHM)

Names of eligible ATMS members will be automatically sent to AHM each month. ATMS members can check their eligibility by telephoning the ATMS on 1800 456 855.

AUSTRALIAN REGIONAL HEALTH GROUP (ARHG)

This group consists of the following health funds:

ACA Health Benefits Fund

Cessnock District Health

CUA Health (Credicare)

Defence Health Partners

GMF Health (Goldfields Medical Fund)

GMHBA (Geelong Medical)

Health Care Insurance Limited

Health Partners

HIF (Heath Insurance Fund of WA)

Latrobe Health Services

Lysaught Peoplecare

MDHF (Mildura District Health Fund)

Navy Health Fund

Onemedifund

Phoenix Welfare

Police Health Fund

Queensland Country Health

Railway and Transport

Teachers Union Health

St Lukes

Teachers Federation

Transport Health

Westfund

When you join ATMS, or when you upgrade your qualifications, details of eligible members are automatically sent to ARHG by ATMS monthly. The details sent to ARHG are your name, address, telephone and accredited discipline(s). These details will appear on the AHHG websites. If you do not wish your details to be sent to ARHG, please advise the ATMS office on 1800 456 855.

Remedial massage therapists who graduated after March 2002 must hold a Certificate IV or higher from a registered training organisation. Please ensure that ATMS has a copy of your current professional indemnity insurance and first aid certificate.

The ARHG provider number is based on your ATMS number with additional lettering. To work out your ARHG provider number please follow these steps:

1. Add the letters AT to the front of your ATMS member number
2. If your ATMS number has five digits go to step 3. If it has two, three or four digits, you need to add enough zeros to the front to make it a five digit number (e.g. 123 becomes 00123).
3. Add the letter that corresponds to your accredited modality at the end of the provider number; **A** Acupuncture, **C** Chinese herbal medicine, **H** Homoeopathy, **M** Remedial massage, **N** Naturopathy, **O** Aromatherapy, **R** Remedial therapies, **W** Western herbal medicine. If ATMS member 123 is accredited in Western herbal medicine, the ARHG provider number will be AT00123W.
4. If you are accredited in several modalities, you will need a different provider number for each modality (e.g. if ATMS member 123 is accredited for Western herbal medicine and remedial massage, the ARHG provider numbers are AT00123W and AT00123M.

AUSTRALIAN UNITY

Names of eligible ATMS members will be automatically sent to Australian Unity each month. ATMS members can check their eligibility by telephoning ATMS on 1800 456 855.

BUPA (INCLUDING MBF, HBA AND MUTUAL COMMUNITY)

Names of eligible ATMS members will be automatically sent to BUPA each month. ATMS members can check their eligibility by telephoning ATMS on 1800 456 855.

CBHS HEALTH FUND LIMITED

On joining ATMS, or when you upgrade your qualifications, the details of eligible members are automatically sent to CBHS each month. The details sent to CBHS are your name, address, telephone and accredited discipline(s). These details will appear on the CBHS website. If you do not want your details to be sent to CBHS, please advise the ATMS office on 1800 456 855. Please ensure that ATMS has a copy of your current professional indemnity insurance and first aid certificate.

DOCTORS HEALTH FUND

Names of eligible ATMS members will be automatically sent to Doctors Health Fund each fortnight. ATMS members can check their eligibility by telephoning ATMS on 1800 456 855.

GRAND UNITED CORPORATE

To register with Grand United Corporate, please apply directly to Grand United on 1800 249 966.

HBF

To register with HBF, please contact the fund directly on 13 34 23.

HCF AND MANCHESTER UNITY

Names of eligible ATMS members will be automatically sent to HCF and Manchester Unity each fortnight. ATMS members can check their eligibility by telephoning ATMS on 1800 456 855.

MEDIBANK PRIVATE

Names of eligible ATMS members will be automatically sent to Medibank Private each month. ATMS members can check their eligibility by telephoning ATMS on 1800 456 855.

NIB

NIB require Health Training Package qualifications for naturopathy, Western herbal medicine, homoeopathy, nutrition, remedial massage, shiatsu and Chinese massage. Australian HLT Advanced Diploma qualifications are the minimum requirements for acupuncture and Chinese herbal medicine. Names of eligible ATMS members will be sent to NIB each week. NIB accept overseas qualifications which have been assessed as equivalent to the Australian qualification by Vetassess or and RTO college.

All recognised provides must agree to the NIB Provider Requirements, Terms and Conditions as a condition of NIB provider status. The document is available at http://providers.nib.com.au. Alternatively, a copy can be obtained by emailing providers@nib.com.au or calling NIB Provider Hotline on 1800 175 377. It is not necessary for ATMS members to complete the application form attached to NIB Provider Requirements, Terms and Conditions.

ATMS members currently recognised by NIB and who have not submitted their renewed professional indemnity insurance and/or first aid certificate to ATMS must do so immediately, or they will be removed from the NIB list. Documents needed for members to remain on the health fund list. To remain on the health funds list, members must have a copy of their current professional indemnity insurance and first aid certificate on file at the ATMS office and must meet the CPE requirements. Please ensure that you forward copies of these documents to the ATMS office when you receive your renewed certificates. Lapsed membership, insurance or first aid will result in a member being removed from the health funds list. Upgrading qualifications may be required to be re-instated for some health funds.

CHANGE OF DETAILS

The ATMS office will forward your change of details to your approved health funds on the next available list. Health funds can take up to one month to process change of details.

Health Fund Update

Health Fund	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Australian Health Management	✔		✔	✔			✔	✔	✔		✔	✔	✔	✔	✔		✔			
Australian Regional Health Group																				
ACA Health Benefits Fund	✔			✔			✔	✔				✔			✔	✔				
Cessnock District Health	✔		✔	✔			✔	✔				✔			✔	✔				
CUA Health *(Credicare)*	✔			✔			✔	✔			✔	✔		✔	✔	✔				
Defence Health Partners	✔		✔	✔			✔	✔				✔			✔	✔				
GMF Health *(Goldfields Medical Fund)*	✔			✔				✔				✔		✔	✔					
GMHBA *(Geelong Medical)*	✔		✔					✔				✔			✔	✔				
Health Care Insurance Limited	✔		✔	✔			✔	✔				✔			✔	✔				
Health Partners	✔		✔	✔			✔	✔				✔			✔	✔				
HIF *(Health Insurance Fund of WA)*	✔			✔				✔				✔			✔	✔				
Latrobe Health Services	✔							✔				✔			✔					
MDHF (Mildura District Hospital Fund)	✔											✔			✔					
Navy Health Fund	✔		✔	✔			✔	✔				✔			✔	✔				
Onemedifund	✔			✔			✔	✔				✔			✔	✔				
Peoplecare Health Insurance	✔			✔			✔	✔				✔			✔	✔				
Phoenix Health Fund	✔		✔	✔			✔	✔				✔			✔	✔				
Police Health Fund	✔		✔	✔			✔	✔				✔			✔	✔				
Queensland Country Health	✔							✔				✔			✔					
Railway and Transport	✔			✔			✔	✔				✔			✔	✔				
Reserve Bank Health Society	✔			✔			✔	✔				✔			✔	✔				
St Lukes	✔			✔			✔	✔				✔			✔	✔				
Teachers Federation	✔	✔	✔	✔			✔	✔			✔	✔		✔	✔	✔	✔			
Teachers Union Health	✔		✔					✔				✔	✔		✔	✔				
Transport Health	✔		✔	✔			✔	✔				✔			✔	✔				
Westfund	✔											✔			✔	✔				
Australian Unity	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
BUPA^	✔		✔	✔			✔	✔			✔	✔		✔	✔		✔		✔	
CBHS Health Fund	✔		✔	✔			✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔	
Doctors Health Fund															✔					
GU Health (Grand United)*	✔		✔	✔			✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			
HBF*	✔			✔			✔	✔				✔	✔	✔	✔					
HCF	✔	✔		✔				✔				✔	✔		✔					
Manchester Unity#	✔	✔	✔	✔			✔	✔			✔	✔	✔	✔	✔		✔			
Medibank Private	✔	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	✔	✔		✔		✔	
NIB	✔			✔			✔	✔				✔	✔		✔		✔		✔	

✔ *Therapy covered by Fund*
* *Need to Apply directly to Fund*

^ *BUPA includes MBF, NRMA Health Insurance, HBA, Mutual Community, SGIC Health Insurance, and SGIO Health Insurance*
\# *Manchester Unity no longer accepting new providers after merge with HCF*

LEGEND	
1	Acupuncture
2	Alexander Technique
3	Aromatherapy
4	Chinese Herbal Medicine
5	Counselling
6	Deep Tissue Massage
7	Herbal Medicine
8	Homeopathy
9	Hypnotherapy
10	Iridology
11	Kinesiology
12	Naturopathy
13	Nutrition
14	Reflexology
15	Remedial Massage
16	Remedial Therapies
17	Shiatsu
18	Sports Massage
19	Traditional Chinese Massage
20	Traditional Thai Massage

Please note that this table is only a guide to show what funds cover ATMS accredited modalities. If the modality that you are accredited for is not listed, this means that no health fund covers the modality. The only exceptions are Chiropractic and Osteopathy.

ATMS accreditation in a modality does not guarantee provider status as all funds have their individual set of strict eligibility requirements. Please see our website www.atms.com.au or contact our office for current requirements.

Rebates do not usually cover medicines, only consultations. For further rebate terms and conditions, patients should contact their health fund. Policies may change without prior notice.

HICAPS do not cover all Health Funds nor all modalities. Please go to www.hicaps.com.au for further information.

Advance Notice ATMS AGM 2012

Date: Sunday 23 September 2012
Location: Rydges Hotel, Parramatta, Sydney 116 James Ruse Drive Rosehill NSW 2142
For accommodation please phone Rydges on +61 2 8863 7600.

Registration :	*8.45 am Refreshments will be available.*
Opening:	9.30 am – 9.45 am Official opening and welcome by Sandi Rogers.
Hall of Fame Presentation:	9.45 am – 10 am. Hall of Fame inductee presented by Bill Pearson.
First Skills Update speaker:	10 am – 10.45 am. Kate vanderVoort will present social media for your business. Kate will get you excited about the possibilities that social media may offer your business.
Morning tea:	*10.45 am – 11.15 am.*
AGM - General Meeting:	11. 15 am – 12.45 pm Formal notice of the AGM will be sent to all members in mid to late August.
Lunch:	*2.45 pm – 1.30 pm.*
Second and third Skills Update:	Speakers to be announced 1.30 pm – 3.00 pm.
Close:	*The meeting will be followed by a cocktail party.*

I hope to see you in Sydney on 23 September 2012
Sandi Rogers, ATMS President

Continuing Professional Education

Continuing professional education (CPE) is a structured program of further education for practitioners in the professional occupations.

The ATMS CPE policy is designed to ensure its practitioners regularly update their clinical skills and professional knowledge. One of the main aims of CPE is keep members abreast of current research and new developments which inform contemporary clinical practice.

The ATMS CPE Policy is based on the following principles:

- Easily accessible to all members, regardless of geographic location
- Members should not be given broad latitude in the selection and design of their individual learning programs
- Applicable to not only the disciplines in which a member has ATMS accreditation, but also to other practices that are relevant to clinical practice which ATMS does not accredit (e.g. Ayurveda, yoga)
- Applicable to not only clinical practice, but also to all activities associated with managing a small business (e.g. book-keeping, advertising)
- Seminars, workshops and conferences that qualify for CPE points must be of a high standard and encompass both broad based topics as well as discipline-specific topics
- Financially viable, so that costs will not inhibit participation by members, especially those in remote areas
- Relevant to the learning needs of practitioners, taking into account different learning styles and needs
- Collaborative prSetocess between professional complementary medicine associations, teaching institutions, suppliers of therapeutic goods and devices and government agencies to offer members the widest possible choice in CPE activities
- Emphasis on consultation and co-operation with ATMS members in the development and implementation of the CPE program

ATMS members can gain CPE points through a wide range of professional activities in accordance with the ATMS CPE policy. CPE activities are described in the CPE policy document as well as the CPE Record. These documents can be obtained from the ATMS office (telephone 1800 456 855, fax (02) 9809 7570, or email info@atms.com.au) or downloaded from the ATMS website at www.atms.com.au.

It is a mandatory requirement of ATMS membership that members accumulate 20 CPE points per financial year. Five 5 CPE points can be gained from each issue of this journal. To gain five CPE points from this issue, select any three of the following articles, read them carefully and critically reflect how the information in the article may influence your own practice and/or understanding of complementary medicine practice:

- Wollumbin, J.
  Holistic Primary Health Care: Origins and History
- Boyle, M
  The Dynamic of Stress
- Muscolino, J.
  Lumbopelvic Rhythm
- Iseri, S.O. & Cabioglu, T.
  Migraine Treatment and the Role of Acupuncture:
  A Literature Review
- Dellman, T. & Lushington, K.
  Characteristics of Experienced Natural Therapists.
- Grant, A.
  Incorporating spirituality into the work of the holistic practitioner.

As part of your critical reflection and analysis, answer in approximately 100 words the following questions for each of the three articles:

1. What new information did I learn from this article?
2. In what ways will this information affect my clinical prescribing/techniques and/or my understanding of complementary medicine practice?
3. In what ways has my attitude to this topic changed?

Record your answers clearly on paper for each article. Date and sign the sheets and attach to your ATMS CPE Record. As a condition of membership, the CPE Record must be kept in a safe place, and be produced on request from ATMS.

Code of Conduct

PREAMBLE

Complementary medicine is a holistic approach to the prevention, diagnosis and therapeutic management of a wide range of disorders in the community. Complementary medicine practice is founded on the development of a therapeutic relationship and the implementation of therapeutic strategies based on holistic principles. Complementary medicine encompasses a diversity of practices to improve the health status of the individual and community for the common good.

The aim of the Code of Conduct is to make it easier for members to understand the conduct which is acceptable to ATMS, the complementary medicine profession and to the wider community, and to identify unacceptable behaviour. The Ethical Principles underpin the standards of professional conduct as set out in the Code of Conduct.

The intention of the Code of Conduct is to identify ethical dilemmas and assist ATMS members in resolving them. ATMS members are accountable for their clinical decision making and have moral and legal obligations for the provision of safe and competent practice.

Where an ATMS member encounters an ethial quandary, it is advisable to seek appropriate advice. If this action does not solve the matter, the advice of ATMS should be sought. The purpose of the Code of Conduct is to:

- Identify the minimum requirements for practice in the complementary medicine profession
- Identify the fundamental professional commitments of ATMS members
- Act as a guide for ethical practice
- Clarify what constitutes unprofessional behaviour
- Indicate to the community the values which are expected of ATMS members

The Code of Conduct was established as the basis for ethical and professional conduct in order to meet community expectations and justify community trust in the judgement and integrity of ATMS members.

While the Code of Conduct is not underpinned in statute, adoption and adherence to it by ATMS members is a condition of ATMS membership. A breach of the Code of Conduct may render an ATMS member liable for removal from the Register of Members.

ETHICAL PRINCIPLES

Practitioners conduct themselves ethically and professionally at all times.

- Practitioners render their professional services in accordance with holistic principles for the benefit and wellbeing of patients.
- Practitioners do no harm to patients.
- Practitioners have a commitment to continuing professional education to maintain and improve their professional knowledge, skills and attitudes.
- Practitioners respect an individual's autonomy, needs, values, culture and vulnerability in the provision of complementary medicine treatment.
- Practitioners accept the rights of individuals and encourage them to make informed choices in relation to their healthcare, and support patients in their search for solutions to their health problems.
- Practitioner treat all patients with respect, and do not engage in any form of exploitation for personal advantage whether financial, physical, sexual, emotional, religious or for any other reason.

DUTY OF CARE

- The highest level of professional and ethical care shall be given to patients.
- The practitioner will exercise utmost care to avoid unconscionable behaviour.
- The patient has the right to receive treatment that is provided with skill, competence, diligence and care.
- In the exercise of care of the patient, the practitioner shall not misrepresent or misuse their skill, ability or qualifications.

PROFESSIONAL CONDUCT

- Practitioner members must adhere to all of the requirements of this Code of Conduct and State, Territory and Federal law within the scope of their practice.
- The title of Doctor or Dr will not be used, unless registered with an Australian medical registration board.
- Under no circumstances may a student, staff member or another practitioner use someone else's membership number or tax invoice book for the purposes of issuing a health fund rebate tax invoice. The member is responsible for the issue of their own tax invoices.
- The practitioner shall not provide false, misleading or incorrect information regarding health fund rebates, WorkCover, ATMS or any other documents.
- The practitioner shall not advertise under the ATMS logo any discipline(s) for which they are not accredited with ATMS.
- The practitioner shall not denigrate other members of the healthcare profession.
- The practitioner shall be responsible for the actions of all persons under their employ, whether under contract or not.
- Telephone or Internet consultations, without a prior face-to-face consultation, must not be conducted

- The fee for service and medicines charged by the practitioner must be reasonable, avoiding any excess or exploitation

RELATIONSHIP BETWEEN PRACTITIONER AND PATIENT

- The practitioner shall not discriminate on the basis of race, age, religion, gender, ethnicity, sexual preference, political views, medical condition, socioeconomic status, culture, marital status, physical or mental disability.
- The practitioner must behave with courtesy, respect, dignity and discretion towards the
- Patient, at all times respecting the diversity of individuals and honouring the trust in the therapeutic relationship.
- The practitioner should assist the patient find another healthcare professional if required.
- Should a conflict of interest or bias arise, the practitioner shall declare it to the patient, whether the conflict or bias is actual or potential, financial or personal.

PROFESSIONAL BOUNDARY

- The practitioner will not enter into an intimate or sexual relationship with a patient.
- The practitioner will not engage in contact or gestures of a sexual nature to a patient.
- Mammary glands and genitalia of a patient will not be touched or massaged and only professional techniques applied to surrounding tissue.
- Any internal examination of a patient, even with the consent of the patient, is regarded as indecent assault which is a criminal offence.
- Any approaches of a sexual nature by a patient must be declined and a note made in the patient's record.

PERSONAL INFORMATION AND CONFIDENTIALITY

- The practitioner will abide by the requirements of State, Territory and Federal privacy and patient record law.
- The practitioner shall honour the information given by a person in the therapeutic relationship.
- The practitioner shall ensure that there will be no wrongful disclosure, either directly or indirectly, of a patient's personal information.
- Patient records must be securely stored, archived, passed on or disposed of in accordance with State, Territory and Federal patient record law.
- Appropriate measures shall be in place to ensure that patient information provided by facsimile, email, mobile telephone or other media shall be secure.
- Patient records must be properly maintained with adequate information of a professional standard
- The practitioner must act with due care and obtain consent when conveying a patient's information to another healthcare professional.
- The patient has a right to be adequately informed as to their treatment plan and medicines, and access to their information as far as the law permits.

ADVERTISING

- Advertisements, in any form of printed or electronic media must not:
- Be false, misleading or deceptive
- Abuse the trust or exploit the lack of knowledge of consumers
- Make claims of treatment that cannot be substantiated
- Make claims of cure
- Use the title of Doctor, unless registered with an Australian medical registration board
- Encourage excessive or inappropriate use of medicines or services
- List therapies for which the practitioner foes not have ATMS accreditation if the ATMS logo or name is used.


ATMS