

**A retrospective survey of perceptions and opinions of  
M.Tech:Homoeopathy graduates around the role and scope of  
homeopathic internship, in terms of the current legislation.**

By

Laura Chella

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

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

.....

Signature of student

.....

Date

APPROVED FOR FINAL SUBMISSION

.....

Signature of supervisor

Dr D Naude

M.Tech:Homoeopathy (TN)

.....

Date

.....

Signature of co-supervisor

Dr A.H.A Ross

M.Tech:Homoeopathy (TN)

**TO MY NONNA CLARA  
AND  
MY DEAR ANDRE  
FOR YOUR INFINITE LOVE AND SUPPORT**

## **ACKNOWLEDGEMENTS**

I would like to acknowledge the following people for their contribution to this study and to my homoeopathic education.

My parents, Valerio and Claudia, without whose support I would never have been able to complete my degree.

To Andre' for your patience and love.

To my grandparents and Meri for your unending enthusiasm and interest in my chosen career.

To Elisa, Giulia and Paolo for being willing to try my suggestions, testing my knowledge and finding amusement in my medical jargon.

To Dr Ashley Ross for teaching me the art of English and putting up with my passionate outbursts throughout my studies.

To Dr David Naude for being a committed supervisor and for reviewing my work with such precision.

Nicholas Nell for promptly doing the stats.

Anitha Shah for willingly collecting the responses.

Dr Schultz for toughening me up and teaching like no other.

Dr Maharaj for making materia medica such a vivid pleasure.

Debs, Abbey and Liesl for sharing your knowledge and notes, and for all your humor.

All respondents, a hearty thanks for taking the trouble to answer my questions.

For those respondents who thanked me for undertaking this research and those who urged me on giving me renewed vigor, you made it worthwhile.

## **ABSTRACT**

The first formal Homeopathic education programme in South Africa began in 1989 and was instituted by Technikon Natal, now Durban University of Technology – DUT. The course offers a Master’s Degree in Technology in Homeopathy. Similarly Witwatersrand Technikon now University of Johannesburg began offering the course from 1993. Since the first (from DUT) intake there have been 13 years of graduates.

Included in the course is excellent homeopathic training and a comprehensive medical training programme, consisting of anatomy, physiology, pathology, histology and diagnostics subjects. Although a statutory requirement no postgraduate internship training regarding graduates of this programme has been formalised. Thus this study was deemed valuable as it aimed to provide clarity on past internship received and a perception of what an internship ought to entail.

The purpose of this retrospective survey was to determine the perceptions and opinions of M.Tech:Homeopathy graduates around the current non-implementation of statutory internship, in order to inform the formulation of an appropriate and effective homeopathic internship, as required by Act 63 of 1982 (as amended). Other objectives included gathering data/perceptions regarding the contents and outcomes of a proposed Homeopathic internship as perceived by M.Tech:Homeopathy graduates. As well as assessing/determining the possible existence of associations between demographic factors and the perceptions around internship regarding its recommended contents and outcomes.

The study was aimed at all graduates who have completed a Masters degree in Technology:Homeopathy. The study was conducted via a self-administered questionnaire (Appendix B). The questionnaire was divided into four parts concerning demographic data, current legislation regarding internship, past internship that applied to graduates that received some form of internship training and recommendations for an internship programme.

The researcher captured the data, which was analysed statistically using SPSS® for Windows version 14.0. The results which were interpreted reflected that the majority of graduates feel that they benefited greatly from their internship regardless of its structure or duration. Those who did not receive formal internship training believed for various reasons that they would have benefited from one. Some had a greater bearing on their decisions than others. A definitive outline as to the contents of an internship was determined and recommended.

## **TABLE OF CONTENTS**

	PAGE
<b><u>DEDICATION</u></b>	I
<b><u>ACKNOWLEDGEMENTS</u></b>	II
<b><u>ABSTRACT</u></b>	III
<b><u>TABLE OF CONTENTS</u></b>	1
<b><u>LIST OF FIGURES</u></b>	6
<b><u>LIST OF TABLES</u></b>	8
<b><u>DEFINITIONS</u></b>	10
<b><u>CHAPTER ONE: INTRODUCTION</u></b>	11
1.1 Introduction	11
1.2 Aim of study	11
1.3 Rationale for study	12
1.4 Benefits of study	13
1.5 Limitations	13
<b><u>CHAPTER TWO: LITERATURE REVIEW</u></b>	14
2.1 Survey methodologies	14
2.1.1 Introduction	14
2.1.2 Advantages and Disadvantages of Surveys and Questionnaires	14
2.1.3 Sampling	15
2.1.4 Types Of Survey And Data	15
2.1.5 Data collection	16
2.1.6 Questionnaire design	16
2.1.7 Review of questionnaire	17
2.1.8 Distribution of questionnaire	18
2.1.9 Statistical analysis	18
2.2 Introduction	19
2.3 Implementation of internship	19
2.4 History of Homoeopathic internship in RSA	20
2.5 Medical and dental internship in South Africa	21

2.6 International internship evaluation	23
2.7 Previous relevant research	24
2.8 Problems formulating an internship	26
2.9 Other internships governed by the AHPCSA	27
2.10 Role of the graduate	28
2.11 Towards formulation of Homoeopathic internship	29

## **CHAPTER THREE: METHODOLOGIES** 30

3.1 Study type design	30
3.2 Research participants	30
3.2.1 Inclusion criteria	30
3.2.2 Recruitment	30
3.3 Design of research instrument	31
3.3.1 Pre-testing of questionnaire	31
3.3.1.1 Statistician Assessment of Questionnaire	31
3.3.1.2 Focus Group	32
3.4 Data Collection	33
3.4.1 Mode of Receiving Questionnaire:	33
3.4.2 Mode of Response to Questionnaire:	33
3.5 Data storage	34
3.6 Bad or non-responses	35
3.6.1 Role of The Information Letter	35
3.6.2 Time Constraints of Participants	35
3.6.3 Convenient Methods Of Response	36
3.7 Data analysis	36
3.8 Flow chart of processes	36

## **CHAPTER FOUR: RESULTS** 38

4.1 Introduction	38
4.2 Overview of results chapter	39
4.2.1.1 Demographics	39
4.2.1.2 Level of understanding of current legislation	39
4.2.1.3 Past internship options accessed	39

4.2.1.4 Recommendations for the internship program	39
4.2.2 Analysis	39
4.2.3 Comments	40
4.3 Abbreviations	40
4.4 Sample characteristics	41
4.5 Descriptive statistics	42
4.5.1 Demographics	42
4.5.2 Knowledge of current legislation	48
4.5.3 Past internship structures accessed	52
4.5.4 Recommendations for the internship Program	59
4.6 Correlation analysis	65
4.6.1. Hypothesis testing- Demographic and Background Variables compared to variables from Part B (understanding of current legislation).	65
4.6.2 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part C (Questions Describing the respondents previous experience of Internship)	68
4.6.3 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part D (Questions Describing the respondents recommendations for the Internship)	70
4.6.4 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part D (Questions Describing the respondents recommendations for the Internship)	72
4.6.5 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part D (Questions Describing the respondents recommendations for the Internship)	74



4.6.6 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part D (Questions Describing the respondents recommendations for the Internship)	76
4.7 Correlations within questions	78
4.7.1 Question 4.4 Perceived gain experienced from internship - Dendrogram using Ward Method	79
4.7.2 Question 5: Perceptions of what skills should be acquired or enhanced during the internship - Dendrogram using Ward Method	80
4.7.3 Question 8: Recommendations with respect to what emphasis should be placed on the internship. Dendrogram using Ward Method	81

<b><u>CHAPTER FIVE – DISCUSSION</u></b>	<b>83</b>
5.1 Introduction	83
5.2 Sample characteristics	84
5.3 Demographics	85
5.3.1 Gender	85
5.3.2 Geographical demographics	85
5.3.3 Qualification	85
5.4 Knowledge of current legislation	86
5.4.1 Awareness of legislation	86
5.4.2 Respondents perceptions of responsibility for internship programme	87
5.5 Past Internship Structures Accessed	88
5.5.1 Location of Internship Undertaken	88
5.5.2 Length of time devoted to Internship	89
5.5.3 Duration of Internship	90
5.5.4 Nature of Internship programme	90
5.5.4.1 Seeing patients on a one to one basis	90
5.5.4.2 Supervision	90
5.5.5 Possible perceived benefits from an internship	91
5.5.6 Purpose of an internship	92
5.6 Evaluation of Internship	93
5.7 Recommendations for an Internship Programme	94
5.7.1 Perceptions of which skills should be acquired/enhanced in an internship	94
5.7.2 Favoured duration of an Internship programme	96
5.7.3 Evaluation of where respondents thought that the internship should be conducted	96
5.7.4 Perceptions around the focus of an internship	98
5.7.5 Remuneration	98
5.7.6 Affiliation of the Homoeopathic internship process	99

<b><u>CHAPTER SIX - CONCLUSION AND</u></b>	100
<b><u>RECOMMENDATIONS</u></b>	
6.1 Conclusion	100
6.2 Recommendations	101
6.2.1 Recommendations to the Representative Professional Bodies	101
6.2.2 Recommendations for future studies of a similar nature	102
6.2.3 Recommendations for future studies	103
<b><u>REFERENCES</u></b>	104
<b><u>APPENDICIES</u></b>	
APPENDIX A - Act 63 of 1982 section 19	109
APPENDIX B - Questionnaire	110
APPENDIX C - Practitioner Information Sheet	118
APPENDIX D – Thank you letter	120
APPENDIX E - List of member of Focus group	121
APPENDIX F - List of DUT Graduates	122
APPENDIX G - List of UJ Graduates	124
APPENDIX H - Map Of South Africa Showing Provinces	126

## **LIST OF FIGURES**

	<b><u>PAGE</u></b>
Figure 4.1 Chart showing percentage of breakdown of questionnaire returns	42
Figure 4.2 Chart showing gender proportions of the sample	43
Figure 4.3 Graph showing country of residence of respondents	44
Figure 4.4 Graph showing provincial residence of respondents	46
Figure 4.5 Graph showing calendar year in which respondents qualified	48
Figure 4.6 Graph showing proportion of respondents aware of the legislation	49
Figure 4.7 Graph showing source of awareness of legislation	50
Figure 4.8 Graph showing respondents perceptions of responsibility for internship program	52
Figure 4.9 Graph showing nature of internship undertaken as part of course	54
Figure 4.10 Graph showing location of internship undertaken	55
Figure 4.11 Graph showing length of time devoted to internship	56
Figure 4.12 Graph showing duration of Internship	57
Figure 4.13 Graph showing whether patients were seen on a one to one basis during the internship program	58
Figure 4.14 Graph showing specific areas of benefit derived from the internship	59
Figure 4.15 Graph showing respondents perceptions of which skills should be acquired/enhanced in an internship	60
Figure 4.16 Graph Showing Respondents perceptions of which skills should be acquired/enhanced in an internship against perceptions of improvements in skills from an internship	61
Figure 4.17 Graph showing where respondents thought that the internship should be conducted	63

Figure 4.18 Graph showing perceptions of what the internship should focus on	64
Figure 4.19 Graph showing remuneration options supported by respondents	65
Figure 4.20 Graph showing preferences of respondents for affiliation of the Homoeopathic internship process	66
Figure 4.21 Graph showing percentage of respondents who were previously aware of the legislation regarding the internship	68
Figure 4.22 Graph showing the percentage of respondents who undertook an internship according to a particular year of qualification	71

## **LIST OF TABLES**

	<b><u>PAGE</u></b>
Table 4.1 Table showing population size and responses received	42
Table 4.2 Gender distribution of respondents	43
Table 4.3 Country of residence of respondents residing in RSA	44
Table 4.4 Table showing provincial residence of respondents	45
Table 4.5 Table showing calendar year in which respondents qualified	47
Table 4.6 Table showing source of awareness of the legislation	60
Table 4.7 Table showing respondents perceptions of responsibility for internship programme	51
Table 4.8 Table outlining nature of internship undertaken as part of course	53
Table 4.9 Table showing location of internship undertaken	54
Table 4.10 Table showing length of time devoted to Internship	55
Table 4.11 Table showing duration of internship	56
Table 4.12. Table showing whether patients were seen on a one to one basis during the internship program	57
Table 4.13 Table showing whether the respondents were supervised	58
Table 4.14 Table showing respondents perceptions of which skills should be acquired/enhanced in an internship	60
Table 4.15 Table showing favoured duration of an internship	62
Table 4.16 Table showing where respondents thought that the internship should be conducted	62
Table 4.17 Table showing perceptions of what the internship should focus on	64
Table 4.18 Table showing remuneration options supported by respondents	65

Table 4.19 Table showing correlations between demographic and background variables and variables describing respondents knowledge of current legislation with respect to internship	68
Table 4.20 Table showing correlations between demographic and background variables and variables describing respondents' past experience of internship	70
Table 4.21 Table showing correlations between demographic and background variables and variables describing respondents' recommendations for internship	73
Table 4.22 Table showing correlations between variables describing knowledge of the current legislation with respect to internship and respondents' past experiences of internship	75
Table 4.23 Table showing correlations between variables describing knowledge of the current legislation with respect to internship and respondents' recommendations for internship	77
Table 4.24 Table showing correlations between variables describing past experience of internship and respondents' recommendations for internship	79

## **Definition of terms**

### Allied Health Professions Council of South Africa (AHPCSA):

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

### Graduate:

A holder of an academic degree. In this study refers to a Master's Degree in Technology:Homoeopathy from the Durban Institute of Technology (formerly Technikon Natal) or from the University of Johannesburg formerly Witwatersrand Technikon).

### HNPPB

Homoeopathic, Naturopathic and Phytotherapeutic Professional Board

### H.S.A

Homoeopathic Association of South Africa. The current body representing Homoeopaths and Homoeopathic students

### CASA

Chiropractic Association of South Africa.



# **CHAPTER ONE: INTRODUCTION**

## **1.1 Introduction**

Homoeopathic Education in South Africa began some 19 years ago when the then Technikon Natal established the first tertiary programme for educating Homoeopaths. Subsequently the institution has changed its name to Durban Institute of Technology (DIT) and then to the current Durban University of Technology (DUT). Similarly the Technikon Witwatersrand, now University of Johannesburg offered the same programme from 1993, which is a Master's Degree in Technology: Homoeopathy (M.Tech:Homoeopathy). This was designed to be five years of full time study and one year of practical internship. The DUT programme has produced 13 years of graduates. As far as can be ascertained no other studies regarding the delivery of a Homoeopathic internship for tertiary institutions have been conducted.

## **1.2 Aim of study**

The purpose of this retrospective survey was to determine the perceptions and opinions of M.Tech:Homoeopathy graduates around the current non-implementation of statutory internship, in order to inform and propose an appropriate and effective homoeopathic internship, as required by Act 63 of 1982 (as amended) (Appendix A).

### **1.3 Rationale for study**

Most medically related courses have a mandatory internship programme that has proved to be very beneficial and essential in the preparation of successful and competent graduates in the various fields. The Chiropractors, Homoeopaths and Allied Health Professions Act (Act 63 of 1982) as amended, legislates an internship as a precondition for registration as a homoeopathic practitioner. Currently this legislative imperative is not being implemented due to failure on the part of the relevant professional board to formulate an appropriate internship programme.

The Allied Health Professions Council of South Africa (AHPCSA) has the responsibility of implementing an internship programme, once one has been formulated by the Homoeopathic, Naturopathic and Phytotherapeutic Professional Board (HNPPB); this study aimed to aid in the planning and implementation of that programme by providing formal evidence on perceptions of the role and scope of a homoeopathic internship, as provided by graduates of the longest-standing provider of homoeopathic training in South Africa .

The M.Tech.Homoeopathy graduates of Technikon Natal/DIT/DUT and TWR/UJ are a heterogenous mixture of individuals, which span members who have completed various forms of internship prior to registration, to individuals who have completed no internship whatsoever. The impact of both extremes, and the shades in-between, have not been formally investigated, and it was anticipated that such an evaluation would shed light on the role of internship in terms of broader professional development and success.

The gathering of this data was aimed to assist the HNPPB in the development of regulations pertaining to the Homoeopathic internship.

#### **1.4 Benefits of study**

The study aimed to benefit the Homoeopathic profession in the following ways:

1. Provide the professional board (HNPPB) with a guideline regarding internship and as an aid to implement action of such a programme. As well as provide formal information on the subject by taking into account the past experiences of graduates.
2. Provide educators of Homoeopathy with a retrospective view on past internship and its benefits or lack thereof.
3. Provide information that will develop the profession as a whole.

#### **1.5 Limitations**

1. Only M.Tech:Homoeopathy graduates were included in this study.
2. Only persons that graduated between and including 1994 to 2006 were considered for the study.
3. Only correctly completed questionnaires were analysed.
4. Only graduates who could be contacted were given the opportunity to partake in the survey.

# **CHAPTER TWO: LITERATURE REVIEW**

## **2.1 Survey Methodologies**

### 2.1.1 Introduction

In order to collect data on phenomena that cannot be directly observed, a non-experimental, descriptive research method must be utilised. The best research method of achieving this is to conduct a survey. Surveys can be useful to ascertain opinions and are used extensively to assess attitudes and characteristics of a wide range of subjects.

### 2.1.2 Advantages and Disadvantages of Surveys and Questionnaires

The main advantages of surveys are:

1. They can be used to investigate problems in realistic settings,
2. Allow researchers to examine a large number of variables, which can be analysed with the help of multivariate statistics.
3. Data can be collected with less effort and expense than most other data gathering techniques, especially in the case of self-administered questionnaires.
4. Self-administered surveys are relatively inexpensive to conduct.
5. Self-administered surveys allow for anonymity (Mitchell and Jolley, 1992).

The main disadvantages are:

1. That independent variables cannot be manipulated as in experimental research.
2. Unfortunately, a low return rate is characteristic for self-administered questionnaires/surveys.
3. Should any errors or oversights occur they cannot be corrected, as the researcher and respondent do not interact.
4. Furthermore, the researcher will never know if the respondent is interpreting the questions correctly (Mitchell and Jolley, 1992).

### 2.1.3 Sampling

When one conducts a survey, the researcher/s must establish a sample population. Basha and Harter (1980) state that "a population is any set of persons or objects that possesses at least one common characteristic." In most instances a population size can be quite large, this being the case, the researcher/s can directly question only a sample, and therefore a smaller proportion of the population. In this study, it was deemed feasible to contact the entire population group (313 M.Tech:Homoeopathy graduates) as this number was small enough to be deemed contactable (Mitchell and Jolley, 1992).

When designing a survey the question design and sampling characteristics are factors that must be taken into consideration.

A sample is representative when it is an accurate proportional representation of the population under study. Statistically speaking, a sample can only be representative of the population included in the sample frame. Because the sample size was in fact the total population it was not necessary to establish a sample group (Fowler, 1993).

In broad terms questionnaires can be qualified by two main styles of questioning that can be adopted. Either qualitative which are open-ended questions, or quantitative utilising forced choice questions. Quantitative questioning generates absolute answers that are clearly defined and finite. Qualitative questioning style results in more descriptive answers and allows for opinions to be viewed. The questionnaire compiled in this study utilised both qualitative and quantitative styles of questioning (Fowler, 1993).

### 2.1.4 Types of Survey and Data

Descriptive survey: a descriptive research is a study that attempts to describe that which exists as accurately as possible. The purpose of a descriptive or observational survey is to count, descriptive surveys chiefly tell us what proportion of a population has a certain opinion or characteristic (Fink, 1995).

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

Qualitative survey: a qualitative research survey has an undefined scope and procedures are not strictly formalised, the approach is of a rather philosophical nature. Thus is characterised by open-ended questions requiring personal input and opinions (Mitchell and Jolley, 1992).

Quantitative survey: qualitative data collection is highly formalized, explicitly controlled, and has exactly defined range. Thus questions are of a precise nature (Mitchell and Jolley, 1992).

Cross-sectional surveys are used to gather information on a population at a single point in time. These are primarily used to determine prevalence.

Prevalence equals the number of cases in a population at a given point in time (Fink and Kosecoff, 1985).

Longitudinal surveys gather data over a period of time, after which the researcher/s may then analyse the changes in the population and attempt to describe and/or explain them (Fink and Kosecoff, 1985).

#### 2.1.5 Data collection

The method of data collection must be considered, either via a questionnaire or interviews. An important component of data collection is confidentiality. Issues around anonymity must always be treated with great care, including the storage and disposal of the data (Mitchell and Jolley, 1992).

#### 2.1.6 Questionnaire design

The following are factors and pointers to consider when designing a questionnaire:

Questions included must be understandable and as easy to answer as possible. Keeping questions short will ensure they are read, understood, and answered quickly. Double-barreled questions should always be avoided.

Questions should be relevant, insofar as possible questions with similar content must be placed together in the survey instrument. Negative and biased items should be steered clear of, as this will ensure questions are as impersonal as possible. It is also important to remember not to bias later responses by the wording used in earlier questions, as this could affect the responses. Another method to employ is whenever possible, to develop consistent response methods. As an ordinary rule, questions should be sequenced from the general to the specific. When employing closed questions, it is advisable to develop exhaustive and mutually exclusive response alternatives. It is important to define any unique and unusual terms with very clear definitions where needed. The format and layout of a questionnaire is a factor that can aid in conveying a professional image, therefore a good quality questionnaire using an attractive questionnaire format is worthwhile (Mitchell and Jolley, 1992, Fowler, 1993).

In this study, a self-administered anonymous questionnaire was designed in terms of these essential components of design, and sent to graduates. As a questionnaire of this nature has never been previously conducted specific to Homoeopathic internship evaluation, the questionnaire was compiled from a number of different sources. It was largely based on the questionnaire constructed by Babaletakis (2006) and Sweiden (2007). A focus group resembling the eventual sample population was conducted and opinions and perspectives of the focus group were utilised in the composition of the questionnaire.

#### 2.1.7 Review of questionnaire

One effective way of making sure that questions measure what they are supposed to measure is to test them out first, using a pilot study. A pilot study comprising of 'typical respondents' can be held once the questionnaire has been designed. The conclusions and corrections of which should be incorporated into the questionnaire before it is administered to the research population (Fink and Kosecoff, 1985).

### 2.1.8 Distribution of questionnaire

When administering a survey a professional approach must be taken at each step. Initially, one must provide the respondent with a cover letter or an information letter. Clear instructions should be given included must be the fact that participation is entirely voluntary. Thanking the participants is an essential part of the ethics that should be followed when conducting a questionnaire (Mitchell and Jolley, 1992).

There are many options available when considering delivery of self-administered questionnaires to the sample population, whichever method is chosen, it must be performed in a manner that guarantees confidentiality and anonymity. The options most accessible are posting, faxing and emailing. With technology advancing as it has, it has allowed for emailed surveys to become more popular and have prompter returns. A method for contacting subjects was devised based largely on previous research by Babaletakis (2006) and Sweidan (2007) was in which the method appeared to be successful.

### 2.1.9 Statistical analysis

After a reasonable time lapse, and once the questionnaires have been returned with a satisfactory response rate, the data must be analyzed and reported. Most often descriptive statistics (means, medians, modes, %, demographic data etc) will be used. Data must be averaged and relationships compared. A statistician is often required to review the statistics should the complexity of the questionnaire be out of scope of the researcher. Once the statistics have been completed, they must interpret and the findings discussed (Mitchell and Jolley, 1992).



## **2.2 Introduction**

An internship is an academic, curriculum-based practical work experience in a particular field of study that enhances student learning, and for which a student is enrolled (What is internship, 2006). A medical intern is a physician in training who has completed medical school and is undergoing first year of post-graduate training in a hospital under supervised training (Wikipedia, 2006). Supervision is viewed as the cornerstone of clinical skill development. Supportive and empathic supervision allows an intern to consolidate academic and clinical experiences and helps to form a professional identity based on the values of competence, ethics, and service to others (College of Health Professions – Psychology Internship, 2006).

The transition from undergraduate student to fully registered doctor is accomplished during the intern period. The overall aim of the intern year is to provide an educationally sound experience for the new doctor in terms of skills and attitudes together with personal development (Medical Council Postgraduate training, 2006).

## **2.3 Implementation of internship**

In implementing an internship programme the identification of clear objectives and activities are necessary. This will assist the student in identifying objectives that are consistent with the intention of such a programme. This is an imperative component of their training, and will affect the efficacy of the course and ultimately their capabilities (Internship programme, 2006).

A survey of current internship practices suggests a process in which, the 'Training Director' meets with each intern to review the intern's prior training and to mutually agree upon experiences that are necessary for the intern's transition from a graduate student to an independent clinician. This occurs early in the internship year. A written training plan is generated for each intern that addresses certain areas of competence. This training plan is reviewed every two months with the intern, with feedback based on input from

the intern's training supervisors (College of Health Professions - Psychology Internship, 2006).

On completion a final report which is evaluative in nature and which makes recommendations for future internships is written. The report typically consists of more than a diary of activities and intends to provide a thoughtful critique of the experience (Internship programme, 2006).

## **2.4 History of Homoeopathic internship in RSA**

The Department of Homoeopathy at Technikon Natal produced its first graduates in 1994. There was an understanding that the statutory council was responsible for internship for postgraduates. At the outset internship was conducted under preceptorship with preceptors consisting of registered Homoeopaths in private practice. The preceptorship system ran for two years after which it was abandoned due to evident inconsistency in delivery. The understood requirements for internship were relatively few and vague. In light of the above a proposal was put forward in 1996 that the internship be delivered onsite at the then Technikon Natal. It was felt that this would bring consistency, and graduates would have completed a defined academic programme as well as practical programme at the time of registration with the Allied Health Professions Council (AHPCSA) (Ross, 2005).

In 1997 an internship was held at Technikon Natal, funding of which was promised by council but never delivered. In light of the financial burden borne by Technikon Natal the institution was wary of offering similar internship in the future. It was proposed that the council seek alternative means of internship provision. One proposal offered by council was that students fund their own internship. Homoeopathic student representatives questioned the proposal and upon investigation discovered that there was no mention of internship made in the then Chiropractors, Homoeopaths and Allied Health Professions

Act. Effectively this made internship not legally enforceable. In consequence no internship programme was offered in 1999 and 2000 (Ross, 2005).

In 2001 despite internship not being a legally enforceable requirement, individual groups of students voluntarily undertook to create their own internship and utilised the Technikon Natal facilities for clinical training for a period of six months. A portion of the funds generated went to the institution a further portion was paid to external clinical supervisors and the remainder was dispersed to individual interns (Ross, 2005).

By the end of 2001 a new regulation to the act was passed: Section 19 of Act 63 of 1982 as amended by Chiropractors, Homoeopaths and Allied Health Service Professions Second Amendment Act 50 of 2000. This act included an internship requirement, (see Appendix A for copy of section 19.) Under these new regulations an internship officially became a legally enforceable requirement (Ross, 2005).

In terms of the new regulations an internship should span no more than twelve months and the specific structure and regulations thereof are the responsibility of the professional board. As yet such an internship has not been implemented (Ross, 2005).

## **2.5 Medical and dental internship in South Africa**

Medical and Dental internship requirements and legislation is governed by the Department of Health of South Africa in conjunction with the Health Professions Council of South Africa (HPCSA). The academic institutions have no responsibility regarding internship (Zulu, 2006).

The responsibility for maintaining standards of professional practice by determining the content of medical training rests, by law, with the Health Professions Council of South Africa (Zulu, 2006).

The HPCSA have the responsibility of accrediting facilities, and together with the Medical Students Representative Council of Junior Doctors (JUDASA)

allocate students to the respective hospitals. The procedure allows students to request certain hospitals and depending on positions available get allocated accordingly. The Department of Health strives to accommodate students as far as possible and in 2005 granted 83% of students their first choice of internship location (Mtshali, 2006). There is a quota system in place, which allows for a percentage of students from each of the medical universities to be granted placement at each of the accredited hospitals (Mtshali, 2006).

Funding for the internship is provided for by the state. The student interns are remunerated during their internship. They earn approximately R93 000 per annum (Mtshali, 2006).

As a result of ongoing assessment of existing internship arrangements, the HPCSA came to the conclusion that a single year was not producing the desired result. It was decided that it was in public's interest, to increase the period of internship to two years (HPCSA Education and Training, 2006).

The HPCSA compiled a logbook in order to assess and evaluate if interns are being exposed to procedures and disciplines that are necessary. This logbook enables interns to get the most out of their internship by evaluating the adequacy of their own internship training. It then makes the interns aware of the areas in which they are deficient. Secondly, the logbook is aimed at evaluating the hospital the interns are working at and seeing whether it provides an "ideal exposure". The third aim of the logbook is to evaluate interns (especially those who have received poor reports from their supervisors) and show the HPCSA which interns are avoiding exposure. Eventually it is expected that the logbook will be used to evaluate all interns, instead of using an exam after internship, as proposed by some (Department of Health, 2006).

The interns have a possible of 84 accredited facilities (hospitals) around the country where they can perform their internship. During the subscribed period, interns will rotate to different departments within the relevant hospital in order

that they will receive training in all the necessary fields. This may equate to a period of up to four months in one department. Supervision thereof is performed by the relevant qualified doctors, at the outlined hospital, in the specific department. The responsibility for skills/competencies acquired by the interns at an accredited facility is ultimately that of the Intern Curator. Requirements of which are regulated by HPCSA (Mtshali, 2006).

Clinical Psychologists are required to complete a year internship that can be performed in the public or private health sectors. The requirements of which are not governed by the Department of health (Zulu, 2006).

## **2.6 International internship evaluation**

The Accreditation Council for Graduate Medical Education (ACGME) are responsible for the residency accreditation in America. The organisation has mandated a shift from a structure- and process-based educational system to a competency-based system. They dictate that demonstrable competency in the following areas must be completed; patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. No other definitive outlines were established.

An evaluation process in which ACGME-competency-based promotion criteria for residents at the University of Kentucky College of Medicine, was created. Minimum criteria that residents must demonstrate at different levels, along with promotion criteria, the method of instruction and the setting for each criterion were identified. Tools were developed to assess the criteria, including a computer-based "same day preceptor evaluation", a resident portfolio, and multisource feedback instruments. This information was formatted into a matrix, making the task and criteria clearer to learners and allowed them to better demonstrate what is expected of them. Residency educators were then able to use these tools to identify those residents failing to meet the criteria and to improve faculty skills, especially in terms of how to train for and assess competence (Torbeck and Wrightson, 2004).

The Department of Family Medicine, Mayo Clinic, Scottsdale, Arizona has complied with the mandated shift to competency-based education. An evaluation system was implemented to demonstrate that graduates were competent in six key areas in order to establish a comprehensive, competency-based family medicine curriculum. All accredited residencies and fellowships must now be able to verify outcomes data, which must be used to improve each program. The system relied on both formative and summative feedback. In addition to multiple evaluation tools including video monitoring, rotation-specific evaluations, adviser-advisee meetings, faculty meetings, and checklist evaluations of procedures and physical examinations, residents received feedback from patients, faculty, nurses, transcriptionists, as well as from referring physicians. Components of the evaluation included inpatient and outpatient core competencies, a longitudinal didactic curriculum, a competency-based procedures curriculum, and use of medical evidence to improve individual patient care. This model aimed to provide a curricular template for other accredited residency programs (Edwards and Frey, 2007).

## **2.7 Previous relevant research**

A previous study by Babaletakis (2006) of the graduates from DUT revealed that 59.8% of DUT graduates had undertaken some form of internship. Of these, 45.28% conducted their internship at the DUT clinic and 71.7% of internships were between 6 and 12 months in duration. What was most significant was that the respondents who had remained in practice had the highest relative percentage of internships undertaken (67.24%). In the same study conducted on UJ graduates, Sweiden (2007) confirms these findings. The respondents who undertook internships (44.2%) had the highest relative percentage of remaining in practice. The majority of the internships undertaken were in private practice (34.62%) and extended on average between 7 and 12 months. Those that did not complete an internship expressed that their confidence and clinical skills were lacking. Sweiden commented that extended clinical practice in the form of internship appeared to be a large factor in whether graduates ever ventured into practice, but may

only be one of many possible factors as to whether practitioners stayed in practice. This is reinforced by Babaletakis (2006) who discovered that relatively fewer of the respondents who never practiced undertook internships (22.22%). Taking cogniscence of information supplied it could be argued that had this group partaken in an internship programme they may have had more confidence to practice. Babaletakis also proposed that an internship may have also afforded graduates the time and experience allowing them to mature and thus be able to handle the demands of Homoeopathic practice.

A national survey of Canadian dermatology residents was conducted, entitled the 'National appraisal of dermatology residency training', it aimed to provide the first comprehensive assessment of dermatology residency training in Canada. The study was based on the residents' perspective in an attempt to examine and elucidate trends in current residents' envisioned career paths and aspirations [Frieman *et al.*, 2005].

This study provided a current picture of dermatology postgraduate education in Canada from the residents' perspective. A conclusion of the study was that the dermatology residents desired more teaching (namely clinic, didactic, and practice management) and mentorship from their faculty. The data gained was intended to assist dermatology programs with development, evaluation, and improvement of their curricula and could serve as a reference point to gauge future trends [Frieman *et al.*, 2005].

A dissertation from the Journal of the American Dietetic Association describes a similar study to the one conducted in this research dissertation. A questionnaire was developed to survey graduates of the Oregon Health Sciences University (OHSU)/Department of Veterans Affairs (VAMC) Dietetic Internship program. Graduated interns from the past 6 years (1989–1994) and their first employers were surveyed in order to evaluate the preparation of graduates for entry-level dietetic practice. The questionnaire used adjectival descriptors of performance (i.e. superior, strong, average, and weak) to ascertain whether performance requirements and the program outcome goals

were achieved by the graduates (According to the American Dietetic Association).

Additional general and demographic information was requested from the graduates when being surveyed, and permission to contact employers was requested. Permission to survey first employers was granted by 52% of the graduates and the employer response rate was 88%. Significant differences ( $P < 0.05$ ) between entry level and beyond entry level graduate responses were found in ability to accurately complete nutrition assessment and ability to work independently and as a team member. This infers that the internship programme undertaken proved beneficial to those that participated. The study found that employees consistently rated graduates at the same or higher level than graduates rated themselves and concluded that overall ratings showed that the graduates rated themselves with a strong level of competence in the performance requirements and outcome goals (Kraft, 2003).

## **2.8 Problems formulating an internship**

To begin with, the relevant body responsible for the development and implementation of a Homoeopathic internship programme must be identified. That body, being the AHPCSA, working through the department of Health, should therefore enforce Section 19 of Act 63 of 1982, which states internship as a registration requirement. However, that being said, the Homoeopathic Association of South Africa (HSA) and the two academic institutions (DUT and UJ) having no legal obligations, are not prevented from recommending or assisting the AHPCSA in their planning and executing of an internship.

Legally the responsibility of the internship is delegated by the AHPCSA to the professional board, which to date has not produced an internship, and therefore may need assistance in doing so. The HSA who represents the Homoeopathic profession (registered Homoeopaths and students of Homoeopathy), has subsequently engaged more actively with the issue of internship, in the interests of providing educationally sound experience and clinical skill development for future Homoeopaths.



The AHPCSA would have to state the exact specifications of the internship programme, as recommended by the professional board. There are many opinions as to what those specifications should be. Current academic material and literature as well as opinions from qualified practitioners and other medical internship programmes should be evaluated and considered during this formulation period. This survey aims to provide formal evidence and answers to many questions concerning an internship programme. Once a clear theoretical outline has been drawn, the AHPCSA would have to address the issue of funding. Yet another obstacle would be to source and accredit facilities where this internship could occur. Furthermore they must ensure maintenance of a nation wide standard. Student allocation and professional supervision would need to be carried out as well as constant evaluation of the programme and of the interns.

## **2.9 Other internships governed by the AHPCSA**

Chiropractors fall within the AHPCSA ambit, and therefore are governed by the Chiropractors, Homoeopaths and Allied Health Professions Act 63 of 1982. Since 2001 Chiropractic interns were required to complete an internship portfolio designed by the Chiropractic National Internship Committee and approved by the AHPCSA as a precondition for registration. Before 2001 and the introduction of the internship portfolio, students spent a further sixth year in the academic institutions' clinic. They treated patients on a one to one basis while being supervised by clinicians. There were no set requirements one had to attain; any patients seen were over and above the institutional regulations that had to be met in fifth year (Korporal, 2007).

The composition of the internship portfolio must include certified copies of academic and work experience verification. The portfolio has no time constraints other than it may begin to be assembled and collected over a period of no more than two years from the date of submission. The Interns require a total of 480 hours, which can be divided amongst various components falling under the heading of academic and work experience. An

example of which is the provincial hospital in Kimberly, and the Chiropractic clinic at DUT. Sports events, research (excluding Master's dissertation), community service, lectures, courses and conferences are other examples. The AHPCSA awards no funding towards this, and the responsibility rests with the interns (Korporal, 2007).

The difficulty experienced in this method of internship is the way in which the students graduate, which is as individuals and not in classes. Therefore there is no finite group of graduates that one can assign ward rounds to, which results in the internship site not being able to be run solely by interns due to the lack of guaranteed full time 'staff'. This is understandable as the number of circulating interns could pose ethical issues for patients at that internship site in terms of patient accessibility to health care (Korporal, 2007).

A problem perceived by the interns is that the internship is not structured to be a programme that is delivered. The interns must take initiative to structure and schedule their internship. Students have come from a very structured clinic and the internship programme aims to bridge the gap between this and the 'lack of structure' that exists in private practice. Students therefore, having to use their own initiative dictate the nature of their internship, will use this same initiative to source patients and CPD (continuing professional development) points yearly once registered. Once registered, each Chiropractor must accumulate 30 CPD points per annum. The allocation of CPD points or an activity number is issued by the CPD at the Witwatersrand health consortium (Korporal, 2007).

## **2.10 Role of the graduate**

Within the context of internship it is typical that prospective interns register with the relevant body and indicate where they would prefer to perform their internship. Having been allocated their internship site they are required to complete all necessary requirements. Evaluation of skills and training are conducted at regular intervals.

### **2.11 Towards formulation of Homoeopathic internship**

At the time of the study there were 650 registered Homoeopaths in South Africa. Of which 295 have graduated from the M.Tech:Homoeopathy programmes. At this stage it is unknown how many have completed any form of post-qualification clinical supervision, their perception of legislation around internship, or their understanding of the nature and legal responsibility for internship. The impact of completing, or not completing an internship on professional development and success is also unknown.

## **CHAPTER THREE: METHODOLOGY**

### **3.1 Study type design**

The study took the form of a cross-sectional descriptive (observational) survey. In most cross sectional surveys the study population is representative of the group being studied (Fink, 1995). However, in the case of this research project since the group is small enough for all members to be included in the study, the questionnaire was sent to all DUT and UJ M.Tech:Homoeopathy graduates. The survey was conducted by means of a self-administered anonymous questionnaire (see Appendix B).

### **3.2 Research participants**

#### **3.2.1 Inclusion Criteria**

Participants were all graduates of Durban University of Technology, (DUT) Homoeopathic Department, formerly Durban Institute of Technology, (DIT) and Technikon Natal, from the first year of graduates of the course i.e. 1994 to graduates of 2006 and all graduates of University of Johannesburg (UJ) (formerly Technikon Witwatersrand) from 1998 up to and including graduates of 2006. The AHPCSA sent a register containing the names and contact details of all registered Homoeopaths in South Africa. The inclusion criteria were: participants must be graduates of the M.Tech:Hom programme (offered by UJ/DUT) (Participants did not have to be currently practising).

#### **3.2.2 Recruitment**

In order to contact graduates, a list of all the graduates and their contact details was obtained from the DUT and UJ Faculty of Health Officers, the

AHPCSA and the HSA. All graduates were initially contacted by telephone, to introduce them to the researcher and the proposed research study was obtained. Their contact details were confirmed, as well as an initial verbal agreement as to their willingness to participate in the study. If a graduate was uncontactable using the information provided by the above mentioned sources, the researcher attempted to locate them through the following other pathways: contacting parents and family of the graduate, and asking other graduates and previous class mates for the relevant information.

If after these efforts the graduate could still not be located, they were deemed uncontactable and were not considered for this study.

### **3.3 Design of research instrument**

The questionnaire was compiled by the researcher (Appendix B) it aimed to investigate all aspects of internship as it pertains to Homoeopathy. It consisted of four parts, all of which could potentially be answered by one participant. Part A related to demographic data, Part B related to current legislation concerning internship as stated by the Allied Health Professions Act and Part D, relates to recommendations for an internship programme. All participants could complete parts A, B and D. Part C related to past internship and applied to graduates that received some form of internship training and was completed if applicable.

#### 3.3.1 Pre-testing of questionnaire

##### 3.3.1.1 Statistical Assessment of Questionnaire

Once the questionnaire had been compiled it was sent to a statistician for review. This was to determine whether the way in which the questions were asked and possible answers answered was done optimally for easy and applicable statistical analysis. The statistician's comments were taken into consideration and the researcher made the appropriate changes.

### 3.3.1.2 Focus Group

A focus group was conducted to assess the face validity of the questionnaire, as this questionnaire was constructed by the researcher, and had not been used before.

The following points were considered:

- Did the questionnaire provide the needed information?
- Were certain questions redundant or misleading?
- Were the questions appropriate for the people who will be surveyed?
- Was the data gained statistically viable?
- Were the procedures standardized?
- How consistent was the information obtained by the survey?
- How accurate was the information obtained by the survey?

(Adaptation from Fink and Kosekoff, 1985 on purpose of a pilot study)

The questionnaire was distributed to eight individuals for their comments and input on clarity, understandability and possible ambiguity of the questions. They were also asked for suggestions for improvements to the document.

The group of eight people consisted of:

Six members of permanent DUT Homoeopathic Department academic staff, and two sixth year Homoeopathy students (Appendix E).

This group was selected because of the similarity to the respondents who would eventually complete the survey as regards education level and age. (Fink and Kosekoff, 1985).

Once this group had made the assessment, the questionnaire was reviewed

for corrections and updated. This however created an exclusion criterion in that the six members of permanent staff and two students that had already participated in the focus group could not take part in the survey.

### **3.4 Data Collection**

#### 3.4.1 Mode of Receiving Questionnaire:

Once participants were contacted, they were asked how they would like to receive the questionnaire, they were given the following options: via e-mail, post, or fax. They were also asked to confirm via which method they would prefer to return the completed questionnaire.

#### 3.4.2 Mode of Response to the Questionnaire:

All replies were addressed to the DUT Librarian, Ms Anitha Shah, who was the independent third party. The research supervisor elected her, as she is not a homoeopath nor directly involved in a health care profession. All posted questionnaires were supplied with a return self-addressed (stamped) envelope and responses were sent directly to the independent third party. E-mail responses were sent to the third party by means of a website which automatically forwarded the emailed response to her email address. In the case of faxes these were addressed to the same third party. The purpose of the third party was to infer anonymity as once she had received the response, she deleted the name of the respondent (question 1.1) and assigned the completed questionnaire a number, for statistical purposes. E-mail addresses were printed and then deleted.

The researcher allowed for a two week time lapse before re-contacting participants, (in the case of posted questionnaires) for a response. After this time the researcher approached the third party to ascertain which participants had not responded. Those participants were then contacted again by telephone to confirm the receipt of the questionnaire and as a reminder to

complete and return the document. In the case of emailed questionnaires, the email was resent after the two week time lapse, after having ascertained who had not replied. A further two weeks was allowed for the return of questionnaires, after which time the participants were contacted by telephone as a reminder to complete the document. A further four weeks were allowed for the return of the questionnaires (posted, faxed and emailed), as this was over the Christmas/holiday period. All non-responding participants were contacted telephonically again to ascertain if they were still in the possession of the questionnaire, if not a new one was sent via the relevant means. After further two weeks was allowed for the return of the questionnaires, after which time the non-complying candidates were considered as “drop outs” from the study. The researcher then considered the data collection complete and proceeded with data analysis.

All questionnaires were accompanied with an information letter (see Appendix C) with the researcher’s contact details should difficulties or questions have arisen. A letter of thanks was also sent out for every questionnaire returned (see Appendix D).

### **3.5 Data storage**

All the answered questionnaires were anonymous documents. Once the names had been deleted from the questionnaires by the third party, they were stored in a locked filing cabinet in the custody of the researcher. Only the researcher and the research supervisor had had access to the anonymous files. In the case of e-mail replies, the e-mail was printed and then deleted, with no traceable address or name appearing on the printed copy. The hard copy was then stored in the locked filing cabinet. All responses were sent to and received by the same independent person at the DUT Library as mentioned above.



### **3.6 Bad or non-responses**

#### 3.6.1 Role of the Information Letter

In trying to ensure compliance of participants, it was imperative to thoroughly inform graduates of the proposed research and to emphasize the importance of the information. Much care was taken in the presentation of the questionnaire to avoid the notion that the survey was simply a “marketing” ploy or that the information would be used against the respondent. A careful explanation of the intention of the study was laid out in the information letter, which each potential participant received. The information letter also clearly explained the measures, which were taken to ensure the confidentiality of the responses, to avoid responses that may have been given because they sounded proper, rather than truthful.

#### 3.6.2 Time Constraints of Participants

Another serious concern was that, due to the nature of the sample group, participants might be reluctant to spend their valuable time on completing the questionnaire. The questionnaire was limited to only the essential questions revolving around pertinent areas, which were identified by the researcher and confirmed by the focus group. The questionnaire was structured so that there were questions, which required writing of details. Open-ended questions in the form of “Additional comments” were left until last so that participants could add any further information that they felt had been omitted earlier in their answers. Each potential participant was also informed of the estimated time taken to complete the questionnaire, which according to the focus group was approximately 10 minutes.

### 3.6.3 Convenient Methods of Response

To encourage participation in the study, it was important to make the methods by which participants could respond as flexible and convenient as possible. Hence, each participant was offered 3 methods by which they could respond and could do so according to whichever method best suited him/her.

### **3.7 Data analysis**

Fifty percent response of the graduates was considered as a minimum for the results to be valid. Raw data was entered into a computer using the SPSS version 14.0 for Windows statistical package. The responses were analysed statistically using descriptive statistics, frequency tables and The Phi Co-efficient and Kendall's Rank Correlation Co-efficient to determine whether there was any significant association between the factors collected in the responses.

### **3.8 Flow chart of processes**

Questionnaire was drawn up and statistician analysis of questionnaire



Focus group was done on questionnaire



Adjustments were made to questionnaire

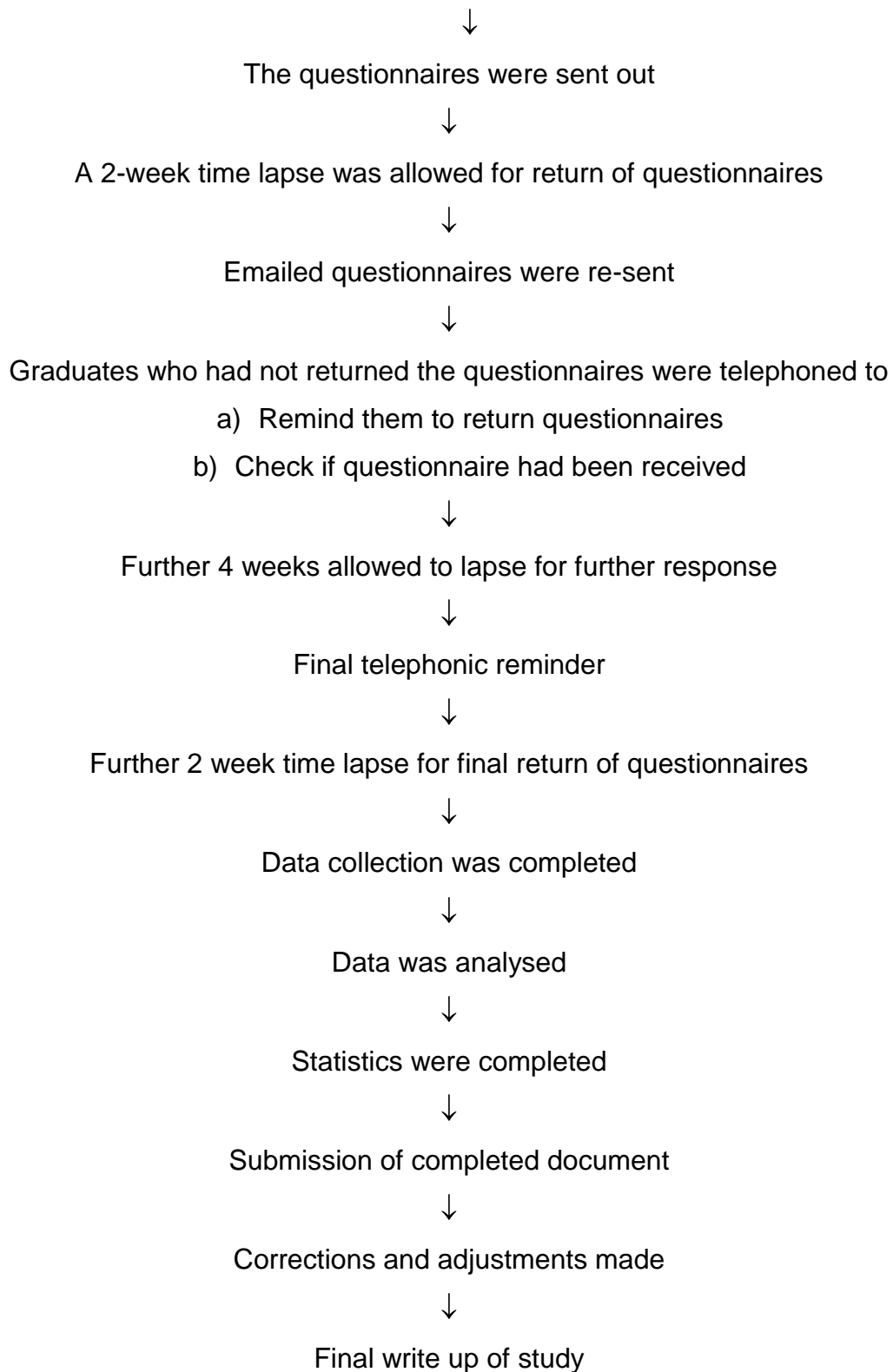


List of graduates obtained and contact details sourced



Graduates were contacted telephonically or by email to confirm:

- a) Their willingness to participate in the study
- b) The method by which they would like to receive the questionnaire



# **CHAPTER FOUR: RESULTS**

## **4.1 Introduction**

Following the methodology described in Chapter 3, the study produced raw data in the form of completed questionnaires. Respondents completed sections A, B, C and D while individuals who did not meet the criteria returned the questionnaire uncompleted or were excluded.

The specific objectives of the analysis were as follows:

- (1) To describe the demographic characteristics of respondents (qualified graduates from either academic institution (DUT or UJ)).
- (2) To describe the current state of awareness regarding the internship issue among the respondents.
- (3) To describe the variety of internship options accessed by respondents.
- (4) To describe the respondents' recommendations for the internship program.
- (5) To determine any statistically significant correlations between demographic variables and variables describing the past internship structures chosen by the respondents, or knowledge of current legislation and recommendations for the internship program.

The analysis of the data was done using SPSS® 14.0 for Windows™ and Excel® XP™.

## **4.2 Overview of results chapter**

### 4.2.1 Descriptive data

#### 4.2.1.1 Demographics

These comprised distribution tables and graphics for the demographic data (Gender, Age Category and Location Details).

#### 4.2.1.2 Level of understanding of current legislation

These comprised summary and descriptive tables and graphs for the respondents' level of understanding of the current legislation as reflected by the responses to Section B of the questionnaire.

#### 4.2.1.3 Past internship options accessed

These comprised summary and descriptive data for the past internship options accessed by the respondents. These were reflected in Section C of the questionnaires.

#### 4.2.1.4 Recommendations for the internship program

These comprised summary and descriptive data for the respondents' recommendations for the internship program as reflected by the answers to Section D of the questionnaires.

### 4.2.2 Analysis

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

### 4.2.3 Comments

This comprised a description of the comments made by respondents. Further discussion of these in light of the above statistical analysis follows in Sections 5.5.5 and 5.5.6.

### **4.3 Abbreviations**

Respondent = individual satisfying inclusion criteria who completed the questionnaire

$H_0$  = null hypothesis

$H_1$  = alternative hypothesis

S.D. = Standard deviation

z = Standardised z value for statistical measurements

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

N.S. = No statistically significant difference

S = Statistically significant difference

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

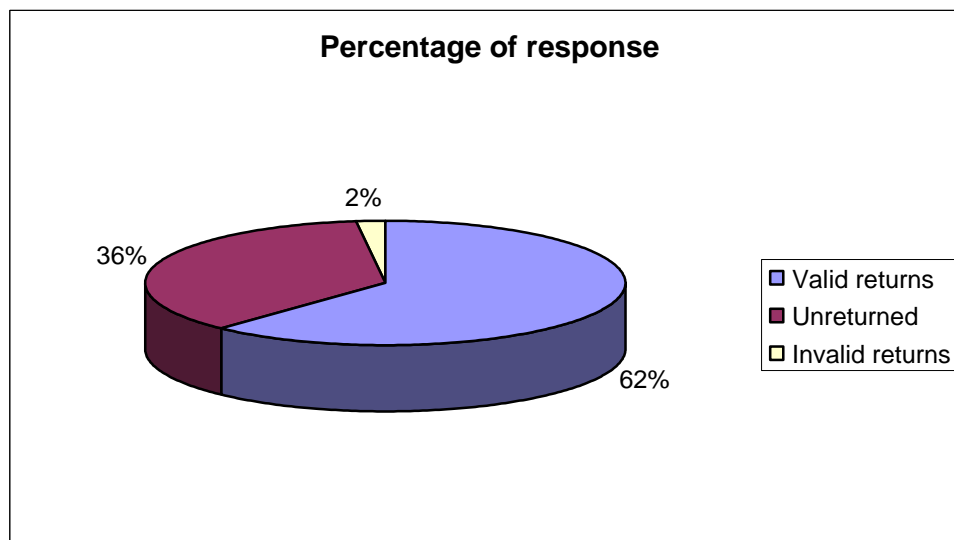
If  $p > 0.05$  then no significant difference was concluded (5% level of significance)

#### 4.4 Sample characteristics

**Table 4.1 Table showing population size and responses received**

	Number of responses	Percentage of responses
<b>Total Graduates</b>	313	
<b>less: Focus group</b>	7	
<b>less: other</b>	2	
<b>Net sample size</b>	304	
<b>Uncontactable graduates</b>	82	26.9
<b>Contacted graduates</b>	222	73
<b>Responses</b>	147	66
<b>Viable responses</b>	137	61.7
<b>Incomplete questionnaires</b>	5	2.25
<b>Refusals</b>	5	2.25
<b>Unreturned questionnaires</b>	75	33.78

**Figure 4.1 Chart showing percentage of breakdown of questionnaire returns**



## **4.5 Descriptive statistics**

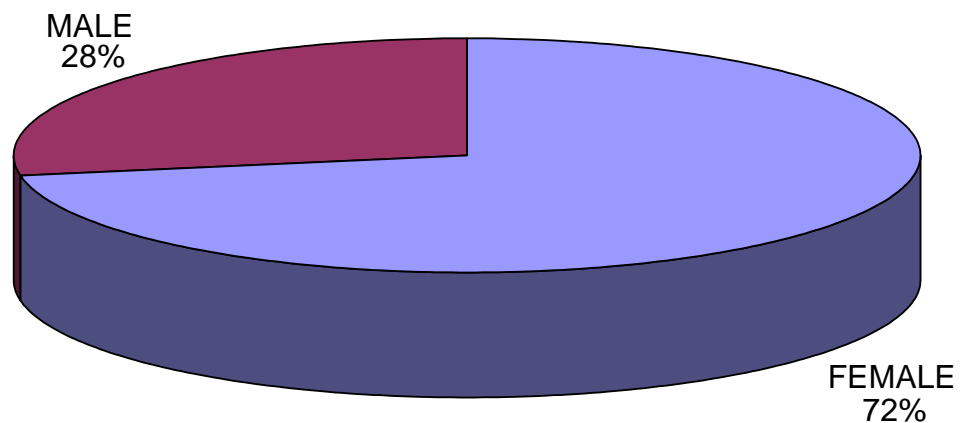
### **4.5.1 Demographics**

In terms of Objective one described in the Introduction, the distributions of the demographic variables are described.

**Table 4.2 Gender distribution of respondents**

Gender	Number of respondents	Percentage of respondents
<b>Male</b>	<b>38</b>	<b>28</b>
<b>Female</b>	<b>99</b>	<b>72</b>

**Figure 4.2 Chart showing gender proportions of the sample**



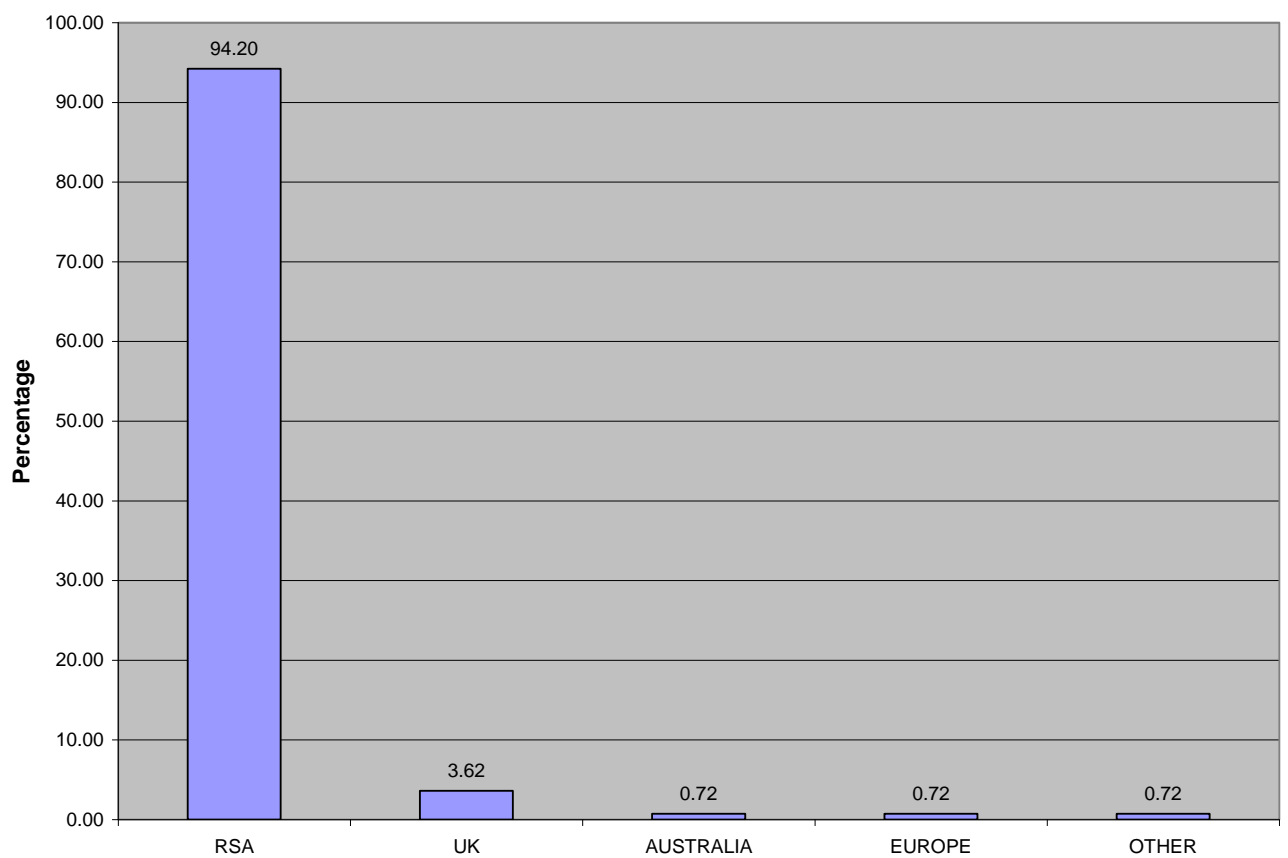
The preponderance of Female respondents is in accordance with impressions of the general population of Homoeopathic practitioners. This is also supported by Babeletakis (2006) and Maidens (Work in progress).



**Table 4.3 Country of residence of respondents residing in RSA**

Country	Number of respondents	Percentage of respondents
<b>RSA</b>	<b>129</b>	<b>94.20</b>
<b>UK</b>	<b>5</b>	<b>3.62</b>
<b>Australia</b>	<b>1</b>	<b>0.72</b>
<b>Europe</b>	<b>1</b>	<b>0.72</b>
<b>Other</b>	<b>1</b>	<b>0.72</b>

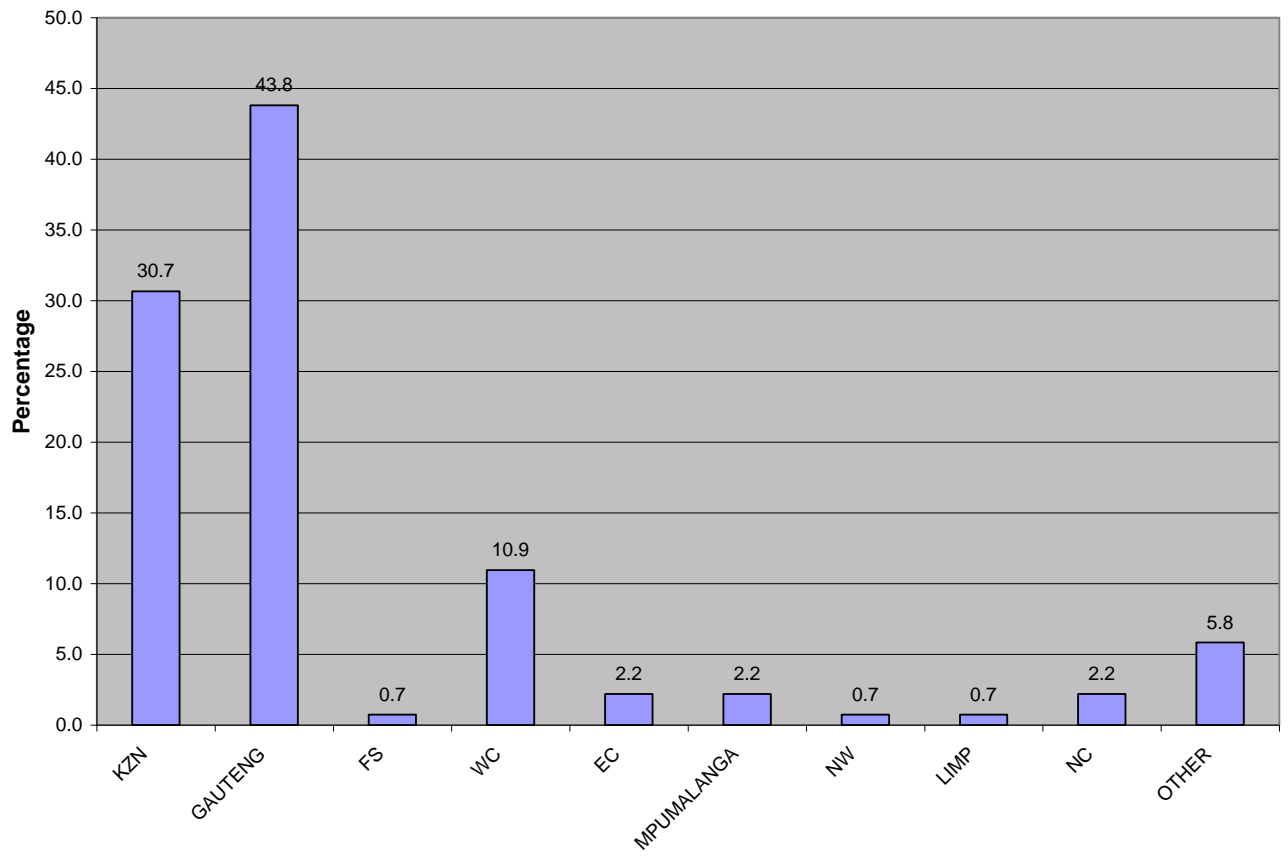
**Figure 4.3 Graph showing country of residence of respondents**



**Table 4.4 Table showing provincial residence of respondents**

Province of residence	Number of respondents	Percentage of respondents
<b>KZN</b>	<b>42</b>	<b>30.7</b>
<b>Gauteng</b>	<b>60</b>	<b>43.8</b>
<b>Free State</b>	<b>1</b>	<b>0.7</b>
<b>Western Cape</b>	<b>15</b>	<b>10.9</b>
<b>Eastern Cape</b>	<b>3</b>	<b>2.2</b>
<b>Mpumalanga</b>	<b>3</b>	<b>2.2</b>
<b>North West</b>	<b>1</b>	<b>0.7</b>
<b>Limpopo</b>	<b>1</b>	<b>0.7</b>
<b>Northern Cape</b>	<b>3</b>	<b>2.2</b>
<b>Other</b>	<b>8</b>	<b>5.8</b>

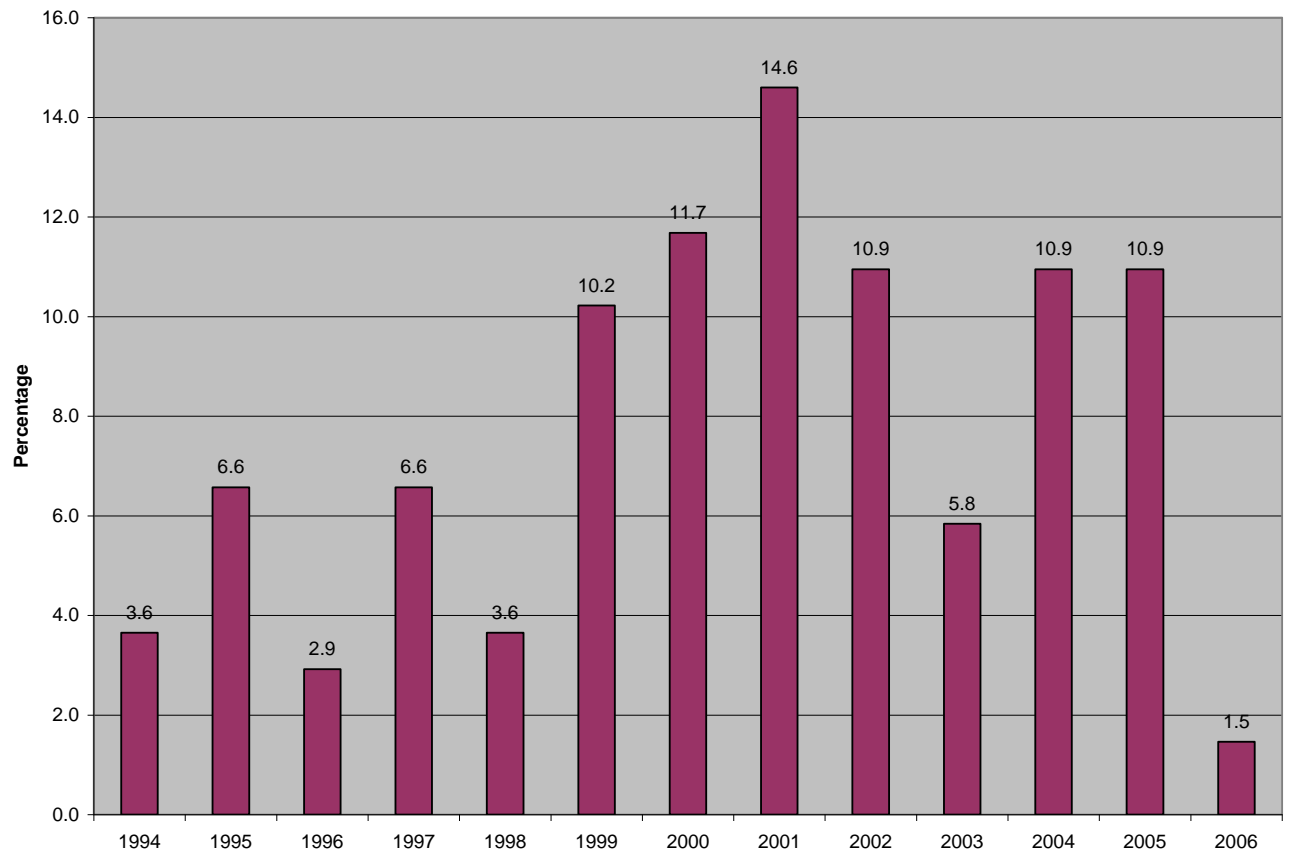
**Figure 4.4 Graph showing provincial residence of respondents**



**Table 4.5 Table showing calendar year in which respondents qualified**

Calendar year	Number of respondents	Percentage of respondents
<b>1994</b>	<b>5</b>	<b>3.6</b>
<b>1995</b>	<b>9</b>	<b>6.6</b>
<b>1996</b>	<b>4</b>	<b>2.9</b>
<b>1997</b>	<b>9</b>	<b>6.6</b>
<b>1998</b>	<b>5</b>	<b>3.6</b>
<b>1999</b>	<b>14</b>	<b>10.2</b>
<b>2000</b>	<b>16</b>	<b>11.7</b>
<b>2001</b>	<b>20</b>	<b>14.6</b>
<b>2002</b>	<b>15</b>	<b>10.9</b>
<b>2003</b>	<b>8</b>	<b>5.8</b>
<b>2004</b>	<b>15</b>	<b>10.9</b>
<b>2005</b>	<b>15</b>	<b>10.9</b>
<b>2006</b>	<b>2</b>	<b>1.5</b>

**Figure 4.5 Graph showing calendar year in which respondents qualified**

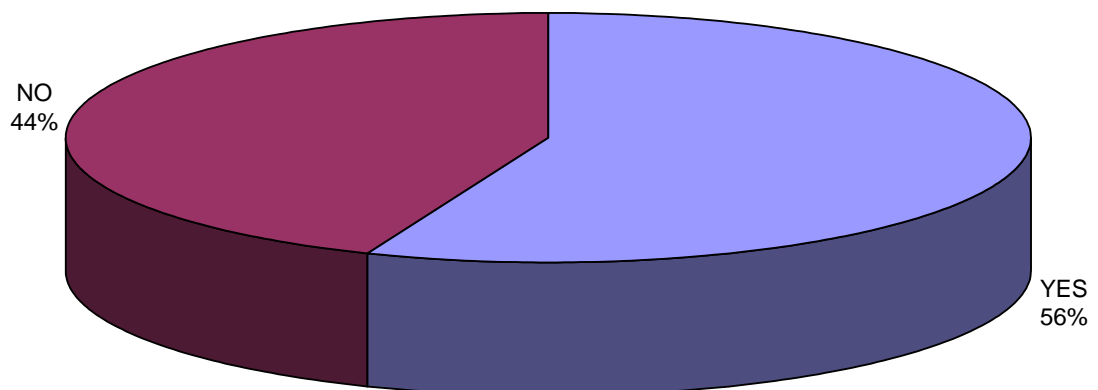


#### 4.5.2 Knowledge of current legislation

These comprised the data derived from responses to questions in Section B.

The majority (78) of the respondents were aware of the law (Act 63 of 1982 section 19 2b), however a significant number (61) were not. A possible reason for this is that 33.7% of the respondents qualified before 1999. They may not have been aware of the law and once qualified did not keep up to date with legislation.

**Figure 4.6 Graph showing proportion of respondents aware of the legislation**

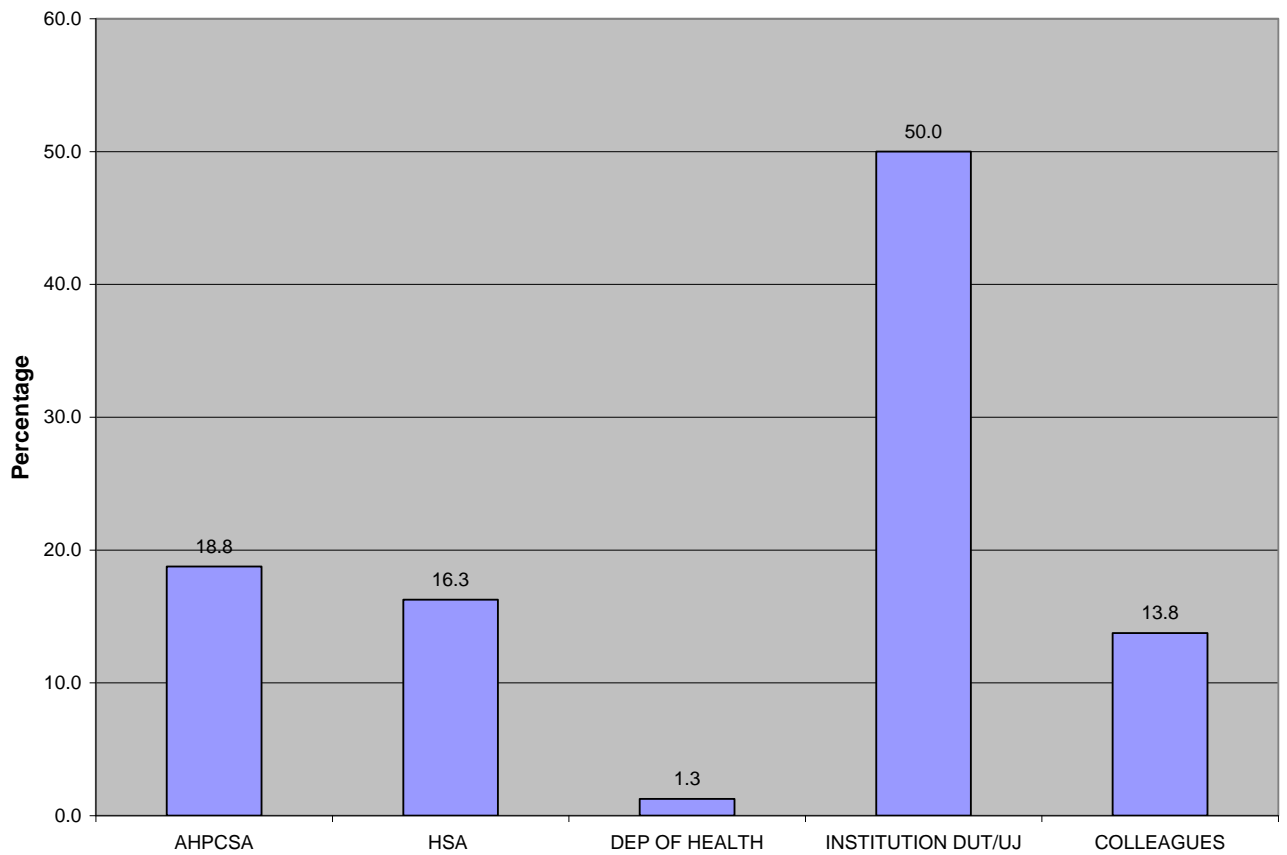


51.8% of the respondents were aware of the law prior to completing the questionnaire. It is evident that the rest of the respondents (5% or 6 respondents) were informed of the law by the questionnaire. The 72 respondents who were aware of the law had become aware of it through various channels. These are detailed in table 4.6 below.

**Table 4.6 Table showing source of awareness of the legislation**

Source of knowledge	Number of responses	Percentage of responses
<b>AHPCSA</b>	<b>15</b>	<b>18.8</b>
<b>HSA</b>	<b>13</b>	<b>16.3</b>
<b>Department of Health</b>	<b>1</b>	<b>1.3</b>
<b>Institution DUT/UJ</b>	<b>40</b>	<b>50.0</b>
<b>Colleagues</b>	<b>11</b>	<b>13.8</b>

**Figure 4.7 Graph showing source of awareness of legislation**



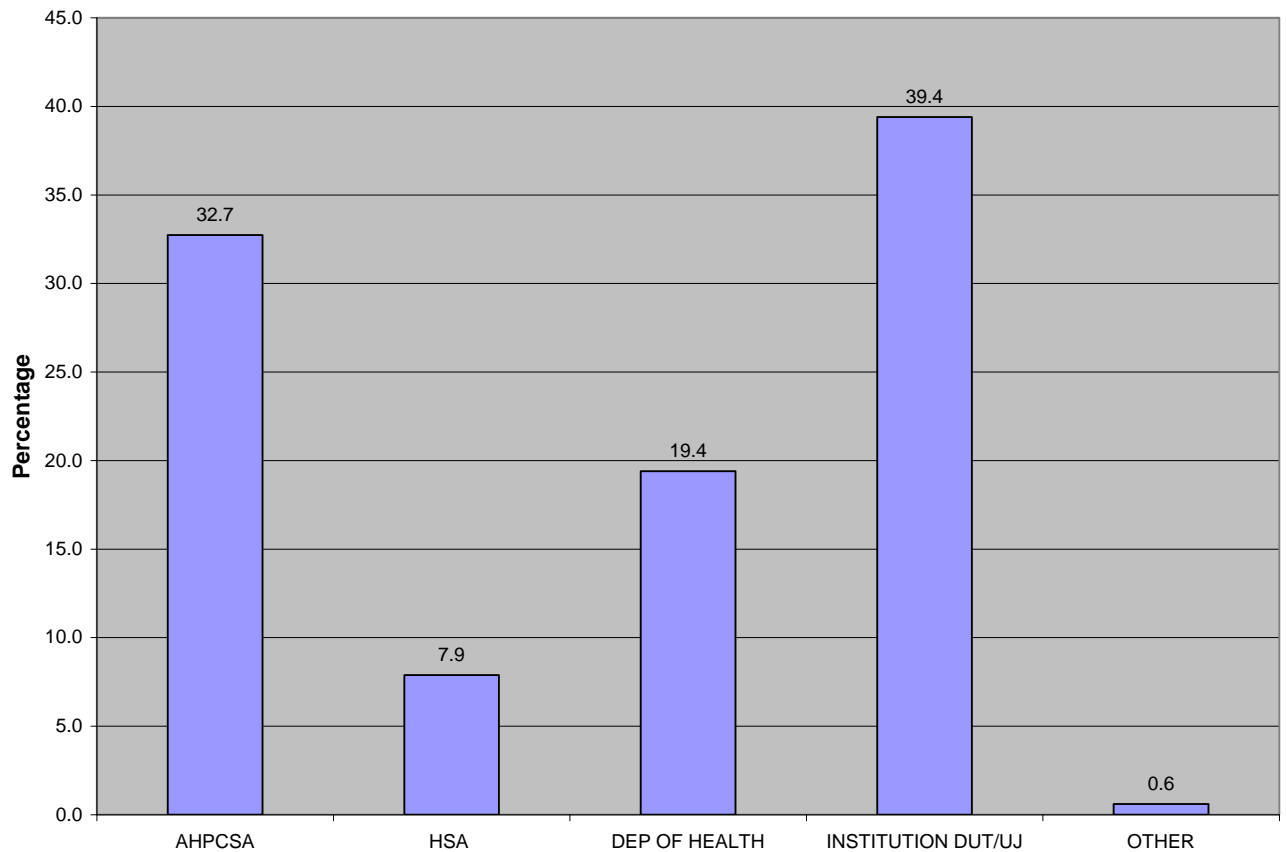
A significant proportion (50%) of the respondents were made aware of the legislation through the institution they belonged to. This may be due to poor communication strategy on the part of the AHSPCA or the HSA. 13.8% of respondents were made aware of the law through colleagues. This is essentially word of mouth transference, thus a relatively informal information channel provided quite significant awareness.

Table 4.7 Table showing respondents' perceptions of responsibility for internship programme

Responsible for internship	Number of respondents	Percentage of respondents
<b>AHPCSA</b>	<b>54</b>	<b>32.7</b>
<b>HSA</b>	<b>13</b>	<b>7.9</b>
<b>Department Of Health</b>	<b>32</b>	<b>19.4</b>
<b>Institution DUT/UJ</b>	<b>65</b>	<b>39.4</b>
<b>Other</b>	<b>1</b>	<b>0.6</b>



**Figure 4.8 Graph showing respondents perceptions of responsibility for internship programme**



The above graph reflects that most of the responses reflect the view that the responsibility for the internship lies with the educational institutions. 39.4% of the responses indicate this, while 32.7% reflect the view that the responsibility lies with the AHPCSA. This is discussed in Section 5.4.2

#### 4.5.3 Past internship structures accessed

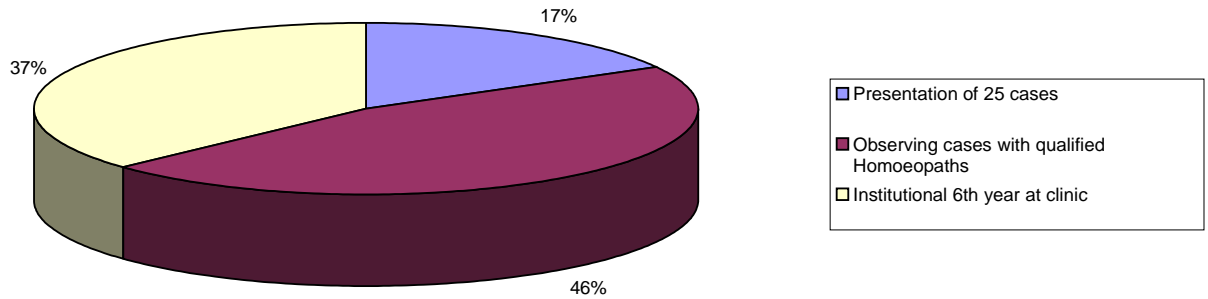
These comprised data reflected in the answers to Section C of the questionnaire.

The majority (74) of respondents had an internship program included in their training course. This represents 53.2% of the respondents, 46.2% did not have an internship program included in their course.

**Table 4.8 Table outlining nature of internship undertaken as part of course**

Nature of internship	Number of responses	Percentage of responses
<b>Presentation of 25 cases</b>	<b>16</b>	<b>16.8</b>
<b>Observing cases– qualified Homoeopaths</b>	<b>44</b>	<b>46.3</b>
<b>Institutional 6th year at clinic</b>	<b>35</b>	<b>36.8</b>

**Figure 4.9 Graph showing nature of internship undertaken as part of course**

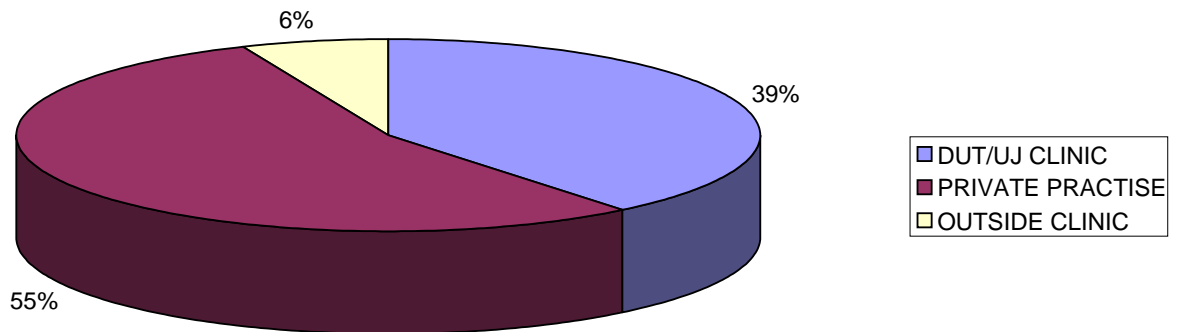


The majority (46%) of the responses indicate that the internship took the form of observing cases with qualified Homoeopaths. This is the least formal of the internship forms that were reported. This is discussed further in Section 5.5.1.

**Table 4.9 Table showing location of internship undertaken**

Location of Internship	Number of responses	Percentage of responses
<b>DUT/UJ Clinic</b>	<b>31</b>	<b>39.2</b>
<b>Private practise</b>	<b>43</b>	<b>54.4</b>
<b>Outside clinic</b>	<b>5</b>	<b>6.3</b>

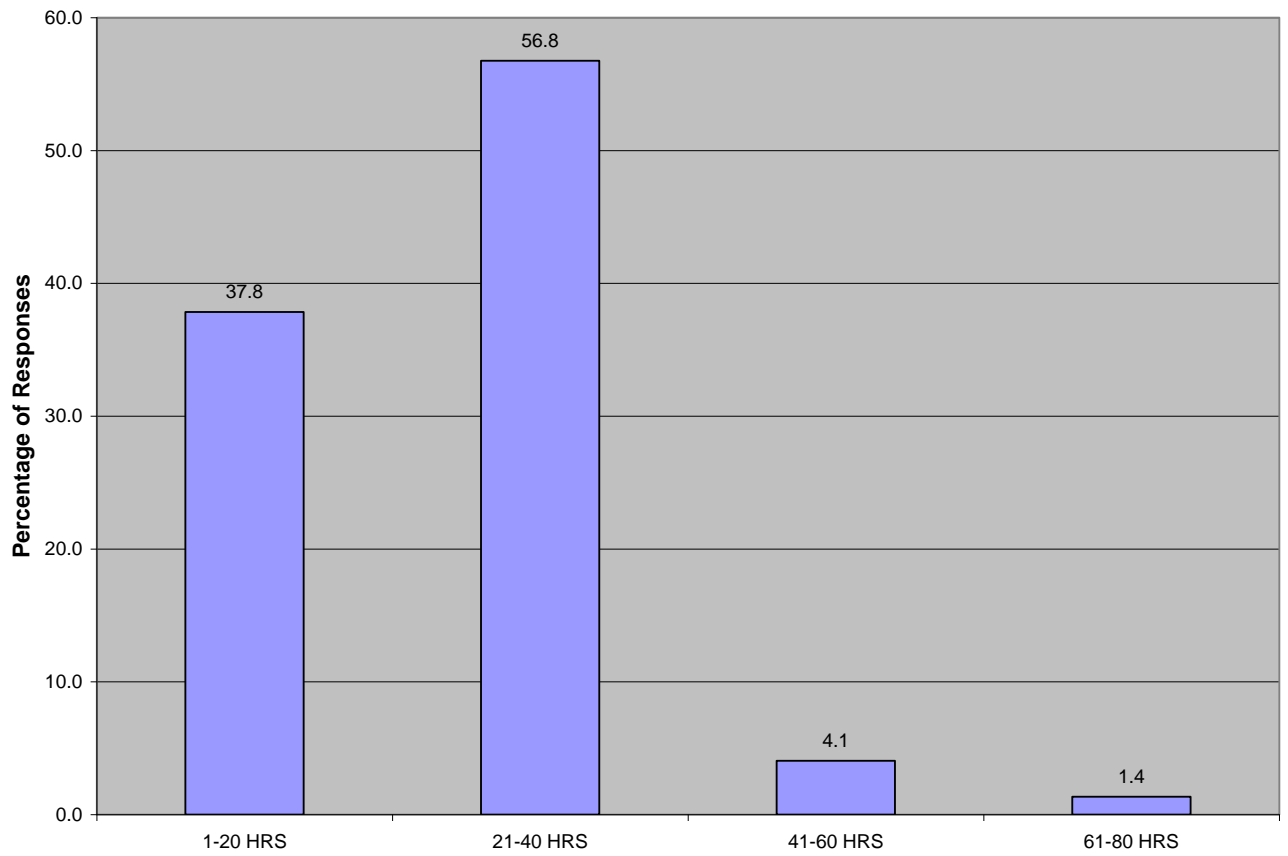
**Figure 4.10 Graph showing location of internship undertaken**



**Table 4.10 Table showing length of time devoted to Internship**

Length of time (per week)	Number of responses	Percentage of responses
<b>1-20 hrs</b>	<b>28</b>	<b>37.8</b>
<b>21-40 hrs</b>	<b>42</b>	<b>56.8</b>
<b>41-60 hrs</b>	<b>3</b>	<b>4.1</b>
<b>61-80 hrs</b>	<b>1</b>	<b>1.4</b>

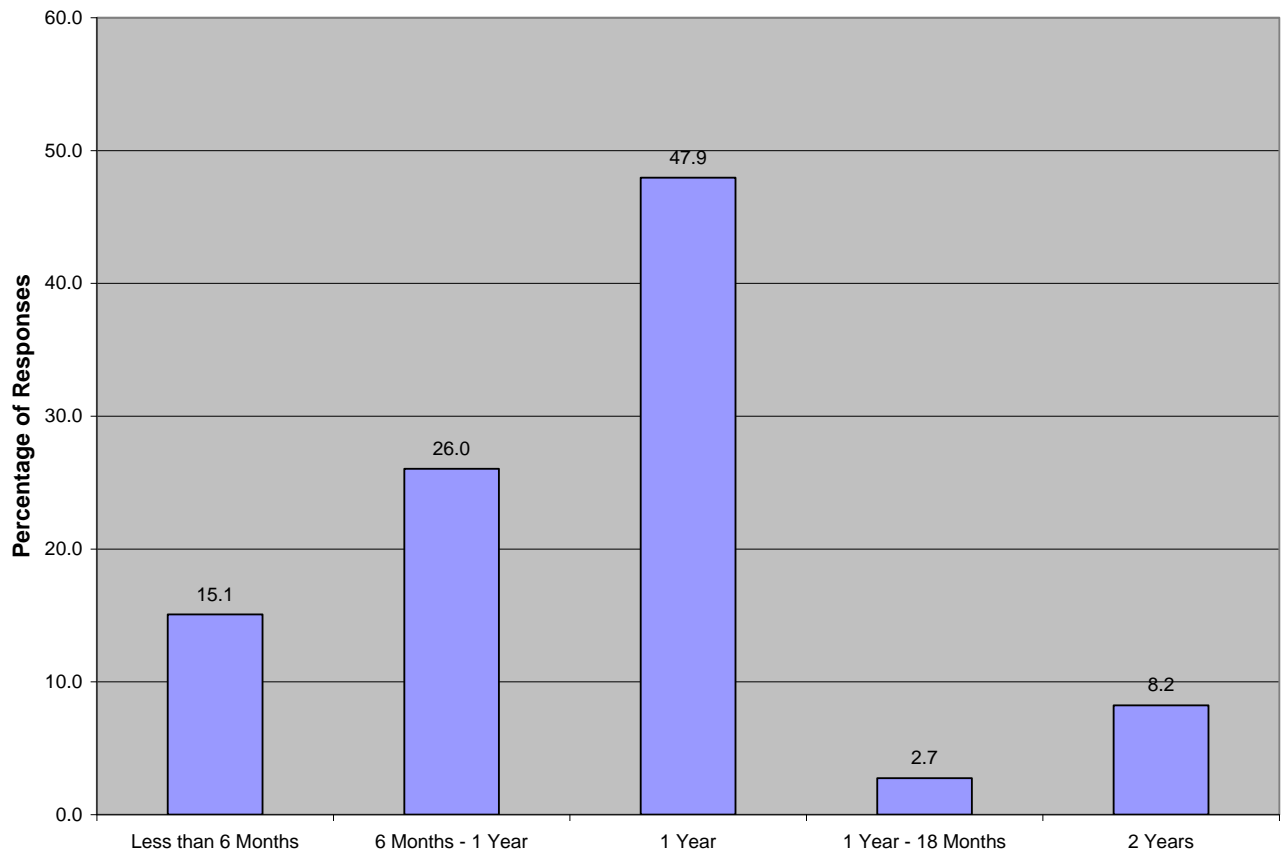
**Figure 4.11 Graph showing length of time devoted to Internship**



**Table 4.11 Table showing duration of internship**

Duration	Number of Responses	Percentage of Responses
<b>Less than 6 months</b>	<b>11</b>	<b>15.1</b>
<b>6 months – 1year</b>	<b>19</b>	<b>26.0</b>
<b>1 year</b>	<b>35</b>	<b>47.9</b>
<b>1 year - 18 months</b>	<b>2</b>	<b>2.7</b>
<b>2 years</b>	<b>6</b>	<b>8.2</b>

**Figure 4.12 Graph showing duration of internship**



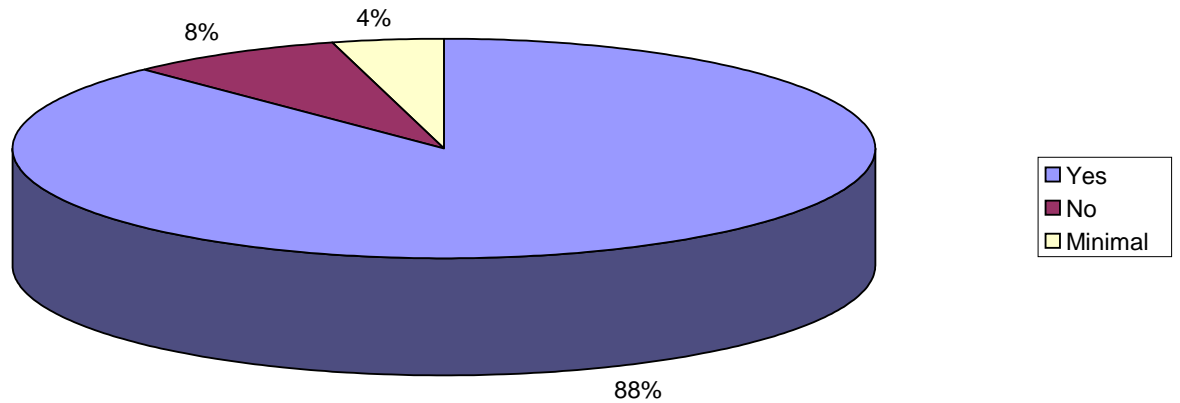
The duration of internships undertaken at the educational institutions appear to be distributed around an average of roughly a year. Only 10% of respondents were involved for longer than a year.

**Table 4.12 Table showing whether patients were seen on a one to one basis during the internship program.**

Patients seen one-to-one	Number of respondents	Percentage of respondents
<b>Yes</b>	<b>64</b>	<b>87.7</b>
<b>No</b>	<b>6</b>	<b>8.2</b>
<b>Seldom</b>	<b>3</b>	<b>4.1</b>

The majority of the respondents were able to see patients on a one to one basis, as 87% of respondents reported.

Figure 4.13 Graph showing whether patients were seen on a one to one basis during the internship program



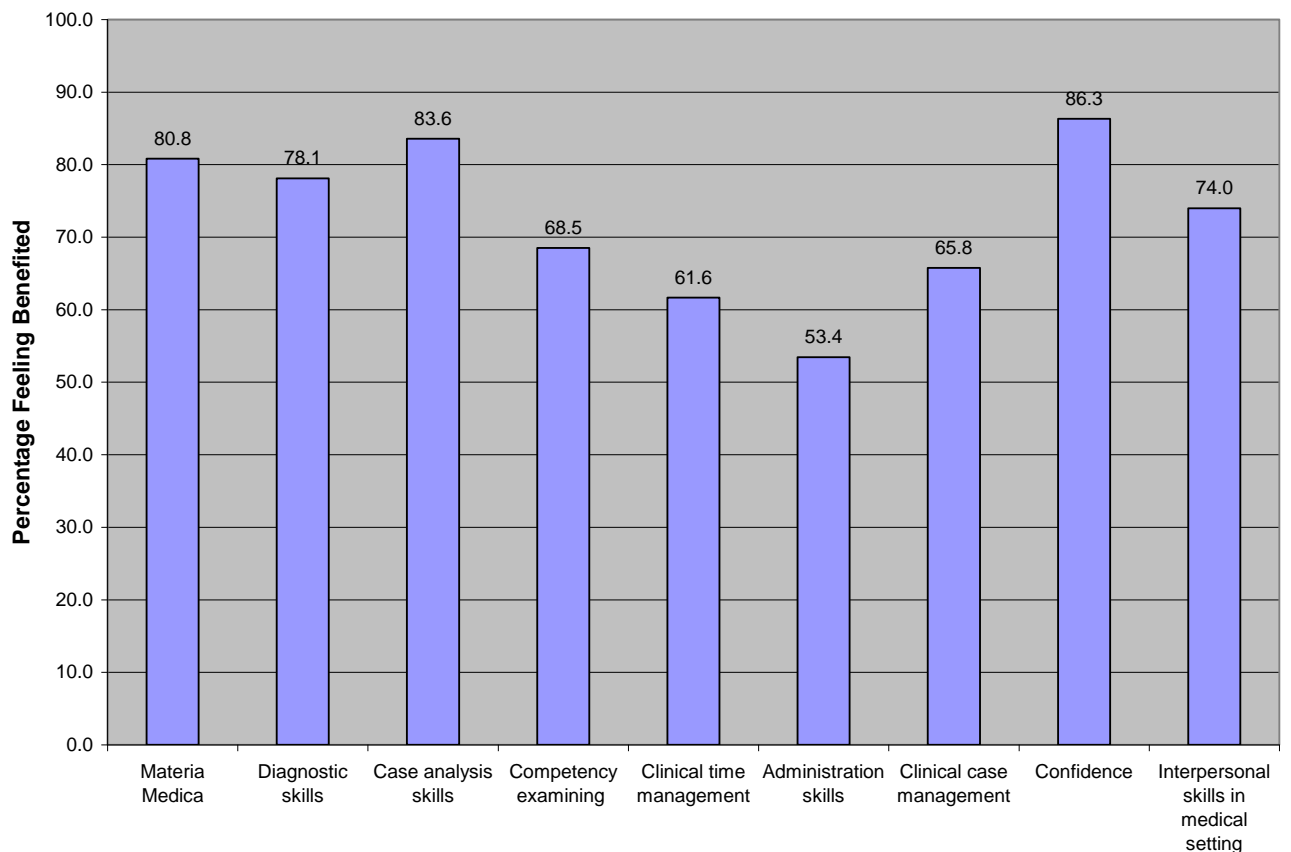
**Table 4.13 Table showing whether the respondents were supervised**

Supervision	Number of respondents	Percentage of respondents
<b>Yes</b>	<b>64</b>	<b>87.7</b>
<b>No</b>	<b>6</b>	<b>8.2</b>
<b>Minimal</b>	<b>3</b>	<b>4.1</b>

The above graphs and tables reflect that internship forms were well supported in terms of supervision and oversight. Most of the responses reflect that respondents spent approximately a year, working up to 40 hours a week, seeing patients on a one to one basis with supervision. (The extent and consistency of the supervision cannot be assessed in this study.)

This results in 90% of the respondents feeling that the internship program was beneficial to them and their Homoeopathic training. Figure 4.14 below illustrates specific areas that respondents felt were improved by the internship.

**Figure 4.14 Graph showing specific areas of benefit derived from the internship**



Of respondents who did not engage in an internship program, 94.2 % felt that it would have been beneficial. The graduate population (as represented by this sample) seems to recognise the importance and value of an internship process.



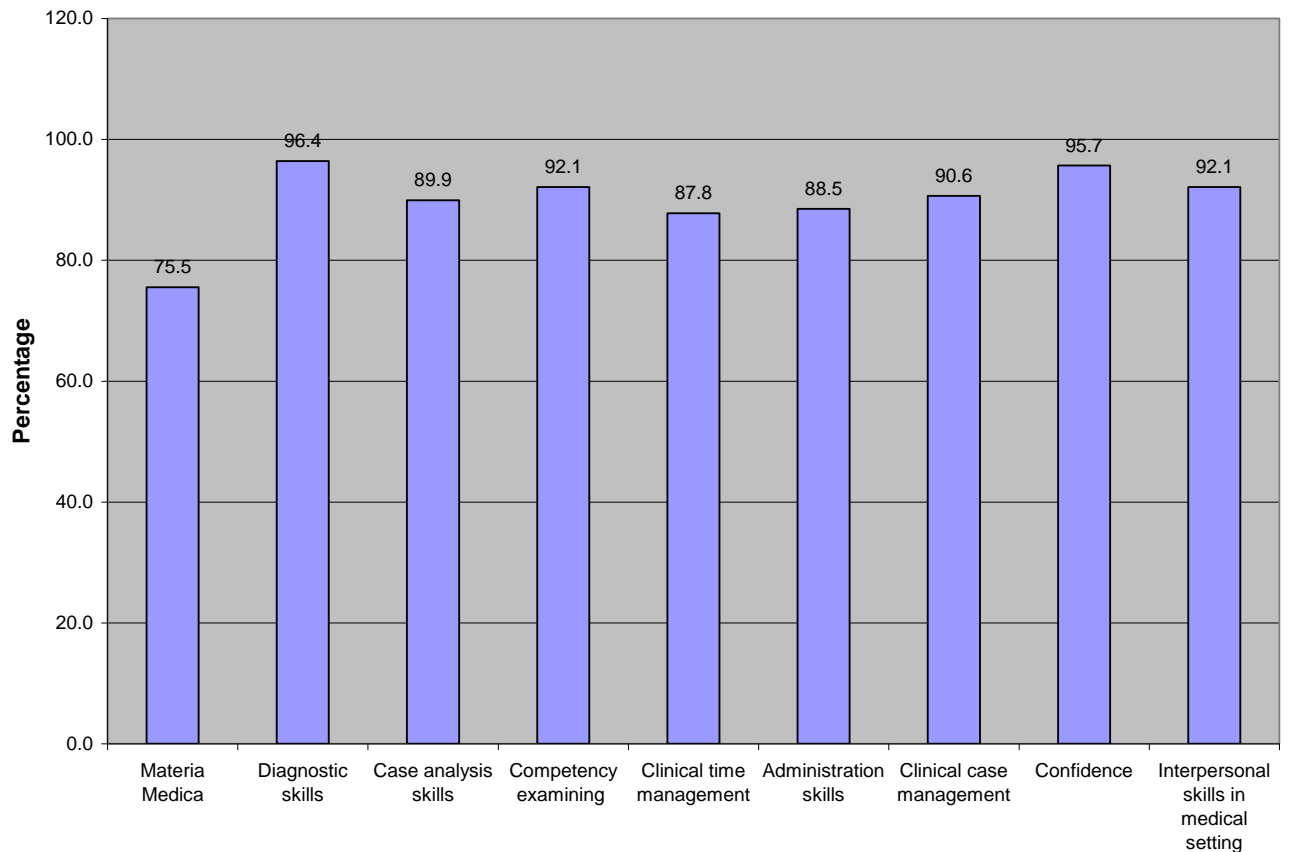
#### 4.5.4 Recommendations for the internship Program

These comprised of descriptions of the data obtained from answers to Section D of the completed questionnaires.

**Table 4.14 Table showing respondents perceptions of which skills should be acquired/enhanced in an internship**

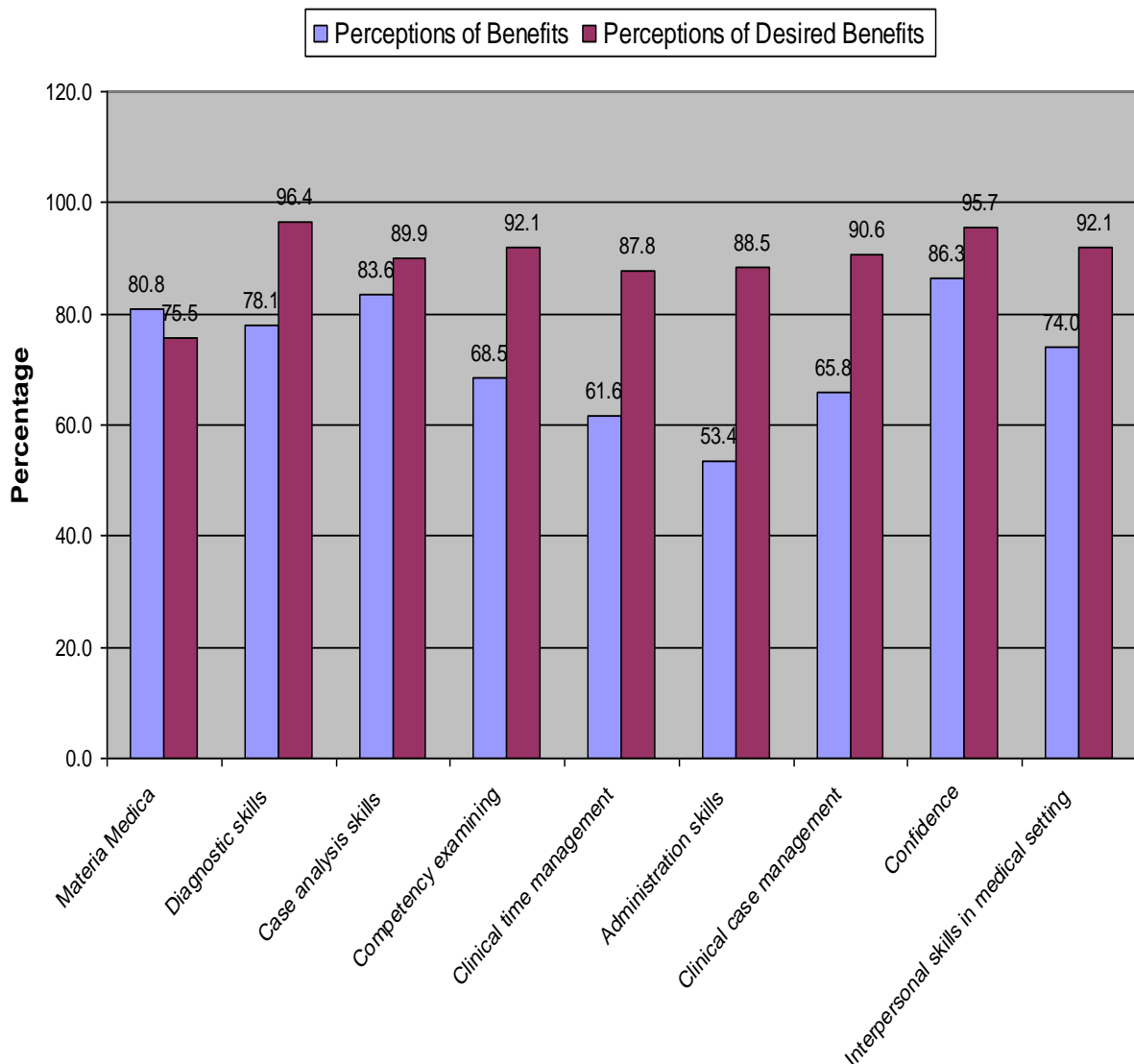
Skill	Important	
	Yes	No
<b>Materia Medica</b>	<b>75.5%</b>	<b>24.5%</b>
<b>Diagnostic skills</b>	<b>96.4%</b>	<b>3.6%</b>
<b>Case analysis skills</b>	<b>89.9%</b>	<b>10.1%</b>
<b>Competency examining</b>	<b>92.1%</b>	<b>7.9%</b>
<b>Clinical time management</b>	<b>87.8%</b>	<b>11.5%</b>
<b>Administration skills</b>	<b>88.5%</b>	<b>11.5%</b>
<b>Clinical case management</b>	<b>90.6%</b>	<b>8.6%</b>
<b>Confidence</b>	<b>95.7%</b>	<b>4.3%</b>
<b>Interpersonal skills in medical setting</b>	<b>92.1%</b>	<b>7.9%</b>

**Figure 4.15 Graph showing respondents perceptions of which skills should be acquired/enhanced in an internship**



Increased/improved knowledge of Materia Medica is seen as important by the fewest number of respondents. Clinical, diagnostic skills are seen as important by the most number of respondents. This perhaps reflects a lack in the existing education with respect to these skills.

**Figure 4.16 Graph Showing Respondents perceptions of which skills should be acquired/enhanced in an internship against perceptions of improvements in skills from an internship**



This graph may illustrate the areas that the internships appear to be lacking. A large number of respondents felt that clinical time management, clinical case management, and administration skills were desirable benefits of the internship.

These skills were perceived to have been improved by relatively fewer numbers of respondents.

Note: It is possible that the impressions of what is important would change during the course of the internship. Thus perceptions of desired benefits (answered by respondents who did not undertake an internship, and may not necessarily be practicing or have practiced) may be less a reflection of the internships' lack than a reflection of a different perception of a different group of respondents.

**Table 4.15 Table showing favoured duration of an internship**

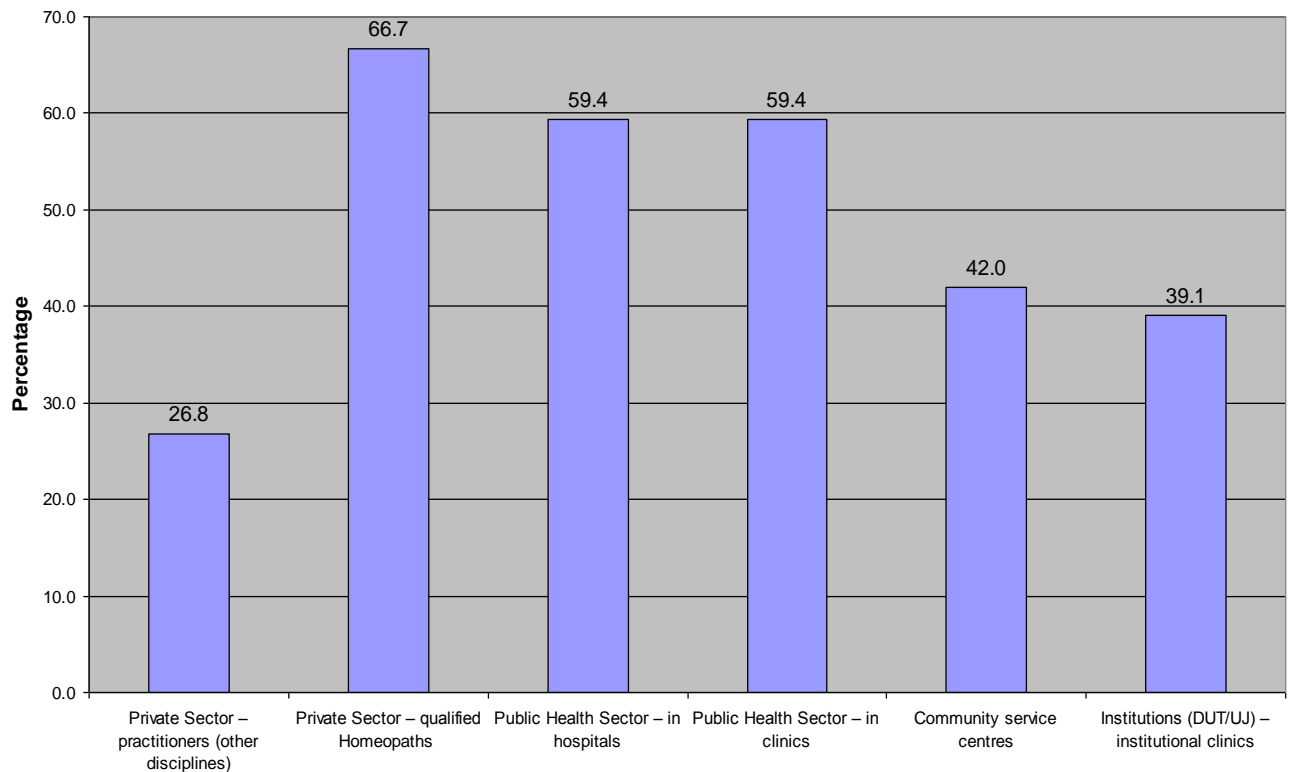
Ideal length of an internship	Number of respondents	Percentage of respondents
<b>6 Months</b>	<b>30</b>	<b>21.7</b>
<b>1 Year</b>	<b>101</b>	<b>73.2</b>
<b>2 Year</b>	<b>6</b>	<b>4.3</b>

The majority of respondents felt that 1 year is a desirable duration for an internship process.

**Table 4.16 Table showing where respondents thought that the internship should be conducted**

Place Internship Conducted	Yes	No
<b>Private Sector – practitioners (other disciplines)</b>	<b>26.8</b>	<b>73.2</b>
<b>Private Sector – qualified Homoeopaths</b>	<b>66.7</b>	<b>33.3</b>
<b>Public Health Sector – in hospitals</b>	<b>59.4</b>	<b>39.9</b>
<b>Public Health Sector – in clinics</b>	<b>59.4</b>	<b>40.6</b>
<b>Community service centres</b>	<b>42.0</b>	<b>58.0</b>
<b>Institutions (DUT/UJ) – institutional clinics</b>	<b>39.1</b>	<b>60.9</b>

**Figure 4.17 Graph showing where respondents thought that the internship should be conducted**

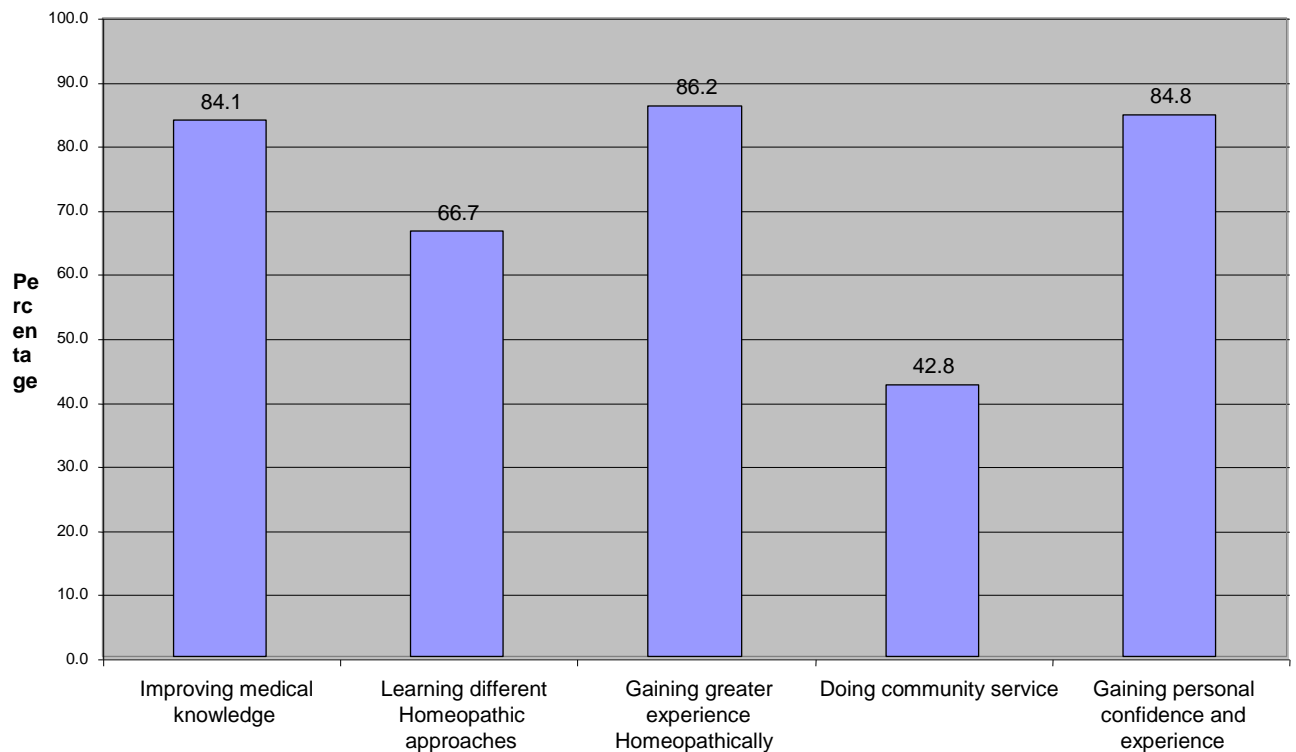


Most respondents felt that the internship should be conducted in the private sector with the supervision of qualified Homoeopaths. Internships in the public health sector (both hospitals and clinics) were also viewed positively. Very few respondents felt that the internship should be held in the private sector with practitioners from other disciplines. A possible reason for this is recognition of the need in an internship to improve on the development of Homoeopathic skills (clinically, philosophically and in terms of practice management).

**Table 4.17 Table showing perceptions of what the internship should focus on**

Focus of the Internship	Number of respondents	Percentage of respondents
<b>Improving medical knowledge</b>	<b>116</b>	<b>84.1</b>
<b>Learning different Homoeopathic approaches</b>	<b>92</b>	<b>66.7</b>
<b>Gaining greater experience Homoeopathically</b>	<b>119</b>	<b>86.2</b>
<b>Doing community service</b>	<b>59</b>	<b>42.8</b>
<b>Gaining personal confidence and experience</b>	<b>117</b>	<b>84.8</b>

**Figure 4.18 Graph showing perceptions of what the internship should focus on**



The majority (84.1%, 86.2% and 84.8% respectively) feel that the focus areas should be on improving medical knowledge, gaining greater experience homoeopathically and gaining personal experience and confidence. This

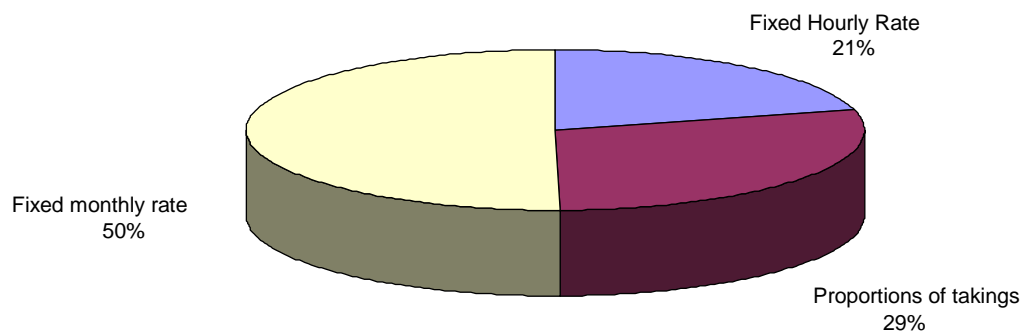
reflects graph 4.16 above, in that both the gained benefits (those who had undertaken an internship) and the desired benefits are in line with these figures.

In terms of the remuneration issue, 94.2% of respondents felt that Homoeopaths should be remunerated for the internship process. The particular mode of remuneration is shown in table 4.18 and figure 4.19.

**Table 4.18 Table showing remuneration options supported by respondents**

Remuneration option	Number of respondents in favour	Percentage of respondents in favour
<b>Fixed hourly rate</b>	<b>27</b>	<b>20.9</b>
<b>Proportions of takings</b>	<b>37</b>	<b>28.7</b>
<b>Fixed monthly rate</b>	<b>65</b>	<b>50.4</b>

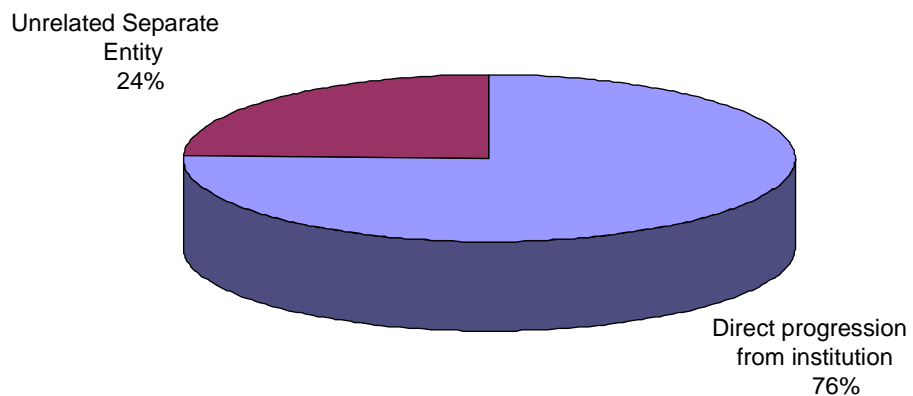
**Figure 4.19 Graph showing remuneration options supported by respondents**



The majority of the respondents favoured a fixed monthly rate for the internship process. A possible reason for this is the other two options allow a looser less formal arrangement i.e. Homoeopaths being paid piecemeal. A fixed monthly rate may be seen to imply a more definite commitment and arrangement.

The majority (76%) of the respondents also felt that the internship program should be affiliated with the relevant institutions and their formal academic training. Again a similar reason is possible.

**Figure 4.20 Graph showing preferences of respondents for affiliation of the Homoeopathic internship process**



#### **4.6 Correlation analysis**

In terms of Objective 5 described in the Introduction, the relationship between the demographic variables and the responses given was explored. This was done by hypothesis testing using the Pearsons Chi squared Correlation Co-efficient and Cramers V and Phi Co-efficients. The level of significance was set at 5% i.e.  $p \leq 0.05$ .

#### 4.6.1. Hypothesis testing- Demographic and Background Variables compared to variables from Part B (understanding of current legislation).

Null hypothesis 1: There was no significant correlation between any of the Demographic and Background Variables (as described by one of Geographical location, Gender, Institution attended or year of qualification) and respondents' knowledge of current legislation with respect to internship (as described by the questions in Part B).

Alternative hypothesis 1: There was a significant correlation between one of the Demographic and Background Variables (as described by one of Geographical location, Gender, Institution attended or year of qualification) and respondents' knowledge of current legislation with respect to internship (as described by one of the questions in Part B).

Correlations between Demographic and Background Variables (as described by one of Geographical location, Gender, Institution attended or year of qualification) and the following factors, were assessed:

- Question 1: Knowledge of legal position of qualification with respect to internship requirements
- Question 2: Prior awareness of the current legislation and the source thereof
- Question 3: Respondents perceptions of with whom responsibility for organising and structuring the internship lies.

Significant correlations were established i.e.  $H_0$  was rejected for certain categories. The significant correlations are shown in Table 4.19 below.

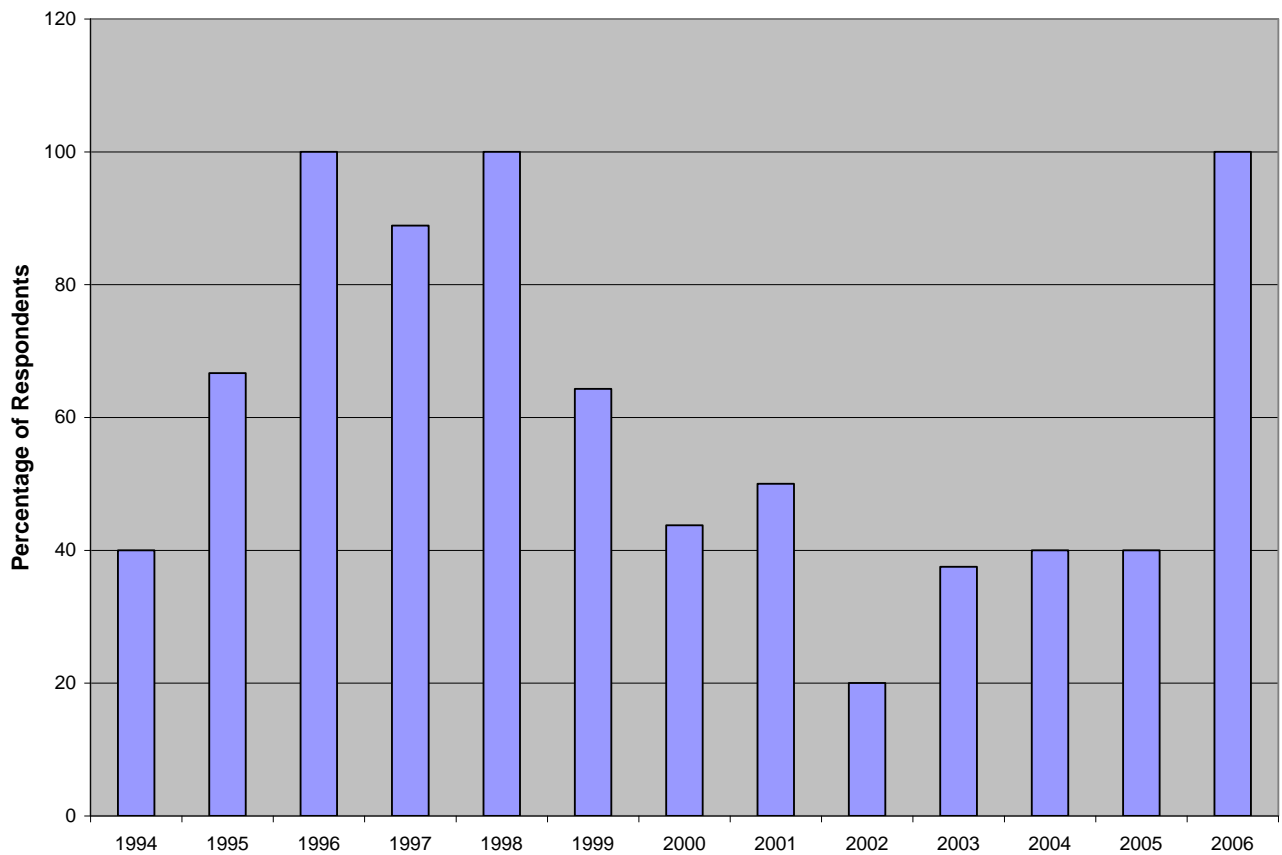
Significant correlations were indicated by marking z- and p-values; if not noted, either no correlation was noted or the correlation was not statistically significant.



**Table 4.19 Table showing correlations between demographic and background variables and variables describing respondents knowledge of current legislation with respect to internship**

Variables	Statistical Measures			Nature of Relationship
	Pearson Chi Square (p-Value)	Significance Value (Z Values)	Value of Asymmetric Measure (Phi)	
Year of qualification * previous knowledge of current legislation	21.904	0.025	0.527	Strong correlation between year of qualification and previous knowledge of current legislation.

**Figure 4.21 Graph showing percentage of respondents who were previously aware of the legislation regarding the internship**



#### 4.6.2 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part C (Questions describing the respondents' previous experience of Internship)

Null hypothesis 2: There was no significant correlation between any of the Demographic and Background Variables (as described by one of Geographical location, Gender, Institution attended or year of qualification) and respondents' past experience internship (as described by the questions in Part C).

Alternative hypothesis 2: There was a significant correlation between one of the Demographic and Background Variables (as described by one of Geographical location, Gender, Institution attended or year of qualification) and respondents' past experience of internship (as described by one of the questions in Part C).

Correlation between Demographic and Background Variables (as described by one of Geographical location, Gender, Institution attended or year of qualification) and the following variables/factors were assessed:

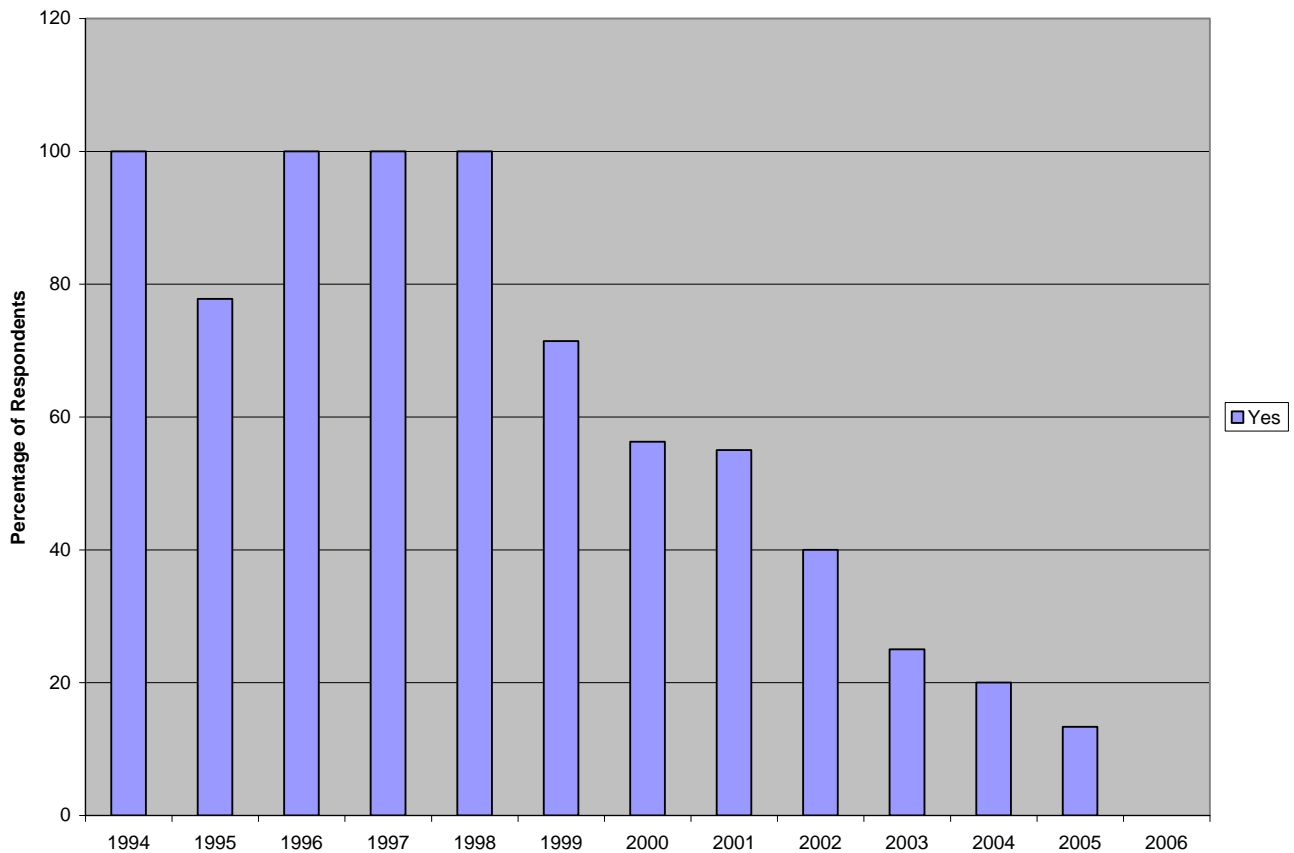
- Question 4.1: Whether an internship was organised at the institution at which the respondent studied.
- Question 4.2: What (if any) the internship consisted of (including location, duration, and presence of supervision, one-on-one consulting, and time intensity).
- Question 4.3: Whether the internship was perceived to have been beneficial to the respondent's training as a homeopath.
- Question 4.4: The ways in which the internship was felt to have benefited the respondent.
- Question 4.5: Whether the respondent felt that an internship program would have benefited him/her (if none was included).

Significant correlations were established i.e.  $H_0$  was rejected for certain categories. The significant correlations are shown in Table 4.20 below. Significant correlations are indicated by marking z- and p-values; if not noted, either no correlation was noted or the correlation was not statistically significant.

**Table 4.20 Table showing correlations between demographic and background variables and variables describing respondents' past experience of internship**

Variables	Statistical measures			Nature of relationship
	Pearson Chi Square (p-Value)	Significance Value (Z Values)	Value of Asymmetric Measure (Phi)	
Year qualified * whether internship was included in study	31.308	0.001	0.630	Very strong correlation between the years of qualification and whether an internship was part of the education process (see Fig 4.22).
Year qualified * one-on-one consultations part of the internship	44.848	0.000	1.101 Cramers V =0.778	Very strong correlation exists between the year of qualification and whether one-on-one consultations were part of the internship. Most qualification year-groups reported seeing patients on a one-on-one basis. There is thus a near perfect correlation- most respondents from every year experienced this form of interaction.
Country of residence * duration of internship	19.511	0.012	0.726 Cramer's V =0.513	A strong correlation between the country of residence of the respondent and the duration of internship. Most (94.2%) of the respondents were resident in South Africa. The internships of RSA residents were generally in the order of 0-12 months.

**Fig 4.22 Graph showing the percentage of respondents who undertook an internship according to a particular year of qualification**



It is apparent that the situation with respect to internship has been worsening over the years that the program has been running. Whether an internship was part of a respondent's training was significantly correlated to the year of qualification.

#### 4.6.3 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part D (Questions describing the respondents' recommendations for the Internship)

Null hypothesis 3: There was no significant correlation between any of the Demographic and Background Variables (as described by one of Geographical location, Gender, Institution attended or year of qualification) and respondents' recommendations for the Internship (as described by the questions in Part D).

Alternative hypothesis 3: There was a significant correlation between one of the Demographic and Background Variables (as described by one of Geographical location, Gender, Institution attended or year of qualification) and respondents' recommendations for the Internship (as described by one of the questions in Part D).

Correlation between Demographic and Background Variables (as described by one of Geographical location, Gender, Institution attended or year of qualification) and the following variables/factors were assessed:

- Question 5: Which skills should be acquired during the internship
- Question 6: Respondents perceptions of an adequate duration of internship
- Question 7: Respondents perceptions of where the internship should be conducted
- Question 8: Respondents perceptions of the aspects of education which should be emphasised in the internship.
- Question 9: Respondents perceptions of whether interns should be remunerated and what form this should take.
- Question 10: Respondents perceptions of to which organisation/body the internship should be affiliated.

Significant correlations were established i.e.  $H_0$  was rejected for certain categories. The significant correlations are shown in Table 4.21 below. Significant correlations are indicated by marking z- and p-values; if not noted, either no correlation was noted or the correlation was not statistically significant.

**Table 4.21 Table showing correlations between demographic and background variables and variables describing respondents' recommendations for Internship**

Variables	Statistical measures			Nature of relationship
	Pearson Chi Square (p-Value)	Significance Value (Z Values)	Value of Asymmetric Measure (Phi)	
Province * Desirable duration	25.338	0.031	0.566	A strong correlation between the province of residence and perception of desired duration. The relationship appears to be that respondents from KZN and Gauteng are more likely to feel that an internship of 6 months would be desirable. This may reflect increased time-pressure and competition in these major centres.
Province * Emphasis placed on Improving medical knowledge	16.368	0.022	0.458	A Strong Correlation exists between the province of residence and the perception of the need to emphasize improving medical knowledge. Residents of the larger provinces (in terms of percentage of respondents and in terms of population size) are more likely to feel a need to emphasize the need to emphasize improving medical knowledge.
Province * Affiliation of internship	19.800	0.006	0.507	A strong correlation exists between the province of residence and the recommendation of where the internship should be affiliated. Again, respondents from the larger provinces felt the internship should be a direct progression from the relevant institution.
Gender * whether the internship should occur at primary health care clinics	4.064	0.044	0.228	A weak correlation exists between the respondent's gender and the recommendation to conduct the internship at a primary health care clinic. Males were far more likely to feel that the internship should be conducted in the public health sector at primary care clinics.

#### 4.6.4 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part D (Questions describing the respondent's recommendations for the Internship)

Null hypothesis 4: There was no significant correlation between any of the variables describing knowledge of the current legislation with respect to internship (as described by the questions in Part B) and respondents' past experiences of Internship (as described by the questions in Part D).

Alternative hypothesis 4: There was a significant correlation between one of the variables describing knowledge of the current legislation with respect to

internship (as described by the questions in Part B) and respondents' past experiences of Internship (as described by the questions in Part C).

Correlation between variables describing knowledge of the current legislation with respect to internship (as described by the questions in Part B) and the following variables/factors were assessed:

- Question 4.1: Whether an internship was organised at the institution at which the respondent studied.
- Question 4.2: What (if any) the internship consisted of (including location, duration, presence of supervision, one-on-one consulting, and time intensity).
- Question 4.3: Whether the internship was perceived to have been beneficial to the respondent's training as a homeopath.
- Question 4.4: The ways in which the internship was felt to have benefited the respondent.
- Question 4.5: Whether the respondent felt that an internship program would have benefited him/her (if none was included).

Significant correlations were established i.e.  $H_0$  was rejected for certain categories. The significant correlations are shown in Table 4.22 below. Significant correlations are indicated by marking z- and p-values; if not noted, either no correlation was noted or the correlation was not statistically significant.

**Table 4.22 Table showing correlations between variables describing knowledge of the current legislation with respect to internship and respondents' past experiences of Internship**

Variables	Statistical measures			Nature of relationship
	Pearson Chi Square (p-value)	Significance value (Z values)	Value of asymmetric measure (Phi)	
Aware of legislation before questionnaire * Nature of internship	9.928	0.007	0.525	Strong correlation. Respondents' prior awareness of legislation was strongly correlated with the nature of the internship undertaken: Respondents who were aware prior to the questionnaire were more likely to have had an internship involving case presentations and observing cases with qualified Homoeopaths. Respondents with no prior awareness were more likely to have undergone an institutional 6 <sup>th</sup> year.
Prior awareness of legislation * Benefit experienced in improved diagnostic skills.	6.546	0.011	0.415	Strong correlation between factors. Respondents who were aware prior to the survey were more likely to have reported an improved diagnostic skill benefit from their internship.
Where prior awareness derived from * Internship involved one-on-one patient consultations.	9.975	0.019	0.689	Strong correlation between factors. Respondents who had heard through colleagues were less likely to have worked one-on-one with patients.
Who respondents felt were legally responsible for internship * Duration of Internship undergone	24.462	0.018	0.813 Cramers V =0.469	Strong correlation between factors. Respondents who felt it was the Department of Health's responsibility to organize the internship were more likely to have undergone longer internships.
Who respondents felt were legally responsible for internship * Improved administration skills were an experienced benefit of internship	7.795	0.050	0.453	Strong correlation between factors. Respondents who felt it was the relevant institutions responsibility were more likely to not report improvement in administration skills as an experienced benefit of their internship.

#### 4.6.5 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part D (Questions describing the respondents recommendations for the Internship)

Null hypothesis 5: There was no significant correlation between any of the variables describing knowledge of the current legislation with respect to internship (as described by the questions in Part B) and respondents' recommendations for Internship (as described by the questions in Part D).

Alternative hypothesis 5: There was a significant correlation between one of the variables describing knowledge of the current legislation with respect to



internship (as described by the questions in Part B) and respondents' recommendations for Internship (as described by the questions in Part D).

Correlation between variables describing knowledge of the current legislation with respect to internship (as described by the questions in Part B) and the following variables/factors were assessed:

- Question 5: Which skills should be acquired during the internship
- Question 6: Respondents perceptions of an adequate duration of internship
- Question 7: Respondents perceptions of where the internship should be conducted
- Question 8: Respondents perceptions of the aspects of education which should be emphasised in the internship.
- Question 9: Respondents perceptions of whether interns should be remunerated and what form this should take.
- Question 10: Respondents perceptions of to which organisation/body the internship should be affiliated.

Significant correlations were established i.e.  $H_0$  was rejected for certain categories. The significant correlations are shown in Table 4.23 below. Significant correlations are indicated by marking z- and p-values; if not noted, either no correlation was noted or the correlation was not statistically significant.

**Table 4.23 Table showing correlations between variables describing knowledge of the current legislation with respect to internship and respondents' recommendations for internship**

Variables	Statistical measures			Nature of relationship
	Pearson Chi Square (p-value)	Significance value (Z values)	Value of asymmetric measure (Phi)	
Who respondents felt were legally responsible for the internship * Whether the respondents felt that improving medical knowledge should be emphasized in the internship.	8.921	0.030	0.338	Moderate correlation between factors. Respondents who felt that the relevant institution should be responsible for organizing the internship were less likely to feel that improving medical knowledge should be emphasized.

#### 4.6.6 Hypothesis testing- Demographic, Educational Status and Health Background Variables against Part D (Questions describing the respondents recommendations for the Internship)

Null hypothesis 6: There was no significant correlation between any of the variables describing respondents past experience of internship (as described by the questions in Part C) and respondents' recommendations for Internship (as described by the questions in Part D).

Alternative hypothesis 6: There was a significant correlation between one of the variables describing past experience of internship (as described by the questions in Part C) and respondents' recommendations for Internship (as described by the questions in Part D).

Correlation between variables describing past experience of internship (as described by the questions in Part C) and the following variables/factors were assessed:

- Question 5: Which skills should be acquired during the internship
- Question 6: Respondents perceptions of an adequate duration of internship

- Question 7: Respondents perceptions of where the internship should be conducted
- Question 8: Respondents perceptions of the aspects of education which should be emphasised in the internship.
- Question 9: Respondents perceptions of whether interns should be remunerated and what form this should take.
- Question 10: Respondents perceptions of to which organisation/body the internship should be affiliated.

Significant correlations were established i.e.  $H_0$  was rejected for certain categories. The significant correlations are shown in Table 4.24 below.

Significant correlations are indicated by marking z- and p-values; if not noted, either no correlation was noted or the correlation was not statistically significant.

**Table 4.24 Table showing correlations between variables describing past experience of internship and respondents' recommendations for Internship**

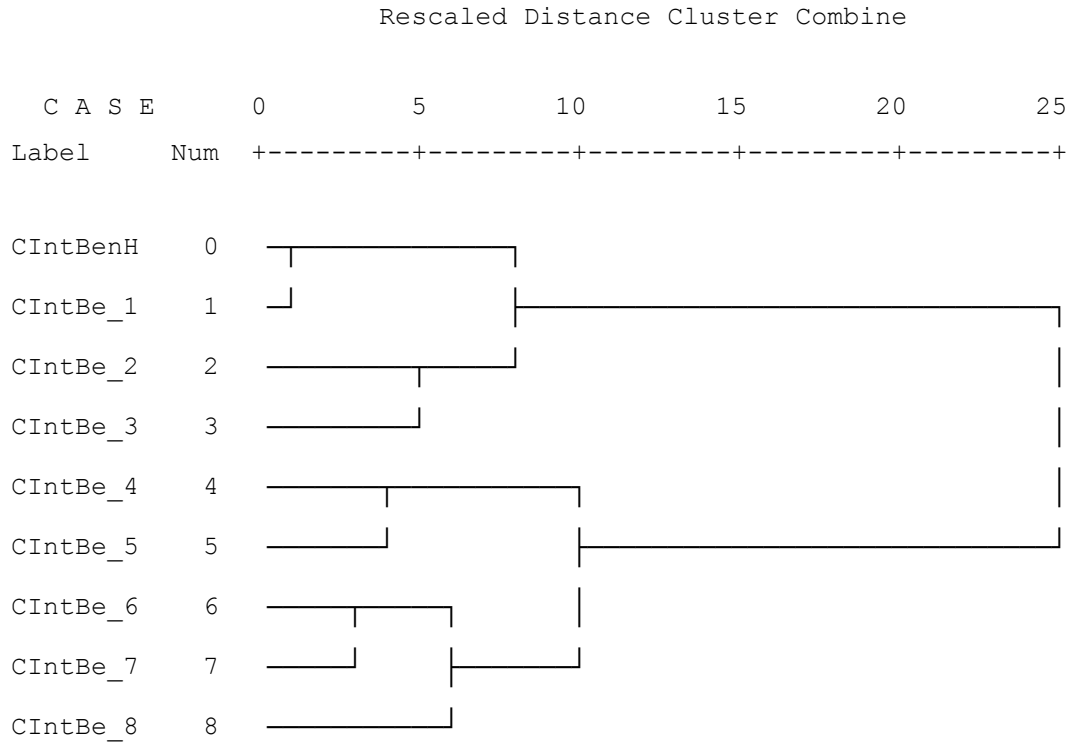
Variables	Statistical Measures			Nature of Relationship
	Pearson Chi Square (p-value)	Significance value (Z values)	Value of asymmetric measure (Phi)	
Whether respondents undertook an internship * How interns should be remunerated	8.049	0.018	0.325	Moderate correlation between factors. Respondents who had undergone an internship were more likely to feel that remuneration should be a proportion of takings. Respondents who had not were more likely to feel that a fixed hourly rate should be used.
Nature of internship undertaken * Recommendation to conduct internship at community service centres	7.244	0.027	0.455	Strong correlation between factors. Respondents who had undergone an institutional 6 <sup>th</sup> year were more likely to have felt that the internship should take place at community centers.
Extent of internship (hrs per week) * Recommendation that interns are paid	18.847	0.000	0.724	Strong correlation between factors. The respondents who worked between 60 and 80 hrs per week were more likely to feel that interns should not be paid.
Duration or internship undertaken * Desirable duration of internship	14.043	0.007	0.616	Strong correlation between factors. Respondents who undertook shorter internships were more likely to recommend shorter internships. Respondents who undertook longer internships were more likely to recommend longer internships.
Whether patients were seen one-on-one * Desirable duration of Internship	6.221	0.045	0.410	Strong correlation between factors. Respondents who did not see patients on a one-on-one basis were more likely to recommend a shorter internship.
Whether internship was felt to have been beneficial * Recommendation to place emphasis on community service	3.841	0.050	0.322	Moderate correlation between factors. Respondents who did not feel that the internship benefited them were more likely to feel that an emphasis should be placed on community service. Respondents who felt that the internship benefited them were less likely to feel that an emphasis should be placed on community service.

#### 4.7 Correlations within questions

For questions where respondents were choosing different aspects of an issue, Hierarchical Cluster analyses were performed. This allowed the identification of clustered themes within responses e.g. respondents answering to one component would be more likely to indicate an answer to another component.

#### 4.7.1 Question 4.4 Perceived gain experienced from internship

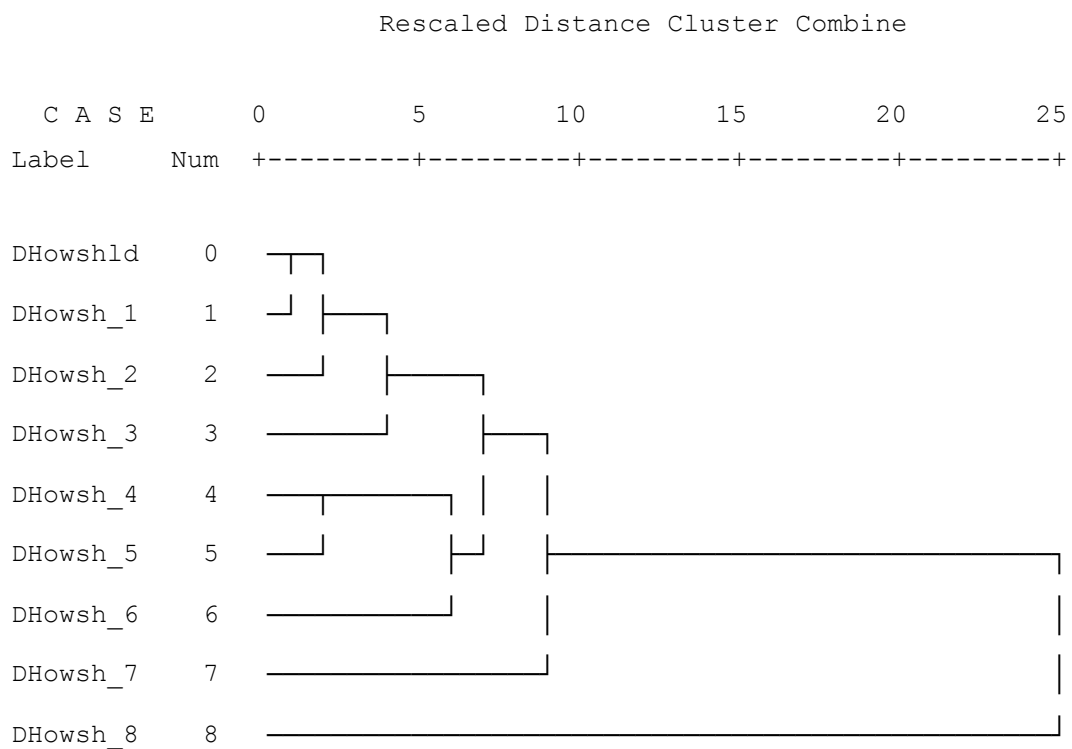
##### Dendrogram using Ward Method



Abbreviated Label	Category name- Full Reason Given
<b>CIntBenH</b>	<b>Administration skills</b>
<b>CIntBe_1</b>	<b>Clinical case management</b>
<b>CIntBe_2</b>	<b>Improvement in clinical time management</b>
<b>CIntBe_3</b>	<b>Developing interpersonal skills in a medical setting</b>
<b>CIntBe_4</b>	<b>Increased knowledge of materia medica</b>
<b>CIntBe_5</b>	<b>Improved case analysis skills</b>
<b>CIntBe_6</b>	<b>Increased diagnostic skills</b>
<b>CIntBe_7</b>	<b>Improved competency in examining a patient</b>
<b>CIntBe_8</b>	<b>Confidence</b>

The above dendrogram suggests a two (or three) cluster situation, namely cluster 1 (#0, #1, #2 and #3) and cluster 2 (the rest of the factors). Cluster 2 could be split into a (#4 and #5) and b (#6, #7 and #8). These clusters are discussed in Chapter 5.

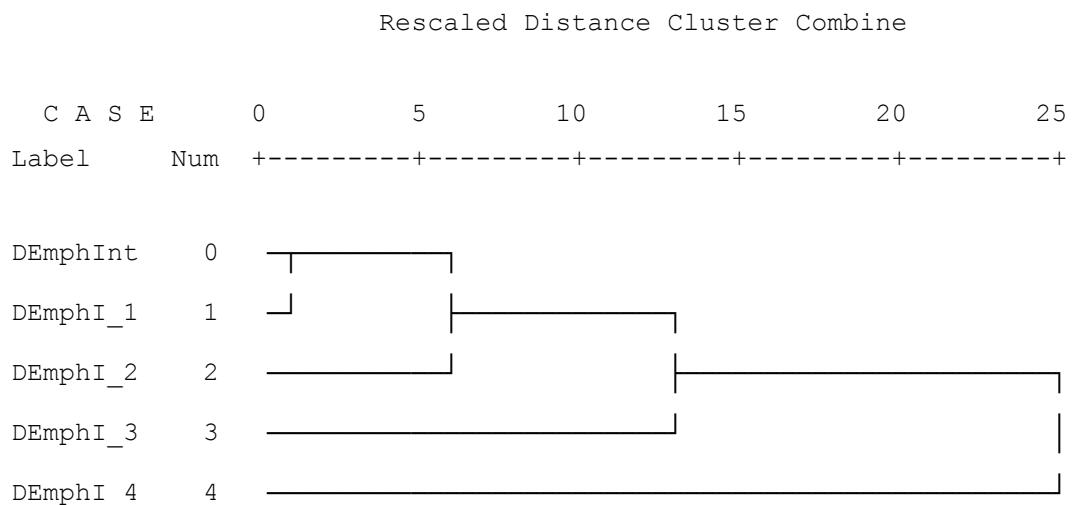
#### 4.7.2 Question 5: Perceptions of what skills should be acquired or enhanced during the internship - Dendrogram using Ward Method



Abbreviated Label	Category Name
DHowshld	Clinical case management
DHowsh_1	Confidence
DHowsh_2	Improved case analysis skills
DHowsh_3	Developing interpersonal skills in a medical setting
DHowsh_4	Increased diagnostic skills
DHowsh_5	Improvement in clinical time management
DHowsh_6	Administration skills
DHowsh_7	Increased knowledge of Materia Medica
DHowsh_8	Improved competency in examining a patient

The above dendrogram suggests four pertinent clusters: cluster 1 (#0, #1, #2 and #3), cluster 2 (#4, #5, and #6), cluster 3 (#7) with factor 8 separate.

#### 4.7.3 Question 8: Recommendations with respect to what emphasis should be placed on the internship. Dendrogram using Ward Method



<b>Abbreviated Label</b>	<b>Category Name</b>
<b>DEmphInt</b>	<b>Improving medical knowledge</b>
<b>DEmphI_1</b>	<b>Gaining greater experience Homoeopathically</b>
<b>DEmphI_2</b>	<b>Gaining personal confidence and experience</b>
<b>DEmphI_3</b>	<b>Learning different Homoeopathic approaches</b>
<b>DEmphI_4</b>	<b>Doing community service</b>

The above dendrogram suggests a three cluster solution. Cluster 1 (#0, #1 and #2), cluster 2 (#3) and cluster three (#4).



## **CHAPTER FIVE – DISCUSSION**

### **5.1 Introduction**

In the following chapter, the demographics of the study as well as four aspects of internship as it pertains to Homoeopathy will be discussed.

The outline of the chapter is as follows:

- Sample characteristics
- Demographics
- Knowledge of current legislation
- Past internship structures assessed
- Evaluation of internship
- Recommendations for an internship

These will be discussed, according to how they relate to and affect one another. All relevant issues will be explored using statistical data obtained from Chapter four.

## **5.2 Sample characteristics**

The population that the research aimed to describe comprised graduates of the DUT and UJ M.Tech:Homoeopathy programme. There are 313 graduates from the two institutions, the final sample size after taking into account the members of the focus group, one deceased graduate and one incarcerated graduate, was 304 graduates. 222 of the total number of the 313 graduates, were contactable (73%) of those contacted 137 replied with viable responses (61.7%)(Table 4.1). This sample size is more than adequate to assume that the data is valid and representative of the DUT and UJ Homoeopathic graduates up until 2006.

Although anecdotal evidence suggested that the majority of graduates did not receive an internship programme; in this study the majority (74) of respondents in fact had an internship program included in their training course i.e. 53.2% of the sample population.

## **5.3 Demographics**

### 5.3.1 Gender

This research supports the anecdotal evidence that there is a greater proportion of female Homoeopaths world wide, as there were 99 (72%) females in this study (Fig. 4.2). Although slightly higher in this study, the conclusion is consistent with that of Babaletakis (2006); in this study 66% of respondents were female. This implies a predominance of female graduates.

### 5.3.2 Geographical demographics

One hundred and thirty of the hundred and thirty seven (94.2%) respondents (qualified graduates) have remained in South Africa. The three largest provincial representations thereof are Gauteng (60 out of 137 i.e. 43.79%), Kwa-Zulu Natal (42 out of 137 i.e. 30.7%) and Western Cape (15 out of 137 i.e. 10.9%). (Table 4.4) (Appendix H for map of South African provinces).

This distribution has lead to a “clustering” of Homoeopaths in the main centres (Johannesburg, Durban and Cape Town) with other parts of the country being poorly covered. Vast areas of the country are inadequately serviced by Homoeopathic graduates with some entire provinces having just a single graduate.

### 5.3.3 Qualification

There was an increase of almost double the number of graduates from 1999 onwards, which can be attributed to the second institution, namely WITS Technikon, (now UJ) producing graduates from 1998. 47.4% of the total graduates in this sample group graduated between the years 1999 and 2002, with the vast majority of 14.6 % having graduated in 2001. It was in this same year that students voluntarily undertook to create their own internship and utilised the Technikon Natal facilities for clinical training.

## **5.4 Knowledge of current legislation**

Internship is a legal requirement for registration with the AHPCSA, the duty or obligation to provide the infrastructure or resources for this requirement does not belong to the educational institution. The onus falls on the statutory professional council to set up and run an internship programme. At present there is no prescribed internship for M. Tech Homoeopathic graduates (Ross, 2005).

The Allied Health Professions Act 63 of 1982 states: “An intern must complete a prescribed internship programme before he or she may be registered as a practitioner of the profession in question.” (Appendix E) Therefore, by law internship should be a condition of registration.

56% of respondents were aware of the law, and 44% were not aware of the legislation concerning internship in Homoeopathy.

### 5.4.1 Awareness of legislation

51.8% of the respondents were aware of the law prior to completing the questionnaire. Of the respondents who were not aware of the law prior to participation in this research, 5% of respondents were informed of the law by completing the questionnaire. The respondents who were aware of the law had become aware of it through various channels (Figure 4.6).

Of these channels, the institution they belonged to, namely DUT or UJ provided the most awareness concerning this law, with 50% of the graduates gaining awareness via this channel. This may be due to poor communication strategy on the part of the AHPCSA or the HSA. Together the AHPCSA and the HSA created awareness in 35.1% of participants. It is interesting to note, that word of mouth transference was a relatively large contribution towards knowledge of the law, as 13.8% of graduates reported that colleagues

informed them of the law. This essentially is a relatively informal information channel (Figure 4.7).

According to hypothesis testing, there exists a strong correlation between year of qualification and previous knowledge of current legislation. Respondents who qualified in the years 1996, 1998 and 2006 all had previous knowledge about the legislation concerning internship (Figure 4.21). Interestingly in 1996 the internship at TN was changed from the preceptorship to an onsite internship at the TN clinic, which ran until the end of 1998. In 2006 there was no internship programme offered, however there was speculation that an internship affiliated with the DUT might materialize. Again speculation might consider that these events contributed to the awareness about the legislation.

A strong correlation between respondents' prior awareness of legislation and the nature of the internship undertaken exists: Respondents who were aware of the law prior to the questionnaire were more likely to have had an internship involving case presentations and observing cases with qualified Homoeopaths. Respondents with no prior awareness were more likely to have undergone an institutional 6<sup>th</sup> year (Table 4.22).

#### 5.4.2 Respondents perceptions of responsibility for internship programme

Figure 4.8 demonstrates that most of the responses reflect the view that the responsibility for the internship lies with the educational institutions. This figure supports the anecdotal notion that (although not supported by law) internship responsibility rests with the educational/training institutions. 39.4% of the responses indicate this, while 32.7% reflect the view that the responsibility lies with the AHPCSA. Ross (2005) stated that the onus rests with the Professional Board, acting through the AHPCSA. This percentage could confirm the sense that exists within the Homoeopathic community that the professional board to date has not produced an internship and could therefore be inadequate to the task. 7.9% of respondents share the view that

the HSA hold the responsibility of implementing an internship programme. This figure could be reflecting the fact that the HSA has engaged more actively concerning the issue of internship as they believe internship can provide educationally sound experience and clinical skill development, and thus the nature and formulation of the programme has become increasingly important and relevant.

## **5.5 Past Internship Structures Accessed**

These comprised data reflected in the answers to Section C of the questionnaire.

The majority 53.2 % of respondents had an internship program included in their training course.

### 5.5.1 Location of Internship Undertaken

Of the respondents who received an internship, 44 respondents (46%) indicated that the internship took the form of observing cases conducted by qualified Homoeopaths. This is the least formal of the internship forms that were reported. Of the internships completed, 54.4% reported they were performed in private practise, with only 6.3% occurring in an external clinic. This form of internship was initially conducted using a preceptorship system, which ran for two years after which it was abandoned due to evident inconsistency in delivery. This was largely due to the fact that at that time, the understood requirements for internship were relatively small and vague. This lead to a general inconsistency in the internship programme, with some interns able to partake in the consultation, others were made to do dispensary work, while others reportedly performed 'receptionist' type tasks.

17% of graduates completed an internship programme by observing Homoeopathic cases. A predetermined number of cases, (25) had to be

presented in a specific format. Completion of presentations, inferred completion of the internship.

The remainder of the respondents, received an internship based at the institution's clinic, which was structured similarly to the previous fifth year clinical work already completed. One of the problems according to a respondent was that 'patients were given preference to fifth year students so our patient numbers dwindled'. This essentially did not provide any new training or expansion of skills and knowledge already acquired as was mentioned by a respondent. It was a continuation of proceedings from the previous year. (Figure 4.8)

Approximately one hundred percent of respondents who graduated from TN and TWR from 1994 to 1998 received an internship of some form or structure. From 1998 onwards, fewer internship programmes existed. It is apparent that the situation with respect to internship has been worsening. Figure 4.22 shows the decline in percentage of internship programmes completed. Whether an internship was part of a respondent's training was significantly correlated to the year of qualification. In 2004, twenty percent of respondents completed an internship programme, and the percentage decreased further, in 2006 not one respondent received any form of internship.

#### 5.5.2 Length of time devoted to Internship

56.8% of interns reported dedicating between 21-40 hours per week completing their internship. 37.8% spent between 1-20 hours weekly. Only 3 respondents spent longer than 41-60 hours per week, and only one respondent spent greater than 61-80 hours weekly. This particular respondent performed her internship in a clinic overseas in India where she worked 11-12 hour days 7 days a week. According to her this 'training was invaluable'. (Table 4.10)

### 5.5.3 Duration of Internship

The majority of respondents, 47.9% reported the duration of their internship to be 12 months, which is in accordance to Ross (2005), who stated that in terms of the new regulations an internship should span no more than twelve months. This appears to be represented largely by graduates who completed a sixth year in one of the institution's clinics, the duration of which is around an average of a year. A smaller percentage of 26% spent a period of between six to twelve months performing internship. Just over 10% of respondents were involved in an internship for longer than one year. Only 6 respondents experienced an internship of two years duration. (Table 4.11)

A strong correlation between the country of residence of the respondent, and the duration of internship exists. Most (94.2%) of the respondents were resident in South Africa. The internships of RSA residents were generally in the order of 0-12 months.

### 5.5.4 Nature of Internship programme

#### 5.5.4.1 Seeing patients on a one to one basis

The vast majority of internships offered the interns the experience of seeing patients on a one to one basis. 87.7% reported having had the opportunity to do so. A very strong correlation exists between the year of qualification and whether one-on-one consultations were part of the internship. Most qualification year-groups reported seeing patients on a one-on-one basis. There is thus a near perfect correlation, most respondents from every year experienced this form of interaction.

#### 5.5.4.2 Supervision

Table 4.13 reflects that internship forms were well supported in terms of supervision and oversight. Most of the responses reflect that respondents spent approximately a year, working up to 40 hours a week, seeing patients



on a one to one basis with supervision. (The extent and consistency of the supervision cannot be assessed in this study.) Respondents reported having had excellent supervision, while others reported that the supervision was 'there if required'.

#### 5.5.5 Possible perceived benefits from an internship

For those graduates who did not receive any form of internship training, only 3% felt that they would not have gained or benefited from such a programme. Of the remaining respondents, increased clinical/practice experience (65%) and increased confidence were the two most prevalent reasons why respondents believed they would have benefited from such a programme. Many respondents made reference to being supervised and guided during an internship, this 'mentoring' was a factor they felt would have contributed enormously to their benefit from such a programme.

Some felt that an internship would potentially fill the void they argue occurred in their fifth year in clinic, as this was 'inadequate and not thorough'. One graduate cautioned that spending time with practitioners could lead to the learning of 'bad habits employed by certain practitioners'. An option is to create a rotation system, which would create exposure to different approaches.

Another motive graduates argue as to why they would have benefited from an internship is that during the period while completing their dissertation much experience and confidence is lost. An internship run for the duration of that period would ensure continuation of skills learnt and growth of knowledge. This statement clearly highlights the lack of understanding of what an intern is. A graduate can only register as an intern once they have completed their research.

Others felt that internship would provide guidance as to the 'pitfalls of starting a practise', and to prevent them from occurring. This would greatly aid

graduates as they begin private practise and help to iron out 'teething problems'.

#### 5.5.6 Purpose of an internship

The greatest commonality in all the answers to the question regarding the purpose of internship was to gain practical experience (38.6%). This could be achieved by applying theoretical knowledge into 'actual practice', by acquiring insights into diagnoses and treatment of disease conditions and by improving on clinical/diagnostic skills. A respondent stated that an internship could aid in the "application of theoretical training which is taught often by lecturers who have limited experience themselves." In order to be effective the belief is that this experienced must be obtained under guidance and supervision of experienced practitioners (which was stressed numerous times). Therefore, an internship would provide insights and guidance seemingly not previously acquired by students. The beauty of an internship is to provide graduates with a 'safety net' within which to learn.

Of interest is that 15% of respondents utilised the following term; 'real world' in their explanation of the purpose of an internship. The context within which it was written, implied that what was learnt at the institutions was something other than 'real' and 'relevant', a protected, rather than realistic environment. The function therefore of an internship would be to 'bridge the gap', to allow for a 'smooth transition' in utilisation of your degree as a Homeopath in private practise. This was summarised by one respondent "To make the transition from a sheltered life at the training institutions to the workings of the real world".

Other areas thought to be consequences of internship training were to learn to work as a team, to learn patient management, gain knowledge and exposure in a variety of areas and create greater job possibilities.

Self confidence was mentioned in 33 replies, pertaining to an apparent outcome of internship training as experienced by some and perceived by

others. The role and consequences internship play seems to be perceived as monumental, as respondents allege that poor confidence (which would greatly improved due to internship training) is a major reason explaining why graduates do not survive in private practise. As is made evident in the following statement, “should an internship be created there would not be so many lost practitioners who turn to other means for careers”.

## **5.6 Evaluation of Internship**

Results show that 90% of the respondents feel that their internship programmes were beneficial to them and their Homoeopathic training. Interestingly a large number of respondents felt improved confidence as a benefit of their internship training. This can be seen to be derived from the improved materia medica knowledge (80.8%), case analysis skills (83.6%) and diagnostic skills (78.1%) that respondents felt were results of the internship programme.

Of noted importance is the improvement in interpersonal skills in a medical setting (74%), improved competence in patient examinations (68.5 %), clinical time and case management that were also deemed improved upon. Of least importance according to the respondents was the improvement in administration skills. Other areas that were improved upon were psychological counselling, homeopharmaceutics, including pharmaceutical ordering and dispensing, medico-legal implications and exposure to different approaches of practising Homoeopathy.

Of respondents who did not engage in an internship program, 94.2 % felt that it would have been beneficial. The graduate population (as represented by this sample) seems to recognise the importance and value of an internship process.

One graduate summed the above-mentioned statistic clearly by stating that her understanding of the purpose of an internship was “To complete the

training.” This clearly reflects the feelings of those who did not complete an internship, in that their training was therefore, incomplete.

## **5.7 Recommendations for an Internship Programme**

These comprised of descriptions of the data obtained from answers to Section D of the completed questionnaires.

### 5.7.1 Perceptions of which skills should be acquired/enhanced in an internship

Respondents were asked which skills were deemed necessary to be improved upon during an internship. The following skills were thought to be of most importance; diagnostic skills (96.4%) and confidence (95.7 %), 92.1% of respondents believed that both competency in examination and interpersonal skills required in a clinical setting were of importance, these were followed by clinical case management (90.6%). This perhaps reflects a lack in the existing education with respect to these skills. Of least importance was improvement or an increase in materia medica knowledge (75.5 %) (Table 4.14).

DUT has in its mission statement that it will aim to produce graduates who will demonstrate competence in differential and holistic diagnosis in order to determine the cause of the patient’s discomfort (Durban Institute of Technology, 2005). The findings in this study suggest that a fair proportion of graduates do not feel competent due to lack of confidence, diagnostic abilities and clinical experience.

As one respondent commented, “Internship would give you confidence and knowledge at your fingertips so that your first two years in practice are not practice.”

Graph 4.16 aims to illustrate the areas that the internships appear to be lacking. A large number of respondents felt that clinical time management, clinical case management, and administration skills were desirable benefits of the internship. These skills were perceived to have been improved by relatively fewer numbers of respondents. However, it is possible that the impressions of what is important would change during the course of the internship. Thus perceptions of desired benefits may be less a reflection of the internships' lack than a reflection of a different perception of a different group of respondents (viz. those who are practising verses those who are not/have never practised).

What is interesting is the importance placed on confidence, 95.7% of respondents believed that an internship would have improved confidence levels, and 86.3% reported that they actually received greater confidence from completing an internship programme.

A strong correlation exists between the province of residence and the perception of the need to emphasize improving medical knowledge. Residents of the larger provinces (in terms of percentage of respondents and in terms of population size) are more likely to feel a need to highlight the necessity of improving medical knowledge.

A moderate correlation between the following factors were found; respondents who felt that the relevant institution should be responsible for organizing the internship were less likely to feel that improving medical knowledge should be emphasized. This could be related to the perception that exists within the Homoeopathic community that training at the institution does not prepare you for the 'real world', as one third of the respondents reported.

Another focus of internship as recommended by respondents is to learn other modalities, such as Ayurveda, Chinese medicine, Heavy metal chelation, Iridology and Ozone therapy.

### 5.7.2 Favoured duration of an Internship programme

The majority of respondents felt that 1 year is a desirable duration for an internship process (Table 4.15).

There exists a correlation between the province of residence and perception of desired duration. The relationship appears to be that respondents from KZN and Gauteng are more likely to feel that an internship of 6 months would be desirable. This may reflect increased time-pressure and competition in these major centers.

Respondents who undertook shorter internships were more likely to recommend shorter internships. Respondents who undertook longer internships were more likely to recommend longer internships. Further correlation revealed that respondents who did not see patients on a one-on-one basis were more likely to recommend a shorter internship. This could perhaps highlight the lack of supervision encountered, thus decreased perceived benefit of an extended internship. One respondent added that the duration should be dependent on the level of exposure. In addition to this, one view concerning duration was that the time allocated needed to be sufficient to allow for follow-up cases, in particular chronic cases.

### 5.7.3 Evaluation of where respondents thought that the internship should be conducted

Most respondents felt that the internship should be conducted in the private sector with the supervision of qualified Homoeopaths. Internships in the public health sector (both hospitals and clinics) were also viewed positively. Very few respondents felt that the internship should be held in the private sector with practitioners from other disciplines. A possible reason for this is recognition of the need in an internship to focus on the development of Homoeopathic skills

(clinically, philosophically and in terms of practice management) and not on the development of an integrated centre.

42% of respondents believed that community service centres should be incorporated as internship 'sites', this figure correlates with the percentage of respondents (42.8%) who believe that one of the intentions of internship should be community service (believed to be of least importance statistically) (Figure 4.17). Respondents who had undergone an institutional 6<sup>th</sup> year and those who did not feel that the internship benefited them were more likely to feel that an emphasis should be placed on community service (Table 4.24).

A weak correlation exists between the respondent's gender and the recommendation to conduct the internship at a primary health care clinic. Males were far more likely to feel that the internship should be conducted in the public health sector at primary care clinics. On speculation, this could be related to the level of safety a female would take into consideration when performing an internship in the public health sector, as opposed to the private health sector. This was not questioned in the questionnaire, and thus remains as speculation.

In its guidelines for Homoeopathic education (1993), the ECCH states that it is crucial for students to have access to practicing Homoeopaths on whom they can rely for their expertise within the context of the clinical situation. This is confirmed by 66.7% of respondents who believe internship should be conducted under the supervision of Homoeopaths in private practice. Students are reliant upon these practitioners to share insights and of great importance, experience. Clinical learning, tutorials and supervision are stressed as an integral part of education for both students and new graduates in the first years of practice. It is evident that graduates feel that their clinical experience and "integration of 'textbook' knowledge" was lacking. However, a practitioner responded by saying that she would find it very difficult to have an intern sitting in on patients, as it is a very personal time for the patient and this might hinder their openness. She therefore feels that a clinic situation would be better suited to internship.

#### 5.7.4 Perceptions around the focus of an internship

The majority (84.1%, 86.2% and 84.8% respectively) feel that the focus areas should be on improving medical knowledge, gaining greater experience Homoeopathically and gaining personal experience. Again confidence was deemed as an important focus for an internship. This is confirmed as that both the gained benefits (those who had undertaken an internship) and the desired benefits are in line with these figures (Figure 4.18).

#### 5.7.5 Remuneration

In terms of the remuneration issue, 94.2% of respondents felt that Homoeopaths should be remunerated for the internship process. The particular mode of remuneration is shown in Table 4.18 and Figure 4.19.

Moderate correlation was discovered between the following factors; respondents who had undergone an internship were more likely to feel that remuneration should be a proportion of takings. Respondents who had not been more likely to feel that a fixed hourly rate should be used (Table 4.24).

However, the majority of the respondents (50%) favoured a fixed monthly rate for the internship process (Figure 4.19). A possible reason for this is the other two options allow a looser less formal arrangement-i.e. Homoeopaths being paid piecemeal, if they see fewer patients, this would result in less remuneration and a disorganised form of income. A fixed monthly rate may be seen to imply a more definite commitment and arrangement, which was implied by a respondent when she stated that an intern will need to know how much income they can be expecting. Another respondent stated that 'remuneration should be more or less in line with medical interns rates'. Medical interns receive approximately R93 000 per annum (Mtshali, 2006).



Of the respondents who believed interns should not be remunerated, there existed strong correlation between the respondents who held this opinion and those who worked between 60 and 80 hrs per week during their internship training.

#### 5.7.6 Affiliation of the Homoeopathic internship process

The large majority (76%) of respondents felt that the internship programme should be a direct progression from an institution, this percentage can be compared to the 39.4% of respondents who felt that the internships responsibility rested with the institutions themselves.

There exists a strong correlation between the province of residence and the recommendation of where the internship should be affiliated. Again, respondents from the larger provinces felt the internship should be a direct progression from the relevant institution.

A comment from a graduate reads, “the institution has five years to impart its knowledge base, internship should be spent gaining knowledge from a wider source, namely outside the institution.” This links with the comments made about gaining broader medical experiences as well as learning different approaches and different modalities entirely. 24% of respondents felt that an internship programme should be an unrelated separate entity from the two training institutions.

# **CHAPTER SIX - CONCLUSION AND**

## **RECOMMENDATIONS**

### **6.1 Conclusion**

In terms of the current legislation, the majority of respondents had an understanding of the law governing internship and it was of their opinion that an internship should be a condition of registration. This can be concluded, as there is a general consensus regarding the importance and relevance of an internship.

From the above it appears that internship will serve to complement the Masters degree in Technology: Homoeopathy course in moulding a well rounded homoeopathic practitioner. As a consequence of the absence of a defined and structured internship programme, the profession of Homoeopathy is compromised. Therefore the formulation of an internship needs to be prioritised.

The following has occurred: the academic institutions have taken responsibility on numerous occasions and have structured and implemented voluntary internship programmes (albeit not their responsibility). To date, no documented information or evidence exists of the exact format and structuring of any of the forms of internship already carried out, prior to this study. Once problems or flaws were identified or encountered, interns withdrew as their participation was voluntary; reasons for withdrawal included; funding, inconsistency or insufficient patient numbers. Funding remains a contentious issue, with neither the Professional Board acting through the AHPCSA nor the Department of Health, having taken any responsibility for formulation or funding of such a programme. The HSA although not legally responsible has expressed its concern over the deficit of an internship, but have been unable to formally act, as the legal responsibility lies with the statutory council. Organisation, creation and support for an internship are still issues that

remain unresolved. Once the relevant bodies can reach consensus clearly identifying their roles and obligations, the planning an internship can occur.

Even though the implementation of the internship rests with the professional board, the HSA and the AHPCSA in conjunction with the training institutions should begin formulating the blueprint of a sustainable and effective internship programme. The Allied Health Professions Act 63 of 1982 has not been applied in recent years and it is evident from this research the importance internship has to play in preparation towards competent practitioners. Further non-implementation and thus failure to acknowledge this fact will have significant adverse implications for new members entering the profession.

## **6.2 Recommendations**

### 6.2.1 Recommendations to the Representative Professional Bodies

The shortfalls and merits of the internship programmes run can be understood as a result of this survey.

Supervision is of paramount importance. The nature of the supervision needs to be carefully explored, as respondents stated that experienced (this was stressed), knowledgeable and varied supervisors are necessary. In order to achieve this, some form of accreditation must be drawn up, prior to appointment of supervisors that will ensure a national standard.

The internship should aim to impart knowledge of a different flavour to what has already been acquired. Therefore, spending a further year at the institutions clinic is undesirable. For greater exposure interns need to be assigned to private Homoeopathic practises. A rotation system seems able to provide sufficient exposure to varying forms of supervision. Interns should also spend time in hospitals or clinics facilitating improved medical knowledge.

A period of one year should be dedicated to internship, and this should occur directly after the clinical fifth year has been completed. Interns must receive some form of remuneration during their internship, a fixed monthly rate was deemed reasonable.

The following are deemed necessary outcomes of an internship programme;

- Practising and improving of skills and techniques needs to be overseen and monitored.
- Definitive outcomes must be outlined and achieved.
- Practise management and administrative/business skills and information must be imparted.
- Integration of medical skills and diagnosis with treatment and management plans must be taught.

Babaletakis (2006) reported that the majority of Homoeopaths would not choose to re-study Homoeopathy against other medical degrees. She attributes this to poor financial viability and lack of confidence. If an internship programme can bridge the gap, expose the workings of the real world and add relevant skills and most importantly improve confidence levels, it may be the answer to the longevity of the profession of Homoeopathy. If nothing else it will produce better-equipped and superior practitioners.

#### 6.2.2 Recommendations for future studies of a similar nature

A longer period of time for return of sent questionnaires should be allocated, especially if practitioners are involved, as they are extremely busy and require reminding to reply as well as sufficient time. If questionnaire responses are to be of a desired quality sufficient time must be allocated. A questionnaire should not be conducted over a holiday period.

Students should seek professional advice when sending questionnaire via email, as many problems encountered in this study could not be resolved by

the researcher due to insufficient computer technical knowledge. Therefore it is advisable for a computer technician to format the questionnaire on line prior to sending it to participants.

### 6.2.3 Recommendations for future studies

In this study, the success of respondents who completed an internship was not assessed. It could therefore not be compared to the profits or net income of a practitioner who was practising but who did not receive an internship programme as part of their training. A future study comparing these variables could provide further insight into exactly how internship has affected practitioners and practises. It would need to assess the number of patients that are seen daily and monthly and the time spent with new and follow up patients. It could then extrapolate how internships affect the financial earnings of practitioners.

## **REFERENCES**

Allied Health Professions Council of South Africa {online}. 2006. Available:  
<http://www.ahpcsa.co.za> [Accessed 2 October 2005]

Babeletakis, FN (2006). *A Retrospective Survey Of Post-Graduate Career Paths Of Durban Institute Of Technology (DIT - Formerly Technikon Natal) Homoeopathic Graduates From 1994 To 2004*. M.Tech:Homoeopathy dissertation, Durban Institute of Technology, Durban

CASA. 2004. *The Chiropractic Internship Programme Manual Kwazulu Natal*

College of Health Professions – Psychology Internship. 2006 Available:  
[http://www.temple.edu/chp/psychology\\_internship/supervision.html](http://www.temple.edu/chp/psychology_internship/supervision.html)  
[Accessed 12 November 2006]

Descriptive Research PEHL 557 [online]. 1999. Available:  
[http://www.cwu.edu/~jefferis/PEHL557/pehl557\\_descript.html](http://www.cwu.edu/~jefferis/PEHL557/pehl557_descript.html) [Accessed 8 May 2007].

Durban Institute of Technology. 2006. *Faculty of Health Sciences Rule book for the Department of Homoeopathy*. Durban. South Africa.

ED 512 Quantitative Research Methods [online]. 1999. Available:  
<http://www.wou.edu/~gatimum/ed512/Ed%20512%20Descriptive%20or%20survey%20research.htm> [Accessed 8 May 2007].

Education and Training [online]. 2006. Available:  
<http://www.hpcsa.co.za/hpcsa> [Accessed 17 March 2006]

Edwards FD and Frey KA. 2007. The future of residency education: implementing a competency-based educational model. *Family medicine*.

[online], 39(2):116-25. Available: PubMed - indexed for MEDLINE, Article number 17273954 [Accessed 9 May 2007].

European and International Councils for Classical Homoeopathy, The. 1993. *Guidelines for Homoeopathic education*. United Kingdom: European Council for Classical Homoeopathy.

Fink, A. and Kosecoff, J. 1985. *How to conduct a survey; a step-by-step guide*. California: Sage Publications. pp18 ISBN 0-8039-2456-9.

Fink, A. 1995. *How to Design Surveys*. California: Sage Publications. pp 48-50 ISBN 0-8039-7388-8.

Fowler, F. 1993. *Survey Research Methods*. 2<sup>nd</sup> ed. America: Sage publications. ISBN 0-0838-5048-9

Freiman A, Barzilai DA, Barankin B, Natsheh A, Shear NH. 2005. National appraisal of dermatology residency training: a Canadian study. *Archives of Dermatology [NLM - MEDLINE]* [online], 141(9):1100. Available: Proquest education journal, Article number 902487661 [Accessed 10 May 2007].

Heard JK, Allen RM, and Clardy J. 2002. Assessing the needs of residency program directors to meet the ACGME general competencies. *Academic medicine. Journal of the Association of the American Medical Colleges* [online], 77(7):750. Available: PubMed - indexed for MEDLINE, Article number 17273954 [Accessed 9 May 2007].

Internship programme [online]. 2006. Available: <http://internships.nres.uiuc.edu/policy.html> [Accessed 12 November 2006]

Korporal, C. Chairperson of National Chiropractic Internship Committee and Senior Chiropractic Lecturer at DUT. Personal Communication 31 January 2007. Interviewed by L.Chella. DUT, Durban, 10:00am – 11:am.

Kraft, N.M, Snyder J.B. and Hagan D. W. 2003. Evaluation of the Ohsu/Vamc Dietetic Internship Program in Preparing Graduates for Entry Level Dietetic Practice. *Journal of the American Dietetic Association* [online], Volume 95, Issue 9, Supplement 1. Available: Science direct. doi:10.1016/S0002-8223(95)00602-8 [Accessed 9 May 2007].

Mtshali N. Medical Students Representative Council representative on JUDASA. 2006. Interviewed by L.Chella. Durban, 4 April, 11.30am.

Postgraduate training. [online]. 2006. Available: <http://www.medicalcouncil.ie/education/postgrad.asp?NCID=18> [Accessed 12 November 2006]

Released by the Communications Unit, 2002. Two-Year Internship: Its Status and Rationale [online]. Available: <http://www.doh.gov.za/search/index.html> [accessed 17 March 2006]

Ross, A. HOD Homoeopathy (DUT). Personal Communication 20 September 2005. Interviewed by L.Chella. DIT, Durban, 8:00am

Sweidan, M *A retrospective survey of post-graduate career paths of Technikon Witwatersrand (TWR) Homoeopathic graduates from 1998 to 2004* (work in progress) M.Tech:Homoeopathy dissertation, Durban Institute of Technology, Durban

Silverman, D. 1997. *Qualitative research Theory, Method and Practise*. Great Britain: Sage publications. ISBN 0-8039-7666-6



Torbeck L, and Wrightson AS. 2005. A method for defining competency-based promotion criteria for family medicine residents.

*Journal of the Association of the American Medical Colleges* [online] 80(9):832-9. Available: PubMed - indexed for MEDLINE, Article number 16123463 [Accessed 9 May 2007].

Types of surveys. [online]. 2006. Available: <http://www.gslis.utexas.edu/~palmquis/courses/survey.html> [Accessed 6 May 2007]

What is internship [online]. 2006 Available: [www.prospectusy.com/resources/byu-glossary/](http://www.prospectusy.com/resources/byu-glossary/) [Accessed 5 May 2006]

Wikipedia, the free encyclopedia. 2006 Available: [http://en.wikipedia.org/wiki/Medical\\_intern](http://en.wikipedia.org/wiki/Medical_intern) [Accessed 5 May 2006]

Zulu, P. Deputy Director Academic Health Service Complex. 2006. Interviewed by L.Chella. Durban, 4 April, 12.30am.

## **APPENDIX A**

**Act 63 of 1982 section 19** as amended by Chiropractors, Homoeopaths and Allied Health Service Professions Second Amendment Act 50 of 2000:

### **Registration of interns**

- (1) Any person who has obtained a qualification which entitles him or her to register as a practitioner of an allied health profession under this Act after the Chiropractors, Homoeopaths and Allied Health Service Professions Second Amendment Act, 2000, commences and who wishes to practise such profession in the Republic, shall apply to the council for registration in the prescribed manner.
- (2)
  - a. A person who has applied for registration in terms of subsection (1) may, on the recommendation of the relevant professional board, be registered by the council as an intern.
  - b. An intern must complete a prescribed internship programme before he or she may be registered as a practitioner of the profession in question.
- (3) The council may, after consultation with the relevant professional board, register a person who has not yet graduated as a student intern and may permit such student to commence with a prescribed internship programme.
- (4) No person may be registered by the council as a practitioner unless he or she has graduated and has completed the prescribed internship.
- (5) The duration, requirements, conditions and rules pertaining to an internship are as prescribed.

## APPENDIX B

### QUESTIONNAIRE

#### PART A: DEMOGRAPHIC DATA

##### Personal Details:

Question 1.1

**FOR INDEPENDENT AUDIT BY THIRD PARTY ONLY**

First Names	
Surname	

Independent third party is to tear off here before passing onto researcher

-----

Question 1.2

City:		Country:	
-------	--	----------	--

Question 1.3 Gender:

Female		Male	
--------	--	------	--

Question 1.4 Year of qualification from Technikon Natal / DIT / DUT

--

## PART B: Current Legislation

### Question 2

At present there is no internship programme available upon completion of a degree in Homoeopathy. Act 63 of 1982 section 19 2b states: An intern must complete a prescribed internship programme before he or she may be registered as a practitioner of the profession in question. Therefore by law internship should be a condition of registration, which means before you can register as a Homeopath you have to complete an internship. Are you aware of this law?

YES	NO
-----	----

### Question 2.1a

Were you aware of this law, prior to completing this questionnaire, concerning internship and registration subject to completion thereof?

YES	NO
-----	----

### Question 2.1b

If yes, how did you come to know about the law?

AHPCSA	
Homoeopathic Association of South Africa	
The Department of Health	
The relevant institution Technikon Natal / DIT / DUT	
Through colleagues	

### Question 2.2

In terms of the law who do you think is responsible for structuring and implementing an internship programme?

AHPCSA	
Homoeopathic Association of South Africa	
The Department of Health	
The relevant training institution	
Other	

## PART C: Past internship

Question 4.1

Upon completion of the 5<sup>th</sup> year of study towards the M.Tech:Hom did you embark on an internship programme?

YES	NO
-----	----

Question 4.2

If no, proceed to question 4.5  
If yes, what did it consist of?

Presentation of 25 case studies	
Observing cases conducted by qualified Homoeopathic practitioners	
Additional patients seen in the relevant educational institutions' day clinic during '6 <sup>th</sup> year'	

Please elaborate:

Location: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Number of Hours per week: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Duration: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Did you see patients on a one to one basis?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Was there any form of supervision?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Question 4.3

Was your 'internship' in your opinion, beneficial to you and your training as a Homeopath?

YES	NO
-----	----

Question 4.4

In which of the following areas did your internship training provide you with some form of gain or improvement?

Increased knowledge of Materia Medica	
Increased diagnostic skills	
Improved case analysis skills	
Improved competency in examining a patient	
Improvement in clinical time management	
Administration skills	
Clinical case management	
Confidence	
Developing interpersonal skills in a medical setting	

Other, or elaborate:

---

---

---

---

---

---

Question 4.5

If answered no to Question 4.1, do you think that you would have benefited from such a programme?

YES	NO
-----	----

Question 4.6

If yes why so?

---

---

---

---

---

Question 4.7

In your opinion what is the purpose of an internship?

---

---

---

---

---

---

---

---

---

---

**Part D overleaf**

## PART D: Recommendations for an Internship

Question 5

What skills should be acquired or enhanced during an internship programme?

Increased knowledge of Materia Medica	
Increased diagnostic skills	
Improved case analysis skills	
Improved competency in examining a patient	
Improvement in clinical time management	
Administration skills	
Clinical case management	
Confidence	
Developing interpersonal skills in a medical setting	

Other:

---



---



---

Question 6

What do you think an adequate duration period for the internship should be?

Six months	
One year	
Two years	

Other:

---



---



---



Question 7

Where should the internship programme be conducted?

Private Health Sector – with qualified practitioners of other disciplines.	
Private Health Sector – with qualified Homoeopathic practitioners	
Public Health Sector – in hospitals	
Public Health Sector – in clinics	
Community service centres	
At the training institutions (DUT/UJ) themselves – within institutional clinics	

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Question 8

On what aspects should the emphasis of the internship programme be concentrated?

Improving medical knowledge	
Learning different Homoeopathic approaches	
Gaining greater experience Homoeopathically	
Doing community service	
Gaining personal confidence and experience	

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Question 9.1

Should the interns be remunerated during the internship training?

YES	NO
-----	----

Question 9.2

If yes, what form do you believe should this remuneration take?

Fixed hourly rate	
Proportion of takings	
Fixed monthly rate	

Other:

---

---

---

---

---

---

Question 10

Should the internship programme be affiliated with the relevant institutions and their formal academic training or should it be a separate entity entirely?

Direct progression from academic programme at relevant institutions	
Unrelated , a separate entity	

Other:

---

---

---

---

Additional comments for Part D:

---

---

---

---

---

---

---

---

---

---

---

## **APPENDIX C**

Practitioner Information Sheet

(On the Durban Institute of Technology letterhead)

Dear \_\_\_\_\_

Title of Research Project: A retrospective survey of perceptions and opinions of M.Tech:Homoeopathy graduates around the role and scope of Homoeopathic internship, in terms of the current legislation

Name of Supervisor: Dr. David Naude (M.Tech:Homoeopathy).

As part of the Masters Degree in homoeopathy, I have chosen to undertake this survey as it is centred on the issue of internship in Homoeopathy. An intern is defined as: A student or a recent graduate undergoing supervised practical training or b. A physician who has recently graduated from medical school and is learning medical practice in a hospital under supervision, prior to beginning a residency program. Internship is therefore the time during which an intern performs his training.

At the present time there is no internship programme available for M.Tech:Homoeopathy graduates of both institutions that offer a masters degree in Homoeopathy. By law internship is a condition of registration, as stated in the Act 63 of 1983 section 19 as amended by Chiropractors, Homoeopaths and Allied Health Service Professions Second Amendment Act 50 of 2000 i.e. unless an internship is completed one cannot register as a Homeopath.

This survey poses to determine whether qualified M.Tech:Homoeopathy graduates are aware of this law and their opinion thereof, as well as to ascertain the form an internship programme should take. Your participation in this survey could provide valid information concerning the delivery of an internship. It will also prove to evaluate the past internship programmes and requirements and to improve upon those. Importantly it also serves to provide information and awareness about the laws on internship that are unknown to some graduates.

Participation will involve completing a questionnaire, which may take up 20 minutes of your time in total. I realise that your time is valuable and thus the questionnaire has been limited to only the most crucial information, yet still including enough questions to ensure that the study provides meaningful information. By completing the questionnaire you provide consent to participate in this study.

Please note that a neutral third party, who is not a homeopath and has no connection with the researcher or Homoeopathy as a profession, will receive all completed questionnaires, she will delete each practitioner's name upon receiving each questionnaire. Each practitioner will be assigned a practitioner number, and therefore be identified by a number only, ensuring anonymity as (the researcher and supervisor) will not know the identity of the respondent. This will reinforce the fact

that all answered and returned questionnaires will have no connection whatsoever to the practitioner who participated and will remain completely anonymous.

The procedure will be as follows:

1. Once the questionnaire 1 and 2 are completed please repost the questionnaire in the self-addressed envelope, or return your completed email questionnaire.
2. The questionnaire is addressed to an independent third party, once they have received the envelope/email, your name will be marked off and deleted, you will then only be known by a number.
3. Upon receiving the questionnaire together with this letter, please return it as soon as possible as there is a two-week time constraint for receiving your response.
4. If the questionnaire has not been returned by the two-week period, the researcher will contact you as a reminder to complete and return the document.
5. Then a further two weeks will be allowed for the return of the questionnaire, after which time non-complying candidates will be considered 'drop-outs' of the study.

The researcher and participants will receive no remuneration for undertaking and participating in the study. The cost of the study will be incurred by the Durban University of Technology. When the dissertation is complete, an abstract and table of contents will be sent to you. A copy of the full dissertation will be available for loan to you if you are interested from the D.U.T. library.

If you have any queries or you are faced with any problem at any time please do not hesitate to contact:

Laura Chella at: 0836870074

Dr David Naude at (031) 2042514

I believe that this study will provide valuable and vital information regarding Homoeopathy in South Africa, and it may contribute to developing the Homoeopathic profession as a whole, due to the importance of the issue asked in the questionnaire. Your co-operation is greatly appreciated.

Yours sincerely

-----

Laura Chella  
Investigator

-----

Dr David Naude  
Research Supervisor

## **APPENDIX D**

Thank you letter:

Dear Graduate

I sincerely thank you for your participation in my survey. I realise your time is of great value to you and I appreciate the fact that you gave of your personal time to take part in my studies and thus to improve Homoeopathy as a whole.

I will be preparing an abstract of my completed research study as feedback to all participants, and I will send these via email to all participants who have access to email.

With thanks and appreciation

-----

Laura Chella  
Researcher

## **APPENDIX E**

List of member of Focus group held at the Department of Dental Technology.

Members of Staff from the Department of Homoeopathy:

Dr I Couchman

Dr C Hall

Dr R Hopkins

Dr M Maharaj

Dr D Naude

Dr A.H.A Ross

Current 5<sup>th</sup> year Homoeopathic students:

Ms Fotini Babeletakis

Ms Clair Speckmeier

## APPENDIX F

### List of DUT Graduates and Year of Qualification

Aleotti	Claudia	1998	Freese	Lorette Elfriede	1997
Alexander	Karen	1994	Giles	Lance Ferneaux	1995
Babaletakis	Fotini	2006	Gillespie(Standage)	Nerena Beatrice	1994
Balding	Tamara Jane	2002	Govender	Nervashnee	2004
Barklie(Taggart)	Tanya Sharon	1999	Hagen	Siobhan Sarah Casey	1996
Basson	Jo-Anne	2002	Hall	Cornelia Maria	1999
Bland	Colleen Margret	1997	Harris	Bronwyn Claire	2003
Bloch	Michael	2003	Harris	Matthew Gregory	2001
Bolling	Birgit	1998	Hellberg(Kotze)	Nicolette Liesel	2001
Bondonno	Roberto Carlo	1996	Hillermann	Roland Manfred	1997
Botha	Isel	2006	Himlok	Karen	2002
Botha	Okker Roelof	2002	Hoffman	Delia	2006
Brammer	Ronel	1995	Hofmeyr	Dorita	2005
Brandsch	Helga Michaela	1997	Hopkins	Crofton Russell	1998
Bresler	Saun Christian	1994	Invernizzi	Jonathan Rai	2003
Bruni	Rouen	2001	Ismail	Shaida	2004
Budree	Rohan Sewdayal	2004	Joseph	Jeanine Dorothy	1994
Carey	Angela Moira	2000	Kaufmann	Holton James	1998
Cason	Angela	2003	Kell	Colette Melissa	2004
Christie	Natalie Nowell	1995	Kent	Kerry	2006
Clark	Lindy Jane	2002	Kerschbaumer	Werner	2004
Couchman	Ingrid Marcelline Stephanie	2001	Kirtland	Karen Andrea	1995
Courage	Michelle	2006	La Grange	Coin David	1999
Cross	Andrew Peter	1997	Langford	Samantha Jane	2002
Curnow(Haggman)	Janine Margaret	**	Lutchman-Maharaj	Sapna	2005
Daphne	Antoinette	1998	Lee	Monique	1998
Davies	Troy Murray	2002	Leong	Sao Lai	2002
Dawson	Nicole	2000	Lever	Yvette	1998
De La Rouviere	Alexandra Mary	1997	Lilley	Dorian Lejan	1998
De Smidt	Johannes Willem	2001	Lockyear	Heather	2004
De Waard	Anton Hans	1996	Louw	Natasha	2004
Dhanraj	Pravith	2001	Low	Lisa	2003
Dlamini	Nomyhandazo	2004	Lyell	Daphne	2005
Domleo	Sinden Jane	2003	Mabuza	Mbuso	2003
Dos Ramos	Antoinette	1999	Macquet	Maurel Louise	2004
Dos Ramos	Maureen	2001	Maharaj	Ashnie	2005
Dummer	Karen	2003	Maharaj	Dheepa	2006
Eatwell	Allen Rowan	2004	Maharaj	Madhueshwaree	2000
Ebrhim	Shera	2004	Main	SL	2005
Eldridge	Julia Kathrine	2000	Makris	Georgina Anne	1994
Erasmus	Fourie	2005	Malan	Jonannes Francois	2003
Farrow	Gregory Alan	1998	Madel	Fritz Johan	1999
Ferrucci	Loretta	1995	Mcdavid	Gillies Malcome	1994

Mcteer (Frances)	Taryn	2004	Ross	Ashley Hilton Adrian	1998
Middleborough	JB	2005	Sarawan	Shanie Mohanlall	**
Mistry	Raakhee Gunvant	1999	Saul	Wayne	2006
Moolla	Farhana	1995	Schultz	Myron	1994
Morris	Catherine Anne	2003	Sengpiehl(Stranski)	Monika	1995
Mostert	Anna Johanna	2003	Sewsunker	Olica	2001
Mostert	Ronell	1999	Singh	Shamanie	2005
Motara	Farhad Essop	2004	Singh	Varuna	2000
Moyal	Orley	2002	Singh	VR	2005
Moys	Estelle Renee	1999	Smal	Lorna	2005
Muller(De Freitas)	Nadine Avril	1997	Small	Deidre	2005
Naude	David Francis	2001	Smith (Nee Smith)	Liesl	2005
Naude	Wayne Stuart	1997	Smulders	Henriette	2001
Nell	Nicholas	2004	Spitze	Brigitte Henriette	1995
Neumann	Jacqueline Watson	1998	Steele	Richard	2000
Naidoo	Dean	2005	Storey	Robert	2000
Nienaber	Silvana	2005	Stubbs	Claire	2002
Nijland	G	2006	Sukdev	Reena	1998
Opperman	Celia	1998	Swan	Carla	2003
Paruk	Fatima	2006	Tak	Eugene Lawrence	2001
Pautz	Joanne Elizabeth	1999	Taylor	Grant Cavill	2000
Peckham	Allen	1996	Thomson	Bruce	2004
Pillay	Annette	2003	Tsolakis	Natalie	1995
Pillay	Bavani	1994	Turner	Taryn	2006
Pillay	Danny	1996	Vaithilingam	Heshma	2006
Pollock(Gray)	Jacqueline	1998	Van Der Hulst	Nicolette	2003
Poolman	Emmerentia Christina	1994	Van Niekerk	Karin	2000
Porter	Lindi	1997	Van Schalkwyk	Christiaan Johannes	1999
Power	Sean Michael	2000	Verhoogt	Mariaan	2003
Puterman	David Joel	1994	Vosloo	Chiquita Louise	2002
Rademan	Wim Marius	1998	Vosloo	Werner	2001
Ramlachan	Shavashni	2003	Webb	Kathleen Ann	1998
Randeree	Aziza Muhammed	2000	Webster	Heather	2003
Reader	Hayley	2002	White	Keryn Elizabeth	1995
Reid	Kim Louise	2002	Williams	Dillon Christopher	2003
Rielly	Patricia Isabel	2003	Wright	Craig Douglas	2000
Ronander	Garnet Edgar	2001	Wulfsohn	TO	2006

\*\* Year of qualification unknown



## APPENDIX G

### Graduates from UJ and Year Graduated

Artemi	Allana	2005		Forster	Heinrich	2006
Baasch	Marianne	2005		Forsyth	Stuart	2004
Baerveldt,(Baker)	Cherise	2001		Fourie	Samantha	2004
Baillie	Trevor Douglas	2000		Frost	Carolyn	2004
Bauer	Rael	2004		Gower	Neil	2005
Bayer	Philip	2001		Groves	Isabel	2000
Bekker	Marelize	2004		Hardy	Robert	2001
Beguín	Lara Elizabeth	2006		Hatzikonstandinou	Kanellie	2000
Bengsch	Heidi	2001		Hohl	Uwe	2005
Beukes	Stefan	2001		Horn	Michelle Andri	2006
Blake	Graeme	2002		Hoorzoak	Zureena	2003
Bond	Joddina	1998		Hutchinson	Shaun Adrian	2006
Bradshaw	Candice Louise	2000		Ings	Zanatoa Tanya	2003
Breedveld	Sancia Nicole	1998		Jacobs	Taryn	2002
Brodie	Kerian	2002		Jeannes	Rene	2001
Buldeo	Nitasha	2006		Jeena	Anjana	2003
Cable	Shelley	2006		Johnston	Gavin Ewan	2000
Cape	Mareza	2005		Jooste	Petra	2001
Cara	Raakhi	2004		Jordi	Marie Louise	2000
Cascioli	Tracy Rozanne	2000		Kalicharan	Gavna	2006
Castro de Canha	Nicole	2003		Kay	Jonathan	2006
Clarke	Michele	2006		Khan	Tandweer	2004
Cockcroft	Donna	2006		Khayltash	Shekufeh	2001
Cole	Caron Luanne	2000		Kholer	Robin	2004
Compere	Vicki	2003		Knipe	Irene	2001
Coutts	Candida	2004		Komar	Tania	2006
Cox	Samantha J	2000		Lala	Brijesh	2003
Da Silva	Monica	2005		Lankesar	Yasmeen	2004
Danks	Miles	2005		Latsky	Desiree	2005
Davey (Clark)	Karen Lee	1999		Lazarus	Kerri Leigh	2002
de Klerk	Marike	1999		le Roux	Yolande	2001
Didcott	Helen Sarah	1999		Leckie	Vera	2002
Dieltiens	Ivy L	2003		Leistner	Elke	2004
Domeison	Debbie	2002		Leggatt	Karin	2002
Donly	Alan	2001		Leibenguth	Manfred	2001
Doolabh	Pranay	2001		Leistner	Elke	2004
Dracevac	Ivanka	2002		Lessing	Anna Christina	1998
du Plessis	Jan Leonard	2001		Lewis	George	2001
Durandt	Gerhardus	2003		Long	Angela Christine	1999
Eden	Julie Michelle	2001		Louw	Mariska	2006
Engelbrecht	Arnold	2006		Martin	Chanel	2002
Ferguson	Glen	2001		Mckechnie	Bronwen	2000
Fleming	Colleen	2002		McLeod	Lynette Ann	2003

Mercer	Monica	2001		Schultz	Jacquelyn Loren	2000
Meyer	Johan	2001		Selli	Tanya	2004
Montgomerie	Kylie	2002		Singh	Raksha	2002
Moore	Heloise	2000		Smit	Adriaan	2001
Motala	Vicky	2001		Smit	Sandra	2002
Moukangoe	Phaswane Isaac Justice	2003		Smith	Debbie	2000
Mower	Gary Wayne	1999		Smith	Lauren	2002
Mullinder	Louis	2004		Snyman	Christinette	2006
Neaves	Nicholas	2001		Squara	Sandra	2001
Noorbhai	Farzana	2005		Staats	Jurgens	2005
Panovka	Leigh	2001		Straus	Leon Christiaan	2000
Parbhoo	Anupa	2003		Sutherland	Jodi Elizabeth	1998
Patel	Jiten	2005		Taylor	Michael	2006
Pellow	Janice	2003		Teixeira	Noel Deon	2001
Pelser	Karin	2003		Thomson	Rowena Emmeline Kathryn	2003
Penny	Bronwen	2004		Torline	John Ross	2001
Penny	Ryan Hilton	1999		Traub	Gabrielle Amber	2000
Penny	Sean Ivan	1999		van de Veen	Robert John	2001
Piedallu	Sacha DM	2000		van Es	Sonia	1999
Pieterse	Carine	1999		van Meygaarden	Erica	2002
Pranglely	Adrian Bryan	2003		van Tonder	Jarne	2006
Pretorius	Nellie Elizabeth	2003		van Niekerk	Sonja	2002
Quaroni	Loretta	1999		Vermeulen	Adele	2004
Rautenbach	Hanli	1999		Vermeulen	Jacqueline	2001
Razlog	Radmila	2000		Vlachos	Dimitrios	2001
Redelinghuys	Arnike	2004		Vlok	Tania Ann	2000
Robinson	Denise	2001		Voshol	Maria Elizabeth	2006
Rohl	Angelika	2003		White	Sally	2005
Roohani	Joanne	1998		Wolf	Natascha Melanie	2000
Sabath	Leanne	2005		Woodcock	Gillian Elizabeth	1998
Saunders	Brenda	2004		York	Joanne	2005
Saunders	Claire	2002		Yutar	Graham Marc	2003
Scarcella	Daniela	1999		Zeiler	Cherene	2005
Schiefelbein	Babette	2003				

## APPENDIX H

Map of South Africa Showing Provinces

